Chapter 8
Creating and Sustaining Community in the Nursing Home

IN PREVIOUS CHAPTERS, WE HAVE DISCUSSED PROGRAMS THAT FOCUSED primarily on the needs of residents, staff members, or families. In this chapter, we will consider involving all of these components at once through programs that work synergistically to address the needs of the nursing home as a community, for when they are part of a community, residents can begin to heal the psychic injuries that were created when they were separated from their families and neighborhoods.

To this end, I will describe several programs aimed at enhancing residents’ quality of life by creating community through the development of meaningful interactions supported by the use of rituals and ceremonies that validate positive roles for the residents, as well as for staff members and families. The programs that we will discuss include rituals related to death and bereavement such as a memorial tea service, an annual memorial service, and a remembrance table, as well as a program that I developed that helps to create community by creating and validating individual one-to-one relationships between staff members and residents—a program called Caring Hearts at Work. While these programs are presented in their entirety, I encourage the reader to adapt any applicable parts of them to their own unique settings, in order to enhance relationships and build community appropriate to the needs and concerns of your practice.

In many ways, it is rituals and ritualized activities with symbolic value that help to define our public roles in society and thus solidify our experience of individual selfhood. As Patricia and Douglas Suggs (2003) note, “rituals give us a foundation, a sense of stability that we need as we tackle challenges and opportunities that confront us on a daily basis” (pp. 17–18). For that reason, I decided to focus on the purposeful use of various interventions to enhance the existence of positive communal feeling for all those involved in the nursing home setting, particularly the residents. In doing so, I have borrowed from anthropological theory, but also from our own social work heritage. This chapter includes the processes
by which I developed programs based on the use of practices, rituals, and ceremonies designed to define roles for the residents in the ambiguous setting of the long-term care institution. It is my hope that the bricolage (Lévi-Strauss, 1966), or “cobbling together” of these various elements and practices will inspire other social workers: combine the fragments of a community culture that exist in your environment, your imagination, and the basic social work skills of relationship development, including positive reframing, problem resolution, and the use of ecological perspective in whatever proportion fits the needs of your resident clients, the facility as client, and your own proclivities. Create a living situation that the residents and caregivers alike can experience as meaningful.

THE NURSING HOME EXPERIENCE:
AN ANTHROPOLOGICAL PERSPECTIVE

In 1908, Arnold van Gennep (1960) put forth the concept that some rituals, specifically rites of passage accompanying major life-stage transitions, consist of three phases: preliminal rites (rites of separation), liminal rites (rites of transition), and postliminal rites (rites of incorporation). In her ethnography of the culture in an American nursing home, anthropologist Renée Shield (1988), applying this theory to the context of nursing home placement, noted that the elderly residents had undergone a separation from the larger community following a change in status in which they were no longer considered to be fully functional adults. In this ambivalent (“liminal”) state, largely avoided by the public, they awaited the final transition that is death without the traditional bonds of friendship and commonality (communitas) among themselves to ease the isolation of their social position.

In the twenty-first century, this situation continues. The initial process by which a resident is admitted to a nursing home sets the tone for the resident’s future experience of loneliness in a crowd. In short order, the new admission is whisked into a bed, where, behind closed curtains, he or she receives a thorough medical evaluation. Without intending to, here at the very beginning, the staff in effect performs a ritual that strips away the residents’ former identity and places the individual in a dependent role in a way that unfortunately still begs for comparison to the stigmatization endured by mental patients in the institutions described by Erving Goffman (1961) over forty years ago.

Without robust social work intervention, this course of depersonalization inexorably proceeds as the resident “adjusts” to his or her new living situation. Although our role is not widely understood or acknowledged (neither Shields nor other nursing home ethnographers make explicit mention of the social worker’s
role in helping to preserve the residents’ identities), we as social workers are responsible for balancing the process of medicalization of our clients with our unique perspective of the person-in-situation that will enable the facility to consider each resident’s individuality when planning for his or her care. Furthermore, as Elaine Brody (1974) hinted at in her early and comprehensive effort to clarify and define the role of social worker in the nursing home, we can have and should have a significant role to play in modifying the institutional milieux of our settings.

In fact, we have great potential power to help preserve our residents’ identities by making changes to established nursing home traditions, which often ignore the individuality of the patients. We can do this, for example, by insisting that the residents’ life histories be known and recognized; by specifically and consistently reporting the residents’ former occupations, achievements, and interests to the care-planning team and the caretaking staff; by helping the team to develop personalized care plans based on this information, encouraging family members to bring in (labeled) pictures from the residents’ pasts to put on their bulletin boards and keep in albums at their bedsides to share with staff; by encouraging staff to refer to these resources; and by working with our activities directors to develop creative ways of enabling residents to engage in meaningful activities related to the residents’ past interests.

Indeed, the development of programs is a way that we can create new rituals and traditions that enhance community in the nursing home and confer the experience of *communitas* among its members. For instance, lingering over breakfast and reading the paper can be a ritualized activity, one that we associate particularly with retired persons and informal socialization with one’s peers at the local coffee shop. Based on this cultural concept, a staff member at a nursing home where I worked developed a “Breakfast Club,” where residents who were able to participate came to the dining room for the morning meal (a meal generally served bedside in most facilities) in their pajamas and bathrobes, chose from a selection of breakfast foods, and stayed as long as they wished, reading the paper and chatting with their tablemates. The program was enormously successful and resulted in the residents developing new friendships, as well as a renewed sense of purpose in their physical therapy and daily self-care. This small example demonstrates the power of reinacting symbolic associations, in this case related to both social status (“retired persons”) and kinship (eating a meal together in one’s pajamas), for creating bonds of commonality and reinforcing a sense of personhood. As social workers, we can and should develop and support the use of both secular ceremonies and sacred rituals that provide comfort and security to the residents.
The use of rituals is not an entirely new idea. They have been used in the past by mental health professionals in the context of family systems therapy. Onno van der Hart (1983) used rituals in his practice to help individuals and families heal from illness, cope with transitions in the life cycle, and strengthen family bonds. Moreover, although it was not articulated as such, the use of ritual has had a place in the social work settlement house and community center traditions. Jane Addams and her colleagues encouraged new immigrants to celebrate their cultures of origin through traditional dance, music, and song while adapting to the exigencies of their new country. It is time that we revisit the use of rituals to effect positive systemic changes on behalf of our clients.

As the growing hospice movement recognizes, life exists right up until it ends. Hospice philosophy emphasizes the importance of meeting the physical, emotional, and spiritual needs of the dying, of allowing them to participate actively in their own care, and of respecting their wishes (Andreae, 2000). Our residents may not be actively dying, but they, too, need to have their emotional and spiritual needs met. Of importance to their well-being is a recognition of their personal and social identities. Our elderly residents, in particular, have had many life roles. They generally have cultural similarities related to the larger community from which they come and/or the particular population served by the nursing home. Let us use our social work skills to discover the residents’ common and unique roles and then educate our colleagues to join us in recognizing and to celebrating them. In our professional capacity, we can work toward modifying the nursing home environment to that of a community devoted to the reverence not just of life, but of the unique particulars of the life that exists inside its walls. We can help to ensure that the residents’ remaining time will be truly imbued with a richness of meaningful relationships and of cultural, spiritual, and personal experiences.

It should be noted, by the way, that not all nursing home residents are elderly. Currently, a trend exists in which younger mentally and physically disabled individuals whose needs cannot be met elsewhere are being housed, often inappropriately, in nursing homes, even though their problems and concerns differ from and may even be at odds with those of the frail elderly who make up the larger part of the nursing home population (Wunderlich & Kohler, 2001). Nursing homes tend to accept such admissions in greater numbers when economic necessity dictates that they do so, and when such clients are admitted, it is sometimes with adverse effects on the safety of all concerned. The task of social workers in such cases is, more often than not, to try to locate a better setting for these clients. But when this is not possible, assuming that these younger individuals can be managed in the nursing home, the developmental needs of this younger
population might also be served with programs and perhaps rituals designed to address their life-stage issues.

**CELEBRATING LIFE: THE MEMORIAL TEA SERVICE**

The memorial tea service is a program that was developed to mark the final rite of passage that is death and to facilitate communal bereavement and the experience of *communitas* among the survivors. In one of the nursing homes where I worked, as often happens, there were no clergy associated with the facility. When someone died, services were held in the deceased’s home community by the family, but no particular attention was paid to the grief of the former resident’s roommates or peers who were left behind or, for that matter, to the spiritual needs of the staff. Instead, the beds were summarily filled with new paying customers. All of this suppressed acknowledgment of death led to a vague feeling of tension and malaise that affected the morale of all concerned.

In order to begin to remedy this feeling of alienation, I undertook the challenge of finding a forum for the residents, family, and staff members to come together to commemorate the deceased, as well as to reaffirm the importance of the individual to the community. With guidance from a behavioral psychologist with experience in program development (David Danforth, personal communication, 1997), each time someone died at that nursing home, I sought to establish a protocol that provided a structure for people to process their grief that was flexible enough to allow all those who wished to do so to participate to the extent that they felt comfortable. Thus, the memorial tea service began.

The format of this informal service was simple. After obtaining the administrator’s permission, I proceeded with a plan to engage the community each month in recognizing and celebrating the lives of those who had passed away during the past four weeks. I notified the families of the deceased and engaged the activities department in helping to spread the word to the residents and staff. I designed the service itself to have a “drop-in” format, which permitted individuals to feel welcome to come in and pay their respects for a few moments or to stay for the duration of the event.

Prior to the service, I obtained pictures of the deceased and prepared statements about them culled from my psychosocial assessments and my knowledge of their personalities. I also selected a song or hymn appropriate to the deceased resident’s religious beliefs (for example, “Amazing Grace” or the Twenty-Third Psalm) to be played on a tape or compact disc or sung by a willing staff member with musical ability. Those things, along with a selection of teas and cookies, completed the preparations.
At the time of the event, I made a particular effort to encourage the deceased resident’s special friends and roommates to attend, as well as the nurses and certified nurse assistants (CNAs) who had cared for them. In practice, I found that those friends and roommates who had been invited usually welcomed the opportunity to attend. The CNAs also responded well to the opportunity to participate, even if their schedules permitted only a brief appearance, while nurses rarely attended. Administrators verbally expressed their support for the program, but were generally too busy to find the time to drop in. In subsequent planning for similar programs, I learned to engage representatives from these groups more directly in the planning for the services so that they would have a greater investment in the outcome and be more likely be involved in the proceedings.

The service itself began in a low-key manner. While serving tea and cookies, my co-leaders and I tried to guide casual conversation gently to the topic of reminiscence about the deceased. From there, we segued into a recitation of the resident’s life stories, encouraging family members to contribute their superior knowledge of the lives of the deceased. From there, we encouraged family, residents, and staff members to share their recollections of the residents as mother, father, sister, brother, friend, or care recipient in the nursing home. The contributions by staff members, who provided evidence of the resident’s enduring qualities, for example, of generosity and kindness expressed as “he always saved me his banana from breakfast,” were enormously comforting to families and also important to staff members, who might otherwise not have had the opportunity to share the significance of their relationship with the resident with others.

We both permitted and encouraged digressions from the topic at hand, especially when the group found the sadness difficult to bear, but we always came back to the theme of the celebration of the life of each individual. The sessions officially ended with the songs or poems that had been previously selected, but we did not rush the participants to leave because a calm and peaceful feeling was what I desired to prevail. Although many nurses resisted direct participation, family members often made a point of visiting them on the residents’ units, providing them an opportunity to say their good-byes.

The elderly residents participated in the services with the poise and grace of those who have witnessed many deaths, and afterward they expressed positive feelings about both the event and the deceased (“He was a good worker, a smart man...”). Their participation in this informal ritual signified to me that they were getting the message that each member of the community was valued and that they, too, would be remembered when their time came.

I noticed a momentary lull in the tense atmosphere after the services. Those of us who had participated in some way shared a brief moment of connection and
transcendence that brought us closer together and that felt sustaining. It was a time to catch our breath and ready ourselves for the new arrival.

At a later date, in a different nursing home, I changed the format of this program by incorporating the suggestions of a nurse familiar with the hospice traditions. This innovation involved obtaining real or artificial flowers prior to the service and passing them out to family members, friends, and caregivers of the deceased shortly after most people had settled into the room. Those holding the flowers, which symbolized the spirit of the deceased in the room, were then invited to place them in a vase, where they would remain for the duration of the service and for a few days afterward, a transitional object to ease the abruptness of the loss of that individual. After trying out this practice, I found that a nice way to end the service was to give some of the flowers, particularly if they were real, to family members to take with them, a final gift from those who cared about their loved one. These symbolic gestures were helpful because they engaged residents, family, and staff members in a meaningful ritual signifying both letting go of the deceased and holding on to their memories.

REMEMBRANCE TABLES

Along the lines of using rituals and ceremonies to address the needs of the nursing home community following a death, at the Soldiers’ Home, I worked with

Figure 6. Remembrance table for a veteran.
our hospice team and a committee of interested staff members to develop a procedure for helping the community of each barracks-type ward to mourn the loss of a beloved veteran. In that particular setting, the residents would become very close. Sharing the intimate details of each other’s lives, the men competed for the nurses’ attention, engaged in petty squabbles, and frequently watched out for their peers like brothers. On more than a few occasions, I observed such tenderness as a mute and angry stroke victim holding the hand of a dying neighbor.

When a resident dies on the ward, the death is felt by all the other residents more intensely than if they were not all sharing a room. While this is a positive sign of the existence of community, it also places the residents at risk for feelings of loss and depression, particularly if the bed is summarily filled by a new occupant. In fact, our remembrance tradition began when one of the nurses remarked, following a difficult year when many residents died, that at least in the past, the bed had sat empty for a number of weeks, allowing the veterans and workers to adjust to the absence of the deceased as they contemplated the vacant space. In the current economic climate, no such luxury exists. The effects of unacknowledged, unaddressed grief were palpable. As I noted in chapter 3, the residents bitterly verbalized their own fears of being next, withdrew into depression, and/or acted out their feelings with belligerent behaviors.

In fact, it was the very clear evidence of the veterans’ grief for their fallen comrades, that fateful year on 2 North, that brought nurse manager Linda and me to the realization that something needed to be done, and that set in motion the process by which our two-part bereavement protocol was created, including both the remembrance tables described in this section and the annual memorial service for the whole nursing home discussed in the next section.

Initially, unsure of how to proceed with the upset residents of 2 North, Linda and I called a meeting with the bereavement coordinator of our contracted hospice service, with whom we had worked extensively in the past when a newly admitted resident on that ward—a person with AIDS and opportunistic lung cancer who was estranged from his family and who insisted on dying alone, which he proceeded to do in his own way, pulling the covers over his head at all times except for those moments when he managed to get himself out of bed to wheel himself in his wheelchair (oxygen and all) out to smoke a cigarette. While my training indicated that this was his right, it was at least as hard on me, the unit social worker, as on the nursing staff that he refused even to consider hospice services. The hospice worker helped us, as a team, to come to terms with our collective sense of helplessness in this situation, holding meetings in which, as a team, we were able to express our feelings and ultimately to feel empowered in allowing him to determine the manner of his own death.
However, after his and many more difficult deaths, the residents were expressing feelings of hopelessness and helplessness, as well as neediness and excessive aggression (I recall one gentleman flinging the walker of the newly admitted patient in the recently vacated bed next to him because it was inappropriately parked in his area). We again called in our hospice consultant. With her assistance, the nurse manager and I began to conceive of ways in which we could enable the struggling ward to come together, not only to grieve their losses but to reassure the surviving residents that they, too, would be remembered when their time came.

One of our interventions, the remembrance table protocol, involved setting up a small display on the unit. I initially thought of this as an altar, but the rest of the staff was averse to this designation, with its religious connotation, and the intensity of their objection to this term almost derailed the whole project before it even got off the ground, a lesson in being sensitive to the culture of the facility, as well as in having the staff members share in the development of a project from its inception in order to feel comfortable with the result. The remembrance table, as I came to call it, held such items as a picture of the deceased veteran, an American flag, flowers, and personal mementoes, such as a cap inscribed with his branch of military service. The table was to be set up, at the discretion of the unit manager and unit social worker, a few days after a death and to be left in place for about a week. Initially, we envisioned a small service associated with the assembly of the table, but in practice, this procedure became unwieldy, and simply setting up the table while engaging the comments of whoever happened to be nearby proved to be sufficient for our purposes.

Acceptance for this procedure involved not only our presenting the concept to our peers at a morning staff meeting (where it was initially met with resistance, due to the language that I used to describe it) but having a meeting with our hospice team and administration, where a formal document describing our bereavement protocol was presented and approved, along with permission to form a bereavement committee to assist us in implementing our program.

The remembrance table is now accepted as one of the usual routines at the facility. If I do not set it up on a timely basis, the staff reminds me to do so. It is clearly beneficial to staff members, who think that the tables are beautiful and sometimes add their own touches to the arrangements. They bring the families to see them, thus validating to both the families and to themselves that the resident was indeed valued in what was in fact a small community.

Since this is a how-to book, a word of advice is indicated here. It is a good idea to gather photographs and mementos to be used for the table before the body is removed to the funeral home, otherwise, it is more difficult to find a decent
picture of the deceased and other objects for the table. It is, of course, necessary to obtain the family’s permission to use their loved one’s personal belongings for this purpose. This actually offers a wonderful opportunity to let family members know about the table and about the importance that the facility places on personally remembering their loved one. If photographs of the deceased are not available, these may sometimes be found in the residents’ identifying information in their records, either in their charts or stored on the facility’s computer system.

There are situations where setting up a remembrance table is inadvisable, and this is something that must be decided between the social worker and the unit manager on each unit. Most notably, this intervention is not especially appropriate for a dementia unit, where the residents might become confused or upset by the display (and would probably dismantle it in short order). The bereavement committee remains available to discuss ongoing modifications to the program, such as a recent idea to build shelves on each unit designated for use as remembrance places, a concept that not only speaks to efficiency but to the incorporation of this life-affirming social ritual into the medicalized environment.

ANNUAL MEMORIAL SERVICES

An annual memorial service is an adjunct to the remembrance table program that provides an opportunity for the entire nursing home to express its unity in honoring the dead, and in doing so, it also validates the importance of the living residents in the community. Moreover, the memorial service addresses the needs of families in a more direct and formal way than the remembrance tables on the units.

At the Soldiers’ Home, the bereavement committee met several times, both formally and informally, over the course of a few months, planning the program for our first annual memorial service, starting with a general outline and working out all of the specifics, down to the smallest details of procuring adequate space, ordering food, making sure microphones and our accordion were in working order, and so on. Our hospice consultant provided us with a sample program for our first annual event, and we used this as a guideline in creating our own. The theme our service was “The Importance of Remembering.” Since we wished to make the service inclusive and ecumenical, we requested that Catholic, Protestant, and Jewish clergy or leaders in their faith communities prepare a short talk on this subject as it relates to their religion. In addition, some committee members volunteered to conduct readings or to read poems related to the program’s theme, while others identified individuals who might be counted on to present such material. A nurse, a certified nursing assistant (CNA), and I all agreed to give a speech on the importance of remembering as it relates to our jobs, and we recruited a family member to discuss this subject from her point of view. Since
the facility is a military one, we were fortunate to have the services of an honor guard. Finally, a contact with someone affiliated with a wonderful Baptist choir provided us with music for our program.

Once we decided on the specifics of the affair, we proceeded to publicize the event. We made posters, placed a notice in the facility newsletter, and asked the family council to spread the word about this occasion. We also created invitations which we sent to all the family members of residents who had died within the preceding year. In order to personalize the event even further, we specified in the invitations that family members who wished to do so might bring a photograph of their loved one for display on a remembrance wall. While we had initially conceptualized this as a large piece of paper mounted on an actual wall, in its final form it consisted of two suitably decorated poster boards mounted for display on standing easels in the front of our auditorium, with a table between them holding still more photographs. This served as a focal point where service participants gathered and shared their feelings as they looked at the pictures together.

The service itself was astonishingly beautiful, the whole ending up being so much more cohesive and meaningful than the sum of its parts. It was not without its glitches, such as when a dormitory resident valiantly representing the Jewish community at the home developed a severe case of stage fright, but moments such as these served to make the production even more human and poignant. It was truly a time when the community felt united, a ceremony that helped us not only to honor our dead, but to celebrate our identity as a veterans’ organization. As soon as the service was over, people began to plan improvements for the next year’s ceremony.

The Soldiers’ Home has a unique identity, and not all facilities would have the occasion to use such a patriotic theme for either a remembrance table program or an annual memorial service. Memorial observances in other nursing homes would have their own unique features based on commonalities (and differences) among their resident population. For instance, many homes are local, and the service might celebrate the residents’ contributions to the greater community during their lifetimes. In any case, while the topic sounds fairly grim, memorial programs are actually uplifting rituals by which social workers can help define and validate the importance of individual lives and strengthen the bonds of communal identity.

THE CARING HEARTS PROGRAM

There are other rituals and ceremonies that can help to enrich the experience of living in a nursing home. One such program that I helped to create was called Caring Hearts at Work. This endeavor brought together residents, staff members, the administration, and families in the formation of caring individual
relationships between residents and staff members. To that end, I collaborated with my coworkers to match interested staff members with residents to spend some quality time together. Participants were allowed to spend at least twenty minutes of their work time socializing with their match. The concept for matching residents with staff members was one that I borrowed from a colleague, Joe Pelland, who presented the idea at a nursing home social work conference. The title of the program and the form that it ultimately took were my own and my colleagues’ contributions.

As in my work in the area of bereavement, I was careful to involve other key members of the staff in this program. I initially presented the concept for this endeavor to my peers as a project for the behavioral committee, which I chaired as the facility social worker. Our mission was to address concerns about the residents’ moods as well as any disruptive behaviors they may have exhibited, preferably doing so without the use of psychotropic medication. Since positive behavioral modification techniques were the committee’s intervention of choice, according to its mission, I felt that this forum was an appropriate place to launch this experiment. I hoped the result would be decreased depression and a lessening of the need to act out on the part of the residents as their emotional needs were being met through their special relationship with a staff member.
After gaining the approval of the committee, which included the activities director, an occupational therapist, and a nurse, I wrote up a proposal for the administrator which was reviewed by my collaborators. After some discussion, we made some revisions to the document and submitted it to the administrator for approval, and it was accepted.

We recruited interested staff members and allowed them to choose a resident to be their Caring Hearts partner. About twelve employees initially signed up. We gave those workers a heart sticker to wear on their badges, signifying their status as members of this program. According to our rules, which we explained to them verbally and in writing, they were allowed to visit with their resident anywhere in the facility or on the grounds for a total of twenty minutes per week, with the consent of their supervisor, and to spend additional time with their match, if desired. We clarified that we expected the relationship to be a caring and professional one and discouraged staff members from sharing overly intimate details of their own personal lives, focusing instead on getting to know the resident better, learning their life stories, and discovering commonalities as well as differences between the lives of their residents and themselves. A requirement was that employees submit a brief check-off form indicating the residents’ mood and concerns, as well as a comment about the week’s visit(s). This allowed me, as the social worker, to monitor the program’s effectiveness and the residents’ concerns in general.

Figure 8. Caring Hearts duo spending time together.
As an incentive for employees to participate in the Caring Hearts Program, the administration agreed to provide a monthly luncheon for staff participants. At these luncheons, the activities director and I facilitated a discussion of each employee’s experiences, validated their achievements in developing trusting relationships, and helped the group solve problems involving any concerns that the workers might have. In this way, we modeled caring, constructive interactions for the staff. We also provided education about the importance of reminiscence and taught the staff members some basic life-review techniques, such as asking questions about pictures in a resident’s room, about his or her occupation, hobbies, family, past holiday celebrations, and seasonal activities, as appropriate.

Eventually, the program grew to include almost forty staff member/resident pairs. Some of the relationships that developed were extraordinary. Several employees visited their Caring Hearts partners on weekends, bringing their children or pets to show the residents. Strikingly, a very demented resident recognized her staff member by name, even though the patient had not made any other intelligible verbalizations for years. Moreover, staff members began to advocate actively for their charges. A physical therapist, for example, made sure her Caring Heart partner was walked daily, something that had not occurred prior to her intervention. Finally, in care-plan meetings, families often mentioned their appreciation for the Caring Heart staff member assigned to their loved one and noted that the residents looked forward to these special visits.

In order to continue to flourish, the Caring Hearts Program, like a garden, needed to be constantly cultivated and tended. I kept the program growing by recognizing the efforts of Caring Hearts staff members and the relationships that resulted from their work with the residents. I wrote an article about the program that was published in the local newspaper. I also took pictures of Caring Hearts duos each year, displaying them as a collage in a prominent location. Thus, Caring Hearts participants acquired a certain cachet that encouraged other staff members to join the program. I also held a contest where staff members competed to design a logo. We had the winning entry (two smiling hearts holding hands) made into T-shirts which we sold at cost to employees, who in turn were permitted to wear them as part of the dress code. The T-shirts were in great demand, and cheerful red hearts appeared daily among the white and pastel floral uniforms. In visible ways, the rituals associated with the Caring Hearts Program helped to humanize the medicalized culture of the facility.

One effect of the Caring Hearts Program that was not so positive, however, was that, having developed meaningful bonds with the elderly residents, staff members were now more vulnerable to the loss of those relationships due to death. In a staff luncheon, one worker reported that when her match died, she...
cried all the way home. We talked about how hard it is to lose someone that you care about. This occurrence brought me back full circle to the issue of bereavement, because life is inevitably, inextricably entwined with death, especially when working with those in the late stages of their development. I instituted the monthly memorial tea services in this nursing home, which I had not previously done, and Caring Hearts staff members quite often attended, even in their off hours.

From my experience in creating these programs, I would recommend being somewhat rigorous in developing procedures to measure and quantify the outcomes of one's interventions. In the case of the Caring Hearts Program, it would be possible to compare depression scores on such instruments as the Folstein Mini-Mental Status Examination or the Cornell Scale for Depression in Dementia pre-match, at three-month, six-month, and yearly intervals. Behavioral changes could be compared on the Multiple Data Set administered in every facility. The behavior check-off sheets filled out by Caring Hearts Program participants could also be tracked over time. The information obtained through these methods could be helpful to a facility in its marketing services, which would in turn increase the value of the program to the administration and ensure continued administrative support for a this type of project. In terms of the remembrance tables, resident moods and behavior could be similarly tracked through the administration of depression protocols and comparison of MDS dates for the residents before and after the program is instituted on a particular unit. For all programs, documenting staff and family comments can serve as indicators of the success of the endeavor.

Nursing homes, like hospitals and similar institutions, remove the elderly from the mainstream of society in order to care for them, and as has always been the case, this type of care engenders an existential crisis for the residents. No longer valued for their economic contributions and not yet dead, they remain in a marginalized netherworld, dependent on attendants who do not really know them, with no ties to each other and frayed bonds with their family members, who no longer know how to treat them. This situation, while admittedly grim, is an opportunity for nursing home social workers to use their understanding of systems, relationships, and human behavior to develop programs that go a long way toward helping our clients to reestablish meaningful identities.