Creating constructive staff-family relationships in the care of older people living in the residential aged care setting

A GUIDELINE FOR RESIDENTIAL AGED CARE STAFF

AIPCA

Australian Institute for Primary Care & Ageing

Disclaimer and copyright statement

Disclaimer

This revised guideline is not binding for health professionals and its use should be flexible to accommodate resident and family wishes and local circumstances. It neither constitutes a liability nor discharge from liability. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors or the Australian Centre for Evidence Based Aged Care give any guarantee as to the accuracy of the information contained in them, nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omissions in the contents of this work. Any reference throughout this document to specific products as examples does not imply endorsement of those products.

Copyright

ISBN: 978-0-9873121-0-5

Acknowledgements

ACEBAC wishes to acknowledge the contribution of the following people to the original guideline (2008):
Ms Megan O'Donnell, Research Officer, ACEBAC
Dr Tenzin Bathgate, Research Officer, ACEBAC
Ms Suzanne Byers, Research Officer, ACEBAC
The managers and staff from the participating residential aged care facilities

Funding

The development of the original 2008 guideline was supported by funding received from Bundoora Extended Care Centre, Melbourne and the Australian Government Department of Health and Ageing.

ACEBAC has as its main aim the improvement of care provided to older people. As this guideline shows the evidence demonstrates that the residents' experience of care is enhanced when staff and family have positive relationships. We hope this guideline assists staff and families to develop constructive and positive ways of working together.

Table of Contents

Guideline development team

Dr Michael Bauer, ACEBAC
Dr Deirdre Fetherstonhaugh, ACEBAC
Professor Rhonda Nay, ACEBAC
Dr Margaret Winbolt, ACEBAC

Purpose and scope of this guideline

This guideline has been developed to assist residential aged care facility staff and families of residents in developing and maintaining constructive relationships in residential aged care setting.

How to use this guideline

This guideline is intended to be a guide to achieving best practice in communication between staff of residential aged care facilities and families of residents. For implementation to succeed, it is important that the guideline be contextualised to meet the needs of the individual residential aged care facility.

This guideline includes an audit tool which will enable facilities to examine their practice and compare outcomes with the guideline's recommendations. The audit tool can be used before and after the implementation of strategies to improve the constructiveness of staff–family relationships. Completion of the audit tool identifies practice gaps and support the development of improvement action plans, as well as determining where current practice is in line with guideline recommendations.

The recommendations in this document which inform the audit tool have been derived from two systematic reviews of research evidence. [15,18] For those interested in more detail, we recommend reading the full systematic reviews referenced in this document.

Summary of recommendations

Recommendations	Level of evidence
Interventions designed to promote constructive staff–family relationships, and promote collaborative relationships between families and health professionals should address: communication, information, education, administration support and involvement of the multidisciplinary team	JBI Level E2
Incorporate staff and family education designed to promote constructive staff–family relationships	JBI Level M2
Develop policy and procedures to enable and support family involvement in decision-making and care planning.	JBI Level E3
Establish formal and informal communication channels for both staff and families	JBI Level E2
Establish environments that support staff in developing and maintaining constructive relationships with families	JBI Level M1

Background

Modern health and aged care philosophy espouses the virtues of holistic approaches to residential aged care and acknowledges that family involvement is appropriate and to be encouraged due to the role it plays in the physical and emotional wellbeing of residents. Such an approach, which attempts to understand the older person in a broader construct of relationships rather than just the individual, is receiving increasing emphasis throughout the entire health care system.[1] Studies of family carers in the institutional setting have identified a broad range of care roles ranging from the provision of affective support [2-4] to assistance with physical care[5]. For older people to benefit from the involvement of their family members, residential aged care staff need an understanding of: family relationships; their own relationships with families; the issues surrounding family presence in the residential aged care environment; and the strategies that best support these relationships.

Families are known to be in need of varying degrees of support, both as carers in the community,[6-8] and after their relative has made the transition to hospital[9] or long-term residential care.[10-13] Care staff are often the first to identify who the family caregivers are and how they are coping. In practice, nurses and other health care professionals assess a family's needs and intervene to support both the family and the older person[14] In residential aged care, involvement of families has been acknowledged as one of the best guarantees of a resident's wellbeing.[15-17] Integration of family into the residential aged care environment has been enshrined in the Australian Government's *Charter of Residents' Rights & Responsibilities* as well as its aged care accreditation standards. Beyond residential care, it has been suggested that there needs to be a greater emphasis on family caregivers as partners within the hospital system[9].

Despite this encouragement to form "partnerships" with family caregivers, it is apparent from the literature examining staff–family relationships that the experience continues to be fraught with problems, and that family involvement is often marked by tension between staff and families. The recommendations described in this document outline how these partnerships can be formed in constructive ways that avoid common problems and tensions.

Recommendations from the systematic reviews[15,18]

1. **Interventions designed to promote constructive and collaborative staff–family relationships should address communication, information, education, administration support, as well as involving a multi-disciplinary team**

Discussion of evidence

Communication skills are one of the most important staff characteristics to promote and maintain relationships with families. Families view communication as a two-way process, and both staff and family should share knowledge of the resident with each other.[19-21] A number of studies highlight poor communication between staff and family.[22-27] Involvement of multi-disciplinary health professional teams in interventions can improve communication, and staff understanding of families contributes to the success of those interventions [28, 29].

The exchange of information between staff and family is equally important. Family members expect opportunities to share information about the resident with staff.[20, 23, 24, 30-39] Family also expect care staff to provide them with information. Strategies to increase the exchange of information, specifically those which promotes the needs and uniqueness of the resident,[31, 37] are required to support the process of collaboration.

Establishing strategies to promote constructive staff–family relationships through education is also required to support the process of collaboration.[40] A variety of educational interventions designed to increase collaboration between staff and families have been reported in the literature.[41-45] Staff and family education on relationship development, power and control issues, communication skills and negotiating techniques is essential for the promotion of constructive staff–family relationships.

The support of management is also important if interventions aimed at promoting staff–family relationships are to succeed. A number of studies have suggested that although administrative staff express support for educational strategies and collaborative approaches to care, in practice barriers are created or existing barriers not addressed.[43, 44, 46, 47]

Interventions focussed on increasing communication skills and collaboration between staff and family members can be successful in promoting constructive staff–family relationships. These interventions are more likely to be successful when implemented using a defined process that establishes goals and expectations in conjunction with ongoing education. Interventions that are offered by a multidisciplinary care team may be more successful.

2. Incorporate staff and family education designed to promote constructive staff–family relationships

Discussion of evidence

Effective communication and the provision of information is the foundation for a collaborative relationship between staff and family members, and the literature strongly supports the importance of education for family members as well as facility staff.[27, 42-45, 48, 49] Family and staff members often have poor communication and understanding of each other's needs, goals and role.[23]

A number of studies have included interventions on educational components including training in relationship issues and communication skills;[42, 45] however, there has not been a strong focus in research studies on providing staff with a basic understanding of power, control and effective communication. Active listening and questioning skills,[28, 29, 50] and demonstration of knowledge and empathy,[51] are known to improve communication and interpersonal relationships with family members.

Education on these issues is required if power inequalities are to be reduced and truly collaborative approaches to care embraced. It is evident throughout the research that staff remain overly concerned with task completion and maintaining control over the environment. In most of the research focused on staff–family relationships, staff rely on traditional medical models of care in their clinical practice, rather than fully collaborating with families.[19, 20, 23, 26, 30, 38, 41, 46, 49, 52-54]

Expert opinion informed by general research in the field suggests that educational strategies need to focus on staff education with a particular emphasis on: reflection and self knowledge;[24, 26, 55] relationship development, interpersonal skills and conflict resolution;[24, 26, 33, 52, 55] training of nurse managers in leadership skills[52] and on power in relationships.[26, 30]

Implementation strategies

Incorporate staff and family education that includes:

- relationship development and conflict resolution.
- the influence of family dynamics on staff–family relationships.
- on power and control issues in relationships.
- communication skills and negotiating techniques.

Suggestions and experience from practice

- Incorporate senior staff education on leadership skills
- Incorporate staff education on self knowledge.
- Informal education between staff and families can be enjoyable and satisfying for staff and an opportunity for families, particularly those in the primary carer role to develop new skills (e.g. learning to measure blood sugar levels) or revisit and discuss any changes in familiar routines (e.g. continence management or medication management).
- Encouraging family members in primary carer roles to undertake some care tasks (under staff supervision) can also be of benefit to both staff and families. Staff may perceive resident preferences more quickly and carers have opportunities to discuss things that may concern them. This may also provide the opportunity for staff to offer some suggestions to families about a better way of doing things, particularly in areas where the evidence base may have changed.
- Informal education is an effective way to build rapport with families and provides both staff and families with an opportunity to better understand each other's roles. This will encourage and facilitate the development of true partnerships in care.

3. Develop policy and procedures to enable and support family involvement in decision-making

Discussion of evidence

Studies that have investigated perceptions of family members' relationships with staff have shown a strong focus was placed on opportunities for the family to be involved in the resident's care.[5, 20, 22, 53] Not only did family members want to perform emotional care and other "visitor" roles traditionally assigned to family members, but there was an expectation that opportunity would be provided by staff to be involved in care planning and hands-on care.[5, 20, 22, 38, 53] Promoting family involvement in decision-making is known to improve communication and staff–family relationships.[33] Many families want more information on procedures and a better understanding of the lines of authority as well as facility policies.[53] Staff need to be aware of residents' preferences with respect to family involvement. Not all residents are comfortable with, or even want, family members to be involved in caregiving or decision-making.[26]

Research suggests that family members believe their involvement in the facility and with the staff would be more constructive if they received facility support in their role. Organisational support is therefore critical to the successful implementation of interventions designed to increase collaboration between staff and family. Staff and family members believe organisational policies and procedures influence the development of collaborative relationships.[15, 26, 53] A family meeting intervention increased the number of collaborative meetings between families and staff and the number of family visits to the facility.[41] To be successful, strategies designed to promote staff–family collaboration need to identify and incorporate the goals and expectations of both groups.[29] Without foundational support from management, interventions designed to promote constructive staff–family relationships are unlikely to show any sustained benefits.[24, 26, 29, 43, 44, 47, 52, 55]

Implementation strategies

- Develop policies and procedures that support residents' decision-making with regard to family involvement in their care planning.
- Develop policies and procedures that support families receiving appropriate information to assist with decision-making and involvement in care planning.
- Ensure information provided to families is both understandable and informative of the topic(s) being addressed.
- Develop policies that support family involvement in care planning.
- Residents are given the choice about their family's involvement in their care and lives and where appropriate other people are appointed to be involved.
- Develop policies that support the changing needs of families.

Suggestions and experience from practice

- Accept, and do not judge:
    - Families' decisions to be involved (or not be involved) in care. Some families want to continue caring for the resident in partnership with staff, while some families are so worn out from caring for their family member they may need to distance themselves from care needs.
    - Residents' decisions to not have family involved in decision-making or care.
- Families often project feelings of guilt, grief and loss onto staff. Staff may identify this in different stages of a resident admission and may label some families as "interfering", "demanding", "judgemental" or "difficult" because of the way these feelings are displayed when they visit the resident at the facility.
- Families can feel embarrassed by the resident if they are "behaving badly" and will often want to justify that this is not a person's "normal way of behaving".

4. Establish formal and informal communication channels for both staff and families

Discussion of evidence

The literature indicates that family members have a desire for communication with staff members and that staff communication skills are an important characteristic of a constructive relationship with family members. Families expect staff members to be courteous, tolerant and respectful towards residents and provide both emotional and cognitive support.[24, 50, 55] Family members expect staff to promote the person's individuality, personal preferences, dignity and values.[19, 31]

The needs of families can vary and change over time. Being able to create a caring, warm environment, free from intimidation and using active listening skills to allow the family to feel heard are essential skills needed by staff members to encourage and support interpersonal relationships.[20, 22, 23, 37, 38, 50, 53, 55-58] Familiarity, trustworthiness, respect and empathy are essential building blocks for the development of a constructive relationship between staff and family members. Families feel comfortable and welcome within the facility when they feel known to staff and are familiar with them at a personal level. Especially for family members of a resident with dementia, having a familiar relationship with staff enhances the visiting experience and motivates them to remain involved.[34, 37, 48] Knowing about the staff's personal interests, work and hobbies is a positive experience for families through which trust is developed.[31, 34, 59, 60]

A constant theme throughout the research literature is that family members have a strong need for the communication of information, the provision of which they believe to be the responsibility of staff members.[20, 23, 35-39, 46] Specifically, family members think it is important for staff members to approach the family to keep them informed, rather than the family member being responsible for constantly initiating the interactions. The provision of information by the staff is seen to demonstrate the staff member's personal knowledge and care of both the resident and his or her family.[20, 23, 35, 37, 38] Staff knowledge about the resident's biography, preferences and personality is essential to the provision of high-quality individualised care and an important factor in establishing a constructive relationship with the family.[33, 59] For many family members, upholding the uniqueness of the resident as an individual is at the heart of quality care and some families monitor care to ensure that it is personalised and sensitive to the needs of the resident.[34, 59]

According to the literature, family members most often need information on: ageing and disease processes; the resident's specific health problems and what to expect; the roles and responsibilities of staff and family; technical skills to assist in their own provision of care for their relative; information on the aged care industry,[4, 36, 37, 39] and greater orientation to the facility, including its policies and procedures.[48, 53] Health professionals from different disciplines can contribute a variety of observation, interpretive and communication skills that can improve communication and understanding.[28, 29]

Implementation strategies

- Support the development of characteristics in staff known to be important in communication, such as:
    - Communicating openly and honestly
    - Providing information
    - Showing respect, trustworthiness and empathy towards family members
    - Working in partnerships
    - Promoting the uniqueness of the resident.

Suggestions and experience from practice

- Make families feel welcome upon first arriving in the organisation to build rapport and trust. This may include:
    - Introducing yourself and other staff members and identifying a central contact person (who may or may not change over time).
    - Orientating families to place and routines such as case conferencing, family meetings, discharge planning.
    - Dealing with any family expectations/preconceived ideas about a resident's room/treatment issues as soon as possible ("The quicker you deal with problems the better the outcome").

  - Recognising and valuing families' appraisal of the situation.
  - Assessing and recognising any organisational barriers to collaboration.
- Accept that:
  - Relationships take time to develop.
  - Some staff members will develop stronger relationships with some families compared to others.
  - Some families do not have strong communication skills and will require more staff effort to build rapport and manage disagreement and conflict.
  - Relationships can change over time and that maintaining relationships requires time and energy.
- Work as a unified team to help establish trust, because families:
  - Need to hear consistent messages from different staff members to trust in the information they are receiving.
  - Become frustrated and less trusting if they are told different things by different staff members.
  - Find it frustrating if the communication between staff members around previously made appointments and arrangements appears to be lacking ("Don't they talk to each other around here?")
- Respect families and get to know their names. This will help to provide opportunities to discuss issues and raise any concerns in a more respectful way.
- Deal with conflict as soon as possible to avoid escalation of the problem/issue and help to preserve a sense of rapport and trust.
- Ensure that relevant information is clear and precisely documented as this is vital to ensure good staff-staff communication. Staff cannot provide families with information if they are unable to find the relevant information themselves.
- Ask families about the resident's biography, preferences and personality.

5. Establish environments that support staff in promoting constructive relationships with families

Discussion of evidence

It is important to create an environment that supports staff to work collaboratively with the families of residents. Ongoing and regular staff training on the processes and practices that promote staff–family collaboration and a stable workforce are important.[44] The research suggests that although there may be a theoretical support for a collaborative model of care by management and/or administrative staff, in practice barriers are often created or not addressed.

Organisational factors that have been identified that impede the development of a constructive staff–family relationship include high staff workloads, lack of sufficient staff, high levels of staff turnover, and other work pressures that interfere with the amount and quality of time staff have to interact with relatives.[19, 26, 39, 46, 51, 53, 54, 61-63] Other issues that can stymie the development of an environment where staff–family collaboration is promoted include: not releasing staff for in-service training; a casual workforce; and having policies and practices that reinforce a task-oriented care model of care.[34, 43, 44, 47, 49, 63]

Implementation strategies

- Professional support (e.g. debriefing).
- Organisational support (e.g. freeing up time for education sessions).
- A person-centred model of care to foster collaborative approach.
- Policy and procedures; for example pre-empting, preventing and/or dealing with family conflict/aggression.

Suggestions and experience from practice

- Peer support for staff and good staff-staff relationships are very important in establishing good staff–family relationships.
- Debriefing and offering each other support, particularly after an unusual day/experience, is important to staff. This assists them in maintaining their own health and helps them to maintain enthusiasm for the job. Support by management to either facilitate or encourage debriefing is important.
- Access to a pastor, counsellor, or social worker is also important in fostering good staff–family relationships. Staff particularly feel that they often fill this role for families and residents if there is limited access to such services.
- Finding some additional time at admission, can make a real difference with establishing good relationships between staff and families. The time required to convey important information, discuss and sort out any unrealistic expectations and explain the way the facility operates, often relates to staff success in building a rapport with families.
- Strong leadership in unusual situations, particularly those including violence or aggression, helps to foster better communication, understanding and partnerships.

Evaluation and Monitoring

Organisations implementing the recommendations in this guideline are advised to consider how the implementation and its impact will be monitored and evaluated.

Establishing "indicators" is part of developing a monitoring system, an important feature of quality systems. Indicators play an important role in quality processes as they are measurable and help to focus the information that needs to be collected to inform evaluation and quality improvement. Care settings frequently undertake auditing as a process to collect data to inform program/service quality. Auditing is a means of collecting data to inform evidence based practice. In particular, auditing is used to both identify whether the program/service practice is best practice and if it is not, what action is needed to close the gap between current practice and best practice (the practice-best practice gap). An audit should be a cyclical process. It needs to be repeated after an agreed period of time to determine the effects of any changes that have been implemented and whether any further changes are required.

To assist staff and administrators in developing an appropriate evaluation framework for building and maintaining constructive staff–family relationships in caring for older adults in the residential setting, the following audit tool has been developed.

Audit tool

The aim of an audit is to improve practice and to support continuous quality improvement. The audit provides a systematic approach to evaluating practice standards.[64] Essentially the audit tool compares current practice to evidence based practice recommendations by identifying what systems, processes and structures need to be in place in order to implement a guideline recommendation, thereby identifying the cause of any gaps. The turning of guideline recommendations into indicators means that they can then be measured and services/facilities can monitor how well they are achieving quality outcomes. Once the indicators have been established then structure, process and outcome criteria can be developed to meet the indicator.

Structure criteria are those which are necessary in the system/service/facility in order to meet the indicator. For instance, if you wanted staff–family to be educated then there needs to be an education program available in the service/facility.

Process criteria are those actions/decisions/behaviours that are taken in order to meet the indicator. For example there may be a staff–family education program in existence, but if staff and family do not attend the education program they will obviously not be educated.

Outcome criteria are what you expect to achieve, the results for which in this instance may be from the perspective of staff, family, or the resident. For example, following from the structure and process criteria about education you might ideally want *all* staff and/or families to have been educated. However, a target of 100% compliance with staff and family education may not be achievable and so outcome results/targets may need to be determined specifically for each service/facility and judged relative to those measured at baseline.

How to use this tool

The tool lists audit indicators arising from the guideline recommendations and lists what is required in order to meet the recommendation. It also provides suggestions for how the data might be collected. Individual facilities are free to alter the percentages for compliance given to meet local needs. An action plan tool is also provided.

Audit Topic:	Constructive staff–family relationships

Audit objectives: To promote constructive staff–family relationships

Rationale: Research evidence demonstrates that constructive staff–family relationships improve resident outcomes and improves the care experience for staff and families.

Audit definitions and abbreviations:
Permanent staff: Staff employed by (and regularly work at) the facility, as opposed to 'agency' staff who work on a casual, adhoc or even "once off" basis.
"New" permanent staff – those who have commenced employment in the previous 12 months

Person Centred Care (PCC): PCC should be defined and measured using a valid PCC tool, such as the Person-Centred Assessment Tool (P-CAT)
Families: people responsible as defined by state administrative law, guardians; primary carers and family members.
New families – families of residents admitted to the facility in the previous 12 months

Audit team:

Evidence-based Guideline Recommendation	**Audit Indicator(s)**
Incorporate into staff development programs education designed to promote constructive staff–family relationships.	1. Permanent staff participate in an education/training program covering the four areas of: (1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge. 2. Families receive information about developing and maintaining constructive staff–family relationships.
Establish policies and procedures which enable and support family involvement in decision-making and/or care planning.	3. Families who wish to be involved in decision-making and/or care planning, and who have the resident's permission to be involved in such decision-making and/or care planning, are involved and supported in doing so.
Establish formal communication channels for both staff and families	4. Families are provided with information on the facility's formal

	communication channels. 5. Families have been given the opportunity to participate in regular* resident–family meetings. 6. Permanent care staff provide detailed information about the resident's health, care, facility policies and procedures, and the aged care industry, (within their scope of practice) as requested by family. 7. Where a complaint has been made, the complaints policy is followed.
Informal communication channels are embedded to encourage staff–family interaction	8. Families report satisfaction with information sharing by staff at the facility.
Environments that support staff /families in promoting constructive relationships exist. E.g. A Person-centred approach to the involvement of families exists.**	9. The facility is perceived to be person-centred by the staff 10. The facility has a procedure to guide staff in the management of family anger/aggression 11. The facility has a procedure for dealing with distressing staff–family communication incidents. 12. Staff and families have the opportunity to participate in formal peer support/debriefing following distressing staff–family communication incidents.

*Regular should be agreed and defined by the facility in consultation with families – e.g monthly
**As measured using an appropriate tool such as the *Person-centered Care Assessment Tool* (P-CAT)

Basic questions for all facilities:

- Number of permanent staff
- Number of residents
- Number of families
- Number of new permanent staff (as per definition above)
- Number of new families (as per definition above)

Indicator 1 **Permanent staff participate in an education/training program covering the four areas of: (1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge.**		
Structure	**Process**	**Outcome**
S1.1 An education/training program about constructive staff–family relationships is available and covers the following four areas: (1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge.	P1.1 This education/training program (covering all four areas) is conducted: • At least annually; and • At times allowing permanent staff working any shift to attend.	O1.1 All permanent staff have attended an education/training program (covering all four areas) in at least the previous 12 months.
S1.2 The facility has staff competencies about constructive staff–family relationships that cover the following four areas: (1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge.	P1.2 Permanent staff have their competency tested in all four of these areas.	O1.2 All permanent staff are competent in all four of these areas.
S1.3 Information for new permanent staff on constructive staff–family relationships is available and covers the following four areas: (1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge.	P1.3 New permanent staff receive this information as part of their workplace orientation program.	O1.3 All new permanent staff received this information as part of their workplace orientation program.

AUDIT QUESTIONS FOR INDICATOR 1

Permanent staff participate in an education/training program covering the four areas of: (1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge.

	Y/N		**Y/N or Number**
Does the facility have an education/training program covering **each** of the following four areas of constructive staff–family relationships: (1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge. *Note:* "education/training program" may be internally or externally provided.		How often is this education/training program offered? (a) quarterly (b) six-monthly (c) annually When is this education/training program scheduled? (a) business hours (b) after hours (c) flexible (e.g. self-guided, online) Can permanent staff who work different shifts participate? How many permanent staff have attended this education/training program in the last 12 months?	
Does the facility have competencies covering **each** of the following four areas of constructive staff–family relationships: (1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge.		How many permanent staff have had their competency tested in the following four areas: (1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge. How many permanent staff are competent in the following four areas: (1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge.	
Does the facility's workplace orientation program include information on **each** of the following four areas of constructive staff–family relationships:		How many new permanent staff received this information as part of their orientation?	

(1) relationship development and conflict resolution; (2) power and control in relationships; (3) communication skills and negotiation techniques; and (4) reflection and self-knowledge.		*Note:* this may be answered by asking all new permanent staff whether they received this information as part of their workplace orientation program	

Indicator 2 **Families receive information about developing and maintaining constructive staff–family relationships.**		
Structure	**Process**	**Outcome**
S2.1 Information about developing and maintaining constructive relationships with staff is available to families.	P2.1 New families receive this information when their relative is admitted to the facility.	O2.1 All new families received this information when their relative was admitted to the facility.
S2.2 An education program for families about developing and maintaining constructive staff–family relationships is available to families.	P2.2(a) New families are made aware of this education program on admission of their relative to the facility.	O2.2(a) All new families were made aware of this education program when their relative was admitted to the facility.
	P2.2(b) This education program for new families is conducted regularly	O2.2(b) All new families have attended this education program.

AUDIT QUESTIONS FOR INDICATOR 2 **Families receive information about developing and maintaining constructive staff–family relationships.**			
	Y/N		**Y/N or Number**
Does the facility have information for families about developing and maintaining constructive staff–family relationships?		In the last 12 months, how many new families have been given this information?	
Does the facility have an education program about developing and maintaining constructive staff–family relationships?		In the last 12 months: • How many of these education programs have been conducted for families? • How many family members have attended these education programs?	
Does the facility inform families about education sessions on developing and maintaining constructive staff–family		How many families have been informed about the availability of education sessions?	

relationships and invite them to attend?		*Note:* this may be answered by asking all families new to the facility in the last 12 months whether they received information about the education program.	

Indicator 3 **Families who wish to be involved in decision-making and/or care planning, and who have the resident's permission to be involved in such decision-making and/or care planning, are involved and supported in doing so.**		
Structure	**Process**	**Outcome**
S3.1 The facility has a policy on family involvement in decision-making and/or care planning, stating that: • The resident should be asked whether they would like their family involved in their decision-making and/or care planning. • With the resident's permission, families who wish to have a role in decision-making and/or care planning are involved, and they are supported in this role by the staff of the facility.	P3.1 Permanent staff are aware of this policy.	O3.1 All permanent staff are aware of this policy.
S3.2 The facility has a procedure (e.g. a consent form) that informs residents of the role their family can play in decision-making and/or care planning and enables residents to give their permission for their family to be involved.	P3.2 New residents are informed of the role their families can play in decision-making and/or care planning, and this procedure to give their permission, on admission to the facility.	O3.2 All new residents are aware of the role their families can play in decision-making and/or care planning, and this procedure to give their permission, on admission to the facility.
S3.3 Information about the facility's policy on family involvement in decision-making and/or care planning is available for families, stating that if they wish to be involved: • The resident must give permission for them to be involved • Where they have permission, their involvement	P3.3 New families are provided this information on admission of their relative to the facility.	O3.3 All new families receive this information on admission of their relative to the facility.

will be supported by staff at the facility.		
S3.4 The facility has a process for documenting resident and family ongoing wishes regarding family involvement in decision-making and/or care planning.	P3.4 The resident's/family's wishes about involvement in decision-making and/or care planning are: • Documented appropriately (e.g. in the resident's medical record or care plan) • Reviewed every six months to ensure that these wishes are ongoing.	O3.4 All resident/family wishes about involvement in decision-making and/or care planning are documented and reviewed every six months.

AUDIT QUESTIONS FOR INDICATOR 3

Families who wish to be involved in decision-making and/or care planning, and who have the resident's permission to be involved in such decision-making and/or care planning, are involved and supported in doing so.

	Y/N		**Y/N or Number**
Does the facility have a policy on family involvement in decision-making and/or care planning that states: • The resident should be asked whether they would like their family involved in their decision-making and/or care planning. • With the resident's permission, families who wish to have a role in decision-making and/or care planning are involved, and they are supported in this role by the staff of the facility.		How many permanent staff are aware of this policy? How many new residents are able to consent to family involvement? Of residents able to consent, how many have been consulted about the involvement of their family? How many families have been consulted about involvement in decision-making and/or care planning for their relative? *Note:* this may be answered by asking all new residents and families if they were asked about their involvement in decision-making and/or care planning.	
For residents able to give consent, does the facility have: • A consent form for them to sign, stating they give permission for the family to be involved in decision-making and/or care planning?		Of residents able to consent: • How many have signed a consent form? • How many have had their consent reviewed in the last six months?	

• A process for reviewing this permission to ensure that it is ongoing?		*Note:* this may be answered by reviewing consent forms and ongoing documentation of resident permission (e.g. medical records).	
Does the facility have information for families about the policy on family involvement in decision-making and/or care planning that states that if they wish to be involved: • The resident must give permission for them to be involved • Where they have permission, their involvement will be supported by staff at the facility.		How many new families have been provided with this information? *Note:* this may be answered by asking all new families whether they received information on involvement in decision-making and/or care planning.	
Does the facility have process for documenting (e.g. in resident's medical record or care plan) family wishes about being involved in decision-making and/or care planning for their relative?		How many families have had their wishes about involvement documented on admission of their relative to the facility? How many families have had these wishes about involvement reviewed every six months?	

Indicator 4 **Families are provided with information about the facility's formal communication channels.**		
Structure	**Process**	**Outcome**
S4.1 The facility has formal channels for communicating with families. *Note:* "formal communication channels" may include staff–family/resident meetings; newsletters; complaints processes etc.	P4.1(a) Permanent staff are aware of the facility's formal communication channels with families. P4.1(b) New families are informed of the facility's formal communication channels.	O4.1(a) All permanent staff are aware of the facility's formal communication channels with families. O4.1(b) All new families are aware of the facility's formal communication channels.

AUDIT QUESTIONS FOR INDICATOR 4 **Families are provided with information about the facility's formal communication channels.**			
	Y/N		**Y/N or Number**
Does the facility have information for families about the facility's formal communication channels, for example, staff–family/resident meetings; newsletters and complaints processes?		In the pst 12 months, how many new families were provided with information about the facility's formal communication channels? *Notes:* this may be answered by asking all new families whether they received written information on formal communication channels How many permanent staff can describe what these communication channels are? *Note:* this may be answered by surveying all staff/sample of staff to see how they describe the facility's communication channels	

Indicator 5 **Families have the opportunity to participate in regular resident–family meetings.**		
Structure	**Process**	**Outcome**
S5.1 Regular resident–family meetings are conducted by the facility	P5.1(a) Families receive information about these resident–family meetings (e.g. dates and agenda) P5.1(b) Resident–family meetings are scheduled at times convenient for families.	O5.1(a) All families receive information about these resident–family meetings O5.1(b) All families satisfied with their opportunities to participate in resident–family meetings

AUDIT QUESTIONS FOR INDICATOR 5 **Families have the opportunity to participate in regular resident–family meetings.**			
	Y/N		**Y/N or Number**
Does the facility conduct regular resident–family meetings with staff?		How many resident–family meetings does the facility hold per year?	
Does the facility publish a meeting schedule detailing dates of meetings in advance (e.g. for the next six months)?		Is information sent to families about the dates and agenda of resident–family meetings? Is information (e.g. flyers) about the dates and agenda for these meetings posted around the facility?	
Does the facility have an agenda proforma or template for resident–family meetings?		Is the agenda for each meeting made available to residents and families prior to each meeting (e.g. two weeks in advance)?	
Does the facility hold resident–family meetings at a time convenient for families?		On average, how many families attend these meetings? How many families report being satisfied with opportunities to participate in resident–family meetings? *Note:* this may be answered by: surveying all families/sample of families to determine how many are satisfied with opportunities available to participate in meetings.)	

Indicator 6 **Permanent care staff provide detailed information about the resident's health, care, facility policies and procedures, and the aged care industry, (within their scope of practice) as requested by family.**		
Structure	**Process**	**Outcome**
S6.1 The facility has a regular way of informing permanent staff about changes to the resident's health and care (e.g. handover; online care plan flags; bed flag)	P6.1 Permanent staff demonstrate they have accessed and understood the changes to resident's health and care (e.g. may be asked provide different aspects of care and changes at handover).	O6.1 All permanent staff demonstrate they have accessed and understood the changes to resident's health and care.
S6.2 The facility has a way of informing permanent staff about changes to facility policies and procedures whenever necessary (e.g. meetings; newsletter; online)	P6.2 Permanent staff access and understand this information (e.g. may be required to present to family meetings or co-workers).	O6.2 All permanent staff receive and understand information on changes to facilities policies and procedures.

S6.3 The facility has a way of informing permanent staff about changes to the aged care industry whenever necessary (e.g. meetings; newsletter; online)	P6.3 Permanent staff access and understand this information (e.g. may be required to present to family meetings or co-workers).	O6.3 All permanent staff receive and understand information on changes to the aged care industry.
S6.4 The facility has a process for communicating with families about changes to/in: • Their relative's care • Facility policies and procedures • The aged care industry generally.	P6.4(a) Permanent staff are aware of the facility's processes for communicating with families about changes. P6.4(b) New families are informed of the facility's processes for communicating about changes.	O6.4(a) All permanent staff are aware of the facility's processes for communicating with families about changes. O6.4(b) All new families are informed of the facilities process for communicating about changes.

AUDIT QUESTIONS FOR INDICATOR 6

Permanent care staff provide detailed information about the resident's health, care, facility policies and procedures, and the aged care industry, (within their scope of practice) as requested by family.

	Y/N		**Y/N or Number**
Does the facility provide updates (whenever necessary) for permanent staff on changes to: • Facility policies and procedures • The aged care industry?		In the past 12 months: • How many updates have been provided to staff on changes to facility policies and procedures? • How many updates have been provided to staff on changes to the aged care industry? • How many permanent staff have received and understood these updates about changes in facility policies and procedures? • How many permanent staff have received and understood these updates about changes to the aged care industry?	
Does the facility have a regular way of informing staff of changes in residents' care?		How many permanent staff demonstrate they have accessed and understood the changes to residents' care?	
Does the facility have a process for communicating with families to update them about changes to/in: • Their relatives' care?		In the past 12 months, how many of these updates were provided to families?	

• Facility policies and procedures? • The aged care industry generally?			

Indicator 7 **Where a complaint has been made, the facility's complaints procedure is followed.**		
Structure	**Process**	**Outcome**
S7.1 The facility has a procedure for resolving complaints in a timely fashion.	P7.1 Permanent staff are aware of the procedure and its use in resolving complaints in a timely fashion.	O7.1 All permanent staff are aware of the procedure and its use in resolving complaints in a timely fashion.
S7.2 The facility has an education/training program about the facility's complaints procedure.	P7.2 This education/training program is scheduled: • At least annually and • At appropriate times for permanent staff (working any shift) to attend.	O7.2 All permanent staff have attended an education/training program about around the facility's complaints procedure and its use

AUDIT QUESTIONS FOR INDICATOR 7 **Where a complaint has been made, the facility's complaints procedure is followed.**			
	Y/N		**Y/N or Number**
Does the facility have a complaints procedure?		How many complaints have been made by residents or family members in the last 12 months? Of complaints made in the last 12 months: • How many have been processed in accordance with the complaints procedure? • How many of these complaints were resolved? • How many residents/families reported being satisfied with the facility's complaints procedure? What is the average length of time for resolving complaints? (a) a week (b) a fortnight (c) a month (d) three months or more *Note:* these questions may be answered by checking facility	

		complaints records.	
Does the facility have an education/training program about the complaints procedure and its use?		How often is this education/training program offered? (a) quarterly (b) six-monthly (c) annually When is this education/training program scheduled? (a) business hours (b) after hours (c) flexible (e.g. self-guided, online) Can permanent staff working any shift participate? How many permanent staff have attended this education/training program in the last 12 months?	

Indicator 8 **Families report satisfaction with information sharing by staff at the facility.**		
Structure	**Process**	**Outcome**
S8.1 A method (e.g. survey/interview) of asking families whether they are satisfied with information sharing by staff at the facility exists.	P8.1 Families are regularly (e.g. annually) asked whether they are satisfied with information sharing.	O8.1(a) All families are given opportunity to report satisfaction with information sharing by staff at the facility O8.1(b) All families responding to the survey report being satisfied with information sharing in the facility/service.
S8.2 The facility monitors family satisfaction with information sharing by its staff	P8.2 Results from this family satisfaction survey are collated	O8.2 Collated results from this family satisfaction survey are used in quality improvement activities

AUDIT QUESTIONS FOR INDICATOR 8 **Families report satisfaction with information sharing by staff at the facility.**			
	Y/N		**Y/N or Number**
Does the facility ask families whether they are satisfied with information sharing by staff (e.g. via survey/interview)?		In the past 12 months, how many families were given the opportunity to report satisfaction with information sharing?	
		Are the results of the families' reporting on satisfaction with information sharing used for quality improvement?	

Indicator 9 **The facility is perceived to be person-centred by the staff**		
Structure	**Process**	**Outcome**
S9.1 The facility expresses a person-centred care philosophy in policy and practice.	P9.1(a) Permanent staff are aware of and understand the person-centred care philosophy and how to embed it in practice.	O9.1(a) All permanent staff are aware of and understand the person-centred care philosophy and how to embed it in practice.
S9.2 The facility uses a person-centred care assessment tool, such as the P-CAT.	P9.2 Person-centred care is monitored and assessed annually to ensure it is embedded into practice.	O9.2 A score of 80% or greater is achieved on person-centred care assessment.
S9.3 An education/training program on person-centred care and how embed it into practice is available.	P9.3 This education/training programs is scheduled regularly (e.g. six-monthly) and at times that allow permanent staff (working any shift) to attend.	O9.3 All permanent staff have attended this education/training program
S9.4 Information is available for new permanent staff on person-centred care and how to embed it into practice	P9.4 New permanent staff receive this information as part of their workplace orientation program.	O9.4 All new permanent staff received this information as part of their workplace orientation program.

AUDIT QUESTIONS FOR INDICATOR 9 **The facility is perceived to be person-centred by the staff**			
	Y/N		**Y/N or Number**
Does the facility express a person-centred care philosophy in a vision, mission or values statement?		How many permanent staff are aware of the facility's commitment to person-centred care?	
Does the facility use a person-centred care assessment tool (e.g. the P-CAT)?		What score did the facility achieve on this person-centred assessment tool?	

Does the facility have an education/training program about person-centred care and how to embed it into practice? *Note:* "education/training program" may be internally or externally provided.		How often is this education/training program offered? (a) quarterly (b) six-monthly (c) annually When is this education program scheduled? (a) business hours (b) after hours (c) flexible (e.g. self-guided, online) Can permanent staff who work different shifts participate? How many permanent staff have attended this education/training program in the last 12 months?	
Does the facility's workplace orientation program include information on person-centred care and how to embed it into practice?		How many new permanent staff received this information as part of their orientation? Note: this may be answered by asking all new permanent staff whether they received this information as part of their workplace orientation program	

Indicator 10 **The facility has a procedure to guide staff in the management of family anger/aggression**		
Structure	**Process**	**Outcome**
S10.1 The facility has a procedure for permanent staff to follow when managing family anger/aggression.	P10.1 Permanent staff are aware of this procedure.	O10.1 All permanent staff are aware of this procedure.
S10.2 The facility has an education/training program about management of family anger/aggression and how to follow the facility's procedure.	P10.2 This education/training program is scheduled: • At least annually and • At appropriate times for permanent staff (working any shift) to attend.	O10.2 All permanent staff have attended an education/training program about management of family anger/aggression.
S10.3 Information is available for new permanent staff on procedure for the management of family anger/aggression	P10.3 New permanent staff receive this information as part of their workplace orientation program.	O10.3 All new permanent staff received this information as part of their workplace orientation program.

AUDIT QUESTIONS FOR INDICATOR 10 **The facility has a procedure to guide staff in the management of family anger/aggression**			
	Y/N		**Y/N or Number**
Does the facility have a procedure stating how permanent staff should manage family anger/aggression?		How many permanent staff are aware of the procedure on the management of family anger/aggression?	
Does the facility have an education/training program for permanent staff about managing family anger/aggression and the facility's procedure?		How often is this education/training program offered? (a) quarterly (b) six-monthly (c) annually When is this education program scheduled? (a) business hours (b) after hours (c) flexible (e.g. self-guided, online) Can permanent staff who work different shifts participate? How many permanent staff have attended this education/training program in the last 12 months?	
Does the facility's workplace orientation program include information on management of family anger/aggression and the facility's procedures for this?		How many new permanent staff received this information as part of their orientation? Note: this may be answered by asking all new permanent staff whether they received this information as part of their workplace orientation program	

Indicator 11 **The facility has a procedure for dealing with distressing staff–family communication incidents.**		
Structure	**Process**	**Outcome**
S11.1 The facility has a procedure for dealing with distressing staff–family communication incidents.	P11.1 Permanent staff are aware of this procedure	O11.1 All permanent staff are aware of this procedure.
S11.2 The facility has an education/training program about how to deal with distressing staff–family communication incidents and facility's	P11.2 This education/training program is scheduled: • At least annually and at appropriate times for	O11.2 All permanent staff have attended an education/training program about distressing staff–family incidents.

procedure to follow in these situations.	permanent staff (working any shift) to attend.	
S11.3 Information is available for new permanent staff about distressing staff–family communication incidents and the facility's procedure to follow in these situation..	P11.3 New permanent staff receive this information as part of their workplace orientation program.	O11.3 All new permanent staff received this information as part of their workplace orientation program.

AUDIT QUESTIONS FOR INDICATOR 11 **The facility has a procedure for dealing with distressing staff–family communication incidents.**			
Does the facility have a procedure for permanent staff to follow in distressing staff–family communication incidents?		How many permanent staff are aware of the procedure on distressing staff–family incidents?	
Does the facility have an education/training program for permanent staff about distressing staff–family communication incidents and the facility's procedure in these situations?		How often is this education/training program offered? (a) quarterly (b) six-monthly (c) annually When is this education program scheduled? (a) business hours (b) after hours (c) flexible (e.g. self-guided, online) Can permanent staff who work different shifts participate? How many permanent staff have attended this education/training program in the last 12 months?	
Does the facility's workplace orientation program include information on distressing staff–family incidents and the facility's procedure in these situations?		How many new permanent staff received this information as part of their orientation? Note: this may be answered by asking all new permanent staff whether they received this information as part of their workplace orientation program	

Indicator 12 **Staff and families have the opportunity to participate in formal peer support/debriefing following distressing staff–family communication incidents.**		
Structure	**Process**	**Outcome**
S12.1 The facility has formal peer support/debriefing program available for staff and families to use after a distressing communication incident.	P12.1 Permanent staff and families are aware of this peer support/debriefing program.	O12.1 All permanent staff and families access this peer support/debriefing program if required.
S12.2 The facility informs staff and family about the peer support/debriefing program available to them and how to access it	P12.2 New staff and families receive written information about the peer support/debriefing program available to them and how to access it.	O12.2 All new staff and families receive information about the peer support/debriefing available to them and how to access it.

AUDIT QUESTIONS FOR INDICATOR 12 **Staff and families have the opportunity to participate in formal peer support/debriefing following distressing staff–family communication incidents.**			
	Y/N		**Y/N or Number**
Does the facility have a peer support/debriefing program available for permanent staff to access following a distressing incident?		How many permanent staff are aware of how to access the peer support/debriefing program?	
Does the facility have a peer support/debriefing program available for families to access following a distressing incident?		How many families are aware of how to access the peer support/debriefing program? *Note:* this may be answered by asking all new families whether they are aware of how to access the peer support/debriefing program.	
Does the facility inform staff and families about the peer support/debriefing program and how to access it following a distressing incident?		Newsletters and flyers are available to inform families of the peer support/debriefing program? Newsletters and flyers are available to inform staff of the peer support/debriefing program? Does the facility's workplace orientation program include information on the peer support/debriefing program?	

References

1. Nolan M, Bauer M, Nay R. Supporting family carers: implementing a relational and dynamic approach. In: Nay R, Garratt S, editors. Older people: Issues and innovations in care. 3rd ed. Sydney: Elsevier; 2009. p. 136-52.
2. Gaugler J. Family Involvement and Resident Psychosocial Status in Long-Term Care. Clinical Gerontologist. 2006; **29**(4): 79 - 98.
3. Brown-Wilson C, Davies S, Nolan MR. Developing relationships in care homes - the contribution of staff, residents and families. Ageing and Society. 2009; **29**: 1041-63.
4. Haesler E, Bauer M, Nay R. Staff-Family Relationships in the Care of Older People: A Report on a Systematic Review. Research in Nursing & Health. 2007; **30**: 385-98.
5. Bramble M, Moyle W, McAllister M. Seeking connection: family care experiences following long-term dementia care placement. Journal of Clinical Nursing. 2009; **18**(22): 3118-25.
6. Australian Bureau of Statistics. Disability, ageing and carers, Australia: Summary of findings, 2009. Canberra: Australian Government; 2009.
7. Chambers M, Ryan AA, Connor SL. Exploring the emotional support needs and coping strategies of family carers. Journal of Psychiatric and Mental Health Nursing. 2001; **8**(2): 99-106.
8. Winbush GB. Family caregiving programs: A look at the premises on which they are based. In: Burton L, editor. Families and Aging. New York: Baywood Publishing Company; 1993. p. 129-33.
9. Li H, Stewart B, Imle M, Archbold P, Felver L. Families and hospitalized elders: A typology of family care actions. Research in Nursing and Health. 2000; **23**(1): 3-16.
10. Campbell JM. Support groups for visitors of residents in nursing homes. Journal of Gerontological Nursing. 1996; **22**(2): 30-5.
11. Dellasega C, Nolan M. Admission to care: Facilitating role transition amongst family carers. Journal of Clinical Nursing. 1997; **6**: 443-51.
12. Kellett U. Searching for new possibilities to care: A qualitative analysis of family caring involvement in nursing homes. Nursing Inquiry. 1999; **6**(1): 9-16.
13. Maas M, Swanson E, Buckwalter KC, Weiler K, Specht J. The elderly in long-term care. In: Vaughan-Cole B, Johnson MA, Malone JA, Walker BL, editors. Family Nursing Practice. Sydney: W.B. Saunders; 1998. p. 273-96.
14. Farran CJ. Family caregiver intervention research: Where have we been? Where are we going? Journal of Gerontological Nursing. 2001; **27**(7): 38-50.
15. Haesler E, Bauer M, Nay R. Recent evidence on the development and maintenance of constructive staff-family relationships in the care of older people - A report on a systematic review update. International Journal of Evidence-Based Healthcare. 2010; **8**(2): 45-74.
16. LaBrake T. How to get families more involved in the nursing home: Four programs that work and why. New York: The Haworth Press; 1996.
17. National Health and Medical Research Council. Guidelines for a palliative approach in residential aged care. Canberra: Australian Government; 2006.
18. Haesler E, Bauer M, Nay R. Factors associated with constructive staff-family relationships in the care of older adults in the institutional setting. International Journal of Evidence-Based Healthcare. 2006; **4**(4): 288-336.
19. Bowers B. Family perceptions of care in a nursing home. The Gerontologist. 1988; **28**(3): 361-8.
20. Duncan MT, Morgan DL. Sharing the caring: Family caregivers' views of their relationships with nursing home staff. Gerontologist. 1994; **34**(2): 235-44.
21. Nay R. Nursing home entry: Meaning making by relatives. Australian Journal on Ageing. 1996; **15**(3): 123-6.
22. Gilmour J. Dis/integrated care: Family caregivers and in-hospital respite care. Jounal of Advanced Nursing. 2002; **39**(6): 546-53.
23. Hertzberg A, Ekman SL. "We, not them and us?" Views on the relationships and interactions between staff and relatives of older people permanently living in nursing homes. Journal of Advanced Nursing. 2000; **31**(3): 614-22.
24. Hertzberg A, Ekman SL, Axelsson K. Staff activities and behaviour are the source of many feelings: Relatives' interactions and relationships with staff in nursing homes. Journal of Clinical Nursing. 2001; **10**(3): 380-8.
25. Shuttlesworth GE, Rubin A, Duffy M. Families versus institutions: Incongruent role expectations in the nursing home. The Gerontologist. 1982; **22**(2): 200-8.
26. Ward-Griffin C, Bol N, Hay K, Dashnay I. Relationships between families and registered nurses in long-term care facilities: A critical analysis. Canadian Journal of Nursing Research. 2003; **35**(4): 151-74.
27. Majerovitz S, Mollott R, Rudder C. We're on the same side: Improving communication between nursing home and family. Health Communication. 2009; **24**(1): 12-20.
28. Bluestein D, Latham Bach P. Working with families in long-term care. Journal of the American Medical Directors Association. 2007 **8**(4): 265-70.
29. Griffith J, Brosnan M, Lacey K, Keeling G. Family meetings - A qualitative exploration of improving care planning with older people and their families. Age and Ageing. 2004; **33**(6): 577-81.
30. Bauer M. Collaboration and control: Nurses' constructions of the role of family in nursing home care. Journal of Advanced Nursing. 2006; **54**(1): 45-52.
31. Caron C, Griffith J, Arcand M. Decision making at the end of life in dementia: How family caregivers perceive their interactions with health care providers in long-term-care settings. Journal of Applied Gerontology. 2005 **24**(3): 231-47.
32. Carpenter BD. Family, peer, and staff social support in nursing home patients: Contributions to psychological well-being The Journal of Applied Gerontology. 2002; **21**(3): 275-93.
33. Gladstone J, Dupuis S, Wexler E. Ways that families engage with staff in long-term care facilities. Canadian Journal on Aging. 2007; **26**(4): 391-402.

34. Gladstone J, Wexler E. Exploring the relationships between families and staff caring for residents in long-term care facilities: Family members' perspectives. Canadian Journal on Aging. 2001; **21**(1): 39-46.
35. Hertzberg A, Ekman SL. How the relatives of elderly patients in institutional care perceive the staff. Scandinavian Journal of Caring Sciences. 1996; **10**(4): 205-11.
36. Higgins I, Cadd A. The needs of relatives of the hospitalised elderly and nurses' perceptions of those needs. Geriaction. 1999; **17**(2): 18-22.
37. Marquis R, Freeguard H, Hoogland L. Influences on positive family involvement in aged care: An ethnographic view. Contemporary Nurse. 2004; **16**(3): 178-86.
38. Nolan M, Dellasega C. 'It's not the same as him being at home': Creating caring partnerships following nursing home placement. Journal of Clinical Nursing. 1999; **8**(6): 723-30.
39. Ryan AA, Scullion HF. Family and staff perceptions of the role of families in nursing homes. Journal of Advanced Nursing. 2000; **32**(3): 626-34.
40. Tisher TB. Aged Care Residential Facility and Family Interface: A Training Program for Staff. Clinical Gerontologist. 2009; **32**(3): 309-23.
41. Anderson K, Hobson A, Steiner P, Rodel B. Patients with dementia: Involving families to maximise nursing care. Journal of Gerontologial Nursing. 1992; **18**(7): 19-25.
42. Maas M, Reed D, Park M, Specht JP, Schutte D, Kelley LS, et al. Outcomes of family involvement in care intervention for caregivers of individuals with dementia. Nursing Research. 2004; **53**(2): 76-86.
43. Pillemer K, Hegeman CR, Albright B, Henderson C, Morrow-Howell N. Building bridges between families and nursing home staff: The partners in caregiving program. The Gerontologist. 1998; **38**(4): 499-503.
44. Pillemer K, Suitor J, Henderson CJ, Meador R, Schultz L, Robison J, et al. A cooperative communication intervention for nursing home staff and family members of residents. Gerontologist. 2003; **43**(Spec No 2 (Apr)): 96-106.
45. Specht JP, Kelley LS, Manion P, Maas ML, Reed D, Rantz MJ. Who's the boss? Family/staff partnership in care of persons with dementia. Nursing Administration Quarterly. 2000; **24**(3): 64-77.
46. Gladstone J, Wexler E. The development of relationships between families and staff in long-term care facilities: Nurses' perceptions. Canadian Journal on Aging. 2001; **21**(2): 217-28.
47. Laakso S, Routasalo P. Changing to primary nursing in a nursing home in Finland: Experiences of residents, their family members and nurses. Journal of Advanced Nursing. 2001; **33**(4): 475-83.
48. Bauer M, Fitzgerald L, Koch S. Hospital discharge as experienced by family carers of people with dementa: A case for quality improvement. Journal of Health Care Quality. 2011; **33**(6): 9-16.
49. Bauer M, Nay R. Improving staff-family relationships in assisted living facilities: The views of the family. Journal of Advanced Nursing. 2011; **67**(6): 1232-41.
50. Gladstone J, Wexler E. A family perspective of family/staff interaction in long-term care facilities. Geriatric Nursing. 2000; **21**(1): 16-9.
51. Marziali E, Shulman K, Damianakis T. Persistent family concerns in long-term care settings: Meaning and management. Journal of the American Medical Directors Association 2006; **7**(3): 154-62.
52. Bauer M. Collaboration and control: A naturalistic study of nurses' constructions of the role of family in nursing home care [[Doctor of Philosophy]]. Melbourne: La Trobe University; 2003.
53. Russell H, Foreman P. Maintaining a relationship with a family member in a nursing home: The role of visitor. Journal of Family Studies. 2002; **8**(2): 147-64.
54. Bauer M. Staff-family relationships in nursing home care: A typology of challenging behaviours. International Journal of Older People Nursing. 2007; **2**(3): 213-8.
55. Pirjo L, Isola A. Promoting participation of informal caregivers in the hospital care of the elderly patient: Informal caregivers' perceptions. Journal of Advanced Nursing. 1996; **23**(5): 942-7.
56. Robison J, Curry L, Gruman C, Porter M, Henderson C, Pillemer K. Partners in caregiving in a special care environment: cooperative communication between staff and families on dementia units. The Gerontologist. 2007 **47**(4): 504-15.
57. Kellett U. Bound within the limits: Facing constraints to family caring in nursing homes. International Journal of Nursing Practice. 2000; **6**(6): 3317-23.
58. van der Smagt-Duijnstee ME, Hamers JPH, Abu-Saad HH, Zuidhof A. Relatives of hospitalized stroke patients: Their needs for information, counselling and accessibility. Journal of Advanced Nursing. 2001; **33**(3): 307-15.
59. Austin W, Goble E, Strang V, Mitchell A, Thompson E, Lantz H, et al. Supporting Relationships Between Family and Staff in Continuing Care Settings. Journal of Family Nursing. 2009; **15**(3): 360-83.
60. Lau W, Shyu Y, Lin L, Yang P. Institutionalized elders with dementia: Collaboration between family caregivers and nursing home staff in Taiwan. Journal of Clinical Nursing. 2008; **17**(4): 482-90.
61. Abrahamson K, Jill Suitor J, Pillemer K. Conflict Between Nursing Home Staff and Residents' Families: Does It Increase Burnout? Journal of Aging and Health. 2009; **21**(6): 895-912.
62. Weman K, Kihlgren M, Fagerberg I. Older people living in nursing homes or other community care facilities: Registered nurses' views of their working situation and co-operation with family members. Journal of Clinical Nursing. 2004; **13**(5): 617-26.
63. Weman K, Fagerberg I. Registered nurses working together with family members of older people. Journal of Clinical Nursing. 2006; **15**(3): 281-9.
64. Morrel C, Harvey G. The Clinical Audit Handbook: Improving the quality of health care. Australia: Elsevier; 2003.
65. Edvardsson D, Fetherstonhaugh D, Nay R, Gibson S. Development and initial testing of the Person-centered Care Assessment Tool. International Psychogeriatrics. 2010; **22**(1): 101-8.