Bladder Cancer Diagnosis, Treatment & Follow-up Care Pathway Map
Version 2018.08

Disclaimer
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Target Population

The Pathway Map is intended for the management of individuals who present with symptoms or incidental findings indicating a suspicion of bladder cancer, and describes the clinical management of patients with a confirmed diagnosis of urothelial carcinoma.

Pathway Considerations

- Photodynamic Diagnosis (PDD) can be considered as an adjunct to Transurethral Resection of Bladder Tumor (TURBT), and Narrow Band Imaging (NBI) as an adjunct to cystoscopy if available.
- Clinical trials should be considered for all phases of the pathway.
- Counseling and treatment for smoking cessation should be initiated early on in the pathway and continued by care providers throughout the pathway as necessary.
- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway. For patients who do not have a primary care provider, Health Care Connect, a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see Person-Centered Care Guideline and EBS #19-2*
- Hypertensins are used throughout the pathway to provide information about relevant CCO tools, resources and guidance documents.
- The term ‘health care provider’, used throughout the pathway, includes primary care providers and specialists, nurse practitioners, and emergency physicians.
- Psychosocial oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families at all stages of the illness trajectory. For more information, visit EBS #19-3*
- For more information on Multidisciplinary Cancer Conferences visit MCC Tools
- For more information on wait time prioritization, visit Surgery
- For more information on the systemic treatment QP5 please refer to the Quality-Based Procedures Clinical Handbook for Systemic Treatment
- The following should be considered when weighing the treatment options described in this pathway map for patients with potentially life-limiting illness: (1) Palliative care may be of benefit at any stage of the cancer journey, and may enhance other types of care - including restorative or rehabilitative care - or may become the total focus of care, (2) Ongoing discussions regarding goals of care is central to palliative care, and is an important part of the decision-making process. Goals of care discussions include the type, extent and goal of a treatment or care plan, where care will be provided, which health care providers will provide the care, and the patient’s overall approach to care.

Pathway Map Legend

**Shape Guide**

- Intervention
- Decision or assessment point
- Patient (disease) characteristics
- Consultation with specialist
- Exit pathway
- Off-page reference
- Patient/Provider interaction
- Referral
- Wait time indicator time point

**Pathway Map Disclaimer**

This pathway map is a resource that provides an overview of the presentation and clinical work-up of a cancer diagnosis that an individual in the Ontario cancer system may receive.

While care has been taken in the preparation of the information contained in the pathway map, such information is provided on an “as-is” basis, without any representation, warranty, or condition, whether express, or implied, statutory or otherwise, as to the information’s quality, accuracy, currency, completeness, or reliability.

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This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. COO and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant scientific findings may have been reported since completion of this pathway map. This pathway map may be superseded by an updated pathway on the same topic.

References

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Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

Diagnostic Procedures

Version 2018.08

Page 3 of 13

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools.

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care.

Type of Cancer

Ta: Noninvasive papillary carcinoma
Tis: Carcinoma in situ
T1: Tumour invades subepithelial connective tissue
T2: Tumour invades muscularis propria
T3: Tumour invades pelveskeletal muscle
T4: Tumour invades any of the following: prostate stroma, seminal vesicles, uterus, vagina, pelvic wall, abdominal wall
PUNLMP: Papillary urothelial neoplasms of low malignant potential
LG: Low-grade papillary urothelial carcinoma
HG: High-grade papillary urothelial carcinoma

WHO/ISUP 2004

1 High risk factors include past tobacco use, history of pelvic irradiation, cyclophosphamide or other carcinogenic alkylating agent exposure, and exposure to occupational hazards such as dyes, benzenes, and aromatic amines.

2 Consider review by pathologist with genitourinary expertise when: variant histology, lamina propria/muscle invasive tumours with minimal invasion, or ambiguity as to whether muscularis propria is involved or a mismatch between clinical/cystoscopic findings is noted.
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Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

From Page 3, 7, 9, 11

Low Risk
Primary, solitary, Ta (LG, <3cm, no Tis)

Intermediate Risk
Ta >3 cm, multiple, or multi-recurrent low grade tumours

High Risk
TaHG or Tis

Mitomycin C (MMC)
Other Chemotherapy

Intravesical therapy (Induction)
Bacillus Calmette–Guérin (BCG)

Low Risk

Follow up at 3 and 12 months
Cystoscopy 3 months post TURBT
Urine Cytology

Intermediate Risk

Relapse
Cystoscopy 3 months post TURBT
Urine Cytology

Evidence of disease?

No

Intravesical Maintenance Therapy (Induction)
Bacillus Calmette–Guérin (BCG)

Early relapse
Follow up every 3 months for 2 years, then every 6 months for 2 years
Cystoscopy
Urine Cytology

Late relapse
Follow up every 3 months for 2 years, then every 6 months for 2 years
Cystoscopy
Urine Cytology

Evidence of disease?

Yes

Intravesical Maintenance Therapy (BCG)
Follow up every 3 months for 2 years, then every 6 months for 2 years
Cystoscopy
Urine Cytology

Yes

Fulguration
For small, low grade-appearing recurrence

Late relapse
Follow up every 3 months for 2 years, then every 6 months for 2 years
Cystoscopy
Urine Cytology

Evidence of disease?

No

Intravesical Maintenance Therapy (BCG)
Follow up every 3 months for 2 years, then every 6 months for 2 years
Cystoscopy
Urine Cytology

No

Intravesical Maintenance Therapy (BCG)
Follow up every 12-24 months
Ultrasound Abdomen & Pelvis or CT Urogram

Late relapse
Follow up every 3 months for 2 years, then every 6 months for 2 years
Cystoscopy
Urine Cytology

Definitions
Failure: Presence of HG disease at 6 months from TURBT (or at 3 months if tumour is T1HG) or disease progression (in grade, stage or appearance of Cis)
Relapse: Recurrence of tumour after being disease free at 6 months
Early relapse 6-12 months
Late relapse >12 months

Adapted from CUA Guidelines (2015) [2]

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care
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Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

Non Muscle Invasive: T1

Definitions

Failure: Presence of HG disease at 6 months from TURBT (or at 3 months if tumour is T1HG) or disease progression (in grade, stage or appearance of Cis)

Relapse: Recurrence of tumour after being disease free at 6 month evaluation

Early relapse 6-12 months

Late relapse 12 + months

Adapted from CUA Guidelines (2015) [2]

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care

Failure: Presence of HG disease at 6 months from TURBT (or at 3 months if tumour is T1HG) or disease progression (in grade, stage or appearance of Cis)

Relapse: Recurrence of tumour after being disease free at 6 month evaluation

Early relapse 6-12 months

Late relapse 12 + months

Adapted from CUA Guidelines (2015) [2]

* Cystectomy should be strongly considered for highest risk pathology (T1HG+CIS, Multiple T1HG,T1HG > 3 cm, or micropapillary, nested/large, plasmacytoid, sarcomatoid, microcystic, small tubules or lymphoepithelioma-type urothelial carcinoma variants, LV+). Review by a pathologist with genitourinary expertise should then be performed if not already done so.
Consider patient preference, performance status, co-morbidities, and if high risk factors present (T1HG+CIS, Multiple T1HG, T1HG > 3 cm, or micropapillary, nested, plasmacytoid variant, LVI+)

Consider other salvage intravesical agents, clinical trials or MCC if patient has repeatedly failed induction (>2 times)

Pathological Stage

TA HG, Tis, T1

Repeat TURBT

Pathology

Cystectomy

Pelvis

Urinary Diversion

Pathological Stage

Non Muscle Invasive Disease

Intravesical chemotherapy induction or reinduction with alternate agent?

Pathological Stage

Cystectomy

Urinary Diversion

Intravesical Maintenance Therapy (if induced)

Follow up every 3 months for 2 years, then every 6 months for 2 years

Cystoscopy

Urine Cytology

Failure or Relapse

Late relapse >12 months

Follow up every 12-24 months

Ultrasound Abdomen & Pelvis

CT Urogram

Adapted from CUA Guidelines (2015) [2]

Definitions

Failure: Presence of HG disease at 6 months from TURBT (or at 3 months if tumour is T1HG or disease progression (in grade, stage or appearance of Cis)

Relapse: Recurrence of tumour after being disease free at 6 month evaluation

Early relapse 6-12 months

Late relapse 12 + months

* Consider patient preference, performance status, co-morbidities, and if high risk factors present (T1HG+CIS, Multiple T1HG,T1HG > 3 cm, or micropapillary, nested, plasmacytoid variant, LVI+)

* Consider other salvage intravesical agents, clinical trials or MCC if patient has repeatedly failed induction (>2 times)
Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

Non Muscle Invasive - Late relapse

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Definitions

Failure: Presence of HG disease at 6 months from TURBT (or at 3 months if tumour is T1HG) or disease progression (in grade, stage or appearance of Cis).

Relapse: Recurrence of tumour after being disease free at 6 month evaluation

Early relapse 6-12 months
Late relapse 12+ months

Adapted from CUA Guidelines (2015) [2]

Consider the introduction of palliative care, early and across the cancer journey. Click here for more information about palliative care tools.

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools.

Follow up with specialist as appropriate.

Consider other salvage intravesical agents, clinical trials or MCC if patient has repeatedly failed induction (>2 times).

Pathology

Pathological Stage

From Page 4 or 5

TURBT

CT Urogram

If not recently performed

Ta LG

Pathological Stage

Ta HG or Tis

Reinduce BCG²

Pathological Stage

Non Muscle Invasive Disease

T1 HG

Repeat TURBT

Pathology

Pathological Stage

Muscle Invasive Disease

Muscle Invasive Disease

Follow up every 3 months for 2 years, then ever 6 months for 2 years

CT Urogram

Pathological Stage

Intravesical Maintenance Therapy (BCG)

Follow up every 2 years

Ultrasound Abdomen & Pelvis

or

CT Urogram

Failure or Relapse

Follow up as appropriate

Annual Surveillance

Cystoscopy

Urine Cytology

Consider every 2 years

Ultrasound Abdomen & Pelvis

or

CT Urogram

TURBT

CT Urogram

Pathology

Pathological Stage

Muscle Invasive Disease

Muscle Invasive Disease

Metastatic Disease

Appropriate therapy may include:

Cystectomy

Clinical Trials

Other treatment as appropriate

Ta LG

Ta HG, Tis, T1

Intravesical chemotherapy induction

Clinical Trials

Other treatment as appropriate

Return to start of page (TaLG).

Proceed to Page 8

Proceed to Page 10

Proceed to Page 12

Follow up as appropriate.

Proceed to Page 9

Follow up as appropriate.

Proceed to Page 8

Follow up as appropriate.

Proceed to Page 8

Follow up as appropriate.
Invasive Bladder Cancer (T2, T3, T4a)

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Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

Treatment

1. Cystectomy selected
2. Cystectomy not selected
3. Highly recommending radiation oncology opinion for small tumours without hydronephrosis and CIS in patients with a desire to pursue bladder conservation
4. Indicated if symptoms present or alkaline phosphatase and calcium levels are elevated as per guideline
5. Consider patient preference, performance status, co-morbidities, and if high risk factors present (micropapillary, nested, plasmacytoid variant)
6. Refer if pT3-4 or N+
7. EBRT can be performed alone if not a candidate for chemotherapy
8. Repeat TURBT to achieve complete resection
9. Blood Work
10. Bone Scan
11. From Page 3, 5-7, 9, 11
12. Consider the introduction of palliative care, early and across the cancer journey

Consider for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about palliative care tools
Invasive Bladder Cancer (T2, T3, T4a) Cont’d

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Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

Patient Post Cystectomy

From Page 5, 6, 8 (cystectomy selected)

Patient Post Bladder Preserving Treatment

From Page 8 (cystectomy not selected)

Follow up

Urethral washings

Frequency of intervention should be based on clinician discretion

Cystoscopy +/- Biopsy

Every 3 months for 2 years then at increasing intervals for the next 2 years. Then continue annually for lifetime.

Urine Cytology

All time of cystoscopy

Chest Imaging

Every 6 months for 2 years then at longer intervals

Or

Ultrasound Abdomen & Pelvis

One of the following:

CT Urogram

Every 6 months for 2 years then at longer intervals

Or

Ultrasound Abdomen & Pelvis

Frequency of intervention should be based on clinician discretion

Evidence of disease?

No

Frankly Positive Cytology & Negative Cystoscopy

Follow up with specialist

Yes

Intravesical Recurrence

TURBT

Pathology

Result?

Ta, Tis

Follow up with specialist

2 T1 or aggressive variant pathology

Follow up with specialist

Pelvic Lymph Node Positive

R

Medical Oncologist

Chemotherapy

MCC

R

Enterostomal Therapist

Urinary diversion

Metastatic Disease

Distant progression on chemotherapy

Return to start of page (Post cystectomy)

13 Urethral washings in high risk patients or urethral symptoms

14 Aggressive variant pathology: micropapillary, nested, plasmacytoid variant

15 Follow up with primary care provider may be considered after initial disease free period

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey. Click here for more information about palliative care
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Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

### Metastatic Disease/T4b

**Version 2018.08**

**Page 10 of 13**

#### Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

- **Characteristic**
  - **Metastases**
    - **after definitive local therapy**

### Disease

- **De novo metastatic disease or T4b**

### Treatment

- **Platinum-based Chemotherapy** (if not already provided and if candidate)

#### Primary Platinum-based Chemotherapy (if not already provided and if candidate)

- **Yes, less than 6 months prior**
  - **Not a candidate for chemotherapy**
    - **R**
      - **Follow up with specialist**
      - **Proceed Page 6-9**
      - **End of life care planning**

- **No response/Progression**
  - **Consider**
    - Clinical Trial
  - **R**
    - **Follow up with specialist**
    - **Proceed Page 12 to (End of Life Care Pathway)**

- **Intractable hematuria**

#### Palliative Care

- **PSO**
  - **Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools**
  - **Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care**

### Follow-up

- **2nd and/or pelvic node positive and responding to chemo**
  - **MCC**
  - **No**
    - **Yes**
      - **Candidate for definitive or radical local therapy?**
        - **No**
          - **Follow up with specialist**
          - **Proceed Page 6-9**
          - **End of life care planning**
        - **Yes**
          - **Psychosocial oncology and palliative care**
            - **Referral to appropriate specialist if additional support is required**
            - **Proceed Page 12 to (End of Life Care Pathway)**

### Palliative Radiation Therapy

- **Consider**
  - **Clinical Trial**
  - **Monitor as needed**

#### Palliative Cystectomy

- **Palliative TURBT**

#### Palliative Radiation Therapy

- **T4b and/or pelvic node positive and responding to chemo**
  - **MCC**
  - **No**
    - **Yes**
      - **Candidate for definitive or radical local therapy?**
        - **No**
          - **Follow up with specialist**
          - **Proceed Page 6-9**
          - **End of life care planning**
        - **Yes**
          - **Psychosocial oncology and palliative care**
            - **Referral to appropriate specialist if additional support is required**
            - **Proceed Page 12 to (End of Life Care Pathway)**

### From Page 6-9

- **Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools**
  - **Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care**

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*If not previously seen*
Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care

<table>
<thead>
<tr>
<th>Type of Cancer</th>
<th>GG</th>
<th>HH</th>
<th>II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary tumour in prostatic urethra</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pT0: No evidence of primary tumor</td>
<td></td>
<td></td>
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<tr>
<td>pTis: Non-invasive papillary carcinoma</td>
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<tr>
<td>pTs: Carcinoma in situ involving the prostatic urethra or periurethral or prostatic ducts without stromal invasion</td>
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<tr>
<td>pT1: Tumor invades urethral subepithelial connective tissue immediately underlying the urothelium</td>
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<tr>
<td>pT2: Tumor invades the prostatic stroma surrounding ducts either by direct extension from the urothelial surface or by invasion from prostatic ducts</td>
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<tr>
<td>pT3: Tumor invades the periprostatic fat</td>
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<tr>
<td>pT4: Tumor invades other adjacent organs (e.g., extraprostatic invasion of the bladder wall, rectal wall)</td>
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</tbody>
</table>

Adapted from College of American Pathologists (CAP) Staging Protocol for Prostatic Urethra (2017) [3]

CT Urogram

If not recently performed

Retrograde pyelogram

If CT not performed

Assessments

Random Bladder Biopsies

Prostatic Urethral Biopsy

Retrograde Ureteral Washings

Pathology

Results

Positive for upper tract disease

Treatment as appropriate

Positive for bladder disease

Positive for prostatic disease

Transurethral Resection of the Prostate (TURP)

Pathology (refer to ‘Type of Cancer’ table on left)

Pathological Stage

Follow up as appropriate

T0, Tis, T1

Proceed to Page 4 (High Risk)

T2 or greater

Proceed to Page 8

Negative

Consider repeat diagnostic assessments including fluorescent TURBT every 2-3 years, or if cytology remains positive

Follow up as appropriate
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**End of Life Care**

- **Revisit Advance Care Planning**
  - Ensure the patient has determined who will be their Substitute Decision Maker (SDM)
  - Ensure the patient has communicated to the SDM their wishes, values and beliefs to help guide that SDM in future decision making

- **Discuss and document goals of care with patient and family**
  - Assess and address patient and family’s information needs and understanding of the disease, address gaps between reality and expectation, foster realistic hope and provide opportunity to explore prognosis and life expectancy, and preparedness for death
  - Introduce patient and family to resources in community (e.g., day hospice programs)

- **Develop a plan of treatment and obtain consent**
  - Determine who the person wants to include in the decision making process (e.g., substitute decision maker if the person is incapable)
  - Develop a plan of treatment related to disease management that takes into account the person’s values and mutually determined goals of care
  - Obtain consent from the capable person or the substitute decision maker if the person is incapable for an end-of-life plan of treatment that includes:
    - Setting for care
    - Resuscitation status
    - Having, withholding and or withdrawing treatments (e.g., lab tests, medications, etc.)

- **Screen for specific end of life psychosocial issues**
  - Specific examples of psychological needs include: anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
  - Consider referral to available resources and/or specialized services

- **Identify patients who could benefit from specialized palliative care services (consultation or transfer)**
  - Discuss referral with patients and family

- **Proactively develop and implement a plan for expected death**
  - Explore place-of-death preferences and assess whether this is realistic
  - Explore the potential settings of dying and the resources required (e.g., home, residential hospice, palliative care unit, long term care or nursing home)
  - Anticipate/Plan for pain & symptom management medications and consider a Symptom Response Kit (SRK) for unexpected pain & symptom management
  - Preparation and support for family to manage
  - Discuss emergency plans with patient and family (who to call if emergency in the home or long-term-care or retirement home)

- **Home care planning**
  - Connect with Home & Community Care early (not just for last 2-4 weeks)
  - Ensure resources and elements in place
  - Consider a Symptom Response Kit (SRK) with access to pain, dyspnea and delirium medication
  - Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

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**Triggers that suggest patients are nearing the last few months and weeks of life**

- ECOG/Patient-ECOG/PRFS = 4 OR
- PPS ≤ 30
- Declining performance status/functional ability
- Gold Standards Framework indicators of high mortality risk

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**Screen, Assess, Plan, Manage and Follow-Up**

**End of Life Care planning and implementation**

- Collaboration and consultation between specialist-level care teams and primary care teams

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**Screen, Assess & Plan within the Psychosocial & Palliative Care Pathway Map**

- While this section of the pathway map is focused on the care delivered at the end of life, the palliative care approach begins much earlier on in the illness trajectory.
- Refer to **Screen, Assess & Plan** within the Psychosocial & Palliative Care Pathway Map

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**For more information on the Gold Standards Framework, visit** [http://www.goldstandardsframework.org.uk/](http://www.goldstandardsframework.org.uk/)
**Patient Death**

**At the time of death:**
- Pronouncement of death
- Completion of death certificate
- Allow family members to spend time with loved one upon death, in such a way that respects individual rituals, cultural diversity and meaning of life and death
- Implement the pre-determined plan for expected death
- Arrange time with the family for a follow-up call or visit
- Provide age-specific bereavement services and resources
- Inform family of grief and bereavement resources/services
- Initiate grief care for family members at risk for complicated grief
- Encourage the bereaved to make an appointment with an appropriate health care provider as required

**Bereavement Support and Follow-Up**
- Offer psychoeducation and/or counseling to the bereaved
- Screen for complicated and abnormal grief (family members, including children)
- Consider referral of bereaved family member(s) and children to appropriate local resources, spiritual advisor, grief counselor, hospice and other volunteer programs depending on severity of grief

**Provide opportunities for debriefing of care team, including volunteers**