

*BEREAVEMENT PRACTICE GUIDELINES*

*for*

*HEALTH CARE PROFESSIONALS*

*in the*

*EMERGENCY DEPARTMENT*

*Best Practices in Supporting the Family and Staff*

*When a Child Dies Suddenly*



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**HEALTH CARE PROFESSIONALS**  
**IN THE**  
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**Best Practices in Supporting the Family and Staff**  
**When a Child Dies Suddenly**

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## INTRODUCTION

Sadly, despite the best of medical care, thousands of children and adolescents die suddenly in Emergency Departments (EDs) each year. No ED ever wants to see a child die. No ED staff member wants to witness the agony of a parent whose child is in critical condition in a resuscitation room. Physicians dread informing a family member that his or her child has died. The emotional toll on parents, siblings, and other relatives is enormous. Their grief reactions may last for months and years, and their lives may never be the same. At the same time, Emergency Department staff members also suffer when a child dies. Their professional training has mostly been in science, learning medical techniques to save lives, rather than in handling communications with terrified, disoriented, and heartbroken parents and siblings. Clearly, when a child dies suddenly, the family members suffer intensely, and the ED staff may find it most difficult to counsel them. The aim of these practice guidelines is to help ED staff members become more comfortable in relating to the families of dying children, thus improving the quality of care that families receive in the ED.

Although some children do not survive their illnesses or injuries, their family members can benefit tremendously by receiving skilled, sensitive, and caring support at a time when they may be truly emotionally devastated. The quality of assistance provided can make a huge difference in the way that a family collaborates with staff and responds to multiple decision-making issues. It also affects memories and grief reactions that they may endure. To provide the family with the care they need to deal with the sudden death of a child requires ED preparation, training, skill, supervision, and emotional support for the staff. These practice guidelines assist the ED staff in

providing family-centered care that may help family members through a crisis of almost unimaginable proportions. Although family members never forget the pain they endured when their child died in the ED; they also never forget how they were treated.

The emergency physicians, nurses, psychiatrists, social workers, chaplains, EMS providers, psychologists, child life specialists, bereaved parents and others who served on the Expert Panel that developed these practice guidelines took a “sequential approach,” to the phases of care, starting with ED preparation. It quickly became apparent to the panel members that the sudden deaths of children present such emotionally draining and complicated communication tasks for ED staff that there needed to be a section of these guidelines devoted to helping staff deal with childhood deaths.

A daunting challenge arose during the writing and revising of this document. On the one hand there needed to be an easy-to-read document that can be referenced quickly by busy ED staff members. On the other hand there needed to be a practice illustration to demonstrate communications by ED staff during critical moments with the family. Therefore, the panelists suggested a section for a practice illustration.

Relating effectively to the communication and mental health needs of families can be a difficult task. Because each ED varies in size, location, culture, and resources available, we recognize that this document alone can not offer the “ultimate solution” to those wishing to be skilled in the work of relating to family members when a child dies. More face-to-face training for ED staff,

publications, and collaboration between community agencies are needed to ensure that the families of dying children receive the help they need when they need it.

## **PHASE I: PREPARING THE EMERGENCY DEPARTMENT TO HELP THE FAMILY OF A CRITICALLY ILL OR INJURED CHILD WHO DIES**

Immediate communication and support for the family as they arrive in the ED helps them to accept the shock of the trauma or illness and understand the medical status and care of their child. Immediate collaboration with the parents may help them to have a measure of control and an ability to play a role in the care of their child. Support and help for the family during the time of death can help them to understand and feel more comfortable with their grief reactions. The following steps are recommended by the panel in preparing the ED for the sudden death of a child:

1. Establish protocols and procedures.
2. Train all ED staff.
3. Designate a family room.
4. Assign a trained family care provider to work with the family.

### **Have Protocols and Procedures in Place**

We recommend that the following considerations be included in preparing the ED to adequately care for the family of a dying child:

- a statement about the ED philosophy of care that calls for family-centered approaches.

Whereas family-centered care has been defined in many ways, this set of practice guidelines calls for health care professionals collaborating actively and continuously with family; providing timely information and support to the parents about the patient; respecting the wishes, strengths, cultural, spiritual, and ethical needs of the family; and providing the support needed by family members who are experiencing the potential or

actual sudden death of a child. The care to the family should be individualized and based on their needs.

- protocols or procedures that outline how the ED team is to relate to the media, police, first responders, private physicians, medical examiner, child protection authorities, organ and tissue teams, and others from the community.
- protocols about when and how ED staff members are to relate to various hospital resource staff and community specialists when they are needed to supplement the care of the ED team.
- protocols about family presence in resuscitation areas. We recommend that parents be given the option of being with the child during the treatment as long as they are not in the way of caregivers and they understand that they may be asked to leave during procedures deemed invasive. A trained family care provider should be with the family in the resuscitation room to provide information and support. A family care provider may play a role in helping to relieve the guilt of a family **not** wishing or able to be in the resuscitation room with the child. The family care provider can help the family leave the room when they no longer wish to be present and help set limits of behavior and presence when necessary. Preparing the family for entry into the resuscitation room and talking with them after resuscitation room presence are other sensitive and necessary tasks for the staff member(s) assisting the family. It should be noted that the option of family presence in resuscitation rooms is still controversial in many hospitals. There are strong advocates on each side of the argument. Those who advocate for family presence as a routine practice say that parents feel more helpful and involved in the treatment process when they can comfort the child with words and touch. It also helps them to appreciate

firsthand the efforts of staff to resuscitate the child. Those largely against the practice of having parents in the resuscitation rooms say that many procedures and events are too excruciating for any family to witness and that flashbacks and nightmares may far outweigh any benefits from presence. Others feel that parents may collapse in the resuscitation room, diverting staff attention from the needs of the child. Still others fear legal repercussions because parents may have unrealistic expectations of ED treatment. In any case, family presence in resuscitation areas needs to be monitored and evaluated carefully. Outcome assessments from the family would be useful data to be shared in the professional literature as well as in training workshops and conferences.

### **Training of Staff**

We recommend that all ED staff, including nurses, physicians, students, security, and clerical staff receive education and training about the needs of families experiencing the sudden death of a child. Although the culture, size, resources, and location of EDs vary widely, the panel recommends the following elements for inclusion when providing training:

- the emotional, cognitive, behavioral, psychological, and social reactions of parents faced with a health care crisis and sudden death of a child
- how children, at various stages of psychological development, react to death
- reactions by parents and siblings to sudden deaths that may be caused by sudden infant death syndrome (SIDS), child abuse, suicides, murders, auto crashes, fires, and drowning
- cultural factors related to family reactions and behaviors
- how to provide reassurance without promising a miracle cure

- how to do a quick assessment of family needs, keeping the focus on the immediate crisis facing them
- giving information, asking questions, and providing support to members of the family
- how to listen carefully to the needs of family members during their stay in the ED
- when to call on hospital or community resources to help the family and staff
- telling the family about the death of their child
- providing support to the family when their child dies
- follow-up care for the bereaved family members.

ED team members can tailor the training to their own particular needs and accomplish it through a variety of means, depending on the resources and their needs. Consultants, experienced ED team members, mental health staff members of the hospital, and community professionals are among those who can help to organize and offer training. Bereaved parents and siblings, when ready, can be a tremendous resource in providing feedback to staff about their ED experiences.

Training is ongoing and can be conducted in several ways. Small group discussions can be held during lunch sessions and different shifts. Training sessions can be videotaped for use on various shifts. An ED manual on sudden death can be made available for quick reference. Some hospitals may want to have training materials on a floppy disk that can be accessed quickly by staff when needed. It takes a lot of time and energy to train staff for successful family outcomes in the ED. However, meeting the communication, spiritual, cultural, and support needs of family members is usually well worth the effort. When provided with sensitive and caring responses from the ED

staff, family members have a healthier adjustment to the death of their child and cooperate more with staff.

### **Designate a Special Room in the ED for the Family**

Such a room needs to be located in or adjacent to the ED and near the treatment and resuscitation rooms. The room is to afford accessibility for ED staff members as well as privacy for the family. A room containing comfortable chairs, table space, a telephone, writing materials, and tissues can help make the ED comfortable and private for the family. The telephone should have access to local and long distance lines. Toys, crayons, dolls, and other items for siblings should be available if the need arises. Adjustable lighting is suggested as well.

### **Assign a Trained Family Care Provider to Work with the Family**

Ideally, the family care provider (FCP) has received professional training in crisis and grief counseling. The FCP understands medical protocols and terminology and can explain them in simple words to the family. The FCP may be a social worker, nurse, chaplain, or other member of the ED team. The general function of the FCP is to interact with the family and the ED team, providing them with information, psychological support, and desired resources. The FCP is skilled at mobilizing the family's strengths to help them deal with the immediate crisis and in gathering pertinent information. The FCP also is sensitive, caring, and skilled in listening and responding appropriately to the needs of the family. An FCP should be available to provide services to the family 24 hours a day. Depending on the ED's resources, the FCP may be on-site or on-call with an immediate availability. The family in crisis requires psychological support as soon as they arrive in the ED.

## **PHASE II: WHEN THE CRITICALLY ILL OR INJURED CHILD AND THE FAMILY ARRIVE IN THE ED**

Knowing or suspecting that a child is in a life-threatening condition may cause many families to arrive in the ED feeling apprehensive, confused, dazed, and even agitated. Reaching out quickly and helping families when they “hit the door” is a recommended overall practice. Being responded to quickly, warmly, and in an organized manner tends to provide family members with a sense of trust and security. If trust can be established early in the process of treatment, it can markedly ease the communication and care if the child eventually dies in the ED. As noted in Phase I, assigning a family care provider trained in crisis and grief work can be extremely beneficial in helping the family make a smooth transition to the ED. The panel recommends the following guidelines during the arrival of the family to the ED:

- If time permits, the FCP should “tune in” to expected family themes before greeting the family. This tuning in is an exercise in preliminary empathy where the workers can put themselves in the shoes of the family. This exercise prepares an individual to understand and respond to the spoken and unspoken needs and questions of the family who may be situationally disorganized and not always clear about their feelings during the initial crisis.
- After greeting the family promptly, the FCP guides the family to a private room as discussed in Phase I.
- The FCP now “tunes in” to the feelings and reactions of the family, which includes listening to them and providing comfort, psychological support, and empathy.
- The FCP serves as a liaison between the family and the ED team, providing them both with pertinent medical and psychosocial information about the child and family.
- With the family’s permission, the FCP or other ED staff contacts the primary care

physician to inform them of the child's treatment in the ED and to obtain additional medical information.

- The FCP remains with the family throughout their stay in the ED providing ongoing support. The worker is available to assist the family with any problems or concerns that they may encounter and uses other staff as needed to provide help to the family.

### **PHASE III: WHEN A CHILD DIES IN THE ED**

The ED physician who has been involved in the treatment of a child informs the parents promptly and compassionately about their child's death after talking with the family care provider about special needs and cultural and spiritual concerns of the family. The staff should be patient, allowing time to answer questions, provide support or just sit with the family. If any siblings are present, a child life specialist may be helpful to them.

- The room used for informing the family should be private with comfortable chairs and tissues (see Phase I, Designate a Room).
- The physician and other staff should be prepared to help the family with their grief expressions that may include anger, sadness, fainting, pacing, or pounding the walls. ED staff should be patient and respond calmly, providing emotional support, answering the family's questions and listening to their concerns.
- The family should be informed of all medical procedures conducted to save their child's life.
- Family members should be given credit for any efforts they took to help the child. For example, noticing the fever or skin rash on the child; providing a good medical history of the child; rushing the child to the ED; or holding the hand of the child and saying comforting words.
- If the law requires an autopsy, the parents should be informed. Information about the autopsy should be given. It is helpful to provide to the family a simple explanation of autopsy procedures to dispel any myths they may have. If an autopsy is recommended, the family should be informed why and written permission should be obtained.

- Optional organ and tissue donation should be discussed with the family when appropriate. ED staff also should follow their state statute regarding organ and tissue donation.
- Offer the parents moments of privacy when appropriate. Privacy gives them time to sort out their reactions, feelings, and questions about the death itself or about any of the “next steps” anticipated.
- If appropriate, offer to contact the family’s religious or spiritual leader or the chaplain assigned to the ED.
- The family should be given the option of spending time with their deceased child before they depart the hospital. Some wish to spend time with their child, while others do not. Support the family members regardless of their choice. Should they desire to spend time, prepare them not only for what the child’s appearance may be but also for the appearance of the room and visible medical equipment that may have been used to save the child’s life.
- When appropriate, discuss funeral arrangements with the family and possible financial concerns they may have. Some families wish to choose a particular funeral home that they know. Others have no idea of the costs of funerals. It helps to have information about private and public funeral resources available.
- Provide the family with the name and telephone number of the FCP who will provide follow-up services to them. The FCP can link the family to key ED or other hospital staff if further services are needed.

- If appropriate, provide the parents with written information in the form of pamphlets or brochures to take home with them. That information may include the following:
  - common grief reactions to expect
  - common concerns of siblings and how to respond to them
  - developmental needs and expectations of children on grief issues
  - information and telephone numbers of support groups.

## **PHASE IV: FOLLOW-UP AFTER THE DEATH OF A CHILD IN THE ED**

ED staff should reach out to the family to help them with immediate needs and problems that may emerge at home after the death in the ED. The following recommendations may be helpful to the family in the days, weeks, and months after the death.

1. Assign a staff member to contact the family after the death. It is not unusual for this person to be the FCP who was involved with the family in the ED. Items that may require follow-up are
  - information about funeral resources and/or assistance with funeral planning
  - helping parents to understand and respond to sibling reactions
  - assessment of family's grief status and whether mental health services are warranted
  - assistance with pending autopsy decisions
  - clarification of any circumstances that may have occurred during their stay in the ED
  - information and referrals to support groups, such as Compassionate Friends, who offer group meetings to help parents with the loss of a child.
  
2. A follow-up plan should be developed to provide ongoing support to the family and to screen for problems. Many EDs follow families for one year. A follow-up plan should include the following:
  - The FCP should contact the family by phone within one week to offer support, answer questions, and assist with problems. Additional telephone calls should be based on the needs of the family.
  - The ED physician involved with the family may send them a letter of condolence and request family to call if they have questions or concerns.

- If an autopsy was performed, a meeting should be set up with the family to discuss the results as soon as they are available. The primary care physician should assist with this meeting also.
- An optional memorial service may be held during the anniversary date of the child's death and may be arranged by the hospital's chaplain.

## **PHASE V: HELPING STAFF COPE WITH CHILDHOOD DEATHS IN THE ED**

Childhood deaths can be very difficult for ED staff and prehospital providers. Competent staff may develop job dissatisfaction and leave if they do not get the help they need in dealing with the stresses caused by the death. Although there is no panacea for staff in emergency services facing childhood deaths, these guidelines may help them cope with one of the most painful aspects of their profession.

- Provide ED staff with proper education, supervision and training to work with children who suddenly die and maintain a supply of training materials such as books and videotapes in the ED for easy accessibility.
- Conduct debriefing sessions by a crisis-intervention specialist who works outside of the ED. The prehospital provider could also benefit from these sessions and other meetings held.
- Use critical-incident stress management to provide support, share frustrations, and discuss cases.
- Provide ED staff with recognition for their outstanding work.

## **SUMMARY**

The medical stabilization and cure of a sick or injured child is the most desired outcome in any ED that treats children. However, when the child cannot be saved, another set of desired outcomes becomes paramount—the provision of sensitive, caring, and comprehensive services designed to stabilize and help the family with the worst of tragedies. Many EDs lack the training and skills necessary to provide families with the supports they need when faced with sudden life-threatening and deadly events. These bereavement practice guidelines, developed by an experienced panel of experts in emergency services, address the steps necessary to help the families. The guidelines cover four basic stages that affect family experiences during their stay in the ED when dealing with sudden death. A fifth stage recognizes that ED staff also require help when dealing with sudden death. Having bereavement practice guidelines in the ED helps improve the quality of care that families receive when dealing with unexpected and profound emergencies.

## **FUTURE DIRECTIONS**

More work needs to be done to help ED practitioners develop and improve their skills in helping the family of the expired child. Face-to-face workshops and conferences, involving a combination of professional and bereaved-parent leadership, can have a great effect on staff skill development on the subject. The development of video tapes, again involving the collaborative efforts of bereaved parents and professionals, would be useful in the skill development process as well. The potential for using these guidelines in an electronic format may be useful to EDs as a template for internal policies or resource books.

There are many questions that need to be studied and researched in relation to providing support for the parents and siblings of the patient who dies suddenly. Suggested here for further inquiry, research, and publication are these items:

1. What practices do family members feel are most helpful and least helpful to them when they are involved in the life and death struggles in the ED?
2. What are the best ways to involve family members in providing feedback to the ED about their experiences?
3. What are the outcomes of family presence as experienced by families in the resuscitation room, and what kinds of supports are necessary to assist them there?
4. What are the outcomes of family presence as experienced by the ED staff when parents are in the resuscitation room?
5. In what ways can the parent and siblings of children who have died in the ED be encouraged to participate in the education of the professionals

who provide the service in the ED? It is postulated here that the insights of family members who have lost children are most valuable in helping staff provide the “best practices” when needed most by families.

It would be valuable for other writers to provide information about their experiences in involving the family in the training of ED and mental health staff.

6. What is the best way for the ED to collaborate with the primary care physician to enhance the medical care of the patient and improve communication with the family during the medical crisis and in follow-up after the death?

## **CASE ILLUSTRATION: THE PATIENT DIES**

The following case is one example of how the practice guidelines can be used to help the family before and after the child dies. It contains basic concepts and approaches that have proven useful and reliable in working with the family of the dying child.

### **CASE SCENARIO**

A 17-year-old male, who recently graduated from high school, was badly injured in an automobile crash near his home shortly after midnight. The family of the patient lived in an upper middle-class neighborhood near a large city. Although the extent of the teenager's medical condition was not yet known, the ED of the local hospital received a report from first responders on the scene that they were working to stabilize the patient, who had suffered a head injury, and would proceed to the hospital in 15 to 20 minutes. The ED nurse notified the FCP on call to come quickly to the hospital to assist the family members who were en route to the hospital. While driving to the hospital, the FCP prepared to work with the family by "tuning in" to what the family might be struggling with as they arrived at the hospital.

As I drove to the hospital, I began to tune in to the parents and siblings that might come. I thought about how the parents might be in shock and unable to believe that their son was involved in a car crash. They would be hoping that any injuries would be minor but fearful that their son was badly injured or killed. The parents may have other children who might need attention in the ED. The parents may or may not have family supports. The parents might be experiencing guilt, anger, sadness, and confusion. They could be in a blaming mode, either blaming others for the crash or blaming their son. They might blame themselves, somehow. They would need information, reassurance, and communication. They could be calm or agitated. The father could react one way

and the mother the opposite to any of the events that unfold. This family may be open about their grief reactions or appear to be stoic.

I hoped to arrive at the hospital before the family. The parents had not arrived at the hospital when I arrived. I waited for them in the ED as I prepared the family room with adequate chairs and a box of tissues and placed a pitcher of ice water and cups on the table. In a few moments I received a page informing me that the parents had arrived and were in the main waiting room. I greeted them and introduced myself as the family care provider who had been assigned to work with them while they were in the ED. I explained to them that their son had not arrived but was expected soon. I took them to the private room I had prepared, where I informed them about how the trauma team works and what to expect while Alec was being treated there. I asked the family what they knew about the accident. They said that the state police had called them at home to tell them that Alec had been injured in an automobile accident, was being transported to this hospital, and to meet him here as soon as possible. The father stated with much anguish, "I hate it when the phone rings late at night because it is always bad news." The mother cried as the father held her hand and said, "This is my worst nightmare." I replied, "Alec's accident is shocking and painful. I will check to see if he has arrived. While I'm away, would you like some coffee to drink?" They refused the coffee but had some of the water on the table.

I entered the resuscitation room and noticed that Alec had just arrived. He was unconscious, and the trauma team was busy assessing his medical condition and providing initial treatment. He was lying motionless on the examination table and had been placed on a respirator. The emergency medical technicians were in the hallway writing their reports, and I approached them to obtain additional information about what had transpired with Alec. Apparently, Alec had been unconscious since their arrival at the scene. They reported that Alec had lost control of his car on a foggy road as he approached a steep curve on a winding road near the river.

When I returned to the family room, the parents were comforting each other and looked at me eagerly for additional information. I informed them that Alec was in the ED receiving treatment for his injuries and that he was unconscious and appeared to have a head injury, which the physicians were evaluating. I reported to them the circumstances of the accident that the

emergency medical technicians had given me. I let them know that one of the physicians would come and talk with them soon. I assured them that the hospital specialized in treating children with multiple injuries and had a staff of skilled emergency physicians and others who would provide Alec with excellent care. I obtained the name and phone number of Alec's primary care physician and called him to inform him that Alec was being treated in the ED. He was not available and a message was left with his answering service to call the ED.

The father began to pace the floor, as the mother prayed that their son would be okay. I said to the father, "Waiting is very difficult." The father replied, "I can't believe this is happening. He just graduated from high school two days ago. He has never had an accident since he received his driving license a year ago. He just has to be okay!" I encouraged the family to continue to provide information about Alec, because they found it helpful to talk about him. They shared that he was an only child who had plans to attend the University of Michigan on an academic scholarship. Alec was vice president of his senior class and a model adolescent who did not drink, smoke, or use drugs. He had a girlfriend and was in good health until today. I asked the mother if she would like to call her minister. She did but learned that he was out of town. I offered to call the hospital chaplain who came within 20 minutes. The father called his brother and the mother called her best friend who, on hearing the news, both decided to come to the hospital. During the next few moments, the mother became agitated. I asked what she was thinking about. She replied that she wanted to be with her son who needed her now. She explained that he would feel better if he knew she was here for him. I informed her that I would go to the treatment room to see if she could be with Alec. I asked the father if he also wanted to see Alec and he replied, "No, I'll wait until the doctors are finished." I spoke with the trauma nurse coordinator about the mother's desire to be in the resuscitation room with Alec. She explained that a chest tube was being inserted this instance and that it was not a good idea because of the medical procedures involved. She said that she would come and get the mother when the procedure was completed. In the meantime, I asked the nurse to have the team inform Alec that his parents were here waiting to visit him. This information would help to comfort Alec if he could hear and also would provide comfort for the

mother if she knew that he was made aware that she wanted to be with him. The nurse then informed me that Alec was very unstable and may not make it.

I returned to the parents and informed them that this was not a good time to visit Alec because the doctors were inserting a chest tube. I explained to them the purpose of this procedure. I reassured them that the doctor would be over to speak with them as soon as he could get away. Because Alec's medical condition was unstable, it was difficult for the doctor to leave him. The mother understood and preferred that the doctors did what they needed to do before she visited or before they came to talk with them. I informed her that I asked the doctors to tell Alec that they were here waiting to see him. She was happy to hear this, and it seemed to provide some sense of relief for her.

The hospital chaplain arrived and prayed with the parents. She listened to their anxiety, fears, and doubts about their faith. She provided much comfort to the parents, who seemed very religious. The brother and best friend came soon after the chaplain and provided additional support to the parents. The ED physician came to the room 15 minutes later. He reviewed Alec's precarious condition and steps taken to treat him. The ED physician informed the parents that Alec was very unstable, that he may not make it, and that the team was doing everything possible to help save his life. The physician then excused himself to return to the treatment room. More tears streamed down the family's faces as they joined hands and prayed harder that their son's life would be spared.

### **Informing the Family of the Death**

The trauma nurse coordinator sent for me and told me that Alec had died. I met with the physician and the nurse for a few moments to review the situation and prepare for telling the parents. I provided the team with information about Alec being the only child, his recent high school graduation, and his plans for college. The family was very close. The three of us decided to inform the family of the death together and entered the family room.

The brother and friend had gone for coffee; the chaplain was with the parents. The physician said that he was very sorry to tell them that Alec had died. The parents wept and cried aloud. It took a while for them to calm down before the physician was able to give them more

information. He explained that Alec had a massive head injury that caused him to be unconscious throughout the entire treatment process. He provided other technical information and reassured the family that staff had done everything possible to save their son's life. The physician informed the family of the role of the medical examiner and the requirement for an autopsy. Although the parents were surprised by the medical examiner's involvement, they accepted it and asked questions about the autopsy procedures, which the physician answered. The physician also discussed organ donation with the family; the family was receptive to it, and arrangements were made to contact the organ procurement team. The parents sat numbed, and the ED staff sat quietly with them. The father asked if the delay in transporting Alec to the hospital caused his death. The physician explained that the emergency medical technicians transported Alec to the hospital soon after their arrival on the scene and that they did an excellent job of stabilizing him and providing initial emergency treatment at the time that Alec required it the most. By this time the brother and close friend entered the room. The parents informed them of Alec's death; tears and words of disbelief filled the room again. The ED team continued to provide comfort, emotional support, and reassurance and answered ongoing questions about Alec's condition and his treatment. When a sense of calmness was felt in the room, the parents were asked if they would like to say goodbye to Alec. They wanted to and were prepared for the appearance of the resuscitation room and Alec. The family, chaplain, and I gathered around Alec's bed while the chaplain offered more prayers. The family tearfully shared their memories of Alec and were given time to be with him alone while the staff waited for them close by.

Funeral arrangements were discussed. The family said that they would use a local funeral home that had taken care of other members in their family who had died. They also had a minister and church that they would contact for assistance. They were encouraged to call me if assistance were needed in this area.

Around 3:30 A.M. the parents left the hospital. They were given the ED physician, chaplain, trauma nurse coordinator, and my written name and telephone number. They also were given written grief information. The parents were informed that I would call them the next day to see how they were doing and if they needed assistance with anything. I walked the family to their

car providing continuous emotional support and assisted them in paying for their parking fees because in their rush to come to the hospital, they had left their wallets at home.

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The National Association of Social Workers (NASW) is the largest organization of professional social workers and serves the critical and diverse needs of the social work profession. NASW works extensively at state and local levels to advance the quality of social work practice, to advocate standards that protect consumers, and to propose and support public policies that improve our social environment.

NASW staff included Hal Lipton, MSW, Project Director, and Mirean Coleman, MSW, Project Manager. The panel of experts and reviewers of the practice guidelines are listed on the following pages.

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