Original Article

Preparedness for Resident Death in Long-Term Care: The Experience of Front-Line Staff

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Abstract

Context. Although resident death is a common occurrence in long-term care, little attention has focused on how prepared certified nursing assistants (CNAs), who provide most of residents' daily care, are for this experience.

Objectives. To identify characteristics of the resident, CNA, and care context associated with CNAs' preparedness for resident death and to determine differential patterns for emotional versus informational preparedness.

Methods. One hundred forty CNAs completed semistructured, in-person interviews concerning their experiences regarding resident death. The associations of CNA characteristics (e.g., personal end-of-life [EOL] care preferences), CNAs' perceptions of resident status (e.g., knowledge of resident's condition), and the caregiving context (e.g., support from coworkers and hospice involvement) with emotional and informational preparedness were examined by the use of bivariate and multivariate analyses.

Results. CNAs who reported that their resident was "aware of dying" or "in pain" expressed greater levels of both emotional and informational preparedness. CNAs who endorsed an EOL care preference of wanting all possible treatments regardless of chances for recovery were likely to report lesser emotional preparedness. More senior CNAs, both in regard to age and tenure, reported greater preparedness levels. Greater support from coworkers and hospice involvement also were associated with greater levels of both facets of preparedness, the latter in particular when hospice care was viewed positively by the CNA.

Conclusion. Having more information about resident status and more exchange opportunities within the care team around EOL-related challenges may help CNAs feel more prepared for resident death and strengthen their ability to provide good EOL care. J Pain Symptom Manage 2015;50:9–16.

Key Words
Preparedness, resident death, caregiving, nursing assistant, direct care staff, grief, bereavement, long-term care, nursing home

Introduction

Certified nursing assistants (CNAs) provide most of personal daily care and interact the most with nursing homes residents compared with other staff. As a result, CNAs often develop close ties with residents for whom they provide care and sometimes see themselves as family surrogates.[1,2] These relationships are found to be one of the primary reasons why nursing home staff remain on the job,[3] an important factor in a work environment in which retaining nursing staff is challenging.[4] Having close relationships with residents means, for nursing home staff and especially for direct care workers like CNAs, that they might have reactions very similar to those of family members when a resident dies. This notion is supported by studies of grief symptoms in a range of nursing home staff members,[5] as well as specifically in CNAs.[6,7] Additionally, one

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study indicated that CNAs often feel completely unprepared for the death of their resident, and that low preparedness is associated with more intense grief after resident death.[7] To our knowledge, no previous study has specifically addressed the variables related to preparedness for death among direct care staff in long-term care settings.

Overall, the topic of preparedness for death has received little research attention, even with respect to family caregivers; however, the few existing studies show that low preparedness for death in family caregivers is associated with greater separation distress, traumatic distress, and more symptoms of complicated grief and depression,[8,9] in addition to quality of life years after the loss.[10] In a similar vein, a study on husbands' preparedness for spouses' cancer found an association between low preparedness and greater anxiety, sleep problems, emotional numbness, poor quality of life, and less grief resolution in young widowers.[11] On the basis of this sample, several important patient and caregiver factors were identified as predictors of preparedness, including patient age and disease progression, health care–related information, and awareness of and willingness to talk about impending death, or efforts to avoid thinking and talk about the topic.[12] Contextual factors, however, were not considered.

As the available empirical evidence suggests that being told a prognosis or accepting the inevitability of death does not necessarily translate into an overall sense of preparedness, it has been noted that preparedness might be better understood if knowledge or information about an imminent death and the emotional or mental aspect of preparedness are differentiated and explored separately.[13] Subsequently, Hebert et al.[14] argued that preparedness for death can be conceptualized as a multidimensional construct and suggested that caregiver preparedness could be enhanced by targeting both cognitive/informational and emotional preparation. Informational preparedness refers to a clear understanding of the patient's condition, care needs, and goals of care. The finding of a significant positive correlation but not complete overlap between emotional and informational preparedness for death among CNAs[7] supports the notion of an emotion- versus information-based facet of preparedness.

Building on previous research related to grief and preparedness for death among family and staff caregivers,[5,7,9,14] we had two aims for this study: The first aim was to identify characteristics of the CNA, the resident (as per 'an's knowledge and perceptions), and the care context that may be associated with the CAN's preparedness for the resident's death. The second aim was to determine which of the associated factors relative to one another accounted for the greatest amount of variance in preparedness and whether associative patterns differ for emotional versus informational preparedness.

Methods

Recruitment and Eligibility

We recruited CNAs from three large nursing home campuses that were all part of the same health care system in Greater New York. CNAs had to have experienced the death of a resident for whom they were a primary CNA within approximately two months of a resident's death to be eligible. Resident deaths were tracked via electronic medical records, and the resident's primary CNAs were identified by unit staff. CNAs were then approached on their units, given information about the study, and asked whether they were interested in participating. Of the 824 eligible CNAs, 219 were approached about participating in the study. We could not reach the remaining 605 CNAs within the two-month time frame after resident death primarily because of limitations in research staffing. It is noted that this did not introduce a systematic selection based on the CNA characteristics. Of the 219 CNAs approached, 143 agreed to participate, 76 refused, and three did not complete the interview, yielding an overall response rate of 64%. With regard to age, sex, race/ethnicity, and tenure, the participating CNAs were representative of the organization's CNA population.

Data Collection and Measures

Trained interviewers with a Bachelor's or Master's degree conducted the in-person interviews at a place and time of the participant's convenience. Interviews lasted on average 80 minutes. Before all interviews, written informed consent was obtained, and participants received $30 for their time. Interviews did not occur during work hours. Data analyses were based on a selection of measures from the research interview pertaining to the focus of this article.

Preparedness for Death. Preparedness for death was assessed with two questions based on previous work examining family caregivers' preparedness for death[9,13,14]: (1) To what extent were you prepared for the patient's death mentally or emotionally? (2) To what extent were you prepared for the patient's death in terms of the information you had about his/her state/your understanding of the situation? Participants scored each of the two items on a four-point Likert scale ranging from 1 = not at all to 4 = very.