CONSTRUCTIVE STAFF/ FAMILY RELATIONSHIPS IN RESIDENTIAL AGED CARE

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The most important beneficiary of this type of research are residents of aged care facilities in Victoria and Australia. We hope that this research will be of direct benefit to them.

ABOUT ACEBAC

The Australian Centre for Evidence Based Aged Care (ACEBAC) is an independent evidence-based research centre at La Trobe University in Melbourne. The Centre aims to improve the care of older people through:

- promoting, supporting and conducting evidence-based research into aged care within a person centred care philosophy
- acting as an agent of change and leader, both nationally and internationally, in aged care including dementia care
- facilitating practical and beneficial changes to care practices, particularly for residents in nursing homes
- acknowledging and engaging all stakeholders, including care staff and family carers, in facilitating positive change in aged care
- facilitating and conducting an interdisciplinary and collaborative approach to aged care

The Director of the Centre is Professor Rhonda Nay. If you would like to find out more about ACEBAC, their current research projects, publications and links to other evidence based sites, please visit their website www.latrobe.edu.au/acebac

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EXECUTIVE SUMMARY

Aims

This report describes a three year research project (2006-2008) undertaken by ACEBAC in association with three residential aged care facilities (RACFs) in Melbourne, Australia. The project aimed to identify and address the barriers to constructive staff-family carer relationships in residential care on the basis of a systematic review of the literature on staff-family relationships.

Background

The Australian Centre for Evidence Based Aged Care (ACEBAC), as part of its Clinical Practice Improvement Program, set out to address the identified challenges to the development and maintenance of constructive staff-family relationships in residential aged care by developing, implementing and evaluating interdisciplinary evidence based clinical guideline for use by staff and families of residents.

Staff-family relationships in the residential aged care setting has been identified by service providers, clinicians and the research literature as a priority area for improved practice and the goal of this project was to contribute to evidence based knowledge, policy and practice in order to assist staff and families of residents to develop more constructive and positive ways of working together. The systematic review sought to present the best available evidence on the strategies, practices and organisational characteristics that promote constructive staff-family relationships in the care of older people in the institutional setting.

Methodology

The systematic review of the literature provided the foundation for the design of the research, which was conducted within an action research framework. The four main strategies were:

- a clinical guideline for staff
- an audit tool for staff
- a consumer booklet for family carers
- a survey on staff and family experiences

Results

The main recommendations from the systematic review were:

- increased education for both staff and families on relationship development, power and control issues
- improved communication skills and negotiation techniques for staff and families and
- more engagement from administration and management staff with collaborative care models and greater assistance with staff workloads

A clinical guideline and audit tool were developed from these recommendations to assist practice change and measurement.

- Feedback on the clinical guideline and audit tool was obtained from facility staff in order to make it applicable for use by staff within a residential aged care setting. The tool proved useful in benchmarking indicators linked to the findings of the systematic review.
- The consumer booklet was published by ACEBAC and will be distributed to family carers so that they too, like staff, will benefit from the results of the systematic review through the dissemination of an evidence-based resource.
- The survey of staff and family carers' experiences in aged care facilities revealed that overall, both staff and family carers were positive about their experience in the three facilities that were surveyed. Within this overall trend staff were more positive than family carers about their experience. Based on the results of the Mann Whitney test, staff and family carers' responses differed significantly on a number of statements. These statements mainly related to the communication skills of staff and the exchange of information. These issues have been identified by the systematic review.

Discussion

Each of the four research strategies informed by the systematic review resulted in different outcomes.

Clinical guideline and clinical audit tool

The workshops with staff were on the whole productive and raised awareness among staff about their relationship with family carers and how to work more productively with them, in addition to enabling the clinical guideline to be implemented at the sites. The audit tool, in particular, enabled the evidence based guideline to be successfully translated into practice. It is clear from discussions with staff that there is a strong commitment to establishing constructive staff-family relationships. Staff welcomed the opportunity to develop positive strategies in dealing with difficult situations with family carers.

Consumer booklet for family carers

The consumer booklet, based on the findings of the systematic review, has been published by ACEBAC and will be distributed across RACFs in Victoria. As an evidence-based information source, it is a resource that will assist family carers in bridging the information and communication gaps that they can experience when a family member goes into a RACF.

Survey of staff and family carers

The survey results confirmed a number of issues identified by the systematic review and will assist future measurement of staff-family relationships and experiences. While survey results must be interpreted in light of limitations of the data, the findings do confirm that overall, across the three sites surveyed, perceptions are positive. There is still much room for improvement particularly in closing the gap between family carers' perceptions and that of staff and addressing the areas identified by the systematic review, particularly in relation to information exchange and communication, which continue to be barriers to constructive staff-family relationships.

Conclusion

The systematic review provided the foundation for the research strategies employed in the project and the evidence-based toolkit of resources that were developed. The outcomes of this project, namely the clinical guideline, audit tool and consumer booklet, give RACFs a greater capacity to facilitate improvements in staff-family carer experiences and relationships.

MAIN REPORT

INTRODUCTION

This report describes a three year research project (2006-2008) aimed at identifying and addressing the barriers to constructive staff-family carer relationships in residential aged care.

The Australian Centre for Evidence Based Aged Care (ACEBAC), as part of its Clinical Practice Improvement Program, set out to address the identified challenges to the development and maintenance of constructive staff-family relationships in residential aged care by developing, implementing and evaluating an interdisciplinary evidence based clinical guideline for use by staff and families of residents.

Staff-family relationships in the residential aged care setting has been identified by service providers, clinicians and the research literature as a priority area for improved practice and the goal of this project was to contribute to evidence based knowledge, policy and practice, in order to assist staff and families of residents to develop more constructive and positive ways of working together. A systematic review sought to present the best available evidence on the strategies, practices and organisational characteristics that promote constructive staff-family relationships in the care of older people in the institutional setting. The systematic review of the research to establish the criteria necessary for constructive staff-family relationships was completed in 2006 (Haesler, Bauer, & Nay, 2006; Haesler, Bauer, & Nay, 2007). An expert reference group consisting of a representative from Carers Victoria, allied health and nursing staff, a geriatrician and internationally recognised academics guided this review process.

The major recommendations from the systematic review were the need for:

- increased education for both staff and families on relationship development, power and control issues
- improved communication skills and negotiation techniques for both staff and families
- strong support from administration and management staff:
    - educational support for staff
    - addressing workloads and staffing issues
    - the introduction of care models focused on collaboration with families.

The review also identified the following staff characteristics important to the development of constructive staff-family relationships:

- ability to communicate openly and honestly
- ability to work in partnerships
- ability to provide information and promote the uniqueness of the resident.

In addition the review highlighted that interventions aimed at promoting constructive staff-family relationships and collaborative relationships between families and health professionals needed to address:

- communication
- information
- education and
- administrative support.

Research project aims

Based on the recommendations from the systematic review this project aimed to:

- improve the satisfaction levels among families of residents and the staff working in RACFs about their relationship with each other and how they experience their relationship with each other in the context of care;
- develop and trial an evidence based guideline to assist constructive staff-family relationships and
- add to existing knowledge on translating evidence into everyday practice.

Clinical Practice Improvement Program

The Clinical Practice Improvement Program, in which the staff-family carer project sits, is an interdisciplinary research program that aims to enable older people to age well and productively by increasing evidence based assessment and care, thereby reducing iatrogenesis in the care setting. Although numerous publications exist on the major care issues in the various health care contexts, there has been little appraisal of the quality of that work and translating this into care. ACEBAC's work to date has identified some practice areas where improvement is required, including inconsistent use of valid and reliable assessment tools and the sporadic use of documented assessments to inform interdisciplinary care. In this report clinical practice

improvement is linked specifically to the development of an evidence-based clinical guideline and audit tool for use by health professionals to promote more constructive staff-family relationships in residential aged care.

The Clinical Practice Improvement Program combines a systematic review of the literature to establish the best available evidence from the research (Sackett, Rosenberg, & Gray, 1996), with Horn's (1997) Clinical Practice Improvement Methodology (CPI), which involves collecting data from the 'real' world setting to provide the basis for examining the relationship between process and outcome. These two processes, together with input from an interdisciplinary reference group, are then used to develop a clinical guideline which is implemented and trialled using modified action research in the care setting. This approach closes the gap between what we may know as best practice and what is actually done by using a combination of the best available evidence and comprehensive analysis of process and experiences based on everyday practice.

A systematic review by Haesler, Bauer and Nay (2006) found that family members' perceptions of their relationships with staff indicated that a strong focus was placed on opportunities for the family to be involved in the older person's care. Staff members also expressed a theoretical support for the collaborative process however, despite wide acknowledgement of the importance of family involvement in the wellbeing of the older person; health care professionals' theoretical support for collaboration did not always translate to their clinical practice.

Key themes in staff-family carer relationships

The role of family carers

It is widely accepted that family can play an important role in the support and care of the older person living in a residential aged care facility. Their involvement is consistent with modern health care philosophy, which encourages holistic care and has been linked to improved physical and emotional well-being. The Australian residential aged care sector has been mandated to acknowledge the significance of the family in two key governing documents, the Commonwealth Charter of Residents' Rights and Responsibilities and the Commonwealth Aged Care Standards of Practice.

The research evidence shows that residents' experience of care is better when staff and family have positive relationships. For older people living in residential aged care to benefit from the participation of their family members, health care professionals need a better understanding of the issues that impact on family involvement as well as the strategies to best support it. An

evidence-based clinical guideline for use by staff and families would be a valuable aid to help to improve practices and processes and to assist staff and families to develop more constructive ways of working together.

Although there is no single explanation for family that encompasses all cultures, age groups and time frames (Johnson, 1998), family is commonly broadly defined to include immediate family and more distant relatives and friends or neighbours who have been designated as 'family-like' by the care recipient (Haigler, Bauer, & Travis, 2004).

The role played by family in providing physical and emotional support to the older person is widely acknowledged and it is an expectation that health professionals work with and involve families by locating family members as important stakeholders within the care giving process (Johnson, 1998). The roles adopted by family carers in the institutional setting range from the provision of affective support (Bowers, 1988; Kellett, 1999) through to assistance with physical care (Laitinen, 1994).

Families are known to be in need of varying degrees of support once the older person has made the transition to long-term care (Campbell, 1996; Dellasaga & Nolan, 1997; Kellett, 1999; Maas, Swanson, Buckwalter, Weiler, & Specht, 1998) and health care professionals are often among the first to identify who the family caregivers are and how they are coping. In practice, health care professionals assess a family's needs and intervene to support both the family and the person needing care (Farran, 2001).

How family carers are involved in the care setting however varies widely, since health care workers' perceptions of their significance and role varies widely. They have been variously typecast as hidden patients (Hills, 1998), servants (Montgomery, 1982, 1983), visitors (Montgomery, 1982, 1983; Rosenthal, Marshall, Macpherson, & French, 1980), workers (Rosenthal et al., 1980; Twigg & Atkin, 1994), health team members (Montgomery, 1982, 1983) partners in care (Harvath et al., 1994; Nolan & Dellasega, 1999), advocates and protectors (Friedemann, Montgomery, Mailberger, & Smith, 1997; Tilse, 1997b), resources (Rubin & Shuttleworth, 1983; Tilse, 1997a; Twigg & Atkin, 1994) a problem (Rosenthal et al., 1980; Safford, 1989), intruders (Gubrium, 1991), disrupters (Tickle & Hull, 1995) and superseded carers (Twigg & Atkin, 1994).

Over twenty years ago Rosenthal, Marshall, Macpherson and French (1980) noted that family involvement in the health care setting was far from being either smooth or widespread. While health care ideology now encourages the formation of "partnerships" with family caregivers, it is apparent from the literature examining staff-family relationships, that the family still hold an

ambiguous position within many aged care facilities (Friedemann et al., 1997; Janzen, 2001) and are often regarded as peripheral to the facility (Levine, 2000).

There are many barriers to the implementation of participatory family care that have been identified (Logue, 2003); (Haesler et al., 2006):

- staff resistance to change
- family members' reticence to get involved
- institutional rules and protocols
- the lack of encouragement of family involvement
- failure to address the needs of the family and
- ineffective communication between staff and families.

The extent to which a family is able to feel comfortable and get involved in a facility depends in some measure on how they are perceived by the staff. Research by Bauer (2006) found that some aged care facility staff still do not view working with families as a legitimate and necessary part of their role, but rather view the family as something that has to be accepted and tolerated. These staff members regarded residents' families as being of secondary importance and many were more concerned with completing the work than engaging with families, who were in some cases seen as a distraction. Staff working in residential aged care have described a range of behaviours exhibited by families that they perceive as annoying. These include showing no interest in the resident or the care delivered, lacking insight into the working conditions of care staff, becoming a hindrance to staff by interfering in care, having unrealistic expectations and making unrealistic demands, complaining about the care and not being satisfied with the care that is delivered (Bauer, 2007). The June 2005 Senate Enquiry - *Quality and Equity in Aged Care* report by the Community Affairs Reference Committee noted that some families fear retribution if they raise issues of concern with staff members.

Davies and Nolan (2006) have surmised that the family often remains an untapped or underutilised resource. According to Wellard (1997), health professionals have failed to take stock of the power relations between nurses and families and McKeever (1999) and Lundh (2003) have noted that the staff and family often have disparate needs and expectations and competing agendas. Care staff are frequently placed in the position where they must juggle a relationship with the family that is predicated on multiple roles. Staff are required to view family caregivers simultaneously as colleagues, subordinates, and people who themselves may be in

need of nursing care. These multiple conceptualisations lead to role ambiguity, and McKeever (1999) concludes, to mutually exclusive approaches to care giving.

Definition of terms

The following definitions have been adopted and referred to throughout this report.

Family/ family carer – Anyone who has been involved and wants to remain involved with the person who is living, or will be living, in residential aged care. This can include friends.

Staff – Primarily, but not exclusively, direct care staff. This includes nurses (Registered Nurse Division 1 [RN] and Registered Nurse Division 2 [EN]) and personal care attendants (PCAs).

Resident – The person living in the residential aged care facility.

Residential care – High and low care RACFs that are either public or private facilities.

METHODOLOGY

Overview

The systematic review of the literature on staff-family relationships provided the foundation for the research design. Four main strategies were employed. These strategies were:

- development of a clinical guideline
- development of an audit tool for staff
- development of a consumer booklet (a resource for family carers based on the findings of a systematic review)
- a survey of staff and families

Action research method

The project was conducted within an action research methodology and evaluation framework. A common outcome of research is that the findings are published but have little impact on practice. The action research approach aims to increase the likelihood that staff will ‘own’ the outcomes and that change will be embedded in practice. Action research is a form of inquiry that facilitates ‘learning by doing’; theory and action are in a continuing interactive partnership. The research

proceeded through cycles of planning, action, data collection, analysis and critical reflection. In this way there was an evaluation and reflection process after every action had been taken (Street, 2003). Examples of how the action research framework was used in practice included:

- action research cycles occurring concurrently with nursing staff to ensure continuous evaluation of the guideline and ongoing evaluation
- nursing staff having continuous input via the action research cycles

Participants and recruitment

Staff and family carers from three RACFs in metropolitan Melbourne participated in the development of the clinical guideline, trialling of the audit tool and survey of staff and families between 2006-2008.[1] The sites included one Public Sector Residential Aged Care Service (PSRACS) and two private RACFs with a range of bed and staff[2] capacity catering for both low care and high care residents.

- Site 1: 30 beds/40 staff
- Site 2: 80 beds/83 staff
- Site 3: 100 beds/70 staff

The sites were chosen as a convenience sample based on the capacity of the research team to have regular contact, the interest of the aged care facilities' leadership (which is essential to success), and the project budget. Contact was initially made with the facilities through the Facility Manager.[3] The project was advertised in facility newsletters for staff and family carers.

The primary co-ordinators and leaders of the development of the clinical guideline and audit tool at the facilities included the Facility Manager and the Clinical Practice Improvement (CPI) consultant nominated by the executive and/or nurse unit manager. The CPI consultant was a facility staff member whose role was to oversee the implementation of the project at the facility by liaising with facility staff and the project team. CPI consultants wore a CPI badge during the

[1] Overall four facilities participated in the development of the clinical guideline, trialling of the audit tool and survey of staff and families. However, only data from three facilities was analysed due to the withdrawal of one site during the survey period. This site was unable to continue participation as a consequence of organisational changes.

[2] The staff numbers are approximate only and were provided by the Director of Nursing at the time of the second survey in December 2008.

[3] The person responsible for the day to day management of each facility carried a different title e.g. Executive Officer; Director of Nursing; Residential Facility Manager. For clarity this report refers to this position as Facility Manager.

project. Depending on the facility, other nominated staff also participated in discussions about the project.

Participants in the survey were staff and family carers from each of the three facilities. Staff were mainly direct care staff (Personal Care Attendants (PCAs), Registered Nurses (RNs), Enrolled Nurses (ENs) and the Facility Managers. In addition a small number of ancillary staff, for instance allied health and catering or service staff, participated in the survey. Family carers who participated in the survey were generally primary carers for a family member resident in the RACF.

Ethical Approval

Ethical approval for participation of staff and family carers at the aged-care facilities was obtained from the relevant Human Research Ethics Committee (HREC) and the La Trobe University HREC. Additional approval was obtained from two facilities that did not have a formal ethics committee.

Expert Panel

At the outset of the CPI Program, an expert panel was convened to provide expertise and input into the 5 priority CPI areas (falls, pain, medication management, unmet needs behaviour and staff/family relationships). With respect to staff/family relationships, the expert panel provided advice on the findings of the systematic review and the contents of the survey.[4]

1. Development of clinical guideline and trialling of audit tool

The draft interdisciplinary clinical guideline and audit tool for use by staff and family to identify the status of current practices, processes and structures, was developed based on the findings of the systematic review (the best available evidence). It was further informed by survey results, interviews and expert panel advice.

The guideline provided a summary of the systematic review findings, recommendations for practice, including an abbreviated discussion of the evidence, and implementation strategies (see Appendix 1). The guideline distilled five evidence-based recommendations from the systematic

[4] Members of the expert panel included ACEBAC staff, as well representatives from Aged Care Service providers, the Office of the Commissioner for Complaints, Carers Victoria, Queensland University of Technology and the Australian Catholic University.

review. Out of these recommendations fourteen audit indicators were developed. Guideline recommendations focussed on practices promoting, supporting and enabling constructive staff-family relationships and encompassed:

- staff and family education
- policies and procedures
- formal and informal communication channels for staff and families
- the work environment

The modified action research cycle occurred concurrently with staff to ensure continuous evaluation of the draft guideline and ongoing education on its use. This occurred through:

- continuous guideline and audit tool modification based on feedback from the expert panel and staff
- education for residential aged care facility staff on constructive staff-family relationships and the use of the guideline

The clinical audit tool that accompanied the guideline allowed facilities to compare current practice to evidence based practice recommendations by identifying the systems, processes and structures required to implement the guideline recommendations, thereby identifying any barriers to constructive staff-family relationships. Further revisions of the guideline occurred according to the findings and recommendations from the second survey, feedback from staff and the expert panel.

As part of the action research approach, ongoing meetings were held between ACEBAC staff and staff from each facility to discuss how the guideline (via the audit tool) could be implemented. During meetings between ACEBAC staff and facility staff (which included the nominated staff CPI consultant), verbal and written feedback from staff assisted in identifying how the audit requirements could be met and hence implemented within current practice. Audit indicators were adjusted accordingly to facilitate implementation.

In summary, the audit tool enabled organisations to ascertain whether their current practices and policies enabled them to meet/not meet the audit indicators and, where there were gaps, what strategies they could put in place to meet the indicators.

Ongoing meetings increased staff ownership of the tool and hence its take-up by the facility. Formal education occurred at the initial orientation meeting with all staff to explain the project and at the concluding meeting. In the concluding meeting ACEBAC staff explained the basis

and purpose of the guideline and how the audit tool could be used. In addition, ACEBAC staff provided a workshop on overcoming barriers to constructive staff-family relationships, by examining generic examples of challenging staff-family relationships that were familiar to staff. Meetings with families were also offered but only taken up at two sites.

2. Development of a consumer booklet

A specific outcome of the systematic review was the development and publication of a 10 page consumer booklet designed to support family carers including friends of older people living in residential aged care. This booklet complements the clinical guideline and audit tool provided to staff of RACFs and enables the findings of the systematic review to be of direct benefit to families.

The information in the booklet examines the caring relationship from the point of view of all parties: the family or friends; the care staff; and the facility management. It was designed to clarify key issues and encourage family carers to seek further information from the facility and from other sources.

3. Survey of staff and families

Family carers of residents and staff from the three RACFs were surveyed before and after the guideline was introduced using a structured questionnaire, designed to determine the staff and family carer experience of residential aged care. An additional benefit of the survey was that it enabled staff and family carers to review the current state of staff-family relationships. In the period between the surveys, a focus group with staff at one site was conducted to clarify aspects of the findings of the first staff survey. [5]

Survey tool

The survey tool was an adapted version of the '*Survey of Carer/Family Experience of Care in Hospital*' and '*Survey of Staff Experience of Family Care in Residential Aged Care*' tool developed by Professor Mike Nolan and a team from the University of Sheffield. This tool was selected on the basis of the items having captured most of the critical domains identified in the systematic review, namely communication, information exchange, education and administration

[5] The focus group was approximately one hour in length and explored issues around what staff saw as good staff-family relationships, the needs of families, the involvement of families in care, conflict with families and how to manage this, issues that were thought to impact on staff-family relationships, the influence of culture and how constructive staff-family relationships could be fostered.

support.[6] The psychometric properties of the original tools' await analysis by the University of Sheffield. The original tool has reported impressive reliability (Cronbach's alpha = 0.926). The adapted version used in the current study was modified to reflect differences in the Australian setting and in order to elicit additional information of interest to the research team.

Survey development

The adapted tool, '*Families carer experience of residential aged care*'/'*Staff experience of families in residential aged care'* consisted of 34 positively (n=22) and negatively (n=12) worded Likert Scale items, with the addition of a 10 point 'satisfaction with relationship' scale (see Appendix 2). Socio-demographic information requested by the expert panel was also obtained from participants. For families this included age; sex; educational level; frequency of visiting; and time of visits. For staff this included age; sex; work status; hours worked per week; length of employment at facility; and qualifications. The use of the tool and its adaptation was approved by Professor Nolan. In addition to *Communication*, *Exchange of information*, *Education* and *Administrative/Management support*, the survey items also addressed the following factors identified by the systematic review as being of importance to collaborative staff-family relationships:

- family involvement in planning and care and family as a monitor of care
- collaborative meetings with staff and/or staff working in partnership with family
- overall satisfaction with staff-family relationships
- point of contact and visiting
- quality of relationship with family carers
- information provision from staff to family carers on resident care
- care plan – family carer involvement
- quality of care and staff knowledge of resident

[6] Four other tools were also compared against the 26 issues identified in the systematic review – Family perceptions of care tool; Family perceptions of caregiving role, Staff perceptions of care giving role and Attitudes about Families checklist. These tools were found not to canvas sufficient factors identified as being of significance to collaborative staff- family relationships.

Survey Administration

The survey was administered twice between 2006-2008. In this report, the term S1 denotes the first survey administration and S2 the second administration of the survey. Two RACFs completed S1 between June and October 2006. The third[7] RACF completed S1 in May 2008. All three sites completed S2 in November/December 2008.

Contact was initially made with the RACFs through the Facility Manager. Members of the project team visited each RACF to discuss the aims of the project, purpose of the survey, and how the survey could best be distributed.

Prior to S1 the project was advertised in facility newsletters sent to families of residents. Prior to S2, progress reports, including a summary of findings from S1, were again published in facility newsletters and sent to families.

Staff and family members from each facility were invited to participate in the surveys. Surveys were placed into staff 'pigeon holes' by the designated CPI consultant at each facility. Surveys for families were either mailed to their home address by the facility, or placed in an envelope to collect at reception. Completed questionnaires were returned using an attached prepaid envelope, or placed into a secure return box provided in each facility. The return box supplied to each RACF was collected by a member of the project team three weeks after the survey had been distributed. Questionnaires did not contain any identifiable information: return of both the staff and family survey implied consent to participate.

Survey analysis

Completed questionnaire data was transferred into the Statistical Package for the Social Sciences (SPSS Version 14.0). Preliminary analysis involved obtaining frequency and descriptive statistics. Appropriate post hoc analysis was also performed.

[7] As discussed in footnote 1 the original third site was unable to continue to participate – hence the later administering of S1 at the third (replacement) site.

RESULTS

Overview

This section describes the results of:

- consultations with staff at three sites on the clinical guideline and audit tool
- the survey results including the non-parametric analysis and responses to questions grouped under key domains
- open-ended responses from the survey and staff focus group

Feedback on the clinical guideline and audit tool

Feedback on the clinical guideline and audit tool was undertaken progressively via designated meetings involving the CPI consultant, the Facility Manager, facility staff and the ACEBAC team following a pre-implementation workshop. There were a minimum of four meetings at each site. Between meetings key facility staff continued to review the audit tool with a view to making it actionable. The meetings followed the general format outlined below:

- First session. Introducing the staff-families project to staff. Generally this meeting occurred during handover time in order to maximise staff attendance. A summary of the project was disseminated.
- Second session. Orientation and familiarisation meeting with key facility staff including the CPI consultant. At this meeting ACEBAC staff explained in more detail the background to the development of the clinical guideline and audit tool. This meeting included provision of an information package which included a summary of the systematic review, a journal article on the same, the clinical guideline and audit tool and the consumer booklet (see Appendices 1, 4 and 5)[8]

[8] The journal article has not been included in the appendices. The reference details are as follows: E Haesler, M Bauer and R Nay (2006). Factors associated with constructive nursing staff-family relationships in the care of older adults in the institutional setting. *International Journal of Evidence-Based Healthcare*, 4, 288-336.

- Third session. This meeting refined the audit tool through discussions with key facility staff about how the facility could meet the indicators given its current policy and practices. This included finalising site agreement on the contents of the audit tool.
- Final session at each site. This session was a workshop on HOUSE (Handover Using Scrutiny and Evidence)[9] provided by ACEBAC staff on addressing difficult staff-family carer encounters that might arise based on a generic but recognisable scenario for staff. Discussion included how the finalised guideline and audit tool could be adopted and beneficial to the facility overall.

Issues raised by staff at these meetings

Discussion at these meetings centred on:

- How the audit indicators could be met and what changes were needed to existing facility processes and proceedings. Key findings were:
    - Most indicators could be met within current practice through more explicit linkage between current policies and practices and formalisation of informal practices. For instance, to achieve the required staff participation in education modules to assist *communication with families* (Audit Indicator 1), one facility required the formalisation of the observational learning that currently took place to be made mandatory, plus arranging back-fill for staff to enable attendance at education modules. Another facility required a policy change in relation to staff induction procedures, in order to achieve a *90% of casual staff orientation in staff/families policy* (Audit indicator 2). A minor adjustment to existing processes to include a policy/procedure to guide staff in the management of family anger/aggression was required at another (Audit Indicator 12).
    - One key indicator that could not be met (in the absence of explicit policy), but which could be met in the foreseeable future with a focussed policy adjustment was '*a person-centred approach to care'* (Audit Indicator 11). More explicit policy changes are required to documents informing organisational Mission

[9] HOUSE (Handover Using Scrutiny and Evidence). HOUSE has its origins in the television show of the same name (HOUSE). HOUSE is an approach developed by ACEBAC which facilitates in-depth exploration of a resident's care needs and subsequent care planning.

Statements and care processes, as well as the development of benchmarks for measuring person centred care, before this indicator can be attained.[10]

- While most indicators could be met in the short-term, establishing truly constructive staff-family relationships was a long term goal that required a cultural shift in staff attitude and an increased number of interested and engaged families.

Consumer booklet

As the consumer booklet *'Supporting families and friends of older people living in residential aged care'* is the result of evidence from the systematic review, there are no specific results for the purposes of this report (see Appendix 4 for consumer booklet).

Survey of staff-families carers

A total of 267 surveys were successfully completed over the two survey periods comprising approximately 50% of staff and 50% of family carers in each survey period.

In the first survey period a total of 145 questionnaires were returned (staff n=72 and families n=74). However, because of the involvement of one site which withdrew from participation after the first survey, the total number of useable surveys returned was actually 116. In the second survey period a total of 151 questionnaires were returned (staff n=77 and families n=74). Whilst this reflects a reasonable return rate for staff, this was not matched by the proportion of completed family carers' surveys.[11]

[10] A valid and reliable measurement tools for measuring person centred care P-CAT has been developed by ACEBAC staff and other researchers. David Edvardsson, Deirdre Fetherstonhaugh, Rhonda Nay and Stephen Gibson (2009) Development and initial testing of the Person-centred Care Assessment Tool (P-CAT). *International Psychogeriatrics*, doi:10.1017/S1041610209990688 Published Online by Cambridge University Press 27 Jul 2009

[11] Although every reasonable effort was made to ensure a robust return rate our expectations were not met for the family carer group. As a result, additional statistical tests were not employed.

Demographic information is provided in Table 1 below:

Table 1: Key demographic information

Demographic information	**Survey 1**		**Survey 2**	
Gender (%)	Female 82	Male 18	Female 83	Male 17
Age breakdown (mean years)	Staff 40	Family 59	Staff 40	Family 58
Primary staff designation (%)	EN 41 PCA 27 RN 12		EN 29 PCA 48 RN 16	
Average hours and years of work (mean hours and years)	Hours per week 32 Years in aged care 9 Facility 4		Hours per week 32 Years in aged care 8 Facility 3	
Most common relationship with resident (%)	Offspring 59 Spouse 11 Other relative 11		Offspring 61 Spouse 18 Other relative 15	
Frequency of visiting (%)	2-3 days per week 38 Weekly 29 Once per day 20		2-3 days per week 33 Weekly 22 Once per day 22	

Some demographic points for noting were that:

- the majority of respondents were female and this trend was most noticeable among staff
- most of the staff surveyed were Personal Care Attendants and/or Enrolled Nurses
- most family carers fulfilled the role of primary carer of the resident they visited with most family carers identifying as children of the resident.
- the most frequently selected visiting period for family carers was 2-3 days per week.

Data trends

The majority of respondents (both staff and family carers) viewed staff-family relationships and quality of care favourably. This was reflected in a greater agree/strongly agree response to positively worded questions. Notwithstanding the overall positive response of both staff and family carers to their experience, staff tended to view relationships more favourably than family carers (see Table 2).

It is noteworthy that a few questions elicited a high undecided response from staff and/or families. Twenty one percent of staff and family carers for instance, were undecided about the

statement '*Family/carers are not always encouraged to be involved in their relative's care and treatment, even though they want to be'* (See Appendix 3).

A synopsis of the 'agree/strongly agree' responses and 'disagree/strongly disagree' responses concerning staff-family experience across survey periods is detailed in Table 2 and 3 (for more detailed responses to these questions see Appendix 3).

Table 2: Response trends (agree/strongly agree) across survey periods

TRENDS: FAMILY CARERS
Family carers were more likely to agree/strongly agree than staff that:
Generally relationships between staff and family carers are very good
Family carers always know who to speak to if they have questions about their relative's care and treatment
Family carers do not always have enough information and other resources available to provide care in the facility
Staff are knowledgeable about relative's care and treatment
Family carers sometimes interfere by making suggestions about their relative's care
TRENDS: STAFF
Staff were more likely to agree/strongly agree than family carers that:
Family carers can always speak to a doctor about their relative's care if they want to
Staff always tell family carers which nurses are responsible for their relative's care and treatment
Staff ask family carers for any information they might have about their relative's needs/wishes
Family carers are not always given enough information about their relative's future care and treatment
There are always enough staff to give good quality care
Staff take time to get to know patients as a person
Staff always listen to the resident's views about their care and treatment

Staff care about family carers' welfare and needs, as well as those of their relative
If family carers have any complaints about their relative's care staff always attend to these promptly
Staff always listen to family carers' views and opinions about their relatives care
Residents' future care and treatment needs are discussed with family carers
Staff discuss fully with family members how to become involved in care
Staff take time to teach family carers the skills they need to care for their relative in the facility
Family carers always have an assessment of their needs as a carer
Family carers are usually asked to leave the room when care is being provided to their relative

Table 3: Response trends (disagree/strongly disagree) across survey periods

TRENDS: FAMILY CARERS
Family carers were more likely to disagree/strongly disagree than staff that:
Family/carers are not always confident that staff have the knowledge and skills needed to give good quality care
Staff are more concerned with getting the job done than caring for residents as individuals
Staff often speak sharply to family/carers or residents
TRENDS: STAFF
Staff were more likely to disagree/strongly disagree than family carers that:
Staff are not always aware of patients' likes and dislikes

Statistical data analysis

Given the nature of the data and the limitations imposed by the design of the study (variance across sites, data collection intervals, unequal responses across respondent groups and between

S1 and S2) the Mann Whitney U Test was used to test for statistical significance (Pett 1997 pp20-29). Dichotomising response items into the categories of 'agree' and 'disagree' was not possible due to the inclusion of a 'don't know' ordinal value in the staff family survey (Altman & Royston 2006).

Mann Whitney U Tests were performed to compare:

1) staff and family carer scores for S1 and staff and family carer scores for S2
2) staff scores at each site for S1 and S2 and family carer scores at each site for S1 and S2

A response resulting in a statistical difference ($p<0.05$) between two respondent groups means there was a difference in the overall response profile between the two groups. The focus of this analysis was overall responses between staff and families rather than the differences at each site. The staff- family carer responses within S1 and S2 are detailed in Table 4. The results of the Mann Whitney U Test for each survey period and for each site together with graphical representation is located in Appendix 5.

Table 4: Mann-Whitney Test Comparing staff with family S1 and S2 ($p<0.05$)

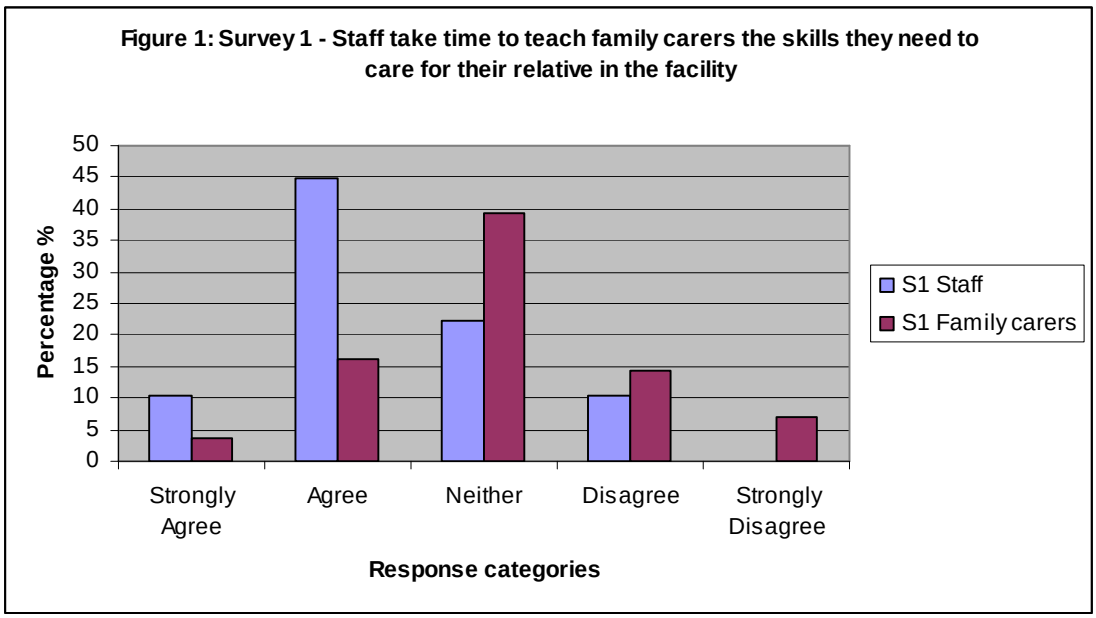
Survey Questions	**S1 Assymp. Sig. (2-tailed)**	**S2 Assymp. Sig. (2-tailed)**
Staff are knowledgeable about relative's care and treatment	.009	
Staff care about family carers' welfare and needs, as well as those of their relative	.042	
Family carers are not always confident that staff have the knowledge and skills needed to give good quality care		.033
If family carers have any complaints about their relative's care staff always attend to these promptly		.022
Patients/residents' future care and treatment needs are discussed with family carers		.001
Staff take time to teach family carers the skills they need to care for their relative	**.001**	**.015**
Staff always listen to the patient's views about their care and treatment	**.004**	**.001**
Family carers do not always have enough information and other resources available to provide care	.019	
Family carers always have an assessment of their needs as a carer	.003	
Staff discuss fully with family members how to become involved in care	.001	

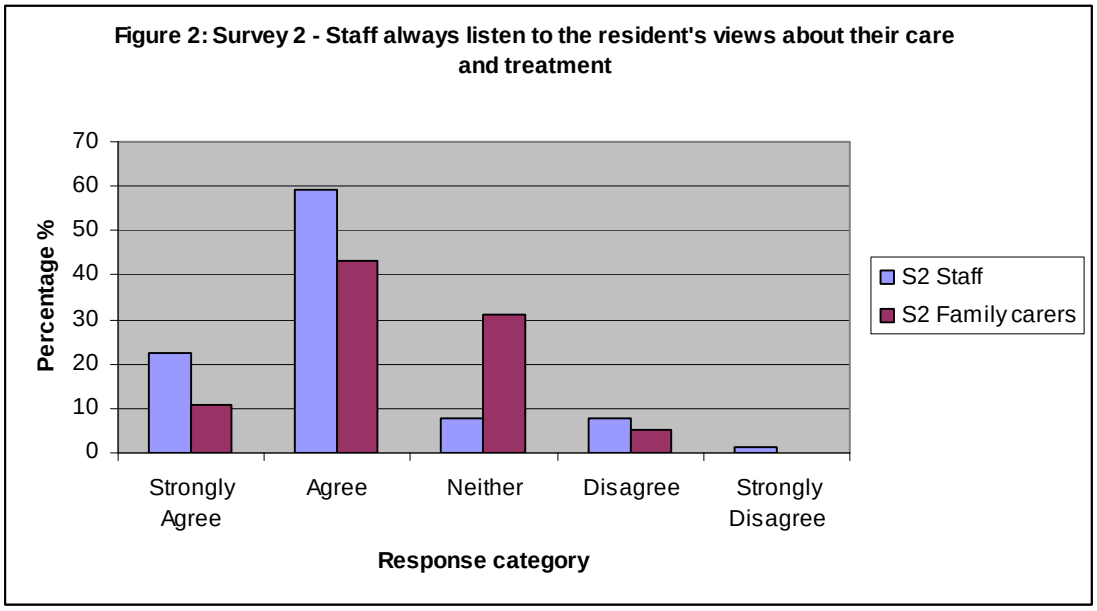
Most of the items that were statistically significant concerned the exchange of information and communication skills of staff, two key areas identified by the systematic review (See Appendices 4 and 6). Of note are two questions that elicited a statistically significant response across both survey periods (see highlighted rows in Table 4). These statements were:

a) *Staff take time to teach family carers the skills they need to care for their relative*

b) *Staff always listen to the patient's views about their care and treatment*

Staff were much more likely to agree with these items than family carers. A closer analysis of the results reveals that family carers responded in quite different ways to staff to these items (although not necessarily consistently across survey periods). For instance in item a) staff had a much higher 'agree' response than family carers while families had a higher 'disagree' response than staff. In item b) family carers had a greater 'neither' response than staff. Examples of this difference are highlighted in the graphs below (Figure 1 and 2).





Qualitative feedback: staff and family carer survey comments and staff focus group

Family carer comments

Favourable comments

Most family carers that included comments on their survey were favourable about the quality and level of care provided to their family member. Twenty-six respondents in S1 and thirty two respondents in S2 expressed favourable comments. These family carers expressed gratitude and appreciation and used terms such as *excellent* and *satisfied*. Respondents mainly referred to the quality of the staff and the level of care provided. More extended comments included the following:

This is the first time we have been exposed to a high-care situation and we have been most impressed with the unfailing kindness shown to the resident by the staff at [name of facility]. Their professional knowledge means that we are very confident that she receives correct and timely care.

They provide her with dignity she deserves which makes our acceptance of her advanced dementia bearable.

I am very happy with the facilities and level of care. My father is treated as an individual and respectively, I too am fond of the staff. A good bunch of larrikins who know how to have a laugh whilst doing a difficult job very well.

Our family is constantly amazed at the care and concern the staff give – doesn't matter whether it's the cleaner, cook or nursing staff.

It is clear from the above comments that quality of care issues are associated with staff attitudes. The following comments reveal that, for family carers, quality of care is also associated with cleanliness, design of the facility and quality of the meals.

My mother is one of the fortunate ones to be in an excellent aged care facility. It is extremely well run, is spotlessly clean, and is as safe an environment as possible. Meals are prepared in its own kitchen and are of good quality and the staff are all very caring and compassionate.

My mother seems very settled at [name of facility] and it is a lovely bright, clean nursing home and whenever I have visited staff have been correctly doing their job. They always listen and note my request.

One respondent identified the importance of staff feeling valued in relation to the quality of care:

Important to know that staff feel valued and if staff happy then it is noticeable to family and care to residents will be improved.

Another respondent stated: *we understand that it is a tough and demanding job*.

Staffing issues for family carers

The remainder of comments highlighted key issues in respect of staff. The majority of comments across both surveys were reserved for issues around staff attitudes and knowledge (n = 10) followed closely by structural issues pertaining to staffing such as staffing levels (n=9) and, finally, communication issues (n=8).

Respondents indicated the importance of appropriate staff attitudes. For instance poor staff attitude was associated with staff being unfriendly or unwelcoming to family carers, being insufficiently informed about the resident, or providing a less than optimal level of care. Respondents also identified the importance of appropriately experienced and qualified staff, particularly in relation to the ability to detect changes in the health of the resident in areas of possible clinical risk. One example given was detecting dizziness which, if undetected, may lead to falls. There was also a perception that weekend and casual staff may be less well informed and the employment of casual staff on weekends or otherwise, is seen to potentially impact on the quality of care provided. A need to improve communication to ensure casual staff were provided with adequate information about the health and care needs of residents at the commencement of a shift was identified.

Family carers were concerned that inadequate staffing levels in their facility increased potential incidents such as falls and reduced the quality of care. As one respondent wrote:

'…suspect most residential care facilities are understaffed.'

Two respondents identified work load as an issue and identified this as a barrier to improving relationships with family carers. As one respondent wrote:

'…time and work pressures make staff less able to relate to relatives.'

Three respondents identified language as a barrier to communication, in this case with staff (generally patient care attendants) from culturally and linguistically diverse (CALD) backgrounds. As one respondent summed up:

'…unfortunately staff are… hampered by language difficulties which has the impact of… restricting information flow to family/carers.'

The importance of clear communication channels was highlighted by four respondents who drew particular attention to a lack of sufficient information from staff about their relative's care. These respondents commented on an inadequate induction process for family carers (n=2) and lack of updates about how their parents were going overall. Finally, one respondent identified a lack of specific information on planned activities in the facility to enable them to visit at a time that did not clash with the activities.

Other miscellaneous issues identified by family carers included:

- clothes and property (n=2)
- diet (n=2)
- senior management (n=1)

The two comments about clothes concerned losing clothes and discolouration of clothes due to mixing whites with colours. With respect to diet one family carer identified the need for more nutritious and interesting meals:

'…more variety in meals re evening especially, more nutritious and interesting i.e. less of the fish fingers and tomato soup.'

One family spoke of how their father was not always happy with the meals but those family carers

'…realise there is a limit to what can be provided.'

One respondent identified the importance of facility managers in promoting constructive relationships between staff and family carers:

'Previous management was negative to most items above [in the questionnaire]. New management is positive to these items and still trying to change the entrenched attitudes of junior, middle staff. It is improving.'

Staff comments

In contrast to family carers only two staff members were unequivocally positive about staff-family carer relationships describing them as *excellent* and *very harmonious*. The staff who commented more positively (n=5) focussed their attention on making the best possible effort in their job according to expected standards. For instance one respondent commented that staff attitudes were improving and another that

'staff… try to provide the residents and their families the best possible care'.

Another respondent described staff as

'competent and attentive';

another that *'…all staff try their best however it never seems to be enough!'*

Staff identified a number of issues with both family carers and staff that hindered staff-family carer relationships. A key issue for staff was the perceived lack of engagement of family carers in the care of their relative. For instance, one respondent described how family carers were encouraged to participate in social events but did not come. This particular staff member saw the need for involvement of more family carers to '*prevent depression in aged care facilities'*. Another respondent identified a lack of interest in knowing the details of their relative's care: '*…sometimes families do not want to (sic) aware of the issue surrounding their relative's care'*. One respondent pointed out that '*there are many families who we never hear from*'. Another respondent pointed out that while families have the opportunity to be involved in care needs of their relative they did not necessarily wish to be involved.

Other individual issues identified by staff included

- lack of family carer understanding of the nurses' role
- lack of family carer understanding of safe care practices
- staff issues with family carers of CALD background whereby some family carers are perceived to have greater expectations than can be met

Staff identified both attitudinal and structural issues pertaining to staff which hindered relationships with family carers. For instance one respondent identified recalcitrant staff:

'*…some [staff] still do not listen to direction or assistance from staff, family or residents.'*

Two responses highlight the issue of demarcation of staff roles and responsibility which impact on their communication with family carers. One respondent pointed out that it was very hard for some staff to let relatives assist with care of the resident. Another staff respondent identified communication with families as the responsibility of the RN although this staff member who was an EN said they would assist within the constraints of confidentiality. One respondent pointed out that there needed to be more appropriately timed meetings that family/carers could attend.

There were other structural barriers. One respondent cited a lack of training of staff in aged care in understanding the needs of older people and valuing them. Staffing levels and high workloads were again identified as barriers to quality care and relationships with family carers.

'Low staffing is a major issue… causes the breakdown in good quality and quantity care towards residents. This issue when addressed and if acknowledged would allow a balanced relationship between family and carers to provide the essential needs…'

A related constraint was time. Two comments highlighted lack of time as one stress factor inhibiting positive staff-family relationships and good quality of care:

'*Aged care is an area that is overworked for staff and time stress arises.*

Time restraints are the biggest hurdle to family carer staff relationships. Staff simply do not have the time to have lengthy conversations with family members much to staff disappointments (sic).'

Staff focus group

The outcomes of the focus group reinforced comments made by staff in the survey. The main issues canvassed by the focus group participants related to:

- Culture and communication:

  - recognising the communication barriers and overcoming them.
  - the need for staff to respond to cultural differences in the way families expressed themselves, such as more physical contact such as a hug, were discussed.
  - staff also noted that in many communities it was not culturally acceptable for children to put their families in care and that these adult children could feel under strain as a consequence of this decision; this pressure could be applied to staff

- Access to pastoral care/counselling. Staff identified a need for a counsellor and/or pastoral care worker on-site to help families early on deal with loss and grief when their family member is placed in care. A pastoral care worker could also assist families with feelings of guilt. Currently there is no formal assistance given to families.

Other needs/issues identified by staff were:

- Recognising the benefits of knowing about the whole life of the resident before they arrived in the facility and/or on admission. This was recognised by staff after attending funeral services of residents and hearing their eulogy. It would also be beneficial to have some documentation about the family dynamics.
- The importance of acknowledging family when they arrived and building a trusting relationship with them
- That while families should be involved in care there needed to be some boundaries with respect to clinical care. For instance, staff did not feel comfortable with families undertaking wound dressings, but did feel comfortable with families providing assistance with meals, changing continence pads and in some cases showering (as some family carers currently did).
- The main strategy for working through conflict with families among staff was communication and sharing information, establishing trust with families and keeping the door open to families
- Staff perceive only a small number of family carers actually want to be closely involved in discussions about residents. While there are family meetings once a month it is the same families that come. Some families choose to keep their distance
- There is a small group of staff that are very task focussed and therefore appear less empathetic than they could be

DISCUSSION

There is clearly a strong commitment to establishing constructive staff-family relationships by the RACFs that participated in this study. The project has been instrumental in facilitating more constructive staff-family relationships in RACFs by providing organisations with a range of evidence based tools to inform their practice in this area; a clinical guideline with strategies to promote better relationships with families and an audit tool with which to benchmark family friendly policies, processes and procedures. The project has also addressed the needs of the family carer by providing a useful resource to inform them about the elements that can promote, as well as impede, good relationships with the staff. The development of these tools has been informed by a systematic review of the research, surveys and interview data.

Clinical guideline and audit tool

Participating staff welcomed the opportunity to develop positive strategies in dealing with difficult situations involving family carers. The workshops with staff were generally productive sessions that raised awareness among staff about their relationship with family carers, how to work more productively with them and enabled the clinical guideline to be fully implemented at the sites. The audit tool provided a practical way of translating the evidence based guideline into practice.

The challenge for Facility Managers is to establish how existing policies and procedures can be shaped in a way that supports the evidence presented in the guideline. CPI Consultants were found to be key players in the dissemination of the project at the facilities amongst staff, residents and family carers and the continuation of this role is encouraged.

The challenge for facilities will also be to ensure the clinical guideline and audit tool is a living document that can be fully implemented in practice. But as the workshops and meetings indicated – this challenge can be met at the three sites.

Consumer booklet for family carers

The consumer booklet, based on the findings of the systematic review, published by ACEBAC, will be available for distribution across RACFs in Victoria. As an evidence-based information source, it is a resource that will assist family carers in bridging the information and communication gaps that they may experience when a family member goes into a RACF. It is

an example of translating evidence-based practice in academic language into easy to read accessible language. As the booklet states: *It is designed to examine the caring relationship from the point of view of all parties: the family or friends; the care staff; and the facility management*. We hope that this booklet will clarify some issues for families and encourage them to seek further information from the facility or other sources if required.

Survey of staff and family carers

The survey identified that overall, the experience of staff and family carers at the three participating sites surveyed was positive. The survey, does however, signal room for improvement in staff-family carer relationships particularly in bringing family carers and staff perceptions closer together and addressing information and communication issues identified in the systematic review. These issues continue to be barriers to constructive staff family relationships.

Although the survey tool had limitations[12] it provided an additional dimension to our understanding of staff and family experiences in residential aged care. This survey has been a first step by ACEBAC in generating a questionnaire appropriate for measuring staff-family/carer experiences of RACFs within an Australian context. Further work with the University of Sheffield on the development and validation of this tool is anticipated.

Qualitative results: Survey comments and staff focus group

The qualitative information provides a human dimension to staff-family carer experience through descriptions, general comments and feedback. It supports the quantitative findings of the survey and the general overall positive response of both family carers and staff. The qualitative information also reflects issues identified by the systematic review including providing a more detailed picture of administrative/ management support issues.

[12] Some of these limitations are discussed in more detail in Appendix 6

CONCLUSION

This project has delivered a number of evidence based strategies that can support the establishment and maintenance of more collaborative staff-family relationships in RACFs. The tools and resources (clinical guideline, audit tool) that have been developed offer facilities the means by which to examine their processes and structures in relation to family care and provide a range of strategies to better staff-family relationships. The consumer booklet provides family carers a previously unavailable evidence-based information resource. Facilities and family now have a much greater capacity to facilitate improvements in staff-family carer experiences and relationships in the residential aged care setting.

RECOMMENDATIONS

To further improve staff-family relationships in the residential aged care environment, the following recommendations are made that:

- Facilities examine their practices in relation to family care and adopt the audit tool against which to benchmark those practices
- Facilities distribute the consumer booklet to all family carers of residents
- The survey tool is further contextualised and tested for use in the Australian residential aged care context
- To facilitate cross-cultural communication, the translation of the consumer booklet into the identifiable languages spoken by residents and their family carers in Victorian RACFs could be pursued.
- A key staff member at each aged care facility be designated as the point of contact for other staff and families and be responsible for driving the adoption and implementation of the clinical guideline and audit tool
- That the research be replicated in a wider range of facilities.

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APPENDIX 1

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

Disclaimer and copyright statement

Disclaimer

Copyright

ISBN: Awaiting number allocation

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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.

Audit Topic:	Constructive staff-family relationships
Audit objectives: To promote constructive staff/family relationships	
Rationale: Research evidence demonstrates that constructive staff/family relationships improves resident outcomes and improves the care experience for staff and families.	
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	
Audit team	
Clinical Guideline Recommendation (EBP)	**Audit Indicator**
Incorporate staff and family education designed to promote constructive staff-family relationships into staff development programs.	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
	3. 100% of families will receive information about developing and maintaining constructive staff-family relationships.
Policies and procedures exist which enable and support family involvement in decision making and/or care planning.	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.
Establish formal communication channels for both staff and families	5. Documented formal communication channels exist.
	6. 100% of families have the opportunity to participate in regular[13] resident/family meetings
	7. 100% of incoming staff participate in HOUSE[14] at the commencement of each shift.
	8. 100% of regular care staff can provide detailed information

[13] Regular should be agreed and defined by the facility with families – eg monthly

[14] Handover Using Scrutiny and Evidence

	(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[15]
	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

[15] 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 completed and reviewed at least 6 monthly P4.3 Families are informed that they have the	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

	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[16] 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

[16] 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	P10.1 Families are able to identify who to contact on any given shift for information	O10.1 90% of families report satisfaction with information sharing
S10.2 Informal information sharing opportunities are provided	P10.2 Facility may have happy hour/ sports days/lunches/dinners etc	

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

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.	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.			

	03.2: 90% of families who attend education sessions report positively on the experience	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, are involved and supported in doing so.	S4.1 S/F Policy/Policies exist S4.2 Procedure/procedures exist to enable policy operation 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	Check whether a policy exists Check there is a policy to support implementation of the policy. (Facilities should list their own here) 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			

	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	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	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			

	majority of families O6.1 90% families are satisfied with opportunities to participate in meetings	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 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 handover procedures Check where handover is held 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	S8.1 Care plans and personal/ medical histories are available for HOUSE	Observe what documentation is used for handover.			

requested by family.	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	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 a complaint is set with family O1 Achieved in 100% of cases	Check whether a complaints policy/procedure documents exist. Check whether negotiated plans and timetables for resolving complaint are set 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	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			

	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 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 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	Check whether a person – centred philosophy exists Check how/if this is measured Check staff have attended 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	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			

	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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APPENDIX 2 Version 2 28/10/08

University of Sheffield

Families/carer experience of residential aged care

ACEBAC The Australian Centre for Evidence Based Aged Care

Adapted from 'Survey of Carer/Family Experience of Care in Hospital'

1. Please indicate if you are Female ☐ Male ☐

2. Please indicate your age in years_____

3. What is your relationship with the person living in residential care?

   Spouse/partner ☐ Son or daughter ☐

   Parent ☐ Other relative ☐

   Other – please specify_____

4. Do you identify yourself as the carer to the person living in residential care?

   Yes ☐ No ☐

5. What is your highest level of education?

Primary school □

Secondary school □

High School Certificate or similar □

TAFE (or similar) diploma/certificate □

Bachelors degree (university) □

Postgraduate qualifications □

6. What is your highest qualification?_____

7. How often do you visit the person living in residential care?

More than 1/day □ Once/day □

2-3 days/week □ Weekly □

Other _____

8. What time of day do you usually visit?_____

9. How satisfied are you with the relationship you have with the staff in the residential care facility? Please tick the box you think is most appropriate.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10
Totally Unsatisfied									Totally Satisfied

Below are a number of statements about the way staff and family carers work together in residential care. The term 'relative' refers to the person living in the residential care facility with whom you are involved. Please indicate how much you agree with each statement by placing a tick in the box that best reflects your opinion:

	Thinking about how staff interact with residents' families/carers I feel that:	**Strongly Agree**	**Agree**	**Neither Agree or Disagree**	**Disagree**	**Strongly Disagree**	**Does not apply**
10	Staff always make family/carers feel welcome in the facility	☐	☐	☐	☐	☐	☐
11	Staff ask family/carers for any information they might have about their relative's needs/wishes	☐	☐	☐	☐	☐	☐
12	Staff sometimes do not provide family/carers with enough information about their relative's care and treatment	☐	☐	☐	☐	☐	☐

13	Staff always tell family/carers which nurses are responsible for their relative's care and treatment	☐	☐	☐	☐	☐	☐
14	Family/carers are not always fully involved in discussions about their relative's care and treatment	☐	☐	☐	☐	☐	☐
15	Family/carers are encouraged to visit their relatives whenever they want to	☐	☐	☐	☐	☐	☐
16	Staff always answer any questions family/carers have about their relative's care and treatment promptly	☐	☐	☐	☐	☐	☐
17	Staff are knowledgeable about relative's care and treatment	☐	☐	☐	☐	☐	☐
18	Family/carers are not always encouraged to be involved in their relative's care and treatment, even though they want to be	☐	☐	☐	☐	☐	☐
19	Staff care about family/carers' welfare and needs, as well as those of their relative	☐	☐	☐	☐	☐	☐

		Strongly Agree	**Agree**	**Neither Agree or Disagree**	**Disagree**	**Strongly Disagree**	**Does not apply**
20	Staff take time to get to know residents as a person	☐	☐	☐	☐	☐	☐
21	Staff are not always aware of residents' likes and dislikes	☐	☐	☐	☐	☐	☐
22	Staff often speak sharply to family/carers or residents	☐	☐	☐	☐	☐	☐

23	Staff always have enough time to give good quality care	☐	☐	☐	☐	☐	☐
24	There are always enough staff to give good quality care	☐	☐	☐	☐	☐	☐
25	Staff are more concerned with getting the job done than caring for residents as individuals	☐	☐	☐	☐	☐	☐
26	Family/carers are not always confident that staff have the knowledge and skills needed to give good quality care	☐	☐	☐	☐	☐	☐
27	Family/carers are usually asked to leave the room when care is being provided to their relative	☐	☐	☐	☐	☐	☐
28	Staff do not always treat family/carers with dignity and respect	☐	☐	☐	☐	☐	☐
29	Family/carers can always speak to a doctor about their relative's care if they want to	☐	☐	☐	☐	☐	☐
30	If family/carers have any complaints about their relative's care staff always attend to these promptly	☐	☐	☐	☐	☐	☐
31	Family/carers sometimes interfere by making suggestions about their relative's care	☐	☐	☐	☐	☐	☐
32	Staff always listen to family/carers' views and opinions about their relative's care	☐	☐	☐	☐	☐	☐
33	Residents' future care and treatment needs are discussed with family/carers	☐	☐	☐	☐	☐	☐

		Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Does not apply
34	Family/carers are not always given enough information about their relative's future care and treatment	☐	☐	☐	☐	☐	☐
35	Family/carers have some control over their relative's care and treatment	☐	☐	☐	☐	☐	☐
36	Family/carers always know who to speak to if they have questions about their relative's care and treatment	☐	☐	☐	☐	☐	☐
37	Staff take time to teach family/carers the skills they need to care for their relative in the facility	☐	☐	☐	☐	☐	☐
38	Staff always listen to the resident's views about their care and treatment	☐	☐	☐	☐	☐	☐
39	Family/carers do not always have enough information and other resources available to provide care in the facility	☐	☐	☐	☐	☐	☐
40	Family/carers always have an assessment of their needs as a carer	☐	☐	☐	☐	☐	☐
41	Staff discuss fully with family members how to become involved in care	☐	☐	☐	☐	☐	☐
42	Generally relationships between staff and family/carers are very good	☐	☐	☐	☐	☐	☐

Your comments

We are very grateful for your help in answering these questions. If there is anything else you would like to add in connection with any of the questions - or if you would like to make any further comments, please use the space provided below.

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……

Thank you for sparing the time to complete the questionnaire.

Please return your completed questionnaire in the attached reply paid envelope or place it in the box provided in the residential care facility.

Version 2 28/10/08

University of Sheffield

Staff experience of families:

Residential aged care

ACEBAC
The Australian Centre for Evidence Based Aged Care

Adapted from 'Survey of Staff Experiences of Family Care in Residential Aged Care'

1. Please indicate if you are Female ☐ Male ☐

3. Please indicate your age in years_____

4. What is your work classification?

SEN (Div 2) ☐ SRN (Div 1) ☐

Clinical Nurse Specialist ☐ Associate Nurse Unit Manager ☐

Nurse Unit Manager ☐ Patient Care Attendant ☐

4. What qualifications do you have?_____

5. How many hours do you work a week?_____

6. How many years have you worked in aged care?_____

7. How many years have you worked in this facility/hospital?_____

8. How satisfied are you with the relationship you have with families? Please tick the box you think is most appropriate.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 2 3 4 5 6 7 8 9 10

Totally Unsatisfied

Totally Satisfied

Below are a number of statements about the way staff and family carers work together in residential care/sub-acute care. The term 'relative' refers to the patient/resident in the facility/hospital. Please indicate how much you agree with each statement by placing a tick in the box that best reflects your opinion:

	Thinking about how staff interact with patients' families/carers I feel that:	**Strongly Agree**	**Agree**	**Neither Agree or Disagree**	**Disagree**	**Strongly Disagree**	**Does not apply**
9	Staff always make family/carers feel welcome in the facility	☐	☐	☐	☐	☐	☐
10	Staff ask family/carers for any information they might have about their relative's needs/wishes	☐	☐	☐	☐	☐	☐
11	Staff sometimes do not provide family/carers with enough information about their relative's care and treatment	☐	☐	☐	☐	☐	☐
12	Staff always tell family/carers which nurses are responsible for their relative's care and treatment	☐	☐	☐	☐	☐	☐

13	Family/carers are not always fully involved in discussions about their relative's care and treatment	☐	☐	☐	☐	☐	☐
14	Family/carers are encouraged to visit their relatives whenever they want to	☐	☐	☐	☐	☐	☐
15	Staff always answer any questions family/carers have about their relative's care and treatment promptly	☐	☐	☐	☐	☐	☐
16	Staff are knowledgeable about relative's care and treatment	☐	☐	☐	☐	☐	☐
17	Family/carers are not always encouraged to be involved in their relative's care and treatment, even though they want to be	☐	☐	☐	☐	☐	☐
18	Staff care about family/carers' welfare and needs, as well as those of their relative	☐	☐	☐	☐	☐	☐

		Strongly Agree	**Agree**	**Neither Agree or Disagree**	**Disagree**	**Strongly Disagree**	**Does not apply**
19	Staff take time to get to know patients as a person	☐	☐	☐	☐	☐	☐
20	Staff are not always aware of patients' likes and dislikes	☐	☐	☐	☐	☐	☐
21	Staff often speak sharply to family/carers or patients	☐	☐	☐	☐	☐	☐
22	Staff always have enough time to give good quality care	☐	☐	☐	☐	☐	☐
23	There are always enough staff to give good quality care	☐	☐	☐	☐	☐	☐
24	Staff are more concerned with getting the job done than caring for patients as	☐	☐	☐	☐	☐	☐

individuals

25	Family/carers are not always confident that staff have the knowledge and skills needed to give good quality care	☐	☐	☐	☐	☐	☐
26	Family/carers are usually asked to leave the room when care is being provided to their relative	☐	☐	☐	☐	☐	☐
27	Staff do not always treat family/carers with dignity and respect	☐	☐	☐	☐	☐	☐
28	Family/carers can always speak to a doctor about their relative's care if they want to	☐	☐	☐	☐	☐	☐
29	If family/carers have any complaints about their relative's care staff always attend to these promptly	☐	☐	☐	☐	☐	☐
30	Family/carers sometimes interfere by making suggestions about their relative's care	☐	☐	☐	☐	☐	☐
31	Staff always listen to family/carers' views and opinions about their relative's care	☐	☐	☐	☐	☐	☐
32	Patients/residents' future care and treatment needs are discussed with family/carers	☐	☐	☐	☐	☐	☐

		Strongly Agree	**Agree**	**Neither Agree or Disagree**	**Disagree**	**Strongly Disagree**	**Does not apply**
33	Family/carers are not always given enough information about their relative's future care and treatment	☐	☐	☐	☐	☐	☐

34	Family/carers have some control over their relative's care and treatment	☐	☐	☐	☐	☐	☐
35	Family/carers always know who to speak to if they have questions about their relative's care and treatment	☐	☐	☐	☐	☐	☐
36	Staff take time to teach family/carers the skills they need to care for their relative	☐	☐	☐	☐	☐	☐
37	Staff always listen to the patient's views about their care and treatment	☐	☐	☐	☐	☐	☐
38	Family/carers do not always have enough information and other resources available to provide care	☐	☐	☐	☐	☐	☐
39	Family/carers always have an assessment of their needs as a carer	☐	☐	☐	☐	☐	☐
40	Staff discuss fully with family members how to become involved in care	☐	☐	☐	☐	☐	☐
41	Generally relationships between staff and family/carers are very good	☐	☐	☐	☐	☐	☐

Your comments

We are very grateful for your help in answering these questions. If there is anything else you would like to add in connection with any of the questions - or if you would like to make any further comments, please use the space provided below.

……

……

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……

……

Thank you for sparing the time to complete the questionnaire.

Please return your completed questionnaire in the attached reply paid envelope or place it in the box provided in the facility/ward.

APPENDIX 3

DEMOGRAPHIC DATA FROM QUESTIONNAIRE

RESPONDENT TYPE

A total of 267 staff and family carers responded to the questionnaire. For the purposes of data analysis S1 comprised 116 respondents and S2, 151 respondents. Within each survey period there was a reasonably even division of staff and family carers with slightly more staff surveyed each time (S1:51.7% and S2:51%) compared with family carers (S1:48.3% and S2:49%) (see Table 1 below).

Table 1: Respondent type for survey 1 and survey 2 by respondent and %

			Survey_Number		Total
			S1	S2	
Respondent Type	Staff residential	Count	60	77	137
		Percentage %	51.7%	51.0%	51.3%
	Family carer residential	Count	56	74	130
		Percentage %	48.3%	49.0%	48.7%
Total		**TOTAL Count**	**116**	**151**	**267**
		TOTAL %	**100.0%**	**100.0%**	**100.0%**

GENDER

The majority of respondents were female (S1:81.9% and S2:82.7%) across both survey periods (see Table 2 below).

Table 2: Gender for survey 1 and survey 2 by frequency and %

		Frequency	Percent %
S1	Female	95	81.9
	Male	21	18.1
	Total	116	100.0
S2	Female	124	82.7
	Male	26	17.3
	Total	150	100.0

A breakdown of gender by respondent type shows that that this trend was evident for both staff and family carers (see Tables 3 and 4). However, the high number of females in the surveys was largely due to the high proportion of female staff (S1:98.3% and S2: 90.8%). For family carers the proportion of females ranged from 64.3% in S1 to 74.3% in S2.

Table 3: Gender by respondent type for survey 1 by frequency and %

			Gender		Total
			Female	Male	
S1	Staff residential	Count	59	1	60
		%	98.3%	1.7%	100.0%
	Family / carer residential	Count	36	20	56
		%	64.3%	35.7%	100.0%
Total		Count	95	21	116
		%	81.9%	18.1%	100.0%

Table 4: Gender by respondent type for survey 2 by frequency and %

			Gender		Total
			Female	Male	
Respondent Type	Staff residential	Count	69	7	76
		% within Respondent Type	90.8%	9.2%	100.0%
	Family / carer residential	Count	55	19	74

		% within Respondent Type	74.3%	25.7%	100.0%
Total		Count	124	26	150
		% within Respondent Type	82.7%	17.3%	100.0%

AGE

The average age of respondents was similar for both surveys with an average age of 48.62 years for S1 and 50.71 years for S2 (see Table 5). The median ages were also close, with 51 years for S1 and 53 years for S2.

Table 5: Mean and median age for survey 1 and survey 2

Survey No	S1	S2
Mean	48.62	50.71
Median	51.00	53.00
Total count	115	143

A breakdown by respondent type shows that in S1 the staff ranged in age from 18 years to 61 years and in S2 similarly from 19 years of age to 63 years of age. The average staff age in S1 was 39.42 years and 40.39 years in S2. The median age was the same – 41 years (see Table 6).

Table 6: Mean and median staff age for survey 1 and survey 2

Survey No.	S1	S2
Mean	39.42	40.39
Median	41.00	41.00
Total count	60	70

In S1 family carers ranged in age from 37 years to 87 years of age and in S2 from 31 years to 86 years of age. The average age of family carers was 58.65 years in S1 and 60.60 years in S2. The

medians were very close with a median age for S1 of 58 years and 59 years in S2 (see Table 7). The age of family carers reflects the preponderance of sons and daughters in this cohort.

Table 7: Mean and median family carer age for survey 1 and survey 2

Survey No.	S1	S2
Mean	58.65	60.60
Median	58.00	59.00
Total count	55	73

STAFF: WORK CLASSIFICATION

The majority of staff work classifications differed in each survey period.

In survey 1 the majority of staff were classified as Division 2 (40.7%; n=24) followed by Personal Care Attendants (27.1%; n=16) and, in last place, Division 1 Nurses (11.9%; n=7) that included 3 Nurse Unit Managers and 2 Associate Nurse Unit Managers (see Table 8 below). The category 'other' (20.3%; n=12) covered a range of positions including allied health and lifestyle staff.

In survey 2 the majority of staff were Personal Care Attendants, not Division 2 Nurses. PCAs made up 47.9% (n=35) of staff followed by Division 2 Nurses (28.8%; n=21) (see Table 8). Division 1 Nurses including 2 Nurse Unit Managers, 4 Associate Nurse Unit Managers and 1 Clinical Nurse Specialist and made up 16.4% of staff (n=12). The category 'other' made up 6.9% of staff (n=5) (see Table 8 below).

Table 8: Work Classification of respondents for survey 1 and survey 2 by frequency and %

Work Classification		S1		S2	
		Frequency	% Percent	Frequency	% Percent
	EN (Div 2)	24	40.7	21	28.8

	RN (Div 1)	7	11.9	12	16.4
	Person care Attendant	16	27.1	35	47.9
	Other	12	20.3	5	6.9
	Total	59	100.0	73	100.0
Total		116		151	

STAFF: QUALIFICATIONS

Information provided by respondents on qualifications builds on the details provided under work classification. However, as mentioned in the methodology, this category was less frequently filled out then work classification in the questionnaire. The responses do give an indication of additional and basic qualifications for Division 1 and 2 staff.

For instance, in Table 9 (below) 13.2% (n=7) of Division 2 nurses in S1 and 12.3% (n=7) of Division 2 nurses in S2 recorded additional endorsement. Generally this endorsement was for medication.

Table 9: Qualifications of respondents for survey 1 and survey 2 by frequency and %

Qualifications	S1 Frequency	S1 % Percent	S2 Frequency	S2 % Percent
EN (Div 2)	17	32	8	14.0
RN (Div 1)	2	3.8	6	10.5
EN (Div2) plus additional endorsement	7	13.2	7	12.3
RN (Div 1) plus additional certificate	2	3.8	0	0
RN plus additional university qualification below Masters	1	1.9	1	1.8

	RN plus additional university qualification below PhD	2	3.8	1	1.8
	Cert III	14	26.4	19	33.3
	Other	8	15.1	15	26.3
	Total	53	100.0	57	100.0

The total percentage of Division 1 nurses with additional qualifications was 9.5% (S1) and 3.6% (S2). Division 1 nurses, unlike Division 2 nurses, had post-graduate qualifications. Division 1 nurses who had additional qualifications were likely to be in a managerial role – either nurse unit manager or associate nurse unit manager.

Of those personal care attendants who answered this question, 26.4% (S1) and 33.3% (S2) of those who listed their qualifications had Certificate III in Aged Care. More personal care attendants recorded that they had Certificate III in S1 (93.75%) than in S2 (80%).

STAFF: HOURS/YEARS WORKED

The average and median hours of work per week for staff in S1 and S2 were very close – with an average of 32.16 and 32.01 hours respectively and a median of 33 and 32 hours per week respectively (see Table 10). The range of hours worked per week was 8-80 hours in S1 and 7-67 hours in S2.

Table 10: Mean and median hours worked per week for survey 1 and survey 2

	S1	S2
N	59	76
Mean	32.16	32.01
Median	33.00	32.00

Table 11: Mean and median years worked in aged care and facility for survey 1 and survey 2

	S1 Years of experience in aged care	S1 Years worked in this facility	S2 Years of experience in aged care	S2 Years worked in this facility
N	60	59	77	75
Mean	8.68	3.73	8.14	4.55
Median	4.25	3.00	5.00	3.00

The average years worked in aged care overall by staff for S1 and S2 was similarly close with 8.68 years in S1 and 8.14 years in S2 (see Table 11). The median in S1 was 4.25 years and 5.0 years in S2. The range of years worked in aged care ranged from 6 weeks to 31 years in S1 and 7 weeks to 31 years in S2.

The average years worked in the facility were 3.73 years (S1) and 4.55 years (S2). The median was the same in both surveys – 3.0 years. The range of years worked in the facility were 6 weeks to 24 years in S1 and 4 weeks to 25 years in S2.

FAMILIES: RELATIONSHIP WITH RESIDENT

The majority of respondents in both surveys were the primary carer for the person in residential care with the highest percentage of people nominating as primary carer occurring in survey 1 (S1:87.5% versus S2:71.8%) (see Table 12).

Table 12: Identified self as carer for survey 1 and survey 2 by frequency and %

		S1 Frequency	S1 Valid Percent	S2 Frequency	S2 Valid Percent
	Yes	49	87.5	51	71.8
	No	7	12.5	20	28.2
	Total %	56	100.0	71	100.0
Total Number		116		151	

In both survey periods the majority of respondents identified as the offspring, that is, they reported being the son or daughter of the resident (S1:58.9% and S2:60.6%) (see Table 13). The next most frequent categories in S1 and S2 differed. For S1 the second most frequent category was 'parent' (16.1%) while for S2 it was the least common category (6.8%). As discussed in the methodology it is likely that some respondents who were 'offspring' mistakenly filled in this category. This may explain the high parent number in S1 and to a lesser extent S2. As can be seen from Table 13 spouse/partner respondents make up the second most frequent category in S2 (17.6%) while in S1 they are equal third with 'other relative' (10.7%).

The category 'other' relative comprised in-laws (daughter, son and mother-in law), niece, grandson and cousin. The majority of 'other relatives' identified themselves as the primary carer (70.6%). Two respondents recorded 'other' and identified themselves as friends – one as a primary carer.

Table 13: Relationship with person in care for survey 1 and survey 2 by frequency and %

		S1 Frequency	**S1 % Percent**	**S2 Frequency**	**S2 % Percent**
Valid	Spouse or partner	6	10.7	13	17.6
	Offspring	33	58.9	45	60.8
	Parent	9	16.1	5	6.8
	Other relative	6	10.7	11	14.9
	Other	2	3.6	0	0
	Total %	56	100.0	74	100.0
Total Number		116		151	

FAMILIES CARERS: EDUCATION AND QUALIFICATIONS

Survey 1 and 2 differed in the proportion and level of education and qualifications of respondents. In S1 the most frequent level of education achieved was secondary school (35.2%) followed by

Bachelor degree (20.4%), with HSC and post-graduate in equal third (14.8%), followed by TAFE or equivalent (13%). Only one person stated that they had attained only primary school education (see Table 14).

In contrast, in survey 2, the highest level of education for most respondents was Bachelor degree (86.1%), followed by TAFE or equivalent (66.7%), HSC or equivalent (52.8%), and finally secondary school (31.9%). This latter percentage approximated that of S1. Eight people (11.1%) had attained primary school education.

Table 14: Highest level of education achieved for survey 1 and survey 2 by frequency and %

		S1 Frequency	S1 % Percent	S2 Frequency	S2 % Percent
Valid	Primary school	1	1.9	8	11.1
	Secondary school	19	35.2	15	31.9
	HSC or equivalent	8	14.8	15	52.8
	TAFE or equivalent	7	13.0	10	66.7
	Bachelor	11	20.4	14	86.1
	Post Graduate	8	14.8	10	100.0
	Total	54	100.0	72	
Total		116		151	

Qualifications were also reflected in the differences between S1 and S2, although the percentage differences were much smaller (see Table 15). For instance in S1 the most frequently reported qualification obtained was a Bachelors degree (27.9%) followed by Secondary School (23.3%): the remaining categories were in equal third at 16.3%**.**

The most frequently reported qualifications in S2 were for those with a TAFE diploma/certificate or equivalent (24.5%), followed by Bachelor degree (22.4%) and in equal third HSC (or equivalent) and Post Graduate (18.4%).

Table 15: Highest qualification obtained for survey 1 and survey 2 by frequency and %

		S1 Frequency	S1 Valid Percent	S2 Frequency	S2 Valid Percent
Valid	Secondary school	10	23.3	8	16.3
	HSC or equivalent	7	16.3	9	18.4
	TAFE or equivalent	7	16.3	12	24.5
	Bachelor	12	27.9	11	22.4
	Post Graduate	7	16.3	9	18.4
	Total	43	100.0	49	100.0
Total		116		151	

FAMILY CARERS VISITING TIMES

As discussed in the methodology very few respondents provided an actual time of visitation. Hence the following mean and median times must be treated with considerable caution as the data comes from only 19 respondents in each survey (S1: 16.38% and S2:12.58%).

Most respondents visited around lunchtime. Of those that did respond, the mean time of visitation was approximately 1:13pm (S1) and 1:24pm (S2) and the median was 12:30pm (S1) and 1:24pm (S2) (see Table 16).

Table 16: Mean and median time of visiting for survey 1 and survey 2

	S1	S2
Number	19	19
Mean	1312.63	1323.68
Median	1230.00	1323.68

As can be seen from Table 17 (below) most respondents visited 2-3 days per week (S1:37.5% and S2:32.9%). The next most frequent meeting time was weekly for S1 (28.6%) and weekly or once per day for S2 (21.9%). The category 'other' in the questionnaire allowed people to give a general time they visited such as afternoon, evening or lunch. The times of visitation ranged from 7:00am in the morning to 7:00pm in the evening. Some respondents wrote that the times they visited varied.

Table 17: Frequency of visiting for survey 1 and survey 2 by frequency and %

		S1 Frequency	S1 % Percent	S2 Frequency	S2 % percent
	More than once per day			4	5.5
	Once per day	11	19.6	16	21.9
	2-3 days per week	21	37.5	24	32.9
	Weekly	16	28.6	16	21.9

	Other	8	14.3	13	17.8
	Total %	56	100.0	73	100.0
Total		116		151	

DESCRIPTION OF RESPONSES TO QUESTIONS ON STAFF-FAMILY RELATIONSHIPS

The next section describes responses to 32 statements about the quality of the relationship between staff and residents and staff and family carers. With the exception of one question responses to each question used a rating scale of ‘strongly agree’, ‘agree’, ‘neither agree or disagree’, ‘disagree’, ‘strongly disagree’ and ‘does not apply’.

The selection by respondents of the ‘neither agree or disagree’ category can be interpreted in a number of ways – for example, a neutral position about the subject, and/or a lack of knowledge and/or uncertainty.

Each question can be categorised as either a positive or negative question, with positive questions assuming beneficial activity and relationships (such as staff-family carer engagement with one another and good staff knowledge of residents’ care needs), while negative questions assume more detrimental impacts (such as a lack of respect between parties or an unwillingness of staff to share information).

For the purposes of this description the responses to each of these questions have been grouped under six main headings that capture the central theme of each question (as opposed to the order they were numbered in the questionnaire). The categories for ordering the questions were:

- **Overall satisfaction with staff-family relationships**
- **Point of contact and visiting**
- **Information provision from staff to family carers on residential care**
- **Quality of care and staff knowledge of resident**
- **Quality of relationships with family carers**
- **Care Plan – Family carer involvement**

OVERALL SATISFACTION WITH THE STAFF-FAMILY RELATIONSHIP

Questions reviewed in this section

(i) How satisfied are you with the relationship you have with families? or How satisfied are you with the relationship you have with the staff in the residential care facility?

(ii) Generally relationships between staff and family carers are very good

There above two questions dealt with satisfaction of staff-family relationships. Responses by staff and family carers to both questions were positive overall. There was a small percentage of respondents who were not satisfied (see Tables 18-23).

The overall responses to other questions indicates that dissatisfaction was generally associated with specific issues, rather than the general relationship overall. Examples of specific issues include information and communication issues for family carers that are discussed further in this report.

The first question (*how satisfied are you with the relationship…*) was worded differently depending on whether the respondents were families or staff. It differed from the majority of questions insofar as it was a ranked/point scoring question rather than a agree/disagree question where respondents were required to rate their satisfaction on a scale from 1 to 10, with the number 1 indicating 'totally unsatisfied' and the number 10 indicating 'totally satisfied'.

In question (i), most respondents expressed satisfaction with the relationship they had with either family carers or staff with a mean satisfaction rate of nearly 8 out of a possible 10 (S1, 7.88 and S2, 7.89). There was a remarkable congruence between S1 and S2 in both the mean and mode.

Table 18: Mean and median satisfaction with the staff/family relationship for survey 1 and survey 2

	S1	S2
Mean	7.88	7.89
Median	8.00	8.00
Number	112	147

Table 19: Frequency and % of each satisfaction rating score with staff/family relationship for survey 1 and survey 2

		S1 Frequency	S1 %	S1 Frequency	S1 %
Valid	1	3	2.7	0	0
	2	0	0	1	.7
	3	1	.9	3	2.0
	4	5	4.5	0	0
	5	5	4.5	14	9.5
	6	8	7.1	13	8.8
	7	16	14.3	15	10.2
	8	24	21.4	41	27.9
	9	21	18.8	32	21.8
	10	29	25.9	28	19.0
	Total	112	100.0	147	100.0

As can be seen from Table 19, S1 and S2 differed in terms of the most frequently rated satisfaction score. In S1, the most frequent selection was 10/10 (25.9%), whereas in S2 it was 8/10 (27.9%). If the rating of 5 and under is taken as an indication of strong dissatisfaction, then in both S1 and S2 approximately 12% of respondents were dissatisfied (S1, 12.5% and S2, 12.2%).

Breaking down these figures by respondent type indicates both common ground between staff and families with the median of 8 common to both groups for S1 and S2 (see Table 20).

Table 20: Rank Satisfaction with the relationship by respondent type and mean and median survey 1 and survey 2

Survey No. and Respondent type	S1 Staff	S1 Family Carer	S2 Staff	S2 Family /Carer
Mean	7.91	7.84	7.93	7.85
Median	8.00	8.00	8.00	8.00
N	57	55	75	72

A further analysis by actual rank (see Table 22) shows that a slightly higher percentage of staff selected 5 or below (S1: 14% and S2: 13.3%) compared with family carers (S1: 10.9% and S2, 11.1%).

Table 21: Satisfaction with the relationship by respondent type for survey 1 by frequency and %

		S1 Staff Frequency	S1 Family carer Frequency	S1 Staff % Percent	S1Family carer % Percent
Valid	1	0	3	0	5.5
	2	0	0	0	0
	3	0	1	0	1.8
	4	5	0	8.8	0
	5	3	2	5.3	3.6
	6	2	6	3.5	10.9
	7	10	6	17.5	10.9
	8	12	12	21.1	21.8
	9	12	9	21.1	16.4
	10	13	16	22.8	29.1
	Total	57	55	100.0	100.0

Table 22: Satisfaction with the relationship by respondent type for survey 2 by frequency and %

		S2 Staff Frequency	S2 Family carer Frequency	S2 Staff Valid Percent	S2 Family carer Valid Percent
Valid	1	0	0	0	0
	2	0	1	0	1.4
	3	1	2	1.3	2.8
	4	0	0	0	0
	5	9	5	12.0	6.9
	6	5	8	6.7	11.1
	7	8	7	10.7	9.7
	8	21	20	28.0	27.8
	9	17	15	22.7	20.8

10	14	14	18.7	19.4
Total	75		100.0	100.0

(iii) Generally relationships between staff and family carers are very good

The response to this question was unequivocal. The vast majority of staff and family carers agreed that *generally relationships between staff and family carers are very good* (see Table 24). There was little or no dissent to this question. This response concurs with the positive response to the question on satisfaction on staff family relationships described above. The combined percentage response for respondents for 'agree/strongly agree' ranged from 88.3% for staff (S2) to 92.9% for family carers (S1). There was no 'disagree/strongly disagree response' for staff or family carers in S2 and the maximum 'disagree/strongly disagree percentage in S1 was 1.8%.

The 'neither' response for all categories of respondents ranged from 5.4% (S1 and S2 family carers) to 11.7% (S2 staff).

Table 23: Generally relationships between staff and family carers are very good by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	32.2	59.3	6.8	0	0	1.7
S1 Fam/carers	37.5	55.4	5.4	0	1.8	0
S2 Staff	27.3	61.0	11.7	0	0	0
S2 Fam/carers	32.4	59.5	5.4	2.7	0	0

POINT OF CONTACT AND VISITING

Questions reviewed in this section

(iv) Family carers always know who to speak to if they have questions about their relative's care and treatment

(v) Family carers can always speak to a doctor about their relative's care if they want to

(vi) Family carers are encouraged to visit their relatives whenever they want to

(vii) Staff always tell family carers which nurses are responsible for their relative's care and treatment

Responses to the first three questions concerned who family carers should speak to about their relative's care and visitor access were more clearly positive than the response to question (vii) *Staff always tell family carers which nurses are responsible for their relative's care and treatment*

(iv) Family carers always know who to speak to if they have questions about their relative's care and treatment

The majority of family carers and staff 'agreed' or 'strongly agreed' that *family carers always know who to speak to if they have questions about their relative's care and treatment* (see Table 25 below). Staff in S1 in particular displayed a more noticeable 'strongly agree' response (30.5%) than other respondent groups

Table 24: Families always know who to speak to if they have care questions by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	30.5	44.1	11.9	10.2	0	3.4
S1 Fam/carers	19.6	62.5	7.1	7.1	3.6	0
S2 Staff	18.2	53.2	15.6	13.0	0	0
S2 Fam/carers	21.9	54.8	9.6	13.7	0	0

(v) Family carers can always speak to a doctor about their relative's care if they want to

Similarly, the majority of staff and families carers 'agreed/strongly agreed' that family carers could *always speak to a doctor about their relative's care if they wanted to* with staff having a slightly higher response than family carers to this question.

However a small group of family carers 'disagreed/strongly disagreed' with this question (S1, 14.3% and S2, 9.5%). In contrast, no staff in S1 disagreed with this question and only 2.6% staff in S2 disagreed with this question (see Table 26).

Table 25: Family carers can always speak to a doctor about their relative's care if they want to by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	36.2	43.1	12.1	0	0	8.6
S1 Fam/carers	14.3	62.5	7.1	8.9	5.4	1.8
S2 Staff	35.1	46.8	15.6	2.6	0	0
S2 Fam/carers	25.7	51.4	12.2	9.5	0	1.4

(vi) Family carers are encouraged to visit their relatives whenever they want to

The majority of staff and family strongly agreed with this question. In other words there was a strong view shared by both family carers and staff that family carers felt encouraged to visit whenever they wanted to (see Table 27).This ranged from 89.5% (S1 family carers S1) to 96.6% (S1 staff).

Table 26: Family carers are encouraged to visit their relatives whenever they want to by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	69.0	27.6	3.4	0	0	0
S1 Fam/carers	57.1	35.7	5.4	0	1.8	0
S2 Staff	50.0	39.5	6.6	1.3	2.6	0
S2 Fam/carers	58.9	35.6	4.1	1.4	0	0

(vii) Staff always tell family carers which nurses are responsible for their relative's care and treatment

While most family carers knew who to speak to if they had questions about their relative's care and treatment including access to a doctor, far less family carers agreed than staff that staff always told them which nurses were responsible for their relative's treatment and care (see Table 28).

In contrast, nurses considered that most family carers did know which nurses were responsible for their relative's care. For instance, between 62.4% (S1) and 64.3% (S2) of staff agreed or strongly agreed that *staff always tell family carers which nurses are responsible for their relative's care and treatment* while only 21.5% (S1) and 35.6% (S2) of family carers agreed/strongly agreed with this question.

For this question there was also a noticeable 'neither' response ranging from 35.7% (S1 family carers) to 22.1% (S2 staff).

Table 27: Staff always tell family carers which nurses are responsible for their relative's care and treatment by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	16.1	48.2	19.6	12.5	0	3.6
S1 Fam/carers	5.4	16.1	35.7	26.8	8.9	7.1
S2 Staff	15.6	46.8	22.1	11.7	3.9	0
S2 Fam/carers	8.2	27.4	17.8	34.2	8.2	4.1

INFORMATION PROVISION FROM STAFF TO FAMILY CARERS ON RESIDENT CARE

Questions reviewed in this section

(viii) Staff always answer any questions family carers have about their relative's care and treatment promptly

(ix) Staff ask family carers for any information they might have about their relative's needs/wishes

(x) Staff sometimes do not provide family carers with enough information about their relative's care and treatment

(xi) Family carers are not always given enough information about their relative's future care and treatment

(xii) Family carers do not always have enough information and other resources available to provide care in the facility

These questions all concern information provision, generally by staff to family carers. Two questions were positively framed and three questions were negatively framed.

(viii) Staff always answer any questions family carers have about their relative's care and treatment promptly

(ix) Staff ask family carers for any information they might have about their relative's needs/wishes

The two positively worded questions concerned information sharing and communication but from different perspectives; question X was focussed on family carers requests for information on resident care while Question Y was focussed on staff requests for information about residents needs and wishes. In both cases the majority of staff and family carers agreed that staff answered questions promptly and that staff felt free to ask family carers for information about the resident's needs/wishes (see Table 29 and 30).

However, there were differences. In question viii) family carers in S1 and S2 had a slightly lower agree/strongly agree response to question ix) suggesting that the flow of information tended to come more from family carer requests for information than the other way around. This is also reflected in the higher 'neither' response among family carers in question ix) compared with question viii).

Table 28: Staff always answer any questions family carers have about their relative's care and treatment promptly by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply

S1 Staff	43.1	43.1	8.6	1.7	1.7	1.7
S1 Fam/carers	35.7	57.1	3.6	0	1.8	1.8
S2 Staff	32.5	54.5	6.5	6.5	0	0
S2 Fam/carers	37.8	41.9	12.2	6.8	0	1.4

Table 29: Staff ask family carers for any information they might have about their relative's needs/wishes by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	37.9	55.2	5.2	0	1.7	0
S1 Fam/carers	30.9	47.3	14.5	5.5	1.8	0
S2 Staff	24.7	67.5	3.9	3.9	0	0
S2 Fam/carers	25.7	43.2	21.6	6.8	1.4	1.4

(x) Staff sometimes do not provide family carers with enough information about their relative's care and treatment

(xi) Family carers are not always given enough information about their relative's future care and treatment

As mentioned at the outset – questions phrased in the negative resulted in a more divided responses among respondents than positively worded questions. These two questions were worded similarly with both considering family carers access to information provided by staff on either current care or future care.

Overall, respondents disagreed with these statements but in varying degrees (see Table 31 and Table 32). For instance, a greater percentage of staff and family carers 'disagreed' with the statement that *family carers are not always given enough information about their relative's future care and treatment* (question xi) than the statement that *staff sometimes do not provide family carers with enough information about their relative's care and treatment* (question x). In question x)there was a strong 'agree' response among all respondent groups ranging from 24.1% (S1 staff) to 32.7% (S1 family carers).

In question xi) family carers in S2 were also evenly divided in their response with 48.7% equally 'agreeing/strongly agreeing' and 'disagreeing/strongly disagreeing'.

Table 30: Staff sometimes do not provide family carers with enough information about their relative's care and treatment by respondent and %

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	3.4	24.1	27.6	32.8	12.1	0
S1 Fam/carers	1.8	32.7	16.4	34.5	9.1	5.5
S2 Staff	1.3	26.3	15.8	36.8	19.7	0
S2 Fam/carers	2.7	32.4	18.9	27.0	17.6	1.4

Table 31: Family carers are not always given enough information about their relative's future care and treatment by respondent and %

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	1.7	8.5	18.6	50.8	16.9	3.4
S1 Fam/carers	5.5	16.4	16.4	43.6	7.3	10.9
S2 Staff	3.9	7.8	20.8	57.1	9.1	1.3
S2 Fam/carers	0	21.6	28.4	33.8	14.9	1.4

It is difficult to interpret the overall difference in responses between these two questions except to say that question x), which elicited a more divided response among respondents, implicitly emphasised current care while question xi) emphasised future care. Future care issues may have been more likely to be addressed at the time the resident entered care with the creation of a care plan.

(xii) Family carers do not always have enough information and other resources available to provide care in the facility

This question implies that family carers wished to provide care in the facility or, conversely, that the staff supported family carers engagement in care (see Table 33). This question elicited a high 'neither' response ranging from 27.3% (S2 staff) to 33.3% (S1 family carers) that perhaps indicated that lack of clarity in this area for both staff and family carers.

While overall, staff and family carers 'disagreed' with this question it was not clear cut. For instance, there was only a 5.2% range of difference for staff between 'agree/strongly agree' and 'disagree/strongly disagree' for both surveys. In contrast the range of difference for family carers for these categories was above 20%. This suggests that staff were more acutely aware than staff of the information gap in providing care in the facility.

Table 32: Family carers do not always have enough information and other resources available to provide care in the facility by respondent and %

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	8.8	21.1	29.8	26.3	8.8	5.3
S1 Fam/carers	3.7	7.4	33.3	29.6	11.1	14.8
S2 Staff	3.9	28.6	27.3	27.3	10.4	2.6
S2 Fam/carers	1.4	19.2	31.5	32.9	8.2	6.8

QUALITY OF CARE AND STAFF KNOWLEDGE OF RESIDENT

Questions reviewed in this section

(xiii) Staff always have enough time to give good quality care

(xiv) There are always enough staff to give good quality care

(xv) Staff are knowledgeable about relative's care and treatment

(xvi) Family carers are not always confident that staff have the knowledge and skills needed to give good quality care

(xvii) Staff take time to get to know residents as a person

(xviii) Staff always listen to the resident's views about their care and treatment

(xix) Staff are not always aware of residents' likes and dislikes

(xx) Staff are more concerned with getting the job done than caring for residents as individuals

(xxi) Staff care about family carers' welfare and needs, as well as those of their relative

(xxii) If family carers have any complaints about their relative's care staff always attend to these promptly

(xiii) Staff always have enough time to give good quality care

(xiv) There are always enough staff to give good quality care

These questions were similar with one focussing on time and the other on staffing levels. Both questions elicited comparatively high 'agree' and 'disagree' responses suggesting the questions were somewhat polarising and that time and staffing levels were issues (see Tables 44 and 45). The questions also elicited marked 'neither' responses (generally above 20%).

Table 33: Staff always have enough time to give good quality care by respondent and %

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	10.3	25.9	24.1	32.8	6.9	0
S1 Fam/carers	5.5	40.0	23.6	25.5	5.5	0
S2 Staff	13.2	30.3	21.1	26.3	9.2	0
S2 Fam/carers	12.2	29.7	28.4	23.0	6.8	0

Notwithstanding the closeness of the percentages for 'agree/strongly agree' and 'disagree/strongly disagree' most respondents were likely to agree than disagree that staff had enough time to give good quality care (see Table 34) while the same was not true for staffing levels where most respondents 'disagreed' that there were enough staff to give good quality care (see Table 35).

Table 34: There are always enough staff to give good quality care by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	11.9	25.4	15.3	33.9	13.6	0
S1 Fam/carers	5.5	30.9	21.8	30.9	10.9	0
S2 Staff	11.7	29.9	20.8	28.6	9.1	0
S2 Fam/carers	10.8	24.3	23.0	31.1	10.8	0

The following two questions were about staff knowledge in relation to care of the resident with one question worded in the positive and the other in the negative. The majority of staff and family carers agreed that s*taff were knowledgeable about their relative's care and treatment* and disagreed that *family carers are not always confident that staff have the knowledge and skills needed to give good quality care* (see Tables 36 and 77).

However, the negatively worded question (see Table 37) elicited a more equivocal response than the positively worded question highlighting the issue of family carer confidence in staff knowledge. There was a strong 'neither' response to this question compared with the previous question (see Table 36) particularly among staff (S1: 22.4% and S2: 32.9%).The percentage of those respondents who agreed that *family carers were not always confident that staff have the knowledge and skills needed to give good quality care* ranged from 17.9% (S1 family carers) to 29.3% (S1 staff).

(xv) Staff are knowledgeable about relative's care and treatment

Table 35: Staff are knowledgeable about relative's care and treatment by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	39.7	51.7	5.2	1.7	0	1.7
S1 Fam carers	22.2	51.9	16.7	7.4	1.9	0
S2 Staff	31.2	53.2	10.4	3.9	1.3	0

S2 Fam carers	24.7	52.1	15.1	6.8	1.4	0

(xvi) Family carers are not always confident that staff have the knowledge and skills needed to give good quality care

Table 36: Family carers are not always confident that staff have the knowledge and skills needed to give good quality care by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	0	29.3	22.4	31.0	15.5	1.7
S1 Fam/carers	7.1	17.9	14.3	42.9	16.1	1.8
S2 Staff	0	26.3	32.9	32.9	6.6	1.3
S2 Fam/carers	4.1	19.2	15.1	41.1	19.2	1.4

(xvii) Staff take time to get to know residents as a person

(xviii) Staff always listen to the resident's views about their care and treatment

These two questions concerned more detailed staff knowledge of the resident and implied a direct or implied focus on person centred care The majority of staff and family carers agreed with both questions (see Tables 38 and 39). .

However, staff and family carers were in more agreement with the first question (xvii) (that staff took *time to get to know residents as a person*) than in the second question (xviii)(that *staff always listen to the resident's views about their care and treatment*). In the first question staff and family carers were closely matched in their agree/strongly agree responses while in the second question family carers responses were lower than staff (S1: family carers 57.1% versus staff 76.2% and S2: family carers 54% and staff 81.6%). There was a marked 'neither' response for family carers in S2 (31.1%).

This difference in response between the two questions between staff and family carers may be partly explained by the more definitive way the second question was worded compared with the first question.

Table 37: Staff take time to get to know residents as a person by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	35.0	46.7	10.0	8.3	0	0
S1 Fam/carers	25.0	55.4	16.1	1.8	1.8	0
S2 Staff	28.6	57.1	5.2	9.1	0	0
S2 Fam/carers	27.4	54.8	11.0	6.8	0	0

Table 38: Staff always listen to the resident's views about their care and treatment by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	25.4	50.8	16.9	5.1	0	1.7
S1 Fam/carers	10.7	46.4	19.6	5.4	5.4	12.5
S2 Staff	22.4	59.2	7.9	7.9	1.3	1.3
S2 Fam/carers	10.8	43.2	31.1	5.4	0	9.5

The next two questions concerned a lack of awareness or concern of individual residents needs and could be described as non-person centred care questions. Overall respondents 'disagreed/strongly disagreed' with these statements but the result was not clear cut with a marked agree response to both questions (see Tables 40 and 41).

(xix) Staff are not always aware of residents' likes and dislikes

In this question there was noticeable dissenting view with between 27.4% (S2: family carers) and 35% (S1: staff) of respondents 'agreeing/strongly agreeing' with this question (see Table 40). There was also a noticeable 'neither' response with 3 out of 4 respondent groups registering above 20%.

Table 39: Staff are not always aware of residents' likes and dislikes by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	1.7	33.3	20.0	28.3	16.7	0
S1 Fam/carers	5.4	30.4	21.4	33.9	5.4	3.6
S2 Staff	2.6	36.4	15.6	28.6	16.9	0
S2 Fam/carers	1.4	26.0	24.7	34.2	11.0	2.7

(xx) Staff are more concerned with getting the job done than caring for residents as individuals

In question (xx) there was a marked 'agree/strongly agree' response from staff (S1:27.6% and S2: 27.3%). There was also a marked 'neither' response for family carers of 30.6% in S2 while the other respondents registered in the vicinity of 20%.

Table 40: Staff are more concerned with getting the job done than caring for residents as individuals by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	5.2	22.4	20.7	31.0	20.7	0
S1 Fam/carers	10.7	7.1	19.6	50.0	10.7	1.8
S2 Staff	3.9	23.4	22.1	39.0	11.7	0
S2 Fam/carers	0	11.1	30.6	41.7	16.7	0

(xxi) Staff care about family carers' welfare and needs, as well as those of their relative

This question in effect broadens the concept of care to include family carers. The majority of respondents agreed that *staff care about family carers' welfare and needs* with staff more likely to agree with this question than family carers (see Table 42). The strength of staff agreement with this question was reinforced by the high agree/strongly agree percentages (S1: 77.5% and S2: 83.1%) compared with family carers (S1:60.7% and S2: 53%). Family carers were more likely than staff to register a 'neither' response (S1: 26.8% and S2: 27.4%) than staff (S1:15.5% and S2: 13%).

Table 41: Staff care about family carers' welfare and needs, as well as those of their relative by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	24.1	53.4	15.5	5.2	1.7	0
S1 Fam/carers	14.3	46.4	26.8	10.7	1.8	0
S2 Staff	18.2	64.9	13.0	3.9	0	0
S2 Fam/carers	19.2	43.8	27.4	8.2	0	1.4

Complaints

(xxii) If family carers have any complaints about their relative's care staff always attend to these promptly

The majority of respondents clearly agreed with this question (see Table 43). It elicited a firmer response in staff than family carers. The combined percentages of 'agree/strongly agree' reflect this particularly in S1 (S1: staff 91.50%, family carers 69.60%).

Table 42: If family carers have any complaints about their relative's care staff always attend to these promptly by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	40.7	50.8	6.8	0	0	1.7
S1 Fam/carers	12.5	57.1	17.9	8.9	1.8	1.8
S2 Staff	27.3	59.7	6.5	5.2	1.3	0
S2 Fam/carers	16.2	58.1	12.2	8.1	0	5.4

QUALITY OF RELATIONSHIPS WITH FAMILY CARERS

Questions reviewed in this section

(xxiii) Staff always make family carers feel welcome in the facility

(xxiv) Staff do not always treat family carers with dignity and respect

(xxv) Staff often speak sharply to family carers or residents

The above three questions highlight aspects of the overall relationship (2 questions) and more specific engagement and communication with residents and family carers (1 question).

(xxiii) Staff always make family carers feel welcome in the facility

In this positively worded question the overwhelming majority of staff and family carers 'agreed or strongly agreed' with this statement ranging from 89.5% (S2 staff) to 94.9% (S1 staff) (see Table 44). The strength of agreement was reinforced by the high percentage of 'strongly agree' responses which outstripped agree responses for staff in S1 and family carers in S2. The unequivocal response is highlighted by the very few 'neither' responses to this question.

Table 43: Staff always make family carers feel welcome in the facility by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	55.2	39.7	3.4	0	1.7	0
S1 Fam/carers	42.9	51.8	3.6	0	1.8	0
S2 Staff	39.5	50.0	7.9	2.6	0	0
S2 Fam/carers	51.4	41.9	1.4	4.1	1.4	0

(xxiv) Staff do not always treat family carers with dignity and respect

(xxv) Staff often speak sharply to family carers or residents

These two negatively oriented questions were focussed on whether or not staff had respectful communication with family carers although the second question also included residents.

Respondents clearly disagreed with the question that staff *do not always treat family carers with dignity and respect*. For staff the 'strongly agree' response outstripped the 'agree' response. The combined disagree/strongly disagree responses of all four groups was above 80% (see Table 45).

Table 44: Staff do not always treat family carers with dignity and respect by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	1.7	6.8	5.1	35.6	49.2	1.7
S1 Fam/carers	1.8	3.6	3.6	57.1	32.1	1.8
S2 Staff	1.3	7.8	6.5	37.7	46.8	0
S2 Fam/carers	2.7	0	12.2	48.6	35.1	1.4

The majority of respondents also disagreed that *staff often speak sharply to family carers or residents*, although the level of disagreement was less than in question (xxv) and ranged from 66.3% (S2 family carers) to 80% (S1 family carers). There was also a marked 'neither' response in S2 of approximately 20%. Surprisingly there was a 13%-13.8% 'agree' response from staff in both S1 and S2 respectively suggesting that this was a noticeable issue for a small group of staff (S1, n= 8 and S2, n=10). There is insufficient information to know whether these staff were criticising other staff in their facility or reflecting on their own behaviour.

Table 45: Staff often speak sharply to family carers or residents by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	1.7	13.8	6.9	46.6	31.0	0
S1 Fam/carers	1.8	0	14.5	52.7	27.3	3.6
S2 Staff	0	13.0	20.8	31.2	35.1	0
S2 Fam/carers	0	2.7	19.2	46.6	30.1	1.4

CARE PLAN – FAMILY CARER INVOLVEMENT

Questions reviewed in this section

(xxvi) Staff always listen to family carers' views and opinions about their relatives care

(xxvii) Residents' future care and treatment needs are discussed with family carers

(xxviii) Family carers are not always fully involved in discussions about their relative's care and treatment

(xxix) Family carers have some control over their relative's care and treatment

(xxx) Family carers sometimes interfere by making suggestions about their relative's care

(xxxi) Staff discuss fully with family members how to become involved in care

(xxxii) Staff take time to teach family carers the skills they need to care for their relative in the facility

(xxxiii) Family carers always have an assessment of their needs as a carer

(xxxiv) Family carers are not always encouraged to be involved in their relative's care and treatment, even though they want to be

(xxxv) Family carers are usually asked to leave the room when care is being provided to their relative

As can be seen from the number of questions above family carer involvement in care comprised the bulk of questions which can be broadly grouped into two main areas:

- Whether or not family carers views and opinions are incorporated into residential care
- Whether or not family carers participate directly in residential care and treatment

The analysis of these questions begins with the first grouping - whether or not family carers' views and opinions are incorporated into residential care.

(xxvi) Staff always listen to family carers' views and opinions about their relatives care

(xxvii) Residents' future care and treatment needs are discussed with family carers

There was overall agreement to positively worded questions and particularly strong agreement to the above two questions (see Table 47 and 48).

In question xxvi), *staff always listen to family carers' views and opinions about their relatives care between* 80.3%.to 86.4% 'agreed or strongly agreed'. In question xxvii) *residents' future*

care and treatment needs are discussed with family carers, the range was between 71.2% and 90.9% 'agreed/strongly agreed' with family carers being at the lower end of this range. Staff also had a noticeably higher 'strongly agree' response than family carers to this question.

Table 46: Staff always listen to family carers' views and opinions about their relatives care by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	35.6	50.8	10.2	1.7	0	1.7
S1 Fam/carers	21.4	58.9	14.3	3.6	1.8	0
S2 Staff	31.2	54.5	9.1	5.2	0	0
S2 Fam/carers	21.6	60.8	13.5	2.7	0	1.4

Table 47: Residents' future care and treatment needs are discussed with family carers by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	42.4	47.5	6.8	0	0	3.4
S1 Fam/carers	12.5	58.9	14.3	5.4	1.8	7.1
S2 Staff	32.5	58.4	6.5	2.6	0	0
S2 Fam/carers	17.8	53.4	15.1	9.6	0	4.1

(xxviii) Family carers are not always fully involved in discussions about their relative's care and treatment

The majority of respondents disagreed with this question with a 'disagree/strongly disagree' response range of 39.2% to 53.3%. The lowest response of 39.2% was from family carers in S2 followed by staff in S1 (48.2%) (see Table 49).

There was, however, a comparatively strong 'agree' response (18.2% to 33.9%) with the highest percentage in the family carers' category (S1 followed by S2). With the exception of S1 family carers there was a strong 'neither' response for all respondent groups.

Table 48: Family carers are not always fully involved in discussions about their relative's care and treatment by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	0	26.8	21.4	33.9	14.3	3.6
S1 Fam/carers	1.8	33.9	8.9	35.7	14.3	5.4
S2 Staff	1.3	18.2	27.3	39.0	14.3	0
S2 Fam/carers	0	29.7	28.4	21.6	17.6	2.7

(xxix) Family carers have some control over their relative's care and treatment

As with previous, similarly worded, questions the was a strong agree response ranging from 77% for family carers (S2) to 87.9% for staff (S1). There was a marked 'neither' response for staff in S2 (22.1% n= 17) (see Table 50).

Table 49: Family carers have some control over their relative's care and treatment by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	17.2	70.7	8.6	1.7	0	1.7
S1 Fam/carers	10.7	69.6	8.9	7.1	3.6	0
S2 Staff	13.0	59.7	22.1	3.9	0	1.3
S2 Fam/carers	10.8	66.2	16.2	6.8	0	0

(xxx) Family carers sometimes interfere by making suggestions about their relative's care

In this question there were quite different responses between staff and family carers with the majority of staff agreeing and the majority of family carers disagreeing (see Table 51). These responses highlight differences in perspectives. For instance, family carers are far less likely than

staff to identify their suggestions as interference. With the exception of S2 staff there was also a marked 'neither' response from respondents ranging from 23.3% to 35.6%.

Table 50: Family carers sometimes interfere by making suggestions about their relative's care by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	8.5	35.6	35.6	15.3	3.4	1.7
S1 Fam/carers	3.6	10.9	25.5	34.5	20.0	5.5
S2 Staff	5.2	53.2	14.3	23.4	3.9	0
S2 Fam/carers	1.4	16.4	23.3	34.2	17.8	6.8

The next group of questions looks more closely at the second grouping - whether or not family carers participate directly in residential care and treatment. The responses to these questions show a more divided response between respondent type. For instance responses to the next three questions were not clear cut and reinforced differences between staff and family carers (see Table 52 -54).

(xxxi) Staff discuss fully with family members how to become involved in care

The majority of staff 'agreed' or 'strongly agreed' with this statement (S1 staff 64.4% and S2 staff 61.1%) although compared with responses to other questions the response was not high. In contrast to staff, the majority of family carers settled on 'neither' with 41.1% for S1 and 30.2% for S2 (see Table 52).

The 'agreed/strongly agreed responses' for family carers were 35.7% (S1) and 30.2% (S2) respectively. Family carers in S2 also had a marked disagree/strongly disagree result (23.2% n=17).

Table 51: Staff discuss fully with family members how to become involved in care by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply

S1 Staff	18.6	45.8	23.7	3.4	0	8.5
S1 Fam/carers	3.6	32.1	41.1	8.9	7.1	7.1
S2 Staff	11.7	49.4	27.3	9.1	0	2.6
S2 Fam/carers	11.0	19.2	32.9	16.4	6.8	13.7

(xxxii) Staff take time to teach family carers the skills they need to care for their relative in the facility

Similar to the previous question there was a divided response between staff and family carers. Only staff were in the majority in their 'agree/strongly agree' response to this statement and this percentage was comparatively low compared (S1 55.1% and S2 44.8%) (see Table 53). In S1 the majority of family carers selected the 'neither' category (39.3%). In S2 the results for family carers were closely matched in each category with 29.3% of family carers 'agreeing/strongly agreeing', 29.7% 'disagreeing/strongly disagreeing' and 25.7% selecting 'neither'.

Table 52: Staff take time to teach family carers the skills they need to care for their relative in the facility by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	10.3	44.8	22.4	10.3	0	12.1
S1 Fam/carers	3.6	16.1	39.3	14.3	7.1	19.6
S2 Staff	6.6	38.2	30.3	18.4	3.9	2.6
S2 Fam/carers	8.1	21.6	25.7	27.0	2.7	14.9

(xxxiii) Family carers always have an assessment of their needs as a carer

As with the previous question responses were equivocal. In three respondent categories the percentage of 'neither; responses outnumbered the 'agree/strongly' agree response (S1 and S2 family carers; S2 staff) with the 4th respondent category staff S1 also exhibiting a high 'neither' response. The overall 'agree/strongly agree' responses were relatively low although not as low as the previous question (29.1% to 49.1%). There was a marked 'disagree/strongly disagree response from family carers in S2 (21.7%) (see Table 54).

Table 53: Family carers always have an assessment of their needs as a carer by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	12.3	36.8	33.3	7.0	0	10.5
S1 Fam/carers	1.8	27.3	30.9	7.3	9.1	23.6
S2 Staff	3.9	36.8	44.7	9.2	0	5.3
S2 Fam/carers	7.2	23.2	31.9	17.4	4.3	15.9

The responses to the above three questions suggests that care of the relative in the facility may not be part of standard practice in these facilities or that only selected family carers choose to take on that role of their own volition. In the discussion on comments at the end of this report a number of staff express frustration at the lack of family carer engagement with residents.

Whether or not family carers receive any formal training or assessment remains unknown. The response to the next question however suggests otherwise.

(xxxiv) Family carers are not always encouraged to be involved in their relative's care and treatment, even though they want to be

The majority of respondents 'disagreed' with this questions with a 'disagree/strongly disagree' response range of (58.9% to 70.7%) with the highest 'disagree/strongly disagree score coming from staff in S1 (see Table 55). There was however, a marked neither response in the vicinity of 20% for all respondents. Responses to this question suggest that there is a level of informal invitation for family carers to participate in residential care.

Table 54: Family carers are not always encouraged to be involved in their relative's care and treatment, even though they want to be by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	0	10.3	19.0	37.9	32.8	0
S1 Fam/carers	1.8	10.7	23.2	44.6	14.3	5.4

S2 Staff	0	11.7	23.4	36.4	28.6	0
S2 Fam/carers	0	9.6	20.5	43.8	20.5	5.5

(xxxv) Family carers are usually asked to leave the room when care is being provided to their relative

This statement elicited quite different responses between staff and family carers reflecting very different viewpoints about the reality and reinforcing the lack of clarity around family carer participation in care.

The majority of staff agreed with this question while the majority of family carers did not (see Table 56). However the 'neither' response for staff was slightly higher for staff than that for family carers suggesting it was not necessarily a clear cut issue for staff. This was also reinforced by the comparatively low 'agree/strongly agree' percentage for staff in both surveys (61%-62.3%).

Table 55: Family carers are usually asked to leave the room when care is being provided to their relative by respondent and % for survey 1 and survey 2

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Does not Apply
S1 Staff	16.9	44.1	22.0	11.9	1.7	3.4
S1 Fam/carers	0	19.6	16.1	46.4	5.4	12.5
S2 Staff	6.5	55.8	19.5	14.3	2.6	1.3
S2 Fam/carers	6.8	14.9	16.2	35.1	17.6	9.5

APPENDIX 4

Supporting families and friends of older people living in residential aged care

We would like to acknowledge the ACEBAC Board for their participation in producing this monograph.

This monograph is informed by the work reported in 'Haesler, E., Bauer, M.& Nay, R. *Factors associated with constructive nursing staff-family relationships in the care of older adults in the institutional setting.* A Systematic Review. International Journal of Evidence-based Healthcare. 4(4) 288-336'.

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Note: The final printed format of this booklet is available in PDF form at *www.latrobe.edu.au/acebac*

Introduction

If you are considering moving, or have already moved, a family member or friend into a nursing home or hostel (now officially called a residential aged care facility) the following information may be helpful. The Australian Centre for Evidence Based Aged Care (ACEBAC) has searched for the best and most current information that will give some insight into how to relate to the people involved in the care program offered by the facility.

The words ‘family’, ‘family member’ and ‘relative’ are used throughout this booklet to refer to anyone who has been involved, and wants to remain involved, with the person who is living, or will be living, in residential aged care. This includes friends even though they may not always be specifically referred to by name in this booklet. The word ‘resident’ is used to refer to the person living in the residential aged care facility.

Older people need to maintain contact with their family and friends. Family members and friends may want to continue to provide some of the care required by the older person when they move into residential care. Aged care facilities have an obligation to consult with family members. However, sometimes there can be misunderstandings on the part of both parties that can lead to frustration and impinge on the relationship between families and care staff. A collaborative approach from both families and staff benefits all concerned.

The information in this brochure is designed to examine the caring relationship from the point of view of all parties: the family or friends; the care staff; and the facility management. We hope this will clarify some issues and help you to seek further information from the facility or other sources if required.

Involvement in Care

If you have been involved in caring for a spouse or family member for some time you will know this person very well. You may have been involved in providing intimate personal care. You may have been under pressure yourself to maintain a balance in your own life, as constant care is tiring and can be demanding on family members. The feeling of ‘giving up’ and relinquishing care to someone else may be both a relief and a frightening prospect. It is therefore very important you maintain your involvement in care in ways that are best for you and your relative. This will mean forming relationships with others that are involved in the care and sharing information about your relative to make the care meaningful for all.

SUMMARY

The following points are a summary of ACEBAC's review of the information about family and staff relationships in residential aged care:

- Collaborative team care between family members and care staff is the best model for delivering care.
- Family members need to understand how the facility works, whether teamwork models are really working and how they can contribute to care delivery.
- Communication avenues should be established from the time when the older person is planning the move into residential care.
- Care planning and monitoring is a team effort and changes to care are best achieved through team decisions.
- Positive relationships are essential for quality of life of people living in residential care.

The summary provided on the previous page is now explained in more detail.

MY FAMILY MEMBER IS AN INDIVIDUAL

- Of course they are! They can never be replaced. Relationships formed over years are the basis for human well being, although they may vary and some are stronger than others. We must respect the fact that others may not see our relationships the way we do but nevertheless they are expected to come to an understanding about how we feel.

- Care staff are taught to respect the individuality of each resident and to encourage the expression of this in the life of the person. We all express our individuality in our own way and our needs may change over time. It can be hard for care staff to meet all these needs especially when they are caring for several people at the same time. Talking to the family to find out how needs can be met is very important for all staff members involved in care.

- You may find some staff are better than others at finding ways to preserve your relative's individuality. You may think that your relationships with these staff are stronger than with others. Appreciation of the care offered by these staff can be expressed in many ways but it is preferable not to seem to favour one staff member over another. Care is delivered over a 24-hour period and therefore many different staff members will relate to the residents in different personal ways.

Family members have needs as well

- Moving a relative into residential aged care has often been described by families as ‘the hardest thing we ever did’ – it is common to feel guilty.

- Sometimes family members feel the strain of visiting their relative and not being able to share in the care experience in the same way as they did at home. The reason for moving into a care facility may also be a factor in determining how families relate to caregivers. A diagnosis of dementia may be devastating for families and any terminal illness will bring grief and feelings of helplessness.

- It is important you make your feelings known to staff and ask about any aspects of care you are uncertain about. Staff need to know your thoughts about involvement in care and how much you would like to participate in the day to day life of your relative and the facility.

- Support for families is important and may be found through external agencies as well, such as Alzheimer’s Australia, Carers’ Association or other organisations concerned with long term illness.

- You may need more information about the facility’s provision of health care and what your responsibilities are as a family member. For example, maintaining suitable clothing, shoes, outings and special treats are things you can provide. Your relative may have attended special health professionals such as the dentist, podiatrist or gone to a hairdresser over many years and you may wish to maintain this relationship and service while they are living in an aged care facility. You can discuss this with the facility manager.

- Further information about other medical issues or diagnoses can be obtained by arranging a meeting with the doctor, reading about the problems, finding out through chronic care associations, using the internet, and asking questions of senior care staff.

MAINTAINING COMMUNICATION

- You have known your relative for a long time; the staff for only a short time. Providing information about the care needs of your relative will help in developing positive relationships between you and the care staff. Often family members feel that staff are reluctant to take notice of information you may have provided. This may be due to the fact that staff feel that the resident's needs, as expressed by their family, cannot be realistically met. A discussion about the roles of the staff and the input from you as a carer, based on the resident's care plan is one way to establish good communication. If a particular staff member seems unapproachable you can discuss this with the facility manager. Resolution of any concerns you may have is best achieved through discussion and clear communication.

- It is important to share clear information. You have a right to receive correct information about care issues. Being honest and talking openly about your expectations should make it easier for staff to know what you require and whether they can meet your needs and those of your relative.

- We all want the best for our relatives but we also need to be aware of the constraints of living in a community environment with many other people. It is often impossible to concentrate solely on one person when there are ten others waiting. Balancing time and complex priorities in care is difficult for staff but they should still listen to your concerns and talk about how a compromise can be reached.

- Communication is a vital ingredient for shared care in a true partnership model between the care staff and you as a relative. Keeping the lines of communication open requires an effort from both partners. The quality of life for the older person living in the aged care facility should be the common focus for all discussion.

CONTROLLING WHAT HAPPENS IN CARE

- Sometimes family members feel they are just bystanders in care delivery and that they can only monitor what happens and report what they see as below standard care. This approach causes friction between care staff and the family as the staff feel they are being watched and reported to management for poor work. It is better to work with staff to achieve the goals set initially and to share concerns with the staff member directly. If there are ongoing issues or staff are inappropriate in their response to your concerns then management should be informed.

- Information and knowledge is power and can be used to maintain control over situations by some staff who feel they cannot let family members be involved in aspects of care. Establishing trust takes time, tolerance and an understanding of reasonable expectations in long term care settings. It is important to remember that no person can know everything at once or be expected to react to demands immediately unless they are life threatening.

Management issues

- The way in which care facilities are managed may affect the relationships between staff and families. Staff workloads, level of training, and care models can work against collaborative care. Families complain about not enough staff, too many fixed routines, staff not having enough time to talk to relatives and poor communication.

- All facilities work to a budget and all are required to meet Australian government standards for accreditation. If you understand these obligations you will see how staff have to operate and this may affect your involvement in care. If you have concerns about poor organisation you should raise this with the management, not the direct care staff. Often there may be friction between staff and management and involving families in these matters may only increase the tension in the facility.

- Quality of care issues that relate to poor management are best dealt with by direct discussion with facility management first. There are avenues for families to raise concerns with the Department of Health and Ageing or to seek advice from advocacy or consumer groups if the problems cannot be solved with the facility management. If you believe work practices are impeding quality care, then you should raise your concerns and seek answers. Organisations provide care for many older people and most try to do their best with the resources available so it is essential you get the facts right before taking matters further.

Collaborative care

To collaborate means to ‘work with’.

- Working with others to achieve a result is teamwork. Staff engaged in care and family members should ideally work as a team, share information and support each other in making decisions about care while ensuring that the older person is involved where possible. How staff are prepared and supported by the organisation will also determine how they are able to function as a team member. You should also expect the staff team members to consult with you before taking action in care matters.

- If team members do not communicate, the result can be competition, not collaboration. The older person receiving care becomes ‘owned’ by the factions that develop and a tug of war ensues that can only be detrimental. Strong personalities should not be allowed to overcome teamwork and disrupt care. Open communication is the way to avoid this problem.

- Teamwork is the only way to deliver care to improve the quality of life for the resident. Care staff cannot provide total care without the input from family members and family members cannot undertake all the care that a skilled caregiver can provide.

Care interventions

- The most important part of care delivery is the first meeting between the family members and the care staff to discuss the care plan. Team meetings are a very good way of getting information and discussing expectations with the 'new' care team. Staff perceive family members in a more positive manner if there is a shared model of care from the start.

- The roles of each team member should be clear and the implementation of care strategies should be shared. Lines of communication should be made clear and avenues for family members to be included in decisions outlined.

- Care staff require management support and guidelines to help develop the team approach.

- Sometimes care interventions undertaken by staff may cause you concern in relation to dementia care, resident safety and behaviour. Team discussions should take place before any decisions are made about altering care e.g. increasing medication, changing rooms etc. These agreed changes should be written up in the care plan.

- In emergency situations decisions may have to be made quickly but family members should expect to be contacted as soon as practicable.

- Again team meetings are the best way to discuss future options for care and any changes that may be seen to be required

We would like to acknowledge and respect your continued involvement in the care of your relative while they live in a residential aged care facility. Some useful contact numbers and websites are provided below.

Useful contacts:

Alzheimer's Australia – there are State offices but the contact number of the National Office is (02) 6254 4233 http://www.alzheimers.org.au

Carers' Australia – there are State offices but the general contact number is 1800 242 636 http://www.carersaustralia.com.au/

Aged Care Complaints Investigation Scheme 1800 550 552

Elder Rights Advocacy 1800 700 600 or 9602 3066

APPENDIX 5

Table 1: Mann-Whitney Test Comparing staff with family S1 and S2 <.05

Survey Questions	S1 Assymp. Sig. (2-tailed)	S2 Assymp. Sig. (2-tailed)
(X). Staff are knowledgeable about relative's care and treatment	.009	
(X). Staff care about family carers' welfare and needs, as well as those of their relative	.042	
(X). Family Carers are not always confident that staff have the knowledge and skills needed to give good quality care		.033
(X). If family carers have any complaints about their relative's care staff always attend to these promptly		.022
(X). Residents' future care and treatment needs are discussed with family carers		.001
(X). Staff take time to teach family carers the skills they need to care for their relative	.001	.015
(X). Staff always listen to the resident's views about their care and treatment	.004	.001
(X). Family carers do not always have enough information and other resources available to provide care	.019	
(X). Family carers always have an assessment of their needs as a carer	.003	
(X). Staff discuss fully with family members how to become involved in care	.001	

Table 2: Mann-Whitney Test Comparing staff by site between S1 and S2 <.05

Survey Questions	Site G	Site Y
	Asymp. Sig. (2-tailed)	Asymp. Sig. (2-tailed)
(X). Family carers are not always fully involved in discussions about their relative's care and treatment	.009	
(X). Family carers sometimes interfere by making suggestions about their relative's care		.042

Table 3: Mann-Whitney Test Comparing family carers by site between S1 and S2 <.05

Survey Questions	Site 0	Site Y
	Asymp. Sig. (2-tailed)	Asymp. Sig. (2-tailed)
(X). Staff ask family carers for any information they might have about their relative's needs/wishes		.015
(X). Staff sometimes do not provide family carers with enough information about their relative's care and treatment	.025*	.041
(X). Family carers are not always fully involved in discussions about their relative's care and treatment	.037*	
(X). Family carers are encouraged to visit their relatives whenever they want to		.048
(X). Family carers are not always encouraged to be involved in their relative's care and treatment, even though they want to be.	.020*	

(X). Family carers are not always confident that staff have the knowledge and skills needed to give good quality care		.019
(X). Family carers can always speak to a doctor about their relative's care if they want to	.040*	
(X). Family carers are not always given enough information about their relative's future care and treatment		.038
(X). Family carers do not always have enough information and other resources available to provide care		.007

* Not corrected for ties

Graphs for responses to questions where significance was identified in the Mann-Whitney Test comparing staff with family S1 and S2 <.05 (Table 1)

(Note: In order to limit the number of bars the 'does not apply' category has been excluded from these graphs)

SURVEY 1

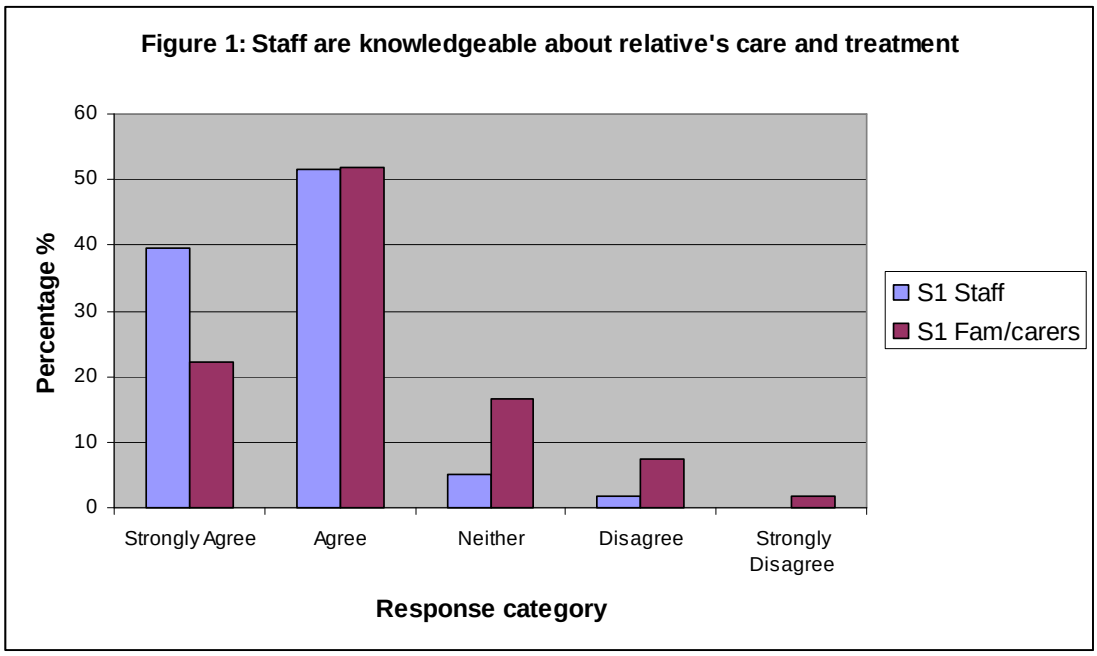


Figure 2: Staff care about family/carers welfare

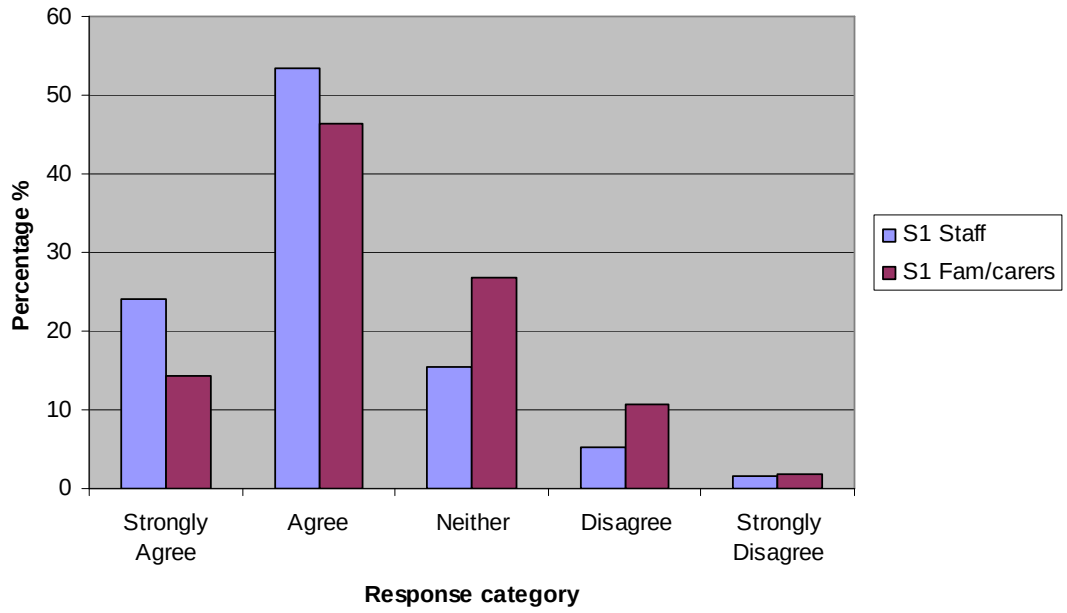


Figure 3: Staff take time to teach family carers the skills they need to care for their relative

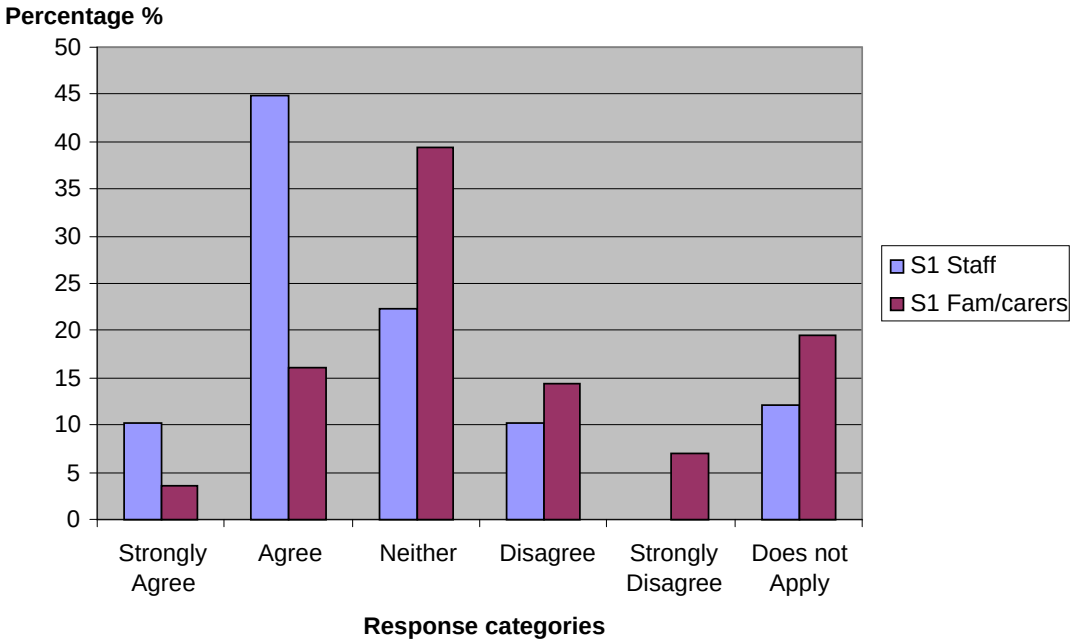


Figure 4: Staff always listen to the patient's views about their care and treatment

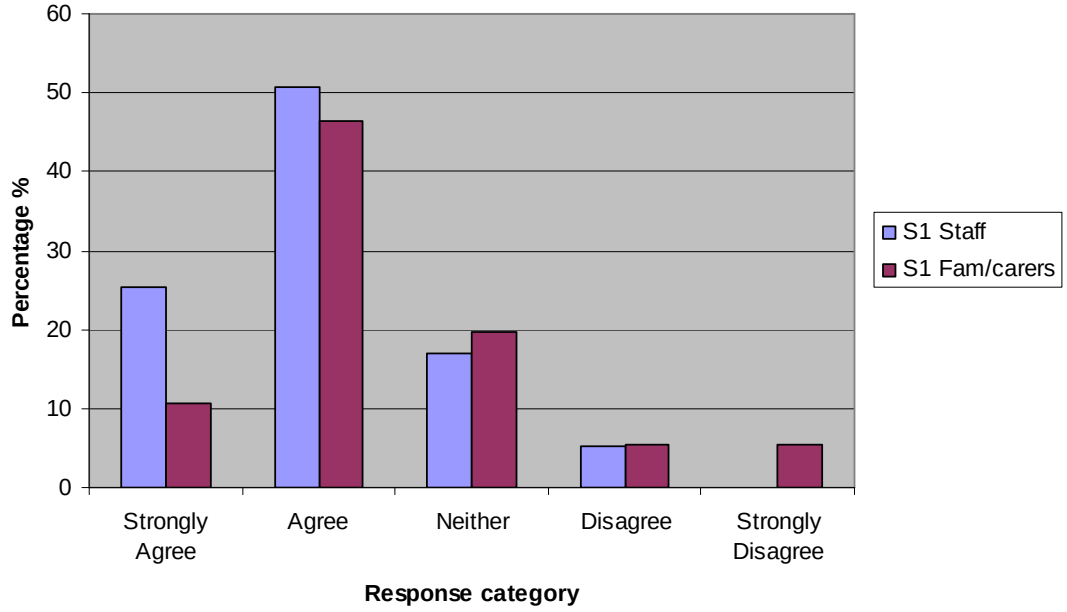


Figure 5: Families do not always have enough information and other resources available to provide care

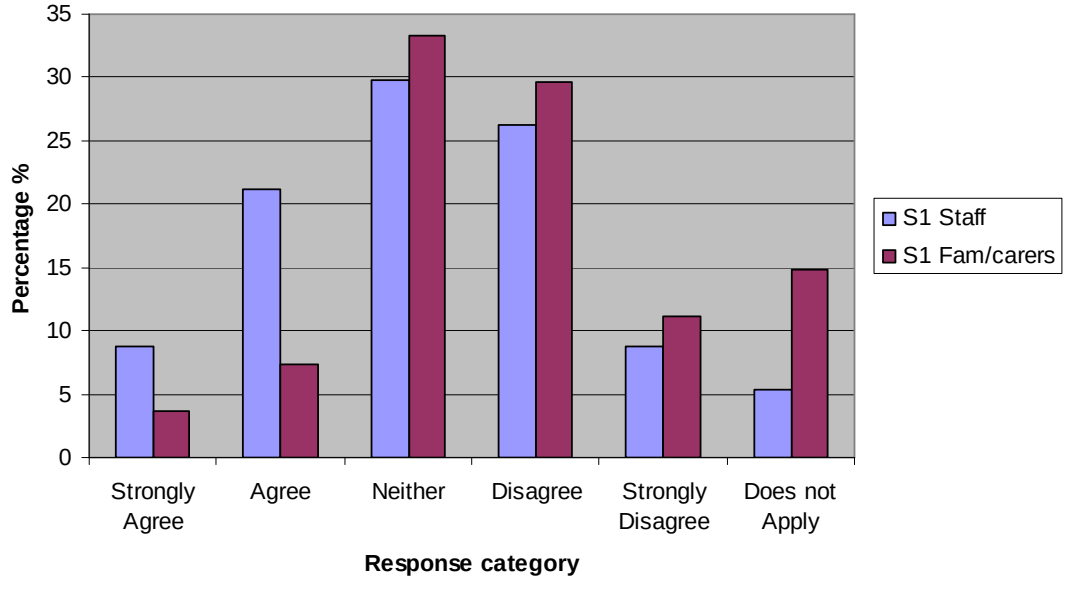


Figure 6: Family carers always have an assessment of their needs as a carer

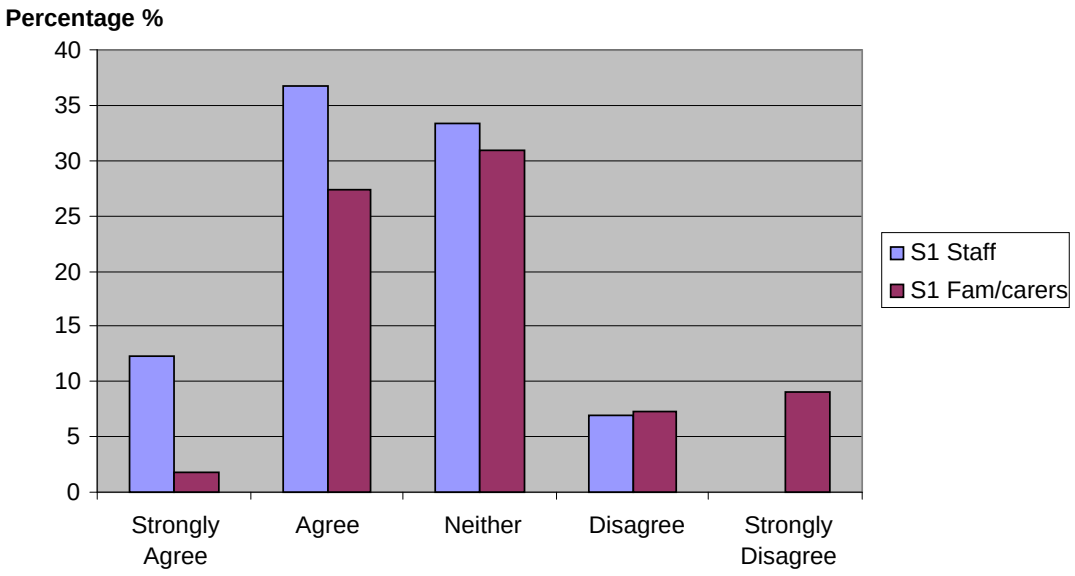
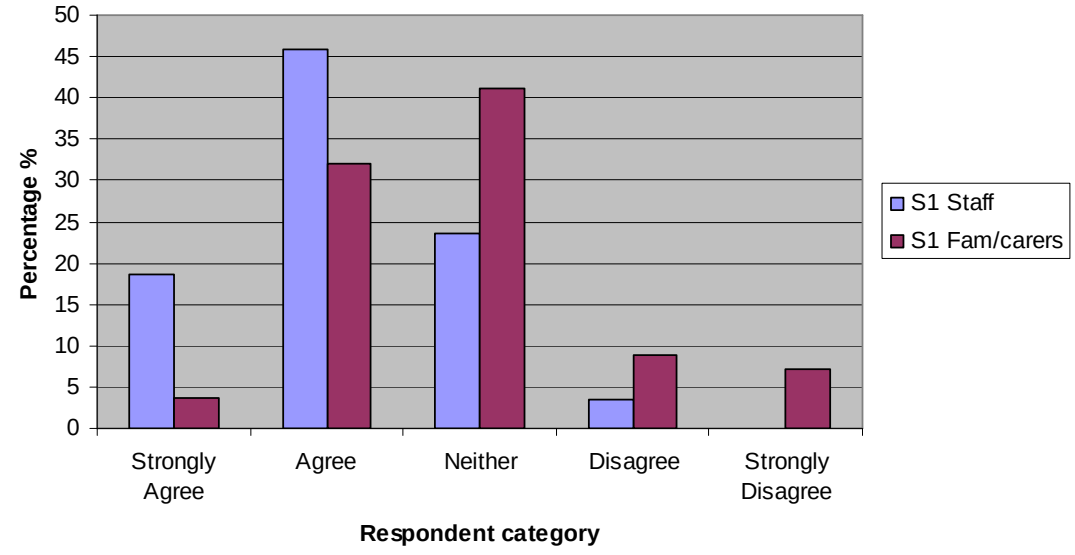


Figure 7: Staff discuss fully with family members how to become involved in care



SURVEY 2

Figure 8: Family carers are not always confident that staff have the knowledge and skills needed to give good quality care

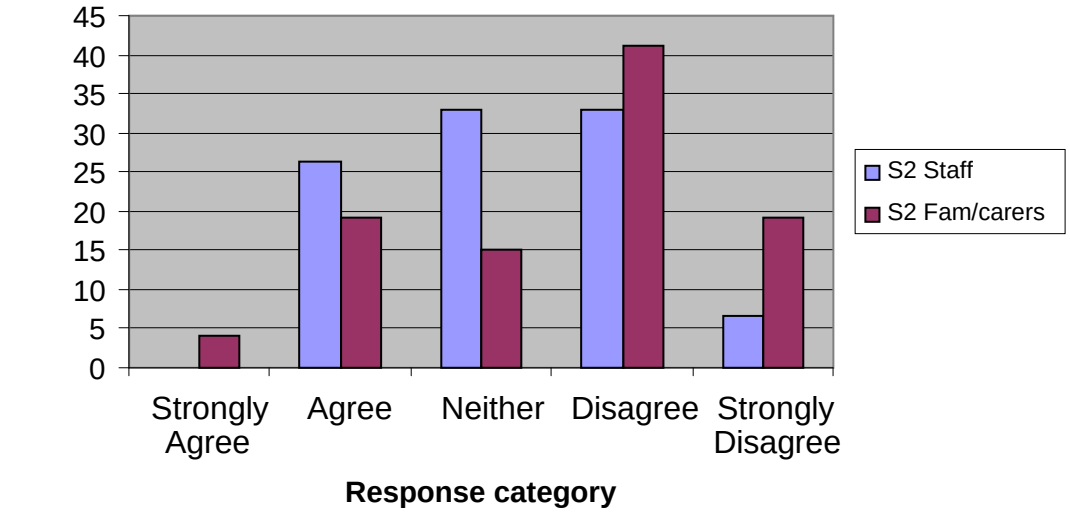


Figure 9: If family carers have any complaints about their relative's care staff always attend to these promptly

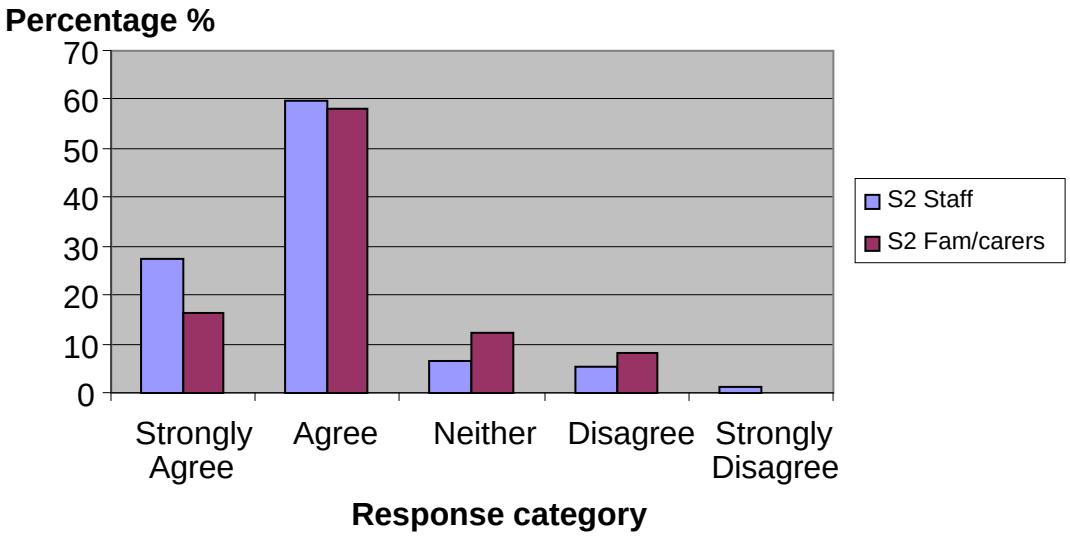


Figure 10: Residents' future care and treatment needs are discussed with family carers

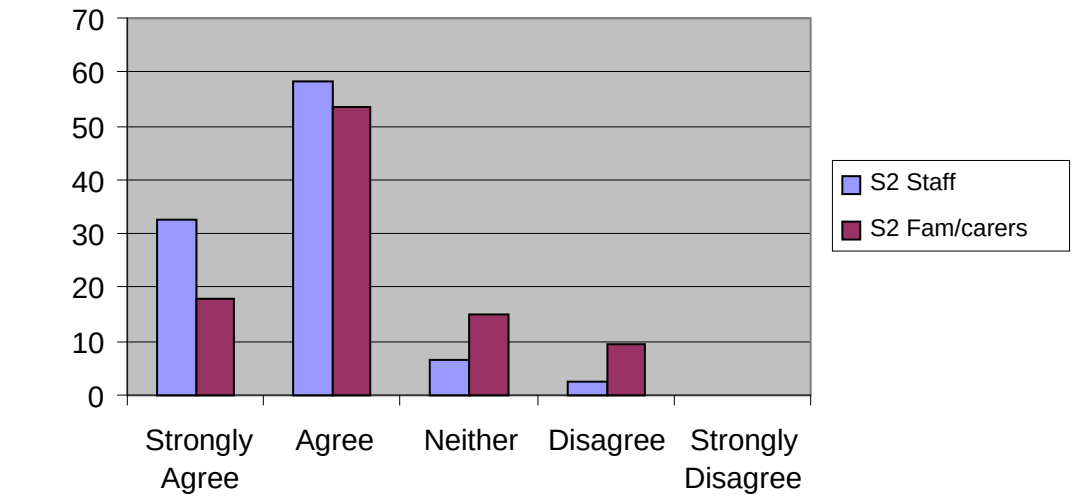
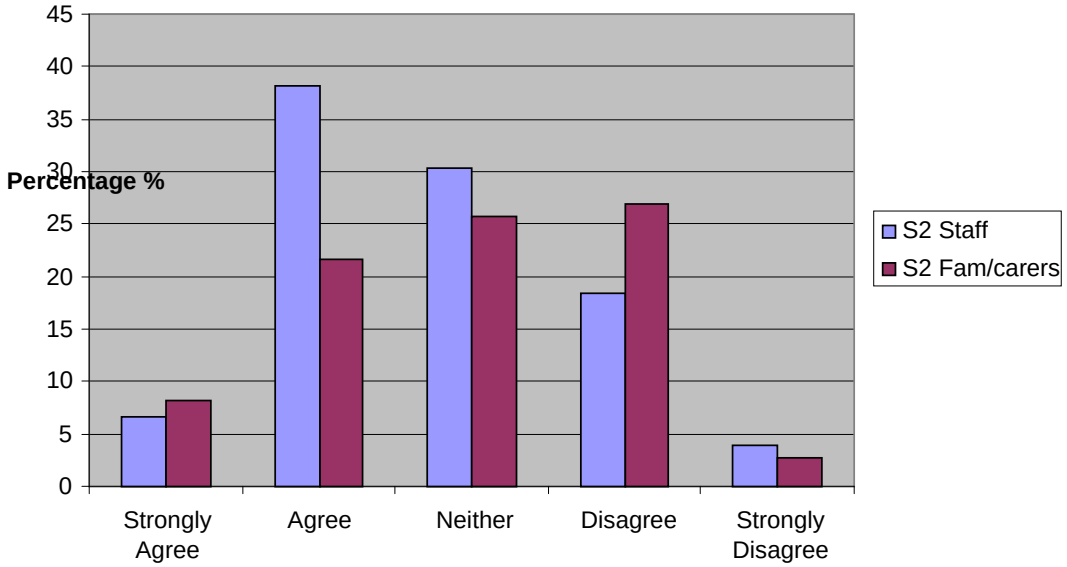
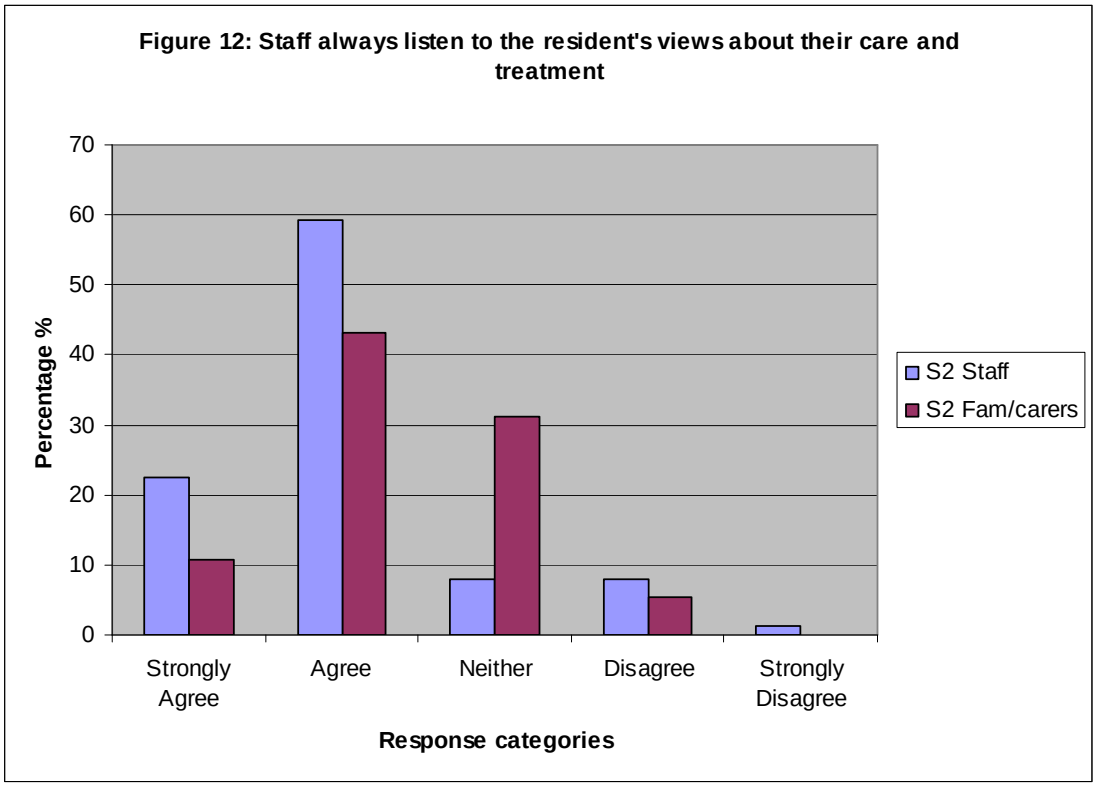


Figure 11: Staff take time to teach family carers the skills they need to care for their relative





Graphs for responses to questions where significance was identified in the Mann-Whitney Test comparing staff by site between S1 and S2 <.05 (Table 2)

SITE G

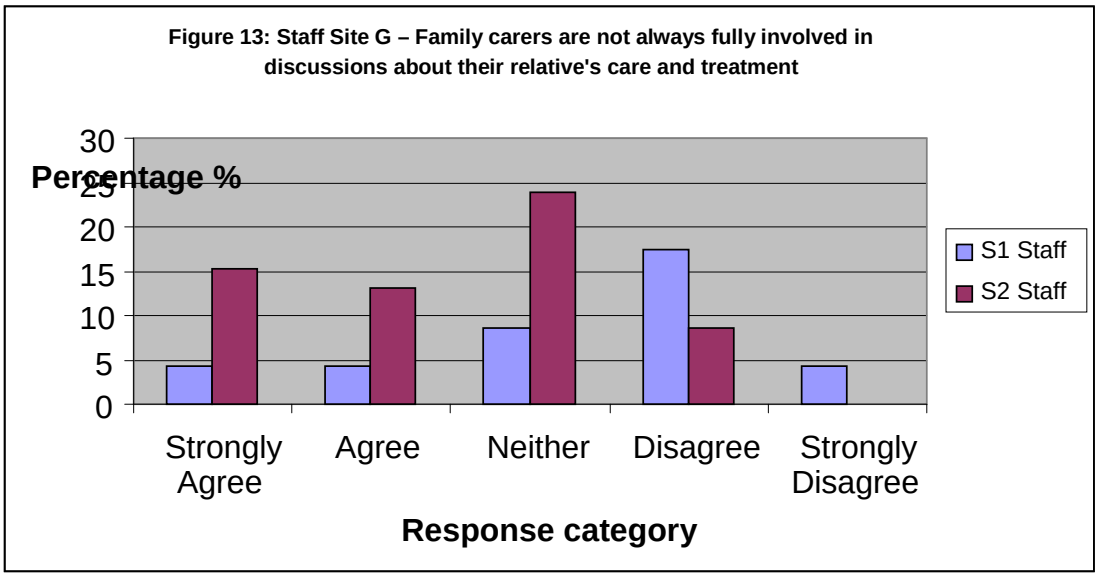


Figure 13: Staff Site G – Family carers are not always fully involved in discussions about their relative's care and treatment
Percentage %
30
25
20
15
10
5
0
Strongly Agree
Agree
Neither
Disagree
Strongly Disagree
Response category
S1 Staff
S2 Staff

SITE Y

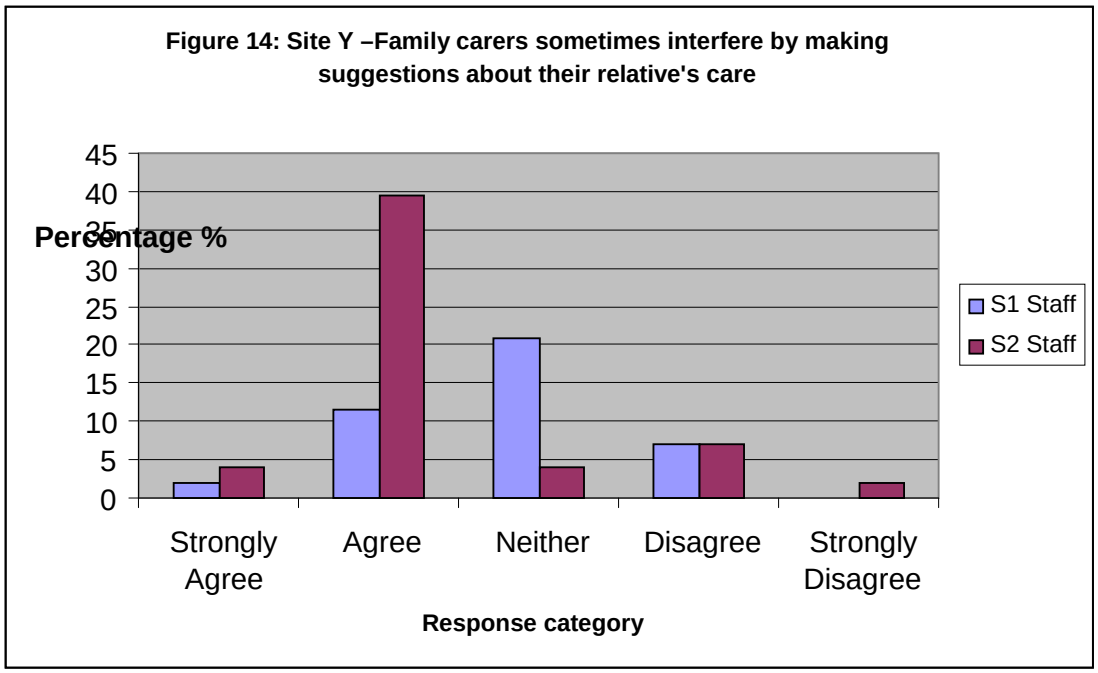


Figure 14: Site Y –Family carers sometimes interfere by making suggestions about their relative's care
Percentage %
45
40
35
30
25
20
15
10
5
0
Strongly Agree
Agree
Neither
Disagree
Strongly Disagree
Response category
S1 Staff
S2 Staff

Graphs for responses to questions where significance was identified in the Mann-Whitney Test comparing family carers by site between S1 and S2 <.05 (Table 3)

Figure 15:
Site Y - Staff ask family carers for any information they might have about their relative's needs/wishes

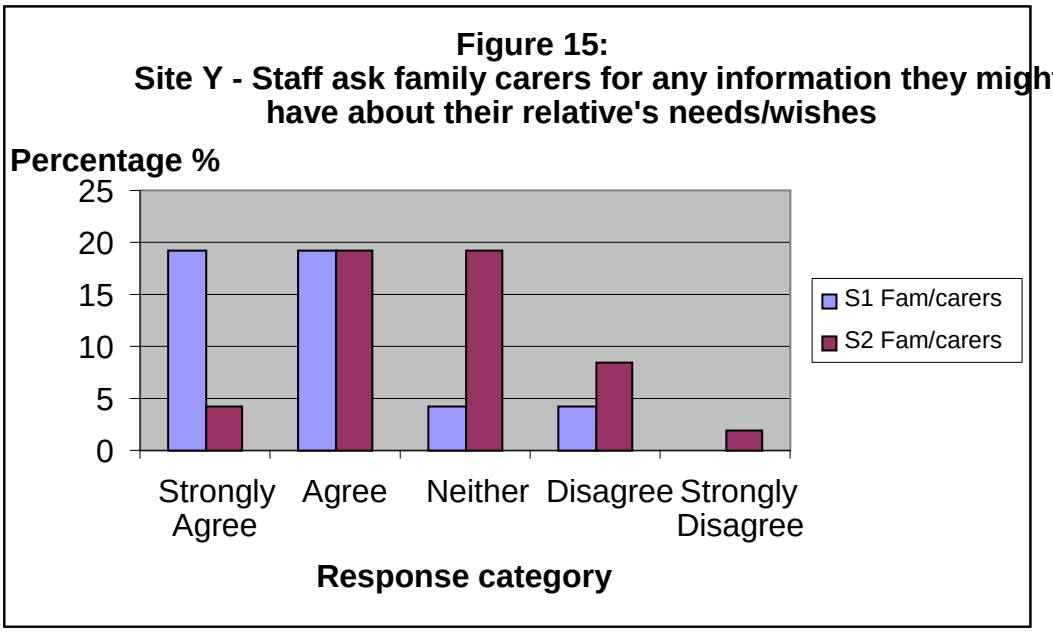


Figure 16: Site O Staff sometimes do not provide family carers with enough information about their relative's care and treatment

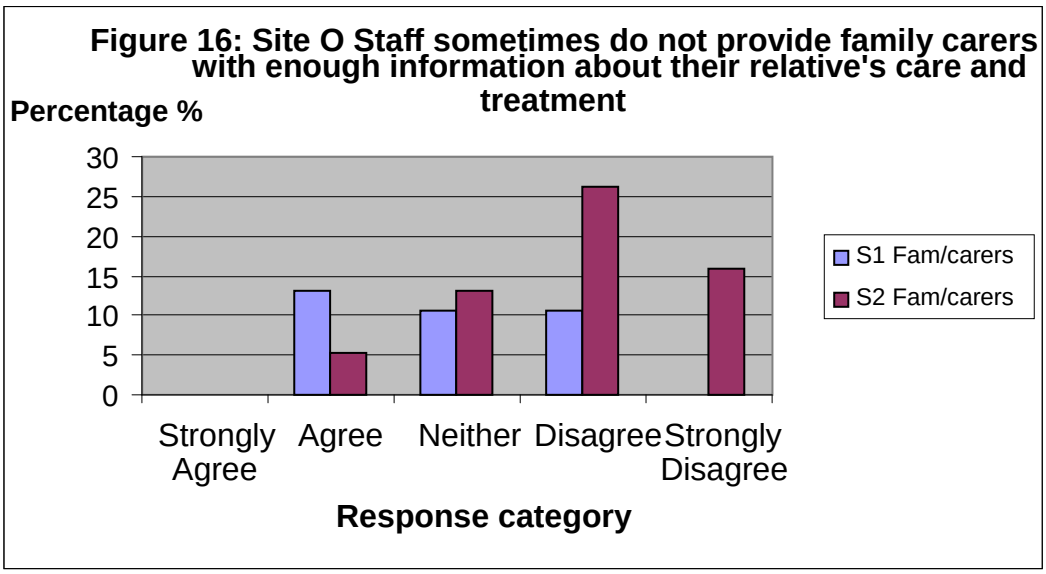


Figure 17: Site O Family carers are not always involved in discussions about their relative's care and treatment

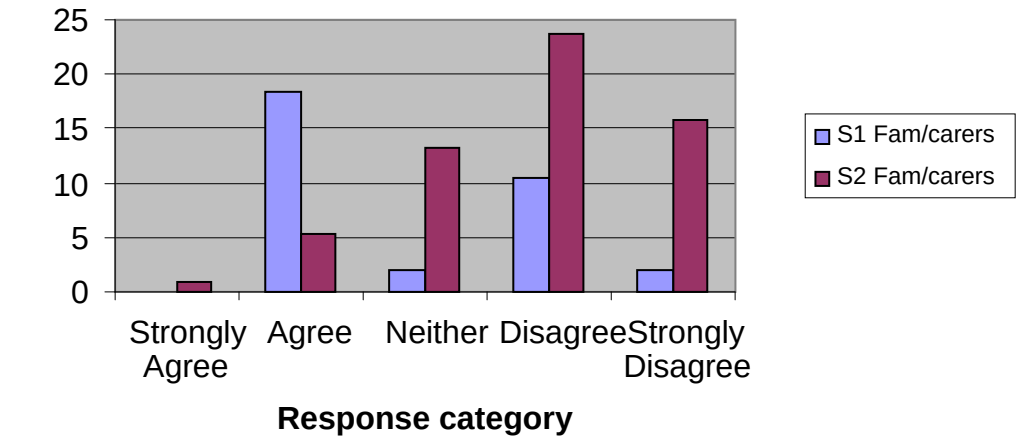


Figure 18: Site Y Family carers are encouraged to visit their relatives whenever they want to

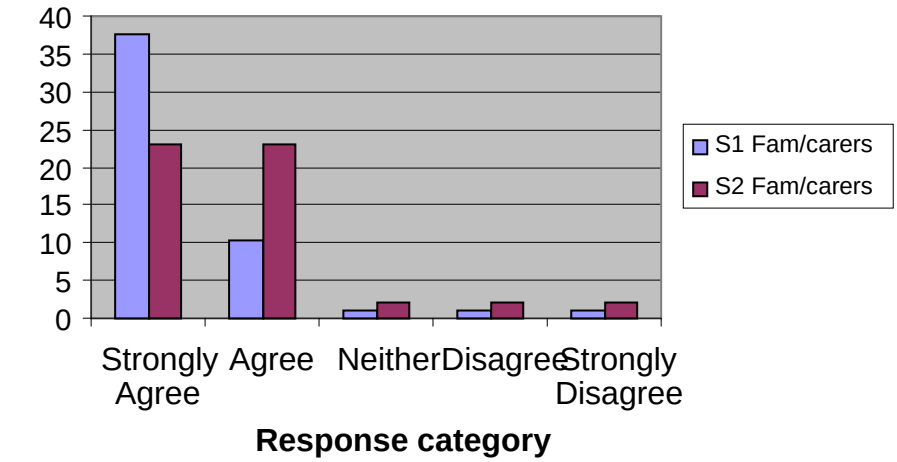


Figure 19: Site O – Family carers are not always encouraged to be involved in their relative's care and treatment, even though they want to be

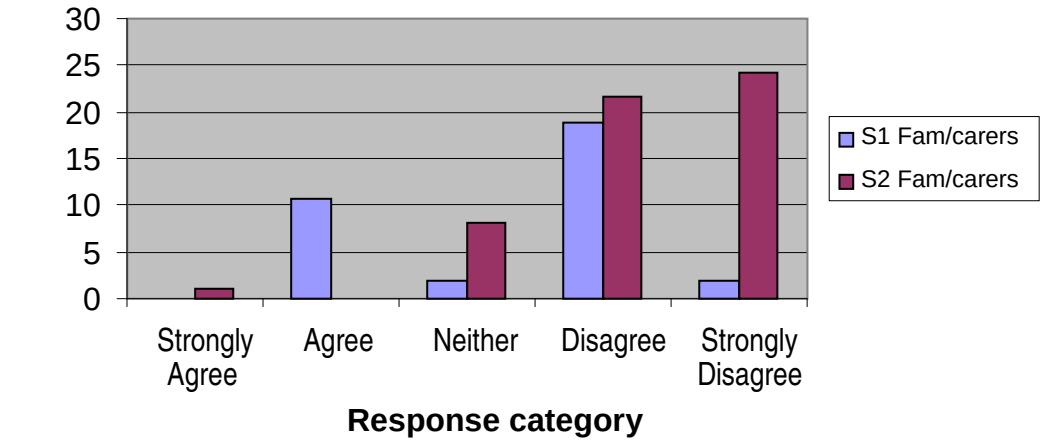


Figure 20: Site Y Family carers are not always confident that staff have the knowledge and skills needed to give good quality care

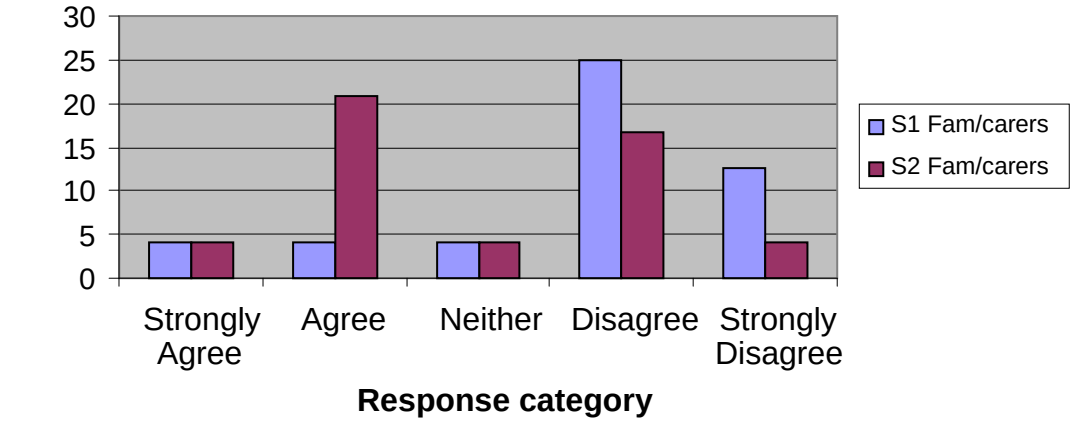


Figure 21: Site O – Family carers can always speak to a doctor about their relative's care if they want to

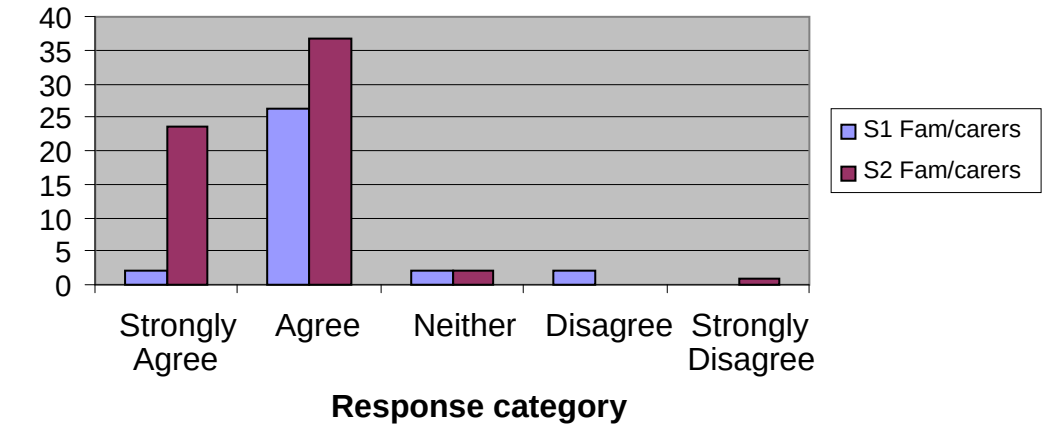


Figure 22: Site Y – Family carers are not always given enough information about their relative's future care and treatment

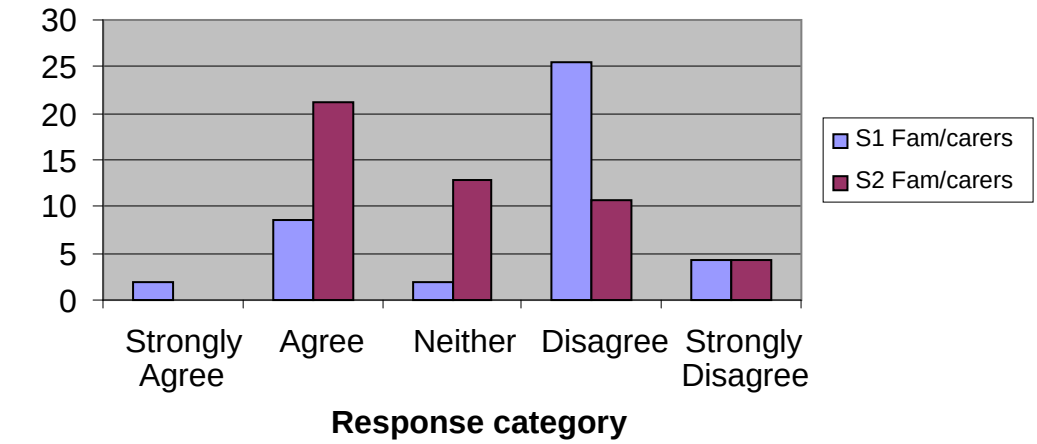
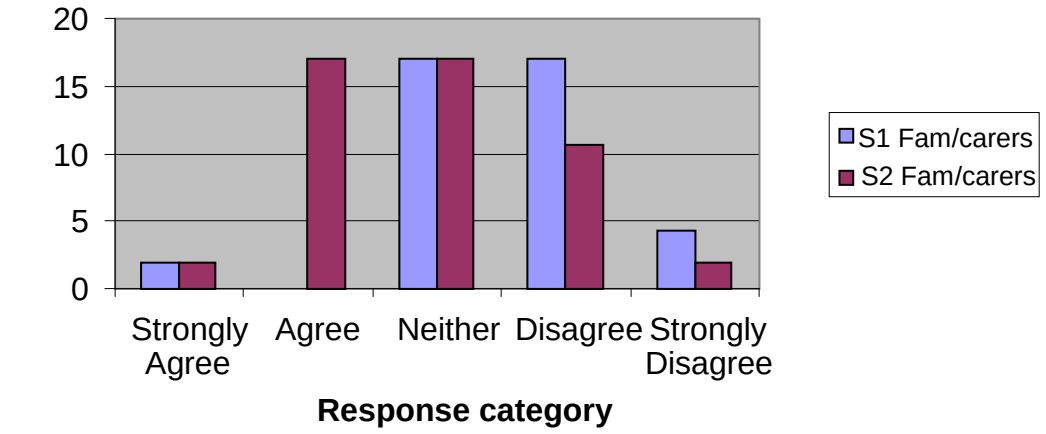


Figure 23: Site Y – Family carers do not always have enough information and other resources available to provide care



APPENDIX 6

Missing data and limitations of the questionnaire

The following points have been compiled to inform the future development of the survey tool.

A number of issues were identified with the way particular questions were worded or framed, particularly in the family carer questionnaire, which led to missing data in a number of cases. Key examples of these issues include the following:

- In the family carer survey a number of respondents were confused by question 3: *What is your relationship with the person living in residential care*. It was apparent from responses, particularly in S1, that some adult children of older residents mistakenly identified their relationship to the resident as 'parent' rather than 'son or daughter'. (This is notwithstanding that in some residential aged care facilities there are some younger residents). Hence, there is an over-estimation of 'parents' in the survey results. In S1 9 respondents (16.1%) of family/carers identified as parents compared with 5 respondents (6.8%) in S2.

  In future, similar questionnaires with the question: *What is your relationships with the person living in residential care*, should be reframed to ensure the ambiguity is removed that led respondents to erroneously select 'parent' rather than 'son or daughter.'

- Question 6 of the family carers' survey asked for their highest qualification but was not filled in by at least 20% of respondents. It appears that some respondents could not distinguish it from question 5 which asked for level of education. In S1 13 respondents (23.2%) did not fill this question in. In S2 25 respondents (33.8%) did not fill this question in.

- Two questions (7 and 8) in the family carer survey concerning the frequency and time of day that family carers visited were insufficient to capture the data required.

  It was apparent from written responses, outside the question boxes, that respondents exercised a degree of flexibility that was not captured by the specific visiting periods and time slots listed in the questionnaire. This was particularly the case in question 8, *What time of day do you usually visit*. Respondents rarely gave a time. Rather they gave a general period such as am or pm and occasionally gave the specific time range they were in the facility such as 1:30pm-4:30pm. As a consequence, there was significant missing data: 47 respondents (63.5%) for S1 and 55 respondents (74.3%) for S2. In future questionnaires respondents should be given the option of specifying how long they visited for.

- In the staff questionnaire a number of respondents were reluctant to give their age. Written comments on some questionnaires indicate that those respondents who omitted their age saw it as private information and therefore not for public disclosure even in confidence). One person wrote *illegal question*! In total 11 respondents did not supply details of their age (S 1, n=3 or 2.1% and S2, n=8 or 5.3%). A request for an age range rather than a specific request for age may have been more appropriate in the questionnaire.

- The format of the substantive 'tick the box' part of the questionnaire occasionally elicited a rote and/or automated response. For example one respondent selected only 'agree' while in other cases individual respondents missed entire questions. In contrast some respondents selected two 'tick the box' answers which effectively voided their response (although making two choices for the same question may also reflect the difficulty some respondents had with making a final choice).
- The absence of questions which indicated people's language and/or culture (Indigenous/non-Indigenous) was a limitation of the questionnaire. As comments revealed a number of family/carers may have been from culturally and linguistically diverse (CALD) backgrounds. Both staff and families raised the issue of CALD families and CALD staff respectively as a communication issue in staff-family relationships. In future surveys cultural and linguistic background should also be identified.
- Three respondents (family carers) identified difficulties with answering some of the questions. Two of these respondents criticised the way the questions were worded. One staff respondent expressed cynicism at the overall benefits of questionnaires. Their comment also raises questions about how engaged some staff were in answering the questionnaire. One staff respondent wrote: *Questionnaires don't fix the problems. The last questionnaire was treated as a huge joke. Sorry.* In contrast to this comment another staff respondent (from another facility) expressed satisfaction with the survey.
- There was a preponderance of females in the survey which in large measure reflects the staff make-up in facilities.
- The vast majority of non-demographic questions were framed negatively or positively. Out of a possible 33 questions 22 were framed positively. The overall strength of response was different depending on whether it was worded positively or negatively.

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