In-Hospital Bereavement Services as an Act of Care and a Challenge

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In-hospital bereavement services as an act of care and a challenge: An integrative review

Context: Globally, people most often die within hospitals. As such, healthcare providers in hospitals are often confronted with dying persons and their bereaved relatives.

Objectives: To provide an overview of the current role hospitals take in providing bereavement care. Furthermore, we want to present an operational definition of bereavement care, the way it is currently implemented, relatives' satisfaction of receiving these services, and finally barriers and facilitators regarding the provision of bereavement care.

Methods: An integrative review was conducted by searching four electronic databases, from January 2011 to December 2020, resulting in 47 studies. Different study designs were included and results were reported in accordance with the theoretical framework of Whittemore and Knafl (2005).

Results: Only four articles defined bereavement care: two as services offered solely post loss and the other two as services offered pre and post loss. Although different bereavement services were delivered the time surrounding the death, the follow-up of bereaved relatives was less routinely offered. Relatives appreciated all bereavement services, which were rather informally and ad-hoc provided to them. Healthcare providers perceived bereavement care as important, but the provision was challenged by numerous factors (such as insufficient education and time).

Conclusion: Current in-hospital bereavement care can be seen as an act of care that is provided ad-hoc, resulting from the good-will of individual staff members. A tiered or stepped approach based on needs is preferred, as it allocates funds towards individuals-at-risk. Effective partnerships between hospitals and the community can be a useful, sustainable and cost-effective strategy.

Key message:

This article describes an integrative review, in which results indicate that bereavement services were focused on the time surrounding the death and were provided rather informally and ad-hoc. Staff acknowledged the importance, but were confined by numerous barriers. Collaborations with other actors are advocated, as supporting the bereaved is everyone's responsibility.

Key words

Bereavement, Community health services, Family caregivers, Hospitals, Review, Risk assessment

Running Title: In-hospital bereavement services as an act of care and a challenge: An integrative review

BACKGROUND

Bereavement care is covered in the World Health Organization's (WHO) definition of palliative care that states that "relatives should be accompanied and supported after the patient's death, if needed" [1]. Yet, a recent literature review by Hudson, et al. [2] showed that bereavement care is still insufficiently resourced, under-researched, and not implemented in a systematic way. Growing evidence advocates needs-based care and developing partnerships, as a blanket approach, wherein bereavement services are provided to all bereaved, is not only unnecessary but even potentially harmful [2, 3]. Furthermore, limited funding requires targeted interventions as post loss bereavement care becomes an unbillable service [2-4].

Although the numbers vary greatly worldwide, a study comparing 45 populations showed that on average 54% of all deaths occured in hospitals [5]. The loss of a loved one is a profound experience which can impact relatives' health, morbidity, and mortality, while offering bereavement support pre or post loss can potentially reduce these risks [6]. Most relatives are resilient enough to cope with the loss supported by their family, friends, and community. Yet, a significant minority, around 9.8% [7], of bereaved will experience grief reactions of such a long duration and in such a high intensity that they are incapacitating and impairing, risking chronic suffering and dysfunction [8]. This syndrome is referred to as prolonged grief disorder, and asks for specialised support. Despite hospitals not being the sole providers of bereavement care, the high number of in-hospital deaths presents them as important actors in this matter. Where people die is an important quality marker, as this is associated with quality of life and bereavement outcomes [9].

The primary aim of this review was to identify the role hospitals take in supporting bereaved adults after an in-hospital adult death. Previous reviews that deal with adult bereavement care, such as the review of Hudson, et al. [2]; Efstathiou, et al. [10]; Grant et al. [11] and Erikson and McAdam [12], were too specifically (e.g. ICU, tertiary hospital) or not solely located within a hospital setting (e.g; palliative care). Secondary aims were (i) to provide an operational definition of bereavement care, (ii) to present an overview of different in-hospital bereavement care services, (iii) to describe how in-hospital bereavement care is currently implemented, (iiii) to explore barriers or facilitators related to bereavement care in a hospital context, and (iv) to look into the levels of satisfaction with bereavement services reported by bereaved relatives. The review was located in western countries, however, studies from around the world were included.

METHODS

Integrative Review

An integrative review was chosen as it presents a summary of current literature and a comprehensive understanding of a particular phenomenon or healthcare problem, here the role of hospitals in providing bereavement care services [13]. It can provide an overview of the current state, quality, and possible gaps in research literature, show directions for future research, present theoretical or conceptual frameworks, pinpoint key issues, generate research questions, identify successful research methods, and build bridges between related areas of work [14]. This aim of an integrative review is in line with the proposed research questions of this paper.

Search Strategy

In December 2020, four electronic databases (PubMed, Embase, CINAHL, Web of Science) were searched using the search string from Table 1. The search terms were deliberately not used for narrowing down the type of article, setting or population, as it can accidently eliminate useful articles. CB and LVH manually selected the articles. Synonyms and modified versions of these terms were searched to best utilise each database/thesaurus. The MeSH or Entry-terms were used in combination with different key words. In addition, the reference lists of retained studies were hand searched by one author (CB) and yielded five new articles [15-19]. Different research designs and primary material were included to cover the broadest possible field of research. Only English articles were included. Finally, publications before January 2011 were not retained, as we wanted to include articles which cover in-hospital bereavement care of the last ten years to provide a recent overview.

Inclusion and Exclusion Criteria

We decided to include English articles which were reports of qualitative, quantitative and mixed methods original research studies related to multidisciplinary bereavement care concerning adult death in hospitals. We kept articles if they reported combined results from hospitals and non-hospital settings.

We excluded studies of bereavement care provided to populations exclusively outside of hospitals, to pediatric or neonatal patient groups, and to adult bereaved persons with intellectual disabilities, studies of non-bereavement support interventions in hospitals, studies on bereavement care after violent death (e.g. war, terrorism or suicide), studies on bereavement care after euthanasia or organ donation, reports published in non-peer reviewed journals, and commentaries, discussion papers, editorials, case studies, conference abstracts and books. Finally, we did not include articles that reported on how healthcare providers themselves dealt with the death of a patient, as the research aims only focus on relatives.

Study Selection and Data Extraction

The identified studies were entered into Endnote and duplicates were removed. Papers were double screened by two independent reviewers (CB en LVH) by title and abstract, supported by Rayyan [20]. This yielded a Cohen's kappa of .86 which indicates a strong level of agreement [21]. All potentially relevant studies were sought in full article format and again assessed by two independent reviewers (CB and LVH). If there was disagreement, discussion occurred until achievement of consensus. The PRISMA chart in Figure 1 provides an overview of the selection process [22]. Two evidence tables, Table 2 and supplemental material Table 3, were created by one author (CB) and then again discussed by two authors (CB and LVH) so a final decision could be made on the eligibility of each study. We excluded articles in the full text screening phase if they reported results which were not within the scope of interest, reported on invalid population or were not accessible. A third reviewer (LD) was consulted in case of unresolved disagreement. Strategies on how to analyse and synthesise data when using an integrative review are not well developed, however, Whittemore and Knafl [13] suggest the constant comparison method as one possible strategy. We used this strategy by extracting the data and individually comparing each item so similarities could be noticed, categorised and grouped together. We constantly compared the coded categories, which aided our analysis and synthesis process [13].

Quality Assessment

The quality of all studies was assessed using the Mixed Methods Appraisal Tool (MMAT) (version 2018), which consists of 17 questions and can be adapted depending on the research design [23]. The majority were qualitative and quantitative descriptive studies, with only one quantitative randomised controlled trial (RCT) and two quantitative non-randomised studies. We scored the overall majority of studies rather good on all criteria. Yet, sometimes information was missing or inadequately described. Study quality was assessed to appraise included studies but did not inform on inclusion or exclusion, because the authors of the MMAT tool usually refrain users of this tool to exclude studies with low methodological quality. We also want to provide a holistic overview of the literature, which is in line with the nature of an integrative review. More information on the quality of the articles can be consulted in the supplemental material Tables 4-8.

RESULTS

Characteristics of Included Studies

In total 1447 studies were identified, of which 755 duplicates were removed. After scanning the titles, abstracts and full texts, 47 studies were included: 16 were quantitative studies, 23 were qualitative studies, and eight were mixed-method studies.

Data was collected via interviews (*n*=16), focus groups (*n*=2), and surveys (*n*=22), a combination of surveys and interviews (*n*=4), a combination of interviews and focus groups (*n*=1), a randomised controlled trial (*n*=1), and an unspecified method (*n*=1). The majority of studies (*n*=18) were performed exclusively at an ICU setting. Only a few reported data exclusively at oncology units or centers (*n*=6), palliative care wards (*n*=4), emergency departments (*n*=2) or cancer centers (n=5). One study [24] recruited participants from acute and psychiatric hospitals, but most of the results were reported separately for each setting. Some articles did not specify which department of the hospital was included in the study (*n*=10) and others (*n*=4) [16, 25-27] were not limited to hospitals but included other settings (such as hospices, community services, etc.) and reported all results together. The data originated solely or partly from different continents, which can be found in Table 2 together with the (specified) countries, mostly from Europe (*n*=18), North-America (*n*=17), and to a lesser extent Oceania (*n*=6), Asia (*n*=4) and both Europe and Asia altogether (*n*=2). One study mentioned the inclusion of respectively 25 countries [16], but did not specify which countries. Furthermore, 20 studies were conducted through relatives' reports about their experiences, 22 studies were proxy reports by healthcare staff, particularly nurses, and five studies included the perspective of both. Finally, all included studies reported on bereavement service(s), most of them also reported on possible barriers or facilitators to offer bereavement care (37/47), and/or described the way in-hospital bereavement care was currently provided (35/47), and/or wrote about relatives' appreciation and effectiveness of bereavement care (32/47). More detailed information can be found in Table 3.

Definition of Bereavement Care

Only four of the 47 studies somewhat specified what was understood as bereavement care. A Scottish interview study defined bereavement care as being initiated when a person staying in the hospital was nearing the end of life after which the focus of care gradually shifted to the relatives. This could be sustained or ended after the person's death [27]. A Danish mixed-methods study categorised bereavement care into two timeframes: services provided close to the death of a loved one and follow-up offered at a later moment (weeks or months after the loss) [28]. A Japanese quantitative survey study understood bereavement follow-up as "direct or indirect care for bereaved relatives after bereavement, which includes a simple provision of interventions and is not necessarily designed as a prepared program with multiple interventions" [29]. An American survey study also defined bereavement care as activities post loss in which the physician kept contact with bereaved relatives [30].

The operational definition of bereavement care that is going to be used in this paper, is a combination of the foregoing definitions. We will define it as services that are not necessarily embedded in a systematic programme but are offered to relatives close to their loved one's death and/or some time afterwards. These services can help relatives prepare for their loved one's imminent death, and/or support them in coping with it afterwards.

Overview of Current In-Hospital Bereavement Care Practices

Current literature listed different in-hospital bereavement care services ranging in time from close to the person's death to follow-up services.

Bereavement Care Services Offered Close to the Death of the Patient

Most common bereavement care services close to the death of the person were: informing relatives of their loved one's (imminent) death [27, 31-35], facilitation of close contact between relatives and the dying person (e.g. relaxing visiting hours and offering private rooms or facilities to sit vigil) [15, 31, 33-39], time alone with the deceased (e.g. in the unit or hospital morgue) [15, 24, 28, 34-36, 40, 41], referrals to certain organisations or professionals [16, 24, 25, 28-30, 37, 40, 42-46], and giving information [15, 16, 19, 24-26, 28, 29, 31, 34, 36, 37, 39-42, 44-50].

Giving information concerned practical (e.g. funeral arrangements) [24, 26, 29, 31, 34, 36, 37, 39], psycho-educational (e.g. grief reactions) [16, 24, 29, 39, 42, 44, 46], or referral information (e.g. hospital- or community-based services) [24, 26, 29, 37, 39-41, 43].

Less frequent services close to death were: supporting (unit-based) farewell rituals [24, 33, 36], turning off medical equipment or hiding it when the person was dying [36, 44], offering a quiet room after death [37, 42, 44], arranging a visit from a chaplain before and/or at the time of death [36, 42, 44], offering emotional support to relatives close to or after the time of death [31, 33, 51], placing a symbol (e.g. stone or candle) to alert busy staff to lower their voice or slow down [36], giving contact details [27, 34, 46, 52], preparing the body (such as removal of invasive lines and machinery) before relatives were offered to view the deceased [33, 34, 36, 44], and handing over keepsakes [43, 44, 47, 53], personal belongings [28, 35] or an ICU diary of the person [28, 38, 54]. Next to these services offered directly to relatives, an English interview study of ICU nurses, showed that 77% of them systematically informed the deceased person's general practitioner, but only occasionally the relatives' one [37].

Bereavement Follow-up Services

Variability was noticeable in the services offered by hospital staff weeks to months after the person's death. Frequently mentioned services were: follow-up phone calls [16, 19, 24, 25, 28-

30, 38-43, 45, 47, 50, 52, 55-62], condolence cards or letters [16, 18, 19, 24, 28, 30, 32, 36, 40-42, 44, 46, 47, 49, 50, 52, 55-65], return visits or meetings [17, 29, 38, 40, 41, 44, 46, 49, 51, 52, 55, 56, 66], and memorial services [16, 19, 24-26, 28, 29, 32, 39, 42, 44-47, 50, 59-63].

Less common reported services were: individual, family, or group counselling [16, 24, 41, 42, 45, 47, 50, 60], support groups [16, 26, 40, 42, 46, 59], grief seminars or education sessions [16, 42, 46], (one-year) anniversary cards [16, 44], screening for prolonged grief disorder (with or without formal risk assessment tools) [24-26, 46, 50, 66], staff attendance at bereavement rituals (e.g. funerals) [16, 30, 51, 56, 58, 60-62], support from volunteers [16, 33], and home visits [16, 25, 50, 57, 58, 60]. A great variability existed in the usage of post loss risk assessment, going from 3.6% of the Swiss palliative care wards [24], over 66.3% of the American ICUs [50] to 91 % of the Australian palliative care services [26]. The former study indicated that screening was generally based on multidisciplinary team opinion (63%), single staff members opinion (49%), or a formal risk assessment tool (43%) [26].

Description of In-Hospital Bereavement Care Implementation

Different studies pointed out inconsistencies regarding timing, involved professions, target group, and evaluation. This resulted from missing or poorly known hospital policies or (national) guidelines, which led to a rather informal and ad-hoc provided bereavement care [16, 24, 27, 37, 38, 40, 50, 51, 55, 56, 61]. A national audit by Berry et al. (2017) showed that only 45% of the English ICU's had written policies regarding bereavement care.

Timing

Most bereavement care was concentrated around the time of death, which was illustrated by three survey studies where at least 80% of healthcare providers reported doing this [28, 51, 66]. Different interview studies in the United Kingdom reported that the contact between staff and relatives often ended the moment they left the hospital [27, 34].

Bereavement follow-up seemed to be less established and often done in a scarce and informal way [24, 27, 34, 37, 50, 60]. While only 31.9% of the ICUs in Australia and New Zealand [41] and 37.6 % of American ICUs [50] offered bereavement follow-up, 76.7% of the Swedish ICUs offered some kind of bereavement follow-up. Yet, it was no routine care: almost half of the time (45.2%) this was done in specific circumstances (such as sudden or unexpected death, lengthy ICU stay or from a relatives' request) [38].

Variation was noticed regarding the exact timing of bereavement follow-up: going from a few days [41, 51, 55], weeks [28, 40, 41, 46, 50-52, 55, 58, 59, 65] or months [28, 38, 40, 50, 52] post loss, to annual services [41, 52, 62, 63]. Relatives declared in an American study by

Downar and colleagues (2014) that they preferably received support less than six months after the loss of their loved one.

Involved professions

The majority of studies mentioned nurses as being (primarly) responsible for bereavement care [16, 24, 26, 28, 29, 31, 40, 45, 50-52, 56, 57, 60]. Other staff members were less frequently mentioned as being involved, such as physicians [16, 24, 29, 31, 40, 50-52, 56, 57, 60], social workers [15, 16, 26, 31, 41, 45, 51, 57, 60], pastoral care workers [15, 16, 26, 31, 45, 51, 52], bereavement coordinators [26, 45, 50], administrative staff [28, 40], psychologists [16, 26, 41], or trained volunteers [16, 26, 50, 59]. Some studies reported community services (e.g. general practitioner) as main actors in providing bereavement care [27, 41, 55]. A quantitative study of Guldin, et al. [16] showed that the use of trained volunteers was rather scarce (23%) compared to nurses (60%) or physicians (45%). Two studies were inconsistent on the fact that physicians thought the contact with bereaved families fell within their job descripton or not [24, 57]. A recent study by Naef and colleagues (2020) showed that physicians rather than nurses screen for prolonged grief disorder. One European mixed-methods study conducted in 18 countries showed that specific staff members were allocated to this task and received one to two hours a week to offer bereavement care [28].

Target group

An Australian interview study showed that it was advised to offer needs-based support due to limited funds [25]. An American survey study reported only 36% of the ICUs had money designated for bereavement follow-up. However, not all staff was convinced that limited funds should be allocated to individuals-at-risk, as they wanted to offer services to all bereaved [50]. An Australian study showed that a vast majority (82%) of staff working in palliative care services offered support to all bereaved, 39%-43% offered support to groups-at-risk, and finally 34%-42% to self-referred relatives [26]. Bereavement screening can help staff to target those in need [16], nonetheless, a study by Downar, et al. [32] showed that only half of the participants with prolonged grief disorder received formal support.

Evaluation

A number of studies indicated that in-hospital bereavement care was rarely formally evaluated and assessed [28, 34, 40, 41, 50]. If it did happen, it was often in a non-formal way and by means of staff or family interviews or surveys [40, 41, 50]. The survey study of McAdam and Erikson [50] showed that only a minority of American hospital wards evaluated their services by means of family (33.7%) or staff feedback (28.1%), and about a quarter did not use any evaluation at all. Moreover, a European survey study reported that only 1% of the ICUs actually made a change to their services after evaluation [28].

Relatives’ Perspective on Currently Provided In-Hospital Bereavement Care and Effectiveness of Bereavement Care Services or Programmes

In general relatives appreciated all the services but some services were perceived as more valuable than others. A study by Stephen and colleagues (2017) also showed that relatives found offered bereavement care services only helpful if they knew the healthcare provider that reached out to them, and if this person took care of the patient in his/her last days. Relatives found that contact reflected caring and they felt an individual rather than a number [18, 67].

Bereavement Care Services Offered Close to the Death of the Person

Interaction with relatives

Relatives wanted to be informed of their loved one’s imminent death in a sensitive way [31], and hereafter be notified on next steps. One study showed that relatives demanded additional information because it reassured them, helped them to manage expectations, and supported their coping strategies [32]. Brochures could also be accessed when needed and even shared with other relatives [47]. A survey study by Ito and colleagues (2020) showed that relatives wanted to receive information regarding required procedures post loss (86.2%), services available within the community (75.2%), but also about grief and loss (66.2%). Finally, emotional support close to or after the death of a loved one was appreciated [31, 51, 68]. Nonetheless, a mixed-methods study reported that only a minority of relatives (16.5%) found speaking with a healthcare provider around their loved one’s death helpful, and even 53% did not want to talk about it with staff. Some relatives (28.6%) stated that they were not approached, but would have liked to have a conversation about this with a healthcare provider [31].

Death-related rituals

One qualitative study by Coombs, et al. [44] in Australia and New Zealand found that death-related rituals, such as being present when their loved one is dying, preparing the body or removing technical and medical equipment by healthcare providers, helped relatives realise the person was transitioning from being alive to deceased. Also two studies showed relatives’ wishes to receive adequate facilities and privacy to optimally say goodbye to their loved one [31, 37]. Moreover, English nurses said that 27% of the relatives found the provided facilities neither comfortable, nor respecting their privacy enough [37].

Bereavement Follow-up Services

Relatives reported in one qualitative study of Downar, et al. [32] that routine follow-up was not perceived as necessary, only when their symptoms worsened or when asked for it by themselves. An interview study done in Canada of relatives' opinions regarding bereavement contact from healthcare staff showed that, on the one hand relatives who were contacted by staff found it reflected carefullness, offered support and facilitated closure. On the other hand, those who were not contacted found it acceptable because they perceived contact by healthcare providers as a courtesy or sometimes as unnecessary. If they needed bereavement care, they contacted healthcare providers themselves [60].

Condolence letter or sympathy card

Relatives appreciated receiving a condolence letter or card that was written and/or signed by staff who cared for their loved one, as they felt recognised and perceived it as a 'symbol of care' [46, 47, 63, 64]. Nonetheless, a study by Erikson and colleagues (2019) showed that most relatives did not find the letter was necessary or comforting. Relatives reported mixed feelings in reaction to receiving a letter [46, 69] and the overall helpfulness was rated neutral in the study of Erikson et al. (2019). Moreover, a French randomised controlled trial study by Kentish-Barnes, et al. [65] showed that after receiving a condolence card relatives' grief symptoms were not alleviated two weeks post loss and at six months there was even a significant increase of developing depression and PTSD symptoms. An additional qualitative study reported that 80% of the relatives felt supported by the letter, but 30% was also surprised and thought the physician was dissatisfied with the provided care or hid something. Only 40% replied because they were afraid to bother staff or because they felt socially obliged. If relatives wished to arrange a meeting with healthcare providers and this request was not granted or ignored, despite the explicit invitation, this resulted in relatives feeling really upset, angry, and questioning the sincerity of the received letter and physician [64].

Follow-up phone call or visit

A follow-up phone call or visit was found helpful by several studies, especially for relatives with lingering questions regarding the person's illness trajectory or death [17, 28, 39, 40, 49, 52, 55, 56]. A study showed that relatives preferred that the healthcare provider that reached out to them was a familiar face or present at their loved one's death [47]. The opportunity to ask questions or visit the place where their loved one died, provided closure and the opportunity to thank staff [28, 40, 56] . A programme evaluation by Kock, et al. [17] regarding follow-up visits in a Swedish ICU showed that, next to the illness trajectory, relatives wanted to talk about feelings of guilt (43%), their grieving process (39%), or their current feelings (37%). Some relatives wanted to be reassured that their loved one's death was unavoidable and that could not have prevented it [17, 28, 49].

Commemorative events or keepsakes

One interview study conducted in an American ICU reported that relatives' reactions towards memorial services or keepsakes, provided by hospitals, were mixed. Most of the time relatives already organised a personalised funeral or ceremony [47]. However, one Japanese study reported positive reactions from relatives regarding commemorative services as they saw it as an opportunity to thank (48%) or talk (38%) to staff, visit the hospital again (38%), or share memories of the deceased (33%). Next, most relatives already had a keepsake, as they were already keeping objects of their loved ones, thus, serving a similar purpose [47]. A Canadian interview study by Neville, et al. [53] showed that keepsakes created with the help of staff were found extremely/very helpful by the majority of relatives (61%). Keepsakes were perceived as valuable and meaningful items that represented the transitional process from being alive to deceased, and immortalised memories. The process of creating a keepsake was experienced to be equally important as receiving one.

ICU diary

An ICU diary was found to be a useful source of information by two studies because it could counter uncertainties, as it can provide rational and emotional understanding [28, 54].

Possible Barriers and Facilitators in providing/accessing In-Hospital Bereavement Care

The studies indicated different barriers and facilitators to in-hospital bereavement care. Healthcare providers' lack of education on grief (20/47) and dedicated time for bereavement care (17/47) were most often cited as possible barriers or facilitators. Less frequently reported barriers or facilitators were: an established relationship between healthcare providers and relatives (13/47), staff's attitudes regarding bereavement care (12/47), emotional demand on staff (11/47), staff's awareness of guidelines and policy (8/47), available support and partnerships to refer to (7/47), in-hospital facilities and privacy (6/47), relatives' socio-cultural constructions regarding grief (5/47), funding (5/47), relatives' contact information (5/47), cost-effectiveness of bereavement care services (4/47), and availability of validated risk assessment tools (3/47).

A lack of education was the number one reported barrier [15, 24, 25, 29, 30, 33-36, 43, 44, 50, 51, 57-59, 61, 66, 68]. Healthcare providers did not receive sufficient training and education regarding bereavement care, which impacted their confidence and resulted in them not knowing what to say and how to deal with emotions [24, 30, 50, 66]. A European study reported that educational support to staff was variable, as some ICUs offered this to all staff, while others only to a few (such as social workers, medical staff, and bereavement coordinators) [16]. A Canadian mixed-methods study by Kalocsai, et al. [51] showed that 82% of ICU nurses and physicians reported an interest in receiving formal training on bereavement care provision.

Two qualitative studies mentioned peer-mentoring and role-modelling as promising avenues to achieve this [15, 34].

The second most mentioned barrier was a lack of time [15, 24-26, 29, 30, 34, 44, 46, 50, 51, 55-58, 68]. Staff reported that bereavement care was time-consuming, and complicated by the heavy workload already experienced [15, 34, 68]. Moreover, an Australian mixed-methods study by Kobel, et al. [26] reported that bereavement care was not recognised within the existing activity-based funding models. English nurses mentioned they had to deal with the 'dilemma of divided attention', where they simultaneously had to care for relatives of a dying/deceased person and other patients of the hospital ward [34].

DISCUSSION

Our integrative review presents an overview of the current role hospitals take in providing bereavement care. Alongside this, we reported an operational definition of bereavement care, the way it is currently implemented, barriers and facilitators healthcare providers are confronted with, and finally relatives' satisfaction regarding these services. These findings are unique as previous reviews [2, 10-12], as mentioned earlier, did not focus on a hospital-wide approach to bereavement care. These reviews showed that bereavement care was provided in a nonsystematic way, and that education, training, follow-up and evidence-based decisions were lacking. Our paper substantiates these findings in another population. In sum, bereavement care can be regarded as an act of care that is provided ad-hoc and resulting from good-will of individual staff members.

The fact that only four articles defined bereavement care and that they focus bereavement care on diverse points of time (pre or/and post loss), denotes a lack of conceptual clarity and uniformity. This is an important finding, as uncertainty about what should be categorised as bereavement care has far-reaching implications on research and clinical practice. When bereavement care is perceived as services limited to the period post loss, services that could be offered to relatives pre loss to prepare them for the imminent death of their loved one are missed. The lack of clarity and uniformity is also apparent in the variation that exists in the way in-hospital bereavement care is currently organised. Bereavement care was rather sporadically provided, mostly by nurses, and mainly concentrated around the time of death, while follow-up was less common. Healthcare providers often did not receive protected time to take up bereavement care and services were mostly created bottom-up, despite existing guidelines and recommendations [2, 12, 70-76]. A European study showed that only 36% of the participants stated that national guidelines exist, 40% was not even aware of guidelines, and only 33% based their bereavement services on these guidelines [20]. Furthermore, the explicit use of risk assessment tools to identify groups-at-risk varied largely between studies, despite recent guidelines [70]. Finally, formal evaluation of bereavement care services by means of relatives or staff feedback was scarce. One study even showed that changing the way of working based on this feedback was almost non-existent, as only 1% of the ICUs did this [28].

Our findings coincide with previous research on a tiered or stepped approach, which promotes that all bereaved relatives should have access to a certain form of bereavement support, and that more intensive, professional care is reserved for groups-at-risk [3, 77]. Currently, however, not all relatives in need of extra support were reached after an in-hospital death, leaving them unattended and at risk for developing psycho-social difficulties [50]. The tiered or stepped approach advocates that it is crucial to prevent, identify and adequately target groups-at-risk early-on and to bereavement care services, as they will benefit the most but are not prone to seek support themselves [2, 16, 45, 60]. A study by Lichtenthal, et al. [78] showed that bereaved caregivers with prolonged grief disorder, although significantly associated with suicidality and poorer health-related quality of life, underutilised mental health services.To succeed in adequately allocating bereaved within this approach (basic care for all versus intensified bereavement care for few), healthcare providers should receive sufficient education, be aware of community resources, and be knowledgeable about risk assessment tools. Yet, confusion exists regarding the content and usage of the different concepts referring to pathologic grief, due to changes over the last years. A lack of uniformity regarding the diagnostic criteria and prevalence of groups-at-risk, endangers the implementation of a tiered- or stepped approach, because the different levels and corresponding access of this model is based on the identified risk of a pathologic grief process. Recent studies on bereavement care guidelines advocated using risk assessment tools to identify those in need and tailor follow-up bereavement [2, 12]. Our review showed that a routine screening by healthcare providers of relatives at risk (pre loss or six months post loss) of developing prolonged grief disorder was not performed due to several reasons, such as reluctance to ask certain questions, inability to use these tools (and a lack of tested and validated risk assessment tools), finding it unacceptable to target certain groups when providing bereavement care [2, 16, 79]. The latter stemmed from a misunderstanding that support is always needed when in contact with (nearly or recently) bereaved relatives [80]. When support is offered to bereaved persons, one should always keep in mind that grief is not to be pathologised, as most relatives can cope on their own without professional help, and inappropriate referrals can worsen bereavement outcomes [3]. Nonetheless, as the tiered approach points out not all social networks are supportive, as such healthcare providers should keep this in mind and check this with relatives.

Furthermore, in-hospital staff may generally have shorter contacts with relatives than community-based caregivers, such as a general practitioner (GP) [79]. Therefore, hospitals should rather focus on the provision (pre loss) general bereavement support, while community services can provide more specific (follow-up) services. However, one of the included studies showed that the relatives' general practitioner was rarely informed of the person's death [37]. Better partnerships and mapping of referral pathways between informal and formal care is indicated as this can strengthen a whole-community approach ('compassionate communities') to loss and is in line with relatives' preference for informal support [81]. It can be valuable to connect bereaved with each other, as bereaved individuals desire someone who understands what they are going through. Supporting others with similar loss experiences could also help the meaning-making process [16, 45, 82]. This illustrates that caring for and supporting the bereaved is not only a task reserved for hospitals, but everyone's responsibility [77].

In conclusion, our findings show how hospitals currently provide bereavement care, but at the same time question the extent of responsibility they should carry towards (nearly) bereaved. Bereavement care is defined as services offered pre and post loss, aimed at preparing relatives for their loved one's imminent death, and/or to support them in coping with it afterwards. A blanket approach of formalised bereavement services to all bereaved should be avoided, as it is not only ineffective but also potentially harmful [2, 3]. The tiered approach seems promising in guiding healthcare providers in implementing effective bereavement care services to those in need. While hospitals should offer general support to all bereaved (such as providing time alone with the deceased, adequate facilities or a follow-up contact). Strong referral pathways to community services should support bereaved with more intensive and specific needs (e.g. grief therapies), as hospitals are not the sole providers. This is consistent with hospitals not perceiving (bereaved) relatives as 'clients' and the mutual understanding that contact ends when relatives depart from the hospital [27, 34]. However, if hospitals do provide follow-up bereavement care, a study by Kentish-Barnes, et al. [64] showed that it is important to inform relatives beforehand as participants were surprised, some even suspicious, and others felt socially obliged to answer the received letter of condolence. Moreover, if hospitals promise any further follow-up contact, this should be done as it can otherwise evoke feelings of anger or relatives being upset [64].This should be avoided as it can worsen relatives' grief reactions, impact the hospital's reputation and may even lead to lawsuits [46, 64]. As such, targeted interventions can support needs and at the same time be cost-effective, sustainable and in line with recent palliative care guidelines [3, 50]. Yet, as our review underlines capacity building and improving connections with services outside the hospital setting are venues to make this happen.

STRENGHTS AND LIMITATIONS

We performed an explicit, comprehensive search strategy by two independent reviewers, covering four databases and the reference lists of the included studies. Even though we performed a sensitive search with broadly defined search criteria, it is possible that we have missed relevant articles. While we made a considerable effort to employ a transparent and systematic procedure using the methodology of Whittemore and Knafl [13], our personal assumptions and theoretical preunderstandings will inevitably have influenced the synthesis of results, and coloured or given blind spots to some findings. We broadly formulated the search strategy, but only included primary sources. We want to describe current in-hospital bereavement care and identify gaps or limitations in recently published articles to formulate recommendations for further research, as this is one of the aims of conducting an integrative review. Another limitation is that we only identified English studies, so this were mostly Western countries or countries with Western values, which leads to limited cultural and ethnographic diversity when presenting an overview.

IMPLICATIONS FOR FURTHER RESEARCH

First, most of the included studies recruited participants through ICUs, a very specific setting, because deaths are frequent, often unexpected, rapid and/or traumatic [44, 83], as such future studies should also include other departements (such as general wards). Second, the current lack of formal evaluation, longitudinal designs and randomised controlled trials, prevent identifying the most effective bereavement care services over time. Clinicians and policy makers should be informed of the merits or disadvantages of certain bereavement services so they can make evidence-based and cost-effective decisions [41]. Third, as the rationale for trained volunteers is not very strong at the moment, further research should explore to which extent they can be implemented within a hospital setting to support staff in caring for the (nearly) bereaved. Fourth, an insight into the concrete expectations of relatives towards in-hospital bereavement care instead of proxy reports could be helpful. Fifth, the definition of bereavement care should be further clarified. Finally, further validation of in-hospital risk assessment tools is needed, as recent studies advocate targeting individuals-at-risk [2, 12, 79].

IMPLICATIONS FOR PRACTICE

To support healthcare providers in taking up bereavement care, the following recommendations can be made: protected time for bereavement care services [56, 59], and better collaboration between hospitals, primary care, palliative care services, and community services [25]. The shared responsibility of formal and informal providers to care for bereaved relatives should be further explored, as this could be a useful, sustainable, and cost-effective approach [3, 77]. Moreover, formal training [51], peer mentoring and role-modelling [15, 34] could help staff feel skilled or confident enough to deal with (nearly) bereaved relatives.

Moreover, staff should be made aware of existing guidelines, and barriers to implementing these should be further investigated. Finally, bereavement screening should lead to concrete actions, as Downar, et al. [32] showed that only half of the participants identified with prolonged grief disorder received formal support.

CONCLUSION

A small amount of research has been directed towards in-hospital bereavement care, and even less to non-ICU settings. Bereavement care was often not based on (national) guidelines, not at all systematically applied or formally evaluated, and challenged by numerous factors. Nonetheless, most hospital staff acknowledged the importance of support to (nearly) bereaved relatives and provided some bereavement care services as an act of care, resulting from good-will. Healthcare providers struggled with insufficient education and time, in which the latter stems from viewing bereavement care as an unbillable service. Staff can be supported by providing education, role-modelling, peer-mentoring, protected time, and collaboration with other actors, as hospitals are not the sole providers of bereavement care. The various limitations and gaps identified through this literature review indicate a need for more in-depth research for a further standardisation of the definition of bereavement care, validation of risk assessment tools, inclusion of non-ICU settings, and research designs that allow to make evidence-based decisions.

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CONFLICT OF INTEREST

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Figure 1: PRISMA chart

No colors needed

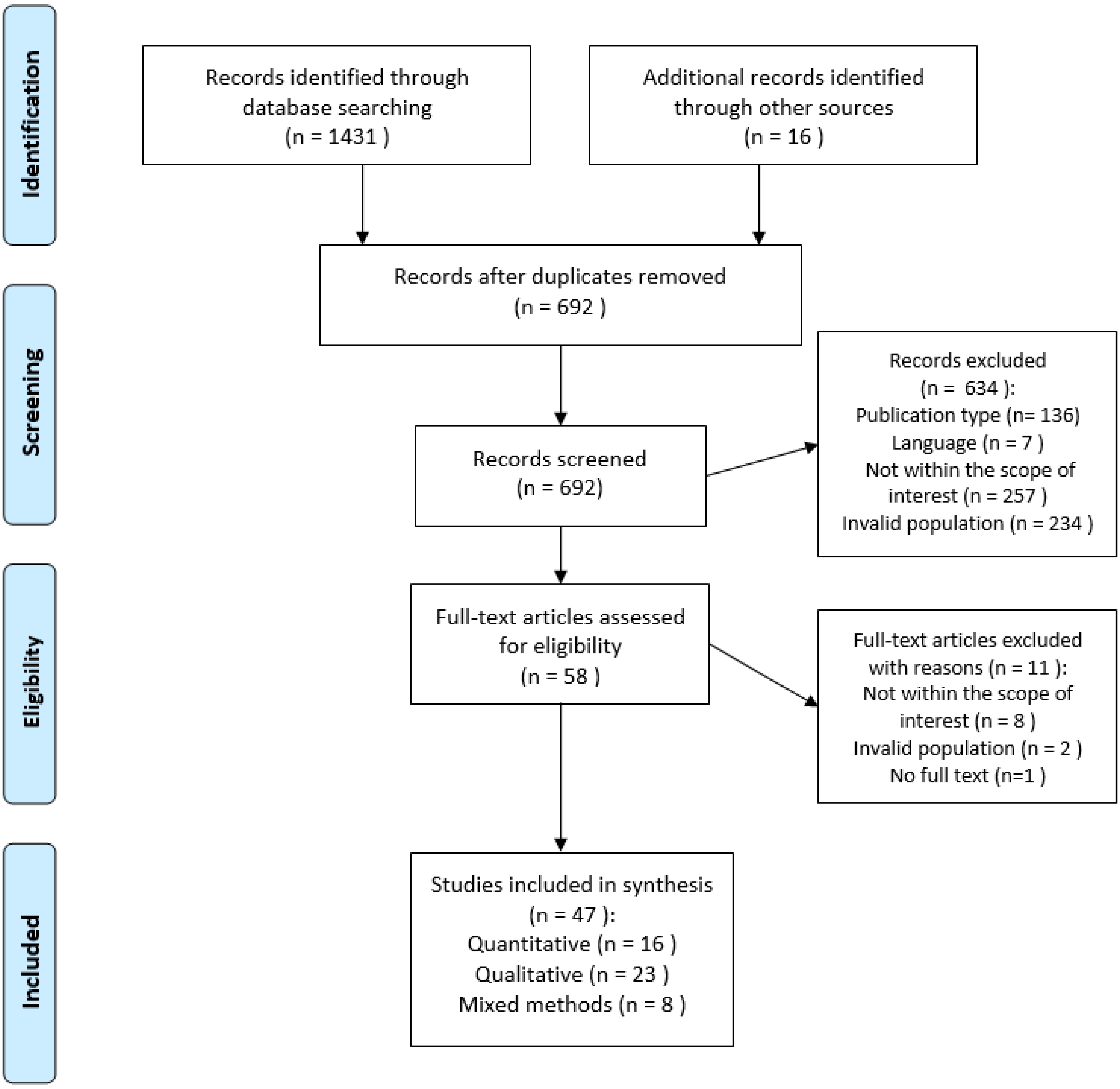

Table 1: Search strategy

Search string
(“bereavement care” OR “bereavement support” OR “bereavement practices” OR “bereavement services”) AND (“support” OR “care” OR intervention” OR “practice” OR “service” OR program*”) AND (“family” OR “bereaved” OR “loved ones” OR “relatives”) AND (“bereavement” OR “grief” OR “loss” OR “mourning”).
The Boolean operator “NOT’ was used for excluding (“minors” OR “children” OR “adolescents” OR “youth”) AND (“perinatal loss” OR “stillbirth” OR “perinatal death” OR “miscarriage” OR “abortion) AND (“child death” OR “child loss”

Table 2: Brief summary of the selected articles (*N*=47)

	First Author, Year of Publication	Continent	Method	Aim	Setting	Sample	Response Rate (RR)	Data collection
1	Banyasz et al., 2017	North-America - USA	Quantitative - Survey - Descriptive statistics and correlation analysis	To explore the bereavement service preferences of bereaved relatives whose loved one died in the hospital and identify group differences in service use among individuals with and without depression and complicated grief (CG)[1], considering time since the patient's death.	One Medical center and one level 1 trauma center	Relatives (n=162)	RR not reported	Survey study: Self-reported (mail, phone, in-person), three to 18 months after the patient's death, CES-D[2], ICG-R[3] and self-developed questionnaire
2	Beiermann et al., 2017	North-America - USA	Quantitative – Survey – Descriptive statistics	1) To study the bereavement experience of families in the ICU. 2) to measure nurses' perception of end-of-life care 3) evaluate the impact of ECG memento[4] by families and nurses	ICU and intermediate cardiac care unit	Patient/family dyads (n=50)	RR not reported	Survey study: Family: SBEQ[5],self-reported Nurses: QODD-ICU[6] with additional question about ECG Memento, proxy report
3	Benbenishty et al., 2018	Europe and Asia 14 countries in Europe : Belgium (n=1), France (n=1), Finland (n=1), Germany (n=2), Greece (n=1), Iceland (n=1), Italy (n=1), Netherlands (n=1), Norway (n=1), Slovenia (n=1), Spain (n=1), Sweden (n=2), Switzerland (n=4) England (n=1) **2 countries in Asia:** Israel (n=3) Palestine (n=1)	Qualitative – Interview - Thematic analysis	To explore European and Middle Eastern intensive care nursing ceremonies and rituals surrounding care provided to patients after death.	Intensive care units (number not reported)	Nurses (n=23)	RR not reported	Interview study: Single time, in-depth, face-to face at (inter)national conferences, workshops, meetings, and seminars

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[1] Important remark: We only use the term 'prolonged grief disorder (PGD)' in our main text, but other concepts for pathologic grief are also used in Table 2. This is because we want to present the results, but also the conceptualisations, as literally as possible. Thus, each row contains the concepts that were mentioned in the specific article. We understand this may cause confusion as both concepts are not identical. We decided to use the concept 'prolonged grief disorder' in the main text because it is more validated, sensitive and predictive. For more information, we want to redirect you to the following article: Maciejewski, P.K., Maercker, A., Boelen, P.A. and Prigerson, H.G. (2016), "Prolonged grief disorder" and "persistent complex bereavement disorder", but not "complicated grief", are one and the same diagnostic entity: an analysis of data from the Yale Bereavement Study. World Psychiatry, 15: 266-275.

[2] Center for Epidemiologic Studies Depression Scale (CES-D)

[3] Inventory of Complicated Grief-Revised

[4] Tangible item from the patient's heart rhythm strip which included a signed sentiment card

[5] Satisfaction With Bereavement Experience Questionnaire (SBEQ)

[6] Quality of Dying and Death in the Intensive Care Unit (QODD-ICU)

	First Author, Year of Publication	Continent + countries	Method	Aim	Setting	Sample	Response Rate (RR)	Data collection
4	Berry et al., 2017	Europe - England	Qualitative – Interview and survey – Analysis not specified	A national audit to compare bereavement services in England against the nine recommendations set out by the Intensive Care Society guidelines.	113 ICUs	Nurses (n=113)	RR=63%	Interview study: Anonymous, nationwide, telephone Survey study: Self-developed questionnaire (with free text response)
5	Bloomer et al., 2013	Oceania - Australia	Qualitative – Focus groups – Content analysis	1)To describe the way nurses working in ICU care for relatives through the patient's dying phase and after death. 2) To explore the nurses' perspectives on their preparedness and ability to provide this care to the family. 3) Identify organisational processes and environmental factors that may exist in the ICU, that either facilitate or limit nursing care.	Two ICUs from two hospitals	Nurses (number not reported)	RR not reported	Focus group study Two focus groups
6	Breen et al., 2013	Oceania - Australia	Qualitative – Interviews – Constant comparison analysis	To explore HCPs experiences who provide grief support for people with cancer and their families in rural, regional and remote areas in Western Australia.	Health care settings (n=10): Hospitals (n=5) Hospices (n=3) Community organisations (n=2) Private practice (n=1)	Health care providers (HCP) (n=11)	RR not reported	Interview study: Semi-structured, single time, online
7	Chan et al., 2013	Asia - China	Qualitative – Interview- Content analysis	To explore the perceptions and experiences of bereavement care among nurses and bereaved relatives.	One oncology unit	Nurses (n=15) Relatives (n=10)	RR not reported	Interview study: Semi-structured, single time, face-to-face, six weeks post loss.
8	Coimin et al., 2019	Europe - Ireland	Mixed methods – Survey – Descriptive statistics, correlational- and thematic analysis	1)To ascertain the quality of end-of-life care in the acute hospital setting from the perspective of bereaved relatives and friends. 2) To identify aspects of satisfactory EOLC and highlight areas where improvements could be made.	Two hospitals	Relatives (n=322) or friends (n=28)	RR= 46%	Survey study: Pen-and-paper, VOICES[7] MaJam (close and open-ended questions)

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[7] Views of Informal Carers - Evaluation of Services

	First Author, Year of Publication	Country	Method	Aim	Setting	Sample	Response Rate (RR)	Data collection
9	Coombs et al., 2017	Oceania - Australia and New Zealand	Qualitative – Survey – Content analysis	To describe the type of bereavement care provided in intensive care units across Australia and New Zealand and the challenges experienced.	ICUs (n=68): Adult (n=37) Pediatric (n=3) Neonatal (n=23) Mixed (n=4)	Nursing managers (n=68)	RR =67%	Survey study: Pen-and-paper and online, self-developed questionnaire (only analysed free text response)
10	Cooper et al., 2019	North-America - USA	Qualitative - Intervention study – Analysis not specified	1) To evaluate the Emergency Department's (ED) Grief Support program 2) To provide ongoing bereavement follow-up to families who were thought to be most at risk for CG.	Three ED within two hospitals	Primary contact person (n=192)	RR not reported	Interview study: Telephone, multiple times
11	Downar, et al., 2014	North-America - Canada	Quantitative – Survey – Descriptive statistics	To determine the desirability and need for an ICU-based bereavement screening and support program for bereaved relatives.	Two ICUs within two Hospital	Relatives (n=32) HCP (n=57): Physicians (n=10) Nurses (n=47)	Relatives RR= 15% Medical staff RR=61%	Survey study: Telephone (relatives) and mail (HCP), ICG-R, SDI[8], self-developed questionnaire, mean of 7.4 months post loss
12	Downar et al., 2020	North-America – Canada	Qualitative – Survey and interview – Thematic analysis	To examine how relatives experience grief, particularly CG, to inform future early screening and support programs in the ICU.	1) First phase: ICUs at nine sites 2)Second phase: ICUs at five sites	Relatives (n=8) 1) Completed the survey (n=105) 2) Interviewed at three months post loss (n=37). 3) Eight participants having an ICG score > 25 at six months post loss. 4) Four participants completed a second interview six months post loss.	RR=34%	Two-phase sequential design Survey study: Surveys completed by relatives and ICU staff (ICG[9]) at three and six months post loss to identify those with symptoms of CG and willing to participate in the qualitative phase. Interview study: Semi-structured interviews with relatives who had an ICG score > 25, six months post loss.

	First Author, Year of Publication	Country	Method	Aim	Setting	Sample	Response Rate (RR)	Data collection
13	Egerod et al., 2018	Europe - Denmark	Mixed methods – Survey – Descriptive statistics	To investigate the provision of bereavement care and follow-up services for bereaved families in Danish ICUs.	46 ICUs from 46 hospitals	Nurses (n=46): ICU nurse manager (n=61) Clinical nurse specialist (n=3) Other (n=13)	RR= 96%	Survey study : Email and nationwide, self-developed questionnaire (with free text response)
14	Egerod, et al., 2019	Europe - 17 countries: Austria, Belgium, Croatia, Denmark, England, Estonia, Finland, France, Germany, Iceland, Ireland, Italy, Northern Ireland, the Netherlands, Norway, Spain, Sweden. Asia - 1 country : Israel	Mixed methods – Survey – Descriptive statistics and narrative reporting	To explore the elements, organisation, and evaluation of ICU bereavement services in European countries (or with European values).	46 ICUs within 29 hospitals	Nurses (n=85):	First phase RR = 34%	Survey study Paper-and-pen, nationwide, self-developed questionnaire (with free text response)
15	Erikson et al., 2019	North-America – USA	Qualitative – Interview – Qualitative descriptive technique	To describe cardiac ICU patients' and families' opinions on six common components of a bereavement programme.	One ICU within one hospital	Relatives (n=12)	RR = 11%	Interview study: Semi-structured, single time, phone interviews, 13-15 months post loss
16	Ford et al., 2013	Europe - England	Qualitative - Intervention study – Analysis not specified	To explore if a new initiative that limitedly engages in the early stages of grief might impact relatives significantly, and if this benefits the relatives, but also the hospital and wider community.	One hospital	Relatives (n=752)	RR not reported	Not specified

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[8] Social Difficulties Inventory

[9] Inventory of Complicated Grief

	First Author, Year of Publication	Country	Method	Aim	Setting	Sample	Response Rate (RR)	Data collection
17	Fridh et al., 2020	Europe - Sweden	Quantitative – Survey – Descriptive statistics and correlation analysis	To investigate family-centered end-of-life care with support for the family during and after the death is supposed to prevent suffering and avoid illness.	73 ICUs	Unit leaders of all adult ICUs or a staff member taking up ICU follow-up or bereavement care (n=81)	RR= 90%	Survey study Self-developed questionnaire
18	Goebel et al., 2017	Europe - Germany	Mixed methods – Intervention study – Descriptive statistics	To inquire relatives' reactions and opinions on receiving a bereavement anniversary card.	One palliative care ward	Relatives: Survey (n=24) Interview (n=6)	Survey study RR = 35%	Survey study: Self-developed questionnaire (with free text response), one year post loss Interview study: Subsequent telephone interview, one year post loss.
19	Granek et al., 2013	North-America-Canada	Qualitative – Interview –Constant comparative analysis	To identify what protocol (if any) exists on dealing with patient loss in hospital settings.	three oncology centers	Oncologists (n=20)	RR not reported	Interview study: Semi-structured, single time, face-to-face
20	Granot et al., 2016	Asia - Israel	Quantitative – Survey – Descriptive statistics and correlational analysis	1) To evaluate the importance attributed to reaching out to bereaved relatives by various oncology staff. 2) To explore whether staff consider this outreach to be within their professional duties 3) To characterize the communication patterns between staff and bereaved. 4) To identify factors preventing them from contacting relatives.	One hospital	Oncology staff (n=107): Physicians (n=37), nurses (n=46), psychologists (n=4), and social workers (n=18), and unspecified (n=9)	RR: 69%	Survey study: Self-developed questionnaire (FACPQ[10]) with free text response
21	Guldin et al., 2015	Europe - 25 countries (not specified)	Quantitative – Survey – Descriptive statistics	To describe the type, level and extent of care provided within palliative care settings in EAPC member countries.	370 services: Inpatient unit/hospice (n=220) Home care service (n=188) Hospital support service (n=99) Day care service (n=55), Other (n=43)	Directors of palliative care services (n=370)	RR = 78% of the countries	Survey study: Email to all EAPC associates Self-developed questionnaire (with free text response)

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[10] Factors Affecting Communication Patterns Questionnaire

	First Author, Year of Publication	Country	Method	Aim	Setting	Sample	Response Rate (RR)	Data collection
22	Hayward et al., 2016	Europe - England	Mixed methods – Survey – Descriptive statistics	To explore the attitudes of oncologists and palliative care consultants towards writing letters of condolence to bereaved patient's relatives.	One cancer center and four cancer units	Oncologists and palliative care consultants (n=47)	RR= 72%	Survey study: Anonymous, email Self-developed (with free text response).
23	Hottensen et al., 2013	North-America – USA	Qualitative – Intervention – Analysis not specified	1) To define the need for bereavement services at the hospital. 2) To identify social workers, social work interns and volunteers who could make follow-up phone calls and to provide individual counseling and lead regularly scheduled support groups. 3) To provide training and supervision for social workers, interns and volunteers. 4) To plan and implement a memorial service for patient's relatives, friends and staff. 5) To evaluate the programme after two years by using feedback gathered from follow-up phone calls and support group members.	One hospital	Relatives (number not reported)	RR not reported	Interview study: Telephone, if risk for CG was high, additional follow-up phone calls were made within one week.
24	Ito et al., 2020	Asia - Japan	Quantitative – Survey – Descriptive statistics	To investigate the current status of bereavement follow-up in Japanese Emergency Departments (ED).	145 Emergency Departments	Unit leaders of all EDs in Japan (n=145)	RR= 50,2%	Survey study: Online and nationwide questionnaire
25	Johansson et al., 2018	Europe - Sweden	Qualitative – Interview – Hermeneutic analysis	To explore how relatives experienced the use of a diary when a patient does not survive the stay in the ICU.	Three ICUs within three hospitals	Relatives (n=9)	RR not reported	Interview study: In-depth, single time, face-to-face 11 months post loss
26	Kalocsai et al., 2020	North-America - Canada	Mixed methods – Survey and interview – Thematic analysis	To explore how clinicians support bereaved relatives, identify barriers and facilitators to support bereaved, and understand relatives' interest and needs for follow-up.	Nine ICUs	*Survey:* Nurses (n=290) Physicians (n=42) *Interviews:* Nurses (n=21) Physicians (n=13)	*Surveys:* Nurses RR = 41% Physicians RR=54% *Interviews:* RR not reported	Survey study: Self-developed questionnaire (with free text response) Interview study: To reflect, expand and explain quantitative results

	First Author, Year of Publication	Country	Method	Aim	Setting	Sample	Response Rate (RR)	Data collection
27	Kentish-Barnes et al., 2017a	Europe - France	Quantitative – Randomized controlled trial study (RCT) – Correlational analysis	To evaluate whether grief symptoms were alleviated if the physician and the nurse in charge at the time of death sent the closest relative a handwritten condolence card after two weeks (intervention group – IG) or not (control group – CG).	22 ICUs	Relatives (n=242)	*First phase:* IG: RR = 87% CG: RR = 79% *Second phase* IG: RR = 85% CG: RR= 76%	RCT study 1:1 assignment to IG or CG , telephone interview 30 days and again at six months post loss, study outcome scores on HADS[11] and IES-R[12], ICG[13] and CAESAR[14]
28	Kentish-Barnes et al., 2017b	Europe - France	Qualitative – Interview (part of a larger RCT study) – Thematic analysis	To investigate relatives' experience and reactions in receiving a letter of condolence by recording every spontaneous saying or feedback regarding the condolence letter.	22 ICUs	Relatives (n=78)	RR not reported	Interview study: Spontaneous sayings or feedback (verbal and non-verbal) regarding the condolence letter
29	Kirby et al., 2018	Oceania - Australia	Qualitative – Interview – Framework approach	To examine bereaved relatives' experiences to provide a comprehensive understanding of the factors that may shape engagement with bereavement support services.	One palliative care unit within one hospital	Relatives (n=15)	Second interview: RR = 4.47%	Interview study: Semi-structured, multiple times, face-to face, close to the death and three to nine months post loss.
30	Kobel et al., 2019	Oceania - Australia	Mixed methods – Survey – Descriptive statistics and content analysis	1) To assess the equity of access to bereavement support across Australian palliative care services by using survey data to compare services according to location (metropolitan vs. regional). 2) To evaluate changes in bereavement support over the last decade by comparing findings to results of a previous Australian study	180 palliative care services (metropolitan and rural): Integrated (inpatient and community) service (n=62), community service (n=58) inpatient service (n=46) and other (n=14)	HCP (n= 180)	RR= 84%	Survey study: Online, nationwide, questionnaire based on previous research and self-developed (with free text response)

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[11] Hospital Anxiety and Depression Scale

[12] Impact of Event Scale Revised

[13] Inventory of Complicated Grief

[14] An instrument to assess the experience of relatives of patients who die in the intensive care unit (ICU)

	First Author, Year of Publication	**Country**	**Method**	**Aim**	**Setting**	**Sample**	**Response Rate (RR)**	**Data collection**
31	Kock et al., 2014	Europe - Sweden	Quantitative – Survey – Descriptive statistics	To conduct a quality improvement control after four years of offering a follow-up meeting post death with HCP to bereaved relatives to find out if follow-up meeting post-death was appreciated.	One ICU within one hospital	Relatives (n=84)	RR not reported	Survey study: Anonymous, self-developed questionnaire
32	Kusano et al., 2012	North-America – USA	Quantitative – Survey – Descriptive statistics and regression analysis	1) To examine the frequency and nature of bereavement practices among cancer care and palliative care physicians in the Pacific Northwest United States. 2) To identify factors and barriers associated with bereavement follow-up.	Hospitals and cancer centers: community (n=64) and academic hospitals (n=39) cancer centers (n=40), other (n=20)	Oncologists and palliative care- or hospice physicians	RR= 22,7%	Survey study Anonymous, online, self-developed questionnaire
33	Lebus et al., 2014	Europe - England	Quantitative – Intervention study – Descriptive statistics, correlational- and regression analysis	To describe a novel bereavement service in a large secondary care institution and assess its impact. It examines relatives' experience after the first year of operation, categorises the themes of concerns raised, and factors that may predict who will seek follow-up (FU).	One hospital	Relatives (n=142)	RR = 22%	Survey study: Four weeks post loss a letter offering a FU meeting is sent. If they request FU, they are telephoned to discuss questions and concerns raised. If necessary a meeting is arranged.
34	Makarem et al., 2015	North-America - Canada	Qualitative – Interview (part of a larger RCT study) – Thematic analysis	To describe experiences and opinions of caregivers regarding bereavement contact from HCP.	One tertiary cancer center	Relatives (n=61)	RR not reported	Interview study: Semi-structured, single time, face-to-face, one to five years post loss
35	McAdam et al., 2016	North-America – USA	Quantitative – Survey – Descriptive statistics and regression analysis	To describe current bereavement follow-up services (BFUS) in adult ICUs, the evaluation process, barriers, and associated with ICUs offering BFUS vs. ICUs without BFUS.	Hospitals (number not specified)	One ICU nurse leader per unit (n=237)	RR= 24%	Survey study: Online and AACN database, self-developed questionnaire

	First Author, Year of Publication	**Country**	**Method**	**Aim**	**Setting**	**Sample**	**Response Rate (RR)**	**Data collection**
36	Mélin et al., 2020	Europe - France	Qualitative – Focus groups – Analysis not specified	1) To identify the practices used by HCP and palliative care volunteers to support relatives during the agonal phase in a palliative care unit (PCU). 2) To understand the expectations of relatives in terms of support.	One palliative care unit	*Relatives (n=7)* *Staff members of the PCU* (n=25): Nurses (n=3), care-assistants (n=4), physicians (n=5) Psychologists (n=2) ‘individual professionals’ (n= 7), and palliative care volunteers (n=4)	RR not reported	Focus group study: Organized according to the category of participants, amount of groups not reported Relatives participated at least three months post loss.
37	Merel et al., 2015	North-America – USA	Mixed methods – Survey – Correlational analysis	To describe providers’ beliefs and practices regarding expressing condolences to bereaved relatives.	One tertiary referral center associated with a cancer center	Medical staff: physicians (n=80), nurse practitioners (n=57), physician assistants (n=29)	RR= 47%	Survey study: Online, self-developed questionnaire (with free text response)
38	Mitchell et al., 2017	Oceania – Australia and New Zealand	Quantitative – Survey – Descriptive statistics	To investigate the provision of family bereavement support in ICUs across New Zealand and Australia.	128 ICUs: Adults (n=88), pediatrics only (n=8), mixed (n=43), neonates (n=13)	One senior nurse leader per unit (n=229)	RR= 67%	Survey study: Online, nationwide, self-developed questionnaire (with free text response)
39	Morris et al., 2015	North-America - USA	Mixed Methods– Intervention study – Analysis not specified	To understand the impact of a bereavement programme and which components bereaved found most helpful and what other types of support could be offered to recently bereaved.	One hospital	Relatives (n=140)	RR=17%	Survey study: Online, hospital-wide, self-developed questionnaire (evaluation of the programme)

	First Author, Year of Publication	Country	Method	Aim	Setting	Sample	Response Rate (RR)	Data collection
40	Muta et al., 2014	Asia - Japan	Qualitative – Interview – Content analysis	To evaluate bereavement services provided by hospice/PCUs and clarify demands for bereavement care.	Nine palliative care units	Relatives (n=44)	RR = 44%	Interview study: Semi-structured, single time, maximum two years post loss.
41	Naef et al., 2020	Europe - Switzerland	Quantitative – Survey – Descriptive statistics and correlational analysis	To investigate hospital-based bereavement care provision and associated barriers.	Two hospitals (acute and psychiatric) Results reported separately	HCP(n=196): Nurses (n=115) Physicians (n=49) Psychologists (n=16) Miscellaneous (n=16)	RR not reported	Survey study: Online, self-developed questionnaire
42	Neville et al., 2020	North-America Canada and USA	Qualitative – Interview – Content analysis (secondary analysis)	1) To characterize and enumerate keepsakes that were created as part of a qualitative intervention design by using secondary analysis. 2) To understand bereaved relatives' perspective on keepsakes.	Four ICUs	Relatives (n=60)	RR not reported	Interview study: Semi-structured, single time, face-to-face and online, one to 12 months post loss
43	Santiago et al., 2017	North-America - Canada	Quantitative – Intervention study – Descriptive statistics and thematic analysis	1) To develop and administer a formal bereavement programme to bereaved relatives. 2) To measure the feasibility of implementing each of the programme contents. 3) To determine relatives' attitudes towards the programme and each component.	One ICU	Relatives (n= 11)	RR = 37%	Survey study: Email, self-developed questionnaire (with open- and close ended questions)
44	Stephen et al., 2013	Europe - Scotland	Qualitative – Interview – Framework approach	1) To explore HCP' experiences of caring for bereaved (older) relatives and relatives' experiences of bereavement care (BC) after a loved one's death in a healthcare setting. 3) To clarify what was done for bereaved relatives and how communication may help or hinder coping. 4) To potential for the enhancement of bereavement care	Health care settings: Hospital (n=12), General practice (n=9), Care home (n=10), Others (n=2) Results reported together.	Relatives (≥ 65 year old) (n=6) HCP (n=33)	RR not reported	Interview study Semi-structured, single time, face-to-face, six months to five years post loss

	First Author, Year of Publication	Country	Method	Aim	Setting	Sample	Response Rate (RR)	Data collection
45	Stilos et al., 2020	North-America -Canada	Qualitative - Intervention study – Analysis not specified	To explore the impact of bereavement support on patients, families, and institution	One hospital	Relatives (n=104)	RR = 53%	Interview study: Telephone call after four to six weeks post loss to express condolences, explore coping tactics, speak about relationship with deceased and to provide details about a hospital-wide memorial service.
46	Walker et al., 2016	Europe - England	Qualitative – Interview – Content analysis	To explore nursing interventions for person-centered bereavement care in adult acute and critical care settings.	Emergency care (n=4), critical care (n=4) and cardiac care (n=2) within one hospital	Nurses (n=10)	RR not reported	Interview study Individual and within a group, single time, face-to-face
47	Walsh et al., 2013	Europe - Germany	Qualitative – Focus groups and interviews – Axial coding analysis	To explore how the presence of a dedicated bereavement service within an acute hospital appears to impact staff across clinical and ancillary services.	One hospital (hospital-wide)	*Focus groups:* Health care staff (n=20): Health care professionals (n=8), Ancillary/administrative (n=12) *Interview:* Key informant involved with patient complaints (n=1)	RR not reported	Focus group study: Two focus groups Interview study: One interview, semi-structured

Table 3 (Supplementary File): Findings of the included studies (*N*=47)

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
1	Banyasz, et al., 2017		Offered services and % of actual usage: - Time alone with the deceased (84,8) - Quiet room after death (69/6%) - Sympathy card (75%) - Memorial service (54.1%) - Chaplain before death (43.7%) - Educational grief booklet (59,5%) - Chaplain at time of death (43,7%) - Grief literature: book list (42.2%) - Follow-up phone call (28.2%) - Individual counselling (13.5%) - Support group: six weeks, relationship (7%) - Grief Seminar (1.3%) - Info on funeral planning (36,4%) - Family counselling (3,8%) - Website with grief info (8,4%)	- Hospital bereavement programmes could consider offering some services (time alone with the deceased, a quiet room to be alone after the death, sympathy cards, memorial/remembrance services and chaplain support before and after death) to all bereaved as they were generally considered helpful and may be cost-effective strategies.	
2	Beiermann et al., 2017		*Standard BC services:* - Guidance or logistical support with funeral arrangements - Referring relatives to community resources - Support group or referral to other HCP - Follow-up phone calls (within 24 hours) *Intervention programme:* - ECG momento from the patient's heart rhythm strip, which included a sentiment card (keepsakes)	- A tangible remembrance of the deceased patient was found extremely/very helpful by 61% of the participants.	Barriers - Lack of education: 81% had less than six hours education on end-of-life topics.

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
3	Benbenishty et al., 2019		- Left relatives alone with the dying person or after the patient's death. - Facilitated close contact between relatives and the dying patient. - Arranged religious rituals (e.g. calling clergymen, imam, bringing bible, etc.). - Provided information and practical details - Turned off alarms, screens and infusion pumps during the dying process and removal of unnecessary bedside technical equipment or hiding it behind screens/curtains,… - Took care of the dead persons' body (washing, new clothes, shaving, etc.). - Placed a symbol (like stone or electric candle) on a table in the corridor to signal busy ICU staff to slow down and lower voices. - Provided a post loss follow-up conversation or sending a letter of condolence .		
4	Berry et al., 2017	- Inconsistent provision of bereavement care follow-up (BCFU) and 17% did not provide any information at all regarding follow-up - A specific staff member was responsible for writing, auditing and developing bereavement care policy (54%) - A written bereavement care policy (45%) and regular audit (19%) of the service	At the time of death: - Bereavement leaflet on cultural and religious rites, local services, and support groups (81%) - Information booklet with administrative information on actions following a death (96%) - Informed the GP of the patient's death (77%) but the relatives' GP was done on a completely ad-hoc basis. Follow-up services - Structured booklet listing organisations and groups available at a local and national level (76%)	- 27% of the relatives felt that available facilities were neither comfortable, nor respecting their privacy	Barriers - No access to training in bereavement care and communication skills (53%) - Not aware of staff responsible for this training (80%) or the person responsible for writing, auditing and developing a bereavement care policy. - No written bereavement care policy - No regular audit of the service

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
5	Bloomer et al., 2013	- Staff: nurses, social workers, and pastoral care services	- Provide information - Provide privacy (e.g. single room) and facilities so relatives can keep vigil - Time alone with the deceased		Barriers - High workload and dilemmas (bereavement care vs. next admission) - Unrecognised time of bereavement care (time-consuming) - Lack of privacy and few facilities available - Lack of education - Emotionally demanding for HCPs - Some staff members (e.g. social workers) are not available outside office hours
6	Breen et al., 2013	- Bereavement care is offered very close to the patient's death	- Telephone calls - Home visits - Memorial services - Printed information - Referrals (when required) - Risk assessment tools (three to six months post loss)		Barriers - Funding is less in rural areas - Several roles and added responsibility is a source of fatigue and stress for HCP - Limited access and time for education - Available risk assessment tools do not possess adequate predictive validity - Move towards needs-based service delivery (limited funding) Facilitators: - Partnerships between primary care, palliative care services and community support (public health approach) - A comprehensive, statewide service directory with strengthening referral pathways to and between appropriate services

	First Author, year	Description of in-hospital bereavement care	- In-hospital bereavement care services	- Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
7	Chan et al., 2013		- Information about funeral arrangements	- Emotional support is appreciated (e.g. kind word) - Supportive physical environment so they can accompany dying loved one (e.g. flexible visiting hours)	Barriers: - Emotionally draining for HCPs - Strained manpower and heavy workload - Exhaustion due to sense of powerlessness, grief, frustration and lack of support - Lack of knowledge on bereavement care and counselling skills Facilitators: - Educational opportunities
8	Coimin et al., 2019	- Staff: social workers (29.1%), doctors (28.2%) and nurses (29.1%) were the source of contact for the majority of respondents, sometimes a chaplain contacted (11.7%).	- Providing a single occupancy room when the patient is dying (68.9%) - Providing a family room (76%) - Conversations about feelings around relative's illness and death - Inform relatives of the patient's death - Providing practical information on next steps	- Being informed of the patient's death in a sensitive way (25.5% was not informed that their relative was going to die) - 69.1% found that there was enough privacy when their loved one is dying - 98.6% considered family rooms as warm and welcoming spaces - 16.5 % found speaking with someone of the hospital about their feelings around their relative's death helpful, 28.6% did not but would have liked and 53% does not want to talk about it with a HCP	Barriers - Hospital staff not recognising or failing to acknowledge and communicate the person was dying (need for education) - Facilities: not enough rooms to ensure the patient dies in a single room.
9	Coombs et al., 2017		- Memory boxes (mostly paediatric ICUs) (keepsakes) - Body seen by family without invasive lines and machinery - Quiet environment or side room - Bereavement card 2 weeks after death - One-year anniversary card - Handwritten sympathy card - Follow-up meeting - Annual memorial services - Referral to community support services - Educational provision	- ICU death-related rituals (attendance on the dying patient, removal of technology, washing and preparation of the body, adaptation of the ICU environment) help bereaved family members acknowledge the transition of the patient from being alive to being deceased	Barriers - Ideal timing of BC is unclear - Lack of time and money - Noisy environment of the ICU - Educational provision is variable, some ICUs provide in-service programmes for all nursing staff, while others provide it for a few (social workers, medical staff, bereavement coordinators) Facilitators - In-service programmes for nurses

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
10	Cooper et al., 2019	- Phone calls were done 6 weeks, 6 months and a year post loss - Staff: Chaplains, physicians, nurses, and behavioral health specialist	- Bereavement card - Letter introducing Emergency Department Grief support with contact information for further follow-up (if deceased <45 years) - Phone call - Meeting with HCP (if requested)	- Many relatives had lingering concerns or questions about the patient's last moments or wanted to see the place where he/she died if not present at the moment of death	
11	Downar, et al., 2014	- Clinicians reported that they typically provide support at the time of death (85%) - Relatives wanted to receive support less than six months after their loss	- Screening for CG (complicated grief)[15] and PGD (prolonged grief disorder) - Review events (26% assesses whether bereaved relatives wanted to review events surrounding the death of the patient)	- Strong desire for routine bereavement screening and support (informational, psychological and social needs) regardless of whether or not they were experiencing symptoms of CG and PGD - more than 2/3 of the relatives report that they would want (or more) formal support for their mood and anxiety symptoms, and half of those with subtreshold CG or PGD were not receiving any formal psychiatric or psychological support. - Family members with subtreshold CG or PGD were not more willing to receive support	Barriers: - Incomplete or inaccurate contact information - Lack of time (high workload) - Lack of training (nurses were significantly more willing than physicians to receive support training (90% vs. 64%) - A lack of knowledge about existing supports in the community - Lack of continuity or established relationship with the patient/relative - Not knowing what to say or how to deal with emotions - Lack of validation of bereavement tools in the early bereaved Facilitators - Educational opportunities - A list of available support resources - Dedicated time after the death and at a later date to provide support

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[15] Important remark: We only use the term 'prolonged grief disorder (PGD)' in our main text, but other concepts for pathologic grief are also used in Table 3. This is because we want to present the results, but also the conceptualisations, as literally as possible. Thus, each row contains the concepts that were mentioned in the specific article. We understand this may cause confusion as both concepts are not identical. We decided to use the concept 'prolonged grief disorder' in the main text because it is more validated, sensitive and predictive. For more information, we want to redirect you to the following article: Maciejewski, P.K., Maercker, A., Boelen, P.A. and Prigerson, H.G. (2016), "Prolonged grief disorder" and "persistent complex bereavement disorder", but not "complicated grief", are one and the same diagnostic entity: an analysis of data from the Yale Bereavement Study. World Psychiatry, 15: 266-275.

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
12	Downar et al., 2020	- Only half of the participants with complicated grief (CG) received formal support	- Communication about the dying process - Condolence letter - Memorial services	- Need for a personalised approach in providing bereavement care - The majority could see positive aspects of a bereavement screening and support programmes, some express disbelief that support was not yet routinely offered and others stated that routine follow-up would not be necessary, only if symptoms worsened or if requested.	Barriers: - Lack in continuity of care (inconsistency and difficulty creating a relationship between HCP and relatives) and a personal approach to bereavement support - No systematic approach of offering bereavement care
13	Egerod et al., 2018	- Bereavement care was offered to the family at the time of the patient's death and timing of follow-up varied (telephone call one to eight weeks, letter of condolence two to five weeks, - Only 59% of the ICUs offered bereavement follow up services - Number and type of health professionals involved in bereavement follow-up varied (one to six staff members, mostly ICU nurse managers (15%), intensivists (7%), ICU nurses (28%), and secretaries (20%). - Evaluation was done in 20% of the units: verbal feedback from family or staff, family survey or staff interviews (annually, monthly or continuously) - No model of bereavement follow-up, but bereavement practices, to some extent, rely on individual providers (good-will)	Bereavement care - Viewing of the deceased in the ICU (100%) - To assist the family to view the patient in the hospital mortuary (59%) - Information regarding hospital-based follow-up for the family (72%), only one unit provided information on community-based bereavement follow-up Bereavement follow-up services - ICU visit for family (41%) - Meeting with medical staff by request (30%) - Letter of condolence (28%) - Phone call to family (26%) - Referral to priest or clergyman (24%) - Referral to other counseling (11%) - Support group (/)	- Return visit was preferably done by the individuals who had been present at the patient's death so they could review the patient's illness trajectory and explain some of the equipment used - Most appreciated were meetings with the nurse and physician, a phone call to answer questions a review of the illness trajectory, and understanding that the relative's death was unavoidable (provided closure)	Barriers: - Lack of national consensus

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	- Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
14	Egerod, et al., 2019	- 41% ICUs had a bereavement follow-up (FU) service, wherein 31 % of them for more than ten years. - 57% of the ICUs did not offer bereavement support - None reported the use of a guideline for bereavement FU - Formalised bereavement support is often lacking (still not standardised) - Condolence letter: three to four weeks post loss by a nurse in charge, secretary or nurse who was present when the patient died - Phone call variable, three to five weeks vs. two to three months. - Meeting ICU: < one month post loss - One to five staff members are responsible (mostly one to two hours a week) - Staff: bedside ICU nurses, clinical nurse specialists, ward clerks, nurse managers, head physicians, nurse researchers and nurse educators. Mostly the responsibility of the nurse caring for patient at time of - On a permanent basis rather than rotated among colleagues - 11% evaluate FU services - Interviews or surveys with staff or relatives, 1% made changes to the bereavement service after evaluation	- Viewing the deceased in the ICU (91%) or the hospital mortuary (53%) - Information on hospital- (61.2%)or community-based support (17.6%) - Sympathy card, condolence letter or e-mail (20%) - Phone call from nurse (31%) or other staff member (to offer nurse consultation or sympathy) - ICU diary - Keepsakes of the patient - To arrange a visit with a hospital chaplain - Memorial service at the hospital chapel	- Most appreciated services by relatives are: memorial service (to remember the patient), follow-up visit to the ICU (to thank staff), a chance to talk to the nurse and physician caring for the patient (to obtain closure), a phone call from the nurse (to ask questions), reading the ICU diary with the nurse (to understand what happened), and printed information about support after the patient's death - No elements were considered unnecessary by the relatives	Facilitators - Guidelines for bereavement follow-up services

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
15	Erikson et al., 2019		- Bereavement brochure - Sympathy card - Follow-up phone call - Memory box - Counselling - Memorial service	Brochure: - To have access to information in their own time, re-use it and share it with family and friends, serves both practical and emotional needs (normalisation) Sympathy card - Symbol of caring and recognition of their significant loss - Thoughtful, meaningful and a pleasant surprise but overall rated as neutral in providing comfort - Most prefer it two weeks after the death of the patient and should be signed by staff who cared for their loved one Follow-up phone call (FUPC) - Most families did not feel that a FUPC was necessary or comforting - Needed when confronted with lingering questions about patient's illness and death Memory boxes - Mixed reactions: provide a degree of comfort vs. not useful (objects such as a watch already served a similar purpose) Memorial service - Most would not attend or did not find it a priority because they already had a personalised event - To reconnect with other families they met at the hospital or to see familiar hospital staff and thank them.	

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
16	Ford et al., 2013	- No systematised programme of support, follow-up or care - Once a patient has died, the care of relatives is primarily seen as the responsibility of the GP - Condolence card is sent two to three days after death, - Follow-up letter four to five weeks post loss.	- Condolence card - Condolence letter (with invitation for further support if needed) - Telephone call to talk (if needed) - Meeting to discuss and discern key areas of concern (if needed)		
17	Fridh et al., 2019	- The majority of ICUs (76,7%) offered some kind of follow-up (FU) - 45,2% state they did not always offer this service but it was dependent on special circumstances: if family requested it, if death was sudden or unexpected, patient's ICU care was lengthy or if patient was organ donor - No national guidelines for FU services, so different models are used - Timing: 42% the first month and 58% two to five months post loss	- Phone call (32.7%) - FU visit at post-ICU clinic (7.3%) - FU at ICU (12.7%) - Phone call and FU visit at post-ICU clinic (10.9%) - Phone call and FU at ICU (20%) - Phone call, FU at post-ICU clinic and ICU (10.9%) - Keeping a diary (97.3%) - Providing a private room at the time of death (60.6%) (←→ 39.4% often or always died in shared rooms)		

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
18	Goebel et al., 2017	Timing - One year after patients' death	- Bereavement card - Memorial service - Information material	- Most participants (92%) felt pleased receiving a bereavement card, 92% report a feeling of gratefulness, and 88% felt consoled. Every participant reported at least one positive reaction, but 38% additionally reported on sad feelings - Relatives value a personal touch: HCP had a relationship to the patient and write salutation by hand - Memorial service is appreciated as it provides the opportunity to get in touch with HCP	
19	Granek et al., 2013	- No explicit guidelines on what to do when a patient dies at all 3 hospital sites. Physicians were largely left to decide on their own what to do (often ad hoc strategies), so provided care is arbitrary.	- Attending bereavement rituals such as funerals, shivas or wakes (rare) - Meeting or speaking with the family (rare) - Making a phone call (sometimes vs. consistently) - Condolence card (rare)		Barriers - None of the HCP knew who to contact to find out about the protocol - Attending bereavement rituals is too emotionally draining - Workload - Ambivalence about sending a condolence card (because HCP was present when the patient died) Facilitators: - Close relationship with family and/or patient - A standardised protocol on how to approach families post loss might help oncologists with the emotional demand and engage in these practices more consistently - Receiving protected time to engage in bereavement practices

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
20	Granot et al., 2016	- Physicians and nurses had significantly different perspectives with respect to their role in bereavement FU, more physicians than nurses agreeing that it was important to contact grieving families (89% vs. 52%) and that such contact was important - More physicians than nurses thought that all grieving families should be contacted (57% vs. 30%) and that this contact should be made by treating physician (100% vs. 83%) - Contacting was considered within the responsibility of the treating physician (90%), nurses (84%) or social workers (89%)	- Phone call (88%) - Condolence letter (75%) - Home visit (40%)		Barriers - Emotional overload (68%) - Lack of time (63%) - HCP do not find it important enough - Lack of appropriate tools - Need for education Facilitators - The longer the relationship with the patient, the more important to contact the family after the death (physicians 92% vs. nurses 65%) - Providing bereavement care is found professionally appropriate (84%) - Contacting bereaved relatives is found important (66%)

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
21	Guldin et al., 2015	- 82% offered BC and most provided it free of charge - 47% of ICUs had someone co-ordinating bereavement care. 20% full-time salaried care co-ordinator, 13% part-time 7% a few hours a week, 2% it was undertaken by volunteers. - Providing bereavement care is mostly done by psychologists (61%), nurse (60%), doctor (45%), social worker (42%), and pastoral care worker (41%). In a lesser extent by a bereavement or palliative care volunteer (23%). - 66% of those who offered support, stated that it was not based on any formal policies of guidelines and 40% was not even aware of any guidelines in their country and 33% said formal guidelines did inform bereavement service design - 25% used a formal risk assessment tool	Universal (services offered to all) - Telephone support (84%) - Literature on adult grief (81%) - Information/education sessions on bereavement (65%) - Letters (59%) - Memorial services (56%) - Cards (49%) - Attend funeral (41%) - Anniversary cards (22%) Selective (services offered to selected groups, such as at-risk groups) - One-to-one support (79%) - Home visits (59%) - Referral to support groups run by other agency (58%) - Provide support group (56%) - Provide one-to-one volunteer support (45%) Referral to one-to-one volunteer support provided by external agency (35%) Indicative (services offered to bereaved people with symptoms indicative of complicated grief) - Bereavement counselling (81%) - Referral to other counselling/psychotherapy (77%) - Referral to psychiatrist (64%)		- 60% provided formal training in bereavement care for palliative care staff

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
22	Hayward et al., 2016	- Bereavement care was not a standardised practice - Variable: 61.5% do it within three to six weeks, while 38.5% does this within two weeks. None after six weeks	- Letter of condolence (75%) - Telephone call (9.5%) - Visit family at home (2.4%) - Attend funeral (0%)		Barriers - Perceive as too personal, crossing boundaries (28.6%) or HCP don't see the need (23.8%) - Lack of time/too busy (14.3%) - Unsure how to write it (9.5%) Facilitators - Knowing the patient or family well (31%) - Feeling family would be upset or - A template as a starting point that can be modified
23	Hottensen et al., 2013	- Letters are sent six weeks post-loss - Use of a multidisciplinary team and volunteers	- FU phone calls (with an additional phone call if the risk for complicated grief was high) - Follow-up letters - Support group - Memorial service -	- Only 5% of those who were screened positive for complicated grief received an additional phone call - Family appreciated the follow-up	Barriers - Lack of continuity: constant turnover of staff and finding staff who want to take up bereavement care - Lack of education Facilitators - Use of (trained) volunteers
24	Ito et al., 2020	- 17.9% of the EDs provide bereavement follow-up (FU) - 60% of ED nurse leaders perceive bereavement FU as "necessary but difficult" and 24.2% as "necessary and should be done", and 3.4% as "not necessary" - Almost only doctors and nurses belonging to Emergency Department teams	- Referral to a specialist for psychological treatment (42.3%) - Brochure on community bereavement services (38.5%) - Brochure on procedures required after bereavement (30.8%) - Memorial service (26.9%) - Brochure on information about grief and loss (15.4%) - FU meeting (7.7%) - FU telephone call (3.8%)	- Follow up meeting: Relatives wanted an explanation of the circumstances of death (95.9%), the cause of death (92.4%), the treatment given during final illness (89%), talk about sadness and painful feelings (89%), explanation of medical terms on death certificate/postmortem (87.6%) - Relatives wanted information on the procedures required after bereavement (86.2%), about available community services (75.2%) and grief and loss (66.2%)	Barriers - Lack of time (83.4%), knowledge and skill (63.4%), a multidisciplinary team (62.1%), educators and leaders (55.9%), (55.2%), available funds (41.4%), and community resources and a cooperation system (53.1%) - Physical and psychological burden on staff (53.8%) - Not knowing the needs of bereaved relatives (51.7%) or bereavement follow-up services (43.4%)

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives’ appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
25	Johansson et al., 2018		- Patient diary	- A patient diary is a reliable source of information that promotes rational and emotional understanding	
26	Kalocsai et al., 2020	- More than 80% support families at the time of death, fewer than 6% reported following-up in the days or weeks after death. None of the ICUs had a systematised follow-up plan - Respondents admit that their support is part of a multidisciplinary team effort that also involved social workers and chaplains	- Attend funeral (only if there was a strong rapport with the family) - Follow-up meeting (mostly family-initiated) - Provide emotional support at the time of death (88% nurses vs. 69% physicians)	- Nurses (56%) and physicians (44%) perceived that bereaved families needed emotional support	Barriers - Sociocultural and structural barriers (language, limited time, formal training, space/privacy) - Emotional toll on the HCPs - 50% nurses and 57% physicians felt comfortable supporting bereaved families Facilitators - Situations of concern for HCPs - 40% of nurses and 50% of physicians were willing to provide emotional support to families as part of formal programme if given adequate time and training - 82% was interested to receive formal training in providing bereavement support.
27	Kentish-Barnes et al., 2017a		- Letter of condolence	- Handwritten condolence letter 2 weeks post loss failed to alleviate grief symptoms. At six months there was a significant increased risk of developing depression and PTSD symptoms.	

	First Author, year	- Description of in-hospital bereavement care	- In-hospital bereavement care services	- Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
28	Kentish-Barnes et al., 2017b		- Letter of condolence	- Relatives perceived three benefits of receiving a condolence letter: feeling support and help during bereavement, release emotions, and reassured that the patients was in good hands. - Relatives found it important to receive both personal consideration and extra medical information: HCP confirming that they played a role during the patient's stay, obtaining important information about the dying process, and remembering the experience. - Relatives found that the letter increased their trust in the medical institution (humanization of the medical institute) - A letter encouraged relatives to write the ICU team: to thank them, and to recognize the physician as a person - The letter forms a confirmation of the link between themselves and the caregivers but also helps to close the relationship. - 40% contacted the team after receiving the letter to express thanks and gratitude, while others asked for a FU meeting. However, the majority did not dare to call the team for fear of bothering (despite the letter containing an invitation to contact the team). A small number felt socially obliged to answer the letter. - 30% of relatives felt surprised by the letter and why they deserved this personalized attention. Some thought the physician was hiding something or that the family may be dissatisfied with the quality of care. - If the request to meet was not fulfilled, despite the letter offering this, relatives questioned the sincerity of the letter and physician. It left them extremely upset and angry.	

	First Author, year	- Description of in-hospital bereavement care	- In-hospital bereavement care services	- Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
29	Kirby et al., 2017	- Staff: Social workers, nurses, pastors, and counselors	- Information cards/brochures - Follow-up phone calls - Individual or (within the hospital or at home) group counseling - Memorial services - Assistance with burial/cremation arrangements - Referral to psychological/psychiatric services (both pre and post loss)		Barriers - Relatives' socio-cultural constructions of the character of bereavement support and personal nature of grief - Relatives' perceived limited scope of bereavement support services (unilateral focus on psycho-social) -
30	Kobel et al., 2019	- 91% palliative care services provided bereavement care (BC) - 9 % did not provide BC but would assist bereaved individuals as needed. 41% of these intended to develop a bereavement programme. - 82% offered support to all bereaved persons, and persons identified as high risk by 39% of the metropolitan and 43% of the regional services and self-referred persons by 42% of the metropolitan and 34% of the regional services. - 80% was coordinated by a social worker, nurse or bereavement coordinator/ counselor (social worker 29%, nurse 26%, bereavement coordinator 25%, pastoral care worker (7%), volunteer (2%), psychologist (1%), doctor (0%), other (16%)	- Brief follow-up contact (98%) - Information (psychosocial) (94%) - Information (practical) (79%) - Risk assessment (91%) (multidisciplinary team opinion 63%, single staff member opinion 49%, use of formal bereavement tools 43%) - Memorial service (82%) -		Barriers - Lack of time, staff and funding - Concerns about undertaking work that was not counted in existing activity-based funding models

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
31	Kock et al., 2014		- Follow-up meeting post death (FUMPD)	- 91% of the family members found it important to continue with the routine of a FUMPD for relatives - 78% were satisfied or very satisfied with FUMPD and 96% of them state that they now understood the cause of death - 91% found it important that the physician was present - Relatives wanted to discuss the cause of death 91%, medical treatment 61%, behavior of staff 59%, treatment period (52%), falling ill (48%), if they could have influenced the outcome (43%), the grieving process (39%), how they felt at the time of the meeting (37%), other (16%), and the funeral (4%)	
32	Kusano et al., 2012	- 45% had a bereavement programme, 40% not, and 15% was unsure	- Available for phone call (usually or always 89%) - Sending condolence letters or cards (usually or always 60%) - Refer to bereavement programme (usually or always: 46%) - Physician-initiated phone calls (usually or always 28%) - Attending funerals (usually or always 16%)		Barriers - Lack of time (62.4%) - Uncertainty about which family member to contact - Feeling uncomfortable about what to say - Not received adequate training on bereavement follow-up (68.3%)
33	Lebus et al., 2014		- Information leaflets - Condolence card - Follow-up meeting (offered within a letter)	- 8.6% of the relatives receiving the follow-up letter had a meeting - Meeting concentrated around clinical deterioration (28%), diagnostic questions (79%), final moments before death (29%), "what if?"(27%), end of life decisions (13%), and communication of death (6%)	

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
34	Makarem et al., 2018	- 98% received some form of palliative care before death , 50% received some form of contact after the patient's death, 40% received no contact and 10% could not recall if contact was received - Source of contact : palliative care physician, other physician or other HCP (nurse, healthcare team, social worker, home care staff)	- Phone call - Visit - To attend the funeral - Card, e-mail, letter, or note	If relative received contact: - Contact reflects caring (honouring the patient's memory, recognised as an individual, rather than "just a number") - Contact offers support (actively vs. open door/receive contact information to get in touch if necessary) - Contact facilitates closure (meaningful conclusion to a relationship with HCP instead of an abrupt cutoff) Not contacted - Contact is a courtesy (have appreciated connection but understood HCPs were busy and this expectation of contact might be unrealistic). Most considered it a form of politeness vs. ethical responsibility - Contact is not always necessary (neither expected or noted its absence, they did find it HCPs responsibility but some found it helpful in certain circumstances (not themselves but others who are not able to cope) - Some relatives initiated contact themselves to thank HCP for the care provided or practical reasons. If relatives initiated contact themselves a reply was appreciated and some expressed regret if it not occurred.	

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
35	McAdam et al., 2016	- 37.6% offers follow-up services, of the 62.4% that do not offer follow-up services, 44.6% were interested in starting a bereavement programme - Bereavement care was informal and minimal in nature - Mostly delivered by staff nurse (49.4%), bereavement coordinator (32.6%), physician (9%), volunteers (6.7%) or other (30.3%). - After one month (51.7%), three months (6.7%), six months (4.5%), one year (1.1%), other (35.9%) - 36% do not have money allocated for bereavement follow-up, 28.1% do have, 20.2% do not know. - 33.7% verbal family feedback, 28.1% staff feedback, 21.3% survey, and 25.8% no evaluation	- Bereavement risk assessment tool (66.3%) - Condolence card (62.9%) - Brochure (43.8%) - Follow-up telephone call (36%) - Group counseling (13.5%) - Memorial service (12.4%) - Family counseling (11.2%) - Social group meeting (11.2%) - Individual counseling (9%) - Home visit (4.5%)		Barriers - Lack of education (48%), money (47.3%), knowledge about relatives' bereavement needs (39.9%), feeling qualified to offer services (38.5%), time (32.4%), space (20.3%),interest in implementing a programme (20.3%) - Other hospital services provide intensive care unit follow-up (13.5), not the responsibility of the ICU (6.8%) - HCP perception that families do not need the service (2%)
36	Mélin et al., 2020	-	- Caring for the patient's body (involving relatives) - Time devoted to relatives and the spaces where they could engage - Use of a family room - Anticipation and announcement of death and the time of death - Physical contact with relatives, being present and listening to relatives' concerns - Information on the presence of volunteers and religious representatives - Proposal to meet with the psychologists - Adaptation to the patients' socio-cultural and religious practice	-	Barriers - Lack of knowledge about the agonal phase Facilitators - Therapeutic alliance close to the dying person) - Liasing with colleagues (working together with coherence and cohesion) - Training modules for HCPs

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
37	Merel et al., 2015	- Provision of bereavement care is variable: Condolences are "always" (29%) or "often"(23%), sometimes (21%), rarely (19%) or never (8%) expressed - 6% of the departments had a policy and procedure in place for contacting the bereaved	- Condolences offered through: phone call (38%), handwritten note (28%), commercial card (5%), typed note on letterhead (5%), typed note through electronic medical record (0%), in person at memorial service or funeral (4%)		Barriers - Already expressed condolences at the time of death (60%) Facilitators - Policy or protocol that could be adapted - Education and/or role modeling - Good relationship with the patient - Certain attitudes (e.g. condolences were expressed because staff thought they would appreciate it as well if they were the bereaved relative (68%) - System-wide tool (49%)
38	Mitchell et al., 2017	- Only 31.9% offered bereavement follow-up services - Staff: psychologist/counsellor (14%), physiotherapist/OT (0%), social worker (67.4%), and other (55.8%) - Staff providing these services were permanent within the team (72.4%) - Timing of providing services was variable: follow-up calls mostly done within one week (Australia) to four to six weeks (New Zealand) and return visits: one to two days, six weeks or a year post bereavement - 39% did some form of evaluation but mainly through verbal feedback from staff and relatives, and minimal formal evaluation.	Bereavement care: - Viewing of the deceased in ICU (96.6%) or morgue (56.4%) - Distribution of information on hospital bereavement services (97%) or community bereavement services (71%) - Sending a sympathy card (39%) Bereavement follow-up - Telephone follow-up call (80.9%) - Visit to the ICU (53.3%) - Formal counselling (24%) - Meeting with medical staff (45.7%)		- Most staff received additional training to support them in these roles (70.5%)

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
39	Morris et al., 2015	- Condolence call is done one to two weeks post-death. - Risk assessment prior to death. - Bereavement programme is formally evaluated through surveys	- Providing contact details - Information (printed and web-based) - Return visit to the hospital - Referral to community services - Risk assessment - Memorial events - Sympathy cards or condolence letters - Seminars for families about coping with grief or the nature of grief or based on Cognitive Behavioral Therapy	- Receiving a letter of condolence was evaluated positive on their grieving by most relatives (69%), 30% had a neutral response. - Wanted to receive more information about local resources and opportunity to ask questions - Contact from the patient's oncologist and nurse was especially well received. 90%/93% reported the call from the oncologist/nurse had a positive impact on their grieving	Barriers - Inaccurate contact information - HCP' perception that grief is an unique experience and individuals will need different things at different times
40	Muta et al., 2014	- Memorial service was held 1 year after the patients' death	- Memorial service (86%) - Sending memorial cards/letters (57%) - Sending condolences (25%) - Regular support groups (16%) - Telephone contact (16%) - Participation in funeral (5%)	- 55% of the relatives attended a memorial service. Most regarded it as positive as it provided the opportunity to thank staff (48%), visit the hospital again (43%), talk to staff (38%), share memories about loved one's hospital stay with staff (33%). For 19% it provided an opportunity to emotionally close the door on this segment of life. Not wanting to attend was mostly because relatives had the feeling they already coped on their own (35%), bad timing (29%) or did not know any other bereaved families (18%) or did not find it important to talk to other bereaved (18%)	Barriers - HCP' perception that painful emotions following a death is something relatives want to cope with on their own (10.23%) Facilitators - Build trusting relationships by providing ongoing care that starts while the patient is still hospitalised (16.36%)

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
41	Naef et al., 2020	- Bereavement services that target the time surrounding the death, such as viewing the body, providing information on the funeral, and making referrals are more established than services that follow bereaved relatives over time - 40.6% of acute care setting has a hospital bereavement guideline - Nurses enabled bereaved family members to see the deceased on the unit or hospital mortuary and send sympathy cards significantly more often than physicians - Physicians screen more often for complex bereavement disorders than nurses	- Viewing the deceased on the unit (73.7%) or hospital mortuary (68.8%) - Providing information on bereavement support services (45.7%), funeral arrangements (48.6%) or grief reaction (34.1%) - Unit-based individual farewell rituals (40.6%) - Referrals to a grief specialist (37%) - Sending a sympathy card (31.9%) - Memorial services or commemorative events (16.7%) - Attend funeral service (7.2%) - Screening for complex bereavement or prolonged grief disorder (3.6%)		Barriers - Less than half of the HCP feel skilled and competent (47.7%) - Lack of time (55.1), organisational support (47.8%), training (38.4%), privacy (36.2%) - The understanding that bereavement care is someone else's job (24.6%) or part of HCPs' role (15.9%) - Physicians find bereavement care more often than nurses not a part of their role - HCPs being afraid that relatives feel awkward (10.9%) - HCPs' dislike to talk about grief and loss (9.4%)
42	Neville et al., 2020		- Receiving keepsake (47%)	- 15% of relatives wanted to receive keepsakes.Keepsakses were viewed as cherished and meaningful items. It represented something positive during a time of suffering that lessen the pain of loss and memories of the deceased are immortalised by the keepsake. - The process of creating the keepsake was equally important as the final product of the keepsake itself. - Helped relatives realise that EOL was near - Can be valuable for family members who cannot visit or have restricted bedside presence.	

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
43	Santiago et al., 2017		- Brochure (about community support systems and educational materials about grief management) - Sympathy card - Telephone FU phone call - Memorial services	- 43% reported to find the brochure helpful, while 53% rated it neutral. only 40% reported that HCP reviewed the brochure with them. - All respondents found the sympathy card meaningful: they felt touched and thankful because they were not forgotten, but also happy and sad. They appreciated personal messages and staff identifying their role in the patient's care and staff taking the time to consider their feelings. - 50% of the relatives could not be reached for a telephone FU call, despite three attempts. The majority(67%) of reached relatives found it helpful because the verbal support gave them hope and the call was found thoughtful and a caring gesture. - The more successful phone calls, were those where the patient was in the ICU for several days to weeks - Only 29% of relatives attended the quarterly memorial service	
44	Stephen et al., 2011	- Follow-up to bereaved relatives was variable, scarce and informal. And generally falls to community services (within established relationship between a GP or nurse and a relative) . - There is an implicit understanding that the relationship between relatives and HCPs will end at some point after the death, in hospitals this is often very close to the time of the death.	- Alerting relatives to the imminent death - Providing contact details -	- Bereavement care is only perceived helpful when the HCP is known to the patient and relative and had knowledge of the care of the patient in the lead up to death - Relatives want a clarification of events leading up to the death or a meeting to ask unanswered questions	Barrier - Some circumstances (e.g. sudden death) do not make it possible to develop relationships between HCP and relatives - HCP' understanding that relatives have to work their own way through bereavement Facilitator - Established relationship between patient's relative and - Leave options for re-entering the relationship with HCP if there is a need.

	First Author, year	Description of in-hospital bereavement care	In-hospital bereavement care services	Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
45	Stilos et al., 2020		- Telephone call - Memorial service - Providing comfort and facilities (e.g. single room) - Providing information (on grief, administration, and bereavement support in the community)	- Relatives expressed gratitude for the call but were also surprised that the hospital remembered them - Relatives requested more information about grief and the grieving process	Barriers - Relatives' Incorrect or missing contact information Facilitator - Ensure contact information is captured before the patient's death
46	Walker et al., 2016	- Provision: for most, contact with the family ended at the point of their departure from the hospital. There were no established forms of bereavement follow-up Evaluation: no formal feedback	- Providing information on post loss procedures - Providing facilities (e.g. relatives' room) - Preparation of the deceased for family viewing - Relaxing departmental guidelines of visiting times and number of visitors at the bedside - Provide a contact number to relatives		Barriers - Busy environment and environmental pressures (dilemma of divided attentions) - Lack of continuity of care (e.g. shiftwork, brevity of encounters), staff, experience or confidence Facilitators - Personal experience of dying and death - Formal education, role modelling, peer support and experiential learning

	First Author, year	- Description of in-hospital bereavement care	- In-hospital bereavement care services	- Relatives' appreciation and effectiveness of bereavement care	Barriers and facilitators to provide bereavement care
47	Walsh et al., 2013		- Providing facilities - Return of personal belongings - Viewing the deceased in the mortuary		Barriers - Sudden or unexpected deaths - Less familiar with patients dying on department - Relatives are overwhelmed so they do not capture (all) information - Staff are not aware of the extent of bereavement services offered or how to access them Facilitators - External drivers (changed public expectations, public debates, increased publicity about and promotion of hospice and palliative care services) - Internal drivers (establishment of the palliative team, management-led initiatives to change practices) - coordinator was perceived effective in raising staff awareness and in developing a whole hospital commitment through training and information dissemination

Table 4 (Supplementary File): Qualitative studies' quality assessment using the MMAT (*N*=23)

			Screening Questions		**Qualitative**				
	First author & year	**Type of study**	**A. Are there clear research questions?**	**B. Do the collected data address the research question?**	**1.1 Is the qualitative approach appropriate to answer the research question?**	**1.2 Are the qualitative data collection methods adequate to address the research question?**	**1.3 Are the findings adequately derived from the data?**	**1.4 Is the interpretation of results sufficiently substantiated by data?**	**1.5 Is there coherence between qualitative data sources, collection, analysis and interpretation?**
1	Benbenishty et al., 2018	Interview	Yes	Yes	Yes	No	Yes	Yes	Yes
2	Berry et al., 2017	Interview	Yes	Yes	No	No	Yes	No	No
3	Bloomer et al., 2013	Focus group	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4	Breen et al., 2013	Interview	Yes	Yes	Yes	Yes	Yes	No	Yes
5	Chan et al., 2013	Interview	Yes	Yes	Yes	Yes	No	Yes	No
6	Coombs, et al., 2017	Survey	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7	Cooper et al., 2019	Interview	Yes	Yes	No	No	Yes	No	No
8	Downar et al., 2020	Interview	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9	Erikson et al., 2019	Interview	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10	Ford et al., 2013	Unspecified	Yes	No	No	No	Yes	No	No
11	Granek et al., 2013	Interview	Yes	Yes	Yes	Yes	Yes	Yes	Yes
12	Hottensen et al., 2013	Interview	Yes	Yes	No	No	Can't tell	No	Can't tell
13	Johansson, et al., 2018	Interview	Yes	Yes	Yes	Yes	Yes	Yes	Yes

			Screening Questions	**Qualitative**					
	First author & year	**Type of study**	**A. Are there clear research questions?**	**B. Do the collected data address the research question?**	**1.1 Is the qualitative approach appropriate to answer the research question?**	**1.2 Are the qualitative data collection methods adequate to address the research question?**	**1.3 Are the findings adequately derived from the data?**	**1.4 Is the interpretation of results sufficiently substantiated by data?**	**1.5 Is there coherence between qualitative data sources, collection, analysis and interpretation?**
14	Kentish-Barnes et al., 2017b	Interview	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15	Kirby et al., 2018	Interview	Yes	Yes	Yes	Yes	No	No	No
16	Makarem et al., 2018	Interview	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17	Melin et al., 2020	Focus group	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18	Muta et al., 2014	Interview	Yes	Yes	Yes	Yes	No	Yes	Yes
19	Neville et al., 2020	Interview	Yes	Yes	Yes	Yes	Yes	Yes	Yes
20	Stephen, et al., 2013	Interview	Yes	Yes	Yes	No	Yes	Yes	Yes
21	Stilos et al., 2020	Interview	Yes	Yes	Yes	Yes	Can't tell	No	No
22	Walker et al., 2016	Interview	Yes	Yes	Yes	Yes	Yes	Yes	Yes
23	Walsh et al., 2013	Focus group & interview	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Table 5 (Supplementary File): Quantitative Randomised Controlled Trials' (RCT) quality assessment using the MMAT (*N*=1)

			Screening Questions		**Quantitative: Randomized Controlled Trials**				
	First author & year	**Type of study**	**A. Are there clear research questions?**	**B. Do the collected data address the research question?**	**2.1 Is randomization appropriately performed?**	**2.2 Are the groups comparable at baseline?**	**2.3 Are there complete outcome data?**	**2.4 Are outcome assessors blinded to the intervention provided?**	**2.5 Did the participants adhere to the assigned intervention?**
1	Kentish-Barnes et al., 2017a	RCT	Yes	Yes	Yes	Yes	No	Yes	Yes

Table 6 (Supplementary File): Quantitative Non-Randomised studies' quality assessment using the MMAT (*N*=2)

			Screening Questions		**Quantitative: Non-Randomized**				
	First author & year	**Type of study**	**A. Are there clear research questions?**	**B. Do the collected data address the research question?**	**3.1 Are the participants representative of the target population?**	**3.2 Are measurements appropriate regarding both the outcome and intervention (or exposure)?**	**3.3 . Are there complete outcome data?**	**3.4 Are the confounders accounted for in the design and analysis?**	**3.5 During the study period, is the intervention administered (or exposure occurred) as intended?**
1	Kock et al., 2014	Cross-sectional	Yes	Yes	Yes	No	Can't tell	Can't tell	Yes
2	Santiago et al., 2017	Non-randomized	Yes	Yes	Yes	Yes	No	No	No

Table 7 (Supplementary File): Quantitative Descriptive studies' quality assessment using the MMAT (*N*=13)

			Screening Questions		**Quantitative: Descriptive**				
	First author & year	**Type of study**	**A. Are there clear research questions?**	**B. Do the collected data address the research question?**	**4.1 Is the sampling strategy relevant to address the research question?**	**4.2. Is the sample representative of the target population?**	**4.3. Are the measurements appropriate?**	**4.4. Is the risk of nonresponse bias low?**	**4.5. Is the statistical analysis appropriate to answer the research question?**
1	Banyasz et al., 2017	Cross-sectional	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes
2	Beiermann et al., 2017	Cross-sectional	Yes	Yes	Yes	Yes	Yes	No	Yes
3	Downar et al., 2014	Cross-sectional	Yes	Yes	No	No	Yes	No	Yes
4	Fridh et al., 2020	Cross-sectional	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5	Granot et al., 2016	Cross-sectional	Yes	Yes	Yes	Yes	Yes	No	Yes
6	Guldin et al., 2015	Cross-sectional	Yes	Yes	Yes	Yes	Yes	No	Yes
7	Ito et al., 2020	Cross-sectional	Yes	Yes	Yes	No	No	No	Yes
8	Kusano et al., 2012	Cross-sectional	Yes	Yes	Yes	Yes	Yes	No	Yes
9	Lebus et al., 2014	Cross-sectional	Yes	Yes	Yes	Yes	Yes	No	Yes
10	McAdam et al., 2016	Cross-sectional	Yes	Yes	Yes	Yes	Yes	No	Yes
11	Mitchell et al., 2017	Cross-sectional	Yes	Yes	Yes	Yes	Yes	No	Yes
12	Morris et al., 2017	Cross-sectional	Yes	Yes	Yes	Yes	Can't tell	No	Can't tell
13	Naef et al., 2020	Cross-sectional	Yes	Yes	Can't tell	Yes	Can't tell	No	Yes

Table 8 (Supplementary File): Mixed methods studies' quality assessment using the MMAT (*N*=8)

			Screening Questions		Mixed-methods: qualitative, descriptive															
	First author & year	Type of study	A. Are there clear qualitative and quantitative research questions, or a clear mixed methods research question?	B. Do the collected data address the research question?	1.1 Is the qualitative approach appropriate to answer the research question?	1.2 Are the qualitative data collection methods adequate to address the research question?	1.3 Are the findings adequately derived from the data?	1.4 Is the interpretation of results sufficiently substantiated by data?	1.5 Is there coherence between qualitative data sources, collection, analysis and interpretation?	4.1 Is the sampling strategy relevant to address the research question?	4.2. Is the sample representative of the target population?	4.3. Are the measurements appropriate?	4.4. Is the risk of nonresponse bias low?	4.5. Is the statistical analysis appropriate to answer the research question?	5.1. Is there an adequate rationale for using a mixed methods design to address the	5.2. Are the different components of the study effectively integrated to answer the research question?	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
1	Coimin et al., 2019	Convergent	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
2	Egerod et al., 2018	Convergent	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes
3	Egerod et al., 2019	Convergent	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	No	Yes	Yes	Yes	Yes	Can't tell	Can't tell
4	Goebel et al., 2017	Sequential exploratory	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes

5	Hayward et al., 2016	Convergent	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Can't tell	No	Yes	Yes	Yes	Yes	Yes	Yes
6	Kalocsai et al., 2020	Sequential exploratory	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

			Screening Questions		**Mixed-Methods: qualitative, descriptive**														
	First author & year	**Type of study**	**A. Are there clear qualitative and quantitative research questions, or a clear mixed methods research question?**	**B. Do the collected data address the research question?**	**1.1 Is the qualitative approach appropriate to answer the research question?**	**1.2 Are the qualitative data collection methods adequate to address the research question?**	**1.3 Are the findings adequately derived from the data?**	**1.4 Is the interpretation of results sufficiently substantiated by data?**	**1.5 Is there coherence between qualitative data sources, collection, analysis and interpretation?**	**4.1 Is the sampling strategy relevant to address the research question?**	**4.2. Is the sample representative of the target population?**	**4.3. Are the measurements appropriate?**	**4.4. Is the risk of nonresponse bias low?**	**4.5. Is the statistical analysis appropriate to answer the research question?**	**5.1. Is there an adequate rationale for using a mixed methods design to address the research question?**	**5.2. Are the different components of the study effectively integrated to answer the research question?**	**5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**
7	Kobel et al., 2019	Convergent	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8	Merel et al., 2015	Convergent	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Can't tell	Yes