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INTRODUCTION

The concept of loss has been explored over many decades (Lindemann, 1944; Kubler-Ross, 1969; Bowlby, 1997; Robinson & McKenna, 1998; Pilkington, 2006) and its various components have been identified (Touhy *et al.,* 2005; Phillips *et al.,* 2006; Munn *et al.,* 2008*).* Experience of loss is determined by many factors including gender, cultural context, social environment, age of both the deceased and the survivor, and type of death (Noppe, 2000). Moreover, the nature of close relationships and attachments also play a fundamental role in the process of loss.

Loss and grief are terms used interchangeably, and one of the primary antecedents of grief is loss (Reed, 2003). However, not all loss necessarily results in grief. Grief and loss is often part of nurses' work. This is captured in Papadatou *et al.'s* (2002) descriptive study of 16 paediatric oncology nurses' grief responses. Nurses frequently developed personal relationships with the children and their parents, allowing them to invest with meaning in their professional role. Moreover, they sought support from colleagues with whom they shared personal experiences (Papadatou *et al.,* 2002).

Many studies exploring nurses' experience of loss have centred within acute settings (Brosche, 2003; Thompson *et al.,* 2006; Enns & Gregory, 2007), paediatric care (Rashotte *et al.,* 1997; Papadatou *et al.,* 2002) or palliative care areas (Wowchuk *et al.,* 2007; Johnston & Smith, 2006).

Nurses caring for older persons in long care settings regularly encounter death and dying. However, minimal attention has been given to the emotional involvement of the nurse before, during and after the death of older persons in long term care settings (Brosche, 2003; Brunelli, 2005). Understanding nurses' emotional involvement is important because its nature can affect nurses' experience of loss and grief (Gerow *et al.,* 2010).

The long term care setting is often the residents' 'home' and where many residents expect to die. Nurses working in long-term older person care settings establish long-standing relationships with residents. This study sought to illuminate nurses' lived experience of loss on the death of residents in their care.

METHOD

An interpretative phenomenological analysis (IPA) approach was adopted for this study. IPA aims to examine cognitions and emotions underlying descriptions of subjective experiences (Smith *et al.,* 1999). IPA is phenomenological in that it seeks perspective on the individual's lived experience and interpretative in that it acknowledges the researcher's personal beliefs and experiences (Fade, 2004). The role of the researcher focuses on interpreting a participant's understanding; a two-stage interpretation process referred to as a *double hermeneutic* where the researcher "is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2008, p. 53). The researcher's personal ways of thinking and assumptions are not considered as '…'biases' to be eliminated' but a '…necessary precondition for making sense of another person's experience' (Willig, 2008, p. 69). This highlights the tension for phenomenological researchers who are caught between the tensions of 'bracketing pre-understandings and exploiting them as a source of insight' (Finlay, 2008, p. 3).

However, when interviewing with IPA, the researchers is cautioned to 'park or bracket...pre-existing concerns' in order to facilitate focusing on the participants' words (Smith *et al.,* 2009, p. 64). A reflective journal was therefore maintained. Reflections and observations were documented following each interview and these notes were later utilised in the analysis phase to inform the interpretative process.

IPA is also idiographic in that it attempts to understand how a particular experiential phenomenon is understood from the individual's perspective in a particular context (Smith *et al.,* 2009). The *idiographic* approach entails a detailed engagement with each participant's transcript and integration only occurs later in the analysis (Willig, 2008).

Study participants

The sample of nurses interviewed all worked at a public long-term residential care setting in the West of Ireland. Seven nurses (five female and two male) volunteered to be interviewed in response to a study information leaflet displayed in clinical areas inviting participation.

All seven nurses had worked in a long-term residential care setting for a minimum of two years post registration (on both day and night duty), and five had worked with older people for over 15 years. Three of the nurses had a postgraduate qualification in gerontological nursing.

Interviews

Following initial contact, interviews were conducted at a time and place chosen by the participants. Semi-structured interviews guided by an interview schedule were used. Researchers adopting IPA usually employ an interview schedule (Landgridge, 2007; Smith *et al.,* 2009) which 'facilitates the discussion of relevant topics' to the study (Smith *et al*., 2009, p. 58).

The interview schedule allows the researcher to 'set a loose agenda' and pose questions 'in suitably open forms' (Smith *et al.,* 2009, p. 58). As advised by Smith *et al.* (2009), the interview opened with descriptive questions with more analytical questions introduced afterwards. The opening questions asked participants how long they had worked in a long-term residential care setting and to describe a recent experience of a death of an older person in their care. The nurses were later asked what loss meant to them. The interviews were recorded and transcribed verbatim.

Ethical considerations

Ethical approval for the study was granted from the ethics committee responsible for research undertaken at the long-stay unit. All nurses who volunteered to participate

in the study were provided with an information leaflet on the study at least one week prior to interview.   Written consent was obtained from each participant on the day of their interview. The nurses were asked to choose their own pseudonyms.

Data analysis

The first author undertook the data analysis. The reflective journal was continued during data analysis, following the advice of Smith *et al.* (2009) who suggest that a research diary is kept to record descriptions and reflections on the unfolding analysis. The researcher 'will not necessarily be aware of all...preconceptions' before analysis; reflective practices are therefore required to identify and bracket preconceptions' (Smith *et al.*, 2009, p. 35).

Each transcript was analysed case by case, as outlined in IPA (Smith *et al.,* 2009). Sub themes were then identified prior to the development of an overall group analysis. The final stage of analysis involved identifying super-ordinate themes resulting in an outline of the meanings inbuilt in the participants' experience.

Two practice development nurses with prior research experience were each asked to review two transcripts and the themes identified. Convergence with the interpreted themes was agreed. Smith *et al.* (2009) argue that 'the independent audit is a really powerful way of thinking about validity in qualitative research' (p. 183). However, they stress that the independent auditor 'is attempting to ensure that the account produced in a credible one, not that it is the only credible one' (Smith *et al.,* 2009, p. 183).

RESULTS

Three super-ordinate themes emerged from the data as central to nurses' experience of loss in long-term care as follows: 'Life's final journey', 'Family' and 'Professional carer'. These supra-ordinate themes represented the sub-themes interpreted from the analysis of each individual interview (Table 1).

Table 1

Study findings

Super-ordinate themes	Sub-themes
Life's final journey	'I knew these patients well' Dying with dignity 'They are not going to be forgotten'
Family	Family involvement Forgotten person Ward family
Professional Carer	The emotional impact of loss Support for the nurse

Superordinate theme 1: Life's final journey

This super-ordinate theme represents the participants' views on aspects of care delivery at end of life, focusing on the key areas they view as having a positive contribution to life's final journey. However, to attend to residents' dignity at 'life's final journey', nurses needed to 'know these patients well'. Knowing residents and maintaining their dignity at their end of life was paramount for these nurses, as illustrated by Combo who talked about care being given "...*with a sense of dignity and not ceremony...*[so that dying is] *treated with the utmost respect to the patient's wishes'*

Loss for this group of nurses was one experienced in the context of the older person's life in the long-term care setting. The nurses interviewed placed much emphasis on aspects of care delivery at end of life, focusing on the key areas they considered made a positive contribution to life's final journey.

Sub-theme 1.1: *'I knew these patients well'*.

Within long term residential care units, resident turnover is slow, with some residents staying up to twenty five years, allowing time to build bonds and develop attachments. *"This person belonged you know. Yes, you know him; they're not just a number to fill up your beds"* (Mise 1.8.16).

Familiarity and companionship come from getting to know the 'person' from their own little peculiarities, to their likes, dislikes and fears. Participants spoke fondly of *'jigging about' (*Mise 1.9.22*)* with the lady who loved céili [Irish] music or singing badly to another lady who liked the sound of her voice. Residents have a place within what is seen as *"...their house and it's their home"* (Hannah 6.8.9). This sense of 'belonging' is what contributes to the home like atmosphere that prevails within the care setting and is depicted in Hannah's account of a resident who was independent in many ways and on occasion liked to visit the local public house.

> Hannah: *" Oh he had great independence yeah, it was his bed, but it was his home and he treated it like he was living in a house because he came and went and did his own thing as normal...he never felt he had to stay to people 'well I'm going down town'"*. (6.9.24).

Reciprocity prevails in the relationships nurses have with residents. The nurses spoke of how the residents *"...know our families and they know our children and they know what our children are at"* (Hannah 6.2.21). Similarly, Mise expressed the view that: *"I know I'm being paid to work but there are some people you just enjoy so, so much and while you're there. They are great companions"* (1.9.4).

The rapport between nurses and residents was not hampered by a resident's cognitive ability *"…even in his confusion he was happy"* (Jenny 4.5.12) or residents' inability

to communicate: *"...the touch and the feel of the presence of somebody else there, is very important to them"* (Mise, 1.5.21). The participants' use of endearing language such as: *"...he was loveable" (*Jenny 4.3.22) was frequent in the interviews.

The nurses also talked about their acknowledgment of residents' personal identities. Mise referred to the residents as being *"...somebody's daughter, somebody's aunt and somebody's wife"* (1.8.9). Rachel's view of one resident reflects this: "*He was always worried about the daughter, wondering, why and where and when and you know?"* (Rachael 7.6.15).

Sub-theme 1.2: *Dying with dignity*

The nurses talked about the death of a resident in terms of a *"celebration of life"* (Hannah 6.14.15*)* as the inevitable end of life's final journey that they had shared with each resident and family. It was agreed that death was not something that could be *"...shied away from"* (Combo 2.7.27) but through open and honest communication it could replace fear and anxiety with understanding and acceptance.

> Combo*:* "......[death] *can be discussed informally 'cos you have, in a long-term care setting particularly a healthy therapeutic relationship , you know if they ask you, you can talk about it and they might say something to you that they wouldn't say to the family "* (2.8.1).
>
> Jenny: *"You're very aware when somebody is dying, and I would be very aware and I would be in and out all the time. And not leave them on their own... 'cos its frightening, and people can be very frightened.... Even though somebody is dying and they know they are dying, they are always kind of looking at the nurse as much as to say, oh is he going now... or they'd be saying like " How bad is he?"* (4.8.15)

However, although death was something the nurses had accepted "*as nature"* (John, 3.3.16) and part of their professional experience, it was nevertheless difficult for them, illustrated in the following viewpoint: "…*you never become used to dealing*

with death. With any death, even if you deal with death every day, death is such a major thing" (Hannah, 6.6.8).

How residents died was important to the nurses. *"He had the most beautiful death, just drifted away in his sleep and the whole experience, for them, was lovely"* (Hannah, 6.5.21). Also important to the nurses was the view that death was not just *"another chore"* (Angela, 5.2.8) and a realisation that you have *"only one chance"* (Combo, 2.4.16) to ensure that residents die with dignity.

A fundamental right to dignity in dying was prominent in all interviews. The nurses understood that their own role was to show *"the utmost respect to the patient's wishes"* (Combo, 2.5.1). In upholding this fundamental right to privacy and dignity, a private room proved beneficial to residents and their families. This also inadvertently reduced the impact that witnessing a death can have on other residents.

> *"If you are lying in a bed and there is somebody dying next to you, it must be a terrible experience for them...... for an elderly person, or for the rest of the residents. 'Cos they're there thinking "Well this is going to be me"... "I'm here now and for me the only way out of here, is this way"* (Hannah, 6.6.17).

Whether or not family or friends could be present at the death of a resident, the nurses were all resolute on the importance of ensuring that they didn't die alone.

> *"I don't think anybody should die alone...You know be it a relative or whatever.... and I think there should be a light on and not darkness ....be it a candle or whatever...depending on the domain, I really do, I think its dignity at the end of the day."*
>
> (Rachael, 7.9.24)

In some cases, family could not be present as relations had broken down in the past or no family remained. In such cases , nurses *"... took the place of the family there"* (Angela, 5.4.8).

Sub-theme 1.3: *'They are not going to be forgotten'*

Even though the participants acknowledged that death is final, the memories of the residents live on and as a result they will not be forgotten. Following the death of a resident a realisation of loss occurs: *"…you know, I'm never going to see them again... and you have all these memories alright"* (Hannah: 6.12.19). Many small things reminded the nurses of deceased residents. These reminders were reflected in chats with other residents and colleagues, or toy dogs that sat on the window sill, *"They have become part of your life and they are not going to be forgotten"* (Mise, 1.4.13). This attention to 'not forgetting' is evident in Rachel's account of visiting a deceased resident's grave. *"His grave has never been visited except that I go.....Maybe once a week to put on a few flowers ..."* (Rachael, 7.3.5.)

Mise's account acknowledges the existence of and the need to remember each unique person and the special nurse/resident relationship they possessed.

> *"But you know if maybe every once in a while we sit down and we acknowledge that this person was here,… for a day,……a month,……a week,….. a year or whatever. We acknowledge that we looked after them "* Mise (1.7.26)

Superordinate theme 2: 'Family'

This super-ordinate theme represents nurses' views on family involvement in the resident's life and especially at life's final journey.   The support and presence of family was seen by all the nurses as both essential for the resident and therapeutic for the family.

Sub-theme 2.1: *Family involvement*

The nurses talked about facilitating families to come and go freely and spend as much time as possible in a private space with residents.

> Combo*: "They* [family] *could come at different times so we tried to provide this room for them and they could use that back door, you know coming off night shift or day shift or whatever shift they were on. In and out as they pleased, and em... we gave them free run of the place and they were extremely grateful, so you know, I think that was a success."* (2.3.11)

> Jenny: **"And his wife was very attentive to him and he had one son, and his family were in and out, and his sisters were very concerned and then lucky enough we could put him in a room that he could.., our respite room was available and we put him in there. So the family could come and go so they had, you know, great comfort."** (4.2.1)

Bonds of attachment with families were seen as supportive by all the nurses. End of life care decisions were planned with both the resident and their families at an early stage. Family involvement was actively encouraged *"…because it's too late afterwards to have regrets"* (Combo: 2.4.8).

Within Irish culture, family, neighbours and the wider community have always been important throughout life. The nurses spoke about neighbours visiting and being present at the time of death.

> Jenny: *"He* [resident] *was their neighbour all their life but he was a real loveable type of man. And they'd bring him the bottle of 7Up … they'd always bring the bottle of 7Up. And they'd be real concerned if they thought he was sick, and "how's he today now?" and "did he see the doctor?", and they were only neighbours now. And for two young fellas now to call and they were only in their 20's, I thought it was lovely. But he had that nature in him."* (4.4.1)

> Hannah: *"……… even his neighbours, his immediate neighbours had actually come in and they were delighted to be there. To be part of this and they thought the whole experience of the man actually dying was absolutely beautiful."* (6.5.1)

Sub-theme 2.2: *Forgotten person*

Incidences of family detachment were recalled by the nurses with sadness. In some cases family ties had been cut for various reasons and dying or death did not appear to resolve issues from the past.

> Rachael: "I just felt that this person was lost in society, kind of disowned by his family, made amends in years to come and ah.... his daughter ,which he had been very good to and had did everything for, just to... kind of didn't make any effort to come to see him. Or em......he just lived for those letters and those phone calls. He tried everything and ....she wrote and everything, while money was flowin'....and everything was good. And on his hospital bed she spoke to him..... [pause]" (7.1.23)

> Hannah: "And you know there have been a few people that we've had and they have had no immediate family or the immediate family didn't appear until the man died or something. And we didn't even know that they were there". (6.7.3)

> Angela: "... it was terribly, extremely.., my biggest experience of , my greatest experience of death here in long stay care…
> This lady... it took several days to contact her family because she had a brother, but he didn't want to be present. Eventually he did come and when he came to the ward he asked [raises her voice] "Where was THAT ONE? She disgraced our family years ago." And this lady was, at that stage, in her late 80's and he was in his early 80's." (5.2.18)
> "And she died, ...as she lived, ...ALONE" (Angela 5.4.23)

> Combo: "......most surreal experience in my working career he didn't have anyone, HE DIDN'T HAVE ANYONE (emphasis placed on the words), there was nobody to ring to say that the man had died....... there wasn't a phone number" (2.3.18).

It is within the clarity of one man's final moments that the reality of his isolation becomes increasingly apparent, creating a new depth to the word "ALONE".

With older people living longer this insight is an aspect of life in long-term care areas that may not be apparent to those outside. At times like this participants spoke

of an unrelenting sense of duty to the person in their care stating '*we took the place of the family there*' (Angela 5.4.8).

Sub-theme 2.3: *'Ward family'*

The 'ward family' is made up of residents, staff and families whose lives are intertwined. The nurses considered it important to include other residents when a death was imminent in order to "*…prepare them as well…. not just family. Because these people are part of family like. They have shared little chats and this, that and the other*" (Angela: 5.7.8).

Rachel spoke of the special relationships forged with residents' families, "*…'cos you're part of the family for so long, you certainly do kinda get very attached to them…*" (Rachael 7.5.1), which in some cases continued following death, with some families returning each Christmas after the resident's death maintaining links with this extension of 'family'.

> Rachael: "*Because they feel that we were like part of the family for so long and whatever and they appreciated what was done and the whole lot and they do come back out of respect and are so nice every year*" (6.5.10).

In cases where there is no family or no connection to family, care did not end at the death of a resident but continued throughout the wake and funeral. The nurses spoke of being able to have the resident's funeral within the home and involving staff from "*… a lovely mass, choir and everything*" (Rachael 7.4.12) , to "*...the maintenance crew that carried her coffin*" (Mise 1.6.24). Acknowledging the sadness of the occasion, nurses also relayed the pride and satisfaction gained allied with the therapeutic affect the whole process had on them.

> Combo: "*I thought that was particularly sad but I was quite proud because without being prompted, hm... all the staff from the ward ,and many from here, went to his funeral and walked behind the coffin up to the graveyard and only for that , the staff and the priest, there would have been no- one else there*" (2.3.25).

Superordinate theme 3: Professional carer

This super-ordinate theme represents the unique role adopted by nurses caring for residents in long-term care.

Family and residents turn to the nurse for comfort and consolation when the finality of death is looming:

> Hannah: *"There are people and they are nearly drawing their last breath and they nearly think that you're going to, you're going to perform some miracle and they'll be back sitting up in the bed in an hour's time. When you know in your heart and soul that this is the end"* (6.13.22)

The role of the nurse at end-of-life was seen by participants as ensuring the resident was comfortable, pain-free and aware of their condition. Care decisions are made proactively and in a non-judgemental manner involving both the resident and the family to eliminate regrets.

> Combo: *".........my feelings remain professionally, professional, am I think I have established a professional detachment and I can look at it clinically, in that I myself set goals that I would firmly believe in making my priorities to... the patient is warm ,safe, feels safe, comfortable and pain free, and if I can achieve that I'm happy"* (2.2.7).

This professional side of nurses enabled them to act as an advocate both for the resident and the family and was viewed as a vital part of their role.

> *"You can't really fall to pieces in their presence because your suppose to be the Nurse... and your suppose to be strong,.. after all you are the nurse (laughs), you know but we're human ... but we're human. With loads of emotions* [laughs]" (Angela 5.5.23).

The nurses also talked about the importance of being prepared for a resident's death.

> Combo: *"We do have wonderful care staff here and auxiliary staff, and the nursing staff I find are excellent, so when it comes to make*

a decision or if you have doubts you can discuss it with, as well as the family, with all your colleagues hmm.... we have a good number of years experience between us hm.. You know you could thrash out the options, if you do have doubts it's great to get some positive reinforcement that you are going in the right track"
(2.5.6)

The clinical challenge of providing appropriate end-of-life care was identified by some participants especially in the case of sudden or unexpected death. Even though death was seen as a natural part of life, sudden death elicited different emotions and was described by John as a *"... nurse's worst nightmare"* (3.4.16) bringing with it feelings of helplessness and *"...you had a sense of just, I'm there and Jesus I'm useless in a way"* (John 3.2.10).

Sub-theme 3.1: *The emotional impact of loss*

Nurses spoke of the finality of death and of never seeing a resident again and the emotions that came with that loss. The nurses recounted relationships with some residents where their feelings of loss equated to the loss of a close family member, evidenced in the following:

"I felt as if it was like it was my own parent, 'cos he certainly was...."
(Rachael: 7.1.21)

"…the first time I walked through the door and she wasn't there, it was just an empty bed.... it was an awful shock again" (Mise 2.3.1).

John: *"It's the end of the road, that's it, you're gone, do you know what I mean, that you're never going to see that person again or ......that's loss to me ....."* (John: 3.6.7)

Similarly, Angela's description of her feelings of loss reveal the many emotions experienced:

Angela: *"Pain, loneliness hmm.......pain, loneliness, I suppose a vacancy, hmm... a vacancy in one sense but yet closeness with*

> *other members of the family that may not have been there before that. A mixed, a very mixed bag of emotions"* (5.6.1)

This void is not filled with the admission of another resident as memories live on long after the person has died.

> Mise: *"You know, I missed her; I still miss her."* (1.3.1)

Even though death was seen as a natural part of life, sudden death elicited different emotions and was described by John as a *'nurse's worst nightmare'* (3.4.16) bringing with it feelings of helplessness and *'you had a sense of just, I'm there and Jesus I'm useless in a way' (John 3.2.10).*

> John*:"..... you turn around the corner and they die suddenly and they are having a massive coronary and you know that they are in pain like and everything else, it does affect you like, definitely without a doubt." (3.3.1)*

In the same way participants spoke of residents dying in an acute setting and not with them as being particularly sad: *'there was a great sense of loss when he died, do you know. And the thing about him was he didn't die with us, which was the worst thing for us. We found it an awful sense of loss' (*Hannah: 6.11.1).

Participants spoke of feelings like *'sadness' (Rachael 7.1.19 / Combo 2.3.25), 'I felt part of me was missing' (Rachael 7.1.19) and' I am still not the better of it' (John 3.1.22)* depicting the deep emotional impact of the nursing staff when they experience the loss of a resident, described by one of the participant's as *'a rollercoaster of emotions'.*

Death was however, viewed as a beautiful thing, involving the delivery of compassionate care throughout the natural process of life's final journey. Participants acknowledged that while their role was professional it also contained an emotional connection *'because you have feelings and you feel their hurt and you feel their pain. The pain of loss and you'd have experienced your own loss and you know what you went through' (Angela 5.5.1).*

> Hannah: *"So all I could do was, I said "I'll tell you what we can do is we'll hold his hand and anyone that is up near his shoulder, just put your hand on his shoulder. Reassure him that you are here with him (yeah) and speak to him". But they were saying "sure he won't hear us". And I said "No, he will,*

he hears everything that is going on" (yeah). Just say " Johnny we're here with you and whatever, and we're all with you now. And it's obvious your time has come to leave us and we're all, whatever".

And do you know, it was so... and as I said you'd nearly be crying; I was nearly crying myself with them. Because, it was so lovely to see him ....die, but he was surrounded by his whole family."(Tears well up in her eyes and the quiver in her voice denotes her emotional connection) (6.4.1.)

The human face of nursing which was evident throughout all the participant interviews is best summed up in Angela's words:

Angela: "You can't really fall to pieces in their presence because your suppose to be the Nurse... and your suppose to be strong,.. after all you are the nurse (laughs), you know but we're human ... but we're human. With loads of emotions."(5.5.23) (Laughs)

Sub-theme 3.2: *Support for the nurse*

Of the seven nurses interviewed, five acknowledged the support given by nursing colleagues, described as " *backup of your colleagues* " *(*Jenny *4.6.8)* and healthcare staff, following the death of a resident as *" a team behind you as such , does that make sense, a team do you know what I mean"* (John 3.5.8). This team spirit was evident in many of the transcripts and contributed positively to the end of life experience for all concerned.

Angela : *"I like to see involvement of staff and consideration rather than, the thing of it just being another chore, yeah.... I love the personal touch and I love the ... and really the team here now at the moment, they're brilliant,..... they're absolutely brilliant. Like everybody's involved and everybody helps out and they're there to support. And the support mechanism is good at the minute. At ward level."(5.2.8)*

Attending the funeral or just simply *"...talking about it"* (John:3.5.21) with colleagues was also seen as helpful as it was recognised that people outside the workplace would not understand nurses' feelings.

Hannah : ""This lad had been a great character and had a great rapport with the staff and whatever (yeah). And ah... all that, that did have a big impact on the...so, as I said, what do you do then. It's very difficult in the sense that, sometimes staff would go to funerals and I suppose that is one

> *way, I suppose of dealing with the death, do you know, but if you can't then*
> *.... You know, we do sit and we do talk about the death..." (6.11.13)*

The support mechanism at ward level appeared good and in some cases the family recollections and anecdotes acted as support for the participants.

> Angela: *"Well I find, the family in their own right, because they'll*
> *tell you stories about Mammy or Daddy and the life they had and*
> *how much they appreciate them ..."* (5.6.1).

However, two participants felt that there was no support for them. Rachel revealed that there was: *"...nobody that you can kind of sit down with and say' I was very close to him..."* (Rachael 7.7.5). Similarly, Mise felt there was little or no acknowledgement of her feelings or needs following a resident's death.

> Mise: *"There was one person in my experience of where I am*
> *working for the last 7 years that has come up to me and said "How*
> *do you feel about that person's dying, you must have cared 'cos*
> *you've looked after them for a long time?"* (1.6.13).

DISCUSSION

The aim of this study was to explore and describe the experience of loss among nurses working in a long-term residential care setting. IPA requires the researcher to adopt a *reflexive* attitude (Willig, 2008), as described earlier. Therefore, the first author recorded personal reflections before, immediately after and one day after each interview. Reflections during data analysis revealed that some participants' comments were difficult to move away from because of their use of emotive language. Reflections during data analysis also revealed the challenges in identifying superordinate themes when there were many subordinate themes.

The end of life care for residents was viewed by the study participants as central to their nursing role. A person centred approach to care was evident in their descriptions of care given to residents. In addition, the nurses placed emphasis on residents' dignity, a view also reported elsewhere (Walsh & Kowasko, 2002). A central tenet for person centred care is autonomy (McCormack, 2003). The nurses acknowledged the significance of resident autonomy as paramount, and discussed

how this is accomplished through effective communication with the resident and their family. The nurses also talked about the connections residents had with neighbours, friends and family, and relayed with pride accounts of their provision of holistic care to residents at the end of life. Holistic end of life care for older persons requires attention to dignity, open communication and symptom control (O'Shea *et al.,* 2008).

Older persons form attachments with nurses, healthcare personnel and the clergy to satisfy their need for comfort and emotional support (Cicirelli, 2010). For the nurses interviewed, this acknowledgement of residents' need for comfort and emotional support was a significant component in their provision of holistic end of life care. This acknowledgment was particularly evident in the nurses' descriptions of providing end of life care.

Another major concern for the nurses was the need to ensure that residents did not die alone; a finding reported elsewhere (Touhy *et al.,* 2005; Phillips *et al.,* 2006). The nurses talked about a sense of familial isolation among some residents and how they would 'drop in and out' to ensure that there was always someone present with the dying resident, particularly when there was no family involvement.

Connected attachments between nurses and the residents contributed significantly to the nurses' sense of loss on the death of a resident. Nurses in other settings have described similar emotions of loss (Rashotte *et al.,* 1997; Johnston & Smith, 2006; Holman *et al.*, 2006; Gerow *et al., 2*010). The nurses' description of their relationships with residents suggests a relationship-centred approach to care. Nurses talked about the reciprocity in their relationships with residents. Interpersonal relationships between patients and staff in long-term older person care settings are mutually sustaining, with staff acknowledging the patient's need for connectedness with self and others (O'Shea *et al.,* 2008).

All the nurses stressed the importance of family involvement in the resident's care, particularly at end of life. The nurses believed that family involvement provided not only comfort and support to the resident but also had a therapeutic effect in helping families to deal with the grieving process. This is a finding also reported elsewhere (Touhy *et al.,* 2005; Gerow *et al.,* 2010). Moreover, accommodating and welcoming families to come and go as they please, creates an essential homelike atmosphere

(O'Shea *et al.,*2008).   The nurses clearly developed strong bonds with some families and in these cases, the families return each Christmas to the home for a number of years in remembrance of their loved one.

The sense of 'family' and 'home' was evident in the nurses' descriptions of life in the long-term home. This reflects findings reported by Murphy's (2007) study where interpersonal relationships were an important factor within the care environment in order to create a 'home from home'. In some cases, the nurses became the replacement family for those residents who had no-one. This is also reported elsewhere (Touhy *et al.,* 2005; Phillips *et al.,* 2006; Munn *et al.,* 2008). Intimately knowing what is important to residents and being connected with them in a personal relationship, is described as 'like family' (Touhy *et al.,* 2005; Phillips *et al.,* 2006). Nurses' expressions of patients as 'family' is reported by Phillips *et al.,* (2006), who found that 'family'   was demonstrated in nurses' need to protect and care for residents as if they were their own family.

Finally, remembering residents was also important to the nurses. By remembering, they validated the importance of the resident's life. Remembering residents was achieved by talking with family, other residents and colleagues, telling stories and recalling the things the resident had done or said. This kept the resident's memory alive and also provided a support mechanism for the loss felt.

CONCLUSION

This study describes nurses' experiences of loss on the death of residents in a long-term care setting. What emerges strongly is the nurses' commitment to the residents' care and the desire to keep the memories of residents alive. Moreover, the study's findings bring to the fore the significance of reciprocity in the nurse resident relationship. The nurses' accounts of caring reflect caring as an interpersonal interaction, as described by Morse *et al.,* (1990). There are also suggestions of love in the nurses' accounts of their reciprocal relationships with the residents. Love and caring can co-exist when nurses respond with intense caring for some patients (Dowling 2004). The love reflected in the nurses' narratives fits with Campbell's (1984) view of a 'moderated love', where there is a "subtle balance between involvement and detachment" (Campbell 1984, p. 126). This 'moderated love' is

also reported in a study exploring the meaning of nurse-patient intimacy in oncology care settings (Dowling, 2008).

Loss for the nurses in this study is not an emotion considered only in the context of the death of a resident. Loss is framed in the relationship with the resident developed through the delivery of person-centred care over time. Loss is also considered in light of the end of life care the resident experienced and whether family were involved or not. Central to this end of life care are the close reciprocal relationships nurses develop with residents and families. Residents value such relationships greatly (Pilkington, 2005). The kindness of nurses, coupled with warmth and compassion in the context of reciprocal relationships with patients and families are central to good end of life care (Papadatou *et al.,* 2002; Johnston & Smith, 2006; Phillips *et al.,* 2006).

However, a fractured experience of loss is evident in John's description of patients who die unexpectedly. Moreover, where a resident had no one, the nurses' experience of loss was tinged with a sense of responsibility in arranging and attending the funeral.

The loss experienced by nurses was framed in an account of their close relationships with residents and their families, and the need to provide good end of life care. This finding reflects that reported by Gerow *et al.,* (2010) where nurses also revealed their reciprocal relationships with patients, which transcended the professional relationship. However, the findings here differ from that reported by Gerow *et al.,* (2010) in other aspects. Nurses in Gerow *et al's* (2010) study reported having to remain professional and move on to the next patient without acknowledging their loss. Nurses in this study relayed a sense of measured loss with efforts to remember past residents actively sought.

LIMITATIONS

The nurses interviewed were all Irish; nurses of other nationalities work at the care setting where the study took place, but did not volunteer to be interviewed. More cultural diversity in the study participants may have yielded different findings.

IMPLICATIONS FOR PRACTICE

- Nurses working in long stay units should be acknowledged and supported in the end of life care they provide to older residents. When nurses feel they are providing good end of life care, they can deal with loss positively upon the death of the older person.

- Connected attachments between nurses and residents contributed significantly to the nurses' sense of loss on the death of a resident. However, these connected attachments also enhanced the end of life care experienced by all residents, but particularly those who had no-one.

- When an older person dies, whether that is unexpectedly or expected, nurses should be provided with opportunities to discuss this experience among themselves or with their managers.

- End of life clinical care guidelines would support staff in all aspects of quality end-of-life care delivery, especially in the event of a resident's sudden death.

- The provision of a single room at end-of-life would positively contribute to the privacy and dignity participants identified as an essential component of the fundamental right of older people to die with dignity.

- Providing every resident with a single room would minimise the distressing effect on families, staff and other residents when a resident dies suddenly and a coroner's post-mortem is required.

- Representation from the nursing home at a resident's funeral is essential and staff who wish to attend, should be facilitated to do so.

- An annual remembrance day should be organised for deceased residents and staff, maybe in November (a significant religious month for Irish Christians). Engaging in remembrance keeps memories of decreased residents alive and helps place loss in the context of acknowledgment of the person's life.

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Contributions

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