

# Peer Led Debriefing Toolkit: Guidelines for Promoting Effective Grief Support Among Front Line Staff

## Quality Palliative Care in Long Term Care Alliance (QPC-LTC)



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## Acknowledgements

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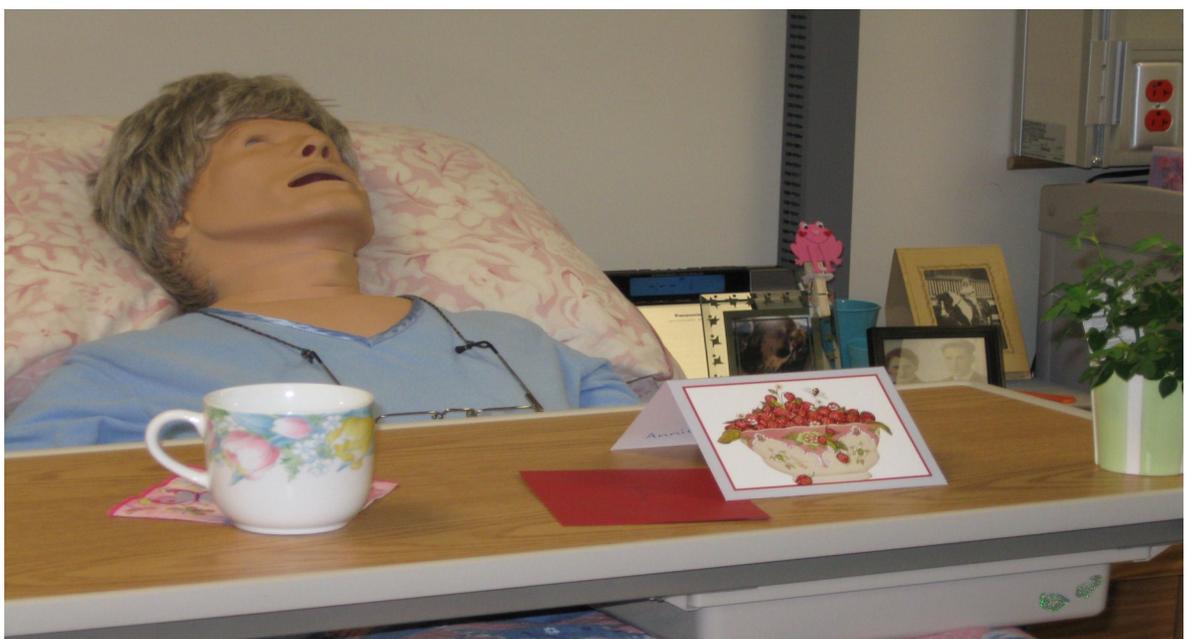
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The Principal Investigator is Dr. Mary Lou Kelley from Lakehead University Thunder Bay Ontario. The research is conducted with four key partners; Lakehead University, McMaster University, the Municipality of Halton and St. Joseph's Care Group in Thunder Bay. The QPC-LTC Alliance partners are municipal, provincial and national organizations that represent individuals, families, caregivers, health care providers, educators and other stakeholders. There are four long-term care (LTC) homes in Ontario that are study sites for the project: Bethammi Nursing Home and Hogarth Riverview Manor in Thunder Bay, and Allendale Village in Milton and Creek Way Village in Burlington.

Leadership on this particular innovation was Dr. Jo-Ann Vis, School of Social Work at Lakehead University supported by graduate student Sandra Vidatto.

Please copy and share this document. We would appreciate you referencing the source of this work as:

Post Death Peer Led Debriefing Toolkit: Guidelines for Implementing Sharing Circles for Front Line Staff, Quality Palliative Care in Long Term Care,



## Introduction

In Ontario today, approximately one in five (17-22%) residents living in long term care (LTC) homes die each year (Canadian Institute for Health Information, 2012). Caring for dying people has become part of the job of direct care staff working in LTC, however, the impact of their grief and loss often goes unrecognized (Quality Palliative Care in Long Term Care, 2012). Research conducted by the Quality Palliative Care in Long Term Care Alliance indicates that front line staff in long term care (LTC) homes develop close “family like” emotional bonds to those residents they care for over many months or years. As a result, long term care home staff experience a tremendous sense of grief and loss after a resident dies (Sims-Gould et Al. 2010). LTC homes need to acknowledge staffs’ grief as well as provide them education and support (Samson & Komaromy, 2001).

In 2011, interviews were completed in two long term care homes to understand how long term care home staff could be supported. During interviews that were conducted front line staff made suggestions on grief support strategies. A full summary of these results accessed by viewing Staff Grief and Loss at <http://www.palliativealliance.ca/organizational-change->

Staff indicated that informal peer support would be beneficial after the loss of a resident. They indicated the importance of having peers assist them in the grief process. It was clear from the data that staff looked to one another for support. While staff informally supported one



another after the death of a resident, they acknowledged that an organized process for staff in long term care homes was lacking. Peer led debriefing are one way to formalize this process for staff members.

***“It’s a hard thing to watch people die...you know, for a living.”***  
(PSW working in Long Term Care)

Debriefings are one type of intervention that can provide individuals with an opportunity to take a step back from an emotionally stressful event and share their experience through a guided process involving specific questions and discussion (Keene et Al., 2010). Peer-led debriefing has been used effectively for grief support in hospices (Anderson et Al., 2010) and is one strategy that LTC homes can implement. To address this unmet need, a debriefing model was developed and named INNPUT as an acronym for:

**I- Introduction**

**N- Need to say**

**N-Need to do**

**P- Plan**

**U- Understand**

**T- Thank everyone for sharing**

The Peer Led Debriefing Toolkit is intended as a practice and training resource that can be incorporated into the palliative care program of a long term care home. Incorporating routine peer led debriefings, also known as “sharing circles”, into organizational culture has been shown to improve overall work place wellness and reduce staff stress and absenteeism.



## What is Disenfranchised Grief?

- Grief is a healthy natural reaction to death or loss. The residents have become like family members to staff and when a resident dies, staff are expected to continue on with their work without dealing with their loss. This grief may cause a range of emotions, and if not dealt with, grief could affect how staff continue on with their tasks. Some common emotions include: anger, sadness, depression, loneliness, hopelessness, and numbness.
- Disenfranchised Grief is defined as a failure of others to acknowledge or recognize an individual's grief and subsequently staff are disenfranchised from experiencing the normal grieving process. **(Doka, Pine)**
- Each grieving experience is unique and each staff member can have a different reaction.
- Staff can experience shame over their emotions, a sense that they are not allowed to grieve or that they do not need to grieve, and / or feeling overwhelmed with grief but are uncomfortable in displaying any grief emotion. **(Kauffman)**

## What is a Peer Led Debriefing?

A debriefing is an activity that:

- provides an opportunity for staff members to take an opportunity to share their experiences among their peers
- can utilize peer leads and offers specific questions to engage staff in a discussion about the experience and plan for self care
- has an emphasis is on discovery and finding meaning
- allows participants to voice their unique experience and takes into consideration the needs of all group members

*Debriefing...it is a time to reflect and to support each other.*  
*(Facilitator)*

When allowing peers to lead the process, it provides a safe and supportive environment for the participant and for those leading the debriefing. Although a debriefing is not therapy it is therapeutic and allows staff to acknowledge their grief and loss in their own way.

Everyone is encouraged to participate. The following points provide some ground rules for the debriefing:

- no one is forced to talk
- front line staff are encouraged to participate from start to finish
- everyone is treated equally
- there are no wrong or right answers
- no interruptions are permitted (examples: cell phones, pagers)
- differences in opinions are expected and valued
- session is led by a staff member who is a trained facilitator
- discussion is guided by the INNPOT Model
- session takes place in a small group or **SHARING CIRCLE**

## Who Should be Trained as a Debriefeer?

Any front line staff member who:

- would be interested in facilitating a peer led debriefing process.
- can personally relate to the impact of disenfranchised grief.
- is comfortable being in a leadership role
- is respected and trusted among their peers
- is currently not in a supervisory role

*Tip: It is recommended that each long term care home consider having enough trained debriefers to cover all home areas, shifts, and leaves/vacation periods.*

## Training

Peer Led Debriefing training consists of:

- three integrated modules (each take approximately 30min)
- an experiential role play enactment to practice the skills (approximately 15min)
- post role play reflection and discussion (approximately 15min)

*Tip: It is recommended that the training be completed in one full session to maximize learning and incorporating the material.*

A minimum of two hours are required to complete this training.

*Tip: The role play is a crucial component to this training as it provides an opportunity for practice and confidence for the first time debriefer.*

## Planning the Training Event

Prior to planning the training event please consider the following:

**Get buy-in from the management team.** It is important for the management team to understand the concept of Peer Led debriefing and for them to understand the organizational impacts of having such a system in place. They should also understand the importance of training front line staff to adequately prepare them as future debriefers. The organization may bare costs related to time, training materials, and recruitment. However, the outcome of well delivered debriefings increases workplace moral, emotional wellbeing, team stability, and quality improvement.

**Advertising the event.** Ensure that the training event is advertised in locations that are accessible for front-line staff well in advance. Front line staff should also be made aware that this is a train the debriefer event thus there is an expectation that when comfortable they may lead an event within the home.

**Staff Compensation.** It is important that you have a clear message on whether the staff will be compensated for this training / education. Can they complete it during work time?

**Who is considered front line staff?** Within each long term care home there will need to be an agreement on who is considered a front line staff member. It is important that only front line staff participate in the training and in the debriefing within the home in order to promote a peer led approach.

**Participation.** It is advised that 5-15 staff participate in the training during a session. This will allow for full engagement of participants.

**Location.** It is recommended that the training room be able to accommodate a lecture type format to present the module material as well as accommodate a space for the role play scenario. This can be done in two separate rooms with one space setup classroom style and the other with seating in circle formation to facilitate an effective group process.

**Facilitation of the Training.** It is suggested that the trainer be someone accustomed in an educator role with an understanding of long term care, an appreciation for the impact of disenfranchised grief, and familiar with the role demands of front line staff.

**High Fidelity vs. Non High Fidelity.**

Training using the high fidelity simulation and the training without the high fidelity simulation are both effective however the process of completing the training will vary. Information regarding both these models will be highlighted within this training package.

*Tip: Local university social work departments can be excellent community partners. Long term care homes may contact them for a training facilitator.*

*Tip: Often this type of training triggers unresolved emotions related to disenfranchised grief. The training facilitator should be cognizant of each participant's reaction during and following the role play and presentation of the material. If a participant is identified as needing extra support it is the facilitator's responsibility and provide effective follow-up.*

**During the event**

**Breaks.** If time allows in the full training session, participants will find it helpful to have a short break following the module presentation, and prior to the experiential role play. The facilitator or trainer may also want to consider a short break following the role play prior to the reflection discussion.

**Discussion.** In most training experiences participants are eager to ask questions. In this training participants frequently ask questions and want to share related personal experiences. It should be noted that relevant discussion enhances the training and incorporation of the material.

*Tip: It is important for the trainer to balance time related to discussion and coverage of material. Trainers may also need to assess and gauge the group discussion to maintain engagement of all participants.*

**Refreshments.** Participants appreciate when refreshments are provided. Any refreshments ie. coffee, tea, water would be welcomed.

## Additional Thoughts:

Following the training it is important that the participants consider the following items to further prepare them for success.

**Buddy System.** In order to maintain confidence and support for the debriefer, participants should be encouraged to seek out a peer-debriefing buddy to provide support and consultation after their debriefing experience.

**Co-Lead Debriefings.** The debriefing buddies may also choose to co-lead future debriefings until they feel comfortable and confident completing a debriefing on their own.

**Advocate for the Debriefing Process.** Participants who completed the training will have a unique appreciation for the impact of disenfranchised grief and the positive benefits of participating in a post death peer led debriefing exercise. Therefore participants should also see themselves as advocates for the process and encourage their peers to attend future debriefings whether or not they are leading them.



## Adding a High Fidelity Simulation Component

This type of educational experience uses high-fidelity manikins (with laptops, software, and compressors) to give a very realistic experience of being at a resident's bedside. Learning in this type of environment is very safe because at any time the scenario can be paused or "frozen" in time to provide opportunity for questions to be asked and answered. The resident (manikin) has fully functioning blood pressure, pulse points, respiratory and cardiac sounds, as well as a chest that rises and falls with breathing! The simulated resident is also able to hold a conversation and usually has many questions for the health care providers. Simulation technologies can be integrated into education programs and education using this technology has received positive feedback from students regarding this unique learning experience. As a result it is recommended that high fidelity simulation can be integrated into adult learning experiences including peer led debriefing training. A suggested training format:

- 1) begin with information about disenfranchised grief, compassion fatigue, and the benefits of debriefing (module 1-3)
- 2) simulated resident death experience
- 3) role play debriefing process

*As PSW reflection on utilizing the simulation lab:*

*"...it was the closest thing to the real thing and when you are sitting down there and you are holding hands and you are caressing the hand you don't feel the manikin..." (PSW )*



## Evaluating the Training

There are many different ways this training can be evaluated.

**Quantitative Evaluation:** Included in the toolkit is a sample questionnaire

(Appendix A) that focused on participants perception of death and grief and loss.

Each LTC home can choose to evaluate a variety of areas ranging from attitudes concerning death to competency concerning peer led debriefing. It would be recommended that a pre and post questionnaire be given prior and following training regardless of the subject matter.

*Tip: To encourage participation the quantitative questionnaire can be give directly pre or post training. Online questionnaires had low response rates.*

**Qualitative Evaluation:** Included in the toolkit is a sample of qualitative questions (Appendix B). In our training we chose questions that captured participants experience about the training itself as well as their self-efficacy in leading future peer debriefings. If the goal is to evaluate the training it is recommended that some type of qualitative interview be conducted immediately after the training in a group or individual format. If the goal is to evaluate implementation into practice, it is recommended that follow-up interviews be arranged 2-6 months following the training.

**A Combination:** The ideal evaluation would include both quantitative and qualitative approaches. Questionnaires provide information that can easily be measured however interviews provide more in-depth information concerning participants experience and capacity.

# **Peer Led Debriefing Toolkit: Guidelines for Promoting Effective Grief Support Among Front Line Staff**

## **Facilitation Guide**



**The facilitation guide includes presentation slides as well as presentation speaker notes which facilitators may find helpful to refer to when presenting to his or her group.**

## Workshop Agenda

Note: This workshop agenda has been created without a simulation lab component. A minimum of two hours is needed for this training. If a simulation component is added please add another 30 minutes to your event.

Introductions

Grief, Compassion Fatigue, and Disenfranchised Grief 30min

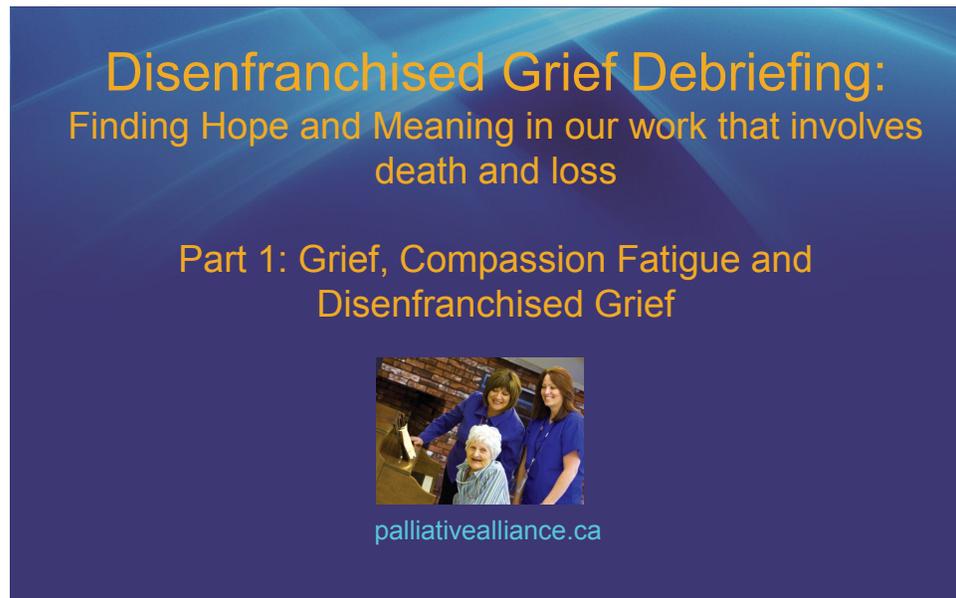
Debriefing 30min

INNPOT Model 30min

Experiential Role Play 15min

Post Role Play Reflections 15min

# Module #1: Grief, Compassion Fatigue and Disenfranchised Grief



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## Facilitator Speaker Notes:

The purpose of this training session to train you (staff) to become a peer led debriefer within your long term care home. This training is divided into three modules:

- grief, Compassion Fatigue & Disenfranchised Grief
- debriefing process
- INNPOT Model

This first module will help us explore more information about grief, compassion fatigue and disenfranchised grief. By the end of this module you will:

- have a good understanding of grief, compassion fatigue, and disenfranchised grief
- be able to recognize disenfranchised grief and issues that may arise if unresolved
- understand factors that contribute to grief and variables that influence the way people grieve
- know ways to combat disenfranchised grief

*Tip: A mindfulness meditation can be used to begin this workshop . An example of this can be found in Appendix C.*

# What is Grief?

## Definition

- Healthy, natural reaction to a death or loss
- Each grieving experience is unique
- Ongoing and influenced by many issues

## Common Emotions

- Anger
- Sadness
- Depression
- Loneliness
- Hopelessness
- Numbness

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- Grief is a healthy natural reaction to the death or loss. As staff in long term care homes you not only experience the loss of the relationship you had with the resident but also the relationship you have with their family and friends.
- The residents have become like family members to staff and when a resident dies, staff are expected to continue on with their work without dealing with their loss. Some common emotions include: anger, sadness, depression, loneliness, hopelessness, and numbness.
- Each grieving experience is unique. You will all have a different reaction to the death of the person. Everyone experiences grief differently, and because of the role that you play you experience grief regularly.
- Grief may not be short term it may be ongoing and it can be influence by many factors

## What is Compassion Fatigue?

Compassion fatigue is a state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it can be traumatizing to the helper. (Smith, 2009)

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- Compassion fatigue is a state experienced by those helpers who find themselves in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it can be traumatizing to the helper (Smith, 2009)
- A physical, emotional and spiritual fatigue or exhaustion that takes over a person and causes a decline in their ability to experience joy or feel and care for others (Lookabill, 2010)
- Those working in long term care can experience compassion fatigue due to the nature of their work. They form close ties with the residents, and when a resident dies, the staff's grief is not usually addressed. The risk of compassion fatigue is present when the staff's grief goes unrecognized and unaddressed.

# What is Disenfranchised Grief?

## Definition

- Failure of others to acknowledge or recognize an individual's grief (Doka)
- Disenfranchised by society from the normal grieving process (Pine)

## Issues that complicate the grieving process

- Ambivalent relationships
- Concurrent crisis
- Exclusion of participation in mourning rituals

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- Connected to compassion fatigue is the concept of disenfranchised grief.
- Disenfranchised grief is the failure of others to acknowledge or recognize an individual's grief (Doka, 1989)
- Disenfranchised by society from the normal grieving process (Pine)
- Issues that complicate the grieving process include:
  - Ambivalent relationships- relationships that aren't recognized, such as those between staff and residents
  - Concurrent crisis- in long term care this could refer to more than one resident dying in a short period of time
  - Exclusion of participation in mourning rituals- because staffs' close relationship with the resident is often unrecognized, they may be excluded from the biological family's mourning rituals, for example attendance at the resident's funeral

## Recognition of Disenfranchised Grief (Kauffman)

- Shame over ones emotions
- Persistence of a previous experience of unsanctioned grief
  - Sense that one is not allowed to grieve or does not need to grieve
- Shame prone personality traits
  - Overwhelmed by feelings of grief – yet feels inhibited in displaying emotions

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- There are three key indicators we can use to recognize disenfranchised grief
- Shame over ones emotions
- Persistence of a previous experience of unsanctioned grief
  - Sense that one is not allowed to grieve or does not need to grieve– an example could be the 24 hour turn around to fill an empty bed after a resident dies
- Shame prone personality traits
  - Overwhelmed by feelings of grief– yet feels inhibited in displaying emotions– there seems to be an unspoken “rule” that one shouldn't show emotion at work, and that is unprofessional

## What is the Impact of Being Exposed to Disenfranchised Grief Event?

- Anyone who has been repeatedly exposed to a disenfranchised grief events will be affected in some way
- The degree of affect is dependent on
  - Factors related to the event
  - Influence of others
  - Acceptance and response to symptoms
  - Understanding of the impact on self

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- Following the definition and recognition of disenfranchised grief it is also important to consider it's impact on staff
- Anyone who has been repeatedly exposed to a disenfranchised grief events will be affected in some way- because of the knowledge that LTC homes are often the last homes of residents, the probability of dying while living in LTC is high. If there is a number of deaths in the LTC home, especially in a short period of time without acknowledgement of staff's grief they will be negatively affected.
- The degree of affect is dependent on
  - Factors related to the event – staff have stated that they feel even worse if a resident has died alone, and this in turn leads to feelings of guilt and shame
  - Influence of others – staff has stated that they would like acknowledgement of the death of a resident from the organization that they work for
  - Acceptance and response to symptoms
  - Understanding of the impact on self –some people don't realize the impact a death of a resident could have on their emotions, and on their ability to continue on with their day when grief is not acknowledged.

## What is the Impact of Being Exposed to Concurrent Disenfranchised Grief?

- Questioning
  - Purpose of life/death
  - I am no longer the same person
  - I can no longer trust myself to develop relationships with residents
  - Exploration of meaning – how people come to make sense of the event
  - Spiritual distress

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- Questioning
  - Purpose of life/death- when there is a death people often question the meaning of life, and ask why questions
  - I am no longer the same person
  - I can no longer trust myself to develop relationships with residents
  - Exploration of meaning – how people come to make sense of the event
  - Spiritual distress-for some people, death makes people question their spiritual values, stating things such as how could god allow this to happen. Death will sometimes make people angry at their spiritual belief system.

## What is the Impact of Unattended Exposure to Disenfranchised Grief?

- Recurrent and intrusive recollections of the event
- Intense psychological distress during the recollection
- General non responsiveness – detached
- Professional burn-out
- Depression/anxiety
- Emotional lability – may connect to self-defeating behaviour – i.e. grief denial

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- Recurrent and intrusive recollections of the event- thoughts replaying in your mind, and what if scenerios
- Intense psychological distress during the recollection
- General non responsiveness – detached
- Professional burn-out
- Depression/anxiety
- Emotional lability – may connect to self-defeating behaviour – i.e. grief denial

## Factors that Contribute to the Severity of Impact

- Speed of onset
- Violent or unexpected loss
- Intentionality
- Perception of suffering
- Degree of exposure – role/proximity
- Concurrent losses and stresses
- Proportion of community/ shared fate

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It is equally important for staff to be aware of contributing factors that impact the severity of disenfranchised grief.

- Speed of onset
- Violent or unexpected loss
- Intentionality: did the resident's death resemble his or her wishes
- Perception of suffering
- Degree of exposure – role/proximity
- Concurrent losses and stresses
- Proportion of community/ shared fate: the degree to which staff and family are able to grieve together over the loss of the resident

# Pre-Incident Variables

- Family stress
- Work stress
- Social stress
- Financial stress
- Personal health
- Stress management skills
- Prior trauma
- Support systems
- Spirituality/Meaning making skills

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In addition to factors related to compassion fatigue and disenfranchised grief are pre and post incident variables. These variables determine to some degree how well prepared staff are to manage their emotions and stressors related to the resident's death.

- Family stress- worries about children or own aging parents
- Work stress- worries about work load
- Social stress- worries about an upcoming event that you aren't comfortable attending
- Financial stress
- Personal health
- Stress management skills- unhealthy skills such as overeating or drinking or drugging
- Prior trauma- deaths that have occurred that you haven't dealt with yet
- Support systems-these could be co-workers, or friends, or family
- Spirituality/Meaning making skills- the need to make sense of why that person died

## Post-Incident Variables

- Secondary concerns
  - Reinforcement of negative thoughts regarding death
  - Complications during death process
  - Family members
  - Employer
  - Job demands

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### Secondary concerns

- Reinforcement of negative thoughts regarding death- question your own ability's and wonder if you could have done something different or done more
- Complications during death process
- Family members-the family members are grieving and pointing fingers
- Employer
- Job demands- you have a heavy work load and feel overwhelmed with emotions and are struggling to keep your emotions from affecting your other residents care

## Not All After-Effects of Trauma are Negative

- Post-traumatic Growth
  - Side benefits
  - Social comparisons
  - Imagining worse situations
  - Focusing less on the negative implications and more on the positive
  - Realizing that the response to the death event is just as important as the death itself
    - individuals do not have control over emotionally stressful events, but do have control over how they manage them

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It is important to remember that not all the after effects of trauma are negative. Research has shown that in fact people experience post traumatic growth. People report that despite they have grown or changed in a positive way as a result of their experience.

### Post-traumatic Growth

- Side benefits: feeling support from a peer, feeling positive about contributing to the resident's "good death" experience
- Social comparisons: recognizing the increased frequency of good death experiences among the residents
- Imagining worse situations: "Mr. Smith's pain was not controlled but at least his family was there. If they were not there his pain would have been worse."
- Focusing less on the negative implications and more on the positive: "I was not able to be there when Mr. Smith died but my last shift I was able to spend some time comforting him. I think he knew people here cared about him."
- Realizing that the response to the death event is just as important as the death itself
  - Individuals do not have control over emotionally stressful events, but do have control over how they manage them

## Ways to Combat Disenfranchised Grief Effects

- Pre and Post prevention
- Physical, emotional and spiritual activity
- Exploration of strengths
- Clear ongoing connection and communication with your peers
- Acknowledgement of your grief (DGD)

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It is vital for staff to be mindful that self care concerning disenfranchised grief needs to go beyond what the debriefing can provide. The following are examples that you (the staff) can consider as part of your self-care activities to manage disenfranchised grief:

- Pre and Post prevention: relate back to pre and post personal and organizational stressors
- Physical, emotional and spiritual activity: exercise, relaxation, and connection with nature
- Exploration of strengths: “One of the things that I am most proud of is my ability to emotionally connect with the residents even though I know at times it might cause me to feel loss when they die.”
- Clear ongoing connection and communication with your peers
- Acknowledgement of your grief (DGD)-Disenfranchised Grief Debriefing

# Further Information

Visit our website

[www.palliativealliance.ca](http://www.palliativealliance.ca)

Contact us with any questions or comments

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# Disenfranchised Grief Debriefing: Finding Hope and Meaning in our work that involves death and loss

## Part 2: Debriefing



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- This module is the second part of a three part learning series on disenfranchised grief debriefing.
- This section presents a variety of different debriefing concepts that can be used to assist staff members with understanding and managing their grief and loss.

# What is Debriefing?

- Traditionally a helping response to a crisis or traumatic event
- An intervention that incorporates information and assimilation
- A preventative intervention that focuses on internal abilities and awareness
- All participants in a debriefing process respond differently
- Emphasis on discovery and meaning

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- Traditionally a helping response to a crisis or traumatic event
- An intervention that incorporates information and assimilation– the idea behind debriefing is to bring people together to discuss the situation with the hope of sending out the message that they aren't alone, and people understand what they are going through
- A preventative intervention that focuses on internal abilities and awareness– this intervention helps people use their own personal strengths and if need be, works with them to bring awareness as to what they are
- All participants in a debriefing process respond differently
- Emphasis on discovery and meaning– there is no right or wrong answer. Debriefing encourages exploration through asking questions about a death or traumatic event to help gain closure

## What Does a Debriefing Provide?

A debriefing provides individuals the opportunity to take a step back from the emotionally stressful event and share their experience through a guided process involving specific questions and discussion. Debriefings are offered in a single event or combination of both an immediate intervention with a follow up debriefing (recommended).

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- A debriefing provides individuals the opportunity to take a step back from the emotionally stressful event and share their experience through a guided process involving specific questions and discussion.

## Snapshot of the Debriefing Process

- Debriefing is not therapy
- No one is forced to talk
- People are encouraged to complete the process – closure
- Confidentiality
- No rank or seniority – everyone is equal
- No right or wrong answers
- No interruptions – cell phones, tablets, etc.
- Difference in opinions are expected

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- Debriefing is not therapy—debriefing is a way to connect and express yourself, and not therapy. If therapy is needed, seek out assistance through EAP or formal supports (if available where you work)
- No one is forced to talk—this is voluntary and only share what you are comfortable sharing
- People are encouraged to complete the process—closure
- Confidentiality
- No rank or seniority—everyone is equal—regardless of your position within the long term care home, during this debriefing everyone is equal. Grieving has no rank or seniority.
- No right or wrong answers: it is the facilitator's role to ensure that all participants feel free to express their experience regardless of how they may be similar or different to that of their peers.
- No interruptions— beepers, pager, etc.— please turn off all cell phones, and close doors for privacy
- Difference in opinions are expected— everyone will have a different opinion and being respectful even if you disagree, will aid in the debriefing process

## Key Ingredients for a Successful Debriefing

- Environment – a safe and structured setting and process
- Re-counting – a re-telling of details, emotions and reactions
- Emotional expression
- Education – information and validation
- Strengthening
- Meaning Making

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As a debriefer, you will want to provide the most comfortable environment possible for your peers. The success of a debriefing often depends on the tone that you can set within a few short moments. The following is a quick checklist to be mindful of when you are conducting a debriefing.

- Environment— a safe and structured setting and process
- Re-counting— a re-telling of details, emotions and reactions
- Emotional expression
- Education—information and validation
- Strengthening—opportunity for staff to discuss how they have or will continue to support each other or discussion about what positive outcome they might have noted about themselves or each other.
- Meaning making—as discussed in the first module staff often reflect on how their grief has effected them and how they came to make sense of their experience. “I have really learned to appreciate my relationship with my grandmother since the death of Margaret.”

## Model Boundaries

- What is your role?
- What does this person need from you at this time?
- What can you address in a brief, limited contact period?
- When is it time to refer out?
- Is there a need for follow-up?

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As the debriefer, you will want to be clear about your boundaries and relationship with your peers in this role. The following questions are worth consideration prior to a debriefing to ensure that you remain within your role and feel confident about the debriefing outcome.

- What is your role?
- What does this person need from you at this time?
- What can you address in a brief, limited contact period?
- When is it time to refer out?
- Is there a need for follow-up?

## How to Assist Someone who has Been Involved in a Death/Loss

- Listen
- Validate
- Ask them what they need
- Don't judge
- Do only what you can
- Don't provide platitudes
- Help them find their strengths
- Encourage them to seek help

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This quick checklist is self-explanatory and can assist the debriefer in remaining focused on your role. If you are able to perform these tasks in your debriefing you will be successful. To validate your strengths as a debriefer a co-debriefer model provides an opportunity for mutual direct constructive feedback on your skills.

- Listen
- Validate
- Ask them what they need
- Don't judge
- Do only what you can
- Don't provide platitudes
- Help them find their strengths
- Encourage them to seek help

## Things to Avoid

- Conversations involving
  - Blame/scape-goating
  - Past trauma
  - Escalating anger
  - Expert advice giving
  - “What if” scenarios

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While it is important to talk about what makes for a successful debriefing it is equally vital to ensure that the debriefing discussion does not include the following:

- Blame / scape-goating
- Past trauma
- Escalating anger
- Expert advice giving
- “What it” scenarios

If you discover that the discussion veers in a direction of the above scenarios it is imperative that you as the facilitator immediately 1– step in and validate their concern, 2– suggest an alternate venue to discuss their point, and 3– re-route the discussion back to the appropriate debriefing content.

For example if you find that the discussion focuses on what if scenarios moving to details or situations that did not happen you might choose to interject at that time with a statement “ While I understand how easy it is to think about what could have happened to Mr. Smith let’s remain focused on what did happen and perhaps this other conversation can be held in another forum.” While it could be possible that staff could learn from the what if scenario that discussion is not appropriate for the purposes of the debriefing.

## Direction for the Debriefer

- Recognize your own limitations
  - Be able and willing to say no to a debriefing request
- Debrief in teams when ever possible
  - Know your partner, know your role
- Be prepared
  - Preparation is the key to a successful debriefing
- Set realistic goals regarding the debriefing process
  - Everything works well in theory – expect the unexpected
- Post Debriefing Self Care
  - Engage in a post debriefing process
  - Education
  - Self care/validation

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- Recognize your own limitations
  - Be able and willing to say no to a debriefing request
- Debrief in teams whenever possible
  - Know your partner, know your role
- Be prepared
  - Preparation is the key to a successful debriefing
- Set realistic goals regarding the debriefing process
  - Everything works well in theory– expect the unexpected
- Post Debriefing Self care
  - Engage in a post debriefing process
  - Education
  - Self care/ validation

## Before you Engage in Debriefing... Do You Know?

- Details of the death of the resident
- Details of the resident who has died
- Who will be participating in the debriefing?
- How many prior resident deaths has this team experienced?
- Are there any family/unresolved issues that are of concern?

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As the facilitator you may not always be privy to the details related to the death of the resident for whom you are conducting the debriefing. This checklist will assist you in obtaining the necessary information to adequately answer questions about the resident's death and lead the debriefing:

- Details of the death of the resident
- Details of the resident who has died
- Who will be participating in the debriefing?
- How many prior resident deaths has this team experienced?
- Are there any family / unresolved issues that are of concern?

# Further Information

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# Disenfranchised Grief Debriefing: Finding Hope and Meaning in our work that involves death and loss

## Part 3: INNPOT Model



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- This part of the learning series will focus on disenfranchised grief debriefing. Part three introduces the peer led debriefing model entitled INNPOT.

## Disenfranchised Grief Debriefing Model : INNPOT

- I - Introduction
- N – Need to say
- N – Need to do
- P - Plan
- U – Understand
- T – Thank everyone for sharing

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INNPOT is an acronym for **I**ntroduction, **N**eed to say, **N**eed to do, **P**lan, **U**nderstand and **T**hank you. This acronym will help the peer led debriefing leader to set the tone for the debriefing and can be used as a guideline only. Following this model will allow flow of conversation to continue and give the leader guidance if one gets stuck on the next stage or where to go with the process next.

# Introduction

- Name the experience
- Show compassion and understanding
- Check in
- Acknowledge

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In the introduction section the goal is to acknowledge the death of the resident and the impact that the death has on the front line staff members. The following comments are examples of what a peer led debriefer might say in the introduction section:

- Name the experience: “I wanted to meet here with you because I just heard about (...’s) death”
- “I just want to let you know that I realize that (...’s) death might be difficult for you, and even though you might have strong feelings about her death, you also have to continue on today (tonight) and finish your shift caring for others.”
- “I know this may be hard to do. Before you have to go back out to your floor (wing) I would like to take a few minutes to check in to see what each of you might need or would like to do to help you get ready to go back out to the floor and continue your shift.”
- We will get a change later in the next few weeks to talk more if you like, but I would like to take about 15-20 minutes to just check in and give you a chance to acknowledge what you have just gone through

## Need to Say

- Ask what the participants needs to say/ask right now

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In the need to say section the goal is to provide an opportunity for the staff member to discuss any aspect about the resident, the resident's death, or impact on her/himself. It is important to inquire whether any staff member has unanswered questions about the resident and/or family members that needs to be clarified before the process can go further. The following comments are examples of what a peer led debriefer might ask in the need to say section to prompt discussion among the group:

- Ask what the participants needs to say/ask right now
  - I am wondering if any of you would like to share some memories or thoughts about (....)
  - Do any of you have any unanswered questions about (...) death or the events leading up to her death? OR "Is there anything that you need to know that you don't know, either about (...) or her family?"

## Need to Do

- Ask what the individual needs right now – i.e. physical/cognitive needs
- Offer immediate information regarding expectations and procedures – assist them when/if possible
- Reinforce that the event has ended, normalize reactions and present follow up plan

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In the need to do section the goal is to determine what the staff might need individually or as a group to manage through their shift, following their shift, and for the next day. The emphasis on needs should be connected to their physical and cognitive needs, as well as self care planning. The following questions are examples of what a peer led debriefer might ask in the need to do section:

- Ask what the individual needs right now – i.e. physical/cognitive needs
- Offer immediate information regarding expectations and procedures – assist them when/if possible
- Reinforce that the event has ended, normalize reactions and present follow up plan
  - “I am wondering if it is okay to maybe go around within the group to check in to see what you might need to help you manage through the shift and for the next 24 hours before you come back to work?”
  - “I would like to remind you that some of you might have similar reactions, while others of you might experience something different. In situations like this there is no one right or wrong way to react. Listen to yourself and make sure you take care of your self and give yourself what you need. As you may know when people see someone who they cared for die there are any number of emotions and behaviours that come up – you may find that you are emotionally different than you typically see yourself – this is all a normal reaction to the death of someone that you have cared for and cared about.”
  - “The most important thing is that you do what you need to do to care for yourself over the next few days.”

# Plan

- Ask what each individual needs
- Remember that if you want to pass – just say so, but know that others will be here through the course of your shift if you need to talk

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In the planning section the goal is to solidify planning for each individual and/or as a group. The debriefer may find that the group naturally progresses to this section following the need to do section. Although this section may seem repetitive it is important to clearly identify plans of action for self care. The following questions and comments are examples of what a peer led debriefer might say in the planning section:

- Ask what the individual needs (anticipates needing) for the rest of the shift and the next 24 hours – assist where possible
- “I wonder if it is okay if we go around the group and just have anyone who wants to – state what they might need before they are able to go on with their shift – or maybe what they will need to do when they get home and prepare for the next shift”
- “To give you an example – some of you might need or want to go back to (...) room and spend a few minutes saying goodbye or others might like to do something in the form of a ritual maybe as a way to say goodbye. Others might just want to keep to themselves for the rest of the shift – while others might want to spend time with others during a break. Or you might think about something you might want to do in private – at home – or on your own”
- Remember that if you want to pass – just say so – but that even if you do not want to share – you might get some ideas or like some of the suggestions that others have made and you might want to join in later or connect with someone later today – and that is fine too”

# Understand Impact

- Incorporation
  - Normalize reactions
  - Connect to individuals external and internal strengths
  - Assist them to formulate a care plan
  
- So if I am clear – here are some of the things that you are going to do to take care of yourself for the rest of the shift today and over the next few days (repeat examples given)

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In the understand the impact section the goal is to provide an opportunity for staff to acknowledge their experience, normalize their reactions and promote a sense of collegial support. This section begins the closure portion of the debriefing. As a result, the peer led debriefer may find her/himself providing more summary comments reflective of the group sharing than actual process questions. The peer debriefer may want to remind the group that the debriefing is coming to a close and that she or he would like to summarize what was shared. The following comments are examples of what a peer led debriefer might say in the understanding the impact section:

- Incorporation
  - Normalize reactions— “...the grief that your experiencing today is normal and expected given your relationship with Mr. Smith”
  - Connect to individuals external and internal strengths—”Mary it seems like your humour and fond memories of Mr. Smith have help you managed through today. It is also obvious that your team appreciates your positive memory and attitude.”
  - Assist them to formulate a care plan
  
- “We are getting close to our ending time and before we finish I would just like to remind you that what you have shared today (mention some of the things that were brought up) are perfect examples of how a death of someone that you care about needs to be acknowledged”
  
- “I hope you remember how you supported each other today and the great examples of what you are going to do to help you take care of yourself and each other (again pull examples from the discussion)”
  
- So if I am clear – here are some of the things that you are going to do to take care of yourself for the rest of the shift today and over the next few days (repeat example plans given)

# Thank-you

- Closure
- Use this time to follow through on any immediate plans – such as saying goodbye or rituals – stick around the room just in case someone might want to speak with you one on one

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In the Thank-you section the goal is to work towards closure of the debriefing, allow for emotion stability and acknowledge the group's efforts. If the group shares a plan to say goodbye to the resident or expresses some other need for immediate plan it is peer debriefer's responsibility to clarify how that plan will take place. The peer led debriefer should also assess the group members to ensure that everyone is comfortable returning back to the floor and offering one on one support to anyone who is not ready to do so. It is also important for the debriefer to informally check in with participants as a means of peer support. If the peer led debriefer does not feel equipped to provide one on one support, he or she should provide contact information of someone is able and available to do so. The following comments are examples of what a peer led debriefer might say in the thank-you section:

- “I want to thank all of you for meeting with me. I know that ending this shift will be difficult, but I also know that you have some good plans to help you through it. I hope it is okay if I check in over the next few days with you to see how things are going and if there is anything else you might need”
- Use this time to follow through on any immediate plans – such as saying goodbye or rituals – stick around the room just in case someone might want to speak with you one on one

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## Experiential Role Play

- 1) During this section of the training the facilitator will lead the participants through an experiential role play. To begin introduce Margaret.**

Margaret Jane is an 86 year old resident in the long term care facility where you work as a PSW. She has lived in LTC for eight years. She was admitted when her dementia and related care needs became too much for her husband to manage for her to remain at home.

Margaret was born and raised in Thunder Bay. She was a teacher for many years before becoming the first female principle in the region. Education was her passion before she met her husband Tony who had recently immigrated to Canada from Italy. Tony and Margaret were married for almost 65 years and had one daughter Conchetta (Connie) late in life, who now lives on the west coast. A number of still births prevented the loving couple from having more children. Margaret said that maybe that was how things were supposed to be as she encountered so many children in her work as a teacher who needed her caring.

Tony worked as a chef in his own restaurant in Thunder Bay and demonstrated his love to Margaret, his "Amore" as he called her, through his cooking. He loved to feed her and often brought his home-cooked meals for her in LTC and treated the staff to meals as well. Tony visited Margaret twice a day and was very involved in her care until he died suddenly two years ago. Since Tony's death, Margaret's condition has deteriorated quickly and her dementia has worsened. She asks for Tony every single day and never

remembers that he has died. Her con-fusion sometimes causes this otherwise gentle and caring woman to become frustrated and angry. On one particularly difficult day she struck out and bruised one of the PSWs caring for her. Once she realized what she had done, she was very remorseful. Usually Margaret is very calm and peaceful and what the staff refer to as "pleasantly confused". She enjoys music and loves to hear stories of her caregiver's events and family.

Margaret's daughter, Connie remains in close contact with her and the LTC facility despite the distance, calling every couple of days and visiting every 4-6 weeks for a few days. Recently however, she has been diagnosed with very advanced breast cancer. She has asked that the staff don't tell her mother as she doesn't want to cause her any additional angst and pain.

Over the last few weeks, staff have noticed a rapid decline in Margaret's condition. She is no longer able to get up and go to her favourite music activity and is eating very little. The staff report that she seems to be more agitated and wonder if she is in pain. There have been conversations about palliative care for Margaret, but the next doctor visit is not until the end of the month. It is often difficult to settle Margaret now because she is more confused than usual.

#### Last few days of life:

The PSWs caring for Margaret recognize that she is dying. They strive to keep her as comfortable as possible. They note she sometimes appears agitated and calls out for both her daughter Connie and her husband Tony. One night at 2am, as one of the PSWs was checking on Margaret, they note that she is talking to someone. When asked who she is talking to, Margaret very clearly states that she is talking to her daughter Connie who has come to take her to Tony's restaurant. The staff find this very distressing as Connie died a week earlier from unanticipated consequences from her cancer and Margaret was not told of her death.

Overall, Margaret's death is a peaceful one as her physical symptoms were well managed. The staff were never quite sure if they made the correct choice by not telling Margaret that her daughter had died and had difficult discussions about this. In her more lucid moments Margaret cried out for Connie and was upset and angry that she wasn't at her bedside. She wondered out loud if maybe she had been a "bad mother" as her daughter wouldn't come when she was dying. As Margaret was the last living member of her family, her estate included a large donation to the LTC facility. There are a great many questions as to how best use this donation.

## **2) Facilitator will now walk participants through a peer led debriefing.**

### **A) INTRODUCTION**

- I wanted to meet here with you because I just heard about Margaret's death"
- "I just want to let you know that I realize that Margaret's death might be difficult for you, and even though you might have strong feelings about her death, you also have to continue on today (tonight) and finish your shift caring for others. "
- "I know this may be hard to do. Before you have to go back out to your floor (wing) I would like to take a few minutes to check in to see what each of you might need or would like to do to help you get ready to go back out to the floor and continue your shift."
- We will get a chance later in the next few weeks to talk more if you like, but I would like to take about 15-20 minutes to just check in and give you a chance to acknowledge what you have just gone through

## **B) NEED TO SAY**

Ask what the participants needs to say/ask right now

- I am wondering if any of you would like to share some memories or thoughts about Margaret
- Do any of you have any unanswered questions about Margaret's death or the events leading up to her death? OR "Is there anything that you need to know that you don't know, either about Margret or her family?"

## **C) NEED TO DO**

- Ask what the individual needs right now – i.e. physical/cognitive needs
- Offer immediate information regarding expectations and procedures – assist them when/if possible
- Reinforce that the event has ended, normalize reactions and present follow up plan
- "I am wondering if it is okay to maybe go around within the group to check in to see what you might need to help you manage through the shift and for the next 24 hours before you come back to work?"
- "I would like to remind you that some of you might have similar reactions, while others of you might experience something different. In situations like this there is no one right or wrong way to react. Listen to yourself and make sure you take care of your self and give yourself what you need. As you may know when people see someone who they cared for die there are any number of emotions and behaviours that come up – you may find that you are emotionally different than you typically see yourself – this is all a normal reaction to the death of someone that you have cared for and cared about. The most important thing is that you do what you need to do to care for yourself over the next few days."

## **D) PLAN**

- Ask what the individual needs (anticipates needing) for the rest of the shift and the next 24 hours – assist where possible
- "I wonder if it is okay if we go around the group and just have anyone who wants to – state what they might need before they are able to go on with their shift – or maybe what they will need to do when they get home and prepare for the next shift"

- “To give you an example – some of you might need or want to go back to Margaret’s room and spend a few minutes saying goodbye or others might like to do something in the form of a ritual maybe as a way to say goodbye. Others might just want to keep to themselves for the rest of the shift – while others might want to spend time with others during a break. Or you might think about something you might want to do in private – at home – or on your own”

Remember that if you want to pass – just say so – but that even if you do not want to share – you might get some ideas or like some of the suggestions that others have made and you might want to join in later or connect with someone later today – and that is fine too”

## **E) UNDERSTAND THE IMPACT**

- Incorporation
  - Normalize reactions
  - Connect to individuals external and internal strengths
  - Assist them to formulate a care plan
- “We are getting close to our ending time and before we finish I would just like to remind you that what you have shared today (mention some of the things that were brought up) are perfect examples of how a death of someone that you care about needs to be acknowledged”
- “I hope you remember how you supported each other today and the great examples of what you are going to do to help you take care of yourself and each other (again pull examples from the discussion)”
- So if I am clear – here are some of the things that you are going to do to take care of yourself for the rest of the shift today and over the next few days (repeat examples given)

## **F) THANK YOU**

- Closure
- “I want to thank all of you for meeting with me. I know that ending this shift will be difficult, but I also know that you have some good plans to help you through it. I hope it is okay if I check in over the next few days with you to see how things are going and if there is anything else you might need”
- Use this time to follow through on any immediate plans – such as saying goodbye or rituals – stick around the room just in case someone might want to speak with you one on one

## Appendix A: Example Quantitative Questions

The following questions may be used or adapted to create your own quantitative evaluation.

1. I am comfortable discussing general issues related to dying and death.
2. I am comfortable leading a discussion with co-worker regarding a resident's death
3. I am comfortable supporting a co-worker who is visibly upset and/or crying.
4. I am comfortable guiding my co-workers in how they support each other after a resident's death.
5. I am comfortable receiving support from my co-workers around the death of a resident.
6. I am comfortable supporting a co-worker after a resident's death
7. My co-workers can rely on me when they need to debrief after the death of a resident.
8. I turn to my co-workers for support when a resident dies.
9. When I get home, I take care of myself before taking care of others.
10. I am kind and loving towards myself when I am feeling emotional pain.
11. I am accepting of my emotions when a resident dies.
12. I am confident to lead a discussion about death, dying, and the grieving process.
13. I accept death as a part of life.
14. I accept the emotional struggles of my co-workers.
15. When a resident dies, I tend to bottle up any emotions that surface so my co-workers don't know I am upset.
16. After a resident dies, I assess the care I provided.
17. I am comfortable in participating in discussions about spirituality.
18. I think that everyone has their own grieving process.
19. I effectively practice self-care.
20. I think staff members grieve the death of a resident.

## Appendix B: Example Qualitative Questions

The following questions maybe used or adapted to create your own qualitative evaluation.

1. To what extent have you taken the knowledge from the debriefing and put it into practice?
2. If you have put it into practice, what benefits do you feel you have gotten from using the debriefing model?
3. If you have not put it into practice, what barriers do you feel have gotten in the way from using the debriefing model?
4. How has being involved in this simulation lab workshop impacted your confidence to be able to manage a debriefing after a resident dies at your long term care home
5. Was this debriefing model of any benefit to you?
6. Did something shift between now and when you originally attended the workshop that changed your perception of debriefing?

## Appendix C: Mindfulness Meditation Exercise

***Mindfulness meditations are extremely powerful. In this meditation exercise participants will find themselves very connected to the memory and emotion that these questions will elicit. It is important for the facilitator to ready the group prior to beginning and invite them to disengage from the exercise if they choose. The facilitator must also be aware of the group process and ensure efficient closure prior to continuing.***

Get comfortable in your chair with your feet on the floor. Take a deep relaxing breath. Gently close your eyes and continue to breath deeply for a few breaths. Become aware of your breathing. Breathe slowly. Now gently take yourself back to a time when you were with a dying person. Bring yourself fully into that

experience. Try to recall as much detail as you can. This may have been a positive or a negative experience. It may have been a resident, a loved one or a friend. Remember who was there.

- What were the expressions on their faces?
- What were you hearing?.
- what were people saying?
- What sounds were in the room?
- What were you feeling?
- What were you thinking?
- What did you say?
- How did you react?
- How do you think the dying person felt?
- How do you think other in the room felt?

Now gently taking your time let go of your focus on the scene and come back to this room. It is hard to watch people die for a living. Your work is very intimate with the resident and thus they feel like family members.

**If you choose to complete this exercise please extend the training by 30 minutes.**

*Tip: Facilitators may wish to plan for this exercise to take approximately 15—20 minutes. The goal of this exercise is for participants to ease into and through their grief experience in mindful manner in order to facilitate this process questions should be asked slowly with enough time between questions for participants to ponder their reaction. The ending should also be timed responsibly to offer enough time for emotional closure and re-connection back to the group.*

*Tip: At the end of the meditation exercise participants maybe willing to share their experience. If the facilitator chooses to ask participants to share their experience she/he must be conscious of the time to allow all who want to share can.*

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