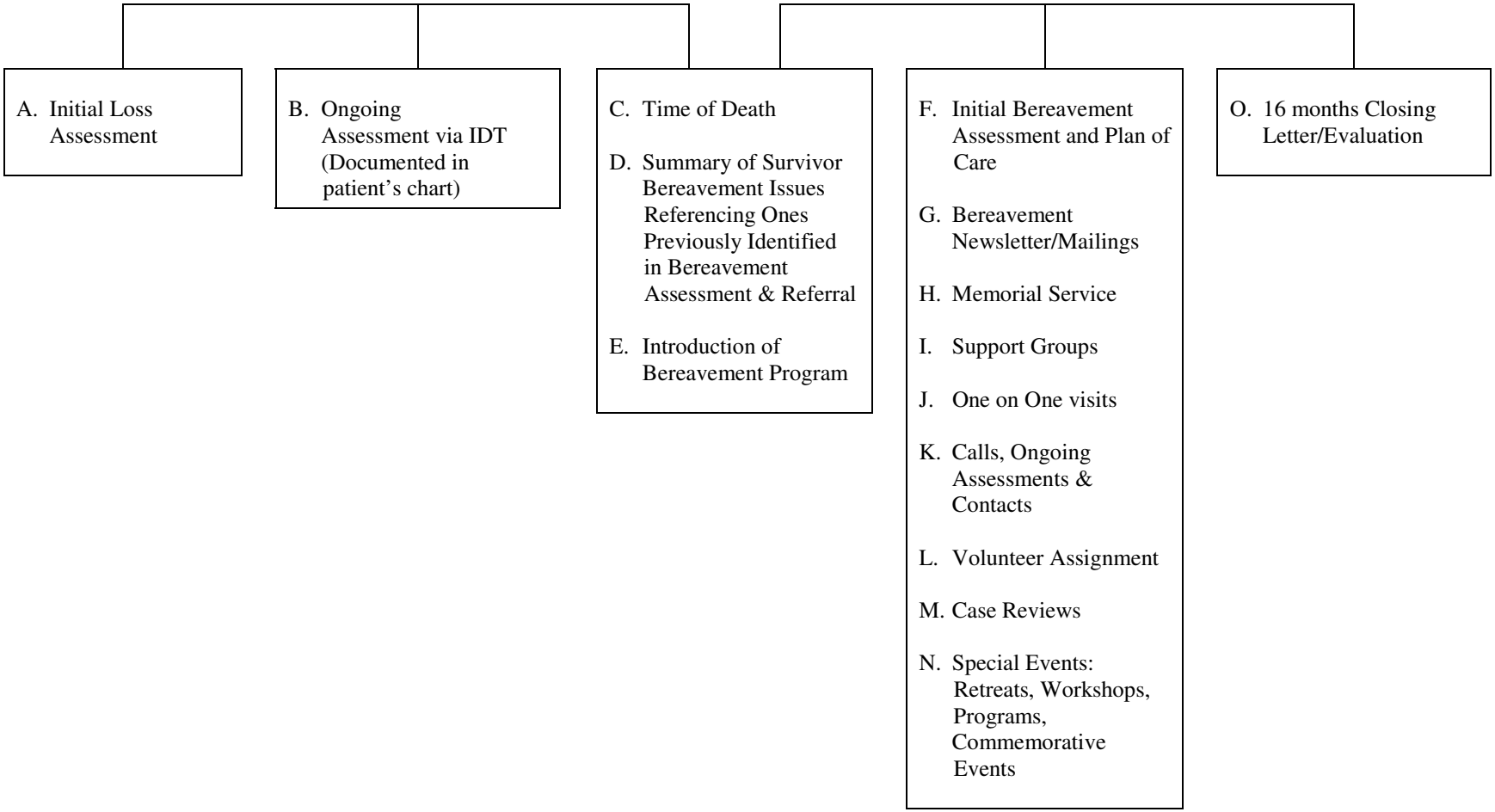
THE BEREAVEMENT CONTINUUM
THROUGHOUT THE COURSE OF HOSPICE CARE



BEREAVEMENT THROUGHOUT THE COURSE OF HOSPICE CARE

Documentation provides a "snapshot" of what you did. If it isn't documented, technically, it didn't happen. Documentation can be considered from the vantage point of different levels. At the Macro Level it is from the industry perspective that you document what you do. Consider how it is that you document the specifics offered in your program. An inherent part of the Macro level is the importance of keeping statistics on all aspects of what is offered. The Micro Level is the individual clinical support you provide. Think about what specific components should be included in good clinical documentation? Also consider any and all ways you can quantify the effectiveness of your grief interventions is encouraged (pre and post tests, evaluations, etc.).

Most bereavement programs focus on normal grief and preventative mental health, assessing the potential for normal response, affirming the natural process of grief and documenting ways that is supported.

<u>Documentation occurs throughout at the following points of bereavement service along the continuum:</u>

A & B: Initial Loss Assessment (at time of hospice admission) & Ongoing Assessment (throughout the course of care)

- Loss history
- Supports
- Stressors
- Strengths
- Coping style
- Spirituality
- Resources
- Children

C: Time of Death

- Specify who contacted family/type of contact
  -- Include how family was coping

D: Summary of Risk Assessment from IDT to bereavement (for individual bereavement referrals at TOD)

- Relationship to deceased
- TOD impact on bereaved
- Loss history
- Supports
- Stressors
- Strengths
- Coping style
- Spirituality
- Resources
  -- Children

E: Introduction of Bereavement Program

F, J & K: Initial & Ongoing Assessment/Bereavement Support (Medicare regulations require a Plan of Care that includes: needs, risk factors, specific follow-up services, referrals with a clear delineation of services provided and consistency of when and how provided.

- Perception of loss
- Relationship to deceased
- Physical, emotional, spiritual grief reactions
- Loss history
- Strengths
- Regrets/fears
- Stressors
- Children
- Support system
- Clinical impressions
- Interventions
- Risk level
- Goals
- Plan
- Obtain NPP if expect ongoing contacts

G: Bereavement Newsletter/Mailings

- Includes how to access bereavement services

H: Memorial Service

- Number attended, what it was, when offered

I: Support Groups

- Who attended, what it was, when offered
- If any client documentation, include NPP
- If clinical documentation, include physical, emotional, spiritual reaction to loss

L: Volunteer Assignment

a. Referral
   - Reason for referral, way(s)/why volunteer will be a support
   - Interests prior to death
   - Lifestyle changes
   - Type of support bereaved client has
   - Type of volunteer that might be helpful (gender, age, location, interests, etc)
   - Bereaved client's expectations and plan

b. Assignment documentation (specifying how frequent contacts will be)
   - Physical, emotional grief reactions
   - Mood
   - Positive coping skills
   - Descriptions re: grief journey
   - Encouraged client to…
   - Current focus in bereaved client's life
   - Volunteer recommendation/plan

M: Case Reviews

- Date discussed
- Plan of care, before and after review

N: Special Events

- Purpose of event, attendance

O: Closing letter/Evaluation

- Explanation of continued availability
- Evaluation to assess:
  - Services were helpful in coping with loss
  - Of different types of services provided
- Document date case is closed

Handout developed by Patti Anewalt, PhD, LPC, FT
for Hospice & Palliative Care Federation of Massachusetts, October 15, 2012