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Developing and Implementing Peer-Led Intervention to Support Staff in Long-Term Care Homes Manage Grief

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Abstract

Front-line staff in long-term care (LTC) homes often form strong emotional bonds with residents. When residents die, staffs' grief often goes unattended, and may result in disenfranchised grief. The aim of this article is to develop, implement, and assess the benefits of a peer-led debriefing intervention to help staff manage their grief and provide LTC homes an organizational approach to support them. This research was nested within a 5-year participatory action research to develop and implement palliative care programs within four LTC homes in Canada. Data specific to this debriefing intervention included questionnaires from six peer debriefers, field observations of six debriefings, and qualitative interviews with 23 staff participants. An original peer-led debriefing intervention (INNPUT) for LTC home staff was developed and implemented. Data revealed that the intervention offered staff an opportunity to express grief in a safe context with others, an opportunity for closure and acknowledgment. The INNPUT intervention benefits staff and offers an innovative, sustainable, easy to use strategy for LTC homes.

Keywords

long-term care homes, grief, peer-led debriefing, palliative care, unregulated care provider, front-line staff

Background

Research shows that approximately 20% of long-term care (LTC) residents die each year (Canadian Institute for Health Information, 2012; Statistics Canada, 2011; Travis et al., 2002), with expectation that this number will reach almost 40% by 2020 (Ross, Fisher, & McLean, 2000). However, there is a major gap in the research regarding LTC staff and how they cope with the substantial losses that they deal with regularly in their profession. A recent study (Osterlind, Hansebo, Andersson, Ternestedt, & Hellstrom, 2011) recognizes the discourse of silence surrounding death and dying in LTC, noting that staff keep death at a distance by concentrating on tasks and routines. Emotions are pushed to the background, and death is surrounded by silence (Cocco, Gatti, de Mendonça Lima, & Camus, 2003; Hopkinson, Hallett, & Luker, 2005; Jenull & Brunner, 2008; Moss, Moss, Rubinstein, & Black, 2003; Wilson & Kirshbaum, 2011).

This experience has been well documented in the literature as disenfranchised grief (Black & Rubenstein, 2004; Boerner, Burack, Jopp, & Mock, 2015; Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013; Thompson & Bevan, 2015). Unregulated health care professionals as identified in the Osterlind et al. (2011) study are direct care staff in LTC homes who provide multidimensional (physical, emotional, spiritual, and social) care to residents. Due to the encompassing and time-consuming nature of their caregiving roles, the relationships that form between front-line staff and nursing home residents can be extremely close, and in some instances forged over years of providing intimate care (Anderson & Gaugler, 2006-2007). For staff, the deaths of residents may be equivalent to the deaths of family members, evoking strong grief reactions that are compounded with each accumulated loss. The failure to acknowledge the relationships between staff and residents, and the denial of deaths in nursing homes, may preclude direct care staff from effectively moving through their grief process (Anderson & Gaugler, 2006-2007). It is therefore essential for LTC homes to promote policies and practices that support a healthy grieving process for staff, and to implement innovative strategies to validate, enfranchise, and improve the process of working through the disenfranchised grief that direct care staff may experience after the death of LTC home residents.

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Based on the above-mentioned research, there is consensus that in fact front-line staff may experience disenfranchised grief, which in turn impacts their mental health and well-being. The new matter, then, is how to effectively support direct care staff in assisting them to manage and prevent disenfranchised grief symptoms.

Direct care staff, consisting of registered nurses (RNs), registered practical nurses (RPNs), and front-line staff (often referred to in the literature as personal support workers, health care aids, nurse's aides, or nursing assistants) who work in LTC homes, can expect to experience the effects of loss and grief as a result of the death of residents for whom they have provided care. Front-line staff in particular provide daily care and form significant relationships with residents and their families. Although the issue of managing disenfranchised grief is important for all direct care staff, this article focuses specifically on the front-line worker. For the purposes of this article, the generic term *unregulated care provider(s)* (UCP) will be used to describe the front-line worker responsible for the majority of the resident's daily health care needs.

Objective

The concept of disenfranchised grief has been well researched and supported in the literature. This article builds on the research and literature concerning disenfranchised grief by developing an intervention aimed to mitigate its effects on UCP in LTC homes.

There are two objectives that this article is reporting on. The first objective was to develop an organizational intervention based on current literature and in collaboration with UCPs, aimed to ease the effects of grief and prevent disenfranchised grief. The second objective was to gauge the perceived benefit of the developed intervention tool (INNPUT) through the use of follow-up qualitative questionnaires, individual interviews, and transcript review of participants' feedback.

Context and Method of the Research

A 5-year study (2009-2014) was conducted in four LTC homes in Ontario, Canada, with the purpose of improving the quality of life for people who are dying in LTC by creating formalized palliative care programs that can be sustained within the LTC homes beyond completion of the project (see www.palliativealliance.ca). The project was completed through the collaboration and active participation of four key partners: Lakehead University, McMaster University, St. Joseph's Care Group, and the Municipalities of Halton and Niagara. These partners created the Quality Palliative Care in Long Term Care (QPC-LTC) Alliance, consisting of 25 researchers and 40 organizations, to help facilitate the project goals. The overarching goal of this project was to develop palliative care programs, using Kelley's capacity development model for LTC and a participatory action research (PAR) approach (Kelley & McKee, 2013). A toolkit, available on the project website, was created that includes a framework for developing palliative care in LTC and more than 40 research-informed innovations, interventions, tools, and resources that support development of palliative care in LTC homes.

In the health services context, PAR is a relatively new approach that brings a social science perspective to knowledge creation to describe, interpret, and explain caregiving as social rather than medical phenomena. PAR can generate both practical and theoretical knowledge, and is able to validate old theories or generate new theories from practice (Webb, 1989). Action research differs from more conventional research paradigms in three ways: its understanding and use of knowledge, its relationship with research participants, and the introduction of change into the research process (Hockley, Dewar, & Watson, 2005). The goal of PAR is to create social change in relation to a desired goal through the empowerment of affected people. The empowerment process, the change process, and its outcomes are systematically documented through a variety of data collection methods before, after, and throughout the research process. Knowledge is co-created by the researcher and participants through a reflective spiral of activity: identifying a problem, planning a change, acting and observing the process and consequences of the change, reflecting on these processes and consequences, and preplanning, acting, observing, and reflecting (repeating the cycle; Kemmis & McTaggart, 2000). In this research, PAR was an appropriate methodology as it reveals greater complexity than other methods and can create social change (Kelley & McKee, 2013). It also recognizes the existing expertise of LTC staff and promotes integration of palliative care into current practices.

Concepts such as inquiry, learning, participation, and change were used as part of a process through which the UCPs were encouraged to share their knowledge about disenfranchised grief and its effects. Acknowledging and validating the staff's knowledge and experience provided valuable research and insight to create change opportunities that will be sustainable over time. This process, one that encourages mutual respect for knowledge and shared dialogue, is part of a PAR process that offers a unique approach to organizational success (Foley, 2001).

PAR emphasizes the importance of recognizing existing knowledge, and advocates for conversations that encourage shared knowledge and learning (Baker, 2001; Bushe, 1999; Cooperrider & Srivastva, 1987; Foley, 2001; Orr, 1996; Patton, 2002; Reason & Bradbury, 2001). Researchers are immersed in the concept of participatory interaction and learning, recognizing the implications for this type of learning interaction and dialogue when organizations attempt to implement and sustain change (Kelley & McKee, 2013). The participatory research method gathers existing internal knowledge and collective ideas, and facilitates collaborative constructions. It was these ongoing collaborative constructions with the UCPs, combined

with research literature that informed the development of the INNPUT intervention.

To develop the QPC-LTC framework and toolkit, the following five-step process was used: needs assessment, engaging community partners, developing innovations, implementing and documenting innovations, and creating a toolkit. In 2009, as a first step, an environmental scan was conducted, with the results indicating that the UCPs in LTC homes repeatedly reported a development of close personal relationships with the residents. These same staff also stated they experience tremendous loss and grief when a resident dies. Consequently, a sub-study was undertaken, aiming to better understand staff's grief experience and to identify their perceived support needs (Marcella & Kelley, 2015). The findings, similar to that of the research by Waskiewich, Funk, and Stajduhar (2012), indicated that the UCP's experiences with loss and grief are complex, much shaped by the emotional impact of each loss, the cumulative burden of ongoing grief, and the organizational culture in LTC. The study identified several recommendations, among them the implementation of organizational procedures to support staff dealing with loss and grief, the implementation of organizational strategies and rituals to acknowledge all residents who die in the LTC home, and supporting staff with time and resources to reach out to colleagues after the death of a resident to acknowledge their loss and grief. Staff strongly indicated the desire to be supported by their own peers and did not want external grief counselors introduced (Marcella & Kelley, 2015).

Research Method for Developing the INNPUT Intervention

The INNPUT intervention evolved as an additional cycle through the continued practice of PAR within the framework of the QPC-LTC project. Front-line staff were highly motivated to participate in addressing their identified need for grief support.

UCPs working in two of the project's LTC homes participated in implementing and documenting the benefits of the INNPUT intervention. Several UCPs consulted on the development, volunteered to be trained as peer-led debriefers, and participated in the implementation by promoting the debriefings with their peers.

As noted by Crawford and Bath (2013), "peer driven research and equitable involvement in research development should be undertaken to ensure that the needs of the PSW (UCP)s and peer organizations are better understood" (p. 579). Through the research, UCPs identified needing a peer support intervention after the death of a resident. Collaboration between research staff was continual throughout the development of the intervention, ensuring that the peer support context would be effective. Once the intervention was established, education was provided to volunteer UCPs to become facilitators of the intervention. Implementation of six peer-led interventions was completely facilitated by peer leaders, with the research staff in presence only as an observer. A total of 21 pages of field notes, seven informal personal interviews averaging 20 to 30 min in length, 74 pages of transcription notes, and six packages of qualitative and quantitative survey evaluations were completed by the peer leaders after each intervention.

Because UCPs comprise the majority of direct care staff in LTC homes (Sharkey, 2008), seeking out their expertise throughout the research process was vital in developing an intervention for grief support that would meet the needs identified by the staff. Therefore, PAR offered a method through which expertise was sought to determine issues, as well as solutions to managing unresolved disenfranchised grief. As a result of the above-mentioned sub-study, the concept of a peer-led debriefing intervention was seen as a potential approach to provide staff with the opportunity to receive the necessary education, take a step back from the emotionally stressful event of a resident death, and have their loss acknowledged. To ensure rigor, the experience and feedback of the UCPs were supported by academic literature.

The need to examine information concerning disenfranchised grief and potential debriefing interventions was evident. Based on the current literature, it was determined that the effects of disenfranchised grief could be mitigated through a peer debriefing intervention that incorporates education, acknowledgment, and support.

Development of the INNPUT Intervention

Reviewing the Literature

An important stage in the development of the INNPUT intervention involved reviewing literature concerning the LTC culture, grief, and crisis debriefing models. It was determined that to develop an intervention tool for support, it was vital that it be based on current research and practice trends. It was also important to review literature related to disenfranchised grief and its impact to ensure that any key interventions be based on noteworthy research.

Disenfranchised Grief

Doka (1989) describes disenfranchised grief as "the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publically mourned, or socially supported" (p. 287). Doka's concept of disenfranchised grief is relevant to the LTC culture as ageism and the frequency of deaths create a belief system that "death is part of the job." Although the grief process has potential benefits such as cathartic adjustment and emotional growth, the stress that is often associated with grief can be debilitating, imparting a global effect that impacts the entire bio-psychosocial spectrum of life (Anderson & Gaugler, 2006-2007).

UCPs are primarily involved in the direct care of residents who are at their end of life, and will be increasingly called upon to provide this care. Providing physical and emotional comfort to residents along with support to the family, over a period of years to one's final days, creates experiences not often understood by many other front-line workers (Waskiewich et al., 2012). In addition, UCPs often face a multitude of factors such as clients' difficult behaviors, demanding work schedules, low salaries, role ambiguity, and low social recognition (Jenero, Flores, & Arias, 2007). Consequently, they may be at higher risk for developing emotional fatigue than others in helping professionals (Alkema, Linton, & Davies, 2008). The LTC home's culture rarely includes acknowledgment of an employee's grief, and dealing with death is considered part of the job. Over time, a belief emerges that supports the notion that death of a resident should be expected and managed accordingly (Maitland, Brazil, & James-Abra, 2012). The accumulated stress of continuously being faced with cumulative losses and difficult dynamics can all have profound effects on professional coping abilities (Showalter, 2010; Waskiewich et al., 2012). Without interventions aimed at the opportunity for managing difficult emotions post death of a resident, UCPs are left struggling in silence regarding their interpretation and/or meaning concerning their reactions to the death of residents (Funk, Waskiewich, & Stajduhar, 2013-2014).

Social support serves as a mediator in the grief process, helping to alleviate the stress of grief and facilitating coping and healing (Anderson, Ewen, & Miles, 2010). Recognizing grief and the benefit of social support are the main goals in the development of peer-led debriefings. Review of the literature suggests that organizations benefit when they invest in a peer support program. It has been reported that social support from colleagues may mitigate the effects of a traumatic situation more than non-work support (House, 1981; LaRocco, House, & French, 1980). In a related study completed by Lowery and Stokes (2005) on the effects of occupational stress injury in paramedic students, the authors learned that students could be protected from the detrimental impact of their duties through a combination of receiving emotional support and being able to discuss thoughts and feelings with a colleague who has gone through a similar experience.

Funk et al. (2013-2014) discuss in their findings that deaths, in particular difficult ones, can create feelings of loss, grief, and in some cases, a sense of shock. As noted previously, the UCPs not only provide direct care, but it is also the nature of the relationship that makes one feel as if the resident is a close friend or family member. This experience is something that is difficult to define, yet is reported consistently among UCPs in the literature (Funk et al., 2013-2014; Waskiewich et al., 2012). Support among peers who can instinctively draw on their own experience and solutions is vital to an intervention intended to address disenfranchised grief. According to Resnick and Rosenheck (2008), "Participation in peer support enhance personal well-being" (p. 1307). The inherent social support involved in the process creates an environment of mutuality that supports self-care.

Peer Support Debriefing as an Intervention to Mitigate Disenfranchised Grief

Employee's loss and grief is often overlooked and minimized as the demands of their workplace take priority (Slawinski, 2005). In many cases, ignoring the impact of potential disenfranchised grief can result in an emotional state of crisis for workers. Therefore, a staff member in LTC may experience a state of crisis as a result of a resident's death. Specifically, when a resident dies and the staff member is not helped or supported, it can result in an inability to function at the same level as before the grief experience. Many theorists believe that a crisis is respondent to the maladaptive coping skills of an individual and lack of supports during the appraisal of a precipitating event that leaves an individual with a lower level of functioning after the initial event (Slawinski, 2005).

Upon review of the literature pertaining to the use and benefit of peer support in other professions, it appears that peer interaction is invaluable. Debriefings are traditionally a helping response to a crisis or traumatic event, and a preventive intervention that focuses on internal abilities and awareness (Slawinski, 2005). Group debriefings have usually been designed to work with groups of people to process a critical event (Miller, 2003). In many debriefing models, the use of a peer debriefer is seen as vital to the success of the process (Mitchell & Everly, 1995)

Upon review of the literature, it appears that the majority of research in the area of peer support models to mitigate occupational stress has been in the emergency services discipline. Several studies have shown that through dialogue with colleagues and others, it is possible to cope with the effects of traumatic and/or difficult experiences (Dyregrov, Kristoffersen, & Gjestad, 1996; Fullerton, McCarroll, Ursano, & Wright, 1992; Jonsson & Segesten, 2003). Social support diminishes stress and makes it understandable, thus making it possible to cope with distressing events (Dyregrov & Mitchell, 1992; Jonsson & Segesten, 2003). In their study with paramedics, Alexander and Walker (1994) noted that there was a preference for discussing incidents with colleagues. It was reported that nearly everyone who used this method to cope with their recent disturbing incidents found it to be helpful, and almost half found it to be very helpful.

UCPs are often confronted with the feeling of not having done enough, even when they have. The ability to speak with another peer allows for a release and sharing of their loss, grief, and the demand to continue on and care for others. Based on this perspective, a peer debriefing intervention could assist UCPs through their grief, and also assist in the development of a plan to manage and support each other. Peer support programs are best delivered when they are unique and address contextual issues such as limitations on time, social stigma and culture, as well as support of management (Fisher et al., 2014).

Table 1. INNPUT Intervention.

INNPUT	
I	*Introduction*—the goal is to acknowledge the death of a resident and the impact that death has on the front-line staff members
N	*Need* to say—the goal is to provide an opportunity for the staff to discuss any aspect about the resident, the resident's death, or impact on herself or himself
N	*Need* to do—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.
P	*Plan*—the goal is to solidify planning for each individual and/or as a group
U	*Understanding*—the goal is to provide an opportunity for staff to acknowledge their experience, normalize their reactions, and promote a sense of collegial support
T	*Thank you*—the goal is to work toward closure of the debriefing, allow for emotion stability, and acknowledge the group's efforts

Based on the above concepts, further literature was explored to develop and support a process that could be used as part of a peer intervention. Pender and Prichard (2009) indicate that the peer facilitator intervention can be used to effectively lead a discussion among staff with the aim of normalizing their responses, educate about the normal path of the grieving process, allow time for reminiscing about the resident, solicit coping strategies, examine what was learned through the experience, and acknowledge the importance of care that was provided to the resident and her or his family. The authors present several open-ended questions, which can establish a dynamic that invites the participants to express their personal and professional responses to the death. Questions such as "What was it like taking care of this patient?" and "What have you experienced since the death?" provide an opening for participants to discuss any physical, emotional, behavioral, or spiritual responses.

The death of a resident in an LTC setting can often create a sense of urgency among staff caring for residents. Peer-led grief debriefings can be an effective intervention to assist staff through the grieving process associated with the death of residents, give them support, and promote self-care. In short, the peer support debriefing process is intended to reduce stress, collectively provide mutual support, healing, and self-help through the process of group interaction.

Similar to Pender and Prichard (2009) and Lane (1994), the INNPUT intervention addresses the need for normalization of emotions, education regarding grief, opportunities to reminisce about the resident, and discussions about coping strategies. What is unique about the INNPUT intervention is that it offers staff a tool to use as a guide to assist them as they facilitate a debriefing among their peers. Although this intervention addresses the impact of disenfranchised grief by outwardly acknowledging the employees' loss, it is the focus on their needs that promotes the appreciation of their experience and self-care. Whether it be discussing details about the resident's death, what they need to do to begin closure or what they need from each other, the attention paid to the needs of the staff are seen as a vital intervention. Waskiewich et al. (2012) support this process through their research, noting the importance of emotional processing as it links to an opportunity for closure following a resident's death. While it is the relationship between the UCP and resident that creates quality end-of-life care, it is this very relationship that must be addressed when this relationship ends through death.

Description of INNPUT Intervention

The INNPUT intervention promotes peer group interaction using four components identified by Lane (1994): cohesiveness, personal insight, support, and installation of hope. Specifically, the intervention is designed to acknowledge the impact of the loss for the employees; provide an opportunity for expression of thoughts, feelings, and experiences; and create an environment for supportive planning and promotion of self-care, all within the context of employee partnership.

Based on the literature and research pertaining to crisis, the grief response INNPUT intervention utilizes a peer-led debriefing approach, designed to maximize support, self-reflection, and self-care planning (Table 1). This intervention, implemented for the first time with UCPs working in an LTC home, was created based on information obtained through a literature review focusing on the impact of death of residents on front-line staff, various debriefing models, and research results from the QPC-LTC project.

The INNPUT intervention is original and was designed to utilize common debriefing techniques and progression categories to process issues that may emerge as a result of disenfranchised grief. Specifically, the intervention aims to focus on the benefit of open-ended questions and capitalize on the benefits of a peer-led process, as noted by Pender and Prichard (2009). The intention of the INNPUT intervention is to capitalize on the peer-led debriefing framework as direct care staff are instrumental in providing support to other staff after the death of an LTC resident.

The following is a break-down of each stage, with a more thorough description and information that might be useful to the peer facilitator.

I—Introduction

In the beginning of the session, the facilitator of the debriefing initiates the discussion concerning the resident's death by first acknowledging the impact the death

may have had on the staff. This may take the form of a general appreciation of the resident and the relationship she or he might have had with the staff. The introduction can also be in the form of a statement outlining why the debriefing is being offered, and welcoming staff to participate. It is also important to use the introduction portion to ensure that all staff have the same accurate information surrounding the resident's death. At this time, any outstanding questions are answered.

N—Need to Say

As a natural flow following the introduction, the facilitator of the debriefing can move to asking employees what they may need or want to say about the resident. It is in this section where staff will typically like to share a special memory or event about the resident. It is likely that once one employee begins, many others will join in, sharing details about their relationship with the resident. When the staff have shared what they need to say, the facilitator may wish to summarize what was said by the group as general memories about the resident. This summary is often a natural progression to the next section regarding what the employees need to do.

N—Need to Do

It is in this section where attention to the employee is given. Following the summary of the memories about the resident, the facilitator of the debriefing will then move to ask questions about what the staff might need to help them manage through the next 24 hr. It is important to recognize that some staff might be coming onto a shift, might be going off for the next day or more in their shift rotation, or might be in the middle of a shift; therefore, needs may vary. It is during this time when staff may discuss needs related to closure, such as going to the resident's room to say goodbye, or engaging in some closure ritual that has been supported in the LTC home such as placing some symbol on the resident's door or window. Other employees may share their needs related to self-care in the form of independent activity to remember the resident, or the need to reach out to other staff. The importance is on the discussion of self-care rather than the actual activity.

P—Plan

Based on the sharing of individual needs, the facilitator of the debriefing may then have the employees elaborate by having them share their plan to meet their need. Again, employees may have a plan that will include others, while some may share plans that are more independent. It is also beneficial for the facilitator of the debriefing to inquire whether there is anything he or she might be able to do to assist the co-workers in achieving their plan.

U—Understanding

The facilitator's goal throughout the exercise is to demonstrate understanding. As a peer, the facilitator of the debriefing can easily empathize with the staff's experiences, and acknowledging their grief is vital. To this end, the debriefer would want to use the time to summarize what staff have shared, what they plan to do to take care of themselves, and acknowledge their loss and grief.

T—Thank You

This part of the intervention includes an opportunity to close the debriefing with thanking the employees for attending. The primary function of the final component of the INNPUT is to acknowledge the importance of staff taking time to realize that they have been impacted by the resident's death. This is also an opportunity to thank staff for their attention to self-care, so that they can continue to provide care and support to other residents.

The INNPUT format provides both structure and flexibility to allow for disclosure that is unique to each group's experience. This intervention can be easily adapted to fit within any LTC environment, and addresses the main initiatives needed to attend to staff's burden of grief. The peer-led approach also acknowledges the perspective that UCPs are in the best position to identify the support and resources their peers may need to manage their loss and grief. As this intervention is intended for LTC home use, it also demonstrates that support through grief and in the work environment is a vital component of a holistic and inclusive palliative care program in LTC setting.

Implementation of INNPUT Intervention

By 2013, the INNPUT intervention was developed and ready to be introduced in the field. Before the intervention was implemented in the LTC homes, educational training sessions were held for staff who would act as facilitators of the debriefing and use the INNPUT. Two training sessions occurred at Lakehead University, with each session having a pre- and post-evaluation done by the researchers to refine the training and develop a toolkit for use in other LTC homes. A total of 23 staff volunteered to participate in the peer-led debriefing training sessions. Recruitment criteria for potential facilitators of the debriefing included the following: expressed interest in facilitating a peer-led debriefing, ability to personally relate to the impact of disenfranchised grief, is comfortable being in a leadership role, respected and trusted among their peers, and currently not in a supervisory role (to promote a safe environment). Disciplines who participated in the training were UCPs (22) and recreation therapy/life enrichment aids (1). A strong focus was on engaging direct care staff in becoming peer-led facilitators of the debriefing

because they provide the majority of resident care and are likely to be affected by the death of the residents.

Training content included information about disenfranchised grief, trauma, compassion, fatigue, and the need for debriefing and incorporating ritual strategies in the workplace. Participants were introduced to the INNPUT intervention. Two mock debriefing sessions were held in a simulation lab with a high fidelity mannequin for participants to practice their debriefing skills. Participant evaluations indicated that mock debriefing training methods were perceived to be effective. As a result of this feedback, no further changes to the intervention were made.

After the staff training was complete, the INNPUT intervention was introduced and implemented in two LTC facilities that were part of the QPC-LTC Alliance. Staff were encouraged to conduct debriefing sessions as soon as possible after each resident's death, taking into account the priority of care demands for residents and family members, immediately following a resident's death. The trained facilitator of the debriefing who was working at the time of the death invited interested staff to attend the debriefing, and decided on the best time to hold the session. Staff attendance at the debriefings was voluntary with most choosing to attend. Ground rules for the debriefing included no one is forced to talk, front-line staff are encouraged to participate from start to finish, everyone is treated equally, there are no right or wrong answers, no interruptions are permitted (e.g., cell phones), difference in opinions are expected and valued, discussion is guided by the INNPUT intervention, and the session takes place in a small group or sharing circle.

Assessment of Perceived Benefits of INNPUT Intervention

One of the researchers was "on call" to observe the debriefings for several months, attending six sessions in total. Implementation assessment data included qualitative questionnaires completed by six UCP peer debriefers, informal interviews with 73 LTC staff participants, and a review of a researcher's field notes after observing six debriefings. The researcher's role within the debriefing sessions was primarily to observe and act as a support if needed, and to document the experience of the UCPs implementing the INNPUT intervention using field notes.

The audio-taped interviews were transcribed verbatim by the research assistant who participated in the education, in the interventions, gathered field notes, and conducted the interviews of the UCP debriefers. The analysis went through a three-level process of analytic induction. Saturation occurred when commonalities arouse from thematic analysis of the data. This approach, called thematic analysis, identified, analyzed, and narrated themes extracted from the data (Vaismoradi, Turunen, & Bondas, 2013).

UCP Experience of Intervention

Thematic analysis of the data identified two main themes. First, staff felt that the INNPUT intervention supported their self-care. As discussed in the literature regarding disenfranchised grief, staff rarely were able to engage in sharing their loss and grief (Boerner et al., 2015; Funk et al., 2013-2014). According to field notes, staff felt that having the debriefings allowed them to say goodbye and to have a closure.

> And finally just some acknowledgment that we do have some grief, and it is like we are making closure for her, because our life here it just continues, one dies and another one come, so we just continue and learn by ourselves. (UCP)

The peers who facilitated the debriefings felt very strongly that all staff benefitted every time a debriefing session was done.

> So I think with time we were prepping ourselves to say the final goodbyes and having this, this communication and getting together and sharing all the stories, I feel good about it, I think this is great and that you guys are here. (UCP)

The second theme was acknowledgment. Staff felt that the INNPUT intervention provided them with an opportunity to openly acknowledge and process their grief. In addition, the management supported the INNPUT intervention. As a result, organizational support, along with team interaction within the INNPUT intervention, provided a unique opportunity to promote individual well-being and organizational culture change.

Interestingly, upon review of the field notes between June and November 2013, there appeared a remarkable transformation regarding UCP's opinion regarding the potential of the INNPUT intervention. Not all UCPs were convinced that the INNPUT intervention would provide a positive outcome; however, after experiencing the debriefings, numerous staff commented on how astonished they were about the experience. Staff noted that they shared and learned more about their grief, as well as how to care for themselves and others. Many were surprised that the intervention created a sense of team support.

Upon review of field notes, staff typically implemented the INNPUT debriefing intervention to meet their specific needs. During debriefings, staff regularly discussed the resident who had died, their memories of the resident, self-care, and anything they felt could have been done better to provide a good death for the resident. They met in a quiet room for about 20 min, usually either before or after their shift, with management support. It was conveyed to the researcher that having management support for debriefings aided the grieving process by acknowledging and validating their loss.

The researcher noted that between 10 and 12 staff on average participated in these sessions, with many of them expressing that the debriefing represented a closure for them.

They felt it was a safe place to share their feelings with people who could relate to their loss and grief. Staff who attended the debriefings included UCPs, nurses, life enrichment, and dietary staff. One of the UCP, who has been working in LTC for more than 10 years, was asked what the peer debriefings meant to her. She offered the following reflection on her experience with the researcher:

> Residents become like family to us. For some staff, the honor of being with resident when they took their last breath, or holding someone's hand until their soul leaves their body, this can stay with you for a long time . . . residents become like family to staff. When they die, another is placed in that bed and we start over. In the past, we just accepted the death and continued on quietly remembering them . . . we needed a way to lessen the burden of grief…staff volunteered their time to be trained in peer led debriefings . . . this is a way to come together and grieve in a safe environment. Staff from every department gather and say what they need to in order to have a closure with a death. Some staff want to be in the room to hear stories and be a part of the ritual. Being with co-workers, listening to stories is a wonderful way to say goodbye and to make room for new residents in our hearts . . . I found that doing and taking part in the debriefings have helped staff to be able to move on quicker, feel good about the work that was done to make this person special, and know their final time with us was a good memory. During debriefings there is laughter, some tears, and some talk about regrets, but we come to terms with things we cannot change nor have control of. At the end of our debriefing, we put the resident's name and the date of death on a leaf. We place the leaf on a tree branch in our home. This way we may come to the tree, look at all the leaves and remember the funny stories, the lessons learned, the gratitude we have for knowing these wonderful human beings. Peer led debriefings is like the period at the end of a sentence. You have to have it or the grief just goes on. (UCP)

Two years later (December 2015), the staff working in these LTC homes continue to conduct debriefings. Implementing this protocol is sustainable because it addresses an expressed need by the staff and requires minimal investment of organizational resources. Over time, however, it will be necessary to train more peer facilitators.

Conclusion

The peer-led debriefing INNPUT intervention offers a facilitated process that helps prevent disenfranchised grief through validation. Ultimately, the message is received that employees have lost a person whom they cared for intimately. Osterlind et al. argue that death and dying in LTC homes is common, yet it evokes fear and avoidance of staff. Death is surrounded by silence, and emotions are pushed into the background (Osterlind et al., 2011).

The INNPUT intervention can be easily adopted by any LTC home and championed by direct care staff. It requires minimal organizational resources to implement and sustain. Through the implementation of this intervention, it is believed that the opportunity for human relatedness and shared experience will lessen the isolated feelings that may lead to disenfranchised grief in LTC.

The lack of research on grief experienced by health care providers in LTC homes is noteworthy. The INNPUT intervention was developed based on auxiliary research. Peer-led debriefing in LTC is in its infancy and warrants further research. Although the long-term benefit of this intervention has not been vigorously evaluated, it is existing in practice with positive results. Further research will need to be conducted to fully support its efficacy.

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