Bereavement Care Planning PC.B10

Regulation(s):	42 CFR 418.54(c)7; 418.64(d)(1)(iv)
L-Tag(s):	531, 596

POLICY: A bereavement care plan is developed for identified family members and other involved individuals after the patient's death.

PROCEDURE:

1. During the immediate needs assessment, the Registered Nurse completes a bereavement risk assessment and identifies if the patient and/or family members are high, moderate or low risk. If a person is identified as being of high or moderate risk, a member of the psychosocial team is called and visits to complete a comprehensive bereavement risk assessment within twenty-four (24) hours. The Bereavement Care Coordinator (BCC) is notified of the high/moderate risk patient/family and participated in the planning of care.

2. If the patient/family is deemed to be of low risk, during the comprehensive assessment of the patient, an initial bereavement assessment is conducted to determine the cultural, social and spiritual factors that may impact the ability of family members or other involved individuals to cope with the patient's death.

3. Findings from the bereavement assessment are incorporated into the patient's plan of care and considered in the bereavement plan of care.

4. Throughout the course of the patient's care, members of the IDG reassess, document and address the anticipatory bereavement needs of the patient, the patient's family, caregivers and significant others.

5. The Bereavement Care Coordinator is notified of all deaths and initiates the bereavement discussion and care planning at the first IDG meeting following the patient's death. All family members/caregivers are assessed and assigned to a specific risk group of either High Risk Bereavement, Moderate Risk Bereavement or Low Risk Bereavement. Based on the assessment of individuals the bereavement plan of care (BPOC) is thus established and risk levels are followed up accordingly.

Created:	Reviewed:	Revised:	Effective:
6/18	2/11/19		4/2019
Reviewed:	**Reviewed:**	**Reviewed:**	**Reviewed:**

6. The bereavement plan of care reflects the assessed needs of the bereaved and notes the kind of bereavement services to be offered and the frequency of delivery.

   High risk bereavement: Will receive ongoing support from social work, spiritual care as well as the BCC. A combination of FTF visits, phone calls and mailings will be utilized to provide monthly, according to the following schedule:
   Visits: Months 1, 3, 6, 8, 10 & 12 months
   Calls: Months 1, 2, 4, 5, 7, 9, 11 & 13 months
   Mailings: Months 1, 2, 5, 7, 9 & 13
   Moderate: BCC will complete at least three FTF visits with bereaved (as able), and continue to visit at a frequency determined appropriate per the BPOC. A combination of visits, telephone calls and mailings will utilized according to the following schedule:
   Visits: 1, 3, 6 & 10 months
   Calls: 1, 2, 4, 8 & 13
   Mailings: 1, 2, 5, 7, 9 & 13
   Low: BCC will make at least two FTF visits and utilize a combination of telephone calls and mailings according to the following schedule:
   Visits: 1, 3 & 6 months
   Calls: 1, 2 & 8 months
   Mailings: 1, 3, 6, 9 & 13 months
   All bereaved receive an anniversary card (and/or visits or calls prn)

7. The Bereavement Coordinator ensures that the bereavement plan of care is followed for 13 months following the patient's death, appropriate to the level of need assessed.

8. Bereavement services listed in a patient's bereavement plan of care may include but are not limited to: bereavement visits and counseling, mailings and/or telephone contact.

9. Support groups, community education, memorial services and/or additional bereavement services are provided on an as needed basis.

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