RESEARCH ARTICLE

Evaluating an education program promoting positive family and staff relationships and collaboration in aged care services: Pre/post/follow-up pilot study.

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Abstract

Research has identified a need to promote positive family and staff relationships and collaboration in achieving quality residential aged care services. We piloted an education program for care staff and resident's families which aimed to achieve this outcome in two Australian aged care homes, using a mixed-methods 14-month pre/post/follow-up design. The 6-module education program was informed by the literature and baseline data (Staff and Family Relationship Audit). Education for direct care staff and residents' family members was facilitated by 12 staff trainers. Thirty of 49 (61%) care staff and 17 of 38 (45%) family members completed pre- and post-intervention measures (Family and Staff Relationship Implementation Tool [FASRIT] and the Combined Assessment of Residential Environments [CARE]), and they participated in follow-up focus groups and interviews. Pre/post-intervention FASRIT scores increased significantly for family (p=0.001) and staff (p=0.01). No changes occurred in pre/post CARE scores, except for staff CARE 'safety' (p=0.014) and family CARE 'significance' (p=0.02). Focus group and interview findings identified that transparent communication policies and procedures, clear communication between families and care staff, and shared care goals and decision-making, are needed to improve care service quality. The education program promoted better understanding, relationships and collaboration between family members and direct care staff, resulting in improvements in two domains of care service quality.

Key words. Educational activities; Family-centred nursing, Homes for the aged; Professional family relationships; Quality of care.

1. Introduction

Australian residential aged care services provide supported living options for older people with advanced physical, cognitive limitations and/or mental health conditions who are unable to live in their own home environments[1]. Resident's lives are often complicated by long term chronic health conditions, including dementia. Moving into residential care is a stressful experience for many older people and their families, giving rise to tensions between family and staff in relation to care service expectations[2]. Tensions can arise when direct care staff and families have disparate needs and expectations and competing agendas[3]. Direct care staff, such as nurse assistants and personal care workers, are generally the first members of staff to whom family members express their concerns and expectations of care service quality[3,4].

From the perspective of direct care staff, family members can be a source of important resident information, comfort and support for aged care residents in care delivery[3]. Families can, however, be considered a hindrance to the smooth running of the care home when they lack insight and/or an appreciation of the demands placed on direct care staff [4]. An Australian study identified a range of attitudes and behaviours exhibited by families which care staff found problematic[5]. These included making frequent requests of staff, complaining unnecessarily about care services, being pedantic in how things had to be done for the resident and expecting immediate attention to the resident's care. Trying to placate families regarding care services was perceived to be extremely difficult for direct care staff and care managers. The lack any appreciation of care staff's efforts and frequent complaints about care services, was reported to be demoralizing[5].

Relationship issues between families and direct care staff are contextualised within a complex, high need, high pressure, high responsibility work environment[5]. These tensions may be reduced through targeted staff and family education which focuses on clear communication, active listening, problem-solving and collaboration in care delivery[3,5,6,7]. To investigate the feasibility of achieving these outcomes, the researchers developed and piloted an education and support program targeting direct care staff and the families of aged care residents. The aims of the pilot study were to:

1. identify if the education and support program improved family/staff relationships and collaboration in achieving perceived care service quality; and
2. obtain participant recommendations on changes in policies and practices that would improve family/staff relationships and collaboration in care services.

2. Methods

2.1 Design

The 14-month pilot study employed a pre-post- intervention mixed-method design. Follow-up qualitative interviews and focus groups took place eight months following the education program implementation.

2.2 Setting and Participants

The pilot study was conducted in a convenient sample of three aged care units, located within two accredited residential care homes, operated by one moderate-sized Australian aged care provider. In care home 1, located in the northern region of Sydney, one low-care unit and one high-care unit with frail-aged residents were included. In care home 2, located in the eastern region of Sydney, one low-care unit for frail aged residents was included. The services provided by the three care units were subsidised by the Australian Government, with resident fees ranging from partial to full subsidy depending on financial capacity and assessed need.

2.3 Ethics

In compliance with the Australian Human Research Ethics National Statements (3.1.18 and 3.1.21)[8], study participants were recruited using an arms-length approach. Participants provided written consent and were allocated a unique identifier code to ensure that confidentiality was maintained. The study protocol was approved by the University of New South Wales Research Ethics Committee (Reference No. HC16594) and the aged care provider executive teams.

2.4 Intervention

The study intervention was a six-module education program developed by the researchers and delivered to staff and families separately by a group of trained care home staff. The education program was informed by the literature, including freely available education resources developed by the Australian Institute for Primary Care and Ageing[9] and the Bradford University, UK[10]. The multimedia education materials were modified to address local needs which were identified from quality audits of all three care units at baseline (see Methods below). An Advisory Group of volunteer family and resident representatives, nurses, care staff and allied health staff and aged care advocates provided advice on improvements to the education program prior to its finalisation. The education resources are freely available on the Dementia Centre for Research Collaboration website[11].

The six staff and family education modules include: 1) family issues, needs and required support, and factors influencing family adjustment in the transition of an older relative to residential care; 2) relationship dynamics, power imbalances and differences in perspectives of family members/carers and care staff on caring needs and responsibilities, and development of trusting relationships; 3) factors giving rise to stress in the care situation, understanding thought patterns and stress responses, and developing alternative thought patterns to reduce stress in the care situation; 4) relationship challenges, strategies to improve relationships between families/carers and staff, and effective communication in discussing and planning care requirements; 5) factors involved in staff/family conflict, overcoming resistance and obstruction in care delivery, and conflict resolution strategies; 6) debriefing on issues of concern and learning opportunities, identifying useful strategies for policy and practice improvements to support positive family/staff relationships, and practical approaches to facilitate positive collaboration between families and staff.

Additional education resources provided to direct care staff included different ways to help the integration of people newly admitted to residential care and their families in care home life, strategies to help residents and families make new friendships and become involved in the care home activities.

Video clips of typical family/staff relationship issues were used to illustrate each module's concepts. The video clips included scenarios and discussions about empathetic responses to the stress experienced by both families and staff, concerns for family/carers associated with placement of a family member in residential care, the effects that dementia and deteriorating health may have on a resident and their family, and how families learn to accept and cope more effectively with the changes occurring through their involvement in the resident's care.

The education program was delivered through train-the trainer approach. Twelve trainers were selected by senior care home managers based on their leadership qualities and educator skills, and their knowledge and experience of the topic areas covered in the education program. Staff trainers included senior registered nurses and allied health staff, while family trainers were social workers. The lead investigator (LC) provided training in program content and learning facilitation techniques to the six staff trainers and two of the family trainers, who subsequently provided training to the remaining four family trainers. The six education modules were delivered in sessions of 1-1.5 hours duration every week or fortnight for participating staff and 28 of the family participants. In response to a request by 10 family participants, training was provided intensively by combining 2-3 modules in sessions of 3-4 hours over 3 weeks.

2.5 Measurement

Table 1 lists the instruments and procedures used in the pilot study. Organizational-level data[12] were obtained at baseline (months 1-2) to identify specific target concepts for the education program and to determine the readiness of the participating care units in adopting the education program concepts. Participant-level data[13,14] were obtained pre and post-intervention (months 4 and 8 respectively) on participant perceptions of family/staff relationships, collaboration in care service planning and delivery, and care service quality. Follow-up data (months 12-14) were obtained on the participants' satisfaction with the education program and their recommendations on how direct care staff and families can form positive relationships and collaborate in achieving care service quality.

Table 1. Study Measurement

***Measure* (Reliability statistic)**	***No. items***	***Constructs and domains***	***Scoring***
Baseline (Months 1-2)		**ORGANISATIONAL-LEVEL DATA**	

***Measure* (Reliability statistic)**	***No. items***	***Constructs and domains***	***Scoring***
		(N=3 care units)	
Family/staff Relationship Audit (FSRA)[12] (reliability statistic not reported)	13	Staff/family relationships in staff programs; procedures supporting family involvement in care planning; formal (a) and informal (b) communication channels; organizational environments promoting relationships; and support for staff and families with communication issues.	Qualitative. Standard coding and classification procedures to derive summary responses to the audit's *a-priori* categories.
Pre/post Intervention (Months 4 and 8)		**PARTICIPANT-LEVEL DATA** (Pre. N=87; n=49 staff, n=38 family) (Post. N=47; n=30 staff, n=17 family)	
Family and Staff Relationship Implementation Tool (FASRIT)[13] (Cronbach's alpha 0.94)	25 7 domains	Self-report questionnaire on frequency of practices and behaviours relating to the following domains: 1. Information sharing 2. Familiarity, trust, respect, empathy 3. Family characteristics and dynamics 4. Collaboration 5. Communication 6. Organizational barriers to positive relationships 7. Promoting positive relationships.	Quantitative. Scored on participant level of agreement with item statements. A higher percentage of agreement indicates more supportive family/staff systems. (Total score = 100)
Combined Assessment of Residential Environment Profiles (CARE)[14] (Cronbach's alphas of 0.78 – 0.94)	34 6 domains	Self-report questionnaire on positive relationship practices between staff, residents and families, and quality care indicators: 1. Safety; 2. Significance; 3. Belonging; 4. Purpose; 5. Continuity; 6. Achievement.	Quantitative. Scored on participant level of agreement with item statements. Higher total and median scores indicate better relationships and care quality. (Total score = 136)
FOLLOW-UP (Months 12-14)		**PARTICIPANT-LEVEL DATA** (N=41; n-24 staff, n=17 family)	
Participant focus groups (1.5-2 hrs.) with staff (n=6) and families (n=3), and **individual family interviews** (N=8)	10	Discussion on issues relating to family relationships with direct care staff, including positive aspects and areas in need of improvement, consideration of FASRIT and CARE Profiles results, and recommendations on collaboration and systems changes required to improve care services.	Qualitative. Standard coding and classification procedures to derive common themes on *a-priori* topics. Key quotes extracted.

2.6 Data collection

The baseline organisational-level data[12] were obtained independently by two of the researchers, the data were compared and consensus on findings was achieved in discussion. Participant-level data[13,14] were obtained pre and post-intervention by one of the researchers. All data were allocated unique identifier codes (e.g. CH01F01 (care unit 1, family 1), CR02S03 (care unit 2, staff 3), CR03F06 (care unit 3, family 6). Pre/post-intervention coded data were dated to track changes over time.

Eight months after implementing the education program, semi-structured follow-up focus groups (N=12) were undertaken with the 12 trainers, 24 of the 30 staff and all 17 family members who completed the post-intervention questionnaires. One-on-one interviews (N=8) were conducted with family members on request. The focus groups and four of the family interviews were conducted by two of the researchers, using an interview guide, in closed meeting rooms located in the two participating aged care homes. Since the majority of focus group and interview participants did not agree to recording their responses electronically, all data were hand-recorded. One researcher (LC) facilitated the focus groups and conducted the interviews and the other researcher (JC) hand-recorded participant responses. Four of eight family interviews were conducted with the same interview guide by only one of the researchers (LC) in her private office off-site, as these participants requested interviews outside of business hours.

The semi-structured focus group and interview guide questions included: processes and factors supporting positive relationships between family and direct care staff; issues (and priorities) to be addressed in improving family/staff relationships; recommended strategies at the care level, unit-level and organisational-level that would help to consolidate and/or improve positive relationships between family and direct care staff; other relationship-focused issues not captured easily by the study questionnaires; and clarification of and information additional to, that reported in the post-intervention questionnaires[13,14]. Participants were also asked to make recommendations on care service improvements in respect of family and staff collaboration. To confirm the accuracy and completeness of the hand-recorded responses, these data were read out to the participants at the end of the session. Where requested by participants, additional and clarifying information was added to the written statements before meeting closure.

2.7 Data analysis

Descriptive statistics were used to characterise the sample and the FASRIT[13] and CARE[14] data. These data were inspected for normality and non-parametric analyses were used where indicated on the pre/post-intervention FASRIT and CARE data. As FASRIT data were not normally distributed, non-parametric analyses were used (Mann-Whitney U-Test). Independent samples t-test was used to compare post-intervention staff and family FASRIT scores, Paired t-test was used to compare pre and post-intervention staff FASRIT score percentages, and Wilcoxon-Signed Rank test was used to compare pre/post

intervention family FASRIT score percentages and family and staff CARE median scores. All data were analysed using SPSS version 22[15] using two-tailed tests with significance levels set at $p< 0.05$.

Qualitative data derived from the FSRA[12], the focus groups and the interviews were analysed by two researchers (LC, JC). These data were checked for accuracy and independently examined by the researchers (LC and JC) and grouped into major content categories related to the study aims. Deductive content analyses were undertaken with the FSRA, semi-structured interviews and focus group responses, with categories developed from the *a priori* topic areas[16]. These defined categories were used to guide the process of allocating data to initial codes and then to common themes, using a structured approach described by Sandelowski[17]. Themes were derived from these different data by viewing the results of independent data categorisation, identifying similar and dissimilar statements recorded for all data, achieving agreement on the relationships between data categories and gaining consensus on the common themes of the topic areas. Data saturation was reached when no new themes were identified among the data and when all data fitted into existing themes.

3. RESULTS

3.1 Organisational-level baseline data

Family/ Staff Relationship Audit (FSRA)[12]

The FRSA data indicated that prior to the education program the organisation had some policies and procedures in place to support aspects of family/staff relationships and interactions. Areas identified for improvement were direct care staff perceived workload and multi-tasking, which had an influence on staff's opportunities to form meaningful relationships with residents and families. The data arising from the FSRA produced three common themes, which informed the education program topics.

Theme 1. Communication knowledge and skills impact on staff/family relationships.

Managers and most senior staff who had accessed internal and external education/training in relationship development, conflict resolution, power relationships, negotiation techniques and reflective techniques, had minimal issues with family/staff relationships and interactions. Very few direct care staff had accessed such education and most had low-level knowledge of communication principles and approaches in conflict situations. These knowledge and skills deficits caused difficulties for direct care staff when communicating with families seeking advice and/or redress for care-related issues.

Theme 2. Organisational communication systems impact on family/staff relationships.

While multiple formal communication channels existed between managers and staff, families and residents, between staff, and between external clients and managers/executive, issues raised by families were not always communicated formally from managers to direct care staff and thus, were not addressed in a timely manner. At times resolutions to pressing family issues were unclear, giving rise to conflict between families and direct care staff. Delays in managerial responses arose from systems policies, including those

which required direct care staff to refer the matters raised by families to their manager, rather than directly providing families with the information requested.

Theme 3. Information sharing between families and staff impacts on care service quality.

Family/staff tensions and conflict arose over care service quality when direct care staff had little knowledge of the residents' psychosocial background and associated care requirements. Families and staff requested that direct care staff: a) have adequate time to review care plans and resident's social and clinical background using on-line reporting systems; b) be provided with adequate information about individual residents by the registered nurses at shift handover; and c) participate in combined clinical review meetings.

3.2 Participant-level baseline data

Participant Demographics

Forty-nine staff and 38 family members were recruited, consented and provided data at pre-intervention. Of these participants, 30 (61%) of 49 staff members and 17 (45%) of 38 family members/carers remained and provided post-intervention data. There were 24 (49%) of 30 remaining staff members and 17 of 38 (45%) remaining family members who participated in follow-up focus groups or interviews. Staff dropout at post-intervention and follow-up was due to staff rotation to other care units or annual leave (n=12), work pressures or sick leave (n=5) and/or resignation (n=2). Family drop-out at post-intervention and follow-up was mostly due to the unexpected death or hospitalisation of their relative (resident) (n=14), or a change in family participant health status (n=7). Participant demographics at baseline, as shown in Table 2, are typical of the staff and family characteristics of accredited Australian aged care homes[1,18]. Possibly the only differences in family characteristics were higher educational levels and occupation[18]. There were no identifiable differences in the pre/post and follow-up characteristics of staff and family participants, other than declared health issues for seven of the family members who did not continue to post-intervention.

Table 2. Baseline participant demographics (N= 87; n=49 staff, n=38 families)

Variable	Direct care staff	Families/carers
Gender composition	Female = 44; Male = 5	Female = 29; Male = 9
Age	<30 = 13; 30-50 = 20; 51+ = 16	<50 =3; 50-70 =26; 70+ = 9
Language spoken at home	English = 21; Other = 28	English = 38; Other = 0
Cultural background/country of birth	Australia = 17; Other = 32	Australia = 10; Other = 28
Education level	High school = 6; Tertiary = 40; N/R = 2	High school = 3; Tertiary =35
Years in aged care	<5 = 25; 5-15 = 16; 16+ = 8	Not assessed
Specific training in aged care	Yes = 39; No = 5	Not assessed
No. of working hours (weekly)	<35 = 13; 35+ = 36	Not assessed
Relation to resident	Not applicable	Daughter = 22; Son = 8;

		Spouse/partner = 6; Other = 2
Home ownership status	Not assessed	Own home = 31; Other = 7
Income source	Not assessed	Pension/self-funded = 25; Employment = 12; N/R = 1
Occupation category (prior or current)	AIN = 17; RN/Team leader = 22; Allied health = 10	Professional = 19; Managerial = 10; Other = 9

AIN = Assistant in Nursing; RN = Registered Nurse; N/R =No Response

3.3 Participant-level pre/post-intervention data

Family and Staff Relationship Implementation Tool (FASRIT)[13]

FASRIT pre- and post-intervention results are shown in Table 3. At pre- and post-intervention the mean FASRIT percentage 'often/always' scores were statistically significantly higher for staff than for families (Pre-intervention: Staff: 34/49, 69.4%; Families: 17/38, 44.7%; p=0.001; Post-intervention: Staff: 22/30, 73.3%; Families: 10/17, 58.8%; p=0.001). These results indicate that while most family 'often/always' scores improved following the study intervention, at both pre- and post-intervention staff participants considered that care home systems and staff actions were far more supportive of positive family/staff relationships than did families. Most differences occurred between staff and families in the domains of staff knowledge of residents, staff asking families for further information about residents, sharing information with families and communicating with families on resident care requirements and outcomes. For participants completing both pre and post-intervention FASRIT, the pre/post change in the family (n=17) 'often/always' total score was statistically significant (p=0.001), as was the total pre/post change in the staff (n=30) 'often/always' total score (p=0.01).

Table 3. Pre- and post-intervention FASRIT scores (% agree often/always)

	PRE	POST	PRE	POST
Item	Staff *(n=49)*	Staff *(n=30)*	Families *(n=38)*	Families *(n=17)*
1. Staff know a lot about each resident	80.5	**90.5***	48.5	50.0
2. Staff have good relationships with families	60.3	**70.5***	73.5	81.2
3. Staff ask families for information about their relatives	51.1	60.3	22.8	**55.2***
4. Staff know what the residents need	84.7	85.0	62.9	65.2
5. Information about the facility is given to families before the decision is made for their relatives to move in	76.1	78.0	62.9	**75.3***
6. Information about the aged care facility's mission, vision, and values is given to families	82.6	83.0	65.7	68.9
7. Families are offered updates about their relatives' care	77.8	80.0	37.1	40.2
8. Families are involved in reviewing the facility's mission, vision, and values	42.2	42.2	8.8	10.0
9. Families are encouraged to ask for information	84.7	85.2	42.9	50.2

10. Families and staff share the same goal about residents' care	80.5	80.6	54.3	55.0
11. Staff and families work well together	65.2	70.1	65.7	**72.0***
12. Staff provide opportunities for families to be involved in decision-making about their relatives' care if they wish	76.2	78.0	48.6	50.5
13. Staff ask residents if they would like their families to be involved in decision-making about their care	60.5	**70.5***	14.7	**25.5***
14. Staff and families are clear about their roles in the care of residents	76.1	80.0	55.9	62.5
15. Staff and families agree about residents' individual needs	70.6	75.0	57.1	65.5
16. Families give feedback to staff about the contribution staff make to their relatives' care	46.6	50.6	28.6	35.7
17. Staff give feedback about the contribution families make to their relative's care	50.0	**65.8***	6.1	**20***
18. There is open communication between staff and families	68.2	75.5	62.9	**78.2***
19. Staff offer emotional support to families	76.1	75.0	25.8	**36.8***
20. Policies explain how staff/family relationships will be promoted	55.5	**65.5***	5.7	**25.6***
21. Policies encourage all levels of staff and families to work together as a team	69.5	75.0	22.8	**36.8***
22. The importance of good staff/family relationships is reflected in the philosophy of the facility	80.5	**90.5***	42.9	**60.0***
23. Opportunities are provided for care staff from non-English speaking backgrounds to help them improve their English language skills	65.2	70.0	5.8	**50.0***
24. Everyone involved in the residents' care work together as a team	82.6	85.0	45.7	**65.5***
25. Staff are proved with training to work with families	62.2	65.5	11.5	15.5

Items with scores below 10% were due to remainder of participants responding 'I don't know'
***** Individual item scores with significant % changes pre/post-intervention at α=0.05.

Combined Assessment of Residential Environments (CARE) Profiles[14].

The CARE Profiles pre/post-intervention results showed no overall change in perceived care quality (p=0.5) in four of the six domains (belonging, purpose, continuity and achievement). Changes occurred in ratings of care quality within only two (safety and significance) of the six CARE domains (Table 4). The pre/post change in staff (n=30) 'safety' median score was statistically significant (p=0.014), while the pre/post change in family (n=17) 'significance' median score was statistically significant (p=0.020). The family and staff raw CARE median scores are detailed in Supplementary File (SF) Table 1 and SF Table 2 respectively.

Table 4. CARE sub-category median score ranges

Sub-categories	Median Score Range Staff		Median Score Range Families		p-value	
	PRE (n=49)	POST (n=30)	PRE (n=38)	POST (n=17)	Staff	Families
Safety	2.5 – 3.5	3-4	2-4	3-4	**0.014***	0.157
Significance	3-3	3-3.5	2-4	2.5-4	0.317	**0.020***
Belonging	2.5-4	2.5-4	3-4	3.5-4	1.000	0.102
Purpose	2-3	2-4	2-4	3-4	0.102	0.317
Continuity	3.5-4	3-4	3-3	3-4	0.317	0.317
Achievement	2-3	3-3	4-4	4-4	0.317	1.001

* indicates statistical significant difference at α=0.05.

Staff and Family Focus Group and Interview findings

Follow-up focus groups and interviews with participating staff and families revealed many similar responses and themes, which are reported together. Where responses differed between staff and families, this is indicated. Direct participant quotes are italicised and attributed with unique participant codes, with the prefix F denoting family and prefix S denoting staff (Table 5).

From the perspective of most participants, the care homes offered a '*continuum of service delivery ranging from an administrative (bureaucratic) model to a humanized (person-centered) model'* (CR01F02), depending on:

i. the overarching philosophy/mission as developed and interpreted by administrators, managers and senior staff, and operationalised by direct care staff;
ii. the service delivery orientation of individual managers and staff within different departments and within different roles; and
iii. the organisational priorities of the different departments and staff roles, from senior division, department and care unit management-level to the direct care-level, and the competition for limited resources and staff positions.

These factors were considered to have a major impact on the way in which families and staff interact and collaborate in pursuing quality care services. Six common themes (Table 5) in the data reflect these factors: 1. Person-centered systems facilitate positive relationships between staff and families; 2. Person-centered systems assist in reducing family stress in their relative's transition to residential care; 3. Managerial leadership facilitates positive family and staff relationships; 4. Staff/family relationships are improved by power sharing in care service decisions; 5. Family and staff participation in resident social and recreational programs foster improved relationships; 6. Communication systems have a major influence on staff/family relationships.

Table 5. Staff and family Focus Group and Family Interview themes

DISCUSSION FOCUS: FAMILY RELATIONSHIPS WITH DIRECT CARE STAFF: ISSUES, POSITIVE ASPECTS AND AREAS NEEDING IMPROVEMENT	
Theme 1. Person-centered systems facilitate positive relationships between staff and families.	**Supporting statements - families and staff**
Families and residents need encouragement to participate in life review with different staff, either before or following admission to the care home. Families and staff require inter-disciplinary education/training and case/family conferences on unique service implementation strategies and programs. Families consider that the focus must be on service to families, not just to residents. Families are happy with staff when the resident health and well-being improve following their adjustment to the care home. A higher level of personalised care and a caring environment occurs when direct care staff are appraised of the older person's life review. Tensions between staff and families are reduced when staff acknowledge family dedication and care skills. Family and staff relationships are positive when managers and team members allow direct care staff to provide individualised care.	*'…direct care staff need to know about past interests, dreams and achievements, as well as clarifying current needs and preferences in daily living'* (CH01F4) *'I would like the AINs to be far more skill minded - most are task-minded…they need exposure to higher-level education and support'* (CR02F11) '*…I would like to be encouraged to be involved in the decision-making process regarding admission, the resident's transition and adjustment to the home'* (CR01F03) '*…tensions eased between me and the staff* when *seeing my parents happy*' (CH01F13) *'…staff want families to trust their judgement on care decisions based on (their) close understanding of the resident's capabilities and needs' (CR02S02)* *'…by acknowledging family skills helps to create a happy, lively welcoming atmosphere… to create friendly staff…and a sense of purpose in our role'(CR02F13)* '*…closer relationships with residents and their families occur through paying attention to resident preferences'* (CH01S02).
Theme 2. Person-centred systems assist in reducing family stress in the transition to residential care.	**Supporting statements - families and staff**
Families who feel a loss of control over the social and environmental world of their older relative require staff understanding. Families want staff to place importance on welcoming residents and families to the home. Families need to feel confident that management and staff care *'about'* their	*'…staff must acknowledge the discrepancies that occurred between the world of the past and the present world of my husband'* (CH01F16) *'…staff need to greet them and help to familiarise them with the surroundings, people, policies and procedures'* (CH01F16) *'… helps me feel calm to speak with staff members who say they enjoy working with my relative*' (CH01F14).

relative, not just care *for* them. Families want to be involved in decision-making concerning their relatives, they want to be listened to. Tensions arise between families and direct care staff when families consider that the level of care provided is inadequate. Tensions occur between families and staff when residents are distressed or despondent. Families require consistency in staffing to provide person-centred services.	‘’*…I need an opportunity to share (with staff), to maintain contact, to provide warmth and achieve togetherness (with my relative*)’ (CH01F16). ‘*For me the time at xxx is mostly hard work. I physically care for my husband regularly where staff fail to do……. I feel being held hostage, am tired and very burdened by it*‘ (CR02F09). *‘… families need to be vigilant with overseeing care and other services’* (CR01F04). *‘…we need less dependence on agency staff…the problem is they do not know the residents' issues and quirks….a happy resident is one who has developed a warm relationship with the staff’* (CR02F14).
Theme 3. Managerial leadership facilitates positive family and staff relationships.	**Supporting statements – families and staff**
Family/staff relationships are influenced by managerial attention to resident, family and staff issues. Staff need managerial support to focus on meeting all resident needs. Staff need to be sensitised to resident and family role transitions. Managers must support resident and family decision-making in discussion with direct care staff. Managers must enable staff flexibility to help them staff work with families. Managers must urge staff to focus on therapeutic care as well as resident safety. Managers must ensure staff have relevant education, skills and supervision.	*‘…management needs to be more visible and be more engaged with staff, families and residents at a human level’* (CRO1F02). ‘…*staff need time and support to balance the resident’s medical, care needs and emotional needs’* (CR02F07*)* ‘…*staff need to ease the transition process’* (CH01F14) *‘…it is essential to institute family, resident and direct care staff information sharing meetings’* (CR02F08) *‘… staff and family relationships can be enabled by flexibility in staff scheduling’* (CR02F10) ‘…*staff need to concentrate on (resident) well-being above all else’* (CH01F16) ‘*staff must be adequately educated and supervised in their work roles’* (CR01F06)
Theme 4. Family and staff participation in resident social and recreational programs foster improved relationships	**Supporting statements – families and staff**
Good relationships between staff and families occur through family involvement in resident recreation/lifestyle programs. Recreation/lifestyle programs enable a high level of socialisation among residents, families and staff.	*‘…to some extent the negative effects of institutionalisation are mitigated when we can participate in the recreation programs’* (CR02S02) *‘…staff will acknowledge the importance of developing friendships among residents and families when they participate in the social programs’* (CR01F05*)*
Theme 5. Staff/family relationships are	**Supporting statements – families and**

improved by power sharing in care service decisions.	**staff**
Policies and programs instituted by managers and senior staff foster closer ties between staff and family members. Family-staff relationships are mutually satisfying when staff provide care in ways that preserve family connectedness to the caregiving role. Families seek to protect their older relative by overseeing care, when they see staff taking ownership of the caring role. Family stress reduces when staff ask them questions about their relative's life experiences, needs and preferences. Family decisions on approaches to palliative care services can be stressful for staff and impact on their ability to provide quality end of life care. Staff can provide better care when families are willing to share information about the resident. Families and staff can develop positive relationships by viewing services from one another's perspective.	*'...policies need to focus on improving the morale of residents and their families, but also the staff'* (CHO1F14). *'...the adjusted caregiving role is one of protection, prevention, anticipation and supervision of (*direct care) *staff'* (CH01F16) *'...I feel that I need to teach care staff appropriate caring* behaviours' (CR02F09) '…*I carefully monitor staff behaviour towards the resident'* (CR02F12). *'...my stress went down when staff reached out to me to seek more information'* (CR01F02) *'...it was the friendliness of staff which helped to reduce stress'* (CR01F06) *'... some families have prevented us from providing quality end-of-life* care- *that is stressful'* (CR01S01) '…*we can provide good care when families are willing to share and trust the staff's judgement on how care services might best support their relative's needs'* (CR01S02) *'...thinking about the care situation from the other's perspective develops mutual respect, understanding and empathy'* (CR01S01)
DISCUSSION FOCUS: RECOMMENDED SYSTEM CHANGES TO IMPROVE FAMILY AND STAFF RELATIONSHIPS	
Theme 6. Communication systems have a major influence on staff/family relationships.	**Supporting statements – families and staff**
Complex communication systems give rise to tension and conflict between families, staff and management. Clear communication is needed on services available to residents prior to and following admission to avoid family and staff conflict and to reduce stress around the time of admission. Families require further details on key staff contact information.	'*...it is essential to redress bureaucratic, multi-layered, convoluted communication systems'* (CH01F13) *'... there is a need for transparent information on systems and services available to their relative prior to admission and as needed during their relative's transition to higher levels of care'* (CH01F15). *'...the information overload during admission very stressful and anxiety-provoking for the whole family'* (CR02F08) *'...I needed simply written, practical advice on policies and procedures and the names, or position titles, and contact details of all available personnel of all relevant*

	departments' (CH01F17)
Families require direct introduction to key personnel involved with the care of their family member.	*'…managers should introduce key members of staff on admission and subsequently, as a reference point for their relative'* (CH01F15)
Direct care staff who use appropriate communication approaches encourage and support residents and their families.	*'…many staff* were *effective team players, (they) were friendly and helpful to families and their colleagues, and were attentive to family reque*sts' (CR02F10)
Managers and senior nurses who make themselves available to speak with families, even out of hours, foster positive staff/family relationships.	*'…these senior staff acted quickly to address concerns or requests'* (CR01F03) *'…it is vital to have requests and concerns addressed quickly by senior staff'* (CR02F11)
Senior staff can facilitate positive family/staff relationships by initiating regular and timely communication with families.	*'… senior staff can improve advice to families, for example, for medical devices/equipment failures and the need for repair'* (CR01F02)
Staff can build positive family/staff relationships through direct communication with families about resident matters.	*'…if we communicate directly to families on resident progress helps to prevent miscommunication between families and staff*' (CR02S02)
Families require timely and sufficient information on planned and unplanned changes to the care environment, and in managerial and staffing assignments and rotation.	*'…having timely information helps families to better prepare their relatives for changes occurring'* (CR01F05)
Manager-endorsed communication systems can assist direct care staff and nurses to respond to family requests and/or concerns in a timely way.	*'…clear communication protocols help staff to know that family members have given permission for changes in care processes, and that support of these changes is given by management'* (CR02S02). *'… families need to have direct communication with the RN on duty on all shifts'* (CR02F11)
Family/staff miscommunication on end-of-life care can occur when families lack knowledge of advance care planning and obtaining their relative's wishes.	*'…discussion on end-of-life care with families…requires the attention of senior staff'* (CH01F14)
Family conferences with all the team, including direct care staff, helps families to communicate resident needs.	*'…frequent family conferences are essential if families and staff are to communicate effectively and collaborate in care* (CR02F09)
Communication skill development, including language skills for staff, is essential in enabling positive family/ relationships.	*'…a good command of spoken English is essential (for all staff) for resident safety and family satisfaction'* (CH01F16)

Coding for supporting statements:
CH01 – Care unit Hxx 1; CR01 – Care unit Rxx 1; CR02 – Care unit Rxx 2
S – Staff; F - Family

4. Discussion

Evaluation of the pilot study placed equal weight on the study process indicators (adoption of the education concepts by staff and families) and the study outcomes (changes in perceived family/staff relationships and collaboration in achieving care quality). A meaningful picture emerged that included what matters most to families and direct care staff, not only in relation to developing positive relationships and learning to collaborate in care planning and decision-making, but also in gaining a deeper understanding of the quality of care services expected and the quality aspects which were achieved. Additionally, the factors associated with care service quality and the major role played by organisational systems in supporting positive experiences for families, residents and direct care staff confirmed previous research findings[3,5,6,7].

4.1 Main outcomes

The baseline FRSA data[12] indicated that education on person-centered systems for direct care staff and families could help them to develop positive relationships and collaborate in achieving improved care services. The focus group and interview data elicited practical examples of how improvements in current services could occur, i.e. through more explicit linkage between current policies and practices and by formalising informal practices. For example, standardised education on family/staff communication techniques could be made mandatory for all new and existing staff in promoting more positive collaboration. Such education could be included in staff induction procedures, and in casual/agency staff orientation to organisational policies. Some adjustments to existing processes could include a more detailed policy/procedure to guide staff in the management of family frustrations arising from unfulfilled expectations of service delivery, as reported in earlier studies[4,19].

The FSRA data also indicated that while some organisational policies and procedures may have inhibited positive family/staff relationships (e.g. staff and family orientation, education, policy appraisal, and communication procedures), most of these structural constraints were amenable to improvement[20]. One key quality indicator (Item 11) could be met with a focussed policy adjustment and clear advice on how the care home's philosophy and care model can achieve a person-centered approach to care and relationships with families[4,13]. More explicit policy changes could be made to documents explaining to families and staff how the organisational mission statement and philosophy inform service delivery and service evaluation. As well, service benchmarks could be developed with the involvement of families and direct care staff, e.g. for measuring the achievement of person centred, family-friendly care[19]. These data suggest that achieving shared goals requires greater opportunities for shared decision-making and care arrangements by an increased number of interested and engaged families.

The differences between staff and family FASRIT[13] scores were informative. For example, the staff considered they offered families regular updates about their relative's care, with families identifying that this occurred infrequently and only

when they requested updates, as previously reported[20]. An issue of concern for families was the delay in receiving advice on incidences occurring for residents and subsequent changes in care and treatments. Twelve of the 17 family participants who remained at follow-up disagreed that staff involved them in care planning. They requested that staff proactively inform them of their relative's progress, changing needs and issues of concern, so that families can help in addressing such issues[5], seek medical advice and discuss issues with other family members[21].

As a measure of family values about the importance of positive family/staff relationships, collaboration, communication and teamwork in care services, the CARE[14] results indicate that families placed far greater emphasis on these factors than do staff [2]. In general, neither the families nor the staff showed an improvement in these aspects of care service quality post-intervention, apart from in the areas of safety (staff) and significance (families). Both families and staff agreed that such collaboration was influenced by staff workload, and there was a shared concern about the lack of time for staff to consult with families on care planning and in giving quality care[3].
One of the differences in staff and family perceptions of care quality was in the area of communication (both at the system- and individual-level). The other differences of opinion regarding care quality was in relation to care goals. Families were uncertain that the staff shared the same goals for meeting resident care needs as themselves, which is a common finding in care-related studies[19,20]. The other area of difference was that while staff considered they offered emotional support to families, families did not feel this occurred to any great extent[2].

Both the staff and family focus groups and family interviews indicate that tensions occur between families and staff when families consider that care services are deficient. In agreement with previous research, to improve care and lifestyle planning families request their involvement in the process[3]. Families suggested this could occur through having opportunities to share useful information about their relative's life history, achievements, interests and abilities[4]. Families considered it important that all direct care staff be made aware of residents' life histories and preferred lifestyles, with clear guidance on how to respond appropriately when caring for individual residents[19].

Families also felt that time constraints prevented staff from personalising the psychological and social aspects of care, which was considered just as important as physical care. The staff and families had concerns with the reliance on relief and agency staff to fill regular staff posts during times of staff shortage. Similar to other study findings, this practice placed burden on regular staff who were required to assist and supervise relief and agency staff, and to cover the additional work not performed by agency staff who were unfamiliar with the residents' individual need requirements[5].

Despite the different perceptions on factors influencing care service quality, families held positive views on recent staff efforts to address family concerns, seek solutions

to ongoing issues and proactively discuss issues with families. Most of the family participants considered that many of the nursing staff were more helpful and friendly following participation in the education program. In contrast with the unchanged CARE[14] results at post-intervention, families considered that most staff could be relied on to pursue solutions for issues of concern, to seek further information and to give timely feedback to families on care matters.

Tensions were reported when families found it difficult to communicate with managers and other staff in seeking redress for issues of concern. Communication system issues were perhaps the most challenging and worrying concerns for families[2], and these had a major impact on their relationships with direct care staff as well as senior staff. For example, family and manager/staff tensions increased when they believed that repeated requests for service improvement were being ignored, or they were inadequately addressed by management and senior staff. The other issue causing tension in family members was when staff failed, or delayed, communicating important information about resident matters with close family members[6].

4.2 Implications for practice

Family focus groups and interviews provided insight into how structural issues can be addressed to pave the way for more collaborative and collegial family/staff relationships, reflecting a person-centred model of service delivery. Advice on improvements included personalised transition processes (including assistance for social integration of resident into the home), more person-centred systems operations and a review of staffing levels and skills. It was important to families that the (sometimes traumatic) transitions from the person's home in the community to the aged care home, and between different care units, should be sensitive to the needs of the person and their families. Such needs should be identified, documented, and shared with the staff teams who are a part of the organisation, delivery and management of all relevant services[3]. In agreement with previous research[6,7], families of residents with dementia and those who required palliative care, identified the benefits of participating in family support groups at the care facility.

To maximise a sense of wellbeing and collaboration among all members of the care home facility, families and staff both recommended that staff education could include different approaches to stimulate/facilitate flows of communication between residents and families, and between residents and staff. They suggested a number of strategies, including providing families with access to dedicated senior members of staff for discussing issues of concern at times that were convenient for the family. What families wanted most is for staff at all levels of the care home to show that they care *about* their relative. Families suggested that staff can demonstrate this by making more effort to learn about the resident and their family, finding out what the family needs in care and support services, share their concerns and feelings about the resident with the family, and offer more frequent care evaluation conferences with relevant team members and the family[2].

Families reinforced that managers and senior staff must to pay particular attention to the structural preconditions for personalising care home systems[3]. Examples included ensuring that all staff are fully aware of their obligation and having systems in place to enable staff to focus on resident wellbeing as well as on physical care needs, an issue that has been raised in previous research[4]. Families strongly advised that their relationships with direct care staff, as well as managers, improved when close staff supervision and mentoring were '*business as usual*' (CRF2F09), especially for new staff and when staff turnover and rotation were occurring.

4.3 Study strengths and limitations

Both the organizational-level and participant-level findings arising from this feasibility study contribute to the literature, by identifying the factors involved in delivering quality aged care services and the factors required to form positive partnerships between families and staff in supporting quality services. The objective measures of service quality at baseline and at post-intervention complemented the subjective experiences of the study participants and helped to clarify, explain and extend these findings. A study strength was the valuable advice provided by the Advisory Group on the study aims and procedures, the education program content and the learning resources, which helped in making the education more accessible to all the participants. The organisational-level data provided useful information about the study context, pinpointed the structural factors that the organisation could attend to in supporting care quality and identified specific topics for inclusion in the education program.

The main study limitations were the selective sampling of a small number of available study sites, the small volunteer sample size and high participant drop-out rate at post-intervention. The high drop-out rate of family carers at post-intervention means that the family outcome data need to be interpreted with caution. As a high number of family participants had tertiary education qualifications and professional careers, participating family members were not necessarily representative of other families with relatives living in Australian aged care homes. Nevertheless, while the families' higher educational levels are likely to have influenced the issues they raised, this enabled more in-depth discussion on family issues and recommendations for service improvement. Similarly, given the high socio-economic location of the study sites, the study findings may not represent organisational-level factors influencing family-staff relationships generally in Australian aged care homes. The findings may not also fully reflect the views of aged care nurses, allied health and care staff concerning family-staff relationships and collaboration in care services.

5. Conclusion

This pilot study confirmed that targeted education on family/staff relationships and collaboration can help to raise awareness of its importance in delivering quality, family-friendly aged care services. Such education has the potential to promote better care delivery, particularly in improving communication between staff and families in making collaborative care

decisions. The key study findings suggest that relationship difficulties between direct care staff and families can occur when there is a mismatch between organizational structures and family expectations, such as the routinized care model which may differ to the family's preferred approach to care. Conversely, the organizational structures that support family expectations of a personalised service, such as joint decision-making on care requirements, can assist staff at all levels to provide both competent and emotionally involved care. Continued staff education on family/staff relations, improved organisational communication systems and clearer communication between direct care staff and families are needed to maintain this positive outcome.

6. Supporting information

SF Table 1 CARE Family median ratings

Questions pertain to the previous month	Pre-int. n = 38 Median	Post-int. n = 17 Median
Safety		
Is there a core team of regular staff?	3.5	3.5
Is there enough time for staff to complete care?	3	3
Do staff appear to have the skills to look after your relative?	3	3
Do staff maintain a pleasant home temperature?[a]	0[a]	0[a]
Do staff have a professional manner?	3	4
Staff remove obstructions that might cause accidents/injuries?[a]	0 [a]	0 [a]
Percentage of 'Don't know' responses	2.6%	0.0%
Significance		
Do staff help your relative maintain their appearance?	3	4
Are you kept up-to-date with changes affecting your relative?	3	4
Do staff respect your relationship with your relative?	4	4
Are case managers available to you?	3	4
Can you discuss things with staff in confidence?	3	4
Do staff give you opportunities to comment on care?	2	2.5
Do staff respect your relative's personal belongings?	3	4
Percentage of 'Don't know' responses	3.3%	5.3%
Belonging		
Are staff approachable?	3	4
Is your relative happy?	3	3.5
Does your relative look comfortable following care?	4	4
Is your relative treated with respect and dignity?	4	4
Do staff greet you when you arrive?	3	4
Do staff knock and wait before entering your relative's room?	4	4
Percentage of 'Don't know' responses	0.0%	0.0%
Purpose		
Are you involved in decisions about your relative's care?	3	3

Do you take part in aspects of your relative's care when you want?	4	4
Do staff provide your relative with interesting things to do?	2	3
Do you take part in recreational activities with your relative when you want?	3	3
Are you given sufficient information about forthcoming events in the home?	3	3
Percentage of 'Don't know' responses	3.1%	2.9%
Continuity		
Do staff keep the home smelling fresh?[a]	0 [a]	0 [a]
Do staff leave your relative's room clean?	3	3
Are there social outings organised for your relative?	3	3
Do staff use language you can understand?	3	4
Percentage of 'Don't know' responses	0.0%	0.0%
Achievement		
Do staff appreciate your involvement in your relative's care?	4	4
Do staff acknowledge your caring role?	4	4
Percentage of 'Don't know' responses	3.8%	7.1%
Frequency of median scores across scale (questions 1 – 30)		
4 (always occurred: includes medians between 3.5 - 4	9	19
3 (usually occurred: includes medians between 2.5 – 3.49)	18	10
2 (sometimes occurred: includes median between 1.5 – 2.49)	2	0
1 (rarely occurred)	0	0
0 (never occurred)	1	0
[a] Items with all responses 'Don't know'	3	3

SF Table 2 CARE Staff median ratings

Questions pertain to the last month	Pre-Int. n=49 Median	Post-Int. n=30 Median
Safety		
Do you have all the information you needed to care for residents?	3	3
Other staff provide prompt assistance when you need help?	3	3
Staff provide services that meet resident's needs?	3	4
Staff use safe moving and handling techniques & equipment?	3	4
Can you deliver care without being distracted?	3	3
Suitable clinical supplies are available when needed?	3.5	4
You are able to protect yourself (and clothes) from body fluids and	3.5	3.5

waste?	3	3.5
There is ample time for each resident's care?	2.5	3
Colleagues are approachable if you need advice?	2.5	3
Are you happy with your day-to-day workload?	1.0%	0.0%
Percentage of 'Don't know' responses		
Significance		
Staff work together as a team to care for residents?	3	3
All aspects of work are shared by all team members?	3	3
All staff grades and roles of the team are equally valued?	3	3
There are opportunities to discuss care of resident with other staff?	3	3
You are encouraged to use your initiative at work?	3	3.5
Percentage of 'Don't know' responses	0.7%	0.0%
Belonging		
Staff are friendly to residents?	4	4
You are kept informed about things that affect the team?	3	3
You are able to attend to residents without feeling rushed?	2.5	2.5
Misunderstandings between the team are quickly resolved?	3	3
You are able to talk to colleagues in confidence?	3	3
Percentage of 'Don't know' responses	1.3%	1.3%
Purpose		
Staff are enthusiastic about working with residents?	3	3
Team members have skills to provide care that residents need?	3	3.5
Is your work interesting?	3	4
Are you motivated to learn new things?	3	4
You are involved in leisure activities with residents?	2	2
Percentage of 'Don't know' responses	1.3%	0.0%
Achievement		
Do the residents' families openly appreciate your work?	3	3
Are residents able to hold a meaningful conversation with you?	3	3

Do other staff (staff in other roles) openly appreciate your work?	2	3
Number of 'Don't know' responses	0.0%	8.3%
Frequency of median scores across scale (questions 1 – 30)		
4 (always occurred: includes medians between 3.5 - 4	6	11
3 (usually occurred: includes medians between 2.5 – 3.49)	22	16
2 (sometimes occurred: includes median between 1.5 – 2.49)	2	1
1 (rarely occurred)	0	0
Items with all responses 'Don't know'	0	0

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