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Feature Article

Nursing home practices following resident death: The experience of Certified Nursing Assistants

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ABSTRACT

This study examined certified nursing assistants' (CNAs) experiences of nursing home practices following resident death. Participants were 140 CNAs who had experienced recent resident death. In semi-structured, in-person interviews, CNAs were asked about their experiences with the removal of the resident's body, filling the bed with a new resident, and how they were notified about the death. The facilities' practice of filling the bed quickly was most often experienced as negative. Responses to body removal and staff notification varied, but negative experiences were reported by a substantial minority. Being notified prior to returning to work was associated with a more positive experience. Learning about the death by walking into a room to find the bed empty or already filled was the most negative experience. Study findings suggest that more mindful approaches to the transitions related to resident deaths would be valued by CNAs and could improve their work experience.

Introduction

Nursing homes not only serve as the final home for many elders but are also often the site of death for many residents.[1–5] Because resident death is such a common occurrence in long-term care (LTC) facilities, nursing home practices around resident death and an examination of the impact on those most exposed to them are an important topic. Hence health care workers' attitudes toward and experiences with death and dying of long-term care patients deserve particular attention.[6]

Rickerson et al[7] found that 72% of long-term care staff reported experiencing at least one grief related symptom in the past month and the number of symptoms increased with the number of deaths experienced. Grief symptoms affected not only the staff members themselves but residents as well. Thirty six percent of staff members stated that the death of a resident impacted their relationships with other residents. Furthermore, complicated grief (i.e., debilitating feelings of loss that do not improve over time) among Certified Nursing Assistants (CNAs) has been found to be significantly related to depersonalization of residents including more emotional hardening and impersonal feelings toward residents.[8] On the other hand, CNAs reporting greater personal growth from their grief experiences reported greater feelings of personal accomplishment. These findings illustrate the negative and/or positive impact that can result from the way resident death is addressed on not only CNAs but also resident care.

The impact of a resident death on CNAs is particularly important to examine as CNAs spend more time with nursing home residents than other staff members and provide residents with most of their direct care.[9] Moreover, CNAs often develop the closest relationships with residents.[3,10–12] Though CNAs are continuously exposed to death in their work context,[8,13] their experiences with death are rarely discussed in the long-term care setting and bereavement support services for staff are widely lacking.[4,13–16] In fact, it has been noted that issues around resident death and dying tend to be avoided in residential elder care settings.[17]

CNAs often handle or at least witness the inevitable transitions that occur in the immediate aftermath of a resident's death. For example, CNAs are typically involved in post-mortem care, and occasionally in informing the family and friends of the resident death.[3,18] Focus groups on death and dying in nursing homes conducted by Osterlind et al[3] revealed that nursing staff perceived taking care of the deceased resident's body as final opportunities to bid farewell to the deceased and as a way of expressing what the resident meant to them. Similarly, in a study by Burack and Chichin, over three quarters of CNAs agreed that caring for a person who was dying can be a very rewarding experience.[19] Involvement in dealing

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with post-mortem aspects of care were thus seen as a potentially important positive experience. However, staff experiences in this context do not always seem to be positive. Dwyer et al[18] observed that both CNAs and nurses expressed a need for common policies around caring for the body, and for a more consistent review of post-mortem procedures. In fact, nursing homes often lack any kind of established protocol or rituals when it comes to the removal of a deceased resident's body. Moreover, some long-term care facilities' practices after the death of a resident can be interpreted by staff members as lacking in respect, as when Munn et al[11] found that some nursing homes took the bodies through the main lobby or left them by the freight elevators. Another study explored the perceptions of Australian nursing home residents concerning the deaths of coresidents.[17] Residents noted that bodies were removed "on the quiet" as to not to upset them. Whereas interviewed staff members (managers, nurses, and therapists, only few CNAs) defended this practice as protecting the residents, the residents themselves considered the attempts to hide death and body removal as unnecessary and even disrespectful.

Following the death of a resident, the nursing home is left with a now empty bed. Due to financial considerations most nursing homes are motivated to fill the bed of a deceased resident quickly. We know little about how CNAs experience this transition. However, as research evidence clearly shows that CNAs often develop very close relationships with their residents,[10] it is likely that being confronted with an immediate filling of the bed constitutes a salient experience that they may view as emotionally difficult. For CNAs who are not present at the time of death, the process by which they find out about the resident's death may impact their overall experience of the death. End-of-life research has focused on the need for effective communication and teamwork when it comes to care delivery for dying residents.[9,20,21] However, less is known about such communications after resident death. For example, in a study on terminal care in the nursing home, participating staff emphasized the importance of more effective communication among staff while caring for dying residents, suggesting to pair new CNAs with mentor CNAs.[9] Similarly, Tan et al[17] observed that being able to talk to fellow staff about a resident's death was valued. But neither study addressed communications among staff in the initial time period after the death.

As the impact of resident death has implications for CNAs and the care they are able to provide for residents, the purpose of this study was to better understand how CNAs experience nursing home practices in the immediate aftermath of resident death. Drawing on the above described literature, we focused on gaining insight into three definable transitions that take place after every resident death, (1) the removal of the resident's body, (2) the filling of the bed with a new resident, and (3) the moment of learning about the death. The decision to include questions about these three aspects in the research interview was also based on pilot inquiries conducted in preparation of the study, in which we consulted with nursing home staff about critical issues associated with the CNA experience after resident death. The ultimate goal was to describe how CNAs view and experience the handling of each of these transitions, to identify which approaches or practices may be likely to trigger either positive or negative responses from the CNAs, and subsequently to be able to provide concrete evidence-based practice recommendations to structure and improve these transition processes.

Methods

Recruitment and eligibility

This study is part of a larger mixed-method study that looked at bereavement in direct care workers.[14] Actively employed CNAs were recruited from three large nursing homes, all part of the same care system in Greater New York. To be eligible, CNAs had to have experienced the recent death (within approximately two months) of a resident for whom they were a primary CNA. Patient deaths were tracked via electronic medical records. CNAs were approached on the units by a research interviewer, informed about the study, and asked if they were interested in participating. Of the 824 CNAs meeting eligibility criteria, we approached 219; 143 agreed to participate and 76 refused. Reasons for refusal to participate included being too busy to participate in an interview, not wanting to talk about patient death, and not wanting to be involved in any type of survey. Three CNAs did not complete the interview. The response rate was 64%. The remaining 605 CNAs could not be reached due to CNAs' schedules (e.g., sick time or vacation) or limitations in research staffing as more resident deaths occurred than could be followed within the intended time frame. Participant CNAs were representative of the organization's overall CNA population with regard to age, gender, race/ethnicity, and length of employment.

Data collection and measures

CNAs were interviewed in-person by trained interviewers with a Bachelor's or Master's degree, at a place and time of their convenience outside of work hours. All study procedures and protocols were approved by the organization's institutional review board. Written informed consent was obtained prior to all interviews. Participants received $30 for their time.

Socio-demographic characteristics collected included age, gender, education, marital status, and race/ethnicity. *Presence at death* was assessed with the question: Were you working on the unit when (resident) died? Where were you when it happened? *CNA experiences during the transitions immediately following the resident death* were assessed with the following open-ended questions: How did you feel about: a) how the resident's body was removed after he/she passed, b) how you were notified about the death, and c) how quickly the bed was filled?

Responses to the open-ended questions were written down verbatim, typed into a word document, and imported into the computer software Atlas/ti.[22] A coding system for these open-ended data was developed with an analytical theme-identification approach often used in qualitative analysis.[23,24] The Principal Investigator and two Research Assistants independently reviewed the responses of the first 10 participants to generate an initial set of codes. The research team then met to discuss, clarify and refine the suggested codes. After agreeing on an initial set of codes and clarifying their definitions, the responses of the next five participants were used to establish inter-rater agreement between two independent coders. This procedure was repeated with batches of five interviews until the agreement strength was substantial (kappa $\geq$ .80). From this point on, interviews were doubled coded periodically to ensure agreement strength was maintained. Occasional coding difficulties were resolved through team discussion. Overall, kappa coefficients consistently ranged from .75 to 1 (average kappa = .92), demonstrating adequate inter-rater agreement.

Codes relating to presence at death reflected where CNAs were when the resident died (i.e., With resident, On unit but not in room, Found resident dead, Resident died during another shift, Resident died in hospital). Codes related to the three transitions around death questions distinguished positive, neutral, or negative experiences of how the transitions were handled in the nursing home context. Additionally, codes related to staff notification indicated whether CNAs learned about the death upon or prior to arrival at work, and how they found out (e.g., were told by nurse, fellow CNA, or resident's family).