Front Line Staff Experiences of Grief and loss in a LTC Home

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Quality Palliative Care in LTC

- Comparative case study design with four LTC homes as study sites
- Participatory Action Research
- Quantitative and qualitative research methods; surveys, interviews, focus groups
- Participants: Residents, Family members, Physicians, PSWs, RNs, RPNs, Recreations, Dietary, Housekeeping, Maintenance, Admin, Volunteers and Community Partners

Quality Palliative Care In LTC

- Improve the quality of life for residents in LTC
- Develop interprofessional palliative care programs
- Create partnerships between LTC homes community organizations and researchers
- Create a toolkit for developing palliative care in LTC homes that can be shared nationally
- Promote the role of the Personal Support Worker in palliative care

Background

- It is estimated that up to 39% of residents living in Long-Term Care (LTC) are anticipated to die each year by the year 2020 (Fisher, Ross, McLean, 2000).
- LTC has become a major location of death for people in Canada
- Formal palliative care programs in LTC homes that aim to relieve suffering and improve the quality of living until a person dies are rare.

Background

- LTC homes often do not formally recognize the grief and loss experienced by the front line staff.
- Due to the nature of the care provided by front line staff, close relationships form between staff and residents.
- These relationships are sometimes referred to by staff as “family like”
- The close personal relationships that staff have with residents contribute to staffs’ grief at death.

Background

- The LTC home environment provides little formal support for front line workers to manage and acknowledge their grief when a resident dies.

Purpose

- To understand the experiences of grief and loss of front line staff, and their perception of how the LTC home could better support them after a resident dies
- To create grief support strategies and a policy for promoting workplace wellness that includes supporting staff grief.

Methodology

- Individual interviews and Qualitative methods were used to conduct the research
- Nine participants (1RN, 2RPNs, 6PSWs)
- Participants provided hands on end-of-life care to residents
- Semi structure interviews were audio recorded and transcribed verbatim
- Thematic analysis and a process of analytic induction were used to analyze data
- Themes that emerged from data were agreed upon by research assistants who had conducted the individual interviews

Results

Findings were organized into four overarching themes that emerged from the data.

1. The organizational context influences grief and loss
2. The burden of grief.
3. The emotional impact of grief
4. Participant suggestions for grief support strategies

Organizational Context Influences Grief and Loss

1. Death is hidden
2. There is no training to prepare staff for loss
3. Death is part of the job
4. There is a silent culture that exists around dying

Death is hidden

- There is little communication around death. Staff often find out that a resident has died when they come on shift.
- Death is referred to as “letting go” “passing”.
- Death is hidden from residents and other staff.

“ When they die their tag from outside their room goes on the ‘in memoriam’ board. So that’s how they officially know that the person is dead. Their tag goes up on the board and that’s it, they don’t have …a little announcement at breakfast…or a moment of silence at breakfast…”(RPN)

There is no training to prepare staff

- No information regarding death, grief and bereavement during orientation
- Communication is difficult
- Staff learn how to manage grief “on the job”
- “There’s noting that I’m aware of that’s in place, and the fact that I’m not aware of it is bad I think, because I think even with orientation as a new employee you should be told what you can do and there’s nothing…in place” (RPN)
- “Our senior staff are…they’ve been around a long time…they’re the ones that are teaching us how to deal with everything…you don’t want to lose that knowledge” (PSW)

Death is part of the job

- Multiple deaths have an emotional burden.
- There is a hierarchy of emotional engagement.
- Resources do not match role expectations.
- “We not only have to work with the death and dying, we have to work with the building…it’s a business.” (RN)
- “I guess we’re just expected to be strong and we just have to…accept that it’s gonna happen…We’re always getting new people in afterwards right? So we just have to … keep going.” (RPN)

A silent culture exists around dying

- Lack of openness impacts EOL care and response to grief
- Staff hold one another accountable
- “I think as PSWs we…do the best we can with what we’ve got and…it’s an inevitable thing…it’s the corridor to the stairway to heaven…”(PSW)

The Burden of Grief

1. No relief from grief and loss
2. Staff use coping strategies to manage grief.

No relief from grief and loss

- Grief and loss are embedded in the nature of the work that is done in LTC.
- Staff learn to detach from residents when a resident dies and then have to reattach to new residents or the residents that they continue to care for.
- There is no control over death and staff learn to cope with loss individually.

- "It's a hard thing to watch people die…for a living" (PSW)

- "Sometimes we have a resident that dies…and two days later there's someone in that bed…and you're learning all about somebody new and you haven't actually…grieved the loss of the last person…but it seems like…they just keep 'em comin" (PSW)

Staff use coping strategies to manage grief

- Staff learn to prepare themselves for a residents death
- Humour is used to manage grief and loss
- Relationships are formed between staff members to help cope
- Staff create meaning in talking about residents
- “If you go in knowing you’re there to make them comfortable just until they pass away then you mentally prepare yourself for it. It’ll still hurt, but you’re mentally knowing that person’s dying” (RPN)

The Emotional Impact of Grief

- No formal opportunities for closure when residents die
- Multiple losses are experienced as staff lose the relationships formed with residents and their families
- The kind of death, nature of relationship with resident and personal characteristics of staff members influence how loss is managed
- “There’s no acknowledgement really; we just go on and just do your job which is really sad” (PSW)
- “Because what happens is they become our family...you get close...you see them everyday and all of a sudden it just stops” (PSW)

Participants' Suggestions for Grief Support Strategies

Staff are in the best position to identify the support and resources needed to manage their grief.

- Formal support
- Education support
- Informal peer support
- Desired protocols after death

Formal Support

- Staff debriefing after a difficult death or multiple losses
- Organizational recognition of residents' death is needed to support staff grief.
- Notification of resident death
- Service of celebration in recognition of residents' deaths
- Memory board/tree

Educational support

- Identified need for education during orientation
- Access to information for both staff and family members on grief and bereavement support

Informal peer support

- Opportunities for staff to talk amongst themselves after a resident death
- Peers guiding peers through the grief process
- Ritual established when a resident dies
- Resident and family support

Conclusion

- The grief and bereavement experience of front line staff is complex
- LTC staff are faced with the presence of grief daily and there are a number of factors which influence how their experience with grief is managed
- There are no formal organizational processes in place to assist staff with handling their grief which contributes to them relying on one another for support

Conclusion

- Front line staff are in the best position to identify the support and resources they need to manage their grief and loss
- A formal process for supporting the grief and bereavement of staff is needed as a component of a holistic and inclusive palliative care program in a LTC home.

Further Information

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