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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.

Keywords

Resident death; nursing assistants; long-term care; nursing home

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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 healthcare workers' attitudes towards 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 towards 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 postmortem 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 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 ofmore effective communication among staffwhile caring for dying residents, suggestingto 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 ≥ .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 interrater 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).

Coded data represented as categorical variables were imported into SPSS to be assessed in terms of frequencies and percentages to and to evaluate associations between variables (Table 2). This quantitative treatment of open-ended data is referred to as "quantitizing."[25]Quantitizing has been described as a useful way to confirm the researcher's impressions from the data and assess the likelihood of co-occurring themes.[26]However, quotes from the open-ended data are used for illustration (Table 3).

Results

The sample's demographic characteristics are summarized in Table 1. Participating CNAs were mostly minority women, reflective of the larger population of CNAs in Greater New York. Most of the CNAs were High School graduates or had at least some college education; about half were married. More than three-fourths were not present during the death of the resident, primarily because the death occurred during another shift. Of the remaining CNAs, most were on the unit but not necessarily in the room when the death occurred, some were with the resident and only a very few were the first to find the resident dead.

Table 2 depicts the frequencies and percentages of CNAs' positive, neutral, and negative reactions to each of the three transitions: (1) the way in which the resident's body was removed, (2) the way in which the bed was filled with another resident, and (3) the way in which the CNA was notified about the resident's death. For reactions to the removal of the resident's body only the responses of CNAs who were present at or after the death to witness the removal of the body were considered (N=61). For bed filling, the responses of all CNAs (N=140) were considered because regardless of whether or not they were present at the time of death, each CNA was able to share their experience of finding the bed filled with a new resident. For experiences related to notification of resident death, we only examined responses from CNAs who required notification, either because they were not on the unit when the resident died or because the resident died in the hospital (N=106).

Overall, results indicated that each of the three areas triggered a variety of positive, neutral, and negative responses. The experience of filling the bed with a new resident had the most negative responses, with a majority sharing negative and less than one-tenth sharing positive experiences. CNAs experiences related to the removal of the resident's body were more equally distributed in terms of valence, yet here too, a third of the sample reported a negative experience. Regarding being notified about the death, about half of the CNAs who required notification gave a neutral response, and about a quarter each had a positive or negative response.

A follow-up analysis of staff notification pathways for CNAs who were not on site when the resident died provided evidence that being notified of the death prior to arrival at work was generally more likely to yield a positive experience. The most negative and least positive responses were given by CNAs who learned about the death by walking into the room and

finding the bed empty or filled with a new resident. Being told about the death by another staff member upon arrival at work appeared to trigger more neutral or positive responses when the informing person was a nurse, whereas being notified by a fellow CNA triggered more neutral or negative responses. In contrast, CNAs were likely to report a positive experience when they were notified by telephone before coming to work, either by a fellow CNA or a resident's family member. None of the CNAs who were told of the death by telephone prior to returning to work reported a negative response to being notified in such a way.

Table 3 provides original quotes from CNAs to illustrate the content and nature of positive, neutral, and negative responses in the three transition categories. Neutral responses in all three areas reflect CNAs not feeling strongly about the issue, considering the handling of the situation as normal or even necessary nursing home practice. Positive comments concerning removal of the resident's body revolved around being able to be there for the resident at and after death by being involved in post-mortem care. However, experiences with post-mortem care were negative far more often than they were positive, and perceived lack of respect for both the resident and the involved CNA was a common theme. CNAs gave positive responses to the filling of the bed with a new resident if they thought the nursing home allowed sufficient time between the death and placement of a new resident in the bed, or when they believed filling the bed would help another person receive good care. Most of the negative responses were regarding the bed being filled too quickly. In some cases this meant the bed was filled before the CNA found out about the death.

Quotes reflecting positive notification experiences indicated that someone had made an intentional effort to let the CNA know about the resident's death, recognizing that the CNA had been close to the resident and that the death was a loss. CNAs had strong negative reactions when they were not notified about the resident death or given the news in a ‘coldhearted’ way. CNAs reported that they should not have to ask about the resident and that it was the nursing homes’ and at times the family's responsibility to notify them about the death.

Discussion

The purpose of this study was to describe how CNAs view and experience the handling of three critical transitions that typically must occur in the immediate aftermath of resident death in the nursing home – removal of the resident's body, filling of the bed with a new resident, and staff notification of the resident's death – and to identify which approaches to these instances may be likely to trigger either positive or negative responses from CNAs.

Findings regarding body removal were consistent with previous observations based on focus groups[3] that involvement in post-mortem care, in the most positive case, can be an appreciated opportunity to be there for the resident and to say goodbye. However, the less positive and more frequent scenario was an apparent lack of guidance and rituals around the post-mortem care, which left some CNAs with the sense of a rather overwhelming experience and the perception that common practices are lacking in respect and dignity for all involved. Thus, in line with previous observations,[11,18]the evidence from the present

study suggests that the positive potential that lies in the involvement of CNAs in post-mortem tasks such as taking care of the deceased and bringing the deceased to a morgue or holding room is unlikely to be reached without adequate training and emotional preparation for this process. Additionally, defined rituals geared towards more dignity for residents and staff would provide a helpful supportive framework. Evidence from previous work suggests that such rituals would be welcomed by the other residents on the nursing home unit.[17]Maitland, Brazil, & James-Abra found that a post-death ritual such as a room blessing has positive implications for staff and residents as it validates grief and provides closure, celebrates the person who passed, brings the community together, and even allows the opportunity to acknowledge and prepare for the welcome of a new resident who will be living in the space.[27] Thus this could potentially also address some of the discomfort experienced when staff encounter a new resident "filling the bed", a positive for both staff members and the new resident.

CNAs experience of facing a new resident filling the bed of a resident who has very recently passed away elicited the most negative responses. However, many CNAs stated that they recognized this as an area where nursing homes have little control. The few positive responses to the bed filling question centered on accommodating the care needs of a new resident. It is possible that open discussions with staff members explicitly framing the relatively quick pace of bed filling with this purpose in mind might soften resentful feelings around this transition. Additionally, it seems that any kind of time lag is appreciated, to "at least let the bed go cold." But most importantly, CNAs' response to bed filling also seemed related to the issue of notification. Seeing the bed filled without having been notified about the death seemed to trigger particularly resentful feelings. Hence, study findings suggest that the inevitable reality of quick bed filling might be more tolerable for CNAs if they learn about the death before seeing the bed filled.

How staff members are notified about the death of a resident is a critical topic because with three shifts and thus three different CNAs having primary responsibility for one resident, it is likely to be the case that with each resident death at least two out of the three CNAs would have to learn about a death that did not occur during their "watch." Generally, arriving at work and finding the bed empty or filled with a new resident was described as a negative experience. Reactions to being told by a fellow CNA or other staff member upon arrival at work was somewhat less negative, but still often perceived as "stumbling onto the news." The most positive experiences reported were the rarer cases when CNAs learned of the death through a telephone call prior to coming to work. This kind of notification was perceived as positive because it conveyed the recognition by others (staff or resident's family members) that the CNA had a relationship with the resident and that knowing about the death was their prerogative. As Anderson[8] has suggested, validating the relationship between CNAs and nursing home residents and creating rituals that CNAs can participate in at the nursing home may promote the positive components of grief and alleviate some of the negative aspect.

Several potential limitations of our research deserve mention. Even though interviews were conducted soon after the death, responses to interview questions about the time around the death reflect retrospective accounts and therefore could be biased by other current or past

events. Furthermore, experiences with post-mortem care are likely to be also influenced by the CNAs' cultural background. With greater knowledge of particular cultural sensitivities, it would be possible to more concretely guide and prepare for involvement of CNAs in these transitions in a way that takes into consideration such cultural beliefs. We did not systematically investigate this issue, and thus our data do not yield enough depth in this respect.

Finally, transitions that occur after a resident death affect not only CNAs and other staff members but also the surviving residents on the unit and even in the room. Developing system wide approaches to the changes that must occur after a death that show respect for the deceased resident and the CNA/resident relationship may also have positive consequences for the remaining residents. They can feel assured that when they pass they too will be honored rather than hurried out a back door without distinction. Further research, should explore the impact of resident death and the nursing home processes following death on resident survivors.

Conclusions

Study findings suggest that more mindful practices around patient death in the nursing home would be valued by CNAs and could improve their work experience. Better training, preparation, guidance and support in the context of post-mortem care and body removal would be important especially early in a CNAs work experience as initial patient deaths can be formative and have an impact on future responses to death.[28]

While post-mortem care must be included in educational efforts around end-of-life care, there should also be nursing home or even unit-specific rituals that might be helpful, such as moments of silence in the room or farewell rituals when the deceased resident is departing from the unit. Additionally, it could be part of the nursing home routine that CNAs who have never prepared a body after death could be paired with a more experienced CNA the first few times this occurs. This often occurs organically that CNAs help each other when a death occurs on the unit, however a more formalized approach could remove anxiety associated with unclarified next steps. Finally, a systematic approach to staff notification of resident death, allowing CNAs to learn about the death of a resident they had primary responsibility for prior to arriving at work, might not only result in CNAs feeling more appreciated in the work context but may also ameliorate negative perceptions of other, less modifiable aspects related to transitions of resident death (e.g., quick bed filling). It might be appropriate for nursing leadership to, with feedback from CNAs, develop a protocol to inform primary CNAs from all shifts of a resident's death before reporting to work. This would help ensure that the CNAs work and relationship with the resident is acknowledged and respected by nursing leadership. In turn, CNA job satisfaction may be enhanced as Bishop et al found that nursing assistants were less likely to be dissatisfied with their jobs when they reported positive feelings towards their supervisors and felt respected for their work.[29]Hence, targeting areas that can be handled more mindfully may help improve the experiences of CNAs in the immediate aftermath of resident death.

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Table 1

Description Information for Sample Characteristics (*N*=140)

Variable	Mean (*SD*)	Range	*N* (%)
Gender (Female)			125 (89)
Age	50.5 (8.9)	24-69	
Ethnicity (Hispanic)			16 (11)
Race			
Black			117 (86)
White			3 (2)
Asian/Pacific Islander/Native American			2 (1)
Other			16 (12)
Education			
Grades 7-11			19 (13)
General Educational Development (GED)			13 (9)
High School graduate			54 (39)
Some college			42 (30)
College graduate			10 (7)
Marital status			
Married/Living as married			74 (53)
Divorced/separated			35 (25)
Widowed			8 (6)
Never married			22 (16)
Years in profession	15.2 (7.4)	1-35	
Months caring for patient	38.9 (36.9)	1-150	
Present when resident died?			
Was with resident			10 (7)
On unit but not in room			18 (13)
Found resident dead			4 (3)
Death occurred on another shift			94 (67)
Resident died in hospital			14 (10)

Table 2

CNAs Responses to Body Removal, Bed Filling, and Notification (*N*=140)

	Positive	Neutral	Negative	Significance[b]
***N* (%)**				
Body Removal (*n* = 61)[a]	13 (21)	20 (33)	18 (30)	
Bed Filling (*n* = 140)	10 (7)	53 (38)	79 (56)	
Notification (*n*=106)	29 (27)	55 (52)	23 (22)	
Notification Pathway:				
Upon arrival at work (*n* = 84)				
Was told by nurse	10 (25)	25 (63)	5 (13)	$\chi^2 = 3.0$, $p = .25$
Was told by fellow CNA	2 (11)	10 (56)	6 (33)	$\chi^2 = 3.4$, $p = .18$
Found bed empty/filled	1 (5)	11 (50)	10 (46)	$\chi^2 = 12.5$, $p = .00$
Prior to arrival at work (*n* = 22)				
Was called by fellow CNA	12 (67)	6 (33)	0 (0)	$\chi^2 = 18.4$, $p = .00$
Was called by family	3 (75)	1 (25)	0 (0)	$\chi^2 = 4.0$, $p = .09$

Note.

[a] Of the 61 CNAs present at/after the resident's death, five reported body removal was delayed to wait for the resident's family to arrive, and therefore it took place during the next shift; another five CNAs did not answer the question.

[b] For all χ^2 analyses: $df = 2$; $N = 106$.

Table 3

Sample Quotes Illustrating CNAs' Reactions to Body Removal, Bed Filling, and Notification of Resident's Death

	POSITIVE	NEUTRAL	NEGATIVE
Removal of Body	I wrapped her. That's why I said, I always like to be there. As I'm wrapping her, I'm telling her I love her, talking to her. It doesn't bother me. It [wrapping a body] bothers a lot of people. I took her down to the holding room. We have a holding room, for until the funeral home come to pick them up.	I don't feel any particular way. It was just normal. I have no thoughts or emotions about it.	Even though she passed away, there is no respect. I've been here 30 years, and the way we used to do when I first started, we closed down everything and took our time, and there was more privacy. Now it's like, throw things in a box and pack them up. The only thing I don't like, they make CNAs take them down to the morgue. That's traumatic to me. They should assign an undertaker. They make a CNA and an orderly do it. That kind of hardens your mind, like if you live in a war-torn zone. I never have, but like in Africa, surrounded by the dead everywhere-like you're a number. Before, I got emotional [when someone died]. It hardens you. We build a relationship. They should let somebody else take them away.
Bed Filling	I didn't feel bad because life goes on, and you have to do what you have to do. Because if someone comes who need the bed, they should be able to get care. That person needs care too. Her bed is filled already. I don't like it. At least let the bed get cold. Actually, this ain't too bad. Sometimes it's the same day, and this was the next day.	I don't have a problem with it. This is an institution, and that's how they make money. You can't say when to fill the bed or not. It's okay.	I hate when they do that. It's just money; it's too quickly. Every day [the bed is empty], they lose money. They ship them out right away, take the luggage, the clothes. Like that, clockwork, abrupt. The same day. They clean the bed, wash the bed, in case there's someone waiting in the wings. Like a food truck. We understand that they [the nursing home] need money but sometimes the bed is filled before we are told that the resident passed away. If a resident dies one day and you have off the next day you will see a new resident in the bed before you even find out that the resident died.
Notification	They felt for me because I was so close to her. Even though we couldn't really talk we were always walking together and she was always smiling. I like that they called me. I think it was a good way. They usually don't tell you. [You have to keep asking about the resident in the hospital, and later they say] “I guess you didn't know, she passed.” They usually don't tell you for weeks, but the nurse called me.	I think it was okay because that's the normal way we're notified, especially through the nurse's report.	They need to tell you because it's your patient. Sometimes it's a real shock because you come in and you aren't expecting the person to die, and you just see the mattress. It's a real shock. Staff members were not notified. I think it was unprofessional to have a person there for five or more years and then the person pass away and they don't say anything. It is understandable if it is a new person, but he was there for a long time and everybody knew him. He was a very nice person.