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Feature Article

Supporting home health aides through a client's death: The role of supervisors and coworkers

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ABSTRACT

This study evaluated home health aides (HHAs) experiences related to the support they received around a client's death. 80 HHAs who had recently experienced a client death participated in semi-structured interviews. They were asked to what extent they felt support was available to them from their supervisor or coworker, whether they sought support, the type of support they sought, and how helpful it was. They were also asked what type of support they would like to receive. Findings showed that just over one third of the HHAs felt they could turn to their supervisors for support and one fifth could turn to their coworkers. Even fewer sought support. However, those who did receive support, found it to be extremely helpful, in particular when the support came from supervisors. Desired types of support were primarily related to having someone to talk to or check in with them, pointing to an important role of nursing supervisors in providing critical support to direct care staff.

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Introduction

Due to the acceleration of the average life expectancy and related growth of the elder population, addressing geriatric care needs has become an increasingly vital issue. Yet, the current geriatric workforce faces major barriers in meeting these needs, including insufficient number of trained professionals entering the field,[1] insufficient training and support mechanisms for staff,[2,3] and high turnover rates in particular among direct care staff who provide the bulk of hands-on care.[4] Direct care workers include certified nursing assistants (CNAs) in nursing homes and home care workers or home health aides (HHAs) in the community.

Home care provided in the community is one of the fastest growing health care sectors, resulting in a massive anticipated growth in the number of HHAs coming into the field, with estimates showing the workforce could reach almost 1.3 million in the U.S. by the year 2018.[5] As many elders indicate a wish to be cared for at home, it is likely that the demand for home care services will exceed the capacity of the workforce.[6] This is in large part due to the instability of the home care workforce, caused in part by problems with HHA turnover, which ranges from 30% to 65% per year.[4,7,8]

Yet, despite the challenges facing this workforce, the role of HHAs is critical to the care of community-based elders. Understanding and addressing the experiences of HHAs is needed to both improve the work environment and skills of this workforce, but also to meet the often complex care needs of older adults aging at home. One area of impact HHAs make on a regular basis for elders is their increasingly important role in providing palliative and end of life (EOL) care in the community.[9] In this care context, HHAs are often confronted with the death and dying of their clients. However, to date, little attention has been paid to HHAs' experiences around a client's EOL and death.

HHAs typically spend significant time one-on-one with their older clients, inevitably resulting in the forming of close relationships, which are often positive for both the client and the aide.[10,11] Close HHA-client relationships have been found to be critical to the overall satisfaction of the care recipient, often seen as a friendship more than a professional relationship, as well as constitute an important component of retaining HHAs on the job.[12–14] Due to these bonds, HHAs can experience emotional upheaval during a clients' EOL and after death, similar even to the experiences of family caregivers.[15,16] How home care agencies support their HHAs in the context of client death appears to be important for both HHAs' job satisfaction and retention in their position. A recent study comparing employment outcomes of HHAs in an agency with a restrictive policy regarding contact with a client's family after

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client death with those of an agency without such a policy in place found that HHAs from the restrictive agency were significantly more likely to be considering other job options. They also reported significantly lower satisfaction with respect to support from their supervisors.[17]

This finding is consistent with previous research on CNAs in nursing homes, showing that the quality of the supervisory relationship can be an important predictor of overall job satisfaction and retention.[18–20] Additionally, feeling supported by the agency and facility where they work, has also been found to influence CNAs' job satisfaction and, when positive, to lower turnover.[21,22] While much of this research was conducted with CNAs in nursing homes, and less is known about the experience of HHAs, it seems likely the supervisory relationship and support from supervisors would be at least, and perhaps even more important for HHAs. Even though HHAs do have exchanges with coworkers during shift change, at trainings and in-services, they have overall fewer opportunities to connect with coworkers than CNAs who work side-by-side one another on a nursing home unit. For HHAs the primary contact person besides the client and client's family, and perhaps some coworker contact, is the supervisor. Thus, given that EOL-related agency policies perceived by HHAs as unsupportive were found to be negatively linked both with HHAs' intent to leave their job as well as their job satisfaction with regard to supervision, shedding light on the role of supervisory support in the context of client EOL and death appears to be an important first step in expanding this research area.

Therefore, this study examined the perceived availability of supervisor and coworker support among HHAs, during the time leading up to their client's death and after, whether they actually sought support from either of these sources, what types of support they received, how helpful the received support was, and what types of support they would have liked to receive. By better understanding HHAs' experiences within their agency in the wake of a client's death, home care agencies, including nursing and supervisory staff, may be able to adjust their approach in order to better support their direct care staff. Providing greater support to HHAs may improve the likelihood that they remain in their position, maintaining consistency in care for other clients.

Methods

The present analysis is part of a larger mixed-methods study that looked at direct care workers' experiences around patient death.[15,23] The parent study included both CNAs and HHAs. The present paper focuses on the subsample of HHAs only. Actively employed HHAs were recruited from the community service division of an elder care system in New York City, and two other agencies that subcontracted by this long-term care organization to serve their clients. These agencies provided standard home care services to community clients (no specialized care, such as hospice). To be eligible for the study, HHAs had to have experienced the death of a client for whom they were the permanent HHA within approximately two months. When client death occurred, the participating agencies' administrative staff informed the research team and asked the primary HHA of the deceased client if the study personnel could contact them. If the HHA agreed, research staff followed up with a telephone call to explain the study and schedule an interview. 122 HHAs were contacted within the two-month time period; 38 could not be reached and 80 agreed to participate (of the 84 who were reached), resulting in a 95% response rate. Once participants were recruited into the study, they were given the choice to conduct their interview in Spanish or English; 19% were conducted in Spanish. The participating HHAs were representative of the larger pool of HHAs serving the organization's clients with regard to age, gender and tenure. However, when compared by race/ethnicity, our study sample was 67% Black and 29% Hispanic, whereas the larger pool of HHAs was 33% Black and 64% Hispanic.

Data collection and measures

Study participants were interviewed in-person at a time convenient for them outside of work hours by trained interviewers. The majority of the interviews took place in the HHA's home. Interviewees were provided with a stipend of $30.00 for their time. All study procedures and protocols were approved by the organization's institutional review board. Written informed consent was obtained prior to all interviews.

Socio-demographic characteristics collected from each respondent included age, gender, education, marital status, and race/ethnicity.

Support assessments included a mixture of closed-ended interview questions with pre-set answer categories, and open-ended questions generating narrative responses. Responses to the open-ended questions were recorded verbatim and uploaded into a qualitative data analysis software. A clustering,[24] or open coding,[25] approach was used to identify themes and recurring patterns within these data. The Principal Investigator and two Research Assistants independently reviewed the responses of the first 10 HHAs to generate an initial set of codes. Next, they met to discuss, clarify, and refine the suggested codes. The responses of another five HHAs were then used to establish inter-rater agreement between two independent coders. This procedure was repeated until the agreement strength was substantial (kappa ≥.80). From this point on, interviews were doubled coded periodically for ongoing quality control. 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. A matrix of dummy variables (reflecting having received a code or not) was exported from Atlas and imported into SPSS to be able to conduct basic descriptive analysis. Quotes from the open-ended data were used for illustrative purposes.

Support availability was assessed with two items drawn from an assessment of support availability and adequacy validated and widely used in family care giving studies (developed by Cantor and Brennan[26]): To what extent do you feel you can turn to your supervisor for support? To what extent do you feel you can turn to your coworker for support? Answering categories were (1) not at all, (2) a little, (3) somewhat, and (4) very much.

Type of support was assessed with four questions that were asked as follow-up to the prior support availability questions: Did you turn to your supervisor for support during the last weeks before (client's) death?; Have you turned to your supervisor for support since (client) died?; Did you turn to your coworkers for support during the last weeks before (client's) death?; and Have you turned to your coworkers for support since (client) died? Each of these questions yielded either a (1) yes, or (0) no, and was followed by the probe: How did [...] help? We subsequently coded what the support received entailed using the coding process described above.

Helpfulness of support was assessed by asking for each reported support instance: How helpful was that? Answering categories were (1) not at all, (2) a little, (3) somewhat, and (4) very much.

Desired support was assessed with one open-ended question: What kind of (added) support could you have used during the time of your client's dying and death? Responses were recorded and coded as described above.

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