

Family Involvement in the Nursing Home: Family-Oriented Practices and Staff-Family Relationships

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Abstract: Staff-family cooperation in caring for elders in nursing homes is recommended but poorly understood. Family involvement and staff-family interactions in nursing homes with differing family orientations were investigated. Friedemann's (1995) system-based family theory guided the study. Of all 208 licensed nursing homes in southern Michigan, 143 completed a survey about their family-oriented practices. Family orientation was ranked accordingly. Twenty-four nursing homes were randomly selected to conduct semistructured telephone interviews with 177 family members. Data were analyzed by thematic interpretation. Findings showed a wide range of involvement patterns that promoted family connectedness, maintenance of control, growth, and learning. Families desired various types of staff cooperation and were given such opportunities in homes with high family orientation. © 1997 John Wiley & Sons, Inc. *Res Nurs Health* 20: 527-537, 1997

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Institutionalization of a family member represents a significant, often traumatic, event in the history of families (S.H. Zarit & Whitlatch, 1992). Most families resort to institutionalization when they can no longer meet the demands of caregiving. Passing on their responsibilities for the physical care of their family member to the nursing home staff does not, however, relieve their sense of burden (Colerick & George, 1986; Townsend, 1990; Vinton & Mazza, 1994; S.H. Zarit, Todd, &

J.M. Zarit, 1986). Instead, there seems to be a shift in the nature of burden as families attend to their loved one's diverse needs in new ways (George, 1984; Spark & Brody, 1970), try to overcome guilt, and attempt to define how they can be involved with the institution (S.H. Zarit & Whitlatch, 1992). Bowers (1988) observed considerable role ambiguity in family members in nursing homes, and the findings of other investigators suggested that such ambiguity may be prompted by

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institutional factors and communication problems with staff (Stephens, Bridges, Ogrocki, Kinney, & Norris, 1988).

Because little is known about the interactive process of families with staff in becoming actively involved in the formal system of a nursing home, the purpose of this study was to investigate family involvement patterns, staff–family interactions, and nursing home factors that families perceive as helpful or inhibiting. Furthermore, from the perspective of the nursing home, family policies and practices were explored and differences in family involvement were examined in relation to such policies.

The study was guided by the framework of systemic organization (Friedemann, 1995). This conceptual framework for family nursing draws upon principles derived from systems theory (von Bertalanffy, 1968) and social ecology relative to family systems (Bronfenbrenner, 1977). From this perspective, patterns of families are greatly diverse, in that each family strives toward the four targets of stability, growth, control, and connectedness in a unique fashion (Friedemann, 1995). Stability signifies the maintenance of existing family structure and behavior patterns. Growth is achieved through adjustment of family processes to change from within the family or the environment. Control is defined as acceptance, rejection, or channeling of information and resources. Connectedness is achieved by attuning the family system to its environment. Each family develops a basic pattern of functioning relative to the way it emphasizes and balances the four targets (Friedemann, 1995).

In this study, families were defined as extended families with distinct relationship patterns. Elders were seen as family members with an acknowledged family role and as contributing to the overall family pattern, whether or not they lived in their caregivers' household before institutionalization. According to Friedemann (1995), the overall family pattern is relatively stable in that each family tends to employ behavior strategies in keeping with it when faced with difficult situations (Kantor & Lehr, 1975).

This suggests that families expand their boundaries to include the nursing home. With that, the nursing home's policies, practices, and care patterns become components of the family environment, and the caregiving staff, necessarily, have to be added as "family members" and integrated in the family process. In the ideal case, the nursing home is supportive to families by offering a wide range of activities addressing needs that pertain to the four family targets. Likewise, nursing home

staff are aware of their added roles as "members" of multiple families, each one having its own expectations about the role of the staff in their system. The nursing home's family orientation and the staff's ability to form relationships with families are, therefore, essential factors in the initial adjustment process and will determine outcomes such as family involvement and satisfaction.

Unfortunately, the process of integrating families in the institutional routine is often problematic (Schwartz & Vogel, 1990). It runs contrary to families' desire to integrate the nursing home into their family routine, and the family's preestablished pattern is threatened. For example, investigators found that families were forced to modify their usual caregiving patterns, adopt new activities, and integrate them with the caregiving patterns of the nursing home staff (Cantor, 1991; Duncan & Morgan, 1994). If families were unsuccessful, Neubauer, LeSage, and Roberts (1989) found that nursing home staff communicated poorly and often avoided contact with them.

The process of establishing relations with staff seems to be a difficult challenge. Families who wanted to contribute to the physical care of their loved one reported that staff viewed them as interfering with their planned care (George & Maddox, 1989); families who suggested improvements in care patterns or routines found that their suggestions were perceived as criticism by insecure staff (Schwartz & Vogel, 1990). Ironically, however, if families opted to visit infrequently, they ran the risk of being labeled lazy and uncaring (Kane, 1985).

To date, involvement of families in the nursing home is still insufficiently studied. Among those who have examined this issue, Montgomery (1980, 1982), in her early work, found that involving the families as team members in organizing and providing care for the residents led to optimal relations with staff. Cantor (1991) recommended cooperative interactions and negotiation of approaches to care. Furthermore, Bowers (1988) explored the perspective of the families who described their involvement by its purpose as a family function rather than by the nature of the tasks. For example, many families worked hard to preserve the residents' dignity and expected the staff to be sensitive to the needs of the residents. Bower's findings are in line with the theory underlying this study: Family–staff cooperation involves the empowerment of families to extend their family to the nursing home by pursuing stability and growth, connectedness, or control in their own unique way.

To gain a better understanding of the families' varying expectations for involvement in the nursing home and the ways the nursing home can facilitate such involvement, the following questions were addressed:

1. What family-oriented policies and practices do nursing homes have?
2. How do families describe the strengths and problems of the nursing home and its staff?
3. How do families describe their involvement in the nursing home?
4. How does the families' involvement in the nursing home differ relative to family policies and practices?

METHOD

The design involved two parts: (a) a nursing home survey of family-oriented policies and practices to explore the nursing home perspective, and (b) an exploration of the family perspective with semi-structured interviews of family members.

Sample

A three-stage sampling design was used for this study. First, all 208 nursing homes in the Detroit metropolitan area and 24 additional counties in southern Michigan were asked to participate in a survey of family-oriented policies and practices. To assure a minimal standard of quality, only nursing homes with Medicare or Medicaid licenses were included. Next, 24 nursing homes were selected at random. Finally, all family members of residents admitted to these 24 homes over a 22-month period were invited to a telephone interview.

Survey of nursing homes. The questionnaire consisted of 20 items constructed for this study. This list of possible family activities in the nursing home was based on Montgomery's (1980, 1982) study according to which family activities pertained to three categories: *team member* functions (participating in care conferences, communicating with staff, etc.); functions as a *servant* to staff (assisting with patient care, seeking instructions, etc.); and *visitor/entertainer* activities. Based on developments in some nursing homes to offer families opportunities to learn and give input about the quality of care, a fourth dimension was added, *learner/patient advocate* activities. To assure content validity, the list of 20 items was presented at a meeting of about 30 nursing home administrators who affirmed that each activity was

offered in at least some homes and judged the list complete.

The questionnaires were sent to the directors of nursing accompanied by a letter of recommendation for the study from the appropriate state nursing home association (either the for-profit or the not-for-profit association). Directors of nursing were asked to indicate the availability of each activity on a 3-point scale from 3 (*activity encouraged*) to 2 (*activity available at request only or not encouraged*) to 1 (*activity not available*). After one reminder, a total of 143 (69%) questionnaires were returned. They represented a mix of large and small, for-profit and not-for-profit homes in proportions similar to those of all homes in the area. Of the 143 nursing homes surveyed, the average size was 121 beds (range = 22–307 beds).

Sampling of the nursing homes. The next task was to sample nursing homes that had the greatest possible variation in family-oriented practices. To explore which variables differentiated the homes and which multiple indicators of family-oriented practices could serve as single measures, a factor analysis was conducted on the 20 items, using Varimax orthogonal rotation. A four-factor structure emerged with the first factor explaining 26.4% of the variance. The factor had seven items expressing learner, family support, and consulting activities and had an internal consistency of .81 (see Table 1). The other three factors had insufficient reliability. As the learner/support/consulting activities varied most among nursing homes, a scale was constructed by adding the seven scores. This composite indicator, with a range of scores from 7 to 21, served as the primary basis for dividing nursing homes along a continuum of availability of family-oriented activities and for sample selection. First, the scores on the composite indicator for the 143 homes were divided into quartiles holding similar numbers of nursing homes. This resulted in 34 homes that ranged in scores from 7 to 11 in the first quartile, and 35 homes ranging from 12 to 14, 40 homes ranging from 15 to 17, and 34 homes ranging from 18 to 21 in the subsequent quartiles. Each home then was assigned a rank corresponding to the quartile in which its composite score was located.

Next, to determine whether certain single items were distributed differently than the learner/support/consulting composite and, therefore, needed to be included in the sampling procedure, cross-tabulations were done. Five single items expressing staff–family teamwork and visiting activities had distinctly different distributions. Although their scores were consistently high with little variance in the homes falling into the upper two quar-

Table 1. Learner/Family Support/Consulting Factor

Item	Factor Loading	Cronbach's Alpha
Family group to help solve nursing home problems	.72	
Instruction in patient care for families	.66	
Classes to learn about chronic illness, etc.	.61	
Support groups for families	.59	
Advisory board open to family members	.54	
Educational materials for families to borrow	.51	
Education about nursing home programs	.44	.81

tiles of the composite, in homes in the lower two quartiles the single-item scores varied greatly. Hence, 7 homes were sampled from each of the lower two quartiles compared to only 5 from each of the upper two.

Sampling of family members. The participants were recruited with the help of the admissions directors. Family members (one per resident) were qualified for inclusion if they lived within 1 hr of the nursing home. To rule out a preestablished pattern of family involvement in a nursing home that could influence the family's present involvement, the resident had to be institutionalized for the first time. Finally, the resident's stay in the present nursing home had to be at least 3 weeks. This time frame was considered a period of adjustment during which families could develop a stable pattern of activities in the nursing home. Spouses were excluded because their needs and involvement in the nursing home had been shown to be distinctly different from other family members' needs (Montgomery & Kosloski, 1994). Furthermore, they constitute only a small proportion of the family members involved with residents (National Center for Health Statistics, 1979). A total of 177 family members agreed to provide information for this study. Of these, 51 were involved with nursing homes ranked lowest in availability of family activities; 49, 29, and 48 family members were involved with homes of the other ranks, in ascending order.

The participants' age ranged from 24 to 79, with an average of 53 years. The majority were women (76%) and adult children (69%). Other relationships in the order of relative frequency were nieces/nephews, stepchildren, daughters-in-law, grandchildren, siblings, and friends who were considered "family." Most participants were White (86%), 13% were African American, and 1% belonged to other ethnic groups. The family income covered a wide range, with 13% earning less than \$20,000, 50% between \$20,001 and \$50,000, and 37% over \$50,000. Most of these family members

(78%) had been involved in prior caregiving for 1 to 15 years or longer.

Procedures

The collection of nursing home data occurred with the survey described earlier. Interviews with family members were conducted by telephone. The interviewing team consisted of two graduate students in psychiatric nursing and a college graduate with extensive business experience in public relations. They were trained by the principal investigator in qualitative interviewing techniques, family issues around institutionalization of an elder, listening, and recording of data. Next, they practiced interviewing, first with each other, then by telephone with a person they knew, and finally, they interviewed two participants while the principal investigator listened and participated if necessary.

The interviews took between 20 min and 1 hr. The interviewing style was minimally directive, supported by reflective and confirming communication techniques; participants were allowed to pursue the topic any way they chose. The interviewers presented themselves as learners whose aim was to understand the families' experiences as fully as possible. Highly general questions were posed. The leading questions involved (a) what type of things the participants usually did in the nursing home; (b) what helped them in doing what they wanted to do; and (c) what hindered their involvement. With the tendency of respondents to describe primarily staff relations, the questions were purposefully kept broad to allow also for inclusion of other positive or negative factors in the nursing home.

This study was approved by the Wayne State University Internal Review Board and strict confidentiality was maintained. Because permission for audiotaping was not given by the nursing homes due to confidentiality concerns, the interviewers made detailed notes, including relevant direct

quotes, during their conversation. They read their notes back to the respondents to verify accuracy.

Analysis

The interview data were analyzed by using a qualitative approach to content analysis as described by Morgan (1993). This method combines naturalistic inquiry (Lincoln & Guba, 1985) with techniques of content analysis. First, the data were broken down into units (words and phrases used to describe certain types of involvement, staff actions, or nursing home conditions). These were copied onto separate pages and coded with the informant number. Next, the notes were sorted according to content relatedness in order to generate categories. Whereas the major dimensions were provided by the research questions (type of family activities, strengths and problems of staff and nursing home), the categories pertaining to strengths and problems were extracted from the data. The conceptual framework was used as a template for categorizing nursing home activities. The themes extracted from the data were evaluated for congruence with the theoretical targets of stability, connectedness, control, and growth, and

organized in these categories. Most activities fit the categories; however, there was a need for an additional category, "taking a break," for participants who did not want to be involved in the nursing home beyond occasional visiting. In addition to describing the responses qualitatively, the modified content analysis included the counting of occurrences of responses pertaining to the defined categories (Tesch, 1990). This technique allowed an easy comparison between responses of participants from nursing homes ranked highest in family orientation ($n = 48$) with those ranked lowest ($n = 51$); the qualitative data and the conceptual framework were used to interpret such differences (Morgan, 1993).

RESULTS

Nursing Home Data

Activities available to families in the nursing homes are listed in Table 2, with the activities most frequently encouraged by the nursing homes entered first. Even though a considerable number of opportunities was available, variation existed in

Table 2. Family Opportunities in Nursing Homes

Opportunities	Percentage of Nursing Homes		
	Encouraged	Available upon Request, but Not Encouraged	Not Available
Staff calling family for advice with resident problems	87	9	4
Personal invitations to family activities	82	12	6
Permission to call unit day or night	80	19	1
Meetings to plan care	73	25	2
One-to-one counseling for family members	65	29	6
Assignment of staff contact person	65	21	14
Education about nursing home programs	64	25	11
Use of a room for family privacy	60	31	9
Volunteer organization	57	16	27
Family council	55	14	31
Guest meals	54	41	5
Hands-on care by families	52	41	7
Support groups for families	48	15	37
Instruction in patient care for families	37	50	13
Family group to help solve nursing home problems	36	18	46
24 hr visiting	36	58	7
Educational materials for families to borrow	28	51	21
Advisory board open to family members	26	21	53
Classes to learn about chronic illness, etc.	25	15	60
Transportation for family to the nursing home	1	21	78

the extent of encouragement of these activities. Most often encouraged were staff calling the family for advice with resident problems, personally inviting families to recreational activities, and the family calling the unit throughout the night. Hands-on care, guest meals, instruction in patient care for families, and 24-hr visiting were available in over 85% of the homes, but were not encouraged by 41 to 58% of the nursing homes. Opportunities least available were transportation for family members, classes to learn about chronic illness and the like, and advisory board open to family members. These activities were unavailable in more than 50% of the nursing homes, and family groups to help solve nursing home problems, support groups for families, family councils, and volunteer organizations were unavailable in 27 to 46% of the homes.

Family Data

Nursing home problems. The problems cited by the respondents in all 24 nursing homes are shown in Table 3. This section refers to the first two columns only. Themes that emerged from the interviews and the categories of problems pertaining to each theme are listed. Frequencies indicated in Table 3 are counts of statements made within each problem category; the percentage column indicates the percentage of all problem statements pertaining to each category. Problems were cited by 63% of the families, and each family described an average of 2.7 problems.

Most frequently, resident care problems concerned the dignity (identity) of the patient in that staff did not view residents as persons with rights, and did not assist them sufficiently with activities essential in maintaining their unique personality or identity. Families also found problems with staff not recognizing the residents' special needs:

My mother was walking, but now she does not. She could regain the ability, but staff have to initiate the walking. She won't do it on her own.

The second group of patient care problems concerned safety. The problems occurred less frequently but were more strongly felt, and were, at times, backed up with reports of blatant negligence:

Mother has trouble swallowing and gets a soft diet. I found her with a sandwich in her mouth and nobody there to help—she could have choked to death. I need to check on her all the time and I'm scared to leave her alone.

As the data in Table 3 show, however, family in-

teraction problems were cited more frequently than any others. The problems were related to two themes: problems with affirmation and problems with cooperation. Families expected to be heard, respected, and affirmed. Instead, many cited problems leading to a perception of being ignored, treated without sensitivity or respect for their concerns:

Here, I have taken care of Mother for 10 years and they send me out of the room when they make the bed, or something. This bothers me. And they could be friendlier and smile a little more.

Families also wished for a cooperative relationship with the nurse aides, which included open communication, mutual informing, guidance about how to help, and encouragement to be involved. Problems arose if the expectations were not met:

The staff should abide by our wish to get her involved in church services and communion. They won't let us get her up and ready either. It would make things easier for all of us. Staff should ask us to help and encourage us to be involved. We feel we are in the way and nobody tells us what we can do.

The last theme, problems related to the nursing home facility, involved complaints about space, privacy, or cleanliness, the control of confused patients, and loss of belongings. Staffing problems often were mentioned by families who excused nurse aides for not giving optimal care:

Residents are treated too rough. But, you know, they (aides) are underpaid for the hard work they do. Some homes are only in it for the money.

In contrast, families were less forgiving if staff complained about their own problems to each other and discussed them in the presence of the family, instead of paying attention to the resident.

Strengths of staff. In spite of the large number of problems cited, family members pointed out many strengths of the staff and the nursing home. An average of 1.7 positive comments were made per participant and 68% of the respondents made such statements. The categories of strengths, the frequencies of statements made, and the percentage of all positive statements pertaining to the various categories are shown in Table 4. As with the problems, citations of strengths referred to the themes of resident care and family-staff interactions.

Family members were keen observers of the kind of care given to the residents, and the trust they had in the staff was the basis for their comfort in the nursing home. Nevertheless, most positive statements were global, such as "good care" or "excellent care," but specific examples of what

Table 3. Problems in the Nursing Home

Problem	All Homes		Least Family Oriented		Most Family Oriented	
	<i>f</i> ^a	% ^b	<i>f</i> ^a	<i>f</i> _{prop} ^c	<i>f</i> ^a	<i>f</i> _{prop} ^c
Resident care						
Lack of patient identity						
Overlook special needs	32	11	12	23.5	8	16.7
Impersonal care/no compassion	9	3	3	5.9	0	0.0
Lack of personal safety for patient						
Patient neglect/abuse	13	4	9	17.6	0	0.0
Staff incompetency/carelessness	10	3	6	11.8	0	0.0
Family interaction						
Affirmation problems						
Overlook family needs/take control	21	7	8	15.7	3	6.3
Exclude family from decision making	24	8	8	15.7	4	8.3
Unfriendly manner of staff	14	5	5	9.8	3	6.3
No reassurance/feedback from staff	19	6	6	11.8	4	8.3
Cooperation problems						
Communication	37	12	11	21.6	9	18.8
No encouragement or instruction for involvement	15	5	4	7.8	4	8.3
No education/information	8	3	3	5.9	2	4.2
Nursing home factors						
Environmental						
Space, appearance, privacy, cleanliness, room assignments, wandering, theft	40	13	9	17.6	6	12.5
Scheduling/lack of activities	23	8	3	5.9	5	10.4
Unreasonable rules	13	4	4	7.8	2	4.2
Staffing						
Overworked/unhappy staff	13	4	9	17.6	1	2.1
Physician access	8	3	3	5.9	1	2.1
Staff turnover	3	1	1	2.0	1	2.1

^aCounts of statements made in each category. ^bPercentage of all problem statements pertaining to each category. ^cProportional frequency relative to a sample size of 100.

was good about the care were relatively infrequent. One example:

They are very friendly and give excellent care. They are trying to get my mother involved in more activities to keep her mentally and physically active. That makes her feel good about the care she is given.

Along the theme of affirmation, most praise referred to positive verbal and nonverbal responses by the staff. Confirming the findings of Bowers (1988), strengths often were described indirectly, in terms of emotional impact. Thus, 22% of the statements referred to global ratings as “great” or “wonderful” when families felt their affection was mutual. A lesser number (12 comments or 6% of all statements) referred to staff making families feel at home in the nursing home.

Similar trends were seen with statements about

cooperation. If their expectations for staff cooperation in caring were met, families responded with great praise. Global evaluations of staff as “being helpful” occurred in 26% of the statements; the other categories less frequently cited referred to specific actions that made the families’ involvement easier:

They are very helpful and caring. They do everything to please my mother. Because of the wonderful care my mother is getting, she has changed from a nasty and hard-to-get-along-with woman to being very sweet and kind.

Of the positive family interactions cited, 16% referred to situations in which staff took the lead in involving the family, informing the family, and modeling/teaching, whereas 13% of the statements were examples of staff allowing the family to give

Table 4. Strengths of Staff

Strengths	All Homes		Least Family Oriented		Most Family Oriented	
	f^a	$\%^b$	f^a	f_{prop}^c	f^a	f_{prop}^c
Resident care						
Competency						
Good/excellent care	26	14	2	3.9	12	25.0
Resident interaction						
Involving the resident	4	2	1	2.0	2	4.2
Being caring	2	1	0	0.0	0	0.0
Family interactions						
Affirmation						
Mutual liking	42	22	11	21.6	6	12.5
Making family feel at home	12	6	2	3.9	5	10.4
Cooperation						
Being helpful	50	26	17	33.3	17	18.8
Involving the family	15	8	5	9.8	5	8.3
Cooperating in problem solving	14	7	1	2.0	9	18.8
Informing family	12	6	3	5.9	4	8.3
Taking family seriously	11	6	2	3.9	2	4.2
Modeling/teaching	3	2	2	3.9	1	2.1

^aCounts of statements made in each category. ^bPercentage of all positive statements pertaining to each category. ^cProportional frequency relative to a sample size of 100.

them direction in the care (e.g., cooperating in problem solving and taking family seriously):

I am like a student in the nursing home experience. Staff answer questions for me and we work together to develop a routine. It has been quite successful. I have been looking out for things they may not be doing right but, so far, I haven't found any.

I want to plan weekend activities for working family members so they can participate in the nursing home, like reading to the residents. The nurses like my ideas. This home has a warm environment that makes you want to be involved.

The last quotation is an example of family-driven care. Often, such activities included other patients or family members and required family leadership and the flexibility of staff and institution to accept it.

Family activities. The family activities are listed in Table 5. Prominent themes were organized under the theoretical categories of family functioning (Friedemann, 1995). The majority (63%) of the activities seemed to target maintenance of family stability and connectedness. As projected by the conceptual framework, these family processes were transferred to the nursing home as families maintained their emotional bond through visits with the resident and regular updates about family events and, sometimes, through

continuing preestablished caregiving activities. These activities referred to the targets of stability and connectedness. Another group of activities involved the target of growth. In the case of these residents, rather than growth and development, the aim was the maintenance of personality and dignity and the prevention of rapid decline. Even though most families felt that the staff should be concerned about entertainment and stimulation of the residents, many took it upon themselves to accompany their relatives to scheduled activities, engage them in other types of activities, or cheer them up in various ways.

The last category of activities referred to the target of control or the maintenance of control of the caregiving situation. Most referred to the protection of their relative, patient advocacy, or actions in compensation for deficient care. At the time of this interview most families had relaxed their initial vigilance. Nevertheless, 24% of the families described activities of standing up for the residents' rights and giving care the staff had neglected as involvement in which they would rather not engage. Only two families seemed to want their overall role to be controlling by getting the staff to follow their care plans. This indicated that most families desired to share power with the staff or to leave the control to the nursing home.

Table 5. Family Activities in the Nursing Home

Purpose/Activity	All Homes		Least Family Oriented		Most Family Oriented	
	f^a	% ^b	f^a	f_{prop}^c	f^a	f_{prop}^c
Maintain stability						
Assistive care	42	12	9	17.6	11	12.5
Treats and objects	21	6	8	15.7	5	10.4
Physical care	19	5	5	9.8	7	8.3
Cooperative planning	13	4	0	0.0	7	8.3
Maintain connectedness						
Social/emotional care	127	36	27	52.9	35	72.9
Maintain control						
Protective care	34	9	14	27.5	5	10.4
Compensatory care	14	4	7	13.7	1	2.1
Patient advocacy	4	1	3	5.9	0	0.0
Supervisory care	2	1	0	0.0	1	2.1
Maintain dignity/promote growth						
Activities/diversions	31	9	7	13.7	9	18.8
Entertain/stimulation	31	9	8	15.7	12	25.0
Take a break						
Little involvement	15	4	3	5.9	6	12.5

^aCounts of statements made in each category. ^bPercentage of all family activity statements pertaining to each category. ^cProportional frequency relative to a sample size of 100.

Fifteen families were no longer willing to be involved to a great extent. The majority of them had cited family problems as their major concern. In concert with the conceptual framework, this phenomenon can be seen as another way of promoting family growth, in that withdrawal from caregiving may present a change necessary to maintain or reestablish family and/or individual health (Friedemann, 1995).

Differences between nursing homes ranked highest and lowest in family orientation. The results of the comparison of family responses derived from nursing homes ranked lowest in family orientation ($n = 51$) with those ranked highest ($n = 48$) also are shown in Tables 3, 4, and 5. To adjust for the difference in sample size and allow comparison, the second column pertaining to each group of nursing homes express proportional frequencies relative to a sample size of 100. Overall, the comparison showed that the care given by staff was of greatest concern to families from lowest ranked nursing homes, whereas families from homes ranked highest in family orientation tended to be more relaxed about it.

The category of personal safety for the patients only applied to nursing homes of lowest family orientation (see Table 3). Examples of blatant pa-

tient neglect, staff carelessness, and incompetency comprised 15% of the problems described in those homes. Furthermore, families of lowest ranked nursing homes voiced an average of 2.2 problems, whereas families of highest ranked nursing homes mentioned only 1.4, and, looking at the proportional frequencies, all but three of the problem areas were addressed more often by families in low-ranked nursing homes.

Nurses aides generally were liked in all nursing homes. In fact, they were given recognition more often in least family-oriented homes, possibly due to their unfavorable work environment. The differences in staff strengths between the two groups of nursing homes are reflected in Table 4. Two items were of particular interest. A specific mention of "good/excellent" care occurred much more often in nursing homes ranked highest in family orientation, and so did staff cooperation in problem solving.

The level of family involvement was similar in both groups of homes with an average of 2.0 activities reported by families from highest ranked homes and 1.8 activities by families from lowest ranked homes. Activities that promoted connectedness and maintained the resident's dignity were mentioned most frequently in all nursing homes,

but were more prominent in highest ranked homes (see Table 5). Maintenance of control was essential in lowest ranked homes and of lesser importance in the others. In particular, families gave care to protect residents, advocated for their rights, and compensated for shortcomings in the care rendered by staff. In terms of maintaining stability through continued direct care, there was also a visible difference. Whereas families in the least family-oriented homes engaged in hands-on activities more often, only families in highest ranked homes cited opportunities for cooperative planning with staff.

DISCUSSION

The nursing home policies and practices meant to encourage family involvement were found to be, at least to some degree, congruent with the families' actual involvement. Activities frequently encouraged by nursing homes, such as contacting families for advice, permitting relatives to call the unit at all times, and inviting them to join in activities were found useful by the families as they promoted the kind of communication patterns families reported as strengths. Contrary to this, other activities some families pursued intensively were minimally promoted by the nursing home or were not available. For example, direct care and related activities were not encouraged in many nursing homes. This seemed to support research findings indicating that staff do not consider hands-on care as part of the family role in the nursing home (George & Maddox, 1989). Family reports of staff problem behaviors, such as overlooking and ignoring families who tried to give them advice or treating them without sensitivity and in an uninviting manner, alluded to the notion of staff protecting their direct care provider role from family interference (George & Maddox, 1989; Montgomery & Montoro, 1995).

Nevertheless, the nursing home survey and qualitative data from the families indicated that there were family-oriented homes that promoted learning and gave the families opportunities to be heard and be part of their operation. Family members involved with these highly ranked homes reported cooperative activities with staff in caring for their relative and, often, for other residents as well. The family interviews provided an in-depth view of the perspective of family members and strongly supported the findings of Bowers (1988). Families were, above all, concerned about the resident's health and well-being and affective care was central. Under favorable conditions, if the care provided to the residents met the families' ex-

pectations, trust in the staff was reported, and mutual affection in relationships with the staff was apparent.

In some homes with little family orientation, however, the concern for the resident's well-being escalated to a concern about resident safety. The families saw a need to remain involved in order to maintain control over the care of their loved one. Many respondents stated that they would have preferred to leave the caregiving responsibility to the nursing home, but were forced to compensate for inadequate care. This finding reached beyond the work of Bowers (1988). As her study was done with high-quality nursing homes only, the finding seems to fill a gap in her theory and warrant further research.

As previously mentioned, the framework of systemic organization (Friedemann, 1995) suggests a focus on the uniqueness of families. This study provided evidence of family differences. For example, family uniqueness was evident in the way family members promoted stability. It became clear that the family members' interpretation of their situation involved their family system as they focused on the resident's physical and emotional health and the family's expectation to maintain it. Another example involves the issue of control over the caregiving situation. Most families were unwilling to relinquish all of their control. Irrespective of the quality of the homes, families were overseeing the care provided by the staff. Some expected the staff to follow special instructions, others were satisfied to be consulted about problems and informed of progress.

It also became apparent that more research is needed to explain family commonalities and the influence of institutional family-oriented practices on the family-staff relationships and the respondents' family process. The extension of family process into the nursing home was evident, but its complexity was greater than originally envisioned. From the perspective of the nursing home, there seemed to be a need for a base level of family support and competency in care delivery that allows trust and mutual affection between families and staff to develop. This precondition being met makes it possible for families to restabilize their family process and protect the resident's dignity (Bowers, 1988) through the promotion of family connectedness and unique cooperative relationships with staff. The success of such partnerships depends on extensive education of staff about families and staff-family relationships and the subsequent willingness of staff to become part of the families' life process.

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