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A qualitative approach

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TITLE PAGE

Title of Paper:

STAFF'S PERSPECTIVES OF RELATIONSHIPS IN AGED CARE: A QUALITATIVE APPROACH

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ABSTRACT

Objective: To explore aged care staff's perceptions and experience of their relationships with co-workers, older people and families via pragmatic exploratory interviews.

Method: 39 direct care staff from 7 residential age care facilities and 12 community organisations were interviewed.

Findings: Staff felt their capacity to develop therapeutic relationships with older people and families was impeded by care tasks and concerns regarding professional boundaries. Positive relationships between staff-family and staff-staff are hindered by staff perceptions of undue care demands, high family expectations, and staff-staff conflict within a hierarchical context and between work shifts.

Conclusions: A relationship-centred approach to care as well as staff training and education should be encouraged to assist the development of therapeutic relationships and management of professional boundaries.

Key words: residential age care, community health care, qualitative research, relationships

Main text word count: 3191 words (3218 – 27 reference points).

Please note that the authors have tried their best to keep to the word limit as much as reasonably possible while making revisions in response to reviewers' comments.

INTRODUCTION

Relationships between staff, families and older people are an important determinant to successful care outcomes (1) and positive life experiences within the community of aged care (2). Older people's individualised care needs are reportedly met when families and staff work collaboratively through strong interpersonal communication and trusting relationships (3). In spite of an emphasis in the literature on building family-staff relationships (4, 5), there has been little emphasis on staff-staff relationships and the importance of team-work within aged care. Organisational culture, which includes team-work, is a key to quality care (6).

A number of key programs working towards improving care relationships have been developed in the UK. These include the Dignity in Care Program (7) and the Senses Framework (8). Improving care for older people is likely to be successful when applied in the context of a relationship-centred approach (9). At the hub of quality care is the therapeutic staff-older person

relationship. A therapeutic relationship is a purposeful, goal-oriented relationship that is based on trust, respect, empathy, professional intimacy and power; and directed at enhancing the health and well-being of the older person (10, 11).

While the above UK programs are important in care of older people, there is limited research that specifically focuses on staff-staff and staff-client-family relationships in Australian aged care services. The aim of this study was to explore the nature of relationships in aged care services from the perspective of staff. The purpose is to improve the provision of quality of care outcomes.

METHOD

Design

A pragmatic exploratory qualitative approach was used to explore staff's perceptions and experience of their relationships with co-workers, older people and families. Relationships in this sense refer to the connection or perceived connection between each or all of these groups. Human Research Ethics Committees from both the University and aged care provider approved the study.

Sample and Setting

Australian aged care can include a variety of direct or non-direct occupations. Direct care workers (i.e. skilled and qualified staff directly involved in the care of older people): registered nurses (RN), enrolled nurses (EN), personal care workers (PCW), community care workers and allied health professionals such as diversional therapists (DT) and occupational therapists (OT), were recruited from nine residential aged care facilities (RACFs) and thirteen community care branches of a not-for-profit organisation located in Southeast Queensland, Australia. Staff working in administration or ancillary workers who provide catering, cleaning, laundry, maintenance and gardening services were excluded from the study as within the participating organisation they have limited contact with families and older people due to the nature of their work.

The nine accredited RACFs, with bed numbers varying from 50 to 105, offer a range of accommodation such as single, twin share and married accommodation with rooms ranging from 8m² to 33m². They provide 24-hour nursing services in low-care, high-care, respite and secure dementia care. In community care, older people's independence at home is maintained through a range of aged care services including: nursing, cleaning services, homecare, personal care and household assistance services.

Convenience sampling was employed. Care managers distributed a research brochure, an informed consent package, demographic survey and a reply-paid envelope, to all direct care staff working in RACFs and community environments via their letterbox and/or during staff meetings. Agreement to participate in the study was implied via return of the completed survey with contact details for interviews. Staff were informed that participation was voluntarily and they were reassured that non-participation would neither involve any penalty or loss of benefits to which they might otherwise be entitled.

Data Collection

Eleven of the 50 consenting participants were excluded from the study as they were not direct care staff (n = 7) or were unavailable for interview (n = 4) due to recreational or maternity leave during the interview period. The 39 participants represented seven RACFs and twelve community care branches. Individual semi-structured interviews were conducted with the 39 consenting participants in 2011 either via telephone or in a private room at their work premises. Interviews lasted between 20 and 58 minutes and were digitally recorded. Participants were invited to talk about their perceptions of relationships (see Table 1) between:

- direct care staff
- direct care staff and clients
- direct care staff and families; and
- factors that attribute and/or impede on therapeutic relationships.

INSERT TABLE 1

A review of the emerging findings indicated that data collection had reached the point of theoretical saturation after these 39 interviews.

Data Analysis

Interview data were analysed using a thematic approach (12). Verbatim interview transcripts were first read and re-read to allow familiarisation of the dataset. A data-driven inductive technique was then applied to identify emerging patterns and where shared characteristics of the data were coded in a methodological fashion across the whole dataset. Coded data relating to similar topics were grouped into categories and subsequently reviewed to produce a thematic 'map'. Finally, informed by the analytical and theoretical ideas developed during the analysis, the emerging

themes were used to generate names for each theme. To ensure rigour and credibility of findings, interview data were independently analysed by the two researchers and discussion of the themes continued until consensus was reached.

FINDINGS

Participants were predominately female (84.6%), PCWs (61.6%) or RNs (28.2%), the majority worked day shift (61.5%) and 38.4% had a degree (see Table 2). Four themes were revealed: "*Professional Boundaries*", "*Task-Related Encumbrance*", "*Care Demands/Expectations*" and "*Discordance*". Exemplars common to participants are used to show support for the themes. Community clients and older people in RACFs are referred to as clients in this paper.

INSERT TABLE 2

Professional Boundaries

The majority of participants indicated confusion on where to draw professional boundaries. In relation to professional work relationships with co-workers (i.e. between and amongst direct care staff), these participants initially believed that forming a friendship with co-workers would make their work life more enjoyable but soon realised that was often not the case. A number of participants felt that it was counter-productive to develop friendships with co-workers and in particular outside of the work environment. They perceived that work-related dynamics might be negatively affected if problems arise with these friendships. "*If you get too familiar with people and do things outside, then if some problem comes up, then it becomes personal when you're at work*" (PCW#3). Apart from professional work relationships, enmeshment of personal and work life, such as friendships with clients or their families outside of the care context, was discouraged and regarded unfavourably by several participants. "*We are trained to not have outside relationships with them or their families. I don't want to merge and meld my work life and my home life*" (PCW#34).

On the other hand, effective care is dependent on a therapeutic staff-older person relationship. The majority of participants reported that connection with clients was integral to the quality of care provision but often impeded by the need to maintain professional boundaries. "*It's very difficult because we're told a lot of times you've got to keep boundaries. You can't touch*

anyone. You can't give them a peck on the cheek. You can't do this and you can't do that... there's a barrier. I find all these rules and regulations a little bit difficult to deal with" (PCW#35).

Another significant challenge for several participants was how to avoid placing themselves and others in a position where they may potentially be exposed to relational exploitation and/or abuse. These participants revealed incidents where they had or were aware of other co-workers who had developed what they termed an exceedingly close relationship with a client. Those who developed such relationships sometimes provided care outside their usual work hours and as a result the client and their families bestowed them with gifts. Their relationships with and care provision for other clients were on occasions adversely affected. *"I really did have a wonderful rapport with her... probably to the point where I was unethical at times... we were really like mother and granddaughter..." (PCW#6).*

Task-Related Encumbrance

Notwithstanding an aspiration to positively engage with clients, the majority of participants often had limited time to develop therapeutic relationships. Their capacity to engage in meaningful conversations was impeded by the competing need to finish their routine tasks. *"We're under-resourced and tasks we need to do can just be really full on. Really no time to talk with them or do anything else" (RN#1).* Their perception of an under-resourced environment often resulted in a workplace milieu that was task-oriented rather than one where the focus was person-centred. Specific examples in RACFs demonstrating task impeded behaviours included witnessing co-workers walking past clients without acknowledgement, pretending not to have heard clients' calling out, and ignoring call bells. These behaviours impacted unfavourably on staff-client relationships. Almost all of the participants conceded that not only were clients unappreciative of such behaviours; these behaviours eroded staff-client relationships. On a positive note, a number of participants recognised the need for a different approach to maintain a positive relationship with clients in their busy work schedule. *"I'm also guilty of brushing off the residents at times when busy. So putting myself in their shoes, I wouldn't like it. So I try to do things differently, even if its thirty seconds..., just say hi, ask about their day and not ignore them" (PCW#10).*

Care Demands/Expectations

Given the nature of their work, community staff generally had minimal contact with families of clients whereas residential staff mostly expressed good relationships with clients' families.

Nevertheless, the majority of staff from both groups reported feeling alienated when they felt that

families placed unrealistic demands and expectations on the care they provided. Numerous participants discussed feelings of stress and anxiety created by their perceptions of undue care demands and expectations that in turn adversely influenced staff-family relationships. *"When he comes in to visit his mother, you think: 'Oh, did I do this? Did I do that? Is everything looking perfect?'"* (PCW#10). Quite a few staff from RACFs suggested that families' demands and expectations might be attributed to their guilt at placing relatives into a care facility. Consequently, they perceived that families attempted to alleviate their sense of culpability by exhibiting relentless criticism and scrutiny of the care provided. *"They can be very demanding of staff like you're not looking after my parent or constantly questioning what we are doing or telling us what to do"* (PCW#35). As a result, staff exhibited poor perceptions of families and a lack of recognition for the importance of staff-family partnerships.

Discordance

Most participants reported their relationship with co-workers at the same level to be amicable and supportive. However, a few participants indicated that management were not supportive of staff-staff relationships. *"They don't talk to us so there's a lot of disagreement with management"* (RN#39). Particularly, in RACFs, tensions arose within a hierarchical context where rivalry and conflict amongst staff were ubiquitous. Some PCWs expressed their resentment towards the RNs whom they felt were overtly focused on care planning rather than showing any genuine interest or appreciation of the role of PCWs. On the other hand, several RNs were bewildered by the animosity displayed by PCWs. *"The PCWs hate the RNs. I don't know why"* (RN#18). Instead of approaching them when encountering work-related problems, RNs noticed that PCWs tended to approach the manager directly and strived to be equally competent or outshine the RNs in care provision. *"The PCWs compete to be better or who can be as good as the RN"* (RN#18).

Discordance between direct care staff from different shifts was rife. Some PCWs were unhappy about having to complete tasks they felt had been left behind by co-workers from the previous shift. Nevertheless, there were a number of PCWs who thought that staff should consider themselves to be part of a team from all shifts and with no specific division to task allocation. *"It's a 24-hour service, and if you can't get one job done, there shouldn't be a big deal about it. The next shift should just pick it up."* (PCW#13).

DISCUSSION

Participants recognised the importance and need for the development of therapeutic relationships with older people but felt that their capacity for developing such relationships was impeded by care tasks and professional boundaries. Furthermore, positive staff-family and staff-staff relationships are respectively hindered by what direct care staff perceived to be as undue care demands and expectations from families, and conflicts within a hierarchical role structure as well as between different work shifts.

Carberry (13) suggested that it may be challenging to outline the parameters of the care roles of nurses due to the lack of unadulterated clarity in the frontiers between the clinical and social facets of a patients' life. It is thus not surprising that given the therapeutic nature of work undertaken in aged care services, staff and older people can be susceptible to professional boundary violations. McGarry (14) argues that straightforward personal and professional boundaries are not achievable due to the impossible task of segregating knowledge and accounts of the older person's life from purely nursing care. In McGarry's research of community aged care, nurses and older people were found to experience close relationships or rapport through relational aspects of the care partnership as a whole rather than a greater degree of knowledge of the home situation or by the care being delivered. For example, older people and nurses respectively described each other as being akin to 'part of the family' and 'becoming' part of the patient's life. However, in our study staff were hindered by the perception that forming any sort of relationship, albeit therapeutic or professional was not something that direct care staff should partake in. Our study participants also did not raise the issue of care partnerships in their interviews.

As older people in RACFs are reliant on carers for care and often as someone to converse with, this can result in an asymmetry of power being placed on direct care staff in their interactions with older people (15). To avoid professional boundary violations, management of RACFs often introduce policies that delineate the professional relationship and the doctrines to be applied by direct care staff as well as the disciplinary sanctions in place when standards are breached (16). However, these policies can restrict staff's capacity to form therapeutic relationships. It is paramount for management to implement a well-considered professional boundary policy and professional boundaries and their influence on staff-client/resident-family relationships need to be carefully considered in training and education (10).

Trusting and supportive relationships are essential in the provision of quality of care (9, 17). As proposed by the Sense's Framework (8) a sense of security, a sense of belonging and continuity allow for the provision of quality of care. Although staff highlighted the limited time in their

schedules for relationship building they failed to recognise that time invested in establishing relationships helps to create an improved and secure environment and therefore the potential to give staff meaning, purpose and fulfilment, and quality of care for clients. Development of relationships needs not to take extensive time. Andrew (18) for example argues that all nurses must know how to make “three-minute” relationships. She suggests this requires “verbal and non-verbal skills to engage with people rapidly, to put them at ease and communicate with them, focusing all your attention on them, if only for a few minutes” (p.20).

Brown-Wilson (19-21) explored the nature and development of relationships of older people, families and staff in three UK care homes. She identified the presence of three types of relationships. She termed Pragmatic Relationship as an individualised task-centred approach; the focal of the pragmatic relationship is the practical nature of caring. This relationship is predominantly developed through communications that are directly related to the care routine rather than an understanding of its significance to the resident. Personal and Responsive Relationship is a resident-focused approach where central is an awareness of the resident as a unique person. This form of relationship is developed through communications that involve social conversations with residents and their families to gain an understanding of what is important and significant to residents. Reciprocal Relationship is based on a relationship-centred approach; pivotal to this relationship are negotiation and compromise where the needs of residents, families and staff are taken into consideration within the context of a trusting relationship.

The omnipresent of *pragmatic relationships*, focusing on the practical nature of caring and developed through communications that are directly related to the care routine (22), are reflected in the current study. Participating staff adopted a task-oriented approach to care and task completion overrode their desire for development of therapeutic relationships. This finding is supported by other research that found the psychosocial or emotional needs of clients are not acknowledged or allowed to hinder staff members' ability to complete their allocated tasks (23, 24). However, relationships between older people, staff and families can evolve over time if staff are educated and trained to work within a relationship-centred model.

This research provides an Australian perspective of care relationships. It reaffirms that relationships in aged care are largely influenced by interaction and communication between staff, older people and families in relation to everyday care routine (17). Valuing daily care routine is a useful starting point in supporting the development of positive relationships (21). Care providers should consider implementing programs such as the *Relationship-Enhancing Program of Care* (25)

that offer a promising effect on improving relational skills of direct care staff working with older people in RACFs.

Staff from RACFs suggested that what they perceived as superfluous care demands and expectations from residents' families might be attributed to their attempts in assuaging feelings of guilt. Transition into RACFs has been known to have a negative effect on the relationship between older people and their families as they adjust to the change in environment and role (5, 26). Further research is needed to explore the influence of RACF transition on staff relationships with older people and their families.

Lastly, participants consistently reported discordance within a hierarchical context and between different work shifts. Problematic relationships with co-workers can be a downside to the work environment (27, 28). Negative staff interactions are widely documented as an issue in aged care literature and can result in an adverse impact on staff retention and care practices (29). It is imperative that management encourage and facilitate communication between staff and across shifts in order to foster positive work relationships. To date, the development of positive relationships has been the primary focus in the literature (19-21, 30). However, unsurprisingly, negative and positive interactions do co-exist and can frequently occur. Thus, it is also important to determine how tensions resulting from negative interactions can be managed to promote positive interactions that lead to constructive relationships.

Generalisability of the research findings may be limited by participation of staff from one organisation and the presuppositions of the researchers relating to the relational perceptions and experience of participating care staff.

CONCLUSIONS

A sense of connectedness and community within the aged care environment remains central to the provision of quality of care. The complexity of staff-older person relationships and the blurring of boundaries in care provision appear to be common. A relationship-centred care model, care routines and professional boundaries that support therapeutic relationships; as well as constructive partnerships between staff and families should be encouraged to enhance overall health and well-being of the older person. Staff training and education may be used to enhance relationship building.

Key Points (*Essential take home messages*)

- Direct care staff were concerned and confused by staff-client professional boundaries

- Direct care staff perceived they had limited time to engage in therapeutic relationships with clients
- A relationship-centred model may support therapeutic staff-older person and staff-family relationships.

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Table 1. Examples of Interview Questions

- How would you describe the relationship ... in aged care?
- How would you describe your relationship with ... in aged care whom you work with / care for?
- Please describe to me any present or past constructive/challenging relationships you have or had with ... whom you work with / care for?
- Please tell me the factors that you think improve and/or support the relationship ... in aged care.
- Please tell me the factors that you think damage the relationship ... in aged care.

Table 2. Characteristics of participants (n = 39)

	Community Care % (n = 21)	Residential Care % (n = 18)	Total % (n = 39)
Age⁺ (ranging from 25 to 65 years of age)	49.8	47.2	48.6
Gender:			
Female	81.0	88.9	84.6
Male	19.0	11.1	15.4
Level of Education:			
Year 10	9.5	11.1	10.3
Year 12	19.0	-	10.3
Certificate/Hospital Trained RN	-	16.7	7.7
TAFE Certificate	19.0	38.9	28.2
TAFE Diploma	4.8	5.6	5.1
Bachelor Degree or Higher	47.6	27.9	38.4
Profession:			
Diversional Therapist	-	5.6	2.6
Occupational Therapist	4.8	-	2.6
Registered Nurse	19.0	38.9	28.2
Enrolled Nurse	4.8	5.6	5.1
Personal Care Workers	71.4	50.0	61.6

Employment Roster:

Day Shift	90.5	27.8	61.5
Both Day & Night Shifts	-	5.6	2.6
Both Day & Weekend Shifts	9.5	38.9	23.1
Both Night & Weekend Shifts	-	16.7	7.7
All Shifts	-	11.1	5.1

⁺ *Reported in mean years*