Creating Constructive Staff-Family Relationships in the care of older adults in the residential aged care setting

A CLINICAL GUIDELINE FOR HEALTH PROFESSIONALS

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Message from the Director of ACEBAC

ACEBAC has as its main aim the improvement of care provided to older people. As this guideline shows the evidence demonstrates that the residents'/clients' experience of care is enhanced when staff and family have positive relationships. We hope this guideline assists staff and families to develop constructive and positive ways of working together.

Professor Rhonda Nay
Director
ACEBAC

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Purpose and scope of this guideline

This guideline has been developed to assist health professionals and families of residents/clients in developing and maintaining constructive relationships in the residential aged care and subacute settings.

How to use this guideline

This guideline is intended to be a guide to practice and although based on the best available research evidence, it is essential that resident/client choice and clinical judgement inform application of the guideline. For implementation to succeed it is important that the guideline be contextualised to meet the needs of the individual facility.

The guideline includes a clinical audit tool which will enable facilities to examine their practice and compare outcomes either with quality standards, clinical guidelines or best practice evidence. Completion of the clinical audit tool can identify practice gaps and support the development of improvement action plans as well as determining where current practice is in line with guideline recommendations.

As with any guideline there is a need to ensure it is current and based on contemporary evidence. We welcome any feedback you wish to provide on your experience of implementation that we can use for future editions.

We have included brief information to support the recommendations as we recognise not all users will want to read lengthy documents, however, for those interested in more details we recommend the full systematic review.

Summary of recommendations

Recommendations	Level of evidence
Interventions designed to promote constructive staff-family relationships, and promote collaborative relationships between families and health professionals, should address communication, information, education and administration support	JBI Level E3
Incorporate staff and family education designed to promote constructive staff-family relationships	JBI Level M2
Develop policy and procedures to enable and support family involvement in decision making and care planning.	JBI Level E3
Establish formal and informal communication channels for both staff and families	JBI Level E3
Establish environments that support staff in developing and maintaining constructive relationships with families	JBI Level M2

Background context

Modern health care philosophy espouses the virtues of holistic care and acknowledges that family involvement is appropriate and something to be encouraged due to the role it plays in physical and emotional wellbeing. Such an approach to care, which attempts to understand the patient in a broader construct than just the individual, is receiving increasing emphasis throughout the entire health care system (Logue, 2003). Studies of family carers in the institutional setting have identified a broad range of care roles ranging from the provision of affective support (Bowers, 1988; Kellett, 1999) to the assistance with physical care (Laitinen, 1994). For older adults in the health care environment to benefit from the involvement of their family members, health care professionals need an understanding of their relationships with families, the issues surrounding family presence in the health care environment and the strategies to best support it.

Families are known to be in need of varying degrees of support, both as carers in the community (Australian Bureau of Statistics, 1993; Winbush, 1993), and after the older person has made the transition to hospital (Li, Stewart, Imle, Archbold, & Felver, 2000) or long-term care (Campbell, 1996; Dellasega & Nolan, 1997; U. M. Kellett, 1999; M. Maas, Swanson, Buckwalter, Weiler, & Specht, 1998). Care staff are often among the first to identify who the family caregivers are and how they are coping. In practice, nurses and other health care professionals assess a family's needs and intervene to support both the family and the client (Farran, 2001). In the residential aged care sector, the involvement of families has been acknowledged as one of the best guarantees of a resident's wellbeing (LaBrake, 1996). The integration of the family into the residential aged care environment has furthermore been enshrined in the Australian Commonwealth Charter of Residents' Rights & Responsibilities and the Aged Care Standards of Practice. Li et al. (2000) suggested that there needs to be a greater emphasis on family caregivers as partners within the hospital health care system.

Although health ideology encourages the formation of "partnerships" with family caregivers, it is apparent from the literature examining staff-family relationships, that the experience for the family continues to be fraught with problems and that family involvement is often marked by tension.

Recommendations with implementation strategies

1. **Interventions designed to promote constructive staff-family relationships, and promote collaborative relationships between families and health professionals, should address communication, information, education and administration support (JBI Level E3)**

Discussion of evidence

The literature has identified four essential elements in the promotion of constructive and collaborative staff-family relationships when caring for older adults in the institutional setting (Haesler , Bauer & Nay , 2006; Haesler, Bauer, & Nay, 2007).

Communication skills are one of the most important staff characteristics to promote and maintain relationships with families. Families are of the view that communication is a two way process and that both staff and family should share knowledge of the patient/resident with each other (Bowers, 1988; Duncan & Morgan, 1994; Nay, 1996). A number of studies have highlighted the poor communication shown by staff and family alike (Hertzberg & Ekman, 2000; Hertzberg, Ekman, & Axelsson, 2001; Shuttlesworth, Rubin, & Duggy, 1982; Ward-Griffin, Bol, Hay, & Dashnay, 2003).

The exchange of information between staff and family is equally important. Family members expect opportunities to share information about the patient/resident with staff (Duncan & Morgan, 1994; Gladstone & Wexler, 2001; Hertzberg & Ekman, 2000; Hertzberg & Ekman, 1996; Higgins, 1999; Marquis, Freeguard, & Hoogland, 2004; Nolan & Dellasega, 1999; Ryan & Scullion, 2000). Family also expect care staff to provide them with information. Establishing strategies to increase the exchange of information, specifically that which meets the individual's needs, is required to support the process of collaboration.
Establishing strategies to promote constructive staff-family relationships through education is required to support the process of collaboration (Russell & Foreman, 2000). A variety of educational interventions designed to increase collaboration between staff and families have been reported in the literature (Maas et al., 2004; Pillemer, Hegeman, Albright, & Henderson, 1998; Pillemer et al., 2003; Specht et al., 2000). Staff and family education on relationship development, power and control issues, communication skills and negotiating techniques is essential for the promotion of constructive staff-family relationships.
The support of management is also important if interventions aimed at promoting staff-family relationships are to succeed. A number of studies have suggested that although administrative staff express a theoretical support for educational strategies and collaborative approaches to care, in practice barriers are created, or existing barriers not addressed (Gladstone & Wexler, 2001; Laasko & Routasalo, 2001; Pillemer et al., 1998; Pillemer et al., 2003).

2. **Incorporate staff and family education designed to promote constructive staff-family relationships (JBI Level M2)**

Discussion of evidence

Effective communication and the provision of information is the foundation for a collaborative relationship between staff and family members and the literature strongly supports the importance of education for family members as well as facility staff (Maas et al., 2004; Pillemer et al., 1998; Pillemer et al., 2003; Specht et al., 2000). Hertzberg and Ekman (2000) have noted that family and staff members often have poor communication and understanding of each other's needs, goals and role.

A number of studies have included interventions on educational components including training in relationship issues and communication skills (Maas et al., 2004; Specht et al., 2000), however there has not been a strong focus in research studies on providing staff with a basic understanding of power, control and effective communication. Education on these issues are required if power inequalities are to be eradicated and truly collaborative approaches to care embraced. It is evident throughout the research that staff remain overly concerned with task completion and maintaining control over the environment. In most of the research focused on staff-family relationships, staff rely on traditional medical models of care

in their clinical practice, rather than fully collaborating with families (Anderson, Hobson, Steiner, & Rodel, 1992; Bauer, 2003; Bowers, 1988; Duncan & Morgan, 1994; Gladstone & Wexler, 2001; Hertzberg & Ekman, 2000; Nolan & Dellasega, 1999; Russell & Foreman, 2000, 2002; Ward-Griffin et al., 2003).

Expert opinion informed by general research in the field suggests that educational strategies need to focus on staff education with a particular emphasis on reflection and self knowledge (Hertzberg et al., 2001; Pirjo, 1996; Ward-Griffin et al., 2003); relationship development and conflict resolution (Bauer, 2003; Hertzberg et al., 2001; Pirjo, 1996; Ward-Griffin et al., 2003), the training of nurse managers in leadership skills (Bauer, 2003) and on power in relationships (Ward-Griffin et al., 2003).

Implementation strategies

- Incorporate staff and family education on relationship development and conflict resolution
- Incorporate staff and family education on power and control issues in relationships
- Incorporate staff and family education on communication skills and negotiating techniques

Suggestions and experience from practice

- Incorporate senior staff education on leadership skills
- Incorporate staff education on self knowledge
- Informal education between staff and families can be enjoyable and satisfying to staff and an opportunity for families, particularly those in the primary carer role to develop new skills (e.g. learning to measure blood sugar levels) or revisit and discuss any changes in familiar routines e.g. continence management or medication management.
- Encouraging people in primary carer roles to undertake some care tasks under staff supervision can also be of benefit to both staff and families. Staff may perceive resident preferences more quickly and carers have opportunities to discuss things that may concern them. This may also offer the opportunity for staff to offer some suggestions to the carer about a better way of doing things, particularly in areas where the evidence base may have changed.
- Informal education is a great way to build rapport with families and provides both staff and families with an opportunity to better understand each other's roles. This will encourage and facilitate true partnerships in care to develop.

3. Develop policy and procedures to enable and support family involvement in decision making (JBI Level E3)

Discussion of evidence

Studies that have investigated perceptions of family members relationships with staff have shown a strong focus was placed on opportunities for the family to be involved in the patient's care (Duncan & Morgan, 1994; Gilmour, 2002; Russell & Foreman, 2000, 2002). Not only did family members want to perform emotional care and other "visitor" roles that have traditionally been assigned to family members, but there was an expectation that opportunity would be provided by staff to be involved in care planning and hands-on care (Duncan & Morgan, 1994; Gilmour, 2002; Nolan & Dellasega, 1999; Russell & Foreman, 2000, 2002). It is clear that that many families want more information on procedures and a better understanding of the lines of authority as well as facility policies (Russell & Foreman, 2002).

The research literature suggests that family members believe their involvement in the facility and with the staff would be more constructive if they received facility support in their role. Organisational support is therefore critical to the successful implementation of interventions designed to increase collaboration between staff and family. Family and staff members believe organisational polices and procedures influence the development of collaborative relationships (Bowers, 1988; Russell & Foreman, 2000, 2002; Ward-Griffin et al., 2003). Anderson et al (Anderson et al., 1992) found that a family meeting intervention increased the number of collaborative meetings between families and staff and the number of family visits to the facility. To be successful, strategies designed to promote staff-family collaboration need to identify and incorporate the goals and expectations of both groups (Griffith, Brosnan, Lacey, & Keeling, 2004). Without foundational support from the administration of facilities, interventions designed

to promote constructive staff-family relationships are unlikely to show any sustained benefits (Bauer, 2003; Griffith et al., 2004; Hertzberg et al., 2001; Laasko & Routasalo, 2001; Pillemer et al., 1998; Pillemer et al., 2003; Pirjo, 1996; Ward-Griffin et al., 2003).

Implementation strategies

- Develop policies and procedures that support families receiving appropriate information to assist with decision making and involvement in care planning.
- Ensure information provided to families is both understandable and informative of the topic(s) being addressed
- Develop policies that support family involvement in care planning
- Develop policies that support the changing needs of families

Suggestions and experience from practice

- Accept and do not judge families' decision to be involved or not be involved in care. Some families want to continue caring for their family member in partnership with staff while some families are so worn out from caring for client/resident they may need to distant themselves from care needs.
- Families often project feelings of guilt, grief and loss to staff. Staff may identify this in different stages of a client/resident admission and may label some families as "interfering" "demanding" "judgemental" "difficult" because of the way these feelings are displayed when they visit their relative at the ward/facility.
- Families can feel embarrassed by the client/resident if they are "behaving badly" and will often want to justify that this is not a person's "normal way of behaving"

4. Establish formal and informal communication channels for both staff and families (JBI Level E3)

Discussion of evidence

The literature indicates that family members have a desire for communication with staff members and that staff communication skills are an important characteristic to promote a constructive relationship with family members. Families expect staff members to be courteous and tolerant towards patients/residents and provide both emotional and cognitive support (Gladstone & Wexler, 2000; Hertzberg et al., 2001; Pirjo, 1996). Family members expect staff to promote the person's individuality, personal preferences, dignity and values (Bowers, 1988).

The needs of families can vary and change over time. Being able to create a caring, warm environment, free from intimidation and using active listening skills to allow the family to feel heard are essential skills needed by staff members to encourage and support interpersonal relationships (Duncan & Morgan, 1994; Gilmour, 2002; Gladstone & Wexler, 2000; Hertzberg & Ekman, 2000; Kellett, 2000; Marquis et al., 2004; Nolan & Dellasega, 1999; Pirjo, 1996; Russell & Foreman, 2000, 2002; van der Smagt-Duijnstee, Hamers, Abu-Saad, & Zuidhof, 2001).

It is a constant theme throughout the research literature that family members have a strong need for the communication of information, the provision of which they believe to be the responsibility of staff members (Duncan & Morgan, 1994; Gladstone & Wexler, 2001; Hertzberg & Ekman, 2000; Hertzberg & Ekman, 1996; Higgins, 1999; Marquis et al., 2004; Nolan & Dellasega, 1999; Ryan & Scullion, 2000). Specifically, family members think it is important for staff members to approach the family to keep them informed, rather than the family member being responsible for consistently initiating the interactions. The provision of information by the staff is seen to demonstrate the staff member's personal knowledge and care of both the patient/resident and his or her family (Duncan & Morgan, 1994; Hertzberg & Ekman, 2000; Hertzberg & Ekman, 1996; Marquis et al., 2004; Nolan & Dellasega, 1999).

The family members' needs for information most cited in the literature include ageing and disease processes; the patient's/resident's specific health problems and what to expect; the roles and responsibilities of staff and family; technical skills to assist in their own provision of care for their relative; information on the aged care industry (Higgins, 1999; Marquis et al., 2004; Ryan & Scullion,

2000) and a greater orientation to the facility including its policies and procedures (Russell & Foreman, 2000, 2002).

Implementation strategies

- Support the development of characteristics in staff known to be important in communication, such as:
    - communicating openly and honestly,
    - providing information,
    - working in partnerships and
    - promoting the uniqueness of the client/resident

Suggestions and experience from practice

- Make families feel welcome upon first arriving in the organisation to build rapport. This may include:
    - Introducing yourself and other staff members and identifying a central contact person (who may or may not change over time)
    - Orientate families to place and routines such as ward rounds, case conferencing, family meetings, discharge planner
    - Deal with any family expectations/preconceived ideas about client/resident room/treatment issues as soon as possible "the quicker you deal with problems the better the outcome".
    - Recognise and value the families appraisal of the situation
    - Assess and recognise any organisational barriers to collaboration
- Accept that relationships take time to develop.
- Accept that some staff members will develop stronger relationships with some families compared to others.
- Accept that some families do not have strong communication skills and will require more staff effort to build rapport and manage disagreement and conflict
- Accept that relationships can change over time and that maintaining relationships requires time and energy
- Working as a unified team helps to establish trust.
    - Families need to hear consistent messages from different staff members to trust in the information they are receiving.
    - Families become frustrated and less trusting if they are told different things by different staff members.
    - Families find it frustrating if the communication between staff members around previously made appointments and arrangements appears to be lacking. "Don't they talk to each other around here"
- Respect families and get to know their names. This will help to provide opportunities to discuss issues and raise any concerns in a more respectful way.
- Dealing with conflict as soon as possible avoids escalation of problem/issue and helps to preserve a sense of rapport and trust
- Clear and precise documentation of relevant information is vital to ensure good staff-staff communication. Staff cannot provide families with information if they are unable to find the relevant information themselves.

5. Establish environments that support staff in promoting constructive relationships with families (JBI Level M2)

Discussion of evidence

It is important to create an environment that supports staff to work collaboratively with the families of patients/residents. Ongoing and regular staff training on the processes and practices that promote staff – family collaboration and a stable workforce (Pillemer et al., 2003) are important. The research suggests that although there may be a theoretical support for a collaborative model of care by management and/or administrative staff, in practice barriers are often created or not addressed.

Organisational factors that have been identified that impede the development of a constructive staff-family relationship include high staff workloads, lack of sufficient staff, high levels of staff turnover, and

other work pressures that interfere with the amount and quality of time staff have to interact with relatives (Bowers, 1988; Gladstone & Wexler, 2001; Russell & Foreman, 2000, 2002; Ryan & Scullion, 2000; Ward-Griffin et al., 2003; Weman, Kihlgren, & Fagerberg, 2004). Other issues that need to be considered that can stymie the development of an environment where staff - family collaboration is promoted, include not releasing staff for in-service training, a casual workforce and having policies and practices that reinforce a task-oriented care model of care (Gladstone & Wexler, 2001; Laasko & Routasalo, 2001; Pillemer et al., 1998; Pillemer et al., 2003).

Implementation strategies

- Moral support e.g. debriefing
- Physical support e.g. freeing up time for education sessions
- PCC approach to foster collaborative approach to care
- Policy and procedures for e.g. dealing with family aggression

Suggestions and experience from practice

- Peer support and good staff-staff relationships are very important in established good staff-family relationships.
- Debriefing and offering each other support, particularly after an unusual day/experience, is important to staff. This assists them in maintaining their own health and helps them to maintain enthusiasm for the job! Support by management to either facilitate or encourage debriefing is important
- Access to a pastor, counsellor, or social worker is also important in fostering good staff-family relationships. Staff particularly felt that they often fill this role for families and clients/residents if there is limited access to such services
- Finding some additional time at admission, particularly in the subacute setting can make a real difference with establishing good relationships between staff and families. The time required to convey important information, discuss and sort out any unrealistic expectations and explain the way the ward/facility operates often relates to staff success in building a rapport with families.
- Strong leadership with unusual situations, particularly with violent or aggressive situations, helps to fosters better communication, understanding and partnerships.

Evaluation and Monitoring

Organisations implementing the recommendations in this clinical guideline are advised to consider how the implementation and its impact will be monitored and evaluated.

Establishing "indicators" is part of developing a monitoring system, an important feature of quality systems. "Indicators" play an important role in quality processes and help to focus the information that needs to be collected to inform on evaluation and quality improvement.

Care settings frequently undertake "auditing" as a process to collect data to inform on program/service quality. Clinical auditing is a means of collecting data to inform on evidence based practice. In particular, clinical auditing is used to both identify whether the program/service practice is "best practice" and if it is not, what action is needed to close the gap between current practice and best practice (the practice-best practice gap).

To assist staff and administrators in developing an appropriate evaluation framework for building and maintaining constructive staff-family relationships in caring for older adults in residential and subacute setting, the following two tables have been provided.

Process for update and review of this Guideline

The Australian Centre for Evidence Based Aged Care proposes to update this Clinical Guidelines for Nursing Health Professionals as follows:

- Following dissemination, this guideline will be reviewed every three years by a team of specialists in the topic area
- ACEBAC staff will continue to monitor for new evidence in this topic area and may recommend an earlier revision period for this guideline based on such monitoring

Clinical audit tool

The aim of clinical audit is to improve health professionals' practice and to support continuous quality improvement. The clinical audit provides a systematic approach to evaluating practice standards (Morrell and Harvey, 2003). Essentially the clinical audit tool compares current practice to evidence based practice recommendations by identifying what systems, processes and structures need to be in place in order for a health professional to implement a guideline recommendation, thereby identifying the cause of any gaps.

How to use this tool

The tool lists audit indicators arising from the guideline recommendations and lists what is required in order to meet the recommendation. It also provides suggestions for how the data might be collected. Individual facilities are free to alter the percentages for compliance given to meet local needs. An action plan tool is also provided.

<table>
<tr><td>Audit Topic:</td><td colspan="2">Constructive staff-family relationships</td></tr>
<tr><td colspan="3">Audit objectives: To promote constructive staff/family relationships</td></tr>
<tr><td colspan="3">Rationale: Research evidence demonstrates that constructive staff/family relationships improves resident outcomes and improves the care experience for staff and families.</td></tr>
<tr><td colspan="3">Audit definitions and abbreviations
HOUSE: Hand Over Using Scrutiny and Evidence rather than simply ‘handing over tasks’.
Regular staff: Staff who regularly work at the facility as opposed to ‘agency’ staff who work on an adhoc/ once off basis.
PCC: PCC should be defined and measured using a valid PCC tool
Families: People responsible as defined by ACAT; Guardians; Primary carers and family members
S/F: Staff Family</td></tr>
<tr><td colspan="2">Audit team</td><td></td></tr>
<tr><td colspan="2">Clinical Guideline Recommendation (EBP)</td><td>Audit Indicator</td></tr>
<tr><td colspan="2">Incorporate staff and family education designed to promote constructive staff-family relationships into staff development programs.</td><td>1. 90% of regular staff will participate in education/training around relationship development and conflict resolution; power and control in relationships; communication skills and negotiation techniques; and reflection and self-knowledge.
2. 90% casual staff will be oriented to the S/F policy and have access to S/F education</td></tr>
<tr><td colspan="2"></td><td>3. 100% of families will receive information about developing and maintaining constructive staff-family relationships.</td></tr>
<tr><td colspan="2">Policies and procedures exist which enable and support family involvement in decision making and/or care planning.</td><td>4. 100% of families that wish to be involved in decision making and/or care planning, and that have the resident/client permission to be involved in such decision making and/or care planning, are involved and supported in doing so.</td></tr>
<tr><td colspan="2">Establish formal communication channels for both staff and families</td><td>5. Documented formal communication channels exist.</td></tr>
</table>

	6. 100% of families have the opportunity to participate in regular[1] resident/family meetings
	7. 100% of incoming staff participate in HOUSE[2] at the commencement of each shift.
	8. 100% of regular care staff can provide detailed information (within their scope of practice) as requested by family.
	9. A documented complaints policy /procedure is followed
Informal Communication channels are embedded to encourage S/F interaction	10. 90% of families report satisfaction with information sharing
Establish environments that support staff /families in promoting constructive relationships with families	11. A person-centred approach to care exists[3]
	12. A Policy/procedure to guide staff in the management of family anger/aggression exists 13. A policy/procedure exists to deal with distressing S/F communication incidents
	14. 100% of staff/families have the opportunity to participate in formal peer support/debriefing following distressing S/F communication incidents

[1] Regular should be agreed and defined by the facility with families – eg monthly
[2] Handover Using Scrutiny and Evidence
[3] As measured using an appropriate tool.

Audit Indicator 1 **90% of regular staff will participate in education/training around relationship development and conflict resolution; power and control in relationships; communication skills and negotiation techniques; and reflection and self-knowledge.**		
Structure	Process	Outcome
S1.1 Education content exists S1.2 Policy exists to enable staff to attend education	P1.1 Regular education sessions are offered P1.2 90% of regular staff are enabled to attend education sessions	O1.1 90% of regular staff have attended S/F education
S1.3: A set of competencies exists related to education	P1.3 90% of regular staff are competency checked	O1.2 90% of regular staff are deemed competent in relationship development, communication skills and negotiation techniques and conflict resolution

Audit Indicator 2 **90% casual staff will be oriented to the S/F policy and have access to education**		
Structure	Process	Outcome
S2.1 Orientation pack for casual staff includes information on S/F relationship policy/expectations	P2.1 90% of casual staff are given S/F information	O2.1 90% of casual staff report receiving S/F information

Audit indicator 3 **100% of families will receive information about developing and maintaining constructive staff-family relationships.**		
Structure	Process	Outcome
S3.1: Written information is available for families	P3.1 Information package is given to 100% of families on admission of a resident to the facility.	O3.1 100% of families are provided with written information about developing and maintaining constructive relationships with staff.
S3.2: Promotional material exists for families re Education sessions	P3.2 Interested families participate in S/F education sessions	03.2 90% of families who attend education sessions report positively on the experience

Audit Indicator 4 **100% of families that wish to be involved in decision making and/or care planning, and that have the resident/client permission to be involved in such decision making and/or care planning, are involved and supported in doing so.**		
Structure	Process	Outcome
S4.1 S/F Policy/policies exist	P4.1 Staff, families and residents collaboratively develop S/F policy/policies and review this every 6 months	O4.1 90% of regular staff and 100% of families report satisfaction with policy. O4.2 90% of residents involved in developing the policy report satisfaction with the policy.
S4.2 Procedure(s) exist to enable policy operation (Facilities should list their own here) e.g. Consent form exists for residents re family involvement Documentation to support family wishes re involvement in resident care exists	P4.2 List here evidence that procedures are known to family and executed e.g. 100% of residents able to consent to family involvement in their care have been consulted Discussion of S/F relationships is a standing item on Family/resident meetings 100% of documentation of family wishes is	O4.3 100% of procedures comply with and support S/F policies O4.4 90% of regular staff are aware of how each family wishes to be involved in care O4.4 90% of families report they are aware that they have the option to participate in care delivery

	completed and reviewed at least 6 monthly P4.3 Families are informed that they have the option to participate in care delivery.	

Audit Indicator 5 **Documented formal communication channels exist.**		
Structure	Process	Outcome
S5.1 Documented formal communication processes exist. e.g. Staff/family/resident meetings; newsletter, complaints processes etc	P5.1 Evidence that processes are followed	O5.1 90% Families/Staff are aware of and satisfied with formal communication channels

Audit Indicator 6 **100% of families have the opportunity to participate in regular resident/family meetings**		
Structure	Process	Outcome
S6.3: Relative-resident meetings	P6.1 Families are aware of meeting dates	O6.1 90% of families report being aware of meeting dates
	P6.2 Families are provided with the agenda prior to each meeting	O6.2 90% of families are provided with the agenda prior to each meeting
	P6.3 Meetings are held at times convenient to the majority of families.	O6.3 90% families are satisfied with opportunities to participate in meetings

Audit Indicator 7 **100% of arriving staff participate in HOUSE[4] at the commencement of each shift.**		
Structure	Process	Outcome
S7.1 HOUSE is structured to enable all incoming staff to participate	P7.1 100% of arriving staff participate in HOUSE	O7.1 100% of arriving staff can report details discussed at HOUSE and thus respond intelligently to family questions
S7.2 A dedicated area to facilitate detailed handover is available		

Audit Indicator 8 **100% of regular care staff can provide detailed information (within their scope of practice) as requested by family.**		
Structure	Process	Outcome
S8.1 Care plans and personal/ medical histories are available for HOUSE	P8.1 Staff use resident files on a daily basis for planning/ evaluation and informing family	O8.1 90% of families are satisfied that staff know the resident and provide information as requested

Audit Indicator 9 **A documented complaints policy/procedure is followed**		
Structure	Process	Outcome
S9.1 Complaints policy/procedure documents exist.	P9.1 A negotiated plan and timetable for resolving complaints is set with family	O9.1 Complaints resolved in 100% of cases

[4] Hand Over Using Scrutiny and Evidence)

Audit Indicator 10 **90% of families report satisfaction with information sharing**		
Structure	Process	Outcome
S10.1 Procedure in place for providing family members with the name of the contact nurse/carer S10.2 Informal information sharing opportunities are provided	P10.1 Families are able to identify who to contact on any given shift for information P10.2 Facility may have happy hour/ sports days/lunches/dinners etc	O10.1 90% of families report satisfaction with information sharing

Audit Indicator 11 **A person centred approach to care exists**		
Structure	Process	Outcome
S11.1 A person-centred philosophy of care exists S11.2 A PCC Measurement tool exists	P11.1 Staff and families are made aware of the philosophy and how to embed it in practice P11.2 PCC is monitored to ensure it is reflected in policies/ processes and practice.	O11.1 A score of 85% or better is achieved on PCC measurement

Audit Indicator 12 **A Policy/procedure to guide staff in the management of family anger/aggression exists**		
Structure	Process	Outcome
S12.1 Policy document exists	P12.1 90% of regular staff are aware of policy	O12.1 90% of regular staff report confidence in implementing the policy / procedure
S12.2 Procedures exist and staff know how to use them	P12.2 Education sessions are held to inform staff of procedures	

Audit Indicator 13 **A policy/procedure exists to deal with distressing S/F communication incidents**		
Structure	Process	Outcome
S13.1 Policy document exists	P13.1 90% of regular staff are aware of policy	O13.1 90% of regular staff report confidence in implementing the policy / procedure
S13.2 Procedures exist and staff know how to use them	P13.2 Education sessions are held to inform staff of procedures	

Audit Indicator 14 **100% of staff/ families have the opportunity to participate in peer support/debriefing following distressing staff/family incidents**		
Structure	Process	Outcome
S14.1 1 Formal peer support/debriefing available for staff and families	P14.1 100% of Staff and families are aware of how to access and utilise the peer support/debriefing program	O14.1 100% of families and staff are satisfied with the peer support/debriefing following incidents

Audit activity detail and findings

Audit Indicator	Criteria	Audit Activity	Findings and Comments	Compliance	
				Achieved	Expected
1. 90% of staff will participate in education/training around relationship development and conflict resolution; power and control in relationships; communication skills and negotiation techniques; and reflection and self-knowledge.	S1.1 Education content exists S1.2 Policy exists to enable staff to attend education P1.1 Regular education sessions are offered P1.2 90% of regular staff are enabled to attend education sessions O1.1 90% of regular staff have attended S/F education	Check that a program is in place. Check that there is a policy or process in place to enable staff to attend. Identify how many staff have attended.			
2. 90% casual staff will be oriented to the S/F policy and have access to education	S1.3 A set of competencies exists related to education P1.3 90% of regular staff are competency checked O1.2 90% of regular staff are deemed competent	Check whether competency statements are in place. Check number of staff undergoing competency checks. Identify how many regular staff are deemed competent.			

3. 100% of families will receive information about developing and maintaining constructive staff-family relationships.	S3.1 Written information is available for families S3.2 Promotional material exists for families relating to Education sessions P3.1: Information package is given to 100% of families on admission of a resident to the facility . P3.2:.Families participate in S/F education sessions O3.1: 100% of families are provided with written information about developing and maintaining constructive relationships with staff. 03.2: 90% of families who attend education sessions report positively on the experience	Check that written information exists and that it is made available to families. Check promotional material exists. Check number of families who have received the information package on admission. Check number of families that have participated in S/F education sessions. Check number of families who have been provided with information. Evaluate education sessions.			
4. 100% of families that wish to be involved in decision making and/or care planning, and that have the resident/client permission to be involved in such decision making and/or care planning,	S4.1 S/F Policy/Policies exist S4.2 Procedure/procedures exist to enable policy operation	Check whether a policy exists Check there is a policy to support implementation of the policy. (Facilities should list their own here)			

are involved and supported in doing so.	Documentation exists re family wishes to be involved in resident care P4.1 Staff, families and Residents collaboratively develop S/F policy and review 6 monthly P4.2 List here evidence that procedures are known and executed 100% of documentation of family wishes is completed and reviewed at least 6 monthly. O4.1 90% of regular staff and 100% of families report satisfaction with policy O4.2 100% of procedures comply with and support S/F policies 90% agreement in regular staff and families understanding of how families wish to be involved in care	e.g. Consent form exists for residents re family involvement Check whether there is evidence that families are involved e.g.: documentation in medical history and/or care plan. Check how often policy is reviewed and who is involved. Check for evidence that policy is being implemented. Eg 100% of residents able to consent to family involvement in their care have been consulted Discussion of S/F relationships is a standing item on Family/resident meetings Conduct satisfaction surveys			

5. Documented formal communication channels exist.	S5.1 Documented formal communication processes exist. P5.1 Evidence that processes are followed O5.1 90% Families/Staff are aware of and satisfied with formal communication	Check whether documented processes exist and for evidence that processes are followed. e.g. Staff/family/resident meetings; newsletter, complaints processes etc Survey staff and families.			
6. 100% of families have the opportunity to participate in regular resident/family meetings	S6.3 Relative-resident meetings P6.1 Families are aware of meeting dates P6.2 Families are provided with the agenda prior to each meeting P6.3 Meetings are held at times convenient to the majority of families O6.1 90% families are satisfied with opportunities to participate in meetings	Check minutes of meetings to ascertain frequency. Check how families are informed of the agenda prior to each meeting Check how many family members attend. Survey families re satisfaction with opportunities to participate in meetings.			
7. 100% of incoming staff participate in HOUSE at the commencement of each shift.	S7.1 HOUSE is structured to enable all incoming staff to participate	Check handover procedures Check where handover is held			

	S7.2 A dedicated area to facilitate detailed handover is available P7.1 100% of arriving staff participate in HOUSE O7.1 100% of arriving staff can report details discussed at HOUSE and thus respond intelligently to family questions	Check whether all incoming staff attend every handover. Interview staff to ascertain knowledge of resident and family needs /involvement			
8. 100% of regular care staff can provide detailed information (within their scope of practice) as requested by family.	S8.1 Care plans and personal/ medical histories are available for HOUSE P8.1 Staff use resident files on a daily basis for planning/ evaluation and informing family O8.1 90% of families are satisfied that staff know the resident and provide information as requested	Observe what documentation is used for handover. Interview staff. To ascertain level of information they can provide regarding the status of a resident. Survey families. To ascertain level of satisfaction			
9. A documented complaints policy exists	S9.1 Complaints policy/procedure documents exist. P9.1 A negotiated plan and timetable for resolving acomplaint is set with	Check whether a complaints policy/procedure documents exist. Check whether negotiated plans and timetables for resolving complaint are set			

	family O1 Achieved in 100% of cases	with families. Check how often timelines for complaint resolution are met.			
10. 90% of families report satisfaction with information sharing	S10.1 Procedure in place for providing family members with the name of the contact nurse/carer S10.2 Informal information sharing opportunities are provided P10.1 Families are able to identify who to contact for information on any given shift P10.2 Facility may have activities such as happy hour/ sports days 90% of families report satisfaction with information sharing	Check whether a procedure exists Ask staff and families whether informal information sharing opportunities are provided Ask families if they are able to identify who to contact for information on any given shift Check whether facility has activities which involve families Survey families to ascertain level of satisfaction			
11. A person-centred approach to care exists	S11.1 A person-centred philosophy of care exists S11.2 A PCC Measurement tool exists	Check whether a person – centred philosophy exists Check how/if this is measured Check staff have attended			

	P11.1: Staff and families are made aware of the philosophy and how to embed it in practice P11.2 PCC is monitored in to ensure it is reflected in policies/ processes and practice. O11.1 A score of 85% or better is achieved on PCC measurement	education program related to person-centred care.			
12. A Policy/procedure to guide staff in the management of family anger/aggression exists	S12.1 Policy document exists S12.2 Procedures exist and staff know how to use them P12.1 90% of regular staff are aware of policy P12.2 Education sessions are held to inform staff of procedures O12.1 90% of regular staff report confidence in implementing the policy/ procedure	Check whether a policy exists Assess staff's knowledge of procedures. Check how many staff have attended the education sessions. Assess how many staff report confidence in implementing the policy/ procedure.			

13. A policy/procedure exists to deal with distressing S/F communication incidents	S12.1 Policy document exists S12.2 Procedures exist and staff know how to use them P12.1 90% of regular staff are aware of policy P12.2 Education sessions are held to inform staff of procedures O12.1 90% of regular staff report confidence in implementing the policy/procedure	Check whether a policy document exists Assess whether staff know how to apply procedures. Assess how many regular staff are aware of the policy. Check whether education sessions are held. Assess how many regular staff report confidence in implementing the policy / procedure			
14. 100% of staff/families have the opportunity to participate in formal peer support/debriefing following distressing S/F communication incidents	S1 Formal peer support/debriefing available for staff and families P1 100% of staff and families are aware of how to access and utilise the peer support/debriefing program O1 100% of families and staff are satisfied with the peer support/debriefing following incidents	Check whether peer support/ debriefing process/program exists Check how many staff and families are aware of how to access and utilise the peer support/debriefing program. Check how many staff and families are satisfied with the peer support/debriefing following incidents			

Outcomes and Actions			
Identified Problems	Action	Responsibility and Expected Date	

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