PATIENT AND FAMILY-CENTERED CARE (PFC)

Principles:

- Providing care and services that are responsive to the needs and exceed the expectations of those we serve.

- The patient and family is the unit of care.

- The hospice interdisciplinary team, in collaboration with the patient, family and caregiver, develops and maintains a patient, family and caregiver-directed, individualized, safe and coordinated plan of palliative care.

- Addressing loss, grief and bereavement needs begins at the time of admission to the hospice with the initial assessment and continues throughout the course of care.

- Anticipatory mourning services are provided to help patients, families and caregivers cope with the multitude of losses that occur during the illness and eventual death of the patient. Bereavement services are provided after death and are based upon a number of factors which include a bereavement risk assessment that assesses intensity of grief, coping and adapting abilities of the survivors and their individual needs.
### Standard:

**PFC 1** Hospice services are available twenty-four (24) hours a day, seven (7) days a week.

**PFC 1.1** The hospice assures a timely response to patient/family and caregiver telephone calls twenty-four (24) hours a day, seven (7) days a week.

**PFC 1.2** Professional staff is available to make home visits to address patient/family and caregiver needs twenty-four (24) hours a day, seven (7) days a week.

**PFC 1.3** Interdisciplinary team support is accessible and available twenty-four (24) hours a day, seven (7) days a week.

**PFC 1.4** Professional staff consultation and home visits provide assessment, instruction, support and when indicated, interventions.

**PFC 1.5** The hospice has reporting mechanisms and procedures to assure that, after normal business hours, staff and volunteers are regularly informed and updated on the patient’s current status.

### Practice Examples:

- A system is in place to respond to contacts and meet patient and family needs after normal business hours.

- Patients and families receive written information at the time of admission regarding how and when to access care after normal business hours. All team members throughout the course of care regularly reinforce this information.

- An established means of staff communication (*e.g.*, written, electronic and voice mail) exists to assure the accurate and timely transfer of information on a daily basis.

- Documentation of actions taken after normal business hours are relayed by facsimile or submitted in writing within twenty-four (24) hours.

- On-call logs document a timely response to all contacts and requests made after normal business hours.

- The primary registered nurse/social worker develops written recommendations, parameters for interventions and updates for staff providing care to patients after normal business hours to ensure continuity of care. The updates include new or changed medications, changes in the patient’s condition, a summary of current issues, helpful approaches, special concerns and information on uncommon diagnoses.
Standard:

**PFC 2** Care is fully coordinated to assure ongoing continuity for the patient, family and caregiver.

- **PFC 2.1** The hospice has criteria and a written process for receiving referrals and verification of eligibility that is used to make admission decisions for both adult and pediatric patients.

- **PFC 2.2** Procedures are established and utilized for initial and ongoing assessment of patients, families and caregivers by all disciplines including processes to evaluate special needs of children based on hospice defined time frames.

- **PFC 2.3** The hospice has criteria for determining levels of care, supports the decision of level of care with documentation, and utilizes all levels of care based on patient and family need.

- **PFC 2.4** The clinical record contains documentation of care coordination as evidenced by team conference notes, telephone communication and the visit records of hospice team members.

- **PFC 2.5** Ongoing, patient-specific comprehensive assessments are completed to accurately reflect the patient’s current health status and needs and the interdisciplinary team’s services are adjusted as required by the patient and family’s needs.

- **PFC 2.6** Clinical pathways are utilized to guide care and assure that appropriate staff coordinate hospice services on an ongoing basis.

- **PFC 2.7** A process is defined to transition family members and caregivers from patient care to bereavement care.

- **PFC 2.8** Information and other documentation support medical prognosis and eligibility.

**Practice Examples:**

- Admission policies and procedures are clearly defined and available to staff. Supplemental guidelines (e.g., NHPCO’s Guidelines for Determining Prognosis in Selected Non-Cancer Diseases or its successor documents) are also utilized in the decision-making process.

- The patient/family/caregiver’s needs are assessed utilizing available tools (e.g., NHPCO’s A Pathway for Patients and Families Facing Terminal Illness) throughout the course of care and the plan of care.

- Interdisciplinary team meetings include contracted service providers, community clergy, attending physicians, volunteers and family members when needed to address issues related to the coordination of care.

- Bereavement services are addressed at the time of admission and reinforced ongoing through written materials, direct contact and a plan for bereavement following the patient’s death.
**Standard:**

**PFC 3** A registered nurse coordinates the hospice interdisciplinary team of professionals and volunteers to assure continuous assessment, planning and integration of the patient’s and family’s needs.

**PFC 3.1** The hospice registered nurse coordinates the care based on the patient’s and families’ unique needs, the skills and specialties of the health professionals and the patient population served by the hospice.

**PFC 3.2** The hospice registered nurse’s responsibilities include:

1. Coordinating the team to ensure adequate assessment, planning and implementation of each patient’s and family’s plan of care; and

2. Ensuring effective interdisciplinary team practice, coordination and communication among team members.

**Practice Examples:**

- The hospice registered nurse is the focal point for current patient information. The hospice registered nurse’s other responsibilities include: attending team conferences and patient, family and caregiver conferences; updating the hospice aide(s) and changing the aide assignment as needed; communicating with the physician and other team members; identifying and addressing ongoing spiritual and psychosocial needs; addressing pain and comfort measures; and supporting the timely retrieval of signed physician orders and other documentation.

- The hospice has written qualifications and responsibilities defined for the hospice registered nurse as team coordinator.

- Care coordination among team members and across care sites is demonstrated through a review of team conference notes, telephone communication and clinical visit notes contained in the clinical record.
Standard:

PFC 4 A written plan of care is developed for each patient, family and caregiver prior to providing care and services.

PFC 4.1 The patient and family have the right to be informed and participate in planning care and treatment.

PFC 4.2 Individuals involved in developing the plan of care include:
   1. The patient, family and caregiver;
   2. The patient's attending physician;
   3. A hospice physician (e.g., the medical director, team physician or other designated physician);
   4. A registered nurse;
   5. A social worker;
   6. A spiritual counselor;
   7. A volunteer;
   8. A hospice aide;
   9. A bereavement counselor; and
   10. Others as appropriate.

PFC 4.3 The plan of care is based on the following data:
   1. Patient/family goals for care;
   2. Primary and secondary diagnosis and any co-morbidities;
   3. Current medical findings, including clinical indicators and data to support the terminal prognosis; and
   4. Interdisciplinary team assessments of the patient's symptoms, patient, family and caregiver functional status, patient, family and caregiver coping status, cultural issues, special needs of veterans and their families, and family resource status.

PFC 4.4 The plan of care includes the:
   1. Desired goals or outcomes;
   2. Patient’s and family’s problems/issues/needs and opportunities for growth;
   3. Interventions directed to achieve the desired goals or outcomes of the patient, family and interdisciplinary team;
   4. Scope, frequency and type of services to be provided, including the interdisciplinary team interventions, pharmaceuticals and medical equipment to be provided; and
   5. Other agencies or organizations which may be involved in the care.

PFC 4.5 The plan of care is based on comprehensive interdisciplinary assessment that includes physical, emotional, spiritual, psychosocial, medication and equipment needs.

Practice Examples:

◆ The admission visit is completed by the hospice nurse, and if available, one other member of the interdisciplinary team. The plan of care is developed by the interdisciplinary team members with input from the patient, family and caregiver, hospice medical director and attending physician.

◆ The plan of care includes the patient’s and family’s problems, issues, opportunities, related interventions and desired outcomes, and the scope and frequency of services to be provided.

◆ Assessment activities performed by the interdisciplinary team members are included in the plan of care and direct the determination of problems, opportunities, interventions and desired outcomes.

◆ The hospice uses the military history checklist to evaluate a patient’s military status and includes the needs identified in the plan of care.

◆ The plan of care is documented and communicated to all team members involved in providing care and services to the patient and family.
Standard:

**PFC 5** The hospice designates an interdisciplinary team that assesses, plans, provides and evaluates the patient’s and family’s care and services.

**PFC 5.1** The interdisciplinary team includes:

1. The patient and family;
2. The patient’s attending physician;
3. Physicians with palliative care education and experience;
4. Registered nurses with education and experience in effective pain and symptom management and competency in physical and other assessments as required by the hospice patient, family and caregiver;
5. Social workers with clinical and educational experience appropriate to the counseling and casework needs of the terminally ill patient, family and caregiver;
6. Chaplains or spiritual counselors with appropriate education, experience and skills related to pastoral counseling and bereavement support;
7. Trained volunteers that are under the supervision of a volunteer coordinator;
8. Hospice aides with appropriate clinical and educational experience;
9. Bereavement counselors with appropriate clinical and educational experience; and
10. Others with appropriate clinical and educational experience.

**Practice Examples:**

- The patient’s attending physician is invited to attend the interdisciplinary team meetings when the patient will be discussed.

- Volunteers who provide patient support/care are invited to attend the interdisciplinary team meetings and participate in discussions regarding their assigned patients.

- Weekly interdisciplinary team meetings include registered nurses, social workers, the hospice medical director, chaplains, hospice aides and volunteers.
**Standard:**

**PFC 6** The interdisciplinary team reviews, revises and documents the plan of care to reflect the changing needs of the patient, family and caregiver.

**PFC 6.1** The plan of care is reviewed by the interdisciplinary team no less than every 15 calendar days and documented on the patient’s clinical record.

**PFC 6.2** The interdisciplinary team revises the plan of care as often as needed to reflect changes in the patient’s and family’s status and needs.

**PFC 6.3** The plan includes an assessment of the individual’s needs and identification of services including the management of discomfort and symptom relief.

**PFC 6.4** Ongoing assessment occurs during any contact or interaction related to the patient, family and caregiver; plan of care is amended to address ongoing needs.

**PFC 6.5** Interdisciplinary team meeting documentation reflects the ongoing assessment of the patient’s and family’s status, needs and agreement with the plan of care.

**Practice Examples:**

- The patient, family and caregiver plan of care is reviewed regularly during the interdisciplinary team meeting.

- The plan of care is updated whenever there is a change in the patient’s and family’s condition that alters their status or needs (e.g., inpatient placement, new onset or increased severity of symptoms, caregiving crisis, inadequate financial resources, etc.).

- The patient’s and family’s needs are reassessed during each visit by a team member, documented on the visit note and significant observations shared with the interdisciplinary team members.

- Significant information obtained during the patient and family’s reassessment that affects the plan of care is immediately shared with other interdisciplinary team members and the plan of care is revised accordingly.

- Progress or visit notes document the reassessment findings obtained by the interdisciplinary team members.

- Documentation supports collaboration by team members as the plan of care is revised in response to the patient and family’s reassessment.
Standard:

PFC 7 The interdisciplinary team members implement the interventions identified in the plan of care.

PFC 7.1 The interdisciplinary team members provide services according to the scope and frequency identified in the plan of care.

PFC 7.2 The interdisciplinary team member's interventions are directed toward achieving the desired goals or outcomes in the plan of care.

PFC 7.3 Each interdisciplinary team member documents and communicates the interventions provided to the patient, family and caregiver, their response to care and services provided and the goals or outcomes achieved.

Practice Examples:

◆ The clinical record contains documentation that the frequency of visits performed by the interdisciplinary team members is in accordance with the visit frequency stated in the plan of care.

◆ The interventions related to the specific problems, issues and opportunities are documented on each care provider’s visit note.

◆ During meetings, team members discuss the appropriate interventions and plan for the patient’s care accordingly.
Standard:

PFC 8 The patient’s grieving response is evaluated and interventions that are based on the patient’s desires, needs and goals are incorporated into the interdisciplinary plan of care.

PFC 8.1 The interdisciplinary team works in partnership with the patient to identify issues that may complicate life closure.

PFC 8.2 The interdisciplinary team encourages, facilitates and validates the patient’s expressions of grief as related to losses identified by the patient.

Practice Examples:

◆ Bereavement staff makes visits to the patient/family prior to the patient’s death.
◆ The hospice team utilizes a music therapist or other complementary therapies to assist in facilitation of a patient’s expressions of feelings.
◆ The psychosocial assessment identifies goals and expectations for the patient and family.

Standard:

PFC 9 The interdisciplinary team identifies a patient’s beliefs and/or philosophies and honors these beliefs in all care decisions.

PFC 9.1 A spiritual assessment is completed within defined time frames and spiritual support is provided according to the patient’s ongoing wishes and needs.

PFC 9.2 The interdisciplinary team recognizes other issues/dilemmas, such as loneliness, guilt, fear and anger, common to the patient and helps the patient deal with them according to the patient’s preferences.

Practice Examples:

◆ Procedures and protocols are in place for involving the patient’s own spiritual support system in the care planning process.
◆ A spiritual assessment is completed that addresses spiritual distress issues.
◆ Documentation indicates that the patient’s spiritual beliefs and traditions are supported by the interdisciplinary team.
Standard:

**PFC 10** The interdisciplinary team promotes opportunities for personal growth according to the preference of the patient.

**PFC 10.1** The interdisciplinary team helps the patient to identify areas of importance in achieving reconciliation and closure including self, family, friends and community.

**PFC 10.2** The patient’s acceptance of his/her own strengths and unique qualities are promoted by interdisciplinary team members.

**PFC 10.3** Additional support is offered and provided according to the patient’s preference as the patient approaches death.

**PFC 10.4** Cultural perspectives on death and cultural beliefs are honored.

**Practice Examples:**

- The hospice has literature that explains what to expect during the dying process for the patient and family \(\text{(e.g., signs and symptoms of approaching death).}\)

- The hospice develops specially trained volunteer teams to provide patient and family support as death approaches.

- At the patient’s request, the hospice chaplain facilitates patient reentry into a faith community when the patient has not participated for many years.

- At the patient’s request, hospice staff facilitate family visits with special needs such as immigration problems or incarceration issues.
Standard:

PFC 11 The patient’s ability for self care is regularly assessed and interventions are implemented in accordance with patient/family wishes when the patient is no longer able to adequately provide self care.

PFC 11.1 Medical equipment is supplied, as indicated, to assist in the care of the patient.

PFC 11.2 Policies and procedures are developed to plan for the care of patients without primary caregivers in the home.

PFC 11.3 Communication strengths and barriers, such as inadequate knowledge, illiteracy and language barriers are routinely assessed and appropriate actions are taken to ensure patient understanding of care.

Practice Examples:

◆ The hospice has literature written in languages for ethnic groups common to the hospice’s service area.

◆ The hospice helps the patient explore possible options for care when the patient cannot remain alone, including a nursing facility, a hospice residence, a family member’s home or paid or unpaid assistants in the home.
Standard:

PFC 12 The family’s unique ability to emotionally or spiritually adjust to changing environmental conditions is assessed as a part of the ongoing, total psychosocial and spiritual patient and family assessment.

PFC 12.1 The care planning process includes interventions that address the needs and goals of the family as they relate to end-of-life or other issues.

PFC 12.2 Family spiritual beliefs, traditions and rituals are respected during the care planning process.

PFC 12.3 Family feelings of loss, despair, loneliness, unresolved guilt, fear and anger are recognized and addressed by the interdisciplinary team.

PFC 12.4 Appropriate and timely communication and education of the patient and family are continuous from admission to death.

Practice Examples:

- Psychosocial assessment tools include assessment of family history and coping skills.
- Bereavement staff routinely attends interdisciplinary team meetings and participate in the care planning process.
- The hospice interdisciplinary team counsels patients’ families to assist in resolving guilt related to continuing to work after the patient is diagnosed with a terminal illness.
- The hospice interdisciplinary team counsels a young patient’s parents to deal with anger over the child’s illness.
- The hospice interdisciplinary team counsels a patient and family in dealing with issues of post traumatic stress disorder or other disorders due to the patient’s military history and combat duty experience.
- The hospice bereavement counselor counsels a patient’s husband on how to cope with the loss of multiple family members, and now his wife within a short period of time.
- The hospice interdisciplinary team educates the family on what to expect at the time of death and bereavement by using appropriate teaching tools.
PFC 13: The hospice interdisciplinary team promotes opportunities for personal growth according to family preference.

**PFC 13.1** The interdisciplinary team helps family members identify important areas for reconciliation and closure.

**PFC 13.2** The interdisciplinary team facilitates communication between the family and the patient by encouraging expressions of love, concern, regret and forgiveness.

**PFC 13.3** Family members are educated about physical, psychological and spiritual aspects of the dying process.

**PFC 13.4** The interdisciplinary team nurtures and supports a sense of meaning for the family related to their relationships with each other and the family’s identity within the community.

**Practice Examples:**

- Family members are encouraged to meet individually with the patient and express their feelings, facilitated by the hospice social worker and chaplain.

- Family members are educated about the patient’s possible withdrawal from them as death approaches and are supported to continue care for the patient.

- The hospice uses a reminiscence tool to help the patient and family members remember and appreciate their lives together as a family.
CARE PLANNING (PFC)

Standard:

**PFC 14** The interdisciplinary team evaluates and supports the family’s physical, cognitive and social capacity to communicate, learn and carry out caregiving responsibilities.

**PFC 14.1** Common care and patient safety issues are regularly evaluated and interventions are incorporated into the care planning process.

**PFC 14.2** The capability and willingness of caregivers are regularly evaluated and, if necessary, intervention for change or improvement is integrated into the care planning process.

**Practice Examples:**

- The hospice nurse or other members of the IDT, at the patient’s request, regularly communicates with family members, including those residing outside the patient’s community to update them on the patient’s condition.

- Volunteers are assigned to provide support and services to patients when a family member needs extended coverage for a special circumstance.

- The hospice considers admission to respite care to provide family members a break so that they can develop an acceptable family caregiving schedule.

- The hospice social worker meets with the caregiver to assist with unresolved grief issues (e.g., miscarriage) in addition to anticipatory grief for the patient.

- The hospice care plan reflects specific arrangements for medication administration and safety when the admission assessment identifies risk of diversion.
Standard:

PFC 15 The interdisciplinary team assesses the patient’s and family’s environmental and financial resources as they relate to the provision of patient care and future family health.

PFC 15.1 Housing, welfare and safety issues, such as problems with shelter or inadequate financial resources, are identified and interventions initiated according to patient and family preferences.

PFC 15.2 Personal business and family welfare issues, such as funeral and memorial service arrangements or financial, legal and other services, are identified and interventions are initiated according to patient and family preferences.

Practice Examples:

- The interdisciplinary team requests that the family remove all ammunition from the home when patients refuse to give up firearms after threatening episodes.
- The interdisciplinary team arranges for respite care and assists family members with nursing facility placement for the patient.
- The hospice staff help the patient and family complete advance directives.
- The hospice staff help families with funeral or memorial service arrangements and the hospice chaplain helps plan and conduct services as requested.
Standard:

**PFC 16** Preparation and support for the patient’s death is provided.

- **PFC 16.1** Interdisciplinary team members are available to attend patient deaths twenty-four (24) hours a day, seven (7) days a week.
- **PFC 16.2** Staff attending a death respect the cultural, religious and spiritual traditions and beliefs of the patient, family and caregiver.
- **PFC 16.3** Each patient death is determined (*i.e.*, pronounced), documented and communicated according to law, regulation and the organization’s policy.
- **PFC 16.4** The patient’s body is handled with respect and dignity and in accordance with the requests of the patient, family and caregiver.

**Practice Examples:**

- The hospice has a written policy guiding death pronouncement and notification procedures.
- Family members and caregivers are informed of standard notification procedures before death occurs.
- On-call services support the ability for staff attendance at all deaths in all settings.
- The hospice nurse attends, and when state law allows, verifies a patient’s death.
- The hospice has a documentation tool for each patient death and related communication needs.
- Family members are afforded needed time with the patient’s body as desired.
Standard:

**PFC 17** The hospice has a defined bereavement program that begins at the time of admission and provides care for a minimum of 13 months following the death of the patient.

**PFC 17.1** The hospice has bereavement policies and procedures that define the scope of bereavement care provided and incorporates confidentiality issues and mechanisms to assure that family and caregiver choices regarding bereavement contact are honored.

**PFC 17.2** The hospice bereavement policies specify the services to be consistently provided within specific time frames during the course of bereavement care.

**PFC 17.3** The hospice bereavement program clearly delineates the nature of counseling services to be provided within specific time frames and the limitations of such services.

**PFC 17.4** The hospice has a defined and ongoing method of evaluating the outcomes and effectiveness of services provided.

**Practice Examples:**

- Bereavement services include:
  - Individual and family counseling;
  - Grief support groups (*general and specialized*) for all age groups;
  - Family and caregiver support visits;
  - Availability of telephone support;
  - Written materials about grief and coping for all ages and developmental levels;
  - Scheduled mailings (*e.g.*, personal, educational and informational);
  - Memorial services and funerals;
  - Camps and retreats;
  - Spiritual and pastoral counseling;
  - Internal inservice programs;
  - External educational offerings; and
  - Referral to community resources.

- Counseling services are geared toward the prevention of negative outcomes in bereavement and include education, encouragement, problem-solving and coping with normal grief manifestations.

- Bereavement outcomes are identified, data is collected and analyzed on an ongoing basis to measure the effectiveness of services provided.

- A means of communicating with out-of-area family members is developed to provide bereavement information and to offer support resources in their area if desired.
Standard:

PFC 18 Hospice patients and all significant family members and caregivers are assessed for grief and bereavement needs.

PFC 18.1 Survivor risk and bereavement assessment tools are utilized by the hospice from admission throughout the course of care.

PFC 18.2 Hospice staff identify, document and address the patient’s, family’s and caregiver’s needs and goals related to anticipatory mourning (before death) and bereavement (following death).

PFC 18.3 Each assessment and reassessment includes a documented evaluation of bereavement needs, the hospice’s response to assessed needs and the bereaved’s response to services provided.

PFC 18.4 The plan of care for these services should reflect family needs, outlining delineation of services and frequency.

Practice Examples:

◆ The assessment process is ongoing (i.e., initially upon admission, periodically during the patient’s hospice care and following the patient’s death).

◆ Assessment includes:
  1. Patient, family and caregiver needs;
  2. Physical and emotional well being;
  3. Past history and life adaptation/adjustments;
  4. Current and anticipated support systems;
  5. Age and developmental level;
  6. Social, spiritual and cultural variables;
  7. Manifestations of grief;
  8. Suicidal ideation/intention and related concerns (e.g., homicide);
  9. Potential for complicated grief (i.e., evidence of risk factors);
  10. Military experience, service-connected trauma and effects of war;
  11. Desire for bereavement care;
  12. A plan for ongoing evaluation of status and needs;
  13. Survivor risk factors;
  14. Caregiver strain index; and
  15. Grief Measurement Scale.
Standard:

PFC 19  A plan of care that includes bereavement needs, interventions, goals and outcomes is developed and documented for designated families and caregivers.

PFC 19.1  Goals and outcomes related to bereavement care are part of the ongoing care planning process, and are determined by family of caregivers in collaboration with the interdisciplinary team/bereavement staff.

PFC 19.2  Bereavement needs, services and interventions are documented in the clinical record.

PFC 19.3  Routine bereavement services are available and offered to the family and caregiver regardless of risk factors.

PFC 19.4  Family members and caregivers whose needs are assessed to be beyond the scope of the hospice bereavement program are referred to appropriate community agencies and/or practitioners.

Practice Examples:

◆ Family and caregiver needs and desires related to bereavement are incorporated into the plan of care.

◆ A plan for bereavement care is developed to meet family and caregiver expressed needs, desires and goals.

◆ The plan of care identifies the interventions to meet the family and caregiver’s goals.

◆ The interdisciplinary team/bereavement staff will implement and monitor the established plan of care.

◆ There is a regular review of bereavement goals and outcomes with those who are receiving bereavement care.

◆ Through an external referral process or internal service, a plan is developed to address the needs of those survivors identified as “at risk” for complicated grief reactions.

◆ The hospice has a mechanism in place to ensure the confidentiality of records for bereaved family and caregivers.
Standard:

**PFC 20** The hospice utilizes qualified staff and volunteers to provide bereavement services.

- **PFC 20.1** Bereavement services are managed and coordinated by qualified, professional hospice staff with education and training appropriate to the position’s responsibilities.

- **PFC 20.2** Bereavement services are provided by appropriate hospice staff and volunteers who receive routine clinical supervision by qualified professionals.

**Practice Examples:**

- The hospice utilizes staff with degrees in clinical social work, mental health counseling or other related fields (including chaplaincy) to provide bereavement services.

- Volunteers receive additional bereavement specific training including but not limited to supportive listening, communication skills, general concepts of grief and loss including risk factors for complications in bereavement, professional boundaries, stress management, self-care, collaboration and communication with the team/bereavement staff.

- The hospice provides evidence of training and education for staff and volunteers working with special patient populations (e.g., critical incident stress management, children, teens, persons with AIDS, etc.).

- The hospice assures that all staff are comprehensively trained in loss, grief and bereavement and are regularly offered continuing education opportunities in grief and loss including the identification of high risk survivors and those at risk for complicated grief reactions.

- The hospice has a plan for providing regular and ongoing supervision of bereavement staff and volunteers.

- Hospice bereavement staff are actively involved in appropriate professional practice organizations.

- The hospice defines bereavement staff roles and responsibilities for providing bereavement support to clinical staff and volunteers.