It's the Little Things that Count: Family and Staff Perspectives on Behaviours that Support Relationships

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Supporting Relationships between Family and Staff in Traditional Continuing Care Settings: A Participatory Action Research Project

- 2004 to 2009
- Funded by The CapitalCare Foundation
- Collaborative research between the University of Alberta and CapitalCare
- Focused on 3 facilities in CapitalCare
- Involved families members of residents and all types of staff from the facilities.

The Team

- **Research Team:**
  - Wendy Austin, PI (John Dossetor Heatlh Ethics Centre, University of Alberta)
  - Vicki Strang, CoI (Faculty of Nursing, University of Alberta)
  - Linda Balt, CoI (CapitalCare)
  - Agnes Mitchell, CoI (CapitalCare)
  - Betty Thompson, CoI (CapitalCare)
  - Helen Lantz, Consultant (MHSA Health Care Consultant)
  - Erika Goble, Project Coordinator
  - Gillian Lemermeyer, Graduate Research Assistant
  - Gwen Thompson, Graduate Research Assistant
  - Kelly Vass, Undergraduate Research Assistant
  - Ratchaneekorn Kertchock, Visiting Scholar & Graduate Research Intern

- **Advisory Working Group:**
  - Jillian Barber, patient care manager, CAPITAL CARE Lynnwood
  - Loretta Bowen, food services, CAPITAL CARE Grandview
  - Louise Brosseau, social worker, CAPITAL CARE Grandview
  - Carolyn Clark, physiotherapist, CAPITAL CARE Dickinsfield
  - Judy Halladay, personal care attendant, CAPITAL CARE Lynnwood
  - Joan Jackson, wife of a resident in continuing care, Edmonton, AB
  - Mike Karbonik, husband of a resident in continuing care, Edmonton, AB
  - Jeanette Stern, registered nurse, CAPITAL CARE Dickinsfield

Data Collection

- **Focus groups**
  - Families of residents (x3)
  - Regulated staff (x3)
  - Non-regulated staff (x3)
  - Care Managers (x1)
  - Physicians (x1)

Iterative Process

- **Guiding Questions:**
  - How do family and staff engage one another?
  - What does a positive and negative relationship look like from the perspectives of family and staff?
  - What environmental constraints, supports, and barriers exist to the formation of positive relationships?
  - What are some practical ways to promote positive relationships?

Findings

Group	Themes
Families	• Needing to be a vigilant advocate • Searching for clues that reveal caring and that staff see their family member as a person • Needing to teach staff how to work with their family member • Learning how to recognize the "good staff" from the "bad staff" • Wanting to understand decisions, but fearing they when they voice concerns they will get "written up" • Recognizing time constraints, but sometimes the system doesn't make sense
Non-regulated staff	• Trying to meet families' expectations, but having no time and knowing expectations are often unrealistic • Looking for small ways to keep families happy • Recognizing the "good family" and the "bad family"
Regulated staff	• Treating families unrealistic expectations as a lack of information, • Trying to work collaboratively with families, but being constrained by time • Importance of knowing the family as a unit, not just individuals • Needing to an advocate for the resident, sometimes counter to the family • Recognizing that even "dreaded families" have good intent. • Recognizing the relationship with the family will ebb and flow

Group cont.	Theme
Physicians	• They rely on regulated staff (particular RNs) being knowledgeable of residents (the proxy relationship)
Care Managers	• Needing to be reactive but wanting to be proactive • Respect is evidenced in actions • Working with limited resources and time • Trying to maintain open, honest dialogue • Working with the undercurrent of "us vs them"

- "We have been cut": There is a lack of resources
- Chasm of "us" vs. "them"
- Knowing your name: Wanting to be recognized, heard, and trusted.
- Experiences of loss, most evident in the issues around laundry
  Personal belongings are markers of identity;
  To lose them is to lose the resident as person.
  Care of belongings is symbolic of the care provided.

The most significant relationships occurs at the front-lines and are shaped by small everyday encounters.

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Supportive Behaviours

Demonstrated by families	Demonstrate by staff
Understands the resident's illness and the behaviours that accompany it.	Understands the resident's illness and is aware of the resident as a person.
Acknowledges staff by name. Speaks respectfully. Takes the initiative to engage in small talk.	Acknowledges family by name. Speaks respectfully and communicates resident's status to family. Engages family in small talk.
Is consistent in frequency of visits and attitude.	Consistently works with the same resident and uses same care plan.
Attends and adapts to the changing needs of their family member.	Attends and adapts to the changing needs of the resident.
Brings extra "little things" for their family member. Replaces ruined belongings.	Does the "little things" for the resident. Shows respect for resident's belongings.
Understands when things go wrong at the facility & appreciates the care provided.	Meets basic care requirements no matter what is happening at the facility.
Has realistic expectations. Agrees on care to be provided. Cooperates with staff.	Orients family to realities of facility. Staff are well-trained as caregivers; knows care plan. Cooperates with family.
Tells the care manager about the good as well as the bad. Is respectful of other residents.	Is willing to listen to concerns. Responds and follows up.

Undermining Behaviours

Demonstrated by families	Demonstrated by staff
Refuses to work with staff to establish the best care plan for the resident. Refuses to acknowledge the expertise of staff.	Refuses to give the family a role in the resident's care, including considering care alternatives suggested by the family.
Is verbally abusive to staff or residents.	Responds "I don't know" to requests for information.
Complains about staff.	Treats all concerns as complaints.
Constantly changes care routine.	Is inflexible in how care is provided.
Ignores or denies the needs of family member.	Disregards personal and medical needs of resident. Does not pay attention to details.
Has unrealistic expectations of staff and facility. Demands more services than are feasible	Provide poor care. Does not recognize when less care becomes negligence or abuse.
Brings extended family issues into the facility.	Does not communicate what works with other staff.
Is judgmental of other families.	Is competitive with other staff.
Shows prejudice, racism, or sexism.	Shows prejudice, racism, or sexism.
Ignores the staff they do not know.	Shows favoritism among residents and families.
Interrupts the care of other residents to speak with staff.	Runs and hides from family members.

Lesson's learned

- The systemic issues have changed little: limited resources for providing quality care to an aging population.
- However, the public discussion about what quality care for persons in continuing care is is opening up.
- Need for ongoing support for and improvement in relationships between family and staff
- Fixing process issues will help - but not ensure - good relationships
- Pillows & Peanut Butter: *At the end of the day, it is the little things that count.*
  - The little actions that family show to staff, staff to family, and both to the resident.

Questions?