

Résumé

**Analyse critique de la relation entre familles
et infirmières autorisées dans
les centres de soins de longue durée**

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Même si on a beaucoup écrit sur le lien unissant les familles et les infirmières, peu d'analyses systématiques ont porté sur cette relation dyadique dans le domaine des soins de longue durée. S'inspirant d'une approche ethnographique critique, les chercheurs ont mené des entrevues individuelles approfondies auprès de 17 dyades famille-infirmière s'occupant de résidents d'un centre de soins de longue durée atteints de la maladie d'Alzheimer ou d'un trouble connexe. L'analyse des transcriptions d'entrevue et des notes d'observation révèle l'existence de quatre types de relations famille-infirmière (traditionnelle, concurrentielle, coopérative et « empreinte de sollicitude » qui mettent en évidence le rôle de l'infirmière et de la famille, les stratégies de négociation et les conséquences. En outre, on s'est rendu compte que des facteurs intrinsèques et extrinsèques venaient influencer l'évolution de certains types de relations. Ces résultats entraînent des conséquences pour la pratique infirmière, l'élaboration de lignes directrices et la recherche au sein des centres de soins de longue durée.

Mots clés : soins de longue durée, relation famille-infirmière, soins de santé

Relationships Between Families and Registered Nurses in Long-Term-Care Facilities: A Critical Analysis

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Although much has been written about the relationship between families and nurses, little systematic analysis has been undertaken of this dyadic relationship in long-term care (LTC). Using a critical ethnographic approach, the researchers conducted separate in-depth interviews with 17 family-nurse dyads caring for residents with Alzheimer disease or a related disorder in one LTC setting. Analysis of interview transcripts and fieldnotes revealed 4 types of family-nurse relationships — conventional, competitive, collaborative, and “carative” — each reflecting the roles of nurse and family, negotiating strategies, and consequences. In addition, it became apparent that intrinsic and extrinsic factors influence the development of certain types of relationships. The findings have implications for nursing practice, policy development, and further research within LTC settings.

Keywords: long-term care, dementia, health-care relationships, family-centred care, caregiving

Introduction

Over the past decade the citizens of the province of Ontario have experienced an upheaval in health care. Years of restructuring and underfunding have created gaps in health care that have led to increased reliance on family members to provide care to elderly persons. There has been a significant movement towards the sharing of care between unpaid family caregivers and paid health-care professionals in hospitals, nursing homes, and the community (Duncan & Morgan, 1994; Harvath et al., 1994; McKeever, 1994). Although much has been written about the relationship between these two types of caregivers and about the benefits, to both family and staff, of “sharing the caring” (Duncan & Morgan; Gladstone & Wexler, 2000), this dyadic relationship has undergone little empirical analysis. We know very little about the relationship between families and staff in long-term-care (LTC) settings and how to improve this relationship to ensure quality care. Hence, while it may be desirable to forge partnerships between staff and family members in LTC settings, the move towards the sharing of care is occurring without a critical analysis of this relationship. Moreover, the limited empirical evidence that

does exist on the successful application of the partnership ideal suggests that the relationship presents challenges (Hertzberg & Ekman, 1996, 2000; McWilliam, Ward-Griffin, Sweetland, Sutherland, & O'Halloran, 2001; Pillemer, Hegeman, Albright, & Hendershot, 1998).

Nurse-family relationships in LTC settings cannot be improved without a better understanding of how these relationships develop and how the practices and policies of each facility contribute to the development of positive relationships. The findings of this qualitative study, based within a program of research focused on health-care relationships, illustrate how family-nurse relationships are formed and negotiated at one particular LTC setting as well as the factors that shape the development of those relationships. The paper concludes with practice, policy, and research implications.

Literature Review

There is a dearth of literature on the relationship between families and health professionals in LTC settings. Most of the work that does exist suggests that conflicts may arise between informal and formal caregivers when professionals fail to recognize family caregivers' experience-based expertise (Duncan & Morgan, 1994; Hasselkus, 1989; Hertzberg & Ekman, 1996; Kellett, 1999), when staff are insensitive to family feelings or needs (Hertzberg & Ekman, 2000), when roles overlap (Cott, 1991; Kaye, 1985; Rosenthal, Marshall, MacPherson, & French, 1980; Schwartz & Vogel, 1990), when roles are rigidly defined (Bowers, 1988; Duncan & Morgan), when there is limited contact between staff and family (Sandberg, Lundh, & Nolan, 2001), or when professional expectations of family caregivers are contradictory (Hertzberg & Ekman, 2000; McKeever, 1992). It appears that family caregivers occupy an ambiguous position in relation to health professionals, who tend to view them as both the problem and the solution (Kaye, 1985; Nolan & Grant, 1989; Thorne & Robinson, 1988; Twigg & Atkin, 1994). This ambiguity can and often does lead to conflict.

Most of the literature on family caregiving is situated within the home (Pearlin, 1992; Ward-Griffin, 2001), with little attention being paid to families who provide informal care in LTC institutions. However, research shows that many families continue to assist in their relative's care following relocation to an LTC setting (Bitzan & Kruzich, 1990; Kellett, 1999; Ross, Rosenthal, & Dawson, 1997b; Sandberg, Nolan, & Lundh, 2001). Some studies indicate that LTC staff must work with families in the transitional period and beyond (Dellasega & Nolan, 1997; Ross, Rosenthal, & Dawson, 1997a, 1997b, 1997c; Sandberg, Nolan, & Lundh, 2001; Tickle & Hull, 1995). In Laitinen and Isola's (1996) study, nursing staff believed that family participation in care requires a family-nurse

partnership of cooperation, equality, and trust, but families noted that nurses lacked the communication skills and expertise necessary to deal with their concerns.

Several studies cite the failure of professionals to value family caregiving expertise and affective work in formal care settings as a source of conflict in formal-informal caregiver relationships (Bowers, 1988; Duncan & Morgan, 1994; Keady & Nolan, 1995; Kellett, 1999; Powell-Hope, 1994; Robinson, 1985; Sandberg, Nolan, & Lundh, 2001). While both families and staff generally consider staff to be primarily responsible for technical care in nursing homes, there is much less agreement concerning the importance and responsibility of affective care. In a study with family caregivers of nursing-home residents, Bowers found that, in order to ensure quality care, family members actively monitored staff and sought to work collaboratively and cooperatively by learning technical skills and teaching individualized preservative (affective) care; however, they felt that both the importance of individualized affective care and the need for complex partnerships to ensure quality care went unrecognized or ignored by staff.

Similarly, Ross, Rosenthal, and Dawson (1997b) found that spouses of institutionalized elders provided preservative care and consistently perceived more tasks as falling within their domain rather than within the domain of staff or as a shared responsibility. These findings are similar to those of Rubin and Shuttlesworth (1983) and Schwartz and Vogel (1990). When asked about their caring work in relation to that of formal caregivers, family caregivers often claim to be experts and expect their expertise to be acknowledged (Ong, 1990), which indicates that their preferred role is that of full partner in care (Hasselkus, 1992; Keady & Nolan, 1995; Kellett, 1999; Nolan & Grant, 1989; Ong, 1990). These findings point to the invisibility of the work and experiential knowledge of family caregivers, particularly in the affective realm.

Few researchers have actively sought insights from both family caregivers and health professionals on how they work together in providing care (Fischer & Eustis, 1994; Frankfather, 1981; Hasselkus, 1992; Twigg & Atkin, 1994; Schwartz & Vogel, 1990; Ward-Griffin, 1998) or how the relationship changes over time (Clark, Corcoran, & Gitlin, 1994; Keady & Nolan, 1995). Some investigators report that negotiating a partnership between professionals and family caregivers is a complex, dynamic process (McKeever, 1992; Powell-Hope, 1994; Thorne & Robinson, 1989; Ward-Griffin & McKeever, 2000). Twigg and Atkin identify four service-agency responses to families as caregivers: as resources, as co-workers, as co-clients, and as superseded carers. Similarly, in their qualitative study of community nurses and family members providing care to elders living at home, Ward-Griffin and McKeever found four distinct yet

interconnected relationships: nurse-helper, co-workers, manager-worker, and nurse-patient. Only the first prototype involved nurses taking the major responsibility for care, with the other three exhibiting various degrees of a “working relationship,” characterized by gradual delegation and transfer of care from nurse to family caregiver. In contrast to the findings of Twigg and Atkin, that study captured the nurse-helper relationship and the surveillance role of the nurse. Social-care agencies, rather than health professionals, were the focus of Twigg and Atkin’s work, which may help explain the difference.

Less clear and less documented, however, are the specific relationships between family members and staff in LTC settings, and the factors that influence the development of these relationships. Gladstone and Wexler (2002) report family perspectives of five types of family-staff relationships in two LTCs: collegial, professional, friendship, distant, and tense. They found the majority of the relationships to be positive, with the most common being professional and collegial. They also found participating in care decisions, sharing experiences, and establishing trust to be associated with positive relationships. Other studies report similar findings (Hertzberg & Ekman, 2000; Ward-Griffin & Bol, 2000). Shuttlesworth, Rubin, and Duffy (1982) remind us that efforts to forge a close partnership between families and nursing staff depend, in part, upon the degree to which institutions encourage and support family involvement. While these studies encourage us to think about factors associated with the development of such relationships, very few investigators have questioned the role of social power in relations between family caregivers and LTC staff. This information is vital if family caregivers and staff are to enter a genuine partnership.

In summary, although much has been written about how families and staff should relate to each other, this dyadic relationship in an LTC setting has undergone little systematic critical analysis. Few studies have specifically examined the distribution of power between families and nursing staff in LTC settings. Greater attention should also be given to the process of negotiating care between family members and nursing staff, with a focus on factors that influence the nature and development of family-nurse relationships in LTC settings. The present study was intended to address this paucity of data and some of the limitations of previous studies.

Method

The purpose of this study was to critically examine the relationships between families and registered nurses caring for residents of an LTC facility for war veterans in the province of Ontario, Canada. This partic-

ular facility used a primary-care approach: once residents were admitted, their care was primarily provided by the same registered nurse for the duration of their stay.

The following research questions were addressed: (1) *How do families and nurses describe their relationships?* (2) *What strategies are used by families and nurses in negotiating their caregiving work?* (3) *What are the consequences of the negotiation process between families and nurses?* (4) *What factors influence this negotiation process?*

Critical ethnography was chosen as the research method because this approach makes explicit those situations that are frequently hidden by familiarity — or taken for granted — and go unchallenged (Quantz, 1992; Thomas, 1993). In other words, critical ethnography increases our experiential capacity to see, hear, and feel. As well, a critical ethnographic approach proceeds from an explicit value-laden framework, promoting transformation and empowerment (Thomas). In this study, a critical ethnographic approach not only helps us to focus on how families and nurses are positioned and how they participate in specific power relations, but also illuminates taken-for-granted assumptions about “family-centred care” in LTC settings.

Recruiting and Sampling Methods

Following University Ethics Committee approval of the study protocol, purposive sampling was used to obtain nurse-family dyads. Registered nurses and family members were recruited from two 40-bed units in the Dementia Care Program of one LTC setting over an 18-month period using a two-phase sampling frame. All registered nurses employed (full-time or part-time) were given a letter describing the purpose and nature of the study and asking if they provided primary care to a veteran diagnosed with Alzheimer disease or a related disorder who also received regular visits (at least twice monthly) from a family member. “Family” was defined as two or more individuals who identified themselves as members of the family either by birth, marriage, adoption, or choice (Allen, Fine, & Demo, 2000). Other, ongoing, recruitment strategies included posting flyers throughout the two units and announcing preliminary findings (Ward-Griffin & Bol, 2000) at an in-service meeting. Potential nurse participants were asked to provide names of eligible family members with whom they had interacted on four or more occasions. These family members were then approached by one of the researchers to participate in the study.

Sample

Seventeen family-nurse dyads participated in the study. All dyads had known one another since the admission of the veteran to the LTC

setting, which ranged from 3 months to 5 years with a mean of 1.5 years. All dyads remained the same for the duration of the stay. Most dyads saw each other weekly. The nurses ranged in age from 31 to 56 years with an average age of 45. All the nurses were women. The majority were Canadian (71%), were married (41%), held a diploma in nursing (65%), and were employed full-time (53%) (see Table 1). The family members ranged in age from 46 to 79 years with a mean age of 65. The majority were women (82%), Canadian (82%), and married (82%), held a high-school diploma (53%), and were wives of the veterans (71%) (see Table 2).

Data Collection

The main data sources used in this study were 34 in-depth focused interviews (Merton, Fiske, & Kendall, 1990) and the corresponding fieldnotes for each interview. Demographic data were also collected from each participant at the end of the interview and analyzed using descriptive statistics. The interviews were arranged at a mutually convenient time and place. With the exception of two family interviews, which were conducted in the family home, all took place in a private office on one of the LTC units. Using a semi-structured interview guide, the researcher encouraged the participant to talk about the care provided to the resident, nurse-family negotiations regarding caregiving responsibilities, and the conditions and consequences of these negotiations. In response to open-ended questions (e.g., Can you tell me what your experiences have been in caring for X? How would you describe your relationship with the primary nurse/family member?), most participants discussed their caregiving activities and relationships easily, without further prompting. The participants were also given the opportunity to raise any other issues they wished to discuss. This approach usually prompts respondents to tell their stories and provides stretches of talk that describe social relations (McKeever, 1992). The interviews averaged 60 minutes in length and were audiotaped.

Data Analysis

As suggested by Miles and Huberman (1994), prior to interviewing a provisional list of codes was drawn up based on the research questions. The categories included types of family-nurse relationships, negotiating strategies, and factors influencing negotiations and were applied to the first set of transcripts and fieldnotes, then examined for fit. Use of this method, which is situated partway between the a priori and inductive approaches to coding, helped to create codes inductively nested in each general category. Early analysis focused on key phrases and themes that emerged from the data. As common themes emerged progressively, new codes were added, producing numerous and varied codes (Lofland &

Table 1 Nurse Demographics

Nurse (n = 17)	Sex		Nationality		Marital Status			Nursing Education		Employment Status		
	M	F	Canadian	Other	Married	Single	Divorced	Diploma	Degree	Full-time	Part-time	Job-share
	0	17	12	5	7	4	6	11	6	9	7	1

Table 2 Family Demographics

Family member (n = 17)	Sex		Nationality		Marital Status			Education			Relationship to Resident		
	M	F	Canadian	Other	Married	Single	Divorced	Primary	Secondary	Post-secondary	Wife	Son	Other
	3	14	14	3	14	2	1	1	1	9	7	12	3

Lofland, 1995). Once the codes were developed, the data were read a second time and coded independently by the senior researcher and two research assistants. Differences in coded responses were discussed until consensus was reached. These codes were inserted into the text by hand and then entered into the NUD*IST software program (Richards & Richards, 1994), which facilitated the sorting and resorting of data to locate patterns in the coding categories.

Findings

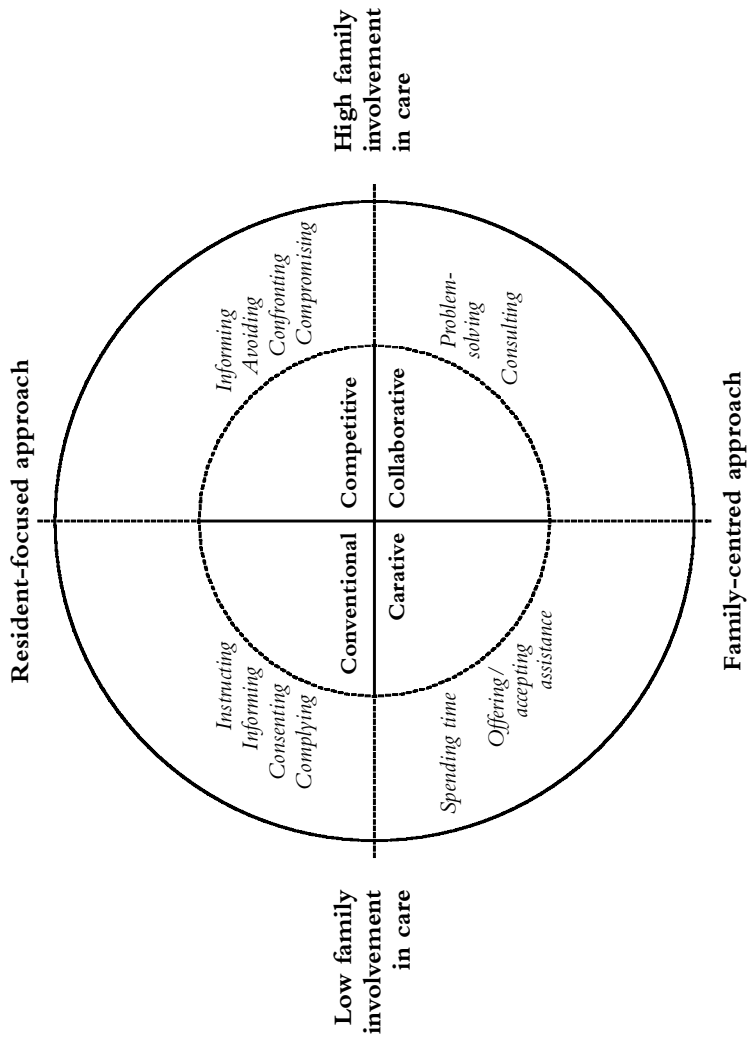
Types of Nurse-Family Relationships

Through the analytic process of coding data to locate patterns within and between dyads, four types of nurse-family relationships emerged from the data: conventional, competitive, collaborative, and “carative.” Figure 1 is a graphic representation of this typology. It is important, however, to remember that these are prototypes; in reality, the dyads often engaged in more than one type of relationship, depending on the situation. The horizontal axis represents the degree of family involvement in care, ranging from low to high. Family involvement in conventional and carative relationships is low, while families in competitive and collaborative relationships are highly involved in care. The vertical axis depicts the position of the family in an LTC setting, which is either peripheral or central. Conventional and competitive relationships reflect a “resident-focused” approach to care, where family issues and concerns are seen as peripheral. In contrast, both collaborative and carative relationships reflect a “family-centred” approach, where families and family issues are central. In the next section, the four prototypes, negotiating strategies, and resulting consequences will be described.

Conventional relationship. In the conventional relationship, the nurse was viewed as the “expert” caregiver, while the family assumed a peripheral, “visitor” role. Although many of the families had once provided intense care to the resident while living at home, their role within the LTC setting was primarily providing companionship. Consequently, in this prototype the nurse was expected, by both the family and the nurse, to assume the bulk of caregiving responsibilities. On the surface, this traditional hierarchical relationship between families and nursing staff is unproblematic. However, rigid role expectations often resulted in minimal family involvement, and therefore minimal negotiations occurred between the family and the nurse. Further, this relationship was characterized by an imbalance of power and status; the nurse in the conventional relationship often used strategies to limit the family’s input.

Families were not actively encouraged by the nurses to become involved in care. Nurses used their authority and status to address prob-

Figure 1 Types of Family-Nurse Relationships



lems affecting the resident, with minimal participation from families. As illustrated by the following comment, if input from the family was sought, it was after care decisions had already been made by the health-care team:

I gave her the care plan and said, "This is what was decided at the team meeting. Is there anything else that you think is important?" She wasn't at the conference, you know, when we talked.

In order to maintain a dominant position, the nurse used controlling strategies such as instructing and informing, which resulted in family compliance:

I always try and explain, but she [family member] does at least know what the rules are now, and the limits, and she abides by them.

In contrast, the family's strategies of consenting and complying reflected a passive response to the nurse's decisions. They rarely asked questions about the resident's care and did not question the nursing care being provided. As shown below, the family member would acknowledge that the nurse was in control of the care situation, especially at the beginning of the relationship:

When [the nurse] came in she was very up-front about what her role and responsibilities were...what she would be looking after and everything, and that's the way it is.

Since the family member in a conventional relationship usually interacted with a team of nurses rather than with one primary nurse, family members reported feeling overpowered and outnumbered. One family member made a suggestion about her husband's care but soon realized the futility of this approach:

I suggested taking him [husband] home once and they said no, so I just dropped it.

Competitive relationship. In the competitive relationship, the nurse and family member worked side-by-side in equal but competing care-giving roles. This relationship was characterized by underlying conflict. In the competitive relationship, unlike in the conventional relationship, both the nurse and the family had high role expectations of one another, in part because they were dependent on one another's care. Since the nurse relied heavily on the family to provide care, the family member was often perceived as a "necessary nuisance."

In the competitive relationship, both the nurse and the family actively engaged in strategies to gain control of the caring situation. This contrasts with the situation in the conventional relationship. Strategies used by the

nurse and the family reflected a “power over” rather than a “power with” approach, including informing, avoiding, confronting, and compromising. The nurse expended a great deal of energy attempting to keep the family in their “rightful place” within the LTC setting, while the family actively resisted being put in their place. This finding suggests that competitive relationships may lead to an over-dependence on the family, a decreasing sense of accomplishment/work satisfaction amongst nurses, and a decrease in the quality of care.

In these relationships, nurses tended to inform family members of the proper care and procedures, often demanding their compliance. In order to circumvent confrontation and ensure family compliance, some nurses aligned themselves with other health-care providers, notably physicians. One nurse explained:

Well, usually you listen to what she has to say...but then I'll still approach the doctor as a nurse... You kind of listen and then do what you were going to do anyway, and then from there put the two together...then you can go back and say, “Well, by the way, we're doing this because of this, because the doctor feels...” So you have another one to back you [up].

Nonetheless, avoidance and confrontation were common in this type of relationship. There were power struggles between the nurse and family; however, at times both parties attempted to avoid confrontation, with varying degrees of success. Usually the assertive behaviour of both parties led to covert or overt aggression, as expressed by one nurse:

Some families are very difficult to talk to and you try to avoid them. You don't mean to, you don't do it on purpose, but they kind of drive you away. When you see them, it's like there's going to be some sort of confrontation.

When a family member monitored the nursing care, there was conflict between the nurse and the family member:

She [wife of resident] is concerned sometimes... If he doesn't have his creams at the bedside or we forget to take off the sticker to do a reorder she'll voice it... So when she does call you for that you better listen because she'll make sure that someone hears about it. She won't back down!

Similarly, feelings of dissatisfaction and distrust of the nurses and the care being provided were common among family members. One family member felt the need to go behind the nurse's back to get a positive outcome. The nurse explained:

Usually what happens is that she'll call the dentist first and the dental hygienist will come up and look at them and see them and what not and she'll plan an in-service where — you know, we all know how to brush teeth... She'll go to whatever staff member is on too. She doesn't necessarily always just come to me.

As well, family members supported each other in order to increase their power base:

Some nurses have put me off and I've had to fight for one of the other ladies... I realize that the nurses are busy but I feel that there is a lack of caring there.

At other times, however, the two parties attempted to reach a compromise in order to ensure that care was not jeopardized. One nurse explained:

I think it's very important for her [family member] to feel like she's in control. She decides when...he's going to have his bath, depending on what she's doing through the week, what evenings she's here, and how much time she can spend with him. So I believe that she really has to feel that she's the guy who's in command.

Collaborative relationship. In the collaborative relationship the nurse and family member worked together towards a common goal. This non-hierarchical relationship was characterized by mutual decision-making and a high degree of family involvement in the resident's care. Unlike in the two previous prototypes, here the family's specific contribution and expertise were recognized and valued; the nurse treated the family as a full partner in care. Rather than relegating the family-nurse relationship to secondary status in the care of the resident, both nurse and family viewed it as a central component of care. Although there was some blurring of the two roles, both parties acknowledged that some overlap was necessary for the partnership to work. Ongoing overt negotiations resulted in positive outcomes for both the nurse and the family. This finding suggests that this family-centred approach to care results in family confidence in nursing care, job satisfaction amongst nurses, and increased quality of care.

In comparison to the two previous types of relationships, in the collaborative relationship the nurse and the family solved problems by consulting with one another. The words of one family member suggest that this type of relationship is built on reciprocity, respect, and trust:

There's been a lot of times we talk things over, like he'll [resident] get a reaction to something and she'll ask me if he ever had it before. So we

work together. There is none of this business of, well, I know better than you. We both share our own ideas.

Similarly, another family member explained that he and the nurse worked together to find a common solution to a problem:

I think that it is kind of a two-way street that we're on here... I mean, it's a good relationship... we're able to arrange things for Dad together.

The nurse within this dyad agreed with the family member's assessment of their relationship:

He mentioned to me not long ago that he thought his dad was having a bit more difficulty.... So together we were able to arrange physiotherapy.

The following comment reflects the essence of the collaborative relationship; the nurse and family worked together as equals, sharing their knowledge and skills:

When I explained the problem that I was having and she [the nurse] explained what she was seeing, we decided then how we were going to go about it. So it was a joint effort. To date, there hasn't been one person that says, "This is how it is going to be done."

Carative relationship. In the final type of relationship, the family was regarded as the unit of care. In other words, the nurse related to both the family member and the resident as clients in need of care. The carative relationship was characterized by a strong emotional connection between the nurse and the family member. The nurse showed genuine concern and compassion for a family member who was struggling with her/his own needs. Consequently, there were minimal expectations of the family to be involved in the care of the resident. The nurse engaged in complementary, proactive strategies such as spending time and offering assistance, while the family used passive strategies such as accepting assistance. In the words of one nurse:

I find usually I know the whole family history. So I'm not just dealing with the resident. I'm really dealing with the whole family unit.

In some situations, nurses offered assistance to family members who needed help to cope with feelings of guilt or loneliness or with the deteriorating mental or physical condition of their relative. As one family member explained:

She [the nurse] is not just looking at me as a wife and [husband] as a patient. She's looking at both of us.

Although this strong connection between nurse and family usually resulted in a positive outcome for the family, a carative relationship can have adverse effects for the nurse over time:

The wife was very alone and she would talk about that, so when she came to [the facility] she just found an ear. I was a listening ear. But there were times, and I can be honest about it...I found it draining. I was drained.

Conditioning Factors Associated with the Development of the Nurse-Family Relationship

The development of nurse-family relationships appeared to have several conditioning factors. As illustrated in Figure 2, these were both intrinsic and extrinsic.

Intrinsic factors associated with relationship development included the nurse's philosophy of care, the family's sense of obligation to provide care, family and nurse expectations of "good" nursing care, and age relations. Nurses who appeared not to value the perceptions and expertise of the family frequently found themselves in conventional or competitive relationships. In contrast, nurses who espoused a family-centred nursing philosophy usually worked within a collaborative or carative relationship. One nurse who valued family involvement commented:

If you were to come in to one of our meetings, or our rounds, we don't just treat the patient. We're treating the families as well. We're thinking a lot about the families, and they're brought into a lot of the planning.

At the same time, the family's sense of obligation and perception of nursing care influenced the development of certain types of relationships. The following comment demonstrates how a poor perception of nursing care on the part of a family member can lead to a competitive relationship in which the family provides more care than they would like:

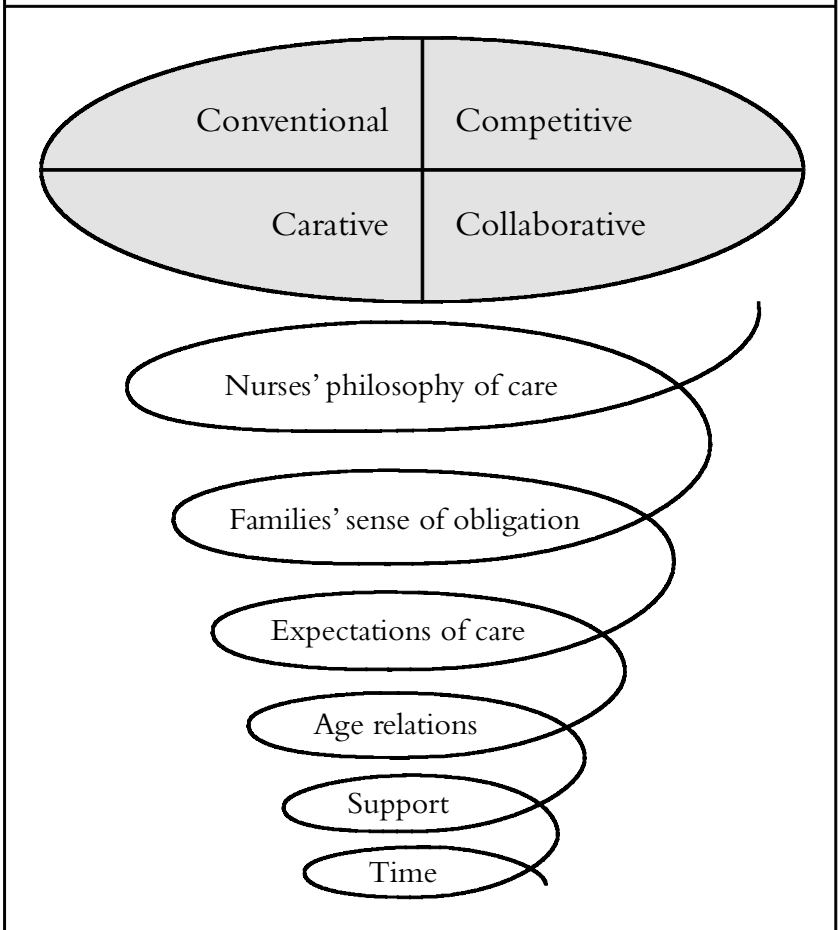
The nurses do take those short cuts. Once he got up from his nap and they didn't bother to make his bed; I had to be the one to straighten up his bed.

Poorly communicated expectations between the family and the nurse also led to conflictual relations:

It wasn't that we were neglecting him [resident]. That's what she [family member] thought... He didn't want to be up and he was in pain... She just couldn't understand that. She thought because it was Father's Day he should be up.

Two other nurses described their responses to family criticism of their nursing care:

Figure 2 *Conditioning Factors Associated with Relationship Development*



There's a lot of nitpicky issues...at times she [family member] would come across [as] rude towards us because in her eyes his needs weren't being met. And she didn't seem to understand that there's other patients too that need our attention...saying that we don't do anything right and "my husband's suffering"... That puts us on the defensive when we're being told he's being neglected, that nothing is right.

It's frustrating, when you know you're doing the best you can and he is getting good care, to always have something that is not right. Like, you never seem to get any hint of appreciation or anything like that. No pat

on the back, no saying that you're doing a wonderful job and they appreciate that you're looking after him. And it's always, you could have brushed his teeth four times that day and someone trimmed a sideburn or something too short...there's always something to offset the goodness that you've done.

Age was also associated with relationship development. In collaborative relationships the family members tended to be in the same age range as the nurse, whereas in conventional or carative relationships they tended to be older, frail women. One family member commented that being close in age to the nurse enhanced communication and trust:

I think that the nurse can talk to me and relate to me differently than maybe an older person — for example, an older woman or somebody that is closer to my husband's age.

Extrinsic factors, such as the time allotted for care and administrative and collegial support, also influenced the development of family-nurse relationships.

Family members' perceptions of how the nurses spent their time varied according to the relationship. In a competitive relationship, families were often resentful of nurses' use of their time, especially at certain times of the day, and saw nurses as allied more with one another than with the resident and the family. One family member was angry because the nurses had "left" her husband in an uncomfortable situation:

Don't ask them to do anything at 2:30...they're sitting there all having a good lot of jokes and talking, but if you're desperate — I have changed [husband's] diaper...I found that if anything happened I'd be to fault, if he was to fall when changing his diaper.

In the conventional relationship, in contrast, the family viewed the nurse as available to meet the resident's needs no matter how much time was required:

It's just unbelievable. There's no such thing as saying, "Well, we haven't time." They just seem to make time to come and do it.

It was also evident, however, that administrative and collegial support either fostered or thwarted the development of positive nurse-family relationships. One nurse found it challenging to develop collaborative relationships with families in the face of limited administrative support for this role:

That's the thing, to spend as much time as you need with them...but the time you spend talking to relatives, to families, and to problem-solve, you don't get credit [from management] for that.

Conversely, other nurses identified the type of tangible administrative and collegial support that helped them sustain a collaborative and carative relationship with families. One nurse in a carative relationship explained that support and recognition from her colleagues helped her to support the wife of a veteran who was aggressive towards other staff members:

I got along with the family member. The reward for that, from a colleague on that floor, was nods, approval, and saying, "It's great that you can get along with her."

Discussion

The findings from this study extend our knowledge of family-nurse relationships in many ways. First, the identification of four prototypes of relationships between families and nurses in LTC settings — conventional, competitive, collaborative, and carative — is a significant finding in that it recognizes the multiplicity of family-nurse relationships in these settings. These relationships vary in terms of the nature of family involvement and degree of family-centredness. Further, the development of family-nurse relationships is conditioned by certain intrinsic and extrinsic factors. The conditioning factors described in this study provide insights into the opportunities and challenges for promoting more collaborative approaches to care.

The findings suggest that two types of family-nurse relationships reflect a family-centred approach to care, one in which the family is heavily involved (collaborative) and one in which the family provides minimal care (carative), thus indicating that the nature of family involvement does not necessarily equate with the degree of family-centred care. Although in both collaborative and competitive relationships the nurse and family were heavily involved in delivering care, only the collaborative relationship reflects a family-centred approach, with the family and nurse working together, as equal partners, in planning and implementing care. The carative relationship also featured a family-centred approach to care. Families and residents were treated as co-clients because the nurse and family focused on the needs of both families and residents. The nurse in a carative relationship did not coerce or place demands on the family to provide care to the resident.

These findings are consistent with those of Guberman and Matheu (2002), who describe three conceptions of caregiver in the family-centred approach to home care: caregiver as joint client, caregiver as resource, and caregiver as partner. The first of these is similar to the carative prototype in which family members are seen as experiencing problems linked to their caregiving role and in need of professional assistance. Caregiver as partner reflects the collaborative family-nurse relationship

described in the present study. However, because of the difference in care settings, caregiver as resource — in which the responsibility for caregiving is placed mainly on the family — was not found in the present study.

The present study also identifies two types of family-nurse relationships that reflect a resident-focused approach to care, one in which the family is heavily involved (competitive) and one in which the family provides minimal care (conventional). Ward-Griffin and McKeever's (2000) co-worker prototype in home care is consistent with the competitive relationship described in this study. In these adversarial relationships, families become frustrated, since their expertise and contributions are rarely acknowledged, and families and nursing staff tend to be critical and distrustful of one another. Gladstone and Wexler (2002) describe this type of relationship in an LTC setting as "tense." Some families may be more inclined to avoid a staff member than risk conflict. In the present study, families and nurses in a competitive relationship frequently used avoidance and confrontation, which can only lead to an even more adversarial situation.

Several intrinsic and extrinsic factors appear to be associated with the type of family-nurse relationship. In the present study the nurse's philosophy of care influenced the type of relationship that was developed with the family. Also, the nurses who valued the skills and expertise of the family frequently found themselves in a collaborative relationship, while those who did not recognize nor value the knowledge and expertise of the family were often in conventional and competitive relationships. While nurses within these latter relationships generally conveyed a sense of understanding the family-centred approach, preoccupation with their status within the organizational hierarchy impeded their conscious awareness of and application of this understanding (McWilliam et al., 2001).

Intrinsic factors related to the family also played a role in developing certain types of relationships. For instance, families who felt strongly about contributing to their relative's care and who also perceived the nursing care as inadequate rarely found themselves in a collaborative relationship. Families who had years of caregiving experience tended to question procedures and policies as well as the individual nurse's knowledge and skills. Families therefore experienced many obstacles and challenges as they attempted to provide care within a hierarchical organization. It was apparent that families and nursing staff tried to influence each other's actions in order to maximize their respective interests, which resulted in a "we-they" power struggle between the parties in a competitive relationship.

The findings also suggest that certain extrinsic factors, such as time allotted to care and degree of collegial and administrative support, play a role in defining the type of relationship that will develop. As previously mentioned, data were collected from families and nurses from two units in one LTC setting. Nurses who were part of a competitive relationship rarely felt that they had enough time to spend with the family and did not feel supported by their colleagues or supervisors to do so; interestingly, this type of relationship predominated in one of the units. In contrast, nurses who were part of a collaborative or carative relationship reported the importance of administrative and collegial support.

The findings of this research provide several insights regarding the delivery of long-term care, not only to veterans with dementia, but to different populations. Since relationships in which the family is a central component of LTC appear to be beneficial for all, nurses need to reflect critically on their philosophy of care and current practices with regard to families. Any critical analysis of social relationships should consider the influence of social power. Central to this discussion is an appreciation of the types of knowledge and authority that both families and nurses bring to the relationship. Most nurses can relate to situations in which competitive relationships with families are established, and are able to differentiate these relationships from more collaborative or carative ones. By understanding the difference between “power with” and “power over” approaches, nurses will be able to develop more empowering negotiating strategies with families. Advanced practice nurses and nurse educators could play a part in this effort through educational sessions. In-service discussions that examine the intrinsic factors that shape different types of family–nurse relationships, review empowering negotiation strategies, and cite case examples can help nursing staff to develop positive relationships with families. As part of these discussions, implementation of best practice guidelines such as those published by the Registered Nurses Association of Ontario would serve to reinforce and inform changes in practice. Two sets of guidelines that would be beneficial are those relating to client-centred care (Registered Nurses Association of Ontario [RNAO], 2002a) and supporting families in care (RNAO, 2002b).

Another insight provided by this study is the importance of building relationships based on mutual respect, including respect for the knowledge and skills of both parties. In order to support families, nurses must understand that families differ in terms of their needs and desires regarding the care of their loved one. Findings from this study suggest that not all families expect, want, or feel the need to provide care and should not be coerced into doing so. On the other hand, some families wish to be active partners in care. The partnership must be flexible enough to

promote a genuine sharing of both authority and expertise (Thorne, 2002). The family's motivation and comfort level should be assessed, and the meaning of family-centred care for all involved should be explored and addressed by both families and nurses.

The findings also highlight the importance of collegial and administrative support in initiating and sustaining family-centred care. The mentorship of nursing staff leaders may help to foster family-centred practices. Changes are most effective, however, when they are initiated and supported by administrative personnel in the LTC facility in collaboration with key stakeholders (Broad, 1997). Unit managers, clinical leaders, and multidisciplinary partners both in LTC settings and in the community need to develop policies that will create and sustain a culture that values family-centred approaches to care. Measures such as ensuring that adequate time and resources are spent cultivating positive family-nurse relationships, having nursing staff document all their care transactions with families, and including family-centred care as part of staff performance reviews may all help to sustain a family-centred approach to care and to achieve genuine partnerships between families and nurses. Allocation of time for family assessments, charting, and conferences, as well as sufficient funding to ensure adequate staffing, all play a role in developing a positive family-nurse relationship. Active problem-solving between families and nurses cannot occur in a vacuum; time to discuss needs and develop mutual goals must be regularly allotted within resident assignments. As well, all must support and value the time that is required by nurses and families to build effective partnerships. Thus, the philosophy, policies, and daily practices need to convey a strong commitment to building genuine partnerships between families and nurses in LTC settings.

The limitations of this study point to some directions for future research. Using a cross-sectional design, the researchers collected data at one point in time. A longitudinal design would result in a more complete understanding of the stages and changes in family-nurse relationships over time. The study was also restricted to the perspectives of registered nurses and family members in one LTC setting. No doubt the perspectives of other types of nursing staff and families in other LTC settings would differ somewhat. While the focus of this study was the development of family-nurse relationships from both perspectives, we know little about this process from the perspective of the resident. Sampling a wider range of staff, family members, and LTC residents would be helpful. As well, the influence of the work environment, such as amount of administrative and collegial support, on the development of relationships needs to be examined more fully. Finally, this study addressed the possible influence of age relations on the development of family-nurse relationships.

Since gender, race, and class are other central features of “social hierarchies” (Bury, 1995), research examining the ways in which social power is distributed between families and nursing staff is clearly warranted.

References

- Allen, K. R., Fine, M. A., & Demo, D. H. (2000). An overview of family diversity: Controversy, questions and values. In D. Demo, K. Allen, & M. Fine (Eds.), *Handbook of family diversity* (pp. 1–14). New York: Oxford University Press.
- Bitzan, J. F., & Kruzich, B. (1990). Interpersonal relationships of nursing home residents. *Gerontologist, 30*(3), 385–390.
- Bowers, B. (1988). Family perceptions of care in a nursing home. *Gerontologist, 28*(3), 361–368.
- Broad, M. L. (Ed.). (1997). *In action: Transferring learning to the workplace*. Alexandria, VA: American Society for Training and Development.
- Bury, M. (1995). Aging, gender and sociological theory. In S. Arber & J. Ginn (Eds.), *Connecting gender and aging: A sociological approach* (pp. 15–29). Buckingham, UK: Open University Press.
- Clark, C., Corcoran, M., & Gitlin, L. (1994). An exploratory study of how occupational therapists develop therapeutic relationships with family caregivers. *American Journal of Occupational Therapy, 49*(7), 587–594.
- Cott, C. (1991). *Informal caregivers' perceptions of formal caregivers of geriatric long-stay patients*. Unpublished master's thesis, University of Toronto.
- Dellasega, C., & Nolan, M. (1997). Admission to care: Facilitating role transition amongst family carers. *Journal of Clinical Nursing, 6*(6), 443–451.
- Duncan, M., & Morgan, D. (1994). Sharing the caring: Family caregivers' views of their relationship with nursing home staff. *Gerontologist, 34*(2), 235–244.
- Fischer, L. R., & Eustis, N. N. (1994). Care at home: Family caregivers and home care workers. In E. Kahana, D. Biegel, & M. Wykle (Eds.), *Family caregiving across the lifespan* (pp. 287–311). Thousand Oaks, CA: Sage.
- Frankfather, D. (1981). Provider discretion and consumer preference in long-term care of serious disabled elderly. *Gerontologist, 21*(4), 366–373.
- Gladstone, J., & Wexler, E. (2000). A family perspective of family/staff interaction in long-term care facilities. *Geriatric Nursing, 21*, 16–19.
- Gladstone, J., & Wexler, E. (2002). Exploring the relationships between families and staff caring for residents in long-term care facilities: Family members' perspectives. *Canadian Journal on Aging, 21*(1), 39–53.
- Guberman, N., & Matheu, P. (2002). Conceptions of family caregivers: Implications for professional practice. *Canadian Journal on Aging, 21*(1), 27–37.
- Harvath, T., Archbold, P., Stewart, B., Gadow, S., Kirschling, J., Miller, L., et al. (1994). Establishing partnerships with family caregivers: Local and cosmopolitan knowledge. *Journal of Gerontological Nursing, 20*(2), 29–35.
- Hasselkus, B. (1989). The meaning of daily activity in family caregiving for the elderly. *American Journal of Occupational Therapy, 43*(10), 649–656.

- Hasselkus, B. (1992). Physician and family caregiver in the medical setting: Negotiation of care. *Journal of Aging Studies*, 6(1), 67–80.
- Hertzberg, A., & Ekman, S. L. (1996). How the relatives of elderly patients in institutional care perceive the staff. *Scandinavian Journal of Caring Sciences*, 10, 205–211.
- Hertzberg, A., & Ekman, S. L. (2000). “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*, 31(3), 614–622.
- Kaye, L. W. (1985). Home care for the aged: A fragile relationship. *Social Work*, July/August, 312–317.
- Keady, J., & Nolan, M. (1995). A stitch in time. Facilitating proactive interventions with dementia caregivers: The role of community practitioners. *Journal of Psychiatric and Mental Health Nursing*, 2, 33–40.
- Kellett, U. (1999). Transition in care: Family carers’ experience of nursing home placement. *Journal of Advanced Nursing*, 29(6), 1474–1481.
- Laitinen, P., & Isola, A. (1996). Promoting participation of informal caregivers in the hospital care of the elderly patient: Informal caregivers’ perceptions. *Journal of Advanced Nursing*, 23, 942–947.
- Lofland, J., & Lofland, L. (1995). Analyzing social settings: A guide to qualitative observation and analysis (3rd ed.). Belmont, CA: Wadsworth.
- McKeever, P. (1992). *Mothering chronically-ill, technology-dependent children: An analysis using critical theory*. Unpublished doctoral dissertation, York University.
- McKeever, P. (1994). Between women: Nurses and family caregivers. *Canadian Journal of Nursing Research*, 26(4), 15–21.
- McWilliam, C., Ward-Griffin, C., Sweetland, D., Sutherland, C., & O’Halloran, L. (2001). The experience of empowerment in in-home services delivery. *Home Health Care Services Quarterly*, 20(4), 49–71.
- Merton, R. K., Fiske, M., & Kendall, P. L. (1990). *The focus interview: A manual of problems and procedures* (2nd ed.). New York: Free Press.
- Miles, M. B., & Huberman, A. M. (1994). *An expanded sourcebook: Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.
- Nolan, M. R., & Grant, G. (1989). Addressing the needs of informal carers: A neglected area of nursing practice. *Journal of Advanced Nursing*, 14, 950–961.
- Ong, B. N. (1990). Researching needs in district nursing. *Journal of Advanced Nursing*, 16, 638–647.
- Pearlin, L. I. (1992). The careers of caregivers. *Gerontologist*, 32(5), 647.
- Pillemer, K., Hegeman, C., Albright, B., & Hendershot, C. (1998). Building bridges between families and nursing home staff: The partners in caregiving program. *Gerontologist*, 38(4), 499–503.
- Powell-Hope, G. M. (1994). Family caregivers of people with AIDS: Negotiating partnerships with professional health care providers. *Nursing Research*, 43(6), 324–330.
- Quantz, R. A. (1992). On critical ethnography (with some post modern considerations). In M. D. LeCompte, W. L. Millroy, & J. Preissle (Eds.), *Handbook of qualitative research in education* (pp. 447–505). San Diego: Academic Press.

- Registered Nurses Association of Ontario. (2002a). Best practice guidelines: Client centred care. Retrieved June 16, 2002, from the World Wide Web: <http://www.rnao.org/bestpractices>
- Registered Nurses Association of Ontario. (2002b). Best practice guidelines: Supporting and strengthening families through expected and unexpected life events. Retrieved June 16, 2002, from the World Wide Web: <http://www.rnao.org/bestpractices>
- Richards, T. J., & Richards, L. (1994). Using computers in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 445–462). Thousand Oaks, CA: Sage.
- Robinson, C. A. (1985). Parents of hospitalized chronically ill children: Competency in question. *Nursing Papers/Perspectives in Nursing*, 17(2), 59–68.
- Rosenthal, C., Marshall, V., MacPherson, A. S., & French, S. (1980). *Nurses, patients and families*. New York: Springer.
- Ross, M. M., Rosenthal, C., & Dawson, P. (1997a). Spousal caregiving in the institutional setting: Visiting. *Journal of Clinical Nursing*, 6, 472–483.
- Ross, M. M., Rosenthal, C., & Dawson, P. (1997b). Spousal caregiving in the institutional setting: Task performance. *Canadian Journal on Aging*, 16(19), 51–69.
- Ross, M. M., Rosenthal, C., & Dawson, P. (1997c). Patterns of caregiving following the institutionalization of elderly husbands. *Canadian Journal of Nursing Research*, 29, 79–98.
- Rubin, A., & Shuttlesworth, G. E. (1983). Engaging families as support resources in nursing home care: Ambiguity in the subdivision of tasks. *Gerontologist*, 23(6), 632–636.
- Sandberg, J., Lundh, U., & Nolan, M. R. (2001). Placing a spouse in a care home: The importance of keeping. *Journal of Clinical Nursing*, 10, 406–416.
- Sandberg, J., Nolan, M. R., & Lundh, U. (2001). “Entering a new world”: Empathic awareness as the key to positive family/staff relationships in care homes. *International Journal of Nursing Studies*, 39, 507–515.
- Schwartz, A., & Vogel, M. (1990). Nursing home staff and residents’ families’ role expectations. *Gerontologist*, 30(1), 49–53.
- Shuttlesworth, G., Rubin, A., & Duffy, M. (1982). Families versus institutions: Incongruent role expectations in the nursing home. *Gerontologist*, 22(2), 200–208.
- Thomas, J. (1993). *Doing critical ethnography: Qualitative research methods* (Vol. 26). Newbury Park, CA: Sage.
- Thorne, S. (2002). Health promoting interactions: Insights from the chronic illness experience. In L. E. Young & V. Hayes (Eds.), *Transforming health promotion practice: Concepts, issues and applications* (pp. 59–70). Philadelphia: F. A. Davis.
- Thorne, S., & Robinson, C. (1988). Health care relationships: The chronic illness perspective. *Research in Nursing and Health*, 11, 293–300.
- Thorne, S., & Robinson, C. (1989). Guarded alliance: Health care relationships in chronic illness. *Image: Journal of Nursing Scholarship*, 21(3), 153–157.
- Tickle, E., & Hull, K. (1995). Family members’ roles in long-term care. *Med-Surgical Nursing*, 4(4), 300–304.

- Twigg, J., & Atkin, K. (1994). *Carers perceived: Policy and practice in informal care*. Philadelphia: Open University Press.
- Ward-Griffin, C. (1998). *Negotiating the boundaries of eldercare: The relationship between nurses and family caregivers*. Unpublished doctoral dissertation, University of Toronto.
- Ward-Griffin, C. (2001). Negotiating care of frail elders: Relationships between community nurses and family caregivers. *Canadian Journal of Nursing Research*, 33(2), 63–82.
- Ward-Griffin, C., & Bol, N. (2000, May 4–5). *Relationships between nurses and family caregivers in long-term care: A pilot study*. Paper presented at Ontario Gerontological Association Conference, Toronto, Ontario.
- Ward-Griffin, C., & McKeever, P. (2000). Relationships between nurses and family caregivers: Partners in care? *Advances in Nursing Science*, 22(3), 89–103.

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