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Coordinating the Roles of Nursing Home Staff and Families of Elderly Nursing Home Residents

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This study examines families' and nurses' perceptions of the functions that should be performed by families of elderly nursing home residents and whether there is congruency between nursing staff and families' perceptions. This was a quasi-experimental study and was based on questionnaires distributed among 85 nurses and 68 families of nursing home residents. The findings indicated that the staff believes that families must assume more roles than the families think they should. In contrast, families believe that they should be more informed of the physical care of residents.
Key words: *communication*, *family role*, *nurses*, *nursing homes*

ELDERLY RESIDENTS, hospitalized in Israeli geriatric units, require long-term rehabilitation, nursing, and medical care. In the last 2 decades, health systems in Israel and Western countries have grown more attentive to the demands of health consumers and are making a greater effort to fulfill the needs of patients and their families.

One way of improving services is by coordinating the expectations of families and of staff regarding the role of the families of elderly nursing home residents. Problems stemming from lack of coordination of mutual expectations between families and staff span many cultures and countries.[1,2] However, there are only a few studies on this subject compared with the numerous studies on the many difficulties encountered by families of elderly nursing home residents.[3–5] The purpose of the research was to examine families' and nurses' perceptions of the functions that should be performed by families of elderly nursing home residents and whether there is congruency between nursing staff and families' perceptions about the role of the family in caring for their elderly relatives residing in nursing homes.

LITERATURE REVIEW

The family's degree of involvement in caring for elderly long-term residents of nursing homes is a major element affecting the mental well-being of these patients. In the United States and Britain, the government recognizes family involvement in caring for elderly residents. Since 1987, the Australian government has elaborated and defined the legal rights of elderly nursing home residents and established national standards of practice. These standards emphasize the fact that families may and should contribute to the independence of elderly residents, to preserving their privacy and dignity, and to their recreational activities.[6]

Family involvement in nursing homes is acknowledged as beneficial to residents both physically and mentally. However, families often have difficulty adjusting to new

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environments and placements. Many studies indicate that families often have difficulty adapting to new places.[7–10] In addition, there is a great deal of confusion regarding division of the burden of care between staff and families. Families are often interested in preserving part of their relationship with elderly relatives prior to hospitalization. Ward routines and maintaining a steady relationship with patients help families adjust to the fact that their relatives are living in a nursing facility and not at home. Cooperation between families and nurses enables families to take part in decision making and thus fulfills their essential need to provide the elderly with continuous support. For families, the need to be involved in caring is based on the belief that the quality of care provided to residents is closely connected to their level of involvement in that care.[11]

Shuttlesworth et al[2] conducted a study dealing with family roles in nursing homes. It was based on a questionnaire distributed to residents' families, listing 100 functions performed in nursing homes. Most of the families stated that most therapeutic tasks were performed by the caregiving staff and only a minority by the families. Rubin and Shuttlesworth[1] studied the issue of mutual expectations of staff and families regarding the therapeutic functions of each in caring for the elderly. That study found that families assume fewer functions because the staff is unwilling to share many of them. By contrast, Ross et al[12] found that families recognized their responsibility for supervising the quality of care provided to residents. This role includes teaching the staff about the unique life habits of their relatives. Families' ability to provide care and mental support depended on their cooperation with the staff.

There is evidence that nursing staff and families are interested in working together and preserving self-dignity of the elderly, which is supported by Schwartz and Vogel.[13] In that study, the staff agreed to share responsibility with the families, but families claimed that they were not sufficiently included in the various tasks and that they were interested in assuming a greater share of the daily care of residents.

Schwiran[14] divided families' roles into two types: skilled technical care and preservative care—providing mental support. Families expect staff to have technical knowledge of illnesses, medications, and nutritional needs, and the technical capability necessary to provide skilled medical and nursing care. However, expert preservative care requires knowledge of the history of the patients, their characters, and their experiences. While families were aware that from a technical aspect their own skills are limited, many families claimed that the staff was not aware of residents' histories and therefore had difficulty giving them optimal care. Thus, families believed that quality care of their relatives must involve cooperation and reciprocity between staff and families.

In Bowers'[15] study, families indicated that the staff could not provide good preservative care to residents. A study by Ryan and Scullion[10] suggested that families believed their major responsibilities were bringing possessions to patients, personal care such as feeding and bathing patients, and taking them on outings. Families were found to have assumed functions that did not disturb the staff's work. Litwak[16] found that families were interested in providing care for the elderly on a daily basis more than the staff was ready for them to help. However, it is possible, as claimed by Mechanic,[17] that there is a disparity between the measurement of views and of the wish to act on the one hand and actual acts on the other hand, because readiness does not take into account social and environmental pressures. Litwak's[16] findings emphasized that families believed staff accepted family involvement in roles connected to social support and personal care in which they were more experienced. Families perceived themselves as less involved in areas of technical management of tasks for which they expected nurses to be more proficient.

Laitinen[18] investigated the roles of families of elderly residents of long-term and short-term care nursing homes in a sample of

45 patients and 147 family members. Families testified that they generally did not provide care related to activities of daily life but focused more on emotional support. Families described 3 major aspects in which they are involved in helping care for the elderly: (1) in maintaining their identities through close relationships, for example, staff's recognition of those family members who continue to love and respect the residents; (2) supervision, which consists of monitoring care provided to the elderly, providing the staff with feedback and reducing knowledge gaps concerning residents; and (3) social support that includes helping patients communicate with other residents, encouraging participation in social events, and maintaining contact with the outside world.

Nurses are the caregivers who have daily contact with the families. They usually manage patient care and determine the role division for managing this care. Two nursing organizations, the International Council of Nurses and Australian Nursing Council, have stressed that the nurse's role includes joint work with families, that family values and beliefs must be appreciated, and that families must be included in caring for the patients. Despite the great significance attributed to family involvement in caring for residents, many studies have shown that staff members perceive most functions as part of their daily work. This in turn restricts family participation in many of the functions due to the organizational structural perception, which focuses on maintaining patients' security and managing risks.[11,18] Ryan and Scullion[10] indicate that many nurses believe that families are overly involved in patient care and do not trust families to provide patients with the most skilled and quality care. Litwak[16] found that families' overinvolvement in technical care was perceived as a nuisance. Moreover, staff members are not overly willing to negotiate the possibility of such involvement.[19] When elderly patients are admitted to long-term nursing homes, nursing care is focused on patients and their physical needs, while families' difficulties and needs are usually not attended to by the nursing staff.[20] The staff may not be aware of the potential of the support of family members and of defining their roles in the care of elderly residents.[21,22]

This disparity between the wishes of family members to be involved in caring for elderly nursing home residents and those of staff members who do not tend to relinquish their professional roles may lead to conflicts and dissatisfaction. Families are usually uncertain of their ability to adjust to the nursing home environment.[8] Bern-Klug and Forbes-Thompson interviewed families that complained about inaction while visiting residents. "Many families sat and stared at their relative for an hour or two every week."[9(p185)] As a result, families were reluctant to come to the nursing home. Visits to the nursing home were associated with feelings of frustration, anger, and guilt. Bauer[23] stated that families reported confusion concerning their responsibility for the patient versus staff responsibility because certain roles were not negotiated. As a result, families often have to learn the nature of their roles and place in the nursing home through a process of trial and error, while the formation of good relationships between staff and families should be based on understanding their mutual responsibilities.[23]

METHODS

Research design

The study used a survey method. The research questions were as follows: what are families' and nurses' perceptions of the functions that should be performed by families of elderly nursing home residents, and is there congruency between their perceptions about the role of the family in caring for their elderly relatives residing in nursing homes?

Research instruments

A 50-item questionnaire developed by Shuttlesworth et al,[2] which included activities/tasks to meet nursing home residents' needs, was used. This inventory has been used in several studies[11,21] and has proven to be a

Table 1. Reliabilities for subscales in nurses' questionnaire

Nursing home roles	Level of reliability
Physical support	0.983
Mental Support	0.812
Friend support	0.835
Source of appreciation and respect	0.882
Contact with the external world	0.852
Contact with the nursing home	0.921

reliable and valid instrument. The inventory was translated into Hebrew by using translation and back-translation; it also was validated by 20 geriatric nurses from Israel. A factor analysis was performed, and 6 subscales were identified by the author of this study: physical support, mental support, friend support, appreciation and respect, contact with the external world, and contact with the nursing home. The internal consistency coefficient (Cronbach α) performed on this study was satisfactory for the total scale (.880) and for the subscales (Table 1).

The family questionnaire consisted of 2 parts. The first part included 15 items of demographic information concerning the family and 8 items dealing with information concerning contact with the elderly resident. The second part included 50 items on roles identified as basic functions performed in nursing homes. Answers regarding nursing home functions were ranked on a 5-choice ordinal scale with the first choice indicating disagreement and the fifth choice indicating full agreement. The nurses' questionnaire also consisted of 2 parts: the first part included 13 items on demographic information and the nurse's education. The second part included the same 50 items dealing with roles identified as basic nursing home functions. The roles were divided into 6 subscales described earlier (Table 1).

Sample

A convenience sample consisting of 85 nurses and 68 family members were invited to participate in this study from the Shoham Geriatric Medical Center, Pardes Hanna, Israel. The researcher distributed the questionnaire among families visiting their departments. A convenience sample of 68 families was formed.

Research process

Approval to conduct the study was obtained from the nursing research committee in the nursing home. The second stage included a meeting with the head nurses of the various departments. The researcher was responsible for distributing the questionnaires among the nurses and patients' families after receiving their informed consent to participate and providing an explanation about participants' anonymity. One hundred questionnaires were distributed to the nurses, of which 85 were completed in full (85%); 100 questionnaires were distributed to families, of which 68 were completed in full (68%). The time provided for completing the questionnaire was limited to 30 minutes. The data were collected over a period of 3 months in winter 2007.

Data analysis

The Statistical Package for Social Sciences for Windows Version 11.5 (SPSS Inc, Chicago, IL) was used to analyze the quantitative data. The scores on the questionnaire (0 ± 5) produced ordinal scale measurements and were analyzed using the factor analysis and the Mann-Whitney U test. The Mann-Whitney U test examines differences in the ranking of the scores for each subject on each question.

RESULTS

Families

Most of the families were children of the patients (73.2%) and mostly women (55.2%). Many were married (70.6%), and a large number of the relatives worked full-time (60.2%).

Most of the relatives had a high school education (35.3%). All were Jewish, mostly secular (52.2%). More than a third of the caregivers (34.3%) were relatives of patients who had been residents of the nursing home for less than a year, and 38.8% of the caregivers were relatives of patients who had been residents for at least 3 years. Most were primary caregivers, and 53.2% had been primary caregivers for more than 3 years.

Relatives' contact with the patients had diminished following institutionalization. Previously 52.9% of the relatives had been in daily contact with the patients; however, while at the nursing home, most (58%) saw the patients only once a week or less and did not even maintain telephone contact, although most of the relatives (80%) testified to medium to high accessibility of the nursing home. Nearly half (48.5%) of the relatives admitted that they were frustrated by the fact that their relatives were nursing home residents.

Nurses

The study consisted of 85 nurses in the following age range: 16.7% were 20 to 30 years, 32.1% were 31 to 40 years, 39.3% were 41 to 50 years, and 11.9% were 51 to 60 years. Most were married with 2 to 3 children. Regarding religion, half of the nurses defined themselves as not religious. Among the sample of nurses, 84.7% were Jewish and 12.9% Arab. Most of the nurses were practical nurses (41.2%); 37.6% were registered nurses, some of whom had degrees in nursing (7.1%) or other fields (3.5%). Thus, most of the subjects were practical nurses with 11 to 22 years of professional experience, and this experience had been achieved mainly in nursing homes.

The staff's mean scores were higher than the families' mean scores on 32 of the tasks, and families' mean scores were higher than those of the staff on the others. There were statistically significant differences on 14 of the tasks in the questionnaire (Table 2).

Table 2. Comparison of results between family and staff on 14 tasks[a]

Statement	Mean (SD)		*P*
	Nurses	Families	
Reading literature to patients	3.57 (1.3)	3.02 (1.4)	.021
Writing letters for patients	3.75 (1.3)	3.06 (1.6)	.012
Seeing that the patient receives daily newspapers	3.81 (1.1)	2.82 (1.5)	.000
Seeing that the patient receives magazines and books	3.89 (1.0)	3.00 (1.5)	.000
Taking patients for meals elsewhere	3.71 (1.2)	2.83 (1.5)	.001
Providing patients with an allowance	3.13 (1.4)	2.40 (1.5)	.002
Identifying patients' changing needs	3.87 (1.2)	4.12 (1.2)	.004
Encouraging good relationships between family members and nurses	4.04 (1.0)	4.42 (0.9)	.014
Helping the staff while caring for patients	2.49 (1.5)	3.03 (1.4)	.031
Seeing that the family is acquainted with the care provided by staff to patients	3.54 (1.3)	3.94 (1.2)	.034
Knowledge of department instructions and regulations	3.53 (1.3)	3.94 (1.3)	.030
Caring for medications not included in health services basket	3.93 (1.3)	3.22 (1.6)	.008
Arranging for outside experts	3.76 (1.4)	3.15 (1.6)	.026
Preparing special food for patients	4.26 (1.1)	3.51 (1.5)	.002

[a]With significant differences between scores on Mann-Whitney *U* tests.

The findings indicated that the staff believes that families must assume more roles than the families think they should. On 9 items, families' mean scores were lower than staff's mean scores. Those items were providing medications not included in the health services basket, arranging for outside experts, providing an allowance, taking patients on outings, preparing special food for residents, writing letters for patients, reading, and providing both books and daily newspapers. In contrast, families believed that they should be informed of the physical care of residents and even be involved in it. There also were items rated the highest by both families and nurses (ie, maintaining good relationships between patients and their families, encouraging good relationships between family members and nurses, encouraging regular family visits, and family knowledge of nursing home regulation).

One of the most important findings from this study is that in general, family members and nurses agree on the roles of family members of nursing home residents, as supported by the lack of significant difference in ratings between family members and nurses on 5 of the 6 subscales. However, in contrast, the study findings indicated a significant difference between nurses' perception and families' perception of "contact with the external world." Nurses believed that families should assume a greater share in caring for this aspect.

DISCUSSION

The study findings indicated only one disparity between nurses' and families' perceptions of the roles of family members of elderly nursing home residents. Nurses were interested in families' assuming more roles than families thought they should. The difference is particularly conspicuous about patients' contact with the external world. In contrast, families would like to assume more roles connected to physical care of patients and to maintain quality care rather than encouraging them to be involved in social and current events outside of the nursing home. This finding supports previous studies that suggest members of the nursing staff do not encourage such opportunities for direct physical care of long-term patients.[15,24,25] It may be that the nursing staff is not always ready to allow family members to take care of personal needs of their relative because of the concern of harm coming to the resident, which ultimately is the responsibility of the nursing staff.

The findings of this study contradict research by Bowers,[15] which indicated that families feel that they contribute to all aspects of the daily care of residents. The existence of a disparity between the role perception of staff and families might lead to misunderstandings between the two. Ryan and Scullion[10] and Shuttlesworth et al[2] found that the reason for the differences was based on the Israeli nursing home concept of openness and family inclusion. Thus, staff members perceive that families should be included in most roles, aside from the role of providing physical care. According to the staff's outlook, if care is not provided by competent staff, the patient might suffer physical harm that could lead to accusations aimed at the staff. In contrast, families perceive the nursing home as a new home for patients, providing them with the opportunity for external ties and also with social and mental support. Relatives were interested in taking part in tasks perceived as important to them at the time of admission such as those related to physical care of patients.

In the research, there were similarities in 5 of the 6 subscales. However, the evidence that there are differences in the perception of integrating the resident with external events outside of the nursing home suggests that there is a lack of effective communication between the staff and patients, which may affect the quality of care.

Clinical implications

Coordinating expectations of families and nurses regarding family roles during the care of elderly residents at nursing homes has significance for the quality of life of residents and

their families. In light of the study results, it is important to construct an institutional procedure that will define and clarify family roles for the duration of nursing home care of elderly residents. After designing the procedure, it should be explained to family members of admitted residents. In addition, family members and staff should engage in a process of mutual feedback at different times throughout the residents' stay at the nursing home about expectations of the family role. Clearly, good communication must underpin any nurse-family relationship. For family caregivers to play as full a role as possible, they need to be involved in the assessment, planning, implementation, and evaluation of care. They need encouragement, information, and perhaps some training to continue their participation in care of their elderly relatives.

Research limitations

The current study has a number of limitations related to the validity and generalization of the study findings. There is a bias concerning the research population, because family members who responded to the questionnaire were usually families that visited the nursing home frequently, and they were not representative of all families. In addition, the sample represents only 1 Israeli nursing home. This population was selected for reasons of methodological convenience, and as such it is not representative of all families of Israeli nursing home residents. In addition, it is possible that nurses tried to demonstrate a positive view of allocating roles to family members as desired by the nursing home, and this may not represent their own real opinions.

CONCLUSIONS

In this study, it was found that, in general, nurses and families agreed about the role that families of residents should take in the care of their relatives other than in external events outside of the nursing home. In addition, nurses believed that families must assume more roles than the families think they should. However, nurses did not think that families should take part in physical care of the residents. In contrast, families believed that they should be more informed of the physical care of residents and even be involved in providing that care.

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