Factors associated with constructive staff-family relationships in the care of older adults in the institutional setting

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CRD summary
The review assessed interventions to promote constructive relationships between staff and the families of older people in health care institutions. The authors concluded that communication skills, information exchange, staff education and administrative support are essential to collaborative partnerships between staff and families. These findings might not be reliable and some relevant studies might not have been included.

Authors' objectives
The wider objective was to review strategies and practices to promote constructive relationships between staff and family in the care of older people in the institutional setting. This abstract summarises the evidence for interventions to promote constructive relationships.

Searching
AgeLine, APAIS-Health, Australian Family and Society Abstracts, CINAHL, MEDLINE, EMBASE, PsycINFO, Social Sciences Index, Dissertation Abstracts, the Cochrane Library and DARE were searched; the search strategies were reported. The reference lists of retrieved articles were checked and content experts contacted. Both published and unpublished studies written between 1990 and 2005 in English were eligible for inclusion.

Study selection
Study designs of evaluations included in the review
Quantitative and qualitative research designs were eligible for inclusion. Textual discussion or opinion papers were also eligible as this evidence, although not a type of study design, was an integral part of the findings.

Specific interventions included in the review
Strategies and practices to promote constructive relationships were eligible for inclusion. The included interventions were partners in caregiving (PIC), family involvement in care (FIC), meetings between family and staff or family, staff and patients, and a primary nursing care model (assignment of a primary nurse to the patient). The PIC intervention involved workshops for nursing staff and family members (including education on communication, active listening, conflict management and values or ethnic differences). The FIC intervention involved negotiation of a partnership between staff and family. The control groups received usual care or, in one study, education on dementia only.

Participants included in the review
Studies of residents and patients over 65 years of age in acute, sub-acute, rehabilitation and residential settings, their family members and health care staff, were eligible for inclusion. The participants included family, staff and residents in nursing homes in the USA and Finland, residents in dementia care units in the USA, and patients in a geriatric rehabilitation hospital in New Zealand.

Outcomes assessed in the review
The outcomes of interest were staff-family relationships, staff outcomes, family satisfaction with the relationship with staff, and resident satisfaction. Staff outcomes included stress, job satisfaction, more inclusive practice, staff retention, and satisfaction with relationships with resident or patient and family. Objective and subjective outcomes were eligible for inclusion. Various scales were used to measure quantitative family and staff outcomes, including behaviour, empathy, caregiver burden and staff burnout, and intention-to-quit. Various methods were used to collect and analyse qualitative information. The follow-up in the quantitative studies was at 8 weeks and 6 months for PIC, up to 9 months for FIC, and within the 12-week study period for the family meeting intervention.

How were decisions on the relevance of primary studies made?
Two reviewers independently assessed the relevance of the studies.

**Assessment of study quality**

Two reviewers assessed study quality independently using standardised critical appraisal tools (available in the report). Any disagreements were resolved through the intervention of a third reviewer.

**Data extraction**

Two reviewers independently extracted data from the included studies. Quantitative data were extracted using a standardised form available in the report. Qualitative data were extracted using the Qualitative Assessment and Review Instrument (QARI). The data appear to have been reported as in the original study manuscripts.

**Methods of synthesis**

How were the studies combined?

The findings from the quantitative and the qualitative studies were summarised in a narrative. Qualitative data were synthesised using the QARI. Meta-synthesis methods were used to combine the findings from qualitative and discursive (i.e. textual data not derived from research) evidence. An established system was used to assign levels of evidence to the synthesised findings, designated as unequivocal, credible or unsupported.

How were differences between studies investigated?

Studies that used a quantitative research design (randomisation to intervention or control) and studies that used a qualitative research design were summarised separately in the text. The studies were grouped differently in tables as experimental (RCT) or qualitative studies, with three of the studies that used a quantitative research design tabulated as qualitative studies (apparently because the methods of data collection and analysis were qualitative). Differences between the studies were discussed in the text. Differences between qualitative studies with regard to purpose, participants, methods of data collection and analysis were summarised in a table.

**Results of the review**

Seven studies of interventions were included. Four studies used quantitative research designs (where reported, 12 patients, at least 1,117 family members and 1,550 staff were included in total) and included one randomised controlled trial (RCT). Three studies used qualitative research designs (where reported, 63 family members, 32 patients and at least 76 staff were included in total).

Quantitative evidence.

PIC: one RCT showed statistically significant improvement in the perceptions that nursing staff and residents’ family members had of each other (p=0.04 at 8 weeks’ follow-up) in the PIC group, compared with a control group. There was no significant decrease in other outcomes such as interpersonal conflict, caregiver burden, staff burnout or depression. The study did not measure the effects on residents or their care.

FIC: one study comparing facilities caring for predominantly African-American residents with those caring for predominantly Caucasian residents found cultural differences in the type of involvement in care relatives preferred to undertake, and that organisational issues could prevent implementation of strategies designed to promote collaboration. Another study showed that the intervention increased some family members' satisfaction with the quality of care. Several measures of staff perceptions of family members improved significantly, but in the intervention group there was also an increase in staff negative response to the resident. One small study concluded that FIC increased collaboration between families and nursing staff and improved residents’ quality of care.

Qualitative evidence.

One study of PIC showed the acceptability of the intervention among families and staff, but also showed that organisational issues, such as willingness to release staff for training, may impede introduction of such collaborative care programmes.
In one study family meetings were perceived as useful by relatives of patients in a geriatric rehabilitation hospital. Using a defined process to implement family meetings may increase their usefulness.

In another study a primary nursing care model alone did not increase collaboration or the quality of the residents’ care. Family members noticed a change in nurses’ behaviour but not in their cooperation with nurses. The nursing home residents did not feel that primary nursing had significantly affected their nursing care.

Synthesis.

One hundred findings were extracted from the qualitative research studies and synthesised with evidence from three textual papers.

The final synthesis found interventions focused on increasing collaboration between staff and family to be most successful for promoting constructive staff-family relationships. Interventions were more likely to be successful when implemented using a defined process that establishes goals and expectations in conjunction with ongoing education. The assigned level of evidence was credible, meaning that it was plausible and could be logically inferred from the data, but being essentially interpretative it can be challenged.

Authors’ conclusions
Communication, information, education and administrative support are essential to interventions designed to support a collaborative partnership between family members and health care staff. Managerial support, care models focused on collaboration with families, and practical support for staff education are essential to gain sustained benefit from interventions to promote constructive family-staff relationships.

CRD commentary
The review addressed a broad question and had wide inclusion criteria for the interventions, outcome measures and study designs. Procedures to minimise reviewer bias and errors in the study selection process were used. Several sources were searched to identify both published and unpublished literature, and the search strategies were provided for inspection. The restriction to the English language could have introduced language bias. An assessment of study quality and the data extraction were done systematically using appropriate tools. The description (in the text) of the included studies of interventions was thorough, but it was not clear that the data obtained from studies that used randomisation were analysed appropriately (e.g. did cluster randomised trials use the correct unit of analysis). Appropriate methods were used to synthesise the data but there was a lack of clarity regarding the study characteristics (design, outcome measures and analysis) used to categorise the evidence as quantitative or qualitative. The authors’ conclusions were derived from evidence which they designated as credible, meaning that it was essentially interpretative and open to challenge. Given that all relevant studies might not have been included in the review and that those that were included were heterogeneous and often small in size, a cautious interpretation is warranted.

Implications of the review for practice and research
Practice: The authors highly recommended the incorporation of staff and family education into interventions to promote constructive family relationships. Interventions should address communication, information provision, education and administrative support. Positive effects are more likely with administrative and management support.

Research: The authors stated that research is needed to determine the most effective education programmes for staff and the effectiveness of interventions incorporating communication, information provision, education and administrative support. Research should consider the patient perspective and satisfaction with care.

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Record Status
This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.