Building Bridges Between Families and Nursing Home Staff: The Partners in Caregiving Program

Karl Pillemer, PhD, Carol R. Hegeman, MS, Bonnie Albright, Charles Henderson, Nancy Morrow-Howell, ACSW, PhD
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Both nursing home staff and family members of residents ideally would benefit from good relationships and "sharing the caring," but they frequently find themselves in adversarial positions (Bowers, 1988; Duncan & Morgan, 1994; Heiselman & Noelker, 1991; Safford, 1989; Stephens, Ogrocki, & Kinney, 1991; Tobin, 1995). Although it is desirable to forge partnerships between the two groups, and to better enable them to work together to improve the residents' quality of life, few programs exist that promote such cooperation and improved communication. Further, facility policies and practices sometimes hinder staff and families from working well together.

In this article, we report on Partners in Caregiving, a model program that attempts to reduce conflict and to improve communication between staff and families in nursing homes. We begin by briefly presenting the theoretical and empirical basis for the intervention design. We then describe the objectives and major features of the intervention project, and discuss insights that emerged from the program evaluation.

Conceptual Basis of Partners in Caregiving

Theoretical work on the relationship between families and nursing homes indicates that structural barriers to cooperation between the two groups exist. In perhaps the most widely cited theoretical approach to this problem, Litwak (1985) notes fundamental differences between large-scale formal organizations and primary groups, such as families. Whereas formal organizations are characterized by bureaucratic structure, formal rules for behavior, and impersonal ties, families are based on ties of birth and love, concern for special characteristics of individuals, and a lengthy (even lifelong) period of contact. Problems result when there is a mismatch between the structure of the formal organization and the types of tasks it seeks to take over from families (Litwak, Jessop, & Moulton, 1994).

In nursing homes, the potential for conflict is height-
ened because long-term care facilities seek to take
over primary group tasks and to fit the performance
of such tasks into a bureaucratic, routinized, organiza-
tional framework (Litwak, 1985). For this reason, Litwak's perspective suggests that the nursing home is a
very appropriate location to attempt to intervene in
these processes. This view has received support from
empirical studies.

One line of research has pointed to discrepancies
between staff and family perceptions of appropriate
tasks for each group (Rubin & Shuttlesworth, 1983;
Schwartz & Vogel, 1990). Although studies vary in their
estimates of the extent of such differences, it is clear
that ambiguity regarding the division of labor be-
tween staff and relatives exists, particularly in the
performance of nontechnical tasks. As Duncan and
Morgan's (1994) work indicates, this ambiguity can
lead to conflict. In their study, family members often
felt that staff did not recognize their expertise, and
they therefore felt "ignored and invalidated." Further,
families resisted an overly rigid division of labor, in
which staff focused only on technical care. Instead,
they wished staff to share responsibility for social and
emotional tasks, as well.

In this context, conflict is likely to result from a
lack of communication. Many residents, and especially
those with cognitive impairments, are unable to give
accurate factual information about their experience
in the facility. Families are thus dependent on direct
care staff for descriptions of the resident's life in the
nursing home. Time pressures, however, often make it
difficult for staff to talk at length with families, and
differing social and cultural backgrounds can hamper
clear communication. Therefore, families find them-
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selves in a position in which they do not receive ade-
quate information about their relative and it is diffi-
cult to find someone to whom they can bring their
concerns (Dobrof & Litwak, 1981; Tobin, 1995).

Despite compelling evidence that improved coop-
eration is desired by staff and family members, and is
likely to have positive outcomes for residents, few in-
terventions have been developed to bring this about.
Most programs focus primarily on the family, offering
individual counseling or support groups for the rela-
tives of residents (Bogo, 1987; Cox & Ephross, 1989;
Hansen, Patterson, & Wilson, 1988; Sancier, 1984;
Tobin, 1995). Other programs attempt to involve family
members in their relatives' care as volunteers (Anders-
on, Hobson, Steiner, & Rodel, 1992; Linsk, Miller,
Pflaum, & Ortigara-Vick, 1988). Many facilities also
employ family councils (Hegeman & Pillemer, 1997).

These types of interventions may have limited suc-
cess for two reasons. First, they typically do not ad-
dress the need for changes in staff perspectives and
behaviors, although a number of family council pro-
grams also involve staff to some degree (for example,
by assisting in staff orientation). Second, most existing
programs do not address issues at the administrative
level, such as facility procedures and policies that in-
hbit family involvement. An important intervention
step is to engage families, staff, and administrators in
a joint discussion of facility practices that hinder co-
operation.

By addressing these issues, we anticipated that the
program would lead to positive changes in attitudes
and behaviors among both families and staff. The goal
of Partners in Caregiving is to bring about outcomes
such as improved experiences with and attitudes re-
garding the other group, increased amount and qual-
ity of communication with the other group, and de-
creased problems in face-to-face interaction, includ-
ing the amount of interpersonal conflict. We also
expected that the program would lead to changes
in institutional policies or practices regarding family
involvement. Further, it is hoped that the program will
ultimately improve residents' well-being by improving
the coordination of care between staff and family
members. However, resident-level data collection was
beyond the scope of the present study.

Program Design and Content

The design of Partners in Caregiving was based on
a model for improving relationships between families
and community institutions developed by Cochran and
Dean (1991), which has been used widely and tested
over the past decade, particularly with parents and
teachers in the school system (Dean, 1994). Approp-
riate components of this successful model were
selected and adapted for use in the nursing home.
Throughout the program development process, input
was sought from long-term care professionals.

An initial version of Partners in Caregiving was pilot
tested in a nursing home and revised accordingly. The
program was then detailed in a comprehensive train-
ing manual. This manual contains directions for facili-
tating each of the sessions, descriptions of the activities
within the training, and master copies for handouts and
overhead transparencies (the manual may be obtained
by contacting the first author).

Major Features of the Program

Partners in Caregiving consists of two parallel work-
shop series, one for nurses and nursing assistants in a
long-term care facility, and one for family members
of residents in the same facility. The staff workshop
is structured as a full in-service day. The family program
includes three 2-hour sessions, to be conducted
weekly. Because this schedule may not be appropri-
ate for all facilities, alternative scheduling options
are also provided in the manual.

The content of both the family and staff training
are summarized in Table 1. The components of the
program are arranged in an order that allows later
units to build on earlier ones. Thus, the program be-
gins with an introduction to Partners in Caregiving,
and a chance for the participants to introduce them-
2
selves. The next unit, "Sharing Successful Family-Staff
Communication Techniques," lets the group mem-
bers express some of their concerns openly, but also
focuses on positive aspects of the facility. The next
two sections, "Advanced Listening Skills" and "Saying
What You Mean Clearly and Respectfully," cover com-
munication and active listening techniques.

The following three units deal with situations in
which cooperative communication is particularly difficult in the nursing home: when there are cultural and ethnic barriers to communication, “Cultural and Ethnic Differences”; when a person is faced with direct conflict, “Handling Blame, Criticism, and Conflict”; and when values among different groups in the facility affect communication, “Understanding Differences in Values.”

The project ends with a joint session in which the staff and family participants meet together to discuss issues of concern with the facility administrator. This session is critically important, as it allows administrators to become involved, as well as providing them with a unique opportunity to learn how staff and families perceive the facility. The goal of the joint meeting is to serve as an empowering experience for all involved, and to create solidarity between staff and families. It provides an opportunity to decide on changes in facility practices or policies that may detract from family-staff cooperation.

A variety of training methods are used in Partners in Caregiving. These include (1) minilectures, where key concepts or skills are briefly presented; (2) case discussions, where participants respond to realistic examples of conflict or communication problems in the nursing home; (3) brainstorming sessions, where participants generate ideas in a free, open discussion; and (4) role plays, in which participants play the parts of staff and family members and have the opportunity to practice communication techniques.

Because of potential literacy problems, Partners in Caregiving is structured so that a person who is unable to read is nevertheless able to participate fully. All written materials are read aloud, and in written exercises, participants are always given the option of “just thinking about their answers” instead of writing them.

The lead facilitator for the training in each nursing home was a social worker employed by the facility. Two co-trainers were also selected; a nursing assistant helped facilitate the staff training and a family member helped facilitate the training for relatives. The opportunity to be trained by “one of their own” was viewed as a key part of the empowerment process for both groups. The facility teams were trained by the project investigators in how to conduct the program.

Field Test of Partners in Caregiving

Six facilities in New York state were selected for the evaluation of Partners in Caregiving. The facilities were chosen because they represented a broad range of nursing homes. The facilities were diverse in terms of size, rural/urban location, and ethnicity of both staff and residents. Five of the facilities were private, non-profit institutions and one was run by the county government.

In each facility, one unit was selected for the Partners in Caregiving program that was considered by the administration to be typical for the nursing home (for example, specialized Alzheimer’s or pediatric units were avoided). To avoid selection bias, staff and families were selected randomly from the unit to participate in the training. A total of 66 staff members and 41 family members participated, distributed almost evenly among the six facilities.

Evaluation Findings

At the close of the training sessions, participants filled out an evaluation of various aspects of the program. Further, respondents were contacted two months later and asked about the long-term effects of the program. Detailed qualitative descriptions of participants’ experiences were also obtained from 31 family members and 24 staff persons who agreed to a follow-up telephone interview. The interview included a variety of open-ended questions about satisfaction with the program and suggestions for improvement.
Both staff and family satisfaction with *Partners in Caregiving* were extremely high. Three items represented concerns we initially had regarding the program: that the nature of the topics to be covered might make participants uncomfortable; that the training might be too long; and that the material might be too complex. The responses to questions about these potential problems indicated that there were no grounds for such concerns. Virtually all participants (98% of staff and 100% of family members) felt comfortable in the training and reported that the material was not hard to understand (100% of staff and 96% of families). Although most staff members (91%) believed that the training was just the right length, nearly a third of the family members felt it was too short, which indicates that they found the training useful (such that they desired even more). When asked to provide their overall evaluation of the program, 94% of both family and staff participants rated the program as excellent or good. Among both staff and family participants, 100% felt that they could relate the training to their own experiences in the facility, and that they would recommend the training to someone else. Satisfaction remained high two months after the training had ended. The majority of both staff members (81%) and family members (55%) reported that communication with the other group had improved since the training. And at this later vantage point, all staff members, and all but one of the relatives, rated the program as helpful to them.

The results of the qualitative interviews confirm the quantitative findings on satisfaction. Most of the interviewees reported a positive experience in the program and could point to specific ways in which the training had helped them. In general, three types of benefits were noted as a result of the program.

First, many respondents reported that they had gained new understanding and insights into the other group. A typical response was: “It gave me a three-dimensional view of family members and the patients, rather than a one-sided view. It made me understand other factors. . . . It helped me to understand [families’] point of view. It makes the relationship more stable than a rocky road. It’s like pulling at a rope sometimes, seeing who is going to be stronger. But *Partners in Caregiving* helps us to both understand each other and how to work for the patient together.”

A second area in which improvement was noted was in respondents’ changed behaviors toward the other group. As one family member noted: “I see things from two sides now. For example, before *Partners in Caregiving*, if I came in and found that [my relative] is incontinent, I would have gone right to staff and demanded an explanation. Now, I will first notice that [the resident] looks nice, and remember that someone helped him to look good. I am more attuned to the efforts of those who are the caregivers.”

Many respondents reported a reduction in interpersonal conflict with the other group.

Third, respondents reported that they had observed changes in the other group, resulting from the program. A typical comment was: “I feel more like a human being to family members. They speak to us more now.” Thus, hostile perceptions of the other group and its behavior appeared to decrease.

A minority of respondents registered complaints or suggested alterations regarding one or more of the specific components of the program. However, these suggestions showed no consistent pattern, and were often contradictory. For example, although several respondents expressed discomfort with the role-playing exercises, a roughly equal number rated these exercises very highly, characterizing them as fun, amusing, interesting, and that they “fostered a sort of closeness among the group members.” Thus, complaints appeared to be idiosyncratic, and related to personal preferences and comfort levels, rather than appearing systematically in the data.

As part of the evaluation, we also attempted a small case-comparison study. Staff and family members were selected randomly from a second unit in each facility, and both the treatment and comparison groups were administered a pretest prior to the training and a posttest two months later. Unfortunately, the sample size was too small to provide definitive findings regarding outcome. However, moderate positive changes in a number of measures were observed between the pretest and posttest, including improvements in each group’s attitude toward the other. Future testing of *Partners in Caregiving* with a larger sample and a more rigorous case-control design is highly recommended.

Another indicator of the success of *Partners in Caregiving* was the concrete change that occurred in each of the facilities as a result of the joint session between families, staff, and administrators. Although these changes were generally on a small scale, they were cited by the participants as positive steps toward improved communication. Innovations included: regular meetings with family members on every unit of the nursing home; development of a family handbook; a bulletin board with staff names and pictures; improvements in the laundry system; initiation of a family council; and a monthly support group for families.

**Considerations for Replication of Partners in Caregiving**

The evaluation revealed several organizational issues that may affect the replicability of *Partners in Caregiving* at other sites. First, the cost of the program is an important consideration. The potential expense is almost entirely incurred in personnel time: specifically, the time required of the facility social worker to organize and conduct the training (approximately 30 hours) and release time for staff who attend the sessions. As the social workers developed expertise in conducting *Partners in Caregiving*, their time commitment dropped for subsequent training sessions. Incidental expenses are also incurred for photocopying of handouts and refreshments at the sessions.

Second, the evaluation indicated that support from administrators was critical to the success of the program. Two of the six pilot facilities noted problems in this area, particularly regarding the administrator’s willingness to release staff for the training program. The experience of the pilot study indicates that
administrator involvement should begin in the planning stages of Partners in Caregiving. Facilities that made administrative staff (especially administrators and directors of nursing) part of the planning team experienced greater success in conducting the program.

Finally, future evaluation efforts should examine the sustainability of Partners in Caregiving over the long term. It is encouraging to note that all of the study facilities continued the program in some form after the close of the pilot project. In several cases, components of Partners in Caregiving were incorporated into the basic or in-service training provided by the facility. Because of staff turnover and the continual entry of new family members, an appropriate long-term strategy appears to be offering the training program on a regular basis. Additional evaluation efforts are needed to determine new, and possibly less time-consuming ways, to deliver Partners in Caregiving in different institutional contexts.

References


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