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The Gerontologist
Vol. 38, No. 4, 499–503

Compelling evidence exists that conflict and communication problems occur between nursing home staff and family members of residents. However, few interventions have been documented that simultaneously address the needs of both groups. The *Partners in Caregiving* program was created to train staff and family members in communication techniques and conflict resolution skills. Through a joint meeting with facility administrators, both groups also have the opportunity to influence facility practices. Evaluation data indicated that satisfaction with the program was extremely high, and that positive changes in staff-family interactions occurred.

Key Words: Nursing homes, Family-staff relationships, Programming, Long-term care

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

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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-

This research was funded by a grant from the van Ameringen Foundation. This article was also supported by a grant from the National Institute on Aging (1 P50AG11711-01). We are grateful to Christiann Dean, Alannah Fitzgerald, Todd Landreneau, and Venus Van Ness for valuable assistance.

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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, organizational 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 between 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 themselves in a position in which they do not receive adequate information about their relative and it is difficult to find someone to whom they can bring their concerns (Dobrof & Litwak, 1981; Tobin, 1995).

Despite compelling evidence that improved cooperation is desired by staff and family members, and is likely to have positive outcomes for residents, few interventions have been developed to bring this about. Most programs focus primarily on the family, offering individual counseling or support groups for the relatives 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 (Anderson, Hobson, Steiner, & Rodel, 1992; Linsk, Miller, Pflaum, & Ortigara-Vicik, 1988). Many facilities also employ family councils (Hegeman & Pillemer, 1997).

These types of interventions may have limited success for two reasons. First, they typically do not address the need for changes in *staff* perspectives and behaviors, although a number of family council programs 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 inhibit family involvement. An important intervention step is to engage families, staff, and administrators in a joint discussion of facility practices that hinder cooperation.

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 regarding the other group, increased amount and quality of communication with the other group, and decreased problems in face-to-face interaction, including 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). Appropriate 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 training manual. This manual contains directions for facilitating 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 workshop 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 appropriate 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 begins with an introduction to *Partners in Caregiving,* and a chance for the participants to introduce themselves. The next unit, "Sharing Successful Family-Staff Communication Techniques," lets the group members 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 communication and active listening techniques.

The following three units deal with situations in

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Table 1. Summary of Components of *Partners in Caregiving*

A. *Introduction to Partners in Caregiving* (30 minutes). Provides a statement of the goals of the program and the major activities. Includes a "warm-up" introduction exercise for group members.

B. *Sharing Successful Family-Staff Communication Techniques* (45 minutes). Involves a brainstorming exercise, in which participants generate examples of things they have done to encourage communication with the other group and their greatest challenge in dealing with the other group.

C. *Advanced Listening Skills* (60 minutes). Provides training in active listening skills (e.g., encouraging others to talk, asking open-ended questions), avoiding "communication blockers" (e.g., labeling, moralizing, avoidance), and using feedback techniques. The skills are practiced in a role-playing exercise.

D. *Saying What You Mean Clearly and Respectfully* (45 minutes). Introduces and practices the concept of "I-messages," a useful communication technique, using a role-play based on participants' own experiences.

E. *Cultural and Ethnic Differences* (30 minutes). Small group discussion of cultural and ethnic differences in the nursing home and of how they can interfere with good communication, as well as brainstorming about how the communication techniques learned earlier can help in such situations.

F. *Handling Blame, Criticism, and Conflict* (60 minutes). Provides a series of seven steps for dealing with the other group in situations of open conflicts or arguments. These steps are practiced in a role-play and discussed.

G. *Understanding Differences in Values* (30 minutes). A guided exercise for exploring differences in values in the nursing home. Participants rate how important they feel various values are for families, staff, and administrators, respectively (e.g., "Residents' freedom of choice should always be respected"). Perceived differences in values, and their effects on communication and conflict, are then discussed.

H. *Planning a Joint Session for Families, Staff, and Administrators* (30 minutes). The group is asked to help plan and organize this joint meeting, and develop an agenda for it.

I. *Joint Session* (1½–2 hours). After both groups have completed the training, they meet with the administrator to discuss their concerns. A format is provided to identify issues for change, prioritize them, and plan next steps.

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, nonprofit institutions and one was run by its 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.

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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

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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.

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Received August 15, 1997
Accepted April 3, 1998

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