

Comprehensive Person-Centered Care Plan

Date	Physical and Psychosocial Needs	Goals/Objectives	Approaches/Interventions	Responsible Discipline
------	---------------------------------	------------------	--------------------------	------------------------

	<p>I have experienced the death and loss of my:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Close friend <input type="checkbox"/> Other: <p>The loss occurred: _____ [date]</p> <p>And I present with psychosocial manifestations of grief resulting from this loss that include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Crying, tearfulness. <input type="checkbox"/> Increased signs and symptoms of anxiety. <input type="checkbox"/> Increased withdrawn behavior. <input type="checkbox"/> Symptoms of mood distress/depression (i.e., anger, sadness, diminished appetite, decrease in self-care, problems sleeping). <input type="checkbox"/> Bargaining <input type="checkbox"/> Other and Comments: <p>I have the following strengths and abilities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Talk about my loved ones. <input type="checkbox"/> Reminisces fondly about this person. <input type="checkbox"/> Expresses feelings, both positive and negative. <input type="checkbox"/> Has a strong family support system. <input type="checkbox"/> Seems to take "one day at a time." <input type="checkbox"/> Seeks support from others. <input type="checkbox"/> Other 	<p><input type="checkbox"/> I will express my feelings regarding the loss that I have experienced, as needed and helpful...</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Provide me with a safe and supportive atmosphere that encourages me to freely and openly discuss and share the feelings that I may have about the loss that I have experienced. Offer me appropriate active listening and reassurance. <input type="checkbox"/> Provide me time and space to mourn. Provide me with empathy, understanding and supportive counseling, as needed. Involve me in programs/interaction with others when I appear ready to engage in such activities. <input type="checkbox"/> Keep my health care team members including my psychiatrist, psychologist, clinical social worker informed regarding the onset of my new mood/behavior symptom indicators and changes in my behavior including any decreases in appetite, insomnia, and/or manifestations of anger. <input type="checkbox"/> Make a referral for me to visit with the Psychiatrist for evaluation and treatment recommendations, as indicated. <input type="checkbox"/> Make a referral for me to visit with the clinical psychologist/social worker for additional support and bereavement counseling, as indicated. <input type="checkbox"/> Encourage me to express my feelings during supportive group and/or one-to-one programs. <input type="checkbox"/> Observe my psychosocial/emotional functioning. Look for mood, affect changes and signs of excessive anger, guilt and prolonged grief that I may have. Signs may include decrease in the amount of time that I spend with others, tearfulness/sobbing, questioning faith and displaying distressing vocalizations, etc. 	<p>Social work Nursing IDT Activities</p>
--	--	---	---	---

SwCG, Inc. ©	Name	Bereavement, Loss, Grieving	Mood Distress CAA's 7,8	Care Plan No. 29
--------------	------	-----------------------------	----------------------------	---------------------

Revolutionary Person-Centered Care Plans

847.729.9980 | 847.729.9522 facsimile | www.swcginc.com | info@swcginc.com