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The Nature of Staff - Family Interactions in Nursing Homes: Staff Perceptions

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Abstract

Each year thousands of older adults are admitted to nursing homes. Following admission, nursing home staff and family members must interact and communicate with each other. This study examined relationship and communication patterns between nursing home staff members and family members of nursing home residents, as part of a larger multi-method comparative case study. Here, we report on 6- month case studies of two nursing homes where in-depth interviews, shadowing experiences, and direct observations were completed. Staff members from both nursing homes described staff-family interactions as difficult, problematic and time consuming, yet identified strategies that when implemented consistently, influenced the staff-family interaction positively. Findings suggest explanatory processes in staff-family interactions, while pointing toward promising interventions.

Keywords

staff-family encounters; demanding families; relationship patterns; qualitative study; communication

1. Introduction

Following nursing home admission, family members of the new resident and the health care staff must interact with each other. Some staff mistakenly think that family members abandon their relatives once they are admitted to the nursing home (Naleppa, 1996; Port et al., 2001; Rowles & High, 2003), but the reality is that most family and friends remain involved in the care of their relative through visits or phone calls (Naleppa, 1996; Stull et al., 1997; Nolan & Dellasega, 1999; Port et al., 2001). Staff members discover that the new resident brings family

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members who both expect continued involvement in care, and need information and attention (Hertzberg, Ekman, & Axelsson, 2001). Research has shown that family members value effective relationships with nursing home staff, whom they see as a source of information and a means of remaining involved in care decisions (Bowers, 1988; Duncan & Morgan, 1994). Also, family members who possess information about residents' preferences, habits and goals of care can assist staff to establish an optimal plan of care that contributes to resident well-being (Rowles & High, 2003). However, staff-family relationships evolve in a social and physical environment that while familiar to staff, is often foreign to family members, who find themselves in a strange place with new roles to play and complex rules to interpret. In a nursing home setting, where because of resource constraints there is little time to accomplish competing tasks and staff turnover is frequent, establishing and maintaining an effective staff-family relationship can be taxing for both parties (Hertzberg & Ekman, 2000; Bowers, Lauring, & Jacobson, 2001).

Staff-family interactions can produce tension and even conflict between health providers and family members of residents (Iecovich, 2000; Gladstone & Wexler, 2002; Hertzberg, Ekman, & Axelsson, 2003; Pillemer et al., 1998). In the state of North Carolina, for example, the state long-term care ombudsman's office reports that the largest percentage (approximately 56%) of nursing home complaints are raised by residents' relatives/friends/legal representatives rather than by the residents themselves, external facility representatives (i.e. hospitals), or anonymous reports (Wilder, 2005). Such reported family member grievances suggest that improved interaction and communication between staff and family are necessary to improve relationships and decrease family complaints that can lead to costly investigations.

Marzialli, Shulman, & Damianakis (2006) reported that nurse managers in long-term care settings spent an inordinate amount of time supporting direct care staff to cope with staff-family conflicts. Bauer (2006) found that some nursing home staff fostered family partnerships, while other nursing home staff maintained adversarial relationships with family members, preferring control. Research on staff-family interactions in other healthcare settings offers insights into the potential capacity of nursing home staff to influence this relationship. Early work in critical care nursing, for example, outlined principles for understanding the nurse-family relationship and proposed that several factors act as barriers to the nurse-family relationship, including lack of time, nurses' perception of family members as a stressor, and nurses' negative response styles (Artinian, 1991).

In a qualitative study of nurses working in intensive care units, Soderstrom, Benzein, & Saveman (2003) described nurse-family relationships as one of two types: inviting or non-inviting. In inviting interactions, nurses valued good relationships with families and perceived a quality relationship to be a prerequisite for good care. In these inviting relationships, nurses confirmed family members by listening, answering questions and offering comfort. In non-inviting interactions, nurses saw their medical, technical tasks with patients as the most important nursing responsibility, described themselves as experts, and perceived family as interfering with their efforts to do their jobs.

Although, there are differences between the hospital and the nursing home, long-term care settings are very much an outgrowth of the traditional model used in hospital settings. As in hospital settings, nursing home staff are in control and emphasize basic care requirements for the resident. Most often, work routines and care management are adapted from hospital work habits that allow for little flexibility to meet family member needs (Bauer, 2006). Bauer's study of nursing homes, like Soderstrom's and Artinian's work in hospital settings, found a task-focused model where completion of assignments was the major focus, limiting interaction and communication with families. Some nursing homes attempt to create homelike environments (Gubrium, 1975, Rowles & High, 2003), but most still center activities around a hospital

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corridor layout that is convenient for nursing home staff work routines. And nursing homes remain a bureaucratic system with little time for interaction and communication other than with designated care recipients (Diamond, 1992).

Poor communication creates scenarios in which crucial information is not exchanged between staff and family. In one early study, communication between staff and relatives of nursing home residents occurred only on a superficial level and the family member frequently had to initiate interactions (Hertzberg & Ekman, 1996). Later research (Hertzberg & Ekman, 2000) has suggested that enhancing a cooperative relationship between staff and family members to promote holistic care of the elderly requires two-way communication between staff and family members. Lack of appropriate information exchange between the two parties adversely affects resident care and become very time consuming for staff (Hertzberg et al., 2003).

Based on work in a hospital setting, Soderstrom concluded that health care providers are capable of promoting either positive or negative staff-family interactions, and found that staff attitudes toward families determine, at least in part, the nature of those interactions. Given the frequency of family contact and family involvement in nursing homes (Bowers, 1988; Zarit & Whitlatch, 1992; Ehrenfeld, Bergman, & Alpert, 1997; Hertzberg & Ekman, 2000), it is important to understand the characteristics of staff-family interactions, their communication patterns and the potential for improving the quality of these interactions.

Using case study methods, therefore, we explored staff-family relationships and looked at the outcomes of these interactions. The staff-family relationship was defined as purposeful interactions between nursing home staff and family members, the accompanying emotional responses, and mutual adjustments of behavior. The investigation considered all nursing home employees who have contact with family members. Exploration was undertaken by observing and interviewing staff about staff-family interactions in two community nursing homes. The study was guided by complexity theory.

1.1. Complexity Theory Framework

Examining organizations like nursing homes through a complexity theory framework (Cilliers, 1996, Stacy, 1998) provides insights about how relationship patterns and information flow facilitate self-regulation and thus increase capacity to develop new behaviors that lead to better quality outcomes for residents and staff (Anderson et al, 2003, Anderson et al, 2004). Complexity theory proposes that an organization, like a nursing home is composed of a complex set of connections between its members, where information exchange occurs and cognitive diversity exists. Characteristics of a complex system are these: (1) there are a large number of elements, (2) interactions are non-linear, with varying feedback loops across connections, (3) these are open systems interacting with the environment, and (4) interactions may be short-range, but the richness of interaction or relations across networks can have wide ranging influence (Cillers, 1998). Emphasis is on the connections or interactions between members. When there are multiple connections with quality information exchange within and across levels of the organization, members (in this case, nursing home staff) are better able to adjust behavior for change or self-regulation; the ability to make sense of a situation or adjust behavior to meet new demands. In this model, interactions can create reiterative feedback loops, by which a member’s action can be fed back and affect future responses. Several research reports using complexity theory framework (Anderson et al., 2005; Colon-Emeric et al., 2006; Piven et al., 2006), have highlighted the role of relationship systems within nursing home organizations as critical for interpreting human behavior and outcomes. These prior studies suggest that altering the pattern of communication and degree of connection between nursing home staff would improve information flow and lead to better care for residents.

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Spontaneous flow of accurate information to the diverse members of a nursing home allows for better decision-making and successful adaptation to changes occurring in the nursing home environment. Thus, complexity theory provided the framework for considering communication and characteristics of staff-family interactions and how the quality of interaction and communication can potentially affect residents and staff.

2. Method

This study, a cross-case comparison of two nursing homes, was part of a larger multi-method comparative case study of relationship patterns and management practices in nursing homes. In the larger study, nursing homes were randomly selected from a pool of nursing homes within driving distance (about 100) miles of the university. The University Institutional Review Board approved the study, and written consent to conduct the study was obtained from the nursing home administrators and directors of nursing, and from all subjects interviewed. Over a 6-month period, two field researchers (an organizational development specialist and a social worker) conducted participant-observations and in-depth interviews in each nursing home. The researchers spent approximately 2-1/2 days per week in the field; the duration of a particular observation or interview varied depending on staff members and their work activities.

During observations, field researchers observed interactions and followed up by informally asking staff questions to expand and verify their observations. For example, a field researcher would observe a care planning meeting or family council meeting and later ask informal questions of staff participants about what was observed. In-depth interviews were conducted using an interview guide with open-ended questions and follow-up probes that focused on defining relationship patterns and the perceived outcomes for staff, residents, families and the organization. For example, a field researcher would say to a nurse, nursing assistant or other staff member: “What kind of contact do you have with the family members who come to the nursing home?” Afterward the field researcher would follow with a probe question, such as, “What is that like and how do you go about doing that?” All questions on the interview guide were addressed before termination of the interview; if work responsibilities interfered with an in-depth interview, the field researcher would reschedule the interview at a later time. Shadowing involved field researchers accompanying a staff member during a work shift to gain details about work processes and work relationships.

Field notes were written by the field researchers during the shadowing and direct observations/informal interviews and transcribed into electronic text files. In-depth interviews were tape recorded and later transcribed verbatim. Transcribed field notes, interviews, shadowing notes and nursing home documents were read by all team members. Each filed note or interview was coded by at least two research team members, identifying family issues with specified codes. The first author then analyzed the coded data to identify emerging patterns and themes related to staff-family relationships, which were presented to the interdisciplinary team for discussion. Comparable staff members from each nursing home were observed and interviewed; they included administrators (5), middle managers (16) (i.e., social work director, admission director, activity director, and environmental director), nurses (44) (registered nurses, licensed practical nurses, and minimum data set nurses), nursing assistants (59), and various other staff members (i.e. physical therapist, occupational therapist) in the nursing homes. As with the intense interviewing and amount of observational time, in Sweet Dell (pseudonym for Case 1), there were 98 direct observation/informal interviews, 14 shadowing encounters, during which staff members were shadowed over a work shift, and 32 in-depth interviews. Data from Safe Harbor (pseudonym for Case 2) included 116 direct observation/informal interviews, 26 shadowing encounters during work shifts, and 39 in-depth interviews.

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Interviews and participant observations occurred in the context of ongoing staff-family interactions in the nursing home setting. Field researchers were able to observe staff-family interactions, listen to staff conversations about their interactions with family members, and explore other staff-family communication approaches (e.g., voicemail messages). This paper presents the views of nursing home staff.

2.1 Settings

Sweet Dell is a long standing nursing home that is part of a religious-affiliated, continuing care retirement community. It has approximately 120 resident beds, and the residents' socioeconomic status is estimated to be middle income or above. Sweet Dell's core values emphasize love and compassion, in keeping with a religious affiliation.

Safe Harbor is a subsidiary of a large for-profit corporation which has operated this home for over 12 years. This 180-bed facility is located in a small urban setting. Most residents in the facility were low income and have working class backgrounds. Safe Harbor's core values underscore, high-quality care, regulatory compliance and resident centered care, in keeping with the values of the larger corporation.

3. Findings

Staff at both nursing homes described staff-family relationships as difficult, problematic and time consuming. Staff at Safe Harbor, however, also included some positive aspects, describing the relationships as helpful, important and trusting. Safe Harbor staff said there were some benefits to staff-family interactions, whereas this was seldom the case at Sweet Dell. The staff's assessment of the characteristics of staff-family relationships and the way these interactions affected outcomes such as communication are briefly described below. Table 1 summarizes staff descriptions of staff-family relationships in the two nursing homes.

3.1 Difficult, Problematic, Time Consuming Interaction

Staff at Sweet Dell primarily described their interactions with family members in negative terms, such as difficult, problematic, time consuming, conflictual, and challenging. For example, a registered nurse (RN) and a licensed practical nurse (LPN) at Sweet Dell compared the time required to interact with families to the amount of time required for resident caregiving tasks.

> RN: And after medications it is treatments and a lot of intervening with family members. Because most of the time I feel like I am treating family members more than I am residents.

> LPN: She is overly enmeshed with her mother and makes life hard. There are a few of those [family members] around here. They come in and we have to spend more time pleasing them, than helping their parent.

Sweet Dell nursing staff also said that interaction with family members was the most difficult part of their job.

> RN: As far as the family members are concerned, I would just rather not see one of them, because that is a real difficulty. That is the hardest part of the job. They take up all of our time.

Nursing assistants (NAs) at Sweet Dell agreed that families were difficult; however, an empathy response was expressed by NAs that was not evident in comments by the nursing and management staff. Some nursing assistants reported understanding family members' frustration because of their relatives' illness experience. They believed that there were times when both families and residents appreciated what nursing assistants did.

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> Nursing assistant: You know sometimes you would run across different situations that will make you feel bad, like what families say. If I was in their [circumstance], I might get a little ticked [frustrated] from time to time.

> Nursing assistant: We get more support from the families than we do from the management. Because most families know when they come in who does what and who they like to take care of their mom or their dad because they see them interact or see how their loved one looks.

Families at Sweet Dell were portrayed as demanding that their relatives' needs be met and not considering the competing needs of other residents. A statement from a nurse at Sweet Dell gives a glimpse of this perceived disregard for the needs of others residents:

> RN: We could be in the middle of a code in one of the rooms… and they (family member) will demand that you take care of their parent. No, so basically I do not like taking care of family members.

The Safe Harbor nursing home administrator (NHA) reported that interactions with families most often involved complaints: "It is about six to one, complaint to compliment." However, the following interaction between a field researcher and nursing assistant at Safe Harbor showed that a nursing assistant understood the necessity of allowing families to vent and not respond to them in anger:

> Field Researcher: So some people say it is hard working with the families. What do you think?

> Nursing Assistant: Some of the families are ridiculous, but most of them have big [guilt] trips [difficulty] about putting momma in [a nursing home], so they come in and give us a hard time. But it is the way you talk to them, if they [family] come off as really angry with you, stand there and give them 5 or 10 minutes and you let them blow some steam. Let them know you are doing the best you can and that is it.

> Field Researcher: So that is your strategy, you just kind of let them vent and then…?

> Nursing Assistant: It does not help if you try and get angry.

At Safe Harbor, anger expressed toward a resident or family member was not tolerated, as demonstrated by the following statement by Safe Harbor's assistant nursing home administrator (AsstNHA): "A nursing assistant got "belligerent" with a resident's family member. The nursing assistant pushed a meal tray at the resident and then left the resident to fend for [her]self." The Asst NHA added, "The family was irate, rightly so, the customer is always right." He then indicated that the nursing assistant had been suspended pending investigation.

3.2 Demanding Families Strain Interaction

In addition to the generally problematic relationships described above, staff from both nursing homes identified a subset of families who were perceived as "problem families" or "demanding families" whom staff were least likely to please and who required or demanded the most attention. The quality assurance nurse, an LPN from Sweet Dell, said:

> LPN: And most families, when they complain they have a right to complain. And I agree with 'em. But it's those few – maybe three or four families – that end up driving you crazy. And sometimes you can ignore 'em and sometimes you can't. So, that would be it. Not having enough patience with that little tiny group [laughs slightly] of families.

At Safe Harbor a nurse also reported that a group of problem or demanding families existed:

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> RN: I have a pretty good relationship with most of the families up here. You know, every hall has them, they're problem families, let's say that they need the extra attention.

Staff described these families as angry, unhappy, and often complaining. Problem or demanding families consumed the most time and caused the most difficulty for staff members. Staff members were reluctant to interact with these problem families, often avoiding them. Other staff, such as the social worker at Safe Harbor, however, recognized that extra attention to families soon after admission could alleviate many of their concerns and lead to improved relationships long-term.

> Social Worker: And if she [admitting nurse] would just think about it, if she would just go in there, be nice to the family, and understand that, yeah, they're complaining already – they haven't been here five minutes – but it is the transition that they've got to make. And if you would make their transition pleasant, they would probably be a nice family for you. Whether that patient was nice to you or not, and you would have the support of that family. Or you can go in and do it like some [nurses], and just complain the whole time, and not be nice to the family, not be cordial, and not build a good relationship based on customer service to begin with.

3.3 Unmatched Expectations Staff-Family Connection

The demanding family members' expectations often clashed with staff expectations. Another Sweet Dell nurse said that some conflict was a result of staff and family members disagreeing about residents' care needs.

> Nurse Supervisor: You know the families need something and the professionals think something else is important and they all are trying to care for the resident but don't always see eye to eye.

A nursing assistant at Sweet Dell reported trying to meet a family member's hygiene care expectation to avoid conflict.

> Nursing Assistant: If her daughter comes by and sees her like this it would not be good.
>
> Field Researcher: We walk in as the daughter of the resident walks in.
>
> Nursing Assistant: I am just checking up on her [speaking to the daughter].
>
> Nursing Assistant: "That was a close one. If she was wet and her daughter came in, it would not have been a good situation [speaking to field researcher once they leave the room].

Unmatched expectations frequently centered on resident care issues, as shown in this example from Safe Harbor:

> RN: One of the most difficult things I am dealing with now is a family member who wants the resident on oxygen all of the time. The resident does not need it and does not want it, and all nurses have a hard time [with the family member].

Other staff members gave examples of conflicting expectations at Safe Harbor:

> RN: Do you know how hard it is to give CPR to a resident who is practically comatose just because the family can not deal with it? It is really hard. But I do what I have to do [resident has a do not resuscitate order].
>
> Nursing Assistant: Yeah she [resident's daughter] always complains about something. She is a hard one to deal with. Sometimes I see family members coming and think, oh here we go again. Yeah a lot of them are just upset that it is not like they would

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> do it at home and you know, it really is not going to be just like they would do it. That is just the reality.
>
> AsstNHA: I guess we'll have to post an armed guard at the door. The family is totally unrealistic about what can/cannot be done. We need to get her [wife] in to discuss reality. She expects him [husband] to be able to jump up and walk.

3.4 Staff Responses Block Connection

Staff from both facilities admitted that their own responses to "problem families" included frustration, anger, avoidance, and thoughts about leaving. On one occasion, the level of frustration was so great that counseling a daughter to transfer her relative to another nursing home was considered. Intent or desire to leave after a difficult family encounter was expressed by a nurse at Sweet Dell.

> Field Researcher: And when you were talking about sometime you just want to kind of walk out of here….
>
> RN: That is usually when I am up against a family member. The family member situation is the hard one.

At Safe Harbor, the assistant director of nursing found it unpleasant to face a family member, and would prefer not having to interact when disagreeable circumstances arose, but discovered that facing family member concerns actually produced positive results; in one situation there was improved pain management for a resident. The following field note explains what happened:

> Field Researcher: After ending a phone call, the ADON said, "The resident's irate sister is here," as we headed out of the administrative area. I said to the ADON, "if the resident doesn't want me to be there, I will leave." {I had actually expected the ADON to tell me to stay behind.} She had no problem with me going with her and as we went to the hall and up the elevator, she seemed nervous and said to me, "I really don't like having to deal with these families." I suggested she take a deep breath. We walked into the room; the television was blaring and the resident was sitting in a wheelchair next to her bed. Her sister, who appeared considerably younger, was sitting on the bed, which was unmade. The ADON stuck her hand out and introduced herself. I introduced myself and explained that if she wanted me to leave, I would be glad to do so. She said no, I didn't need to leave. The conversation was very polite and the sister was reasonable. The issue centered on the fact that the resident had a regularly scheduled procedure yesterday and it created more pain than usual, and she could not get through it because of the pain. The pain persisted through the night and it sounded like the night nurse did not give pain pills. This precipitated the irate phone call. The ADON explained that the staff had already called the doctor and a stronger pain medication had been prescribed.

3.5 Helpful, Important, Trusting Interactions

Although staff at both homes described staff-family relationships as problematic, at Sweet Dell there were few comments about the positive nature of staff-family interactions, and nursing assistants were more likely to share empathetic comments about family members and to see the helpful nature of the relationship. A conversation between the field researcher and a certified nursing assistant showed that the nursing assistant understood how staff-family interaction could be helpful.

> Field Researcher: Any other ideas or things you want to say?

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> CNA: Just try to talk to their family more and see what they [resident] like to do and try to get them [resident] to activities and stuff.
>
> Field Researcher: Could you give me an example when talking to a family was helpful?
>
> CNA: You may talk to the daughter and well, push a patient [to participate in an activity] and then go and talk to the family and they'll say you know she never liked to play bingo and you know not to do that anymore because she don't like to participate in that.
>
> Field Researcher: Okay. So that specifically happened where you talked to the daughter and she said she never liked bingo in the first place. Any time you tried to talk to a family member to understand something about the resident and it wasn't helpful?
>
> CNA: No. They are pretty nice.

Safe Harbor staff, both nursing assistants and others, explained that family members could also be an excellent resource. In her role as coordinator of the federally mandated Resident Assessment Inventory, the minimum data set nurse was guided by this multidimensional instrument to assess residents and their care planning, with the goal of assessing quality of care, which helps to determine payment levels. The minimum data set nurse (MDS) at Safe Harbor explained that family members can be supportive in planning resident care, thus affecting quality:

> MDS Nurse: Some families come to care planning and they are pretty good at letting us know about the care, to help us out and fix the problem. And sometimes with family, we ask them, is there anything unique about your mom or dad that we need to know to make her/his stay more pleasant or more close to being at home as possible?

Some of the Safe Harbor staff viewed families as helpful, who could offer useful problem solving assistance in care planning meetings. Staff said that some families were happy with resident care and trusted staff members.

> Nurse Supervisor: Once you establish a relationship with your family member they feel their family member is safe.
>
> RN: And with families – they trust us and most often we have good rapport with them, to where we are the ones that can make them feel reassured. That way, we're showing that yes, you can expect good care from us.
>
> Nurse Supervisor: The relationship with family is very important. … If you establish a real good relationship, if you are a business person and you establish a good relationship with X, Y, and Z company, then 9 times out of 10, it is a give and take. You are always going to get what you want from them because you have established a good relationship with them.

Safe Harbor staff said that staff-family relationships could be damaged to a point that restoration of the relationship became very difficult, if not impossible. This occurred when the family believed that past poor performance was still the norm, as explained by the director of nursing at Safe Harbor.

> DON: Families that [should] know better, the only thing that I ask them, is to please not judge on what happened a long time ago. Give us a chance. That is not fair [to say], well you know what they say about this place in the community, well you know this place use to be…

Exploring communication patterns in the two homes helped our understanding of how communication between nursing home staff and residents' family members lies at the core of whether an interaction is considered demanding and time consuming or trusting and helpful.

3.6 Communication Patterns

In Sweet Dell, communication between staff and family occurred through face-to-face interactions and non face-to-face interactions (i.e., voice mail, phone, written notes). Communication between staff and family members was not straightforward or direct. Staff explained that there was a preferred chain of command, but families tended not to adhere to it. In Sweet Dell, the expected chain of command for family members was first the charge nurse, next the nurse supervisor and then the director of nursing. Staff were frustrated when families did not adhere to prescribed communication channels, although, it was not clear how families were informed about this expectation. The evidence suggested that some family members had been informed, but chose not to adhere, as indicated by a phone voice message from a family member.

> Field Researcher: The daughter talks about understanding that she is supposed to use the chain of command she was told about. But, she isn't using the chain of command and she has called the director of nursing before speaking to the nursing supervisor.

Family members with complaints at Sweet Dell usually bypassed the direct care staff and complaints were taken directly to the nurse supervisor or the director of nursing (DON). This was thought to be related to long term relationships between the DON and some family members. The nurse supervisor explained it this way:

> Nurse Supervisor: And she [DON] was in this position in this office for a long time and the ones [families] that have been here forever and a day go to her. And that is okay, you know. I always try to encourage them to come to me first, that is the way they should do it. But like I said there are a lot of families who would rather go to her and that is okay.

In addition to being unclear about the appropriate line of communication, Sweet Dell staff appeared confused about who had the authority to handle particular family concerns. This was clearly demonstrated in an observed conversation between the nursing supervisor and the husband of a resident:

> Field Researcher: The nurse supervisor came in and went over to talk with the husband of one of the residents, who was there in her wheel chair as well. They were clearly discussing an issue related to his wife's care… The nurse supervisor raised her voice a little bit and said to the husband. "She [a nurse] doesn't have the authority to make that decision. She has to come to me." They continued talking and she [nurse supervisor] said something to the effect that she and the husband had agreed on something to be done and she [the nurse] could not interfere with that decision and if she wanted to do something different, then to come to the nursing supervisor.

A family member's fear of reprisal was a barrier to direct, open communication at Sweet Dell. The director of nursing explained the concern of a resident in this regard:

> DON: Well [the daughter] came to me a long time ago and said that [another resident's] family member told her that if she rocked the boat here, she would get retribution. She [said she] was afraid to rock the boat because we would mistreat her mother.

One family member resorted to posting notes of instruction to the Sweet Dell staff. The staff's initial response was laughter, and the family member's attempt to communicate with staff was not taken seriously.

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> Field Researcher: She [nurse] was talking again about the note writing and the behavior that she [daughter] displays about her mother – writing instructions to everybody on notes and putting them all over the room. The nurse says the daughter is pitiful; "she is the most frustrating woman in the free world." Everybody laughed at that and she said "oh - the free world."

This style of communication from the daughter caused great consternation among staff and led to a lengthy, time consuming staff-family meeting; which focused on getting the daughter to stop using the notes, instead of acknowledging the daughter's concerns and establishing a mechanism for effective communication. At Sweet Dell, staff recognized the need for communication with family members immediately after a resident was admitted, but failed to discuss any methods for continued communication with family members. Sweet Dell's social worker described trying to address family member concerns after the initial resident admission and seemed to imply that others would handle family concerns thereafter:

> Social Worker: I just kind of hang close the first week, meaning that the families of new residents often have a lot of questions and issues that they will bring and I stay on top of those situations until the resident gets settled in.

> Field Researcher: Apparently at the other end of the phone, the daughter-in-law raised some issues related to the resident's care. SW advised her to communicate directly with the nurses around some of the more nursing oriented issues. She said that otherwise she ends up being the third party messenger kind of person and that doesn't work as well. There was more back and forth in this telephone conversation about how direct the relatives can be with him (medical director) and again the SW urged her to talk with the doctor (medical director).

At Safe Harbor, staff and family communication was also described as being face-to-face, via phone and through the mail. The business manager talked about the amount of communication between family members and staff at this nursing home:

> Business Manager: I mean, because it's such a large facility, if you get 15 to 20 phone calls a day. It's a family member saying, "What's going on with this?" or "What's going on with that?" Well you've taken two hours of your day just talking to someone. I'm not going to say wasted time, because obviously reporting anything on a resident is not wasted time.

3.7 A System of Communication an Opportunity for Accurate Information Exchange

Safe Harbor introduced a system of communication with family members in the first 72 hours after admission. The program was intended as a preventative strategy to ensure that family members were comfortable with their relative's care. During the first 24 hours the admission director telephoned the family, at 48 hours the nurse telephoned the family and at 72 hours the social worker contacted the family. The assistant nursing home administrator admitted that the system was not always followed but believed it worked when adhered to.

> Assistant NHA: Asking them [family members], "Is there anything that we can do different? Is there any concerns that you have today? Is there anything you need to let me know that – you know, I can pass on to whomever to make things better?" And since then, I feel like family complaints went down. Our complaint surveys from the State actually went down [decreased] some.

In an effort to continue open communication after the initial 24-48-72 hour program, management staff were required to implement what they referred to as angel rounds, a system of regular communication with residents and family members. This program was thought to decrease conflicts between staff and family members and improve communication because of the opportunity for management personnel to resolve family member concerns before family

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members visited and to inform family members of residents' health changes. Safe Harbor's Director of Human Resources explained the process:

> Director Human Resources: Each in the management staff are given so many of the patients to visit daily and to call their family members to find out if there's anything they [resident] needs or want. We can do it daily or every few days. We have eight each, sometimes ten. We go visit each day, as we can, and we see if there's anything littering the floor, we check residents to see if they're lying in wet or anything like that. We check their finger nails, their clothes, their hair—all that, just the everyday things. If we see a problem or anything, we call the family member, or if we had a problem during the week with that particular resident, or something has come up, we call the family member or responsible party and let them know. When a new resident comes in, I always send a letter introducing myself. I think it's pretty neat that you get to know the families. And they [family members] will call us if there is a problem, which makes it a lot better than them coming in on the hall and raising cain [causing a disturbance] about something that I could have taken care of had they called me. Since they have met me and they know me now, they will call if anything goes wrong. So it is good that everybody [management staff] has those patients and looks out for them.

The medical records manager described how he incorporates the angel program into his work activities:

> Field Researcher: The medical records manager shows me his angel notebook and asks me if I have ever seen this before. I tell him that I would like to hear about how he does the rounds. I ask him if he has any today and he tells me no. He shows me some note cards and says, "I send these out to family members once a month to let them know how the resident is doing. I see the resident once a week. I have 12 residents." I ask him if the family ever contacts him. He says, "Only one has contacted me, but I keep trying to contact them and leave messages for them. I also keep sending out these note cards."

Safe Harbor staff also communicated face-to-face among themselves and across disciplines about family concerns. The social worker described an aspect of this cross-discipline communication about family issues:

> Social Worker: Well yes a family tells me so and so about whatever. I go talk to the nurses about it and the MDS nurse when we do those forms and stuff. We have to talk to nurses and nursing assistants.

Although informal and often inconsistent, resident care planning at Safe Harbor provided an opportunity for staff to tackle family concerns with family members. With some families, participation in care planning was infrequent, yet additional efforts were made to talk to family members about care decisions.

> Field Researcher: How well do you think the care plans go here, do you think the families are involved and that sort of thing?
>
> MDS Nurse: I can say that some families come to care planning [meeting] and they are pretty good at letting us know about the care and to help us out and fix the problems… As you probably noticed some days we have families coming for care planning and some days we do not. It just depends on who the families are.
>
> Field Researcher: So it just depends?
>
> MDS Nurse: And sometimes, with a resident who is alert and oriented, they like to be involved in their care plan and we ask them if there is anything that they want us to do differently or special. And sometimes with family too, we ask them when we

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> see them, "Is there anything unique about your mom or dad that we need to do to make her stay more pleasant?"

Input into care planning by family members was seen as helpful by staff for confirming or disconfirming staff understanding of the resident, and staff believed participation in care planning was informative for family members. The activity director gave an example of how communicating with family members about the resident's plan of care resulted in improved resident outcomes:

> Activity Director: I think it's very informative for the families. I don't think they know what to expect if they've never been [to care planning] before. And by the end, they're like, "Wow, you know I really have an understanding of what is going on here, and how she's being cared for…" So I did a care plan on her [a resident] for anxiety and being overwhelmed and her daughter [said] "Yeah, she's like that. She doesn't like being around people. She likes being by herself." And then that kind of gave me feedback [that] I needed to do activities with her one-on-one.

In summary, the two nursing homes differed in their communication patterns with family members in several ways. Safe Harbor had multiple avenues for communication with family members, and families had communication links with direct care staff, middle managers, and administrators. In contrast at Sweet Dell, communication was more limited due to the barrier of perceived retribution and chain of command rules. The multiple avenues of communication operating at Safe Harbor suggest an increased capacity for effective communication with families, resulting in increased interactions and connections.

4. Discussion

These study results help explain communication patterns and connections between staff and family members and provide insight into both positive and negative staff-family encounters, while also suggesting possible strategies to improve interactions and relationships between nursing home staff members and family members of residents. Staff characterized interactions with demanding families as difficult and time consuming. An earlier study revealed that the same was true for families, which contributed to unresolved staff-family member conflicts (Marzialli et al., 2006). Heiselman and Noelker (1991) suggested that "distancing" can occur in subtle ways in the relationship between nursing home staff and family members. The study of Soderstrom et al. (2003) showed that nurses who promoted inviting interactions with family members by listening, being present, offering comfort, and answering questions spent less time with families overall than their non-inviting colleagues. Nurses who used "noninviting interactions" became defensive and withdrew from family interactions. This led family members to mistrust staff and spend more time on the unit with their relative: for nurses who had inviting interactions, this was not a problem, but for noninviting nurses, who were task oriented interactions were viewed as time consuming and unproductive encounters.

When staff interact with family members in a particular way because they believe family members are demanding and difficult, an ineffective feedback loop is created due to the staff's negative anticipation, which then causes families to respond based on those negative expectations. For example, if nurses perceive family members to be time consuming and demanding, there may be a tendency to avoid or distance family members. When avoided or ignored, family members become more demanding, with increased requests for information and attention. When this type of model is observed operating in a system, it is considered a self-fulfilling prophecy, not likely to correct itself and leading to distrust and possibly suspicion (Argyris, 1993).

From the perspective of complexity theory, appropriate information flow and multiple avenues of connection are important for self-regulation, the ability of nursing home staff to take meaning

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from an interaction and develop new forms of behavior to meet the demands of family members. This is similar to the finding that multiple connections and increased exchange of accurate information are valuable in staff to staff interactions (Colon-Emeric et al., 2006; Anderson, Corazzini, & McDaniel, 2004; Anderson, Issel, & McDaniel, 2003). Staff persons connecting with family members, with information exchange ultimately affects resident care in a positive way. For example, in this study the activities director changed her interaction with a resident because a family member shared information not available to the activities director, thus leading to a better result.

This study suggests that changing a nonproductive feedback loop and creating positive staff-family interactions requires that staff resist the tendency to avoid or disengage from families, and instead seek connections with them in order to have a more engaging, information rich, cooperative relationship. At Sweet Dell the prevailing pattern of communication between staff members was a vertical chain of command, with fewer connections and limited information exchange. In contrast, Safe Harbor had higher levels of information flow and connections between staff members, which are characteristic of more open communication (Colon-Emeric al., 2006). Although this study suggests that staff feelings of frustration, particularly with family members perceived as problem families who took up excessive amounts of staff time, might lead to staff avoidance behaviors and unproductive interactions, we observed some staff who consistently tried to include the family in care, particularly at Safe Harbor. Staff were observed trying to establish connections with family members soon after a resident's admission, implementing scheduled phone contacts with family members during the first 72 hours and thereafter, encouraging family members to participate in resident care planning, and following through with monitoring residents' care and reporting to family members on a regular basis.

While our findings do not account for the different staff points of view about families at the nursing homes, at Safe Harbor there seemed to be a consistent language at multiple levels which described family members as consumers. Inherent in such a view is that information is to be shared and connections between staff and family members are desirable. In contrast, at Sweet Dell, compassion was espoused more than a consumer or stakeholder oriented staff view. In fact, at Sweet Dell, it appeared that a language of professional as expert was prevalent, and professionals were in control. The consumer model reflected in the language used at Safe Harbor may lead staff to see the family as stakeholders who have more right to an opinion than families who are dealing with professionals in control. This is congruent with the results of Bauer's study (2006), which found that some staff members had adopted practices inclusive of family members, while other nursing home staff members maintained more of an antagonistic, "we are in control" type attitude.

We must consider that some of the differences between the staff attitudes and perceptions of family expectations at Sweet Dell and Safe Harbor might be due to general differences in socioeconomic status. Perhaps the working class families at Safe Harbor were less demanding or more appreciative of the care received by their relative, while the middle and upper middle class families at Sweet Dell may have expected and demanded more.

5. Conclusions

Our study suggests that incorporating connection strategies and communication systems that promote integration of the family, instead of excluding them could yield improved information exchange, increased trust, mutual understanding of expectations and goals, decreased dissonance in the staff-family interaction, and ultimately improved care results for residents.

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Approach behaviors and connections that may be used to engage rather than avoid families and thus facilitate productive interactions include; (1) staff seeking the family out to share information when they are seen on the unit, (2) staff communicating face to face about the resident's condition without family members having to request this information, (3) staff using phone and written contacts to inform family members when anything notable occurs with the relative, both positive and negative, (4) staff expressing an interest in how the family member is coping with the resident's stay in the nursing home and (5) staff providing explanations for treatment in a non-threatening and relaxed manner.

Based on the study results, we hypothesize that by increasing connections and increasing exchange of information between nursing home staff and family members, potentially better outcomes may be realized for nursing home staff members, family members and ultimately residents. Family members would potentially (1) have current information, 2) hold more realistic care expectations, 3) be engaged in productive dialogue with staff, and 4) lodge fewer formal complaints. Staff members may (1) gain valuable family input into care planning, (2) feel appreciated and have more productive encounters with families, (3) have less time taken away from clinical work, and (4) experience fewer state and federal regulatory interventions. Future research is needed to explore the hypothesis that when nursing home staff pay attention to staff-family interactions, using an approach-strategy to forge connections with family members of residents early, immediately and consistently, these behaviors will lead to improved information exchange and staff behaviors that positively impact resident outcomes.

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Table 1

Summarized staff descriptions of staff-family interactions in the 2 nursing homes

Sweet Dell		Safe Harbor
+	Difficult	+
+	Problematic	+
+	Time Consuming	+
−	Helpful	+
−	Important	+
−	Trusting	+

Note: trait absent = negative (−) trait present = positive (+)