DEATH IN THE NURSING HOME: IMPACT ON DIRECT CARE STAFF

Andrea Traskos

A Thesis

Submitted to the Graduate College of Bowling Green
State University in partial fulfillment of
the requirements for the degree of

MASTER OF SCIENCE IN INTERDISCIPLINARY GERONTOLOGY

August 2015

Committee:

Charles Stelle, Advisor

Cynthia A. Spitler
Deaths are common in nursing homes. Mortality increases six months after being admitted into the nursing home facility. Residents are taken care of by direct care staff, which are certified nursing assistants (CNAs), state tested nursing assistants (STNAs) and registered nurses (RNs). The purpose of the study is to examine the literature on the impact that resident death has on direct care staff. The method of this systematic literature review included using eight databases (Academic Search Complete, CINAHL Plus with Full Text, Health Source: Nursing/Academic Edition, MEDLINE, MEDLINE with Full Text, PsycINFO, Social Work Abstracts, SocINDEX with Full Text) to examine the research question. Literature included in the search was from years 1995 to 2015. Results were divided up into two main themes, positive and negative death experiences. Staff felt happy when residents had a good death of being surrounded by family, dying with limited pain and being their spiritual support in the dying process. The majority of staff had trouble accepting a death, as they believed the resident had a bad death due to lack of communication around the provision of care for the resident. Implications from the results included adapting the dual-process model for adaptive coping, improving rituals and practices and increasing education for direct care staff. In conclusion, resident death should not be hidden as direct care staff experience many negative reactions after a death and administrators should improve training, rituals and practices for direct care staff to be able to cope after a death.

Key search terms: nursing home, LTC, death, grief, STNA, staff, and aide.
This thesis is dedicated to all direct care staff who experience the impact of resident death in their line of work. This thesis is intended to inform administrators of nursing home facilities that death should not be ignored in this environment no longer. This thesis is dedicated to my parents for supporting me every step of the way while I pursued my Master’s degree in Interdisciplinary Gerontology at Bowling Green State University. This thesis is dedicated to my entire family and friends as many who have either worked and/or faced death in a nursing home understand why I chose this to be my thesis topic. Thank you all for supporting me.
ACKNOWLEDGMENTS

I am grateful for my Professor and thesis chair, Dr. Charles Stelle for being my mentor and support throughout this entire thesis process. Without Dr. Stelle, my thesis would not be where it is today. I am thankful to Professor Dr. Cynthia Spitler, my thesis committee member, for offering insight and advice throughout completion of this thesis. I am appreciative for Dr. Wendy Watson who introduced me to the master’s program and took the time to guide me through it. I must also acknowledge the many librarians and writing consultants at the Jerome Library Bowling Green State University that have dedicated their time to help me at any point in my thesis process.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>BACKGROUND</td>
<td>1</td>
</tr>
<tr>
<td>Causes and places of death</td>
<td>1</td>
</tr>
<tr>
<td>Death in nursing homes.</td>
<td>1</td>
</tr>
<tr>
<td>Direct care staff</td>
<td>2</td>
</tr>
<tr>
<td>Relationships developed between staff and residents</td>
<td>3</td>
</tr>
<tr>
<td>Impact of stress</td>
<td>3</td>
</tr>
<tr>
<td>Grief in long term care</td>
<td>4</td>
</tr>
<tr>
<td>Research question</td>
<td>5</td>
</tr>
<tr>
<td>METHOD</td>
<td>6</td>
</tr>
<tr>
<td>Search strategy</td>
<td>6</td>
</tr>
<tr>
<td>Screening</td>
<td>6</td>
</tr>
<tr>
<td>RESULTS</td>
<td>9</td>
</tr>
<tr>
<td>Positive death experiences</td>
<td>9</td>
</tr>
<tr>
<td>A good death</td>
<td>9</td>
</tr>
<tr>
<td>Providing emotional, social and spiritual support</td>
<td>9</td>
</tr>
<tr>
<td>Emotional preparation for anticipated death</td>
<td>10</td>
</tr>
<tr>
<td>“Crack the window.”</td>
<td>11</td>
</tr>
<tr>
<td>Negative death experiences</td>
<td>11</td>
</tr>
<tr>
<td>A bad death</td>
<td>12</td>
</tr>
<tr>
<td>Emotionally unprepared for a death</td>
<td>12</td>
</tr>
<tr>
<td>Lack of communication</td>
<td>13</td>
</tr>
</tbody>
</table>
LIST OF FIGURE/TABLE

Figure  | Page
-------|-------
1      | 8     

Flowchart of article selection using the systematic review process

Table  | Page
-------|-------
1      | 16    

Articles used in the systematic review
BACKGROUND

Causes and places of death

Death is defined as the permanent and irreversible cessation of physical and cognitive functioning (VandenBos, 2007). According to the Centers for Disease Control and Prevention (2013), the top three causes of death for adults aged 65 and older are heart disease, cancer and chronic obstructive pulmonary disease. In 2013, there were nearly two million deaths of persons age 65 and older (CDC, 2013). Death typically occurs in hospitals, long-term care facilities, or in the home. Adults over the age of 85 are more likely to die during their hospitalization stay than those who are age 65–74 and 75–84 (CDC, 2010). Thirty-two percent of deaths took place in hospitals, while twenty-four percent of deaths took place at home (AgingStats, 2012). Deaths occurring in the hospital have declined from 49 percent in 1989 to 32 percent in 2009 (AgingStats, 2012). As deaths in hospitals have declined, deaths at home have increased from 15 percent in 1989 to 24 percent in 2012 (AgingStats, 2012).

Death in nursing homes.

In addition to deaths in hospitals and homes, deaths are also likely to occur within the nursing home environment. Of the deaths that occur in skilled nursing facilities, women aged 65 and older are more likely than men to die in a nursing home because they are likely to be residents (AgingStats, 2012). The most common causes of death among nursing home residents are chronic heart failure, renal failure, pulmonary diseases, lower respiratory infections and Alzheimer’s disease (Goldberg & Botero, 2008; Szafara Kruse, Mehr, Ribbe & Van der Steen, 2012). Mortality risk increases after six months of being admitted into the nursing home (Porock, Parker-Oliver, Petroski, & Rantz, 2010). Dehydration, shortness of breath, poor nutrition and
loss of weight contributes to increased mortality risk of resident admissions after 3 to 6 months (Porock et al., 2010; Szafara et al., 2012). Dying residents may experience mild to severe pain, shortness of breath, dyspnea, and trouble keeping their body clean (Hanson, Eckert, Dobbs, Williams, Caprio, Sloane & Zimmerman, 2008).

In the United States, the number of resident death is projected to increase by 40% by the year 2020. (Temkin-Greener, Zheng, Xing & Mukamel, 2013). The majority of nursing homes serve between twenty-six to one hundred residents daily (Harris-Kojetin, Sengupta, Park-Lee & Valverde, 2013). These nursing homes help serve these residents’ care needs by employing direct care staff.

**Direct care staff**

For the purpose of this paper, direct care staff includes certified nursing assistants (CNAs), state tested nursing assistants (STNAs) and registered nurses (RNs) who work in nursing homes. Direct care staff assist in the resident’s activities of daily living (ADL’s). RNs diagnose and plan the resident’s overall care plan in the nursing home (Medicare.gov, 2015). CNAs and STNAs usually assist with tasks such as eating, grooming, hygiene, dressing, transferring, and toileting (Medicare.gov, 2015). When examining the time allocated to care for residents of a skilled nursing facility, RNs have fifty minutes of care per resident while CNAs and STNAs have two hours and twenty-eight minutes set aside for caring for each resident. Given this allocation, the national average of licensed staff hours of caring per resident per staff is one hour and forty minutes. While certain states have certain staffing requirements, requirements for staffing include the presence of a RN for at least eight hours per day, seven days a week within the facility. The presence of CNAs and STNAs is expected 24 hours a day, seven days a week providing care to residents (Medicare.gov, 2015). During this time that the
direct care staff spends with a resident, he or she may develop ongoing and meaningful relationships.

**Relationships developed between staff and residents**

Direct care staff form relationships with the nursing home residents. Staff develop an emotional closeness to new residents as well as continuing a relationship with current residents that they provide care for (Marcella & Kelley, 2015). After a resident dies, direct care staff emotionally detach from the resident (Moss, Moss, Rubinstein & Black, 2003; Wilson & Daley, 1998; Marcella et al., 2015). Some staff may desensitize themselves to the aspect of death. Caring for the resident continues after the resident has died (Wilson et al., 1998). CNA’s often want to prepare the body after death. Cleansing the body is a ritual that demonstrates respect for the person (Wilson et al., 1998).

Staff have also been found to distract themselves from viewing the stressful situation of when a nursing home resident dies (Rai, 2010). Detaching from the resident and dealing with the death is difficult (Ahmad, 2015). Dealing with a loss can be painful as close relationships were developed and now broken (Ahmad, 2015). Direct care staff is expected to keep their emotions from interfering with their medical judgment of providing quality care to residents (Ahmad, 2015). Death may increase stress among care staff.

**Impact of stress**

Direct care staff, depending on their level of in the job-position hierarchy and education received, continue to do work when residents are dying around them. This work-related stress causes emotional exhaustion, which is a state of affective and physical exhaustion or drained energy (Rai, 2010). Emotional exhaustion can be found to increase over time when working with
residents who are becoming frail and who are dying (Rai, 2010). This is not the same level that direct care staff exhibit when they first start to care for the residents after a death (Rai, 2010).

Stressful events have a negative impact on staff job satisfaction, their productivity, and staff turnover, which could affect residents’ quality-of-care received (LoCicero, 1997). Turnover among direct care staff is associated with lower job satisfaction, a heavy workload, poor wages, younger age and having less education (McGilton, Boscart, Brown & Bowers, 2014; Tummers, Groeneveld & Lankhaar, 2013). Research has shown poor pay is the top contributor for direct care workers leaving the job, facility or profession altogether (McGilton et al., 2014; Tummers et al., 2013). Direct care staff feel most stressed when they receive little training on how to respond to death and dying in the nursing home (LoCicero, 1997). However, little research has been done on how death impacts direct care staff on the intent to leave the profession; however, death may cause experiences of grief and bereavement.

**Grief in long term care**

Grief is defined as a natural human response to separation or loss, in this case, the loss of a resident (Buglass, 2010). Along with grief, bereavement is the period of experiencing the loss as an upheaval in the individual’s life (Buglass, 2010; Stroebe, 2001). Grief describes an individual’s personal emotional response to loss and has emotional, physical, behavioral, cognitive, social and spiritual dimensions (Buglass, 2010). Individuals may experience depression, anxiety, insomnia, and helplessness (Buglass, 2010). Within grief, individuals may engage in grief work in response to death or loss (Stroebe, 2001). This requires the individual to confront the loss, to review what lead to the death and the events that occurred during the time of the death, to remember the good memories and to disengage themselves from the departed (Stroebe, 2001; Buglass, 2010).
Research has shown that grief experienced by the direct care staff is often intense when the relationship was longer and closer (Wilson et al., 1998). Literature shows that direct care staff struggle with acceptance of a death and often feel emotionally unprepared for a resident death (Marcella et al., 2015). For CNAs especially, the deaths of residents can be similar to the deaths of family members, which can bring a strong grief reaction with each accumulated loss (Anderson, & Gaugler, 2007). Negative interactions with how one grieves could result in poor well-being or in the inadequate quality of care given to other residents (Wilson et al., 1998).

Research question

Little is known about the experience of grief by direct care staff. This systematic review of the literature is designed to examine grief experienced by direct care staff discussed within the literature. The analysis will focus on the impact resident death has on direct care staff.
METHOD

Search strategy

This systematic literature review examined the research question using eight databases. These databases included Academic Search Complete, CINAHL Plus with Full Text, Health Source: Nursing/Academic Edition, MEDLINE, MEDLINE with Full Text, PsycINFO, Social Work Abstracts, SocINDEX with Full Text. The search terms included combinations of nursing home, LTC, death, grief, STNA, staff, and aide. The last twenty years of literature will be included, from year 1995 to the present.

Screening

The screening process included creating inclusion and exclusion criteria to remove any literature that does match the topic and research question addressed. The primary inclusion criteria, based on the research question, was that the empirical study examined staff experiences providing care within long term care facilities and issues of death and dying. Additional inclusion criteria included articles conducted in nursing homes in the US and westernized international countries (e.g. United Kingdom) and studies published in English. Studies were included when conducted in skilled nursing facilities and excluded those in other long term care facilities (e.g. assisted living). When examining the impact of death on staff, articles were included if they examined direct care staff including registered nurses (RNs), state tested nursing aides (STNAs) and certified nursing assistants (CNAs). Articles were also examined for inclusion based on the age of residents (e.g. mean age of 60+).

When examining articles for inclusion, those studies that focus just on the family perspective of a dying resident were excluded; however, articles that include both the family and
direct care staff perspectives were accepted in the screening process. Literature reviews, periodicals, books, newspapers, magazines, and internet sources were all excluded.

The initial search using the search terms and databases identified yielded a total of 809 articles. The introduction of year limits (1995-present) and academic journals only narrowed the results down to 249. Of the 249 articles, 37 studies made the first screening process based on the inclusion criteria. A second review of articles excluded those not consistent with all of the inclusion and exclusion criteria, including articles focusing on hospital workers, death of children, and articles focusing most on the experience of others (e.g. family) to the death of a resident in a skilled nursing facility. The systematic review process yielded a total of 12 articles. The flow of the screening process is presented in Figure 1.
Figure 1: Flowchart of article selection using the systematic review process

Number of articles retrieved from selected databases, N=809

Number of articles screened, N=249

Number of articles excluded, N=560
Year, type of article & removal of duplicate results across databases

Number of articles that met inclusion criteria, N=37

Number of articles that were excluded, N=212
Another language, location at home or hospital, experience not on staff, not on older adults age 60+

Number of articles included, N=12
2 Mixed-Method
1 Quantitative
6 Qualitative
3 Exploratory descriptive

Number of articles that were excluded, N=22
Published in magazine, focused on other non-care staff, focused just on residents, not on impact of resident death
RESULTS

The results of the systematic review found 12 empirical articles addressing the research question. The articles discussing staff reactions to death of residents are provided in Table 1. The two themes are positive and negative death experiences. The sub-themes of positive death experiences are a good death, providing emotional, social, and spiritual support, emotional preparation for anticipated death and “crack the window.” The sub-themes of negative death experiences are a bad death, emotionally unprepared for a death, lack of communication among the care staff, emotional reaction to resident death and the experience of grief.

Positive death experiences

A good death.

A notion of a good death in the dying process is related being surrounded by family members (Ahsberg & Carlsson, 2013). Direct care staff say that many residents had a good death. A good death was peaceful and when the resident experienced limited pain (Ahsberg et al., 2013; Hanson, Henderson, & Menon, 2002; Munn, Dobbs, Meier, Williams, Biola, & Zimmerman, 2008). Direct care staff were happy when the resident died knowing the resident is now at peace and no longer suffering (Oliver, Porock, & Oliver, 2006).

Providing emotional, social and spiritual support.

Non-verbal communication is a way direct care staff provide support to dying residents and how they process death of a resident (Ahsberg et al., 2013; Hanson et al., 2002). Direct care staff, especially CNAs and STNAs use non-verbal communication with residents. Aspects of this communication includes sitting with a resident, holding the resident’s hand, hugging the resident or giving a gentle massage to help ease their dying process (Ahsberg et al., 2013; Hanson et al.,
Some staff help residents who are near death with closure by sharing stories and feelings (Waldrop & Nyquist, 2011). Staff also report placing stuffed animals next to the dying resident and making trips to purchase their favorite food if they can still manage to eat and drink (Waldrop et al., 2011).

Direct care staff use religion to provide support to the dying resident before and after a death. Some direct care staff felt comfortable reciting prayers, singing religious songs or using a rosary with residents (Hanson et al., 2002; Munn et al., 2008; Waldrop et al., 2011).

After a death, emotional and spiritual support is offered by fellow nursing staff. When a CNA learns of a death of a resident he or she used to provide care for, fellow CNAs may offer to help (Munn et al., 2008; Livingston Pitfield, Morris, Manela, Lewis-Holmes & Jacobs, 2012). These CNAs may offer to cover the fellow CNAs residents for an hour while the CNA sits with the deceased resident or may use the time for reflection (Munn et al., 2008). Nursing assistants manage the body by preparing the deceased resident for departure from the nursing home by washing and dressing them in their own clothes (Ahsberg et al., 2013; Osterlind, Hansebo, Andersson, Ternestedt & Hellstrom, 2011). A phone call to the nursing assistant was seen as positive when they were notified that the resident had died (Barooah, Boerner, Riesenbeck & Burack, 2015).

**Emotional preparation for anticipated death.**

Staff who expect a death in their unit have conversations with other staff members, which in turn helps them to be emotionally prepared for the death (Oliver et al., 2006). CNAs and STNAs who were more emotionally prepared for a death experience little grief (Boerner,
Burack, Jopp & Mock, 2015). Staff are more prepared for a death as they learn that death is common in their work environment as they expect it to happen (Oliver et al., 2006).

“Crack the window.”

Within the literature on staff managing death of residents, the ritual referred to as “crack the window” is practiced. This opening of the window is suggested to allow the spirit to be set free (Oliver et al., 2006; Waldrop, & Kirkendall, 2009). The spirit is set to head home, to a nicer place or heaven (Oliver et al., 2006; Waldrop et al., 2009). Two studies mentioned this practice, Waldrop (2009) briefly mentioned it, and Oliver (2006) went into detail on how this practice came to be. In the study done by Oliver (2006), the interviewer asked how these nursing assistants learned about this practice. Many had learned about it through job experience (Oliver et al., 2006). This practice was passed down from one generation of nurses to the next (Oliver et al., 2006). One of the respondents mentioned that one of the other staff possibly didn’t open the window that day to let the resident’s spirit out and for weeks they would hear this beeping every day at the same time even after the resident was gone (Oliver et al., 2006). This practice is one of the important components in the nursing assistant’s role as it is part of the rituals and practices of how staff manage death (Waldrop et al., 2009). Today it is a common practice as many nursing assistants know about it (Oliver et al., 2006).

Negative death experiences

There are four sub-themes that came from the literature on how direct care staff have negative experiences from death of residents. The four sub-themes discussed include a bad death, care staff being emotionally unprepared for a death, staff experiencing emotional reactions to a death, experiences of grief and poor communication among the care staff.
A bad death.

The studies examined in this systematic literature review described situations of a bad death as dying alone without being surrounded by family members. Many direct care staff felt that their residents' had a bad death (Goodridge, Bond Jr, Cameron & McKeane, 2005; Waldrop et al., 2011). Having pain was another indication the resident had a bad death (Ahsberg et al., 2013; Goodridge et al., 2005). In the study by Goodridge (2005) the staff reported that a bad death was when the dying process did not go as smoothly as what they would have liked for the resident (Goodridge et al., 2005). In the study by Waldrop (2011), the staff reported when family members dictate how their loved one receives end-of-life care, it may get in the way of the nursing assistants doing their job (Waldrop et al., 2011). The nursing assistants try giving the individual the best care to alleviate the pain of dying and consequently provide for a good death (Waldrop et al., 2011).

Emotionally unprepared for a death.

In general, the majority of the direct care staff did not feel emotionally prepared for death (Boerner et al., 2015; Osterlind, et al., 2011; Waldrop et al., 2011; Munn et al., 2008; Hanson et al., 2002; Barooah et al., 2015). Direct care staff having little information about the condition of the resident they provided care for leads the care provider to be emotionally unprepared for the death (Boerner et al., 2015). Nursing assistants (CNAs and STNAs) struggle with accepting a death as they have often formed close relationships with the resident and now the relationship is broken (Boerner et al., 2015; Waldrop et al., 2011). Deaths that occurred unexpectedly and deaths that took a long time were most likely to lead to direct care staff feeling emotionally unprepared for a death when it occurs (Waldrop et al., 2011). Other aspects that influence how direct care staff are emotionally unprepared for a death are by keeping death at a distance and
shifting their focus onto tasks and avoid having discussions about a deceased resident as they do not wish to reflect on it (Osterlind, et al., 2011).

Lack of communication.

Poor communication leads direct care staff to have a negative experience after a death of a resident (Goodridge et al., 2005; Oliver et al., 2006). Provision of care for dying residents is often discussed and argued between RNs and CNAs. Confusion and resistance occur between these two care positions when they discuss what type of care the dying resident actually needs (Oliver et al., 2006). After a decision was made the nursing staff felt poor communication made the dying process not go as smoothly as it should have, implying not a good death (Goodridge et al., 2005). Staff feel uncertainty about the awareness of the death with regard to how to announce (Osterlind, et al., 2011). Many do not know how to deal with death in the nursing home in terms of what is appropriate in the setting (Osterlind, et al., 2011).

Emotional reaction to resident death.

After a death, direct care staff experience many negative emotions and feelings (Osterlind, et al., 2011; Waldrop et al., 2011). Workers experience sadness, such as crying, especially when residents die without any family or social support around them (e.g. a bad death) (Waldrop et al., 2011). Research demonstrates that after a death, direct care staff developed distress that remained with them as they continued to work (Waldrop et al., 2011). The type of distress experiences include nightmares and unpleasant images of deceased residents (Waldrop et al., 2011). Death of residents is emotionally exhausting to the staff as deaths drains the worker’s energy (Osterlind, et al., 2011). Staff reported that they felt they had to contain their emotions in
order for them to continue to care for other residents (Osterlind, et al., 2011). A feeling of emptiness was reported by direct care staff after a death (Osterlind, et al., 2011).

Many nursing assistants often feel powerless and a sense of helplessness when they cannot ease the resident’s pain or ease their fear of death (Ahsberg et al., 2013; Goodridge et al., 2005). Nurses and CNAs had feelings of hopelessness because they could only do so much to provide care for the resident (Hanson et al., 2002).

Many of the staff experienced negative reactions when a bed was filled with a new resident, especially (Barooah et al., 2015). For nursing assistants, beds were more often filled before they had found out about the death (Barooah et al., 2015). Notification of a death to most staff was a negative experience. When nursing assistants were informed by an RN about the death of a resident they reaction were less negative (Barooah et al., 2015). However, when they were informed by fellow nursing assistants their reactions were more negative (Barooah et al., 2015). After the death, the next step is the removal of the body. The removal was seen as negative to some of the nursing staff (Barooah et al., 2015). The staff viewed the removal of the body as a lack of respect for both the resident and nursing assistants (Barooah et al., 2015). Staff who could not be there during the time of death perceived the removal as negative because they were not the ones that were involved in the after-care of the deceased resident. Other aides who were involved in the aftercare did not view the removal of the body as a negative experience (Barooah et al., 2015).

All RNs and nursing assistants have difficulty watching the resident die. It is viewed as difficult as most of the residents have a prolonged or a bad death (Goodridge et al., 2005). It is hard for the staff to handle a death, while trying to be a social support for other residents and the deceased family members (Goodridge et al., 2005; Livingston et al., 2012). Direct care staff over
the years developed close relationship with residents’, this is why the death of a resident is
difficult to discuss with others after the fact (Hanson et al., 2002; Livingston et al., 2012).

Grief.

The grief experienced by direct care staff may be very similar to that which is typically
experienced by family members and friends of the deceased. At least 70% of direct care staff
experience grief symptoms such as crying, missing the deceased and not wanting to recall
memories as they are too painful (Boerner et al., 2015; Munn et al., 2008). RNS, CNAs and
STNAs often form caring relationships with residents, thus after a death grief is evident (Hanson
et al., 2002). When one fails to address their experience of grief it may multiply leading to
complications of grief (Osterlind, et al., 2011). Such complications, lead to what is known as
complicated grief. Complicated grief is experienced when there are higher levels of
depersonalization (Anderson, 2008). Within the majority of these studies, ethnicity was found to
moderate the experience of grief. Caucasian nursing assistants experience grief, whereas nursing
assistants with minority backgrounds often have lower levels of grief (Anderson, 2008; Hanson
et al., 2002; Boerner et al., 2015). It is suggested that minority nursing assistants have skills
which allow them to cope better with grief (Anderson, 2008). This allows them to continue to
remain close with residents even though there are repeated losses (Anderson, 2008). Nursing
assistants reported that there was not enough time to grieve (Livingston et al., 2012).
<table>
<thead>
<tr>
<th>AUTHORS</th>
<th>PURPOSE</th>
<th>SAMPLE</th>
<th>METHOD</th>
<th>KEY FINDINGS</th>
</tr>
</thead>
</table>
| Ahsberg, E. & Carlsson, M.     | To examine the experiences of nursing assistants in palliative care.   | Convenience sample of 7 nursing assistants (6 women, 1 man)          | Focus group met for three 2 ½ hour sessions | Nursing assistants  
• Use non-verbal communication with residents (sit, hold hand, gentle massage)  
• Deal with the dead body by preparing them for death  
• Feel powerless when they cannot ease the residents pain or their fear of death  
• Notion of a good death  
• Gratitude from dying residents to staff for the success of personal care they received |
| Anderson, K. (2008)            | To explore negative and positive outcomes certified nursing assistants (CNAs) experience after resident deaths in nursing homes in relation to burnout and turnover. | Convenience sample of 136 CNAs who worked in 12 nursing homes | Self-administered surveys were distributed | CNAs  
• Experience complicated grief reported higher levels of depersonalization  
• With minority backgrounds may have better coping skills while facing grief  
• Reported having higher levels of personal accomplishment when they experience more growth from their grief  
• Job satisfaction strongly correlated with turnover; grief was not correlated with turnover |
| Barooah, A., Boerner, K., Riesenbeck, I., & Burack, O. (2015) | The purpose of this study was to understand how CNAs experience nursing home practices and transitions following the death of residents. | 143 CNAs (women) who were actively employed at three large nursing homes in Greater New York | Interviews took place following the death of a resident (2 months) | CNAs  
• Experience of filling the bed of a new resident had negative reactions  
• Negative experience with the removal of the resident’s  
• Notification of a death of being told by nurse was positive, and being told by a fellow CNA was negative |
<table>
<thead>
<tr>
<th>AUTHORS</th>
<th>PURPOSE</th>
<th>SAMPLE</th>
<th>METHOD</th>
<th>KEY FINDINGS</th>
</tr>
</thead>
</table>
| Boerner, K., Burack, O.R., Jopp, D.S., & Mock, S. E. (2015) | To determine how grief symptoms are experienced by direct care staff, how prepared the staff were of resident death, and examining the relationship that is formed and how it may be related to staff experiencing grief after resident death. | 143 CNAs and 90 HHAs all from 3 large nursing homes in Greater New York | Interviews were conducted (following 2 months after a death). These 2 groups were compared to the findings from the REACH study of family caregivers. | CNAs  
• More than one-third (70%) experienced grief symptoms that are typically reported by family caregivers  
• Feeling not prepared for the death of a resident  
• Struggled with acceptance of death  
• If emotionally prepared for the death reported lower levels of grief (8%). |
| Goodridge, D., Bond Jr, J., Cameron, C., & McKean, E. (2005) | To examine resident death in nursing homes experienced by nurses, nursing assistants and family members in hope to find commonalities in their experiences. | 26 staff (14 RNs and 8 nursing assistants) and 4 family members | Semi-structured open-ended interviews | Staff  
• Information and coordination of care is lacking, family and nursing staff felt the dying process was not going as smoothly  
• Love frequently used by staff  
• Staff supporting the family at the end of the resident’s life also provided a great deal of satisfaction  
• All staff had difficulty watching prolong death of the. Felt a sense of helplessness in trying to ease their pain. |
| Hanson, L. C., Henderson, M., & Menon, M. (2002) | To examine and understand the characteristics of death and what the staff perceive | 77 participants total (4 groups of RNs, 4 groups of nursing) | 11 focus groups. Each discussion session lasted 90 minutes. | Nurses and CNAs  
• Many residents had a good death  
• Feelings of hopelessness but had pride in their ability to give good care |
<table>
<thead>
<tr>
<th>AUTHORS</th>
<th>PURPOSE</th>
<th>SAMPLE</th>
<th>METHOD</th>
<th>KEY FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Munn, J.C., Dobbs, D., Meier, A., Williams, C.S., Biola, H., &amp; Zimmerman, S. (2008)</td>
<td>To examine what defines a good death in Long Term Care settings through residents, family, non-licensed staff, and licensed staff.</td>
<td>65 participants (11 residents, 19 family members of decedents, 20 paraprofessional staff, 15 licensed staff)</td>
<td>10 focus groups</td>
<td></td>
</tr>
</tbody>
</table>

- Know residents for many years prior to death and formed meaningful relationships
- Nursing home staff valued personalized and individualized nursing care
- Some felt comfortable offering prayer or religious songs to the dying resident
- Became friends to residents without family or friends outside the nursing home
- Formed caring relationships that after a death caused them to grieve

- Strong relationships with residents
- Difficult when residents talked about their own death
- Uncomfortable talking about death to family members
- Support from their co-workers helped them deal with how they felt after a death
- Felt there was not enough time to grieve

- After a death, removed the body by closing doors and removing residents from hallways
- Half reported this represented dignity and respect for the decedent, half of the staff reported this was unnecessary
- Reported relationships with residents as family-like
- Reported they experienced family-like grief and bereavement after a death
- Provided dying residents with emotional and spiritual support
- Nursing assistants provided emotional and spiritual support to one another after a death
<table>
<thead>
<tr>
<th>AUTHORS</th>
<th>PURPOSE</th>
<th>SAMPLE</th>
<th>METHOD</th>
<th>KEY FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oliver, D.P., Porock, D. &amp; Oliver, D.B. (2006)</td>
<td>To discuss the issues surrounding death and to examine the nursing home staff experiences of how they manage end of life care in a dying environment.</td>
<td>Participants (5 RNs, 4 LPNs, 5 CNAs, and 2 SSDs) from 2 nursing homes</td>
<td>Study was based on a secondary analysis and interviewed. Interviews lasted 60-90 minutes.</td>
<td>Staff • Death is common and learn how to deal with death of residents • Conversations about an expected death with other staff members • Confusion and resistance in figuring out what type of care the dying resident actually needs • Practice opening the windows for the person’s spirit to be set free (e.g. “crack the window”) • Positive feelings and emotions were experienced by the staff as they felt happy that the resident is now at peace</td>
</tr>
<tr>
<td>Osterlind, J., Hansebor G., Andersson, J., Ternestedt, B., &amp; Hellstrom, I. (2011)</td>
<td>To explore the discourse of death and dying in the nursing home experienced by the nursing staff.</td>
<td>RNs and nursing assistants, a total of 28 staff (19 women, 9 men)</td>
<td>This study used a discourse analysis with focus groups. 5 focus groups. Each group had 3 to 9 staff members and lasted 45 to 60 minutes.</td>
<td>Staff • Keep death at a distance by concentrating on tasks and routines • Afraid of death, while some are no longer afraid because they have been around deaths in nursing homes longer • Avoiding talking about • Death of residents is emotional and exhausting • Experience being sad and experience grief • Sorrow and grief multiplied when some fail to address it • Experience a feeling of emptiness after the death of a resident • How to announce and deal with the death in the nursing home • Treat deceased resident as a live human being • Rituals need to be considered when announcing a death and saying goodbye</td>
</tr>
<tr>
<td>AUTHORS</td>
<td>PURPOSE</td>
<td>SAMPLE</td>
<td>METHOD</td>
<td>KEY FINDINGS</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Waldrop, D.P., & Kirkendall, A.M. (2009) | To explore how nursing home staff recognize that a resident is dying and to provide descriptive typology of comfort measures as end of life care within one nursing home. | 42 nursing home staff (10 administrators, 15 nurses, 9 nurse aides, 4 social workers, and 4 housekeepers) | Structured interviews were conducted in a nonprofit nursing home, lasting 30 minutes. | Staff  
- Time spent with the dying resident to decrease their fear of dying alone  
- Keeping a vigil was importance for staff and residents to say goodbye to the resident  
- Practice “Crack the window” to allow the spirits out to go home |
| Waldrop, D.P., & Nyquist, K. (2011) | To examine the nursing home staff perspective on how they manage the transition of routine care to end of life care for those individuals in the nursing home setting. | 35 participants composed of 21 nurses, 9 CNA’s, 5 social workers | 35 in-depth interviews, each lasting 30 minutes were conducted from a 122 bed nursing home facility. | Staff  
- Making sure the residents do not die alone  
- Deaths that occurred suddenly and deaths that took a long time had a negative impact on their feelings of coping with a death  
- Challenge in the transition from routine to end-of-life care as they lose a close relationship with the resident  
- Distress (nightmares & unpleasant images) remained with them after death of a resident  
- Feelings of sadness (residents die without family and social support)  
- Supported comfortable deaths- being present with residents who were nearing death and helping them with closure; placing stuffed animals on the bed; purchasing their favorite food and using religious rituals (e.g. a rosary, prayer) |
DISCUSSION

The purpose of this systematic review was to examine the impact of resident death and what evidence the staff experienced grief. The literature had to be screened with the focus on direct care staff experiencing death in a nursing home.

Direct care staff reported both positive and negative death experiences in the nursing home environment. A good death was when the resident died surrounded by family members and had no pain in the dying process (Ahsberg et al., 2013; Hanson et al., 2002; Munn, et al., 2008; Oliver et al., 2006). For residents to have a good death, staff provide non-verbal communication and spiritual support (Ahsberg et al., 2013; Hanson et al., 2002; Munn et al., 2008; Waldrop et al., 2011). Along with a good death, direct care staff, usually nursing assistants “crack the window”, opening the window to let the spirits be free as they head to a nicer place (Oliver et al., 2006; Waldrop et al., 2009). This practice is passed down from one generation to the next and is a very important component in the nursing assistant’s role in how they manage death in the nursing home (Oliver et al., 2006; Waldrop et al., 2009).

Many staff believe that the majority of their residents had a bad death, dying with pain and dying alone (Ahsberg et al., 2013; Goodridge et al., 2005; Osterlind, et al., 2011; Waldrop et al., 2011). Many direct care staff, this includes both RNs and nursing assistants feel helpless and hopeless when they cannot do anymore to ease the resident’s pain or their fear of death (Ahsberg et al., 2013; Goodridge et al., 2005; Hanson et al., 2002; Osterlind, et al., 2011). Many nursing assistants struggle with a death when they have close relationships with the resident and received little information about the current condition the resident is in; making the death of that resident harder to accept (Boerner et al., 2015; Waldrop et al., 2011; Livingston et al., 2012). This finding doesn’t support research suggesting staff making an easy transition from detaching from the
relationship that was formed and now broken (Moss et al 2003; Wilson et al., 1998; Marcella et al., 2015). Negative emotions and feelings are typically displayed among direct care staff after a death of a resident (Osterlind, et al., 2011; Waldrop et al., 2011). One issue is distress stays with the care workers as they try to continue to provide care for other residents. The common types of distress displayed were when the nursing assistant has reoccurring nightmares or unpleasant images of the deceased (Waldrop et al., 2011). Another issue is the emotional exhaustion exhibited by staff on the impact of the dying and deceased residents. This was consistent with the review of the literature finding on staff experiencing emotional exhaustion after a death (Rai, 2010). The entire dying process drains the nursing assistants by the time a death occurs, they typically will not have the same level of energy as they did before (Osterlind, et al., 2011). Therefore both of these issues imply the quality-of-care given may be of lesser quality to other residents as the death of the resident may affect how other residents receive ongoing care (Osterlind, et al., 2011).

Lack of communication between RNs and nursing assistants occur about the best care for the dying resident (Goodridge et al., 2005; Oliver et al., 2006). Confusion and resistance do occur, making the assumption that the resident did not have a good death, that the care was not coordinated to what they thought was the best standard of care (Goodridge et al., 2005; Oliver et al., 2006). Direct care staff mostly among nursing assistants felt uncertainty in how death is announced and how death is dealt with in the nursing home environment (Osterlind, et al., 2011). This implies that many were unsure of what is appropriate to say or do after a death (Osterlind, et al., 2011).

Grief experienced by direct care staff relates to not preventing a bad death. Nursing assistants who formed close relationships with the residents and sought to them to be like family,
experience grief (Boerner et al., 2015; Hanson et al., 2002; Munn et al., 2008). These nursing assistants experience grief such as crying, missing the deceased and not wanting to talk about the resident as the memories are too painful to recall (Boerner et al., 2015; Hanson et al., 2002; Munn et al., 2008). Complicated grief is seen in staff when they fail to let themselves experience grief (Anderson, 2008; Osterlind, et al., 2011). From these major issues, implications came up as a result to prevent a bad death for residents and to assist staff after a death of a resident.

**Implications.**

The results of this systematic literature review suggest several avenues of improving policy and practicing around death of residents. These implications were on developing better coping skills, a need for nursing homes to expand their practices and rituals for bereavement support and to expand education for the direct care staff. From the findings we know direct care staff need to develop better coping skills in facing death. The Dual Process Model (DPM) has been seen as the best practice model used for coping after a loss. The Dual Process Model has two types of coping practices which are loss-orientation and restoration-orientation (Stroebe & Schut, 2001). Loss-orientation refers to the bereaved individuals’ way of processing and experiencing the loss (Stroebe et al., 2001). Restoration-orientation refers to the coping mechanisms aimed at returned back to normal after a loss (Stroebe et al., 2001). The DPM is great for direct care staff to use as it helps with distress and other sources of stress that were experienced after a death (Stroebe et al., 2001). Direct care staff experience both positive and negative aspects of death in the nursing home. The DPM can go hand in hand with these experiences as positive and negative coping is exhibited in the model (Stroebe et al., 2001). Direct care staff did avoid death, this model can help them manage their emotions after resident
death because the model goes back and forth in confrontation and avoidance that is necessary for adaptive coping (Stroebe et al., 2001).

There needs to be an increased opportunity to engage in rituals and practices for bereavement support for direct care staff in nursing homes. Rituals can help remind them that it is normal to die in old age and that a death of a resident in the nursing home environment is a loss for all (Bern-Klug, 2011). The nursing home should be able to provide informal support and counseling to CNAs and other direct care staff as grief experiences arise (Anderson, 2008). One way is providing support groups for the direct care staff. This was seen in a study, a support group for nursing assistants (Burack & Chichin, 2001). This study was conducted to provide support group sessions (five weekly sessions for one hour) to two nursing homes (Burack et al., 2001). CNAs were encouraged to talk about their work experiences, to complete a short questionnaire after each support group session, and at the end to evaluate the support group program (Burack et al., 2001). Overall, CNAs felt positive about their experience in this support program as they valued the chance to listen to other CNAs thoughts and feelings about working with dying residents (Burack et al., 2001).

Another way of providing support to direct care staff is to involve enfranchising grief through rituals. Enfranchising grief acknowledges the direct care staff’s close relationship with the residents and their losses (Anderson, 2008). The top ritual that has demonstrated the most therapeutic effects on the bereaved is funeral rituals. The nursing home may offer the staff the opportunity to remember and reflect on residents who have died (Anderson, 2008). One problem with this is not all direct care staff have an opportunity to attend the services outside the facility (Anderson, 2008). Another nursing home ritual is to provide a moment of silence when a resident dies, or to announce the name over the speakers for a moment of silence in the nursing
home (Bonifazi, 1998; Bern-Klug, 2011). After a death, the staff can drape a white cloth over the body as other staff and residents line up in the hallway as the deceased resident departs from the nursing home (Bern-Klug, 2011). Creating a memory book of the deceased residents can help staff reflect on the resident. A picture of the resident is in the book and a page is blank for the staff to write good memories about the resident as this is a way for the staff to say goodbye. Nursing homes need to have a culture of recognizing the deaths of residents. This recognition will help staff and residents come to terms with a death. Developing rituals based on different cultures will also help. Each person may react differently to these rituals; some may find them more appropriate than others. The overall hope is to make the residents experience in the nursing home satisfying. When the residents are happy this spillover into the staff and family members (Bern-Klug, 2011).

Education needs to be expanded for direct care staff. Education and training need to be offered on how to take care of dying residents, what to expect and how to respond to death in the nursing home environment. One educational program has been developed for both RNs and CNAs. The End-of-Life Nursing Education Consortium has developed training courses for direct care staff that focuses attention on grief, loss, and bereavement issues (Kelly et al., 2010). This additional training may allow RNs who take educational programs like this to take on leadership and mentoring roles by training their LPNs, CNAs and STNAs in their nursing home (Kelly et al., 2010).

Training programs specifically designed for CNAs, such as the Good Endings program, have also demonstrated success (Gross, 2000). The program was developed because there was a lack of education training in nursing homes about death, dying, grief and bereavement. This program was designed to provide comfort care for the dying resident as well as training direct
care staff. Bereavement support, educational workshops and spiritual enrichment are workshops that are highly recommended for direct care staff. When staff do not have the support they need, issues of burnout, grief and depression can arise after a death of a resident. The staff has to provide the family with support as well as making sure they are taking care of themselves. The Good Endings program was implemented at the SunBridge nursing home in East Longmeadow, Massachusetts. The main component of the program includes a volunteer vigil team comprised of volunteers, direct care staff and in some instances a family member (Gross, 2000). The program includes an in-service training video, three music CDs and three books of death, dying, grief and bereavement (Gross, 2004). Courses were on the dying process, what to expect and how to best communicate to the dying resident and to family members. Another component of this program is the team to facilitate support groups for the staff so they can share their feelings after a death of a resident. This is a good benefit for the staff to address their grief instead of pushing their emotions to the side. A benefit from this program is the knowledge that direct care staff will have gained on how to handle death in their work environment. They will know the stages of dying, issues of bereavement with family members and how to best care for themselves while they still provide care to other residents. This program overall has increased the admissions of the SunBridge nursing home and has made it more marketable than other nursing homes in the Massachusetts area. In addition, a step by step guide was developed in how to implement this program in nursing homes. There are nursing home facilities today that apply the Good Endings program (Gross, 2004).

Another way staff could increase their training is by RNs leading in-service trainings, utilizing training videos and bereavement training by social workers or Chaplains (Anderson, 2008). Various training interventions that can be used with Chaplains include prayer and
listening and knowing when it is appropriate to use. Most CNAs in the literature were unsure if and when it would be appropriate to use (Anderson, 2008).

There were several limitations in this systematic literature review. First, most of the literature was found in the United Kingdom and very little was done in the United States. It would have been nice to have some specific information pertaining to United States nursing homes experiences of resident death. Second, while most literature discussed both positive and negative implications of resident death, few had a focus on grief experienced by care staff. Last, most literature used a combination of participants in the sample (residents, family and staff), rather than just a specific focus on the direct care staff.

Conclusion.

Direct care staff and administrators need to promote the discussion of death in nursing homes. It should not be avoided. Administrators need to be aware of the negative experiences direct care staff face. Certain rituals and practices are available and could help nursing home staff deal with a resident’s death. Providing ongoing education and training to direct care staff on death, dying, and what to expect can help staff avoid some of the negative experiences of resident death. Further research needs to be done on grief experiences of direct care staff. This research could identify better means of helping one cope with death in the nursing home. Death should not be silenced in nursing homes.
REFERENCES

http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2012_Documents/docs/SpecialFeature.pdf


of licensed nursing staff. *International Journal of Nursing Studies, 51*(6), 917.
doi:10.1016/j.ijnurstu.2013.10.015

http://www.medicare.gov/NursingHomeCompare/About/Staffing-Info.html

doi:10.1093/geronb/58.5.S290


doi:10.2190/3P8G-5JAD-J2NF-BKGK


