

NURSES' PERSPECTIVES WHEN WORKING WITH FAMILIES WHILE  
DELIVERING FUNCTION-FOCUSED-CARE TO OLDER ADULTS IN ACUTE  
CARE SETTINGS

WHITNEY GREEN

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## **ABSTRACT**

Older adults are at increased risk for developing functional decline during hospitalization, putting them in danger of negative health outcomes including skin breakdown, impaired mobility and infections. Function-Focused-Care (FFC) is an approach to care designed to help prevent these adverse consequences in this patient population during hospitalization. Families are often present with older adults during their hospitalization but little research has explored nurses' perceptions around working with families in FFC. This secondary analysis explored the perceptions of 57 nurses in working with families in delivering FFC to older adults in acute care settings. Two major themes were identified: 1) nurses perceived families as facilitating FFC, and 2) nurses identified families as constraining FFC. In conclusion, nurses viewed families as double-edged swords and described them as creating tension for nurses when caring for older adults. The findings from this study provide insight into the tension nurses experience when providing care for older adults and raises awareness about the importance of nurse-family collaboration in the delivery of FFC to older adults.

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## **Chapter One: Background**

### **Older Adults in Acute Care Settings**

In Canada, the population is ageing and an increased number of older adults are accessing health care services (Health Canada, 2011). According to Hall et al. (2007), older adults are admitted to hospitals three times more often than younger adults. The increased volume of older adults accessing health care services in acute care settings requires nurses to meet the unique nursing care needs of older people and their families (Segaric & Hall, 2015).

Older adults with co-morbidities and cognitive impairment are at increased risk of developing functional decline during hospitalization (Volpato et al., 2007). Declining functional abilities of older adults may negatively impact lifestyle and quality of life (Amador, Reed, & Lehman, 2007). Older adults who experience functional decline may be at greater risk for morbidity, mortality, impaired mobility, infections and pressure ulcers (Campbell, 2009; Ponzotto et al., 2003; Sands et al., 2003). Functional decline of hospitalized older adults is associated with longer hospital stays, increased risk of re-admission to a hospital setting and greater costs and resource consumption (Ponzotto et al., 2003).

Nurses working in acute care settings face many challenges when caring for older adults and their families. Barriers including time constraints, increased workloads and increased patient acuity may prevent nurses from being able to deliver quality nursing care (Hall & Hoy, 2012). These challenges can prevent essential collaboration between nurses, patients and family members and may cause frustration for nurses who take pride in delivering quality care to patients and their families (Segaric & Hall, 2015). Involving

family members in the care of older adults is important to support the wellbeing of older adults (Fry, Gallagher, Chenoweth, & Stein-Parbury, 2014). When nurses form collaborative partnerships with patients and their family members, patients and families feel respected, cared for and understood (Koskenniemi, Leino-Kilpi, & Suhonen, 2012). Yet, in acute care settings, nurses and other caregivers frequently do not meet the needs of family members (Doane & Varcoe, 2015).

### **Importance of Family in Older Adult Care**

Family members frequently accompany older adults during hospitalization and can play an important role in the health and wellbeing of older adults while in acute care settings (Gallagher, Chenoweth, Gallagher, & Stein-Parbury, 2014). Family members and caregivers are important resources, advocates and support persons for older adults, especially in hospital settings (Gallagher et al., 2014). Families can provide nurses with medical information about older adults to be used in assessments and care planning as well as provide emotional and physical support (Fry et al., 2014).

Family members' involvement in older adults' care may help to prevent functional decline while in hospital. Families may offer older adults encouragement while performing activities of daily living and may act as advocates to ensure older adults have available resources to minimize functional decline (Boltz, Resnick, Chippendale, & Galvin, 2014). Older adults who receive encouragement from family members are more likely to engage in activities to minimize functional decline (Boltz et al., 2014b).

When older adults experience functional decline while in acute care settings, it can negatively impact family members. Patients who experience functional decline may become more dependent on family members with their activities of daily living when

returning home creating caregiver stress and fatigue (Li, 2005). Functional decline can also negatively impact older adults' quality of life (eg. depressed mood and physical impairment) and may have negative long-term implications on their health and wellbeing (Palmer, Counsell, & Landefeld, 2003). Nurses need to ensure family members of older adults have knowledge on Function-Focused-Care so families may safely and competently help to prevent functional decline in acute care settings.

### **Function-Focused-Care and Nurses' Roles**

Older adults are at increased risk for developing functional decline during hospitalization and nurses can play an important role in preventing this (Boltz, Resnick, Capezuti, Shabbat, & Secic, 2011). Nurses can help to preserve older adults' functioning by using a Function-Focused-Care approach to care (Fox & Butler, 2016). In FFC, nurses work collaboratively with inter-professional team members to assess older adults' functional abilities and, based on this assessment, provide interventions to preserve and/or restore their physical, cognitive and psychosocial functions (Fox & Butler, 2016; Kresevic & Palmer, 2015). FFC is provided in conjunction with the management of older adults' acute conditions with the overall goal of preserving and restoring functioning (Boltz et al., 2011; Kresevic & Palmer, 2015). For example, one way that nurses can help older adults' maintain their physical functioning during an acute illness or injury is by providing them with direction, support and guidance in independently performing their activities of daily living (e.g. transferring out of bed) instead of nurses performing these activities for older adults (e.g. lifting them out of bed; Boltz et al., 2011). Collaboration between nurses and families of older adults may support older adults' functioning in hospital. According to Fry et al. (2014), families of older adults are knowledgeable about

their relatives' abilities and care needs before they are hospitalized and this information may assist nurses when individualizing and implementing FFC for older adults to help prevent their functional decline.

### **Research Purpose and Research Question**

The purpose of this study is to explore Ontario nurses' perspectives on working with families in providing FFC to older adults in acute care settings. Exploration of this topic is important to identify possible barriers and to develop potential strategies to help advance nursing practice and to improve the quality of care for older adults and their families in acute care settings, thereby preventing functional decline in older adults. This study aims to answer the following research question: What are nurses' perspectives on working with families in providing function-focused-care to older adults in acute care settings?

## **Chapter Two: Review of the Literature**

A review was conducted to identify gaps and limitations in the literature on nurses' experiences and perspectives on working with families of older adults in acute care settings. Identification of these gaps highlights what is already known about this topic allowing my study to contribute new knowledge to this area of research.

A search was conducted using the Current Index of Nursing and Allied Health Literature (CINAHL), Medline, Pro Quest, Joanna Briggs and Cochrane databases to explore existing literature on the topic. Key terms used to search the databases included "nurses", "staff nurses", "older adults", "aging adults", "geriatrics", "aging", "hospital", "acute care setting", "acute care", "experiences", "family" and "caregivers". Searches were limited to English language research studies published in-between 2005 to 2015. Journal articles were selected based on relevancy to topic area. A total of 11 articles were reviewed and compiled for this literature review.

Literature reviewed mainly focused on examining nurses' experiences and perspectives when working with families to identify factors affecting nurse-family relationships. These studies identified workplace, organizational, interpersonal and personal factors perceived by nurses as barriers or contributing factors in nurse-family relationships (refer to Appendix A for the literature review table).

### **Barriers to Nurse-Family Collaboration**

After reviewing the literature, nurse and family member collaboration have been limited by three types of factors: workplace, organizational and interpersonal. First, workload, care routines, staffing models and time constraints were perceived as hindering relationships between nursing staff and family members (Haesler, Buer, & Nay, 2007;

Gallagher et al., 2014; Lindhardt, Rahem Hallberg, & Poulsen, 2008; Stayt, 2007). Insufficient supports identified by nurses and family members were perceived as being detrimental to establishing positive nurse-family relationships. These included insufficient educational training and tools, limited financial resources to support adequate staffing, lack of supervision and support from managers and inadequate resources for nurse and families (Hallgrimsdottir, 2000; Soderstrom, Benzein, & Saveman, 2003; Stayt, 2007; Weman & Fagerberg, 2006).

Second, in terms of barriers, nurses working in intensive care units perceived limited access to knowledge of best practice standards and guidelines about collaboration and working with families as a barrier to nurse-family relationships (Stayt, 2007). Limited access to physicians and patient information negatively impacted nurses' ability to work with family members (Weman & Fagerberg, 2006). Other workplace barriers included role stress, job strain and burnout (Lindhardt et al., 2008; Stayt, 2007).

Third, positive nurse-family interactions can be impeded by nurse and family member personal and interpersonal factors. Nurses working in the emergency department described feeling judged by family members and identified families' lack of understanding of nurses' workloads as impeding nurse-family relationships and patient care (Gallagher et al., 2014). Nurses were fearful of being attacked by family members and this prevented positive nurse-family interactions (Soderstrom et al., 2003). Shyness of family members impeded nurse-family interactions in acute care settings (Astedt-Kurki, Paavilainen, Tammentie, & Paunonen-Ilmonen, 2001). When family members were not present and were not involved, they were viewed by nurses as hindering patient care and the establishment of nurse-patient relationships (Fry et al., 2014; Soderstrom et

al., 2003; Weman & Fagerberg, 2006). Nurses viewed family members as time consuming and interfering with nurses' work resulting in non-inviting nurse-family interactions (Fry et al., 2014; Segaric & Hall, 2015; Soderstrom et al., 2003).

According to Soderstorm et al. (2003), nurses working in intensive care units wanted to distance themselves from families and avoid personal involvement. Nurses feared showing vulnerability, emotion or feelings in front of family members and they desired boundaries between their personal and professional roles (Soderstrom et al., 2003). In attempt to avoid personal involvement, nurses described lacking compassion in their nursing practice (Soderstrom et al., 2003). Inconsistencies in expectations between nurses, patients and family members can impede the development of nurse-family relationships (Segaric & Hall, 2015).

Haesler et al. (2007) found that nurses feel conflict between their ideals for practice and actual practice actions and attitudes and believed this to be a barrier to formulating nurse-family collaboration (Lindhardt et al., 2008). Collaborative nurse-family relationships were impeded when nurses felt they lacked tools, knowledge or resources to support the emotional needs of family members in distress (Hallgrimsdottir, 2000; Soderstrom et al., 2003; Stayt, 2007). Nurses described lacking confidence in working with families, being fearful of saying the wrong thing and not being able to answer and address family member concerns and questions (Stayt, 2007).

According to Haesler et al. (2007), social dynamics of power and control impede the development of positive nurse-family relationships. A qualitative study conducted by Soderstrom et al. (2003) found that disrespect and lack of trust between nurses and families hindered the collaborative nurse-family relationship. Using impersonal business

like approaches with family members, focusing on tasks and negative interactions within the workplace caused nurse-family relationships to disintegrate (Segaric & Hall, 2015). Family dynamics, language barriers, communication difficulties and cultural differences negatively influenced nurse-family relationships when caring for older adults (Weman & Fragerberg, 2006).

### **Contributing Factors to Nurse-Family Collaboration**

Workplace and organizational factors identified by nurses and family members as enhancing nurse-family relationships included interacting with family members using a variety of methods including telephone and face-to-face contact (Astedt-Kurki et al., 2001). According to Haesler et al. (2007), workplaces that implemented collaborative nurse-family meetings and regular training for nurses were believed by nurses to be important resources to support nurse-family relationships. Ensuring sufficient time for nurses and family members to get to know each other and providing educational and other resources to facilitate this was thought to improve collaborative relationships between nurses and family members (Segaric & Hall, 2015).

Collaborative nurse-family relationships may be facilitated when nurses honour the uniqueness and individuality of patients and when nurses respect patient dignity (Gallagher et al., 2014; Hall & Hoy, 2012; Haesler et al., 2007). When nurses support the emotional needs of family members, share their experiences when caring for patients, support family members' educational needs and communicate in an effective manner, nurse-family relationships are impacted in a positive manner (Haesler et al., 2007). Nurses and families described positive nurse-family relationships when nurses were willing to go the extra mile, when they engaged in mutual support and when they

provided supportive gestures to family members (Astedt-Kurki et al., 2001; Segaric & Hall, 2015). Soderstorm et al. (2007) found that nurses perceived the presence of family members as important to establishing nurse-family relationships. Nurses believed when family members understood the nurse's role and efforts, collaborative partnerships between the nurse and family members could be formed (Fry et al., 2014; Gallagher et al., 2014).

According to Segaric & Hall (2015), collaborative nurse-family interactions were established when nurses demonstrated trust, reciprocity and openness. Engaging in active listening, illustrating presence, providing answers to questions and initiating comfort measures to patients and families positively impacted nurse-family relationships (Astedt-Kurki et al., 2001; Hallgrimsdottir, 2000; Soderstrom et al., 2003). Nurses identified that their personal and professional experiences were beneficial to enhancing their skill and intuition used when interacting with family members (Soderstrom et al., 2003). Nurses described their competency and proficiency of nursing skills as enhancing their confidence in nurse-family relationships (Soderstrom et al., 2003).

### **Gaps and Limitations**

There are four major gaps and limitations noted from the literature reviewed. First, few studies have explored nurses' perspectives and experiences in working with families in the care of older adults. Older adults have unique health care needs due to age-related health complications and co-morbidities (Chang et al., 2003; Heslop, Athan, Gardner, Diers, & Poh, 2005). Establishing positive nurse-family relationships benefits older adults in acute care settings to ensure their cognitive, physical and psychosocial needs are met (Hall & Hoy, 2012). Second, the literature reviewed did not explore nurses'

experiences with families in using a FFC approach to older adults' care. Integration of a FFC approach when caring for older adults and their families is important to prevent functional decline in acute care settings (Boltz et al., 2012). Understanding nurses' experiences with families in the delivery of FFC to older adults will help to identify barriers and strategies to better support nursing practice.

Third, the literature reviewed focused on exploring nurses' experiences in specialized areas of acute care hospital settings including the intensive care unit and emergency department. The findings from these studies may not be generalizable and transferable to other acute care settings. Also, an important part of FFC is preparing older adults and their families for discharge home and this was not explored in the literature reviewed (Covinsky et al., 1998)

Lastly, many methodological limitations were noted in reviewing the literature. Qualitative studies conducted by Lindhardt et al. (2008) and Soderstrom et al. (2003) used small sample sizes of 10 or fewer participants. In qualitative research, sample size is based in the quality of information and in obtaining data descriptions that are rich and meaningful (Polit & Beck, 2012). These small sample sizes may have been insufficient to generate in-depth description of the phenomena being studied.

Purposeful sampling in qualitative research is important to acquire rich, meaningful descriptions about participant experiences (Polit & Beck, 2012). Many of the studies included in this literature review did not use purposeful sampling. Studies conducted by Soderstrom et al. (2003) and Hall and Hoy (2012) used convenience sampling whereby participants were recruited for their studies by unit head nurses. Convenience sampling is an easy, inexpensive and weak sampling strategy that may impede validity and reliability

of the study findings (Polit & Beck, 2012).

Identifying and describing eligibility criteria and describing this in the methodology of a study helps to illustrate purposeful sampling (Polit & Beck, 2012). Many studies including those conducted by Astedt-Kurki et al. (2001), Soderstrom et al. (2003) and Hall and Hoy (2012) lacked identification of participant eligibility criteria, limiting transferability of study findings.

Data saturation occurs when no new findings or data themes emerge and is important to ensure reliability of findings (Polit & Beck, 2012). Only the studies completed by Lindhardt et al. (2008), Segaric & Hall (2015) and Weman & Fagerberg (2006) reported having attained data saturation in their data analysis. Consequently, it is difficult to know if the researchers collected data that were rich, redundant and complete.

Data in the studies completed by Astedt-Kurki et al. (2001), Hallgrimsdottir (2000) and Weman & Fragerberg (2006) were obtained using questionnaires while studies completed by Hall & Hoy (2012), Lindhardt et al, (2008), Soderstrom et al., (2003), Stayt (2007), and Segaric & Hall (2015) used one-to-one interviews as their primary method for data collection. Data collection using focus-group interviews was only performed by studies completed by Fry et al. (2014) and Gallagher et al. (2012). Although questionnaires and one-to-one interviews allow researchers to obtain rich data from individual participants about the phenomenon being explored, it does not allow participants to discuss and share their experiences or to build on each others' ideas which is a major strength of data collection using focus-group interviews (Polit & Beck, 2012).

## **Study Implications and Advancement of New Knowledge**

Literature examining nurses' experiences in working with families of older adults in acute care settings is not thoroughly explored. Literature that explored this topic has many methodological limitations. I found no literature examining nurses' perspectives on working with families of older adults in the provision of FFC in acute care settings.

Understanding nurses' perceptions about barriers and facilitators to nurse-family collaboration and potential strategies to facilitate positive nurse-family collaboration may promote FFC in acute care settings. This study will address these gaps and limitations in this body of knowledge.

## **Chapter Three: Methodology**

This chapter outlines the methodological considerations of this study. It will describe the research design, ethics and details of the sampling and recruitment process. The data collection and data analysis process are then outlined followed by a description of the strategies used to ensure rigor.

### **Research Design**

This study used a qualitative descriptive approach to analyze data previously collected by Fox (2014). A qualitative descriptive design is well suited to describing participants' perspectives by allowing participants to describe their perceptions and views of a particular phenomenon in their own terms (Sandelowski, 2000). Researchers using descriptive qualitative studies stay “closer to their data and to the surface of words and events” than researchers using other qualitative approaches (Sandelowski, 2000, p. 336). According to Sandelowski (2010), the purpose of qualitative descriptive research is to describe the participants' experiences using their own words. Although this type of research design requires less interpretation by the researcher than other qualitative research methods, it does involve using an interpretive approach to describe the phenomenon being studied (Sandelowski, 2010).

### **Ethical Considerations**

Ethics approval was obtained for the original study from York University's Human Research Participants Committee (HRPC). Approval was also obtained from HRPC for secondary analysis of the dataset (certificate # STU 2016-031). Informed consent was obtained from all participants. Participation in the study was voluntary and participants could withdraw at any time. All data collected are stored on a secure,

encrypted drive and will only be accessed by Fox and her trainees involved in the study. Names and personal identifiers of participants will not be reported.

### **Sampling and Participant Recruitment**

The sample selected for focus-group interviews in this study came from the sample used in phase II of a two-phase study conducted by Fox (2014). In phase I (a quantitative survey) of Fox's study, a proportional stratified random sample of Registered Nurses (RNs) and Registered Practical Nurses (RPNs) were selected from the College of Nurses of Ontario (CNO) database (Fox, 2014). To be eligible for participation, RNs and RPNs had to meet the following inclusion criteria: considered active in status with the CNO; practiced in Ontario; worked in the hospital sector and acute subsector; primary practice area included emergency, medicine, surgery or critical care; position was staff nurse; and had consented to release their names for research purposes (Fox, 2014). A total of 2012 participants completed the survey that contained a question asking about participants' willingness to be contacted for a future focus-group interview.

Sampling for phase II involved the selection of 57 RNs and RPNs who had agreed in the phase I survey to be contacted to participate in a focus-group interview (Fox, 2014). Participants were selected using purposeful criterion-based sampling based on their professional designation as RNs or RPNs and the teaching status of their hospital. Four subgroups were formed: RNs working in teaching hospitals, RNs working in non-teaching hospitals, RPNs working in teaching hospitals and RPNs working in non-teaching hospital. A total of 13 focus-group interviews were conducted with these subgroups (Fox, 2014). The first eight were homogeneous, so that participants' experiences could be compared, and were conducted face-to-face (Fox, 2014). When

there were no major differences noted between the homogeneous groups' experiences, five more focus-group interviews with heterogeneous groups of participants were conducted over the phone, to overcome geographical and logistic barriers to participation (Fox, 2014). For the purpose of my study, the entire phase II sample was used. See appendix B for an overview of participant demographics.

### **Data Collection**

Fox (2014) collected data using face-to-face and telephone interviews conducted in libraries, community centres, and meeting rooms central to participants' homes or work locations. Focus-group interviews were performed by a Doctorally-trained facilitator who had experience and formal training in conducting focus-group interviews. A Masters prepared, Registered Nurse research assistant arranged the focus-group interviews and was present during the focus-group interviews to take field notes and to control for environmental issues such as participants arriving late and problems with the audio recorder.

The focus-group interviews were directed using a semi-structured interview guide to explore participants' perspectives in providing FFC. Participants frequently discussed patient families in response to the open-ended questions. Follow-up probes were used to seek clarification and to further explore nurses' perspectives on working with families in providing FFC. For example, "how is involving patients and their families in care activities and decisions connected to preserving functional abilities?" See Appendix C for additional probes used to explore nurses' perceptions regarding families and FFC.

During the winter of 2013, thirteen focus-group interviews were conducted. Eight of the focus-group interviews were held face-to-face while five focus-group interviews

were conducted via telephone to encourage participant involvement that may have otherwise been impeded by geographical and other barriers (Fox, 2014). Focus-group interviews lasted between 75 and 140 minutes (Fox, 2014). The interviews were audio-recorded and transcribed verbatim by a professional transcriptionist and the facilitator (Fox, 2014). A second research team member verified the transcripts and field-notes were taken during and after the interviews (Fox, 2014).

### **Data Analysis**

Secondary data analysis was conducted to explore nurses' perspectives on working with families in providing FFC to older adults in acute care settings. Secondary data analysis allows new research questions to be posed of existing qualitative datasets (Corti & Bishop, 2005). Re-analyzing qualitative data permits researchers to employ different methods of analysis to explore new topics that may not have been appropriate during the original analysis (Corti & Bishop, 2005). As Corti and Bishop note "the re-use of qualitative data provides an opportunity to study the raw materials of recent or earlier research to gain both methodological and substantive insights" (p.8, 2005). Secondary data analysis is inexpensive to perform and is useful when conducting research on populations who may be difficult to access (Corti & Bishop, 2005). It can also be used to identify new meanings from the data without having to duplicate the research process (Corti & Bishop, 2005).

Data analysis was completed using an iterative approach and began by reading and re-reading the focus-group transcripts. Data focusing on families were highlighted within the interviews and entered into the computer software program NVivo to help with the coding process. The purpose of data analysis was to maintain an open mind in order

to identify new and familiar themes around nurses' perspectives when working with families of older adults by analyzing data previously collected (Corti & Bishop, 2005).

Initially, first cycle coding was completed to identify recurring themes (Saldana, 2009). Descriptive coding was used to organize the data into broad themes based on similarities and differences in participants' perspectives (Saldana, 2009). These themes were developed using an inductive approach. An inductive approach involves acquiring knowledge from the data itself to create a new theory while a deductive approach involves testing an existing theory or hypothesis by researching the topic (Ryan & Bernard, 2003). To use an inductive approach, I reviewed the data from the transcripts, broke them down into smaller sections, looked for patterns and then generated themes to explain the phenomenon (Ryan & Bernard, 2003). The data were grouped into codes based on shared patterns, similarities and differences and the codes were named (Ryan & Bernard, 2003). Hierarchical tree diagrams were used to illustrate, organize, and display the themes and to help demonstrate connections within the data.

Next, second cycle coding was performed. This step involved re-organizing previously coded data into new or existing categories as it was conceptualized and prioritized (Saldana, 2009). Focused coding was performed in the analysis process to identify the most important themes within the data by looking at the codes and determining what codes were most important to keep (Saldana, 2009). Axial coding was also performed continually throughout the second cycle coding phase by contrasting and comparing the themes to ensure they were truly reflective of participants' perspectives (Saldana, 2009).

Data analysis continued during the post-coding and pre-writing phase. Themes were analyzed in greater detail to explore relationships and differences. During the writing process, themes were sorted and re-ordered to tell the participants' stories and to bring meaning to the data findings. Headings and subheadings were used in the pre-writing phase to help organize the major themes within the data. Cross-validation, which involved my committee members (Fox & Butler) and I reviewing the data independently and comparing our interpretations was used during the analysis process to increase the credibility and dependability of the findings (Miles, Huberman & Saldana, 2014). Wherever our interpretations differed, we discussed and debated until inter-subjective consensus was achieved.

### **Rigor**

Rigor is the use of the criteria involved in the research process to ensure trustworthiness of the research study (Houghton, Casey, Shaw, & Murphy, 2013). Rigor in this study was guided by Lincon and Guba's framework for trustworthiness (Houghton et al., 2013). First, the research design and research question were suitable to address the goal of this study by employing a qualitative, descriptive design to describe nurses' perspectives on the phenomenon. The research design was described in detail to ensure dependability of this study (Polit & Beck, 2012). Second, data collection was conducted using focus-group interviews and this allowed participants to share their perspectives with each other in an interactive environment to obtain rich descriptions about the topic being explored (Tong, Sainsbury, & Craig, 2007). Third, focus-group interviews were conducted using a semi-structured interview guide and probes to further explore and to clarify participants' descriptions. The focus-group interviews were audio-recorded,

transcribed verbatim and verified by a second research team member to ensure dependability (Polit & Beck, 2012). Lastly, secondary data analysis occurred using a cross-validation process to help ensure credibility, dependability and confirmability of the data findings. During the data analysis process, the data findings were regularly discussed with my Research Supervisor (Fox) who had read the focus-group transcripts and committee member (Butler) who had conducted the focus-group interviews and had read the transcripts. To achieve dependability and confirmability, an audit trail was maintained using NVivo and by making handwritten notes when reading the transcripts, during the analysis process and when having meetings with committee members.

### **Reflexivity**

According to Wesam (2014), reflexivity is the continuous process of engaging in self-reflection about personal and professional biases, values and opinions throughout the research process. Reflexivity is important so that researchers have awareness about how their opinions and assumptions may influence the research process and it helps to enhance rigor and credibility of the research study (Wesam, 2014). Reflexivity was demonstrated throughout this research project to increase the credibility and confirmability of the study findings (Polit & Beck, 2012). As a practicing nurse, I have worked with many families in acute care settings while providing care to older adults. My experience of family involvement in older adult care has been both positive and negative. Families are often present with older adults during hospitalization so understanding how nurses perceive families in FFC was an area of interest for me to explore. In this study, I was careful to consider my own personal and professional biases and past work experiences. I had anticipated that families would be perceived by nurses as both

challenging and helpful when involved in older adult care because of my prior knowledge and experience in working with older adults and families. However, I was careful to reflect and consider how this may influence my data analysis. I engaged in dialogue with my committee members often during data analysis to discuss my personal experiences of working with families and older adults and compared my own experiences to those of the nurses in the study. FFC is an approach to care that I was previously unfamiliar with in my nursing practice so I was uncertain of how nurses would describe families in the context of FFC. This allowed me to be open minded during data analysis to ensure the research findings were not influenced by my own personal and professional biases.

## **Chapter Four: Findings**

The findings from this research study illuminate the perspectives of nurses in working with the families of older adults surrounding the delivery of FFC in acute care settings. Two major themes were identified characterizing participants' perceptions of families: 1) families support FFC; and 2) families impede FFC. From this study, it was evident that participants perceived families of older adults as double-edged swords in the delivery of FFC. On the one hand, participants viewed families as supportive when they provided nurses with knowledge and information about their relatives' baseline health status and functional abilities prior to hospitalization and when they helped to support older adults physical and cognitive functioning in acute care settings. Participants also described strategies that they used to help families better support their relatives' functional abilities. In contrast, some participants perceived families as a barrier in FFC when their emotions of fear and burnout prevented them from being involved in their relatives' care and when they had insufficient knowledge about how to support their hospitalized older relatives' functional abilities. The terms "participants" and "nurses" are used interchangeably throughout this chapter. See Figure 1 for an overview of the research findings.

### **Families Facilitated Function-Focused-Care**

The first major theme captures nurses' perceptions of the ways that families support FFC. Participants perceived families as facilitating FFC when they: a) provided knowledge about their relatives' baseline health and functional abilities; b) supported their relatives' physical needs; and, c) supported their relatives' cognitive needs. Nurses also described strategies they used to guide families in supporting their relatives'

functioning. Nurses used the information provided by families to plan care that supported patients' functional abilities. Families were identified as supporting their relatives' physical functioning by providing them with cueing and instructions to perform functional activities including range of motion exercises and walking. Nurses described that families supported the cognitive functioning of their relatives who were experiencing delirium or dementia and that this helped to keep their relatives engaged in physical activities to support their cognitive and physical functioning. Nurses explained that when families expressed a desire to support their relatives' functioning during hospitalization, they encouraged their participation and used strategies including demonstration and instruction with families so that they could support their relatives with activities such as walking and toileting.

**Families contributed baseline information about their relatives.** This sub-theme captures that participants viewed families as valuable sources of information for nurses in FFC. Participants believed information obtained from families allowed nurses to: implement treatments to manage chronic conditions such as pain; assess for changes in cognitive and physical functioning; and help patients and their families learn strategies to use at home after discharge to maintain their relatives' functioning. Participants described families as "knowing the patient best." Families were described as providing nurses with information about their relatives' "baseline health status" and helping to increase nurses' knowledge about their patients' overall medical picture by "answering questions about their [older relatives'] medical history." Families were noted to "have really good knowledge of the patient before they were hospitalized." They give nurses details about their relatives' "patterns and how they function at home" with their

activities including “mobility, toileting and ambulation”. As one nurse noted, “the more that we learn about their patterns and how they would function at home, the better we can serve these clients.”

Families shared information with nurses about their relatives’ medical history including details about their illnesses and health conditions. Nurses used this information to anticipate how their patients’ health may impact their functional abilities and to support their patients with appropriate nursing interventions so they could participate in activities to prevent functional decline. One nurse used the example of how knowing about a patient’s history of pain allowed nurses to manage it more effectively so that the patient could continue to participate in activities to maintain functioning. This nurse explained, “if we can control their pain, we can get them out of the chair and walking... and get them home.”

In addition to being knowledgeable about their relatives’ baseline medical status and functional abilities, participants described that families provided nurses with information to assess for changes in their relatives’ cognitive and physical states. Nurses identified this as helpful when older adults were not able to communicate independently or when nurses were unfamiliar with the patient and unable to recognize subtle changes in their conditions. As one nurse suggested “I always try to have their [older adults’] family come in and give their opinion on what Mom or Dad is looking like now.” One nurse explained how some families could provide nurses with information about their relatives’ baseline cognitive function to help them determine if their patients were experiencing delirium or dementia:

You need to know their baseline... I don't know if that delirium is actually a dementia or if it's a delirium because I don't know what their baseline is. So, that's where then the family thing has to come in again because the family knows their baseline.

Having an understanding about older patients' functional abilities allowed nurses to develop care plans that helped patients to meet their goals in hospital and at home. Families contributed knowledge to nurses about their relatives' "level of abilities from before their admission so we [nurses] know what our goals are." One participant outlined, "I think it's the family... they're that key piece to help link us back to the community and to get that patient back home and back to their previously kind of functioning." Families shared information that nurses need about their relatives' abilities to help nurses minimize their patients' risk for functional decline in hospital. As one nurse asserted, the goal of FFC is to "get them out of here and get them home. Get them back to doing whatever they were doing. Like, driving, walking, whatever because a lot of these guys [older adults] come in functioning. We want them back functioning." Families also provided nurses with information about their relatives' functional abilities so that nurses could become familiar with "where their [patients'] weaknesses are...so you can try to prevent negative outcomes" such as functional decline, skin breakdown and muscle loss in hospital.

**Families supported their relatives' physical functioning while in hospital.**

This sub-theme captures how participants believed that families supported FFC when they provided their relatives with physical support in hospital. Families provided their relatives with verbal cueing, offered instructions during exercises, and physically assisted

them with activities such as walking during hospitalization. Participants identified that families assisted their older relatives in hospital with activities including “range of motion... to lift their arms to help their functioning level” and “walking the patient to the bathroom.” Families also encouraged their relatives to engage in activities including “sitting up in bed” and going for “walks” to support FFC.

Some participants explained that they did not always have sufficient time to spend with their patients to help support their functional abilities. They identified how families could be beneficial by helping nurses to provide physical support to older adults when they assisted their relative with activities including walking and exercises. One participant outlined her experience: “I try to encourage them [families] that they can help walk the patient to the bathroom because the nurses don’t always have the time. So...I find that families are crucial in the healing process of patients.”

### **Families supported their relatives’ cognitive functioning while in hospital.**

This sub-theme describes how families were noted to support their relatives’ cognitive functioning. In addition to believing that families helped in FFC by supporting their relatives’ physical needs, some participants also believed that when families provided cognitive support to their relatives, it helped to prevent physical decline. Although nurses spoke more frequently about how families provided physical support for their relatives than how they provided cognitive support, nurses were clear that, in FFC, it’s “not just their physical well-being, it’s their mental well-being as well” that needs to be tended to. Participants identified that families maintained their older relatives’ cognitive functioning by “keeping their minds busy, to keep their bodies busy.” Supporting a relative’s cognitive functioning during hospitalization was believed to be important when older

adults experienced symptoms of dementia or delirium. Some participants expressed having to use medication or restraints when older adults experienced delirium and identified their use as detrimental to preserving older adults' functional abilities. One nurse described how families could support their relatives during an episode of delirium:

I feel if the family could be there just for mental support even if they're in delirium, they're more likely to respond positively, so we don't have to always use the soft restraints. Because sometimes patients just get so confused and they are surrounded by people who are strange to them. They get more frustrated and then that's when you have to use more medication or you have to restrain them... So that's where I see family just being there.

One participant described a learning resource that families could use to acquire knowledge about delirium in a brochure entitled "A Patient-Caregiver Guide to Preventing Delirium and Functional Decline". This brochure was described as helping families understand details about the condition of delirium and ways that families can support their relatives' cognitive health in order to minimize their risks for functional decline during an episode of delirium.

**Nurses implemented strategies to support family involvement in FFC.** This sub-theme focuses on strategies that participants identified using with families to help them support their relatives' functioning. During the focus-group interviews, nurses described families as playing an important role in FFC. Participants perceived that some families wanted to be involved in their relatives' care but were hesitant or afraid to do so. Participants believed that nurses played an important role in facilitating family involvement in FFC. When families had a desire to be involved, nurses provided them

with encouragement and instructions on how to support their relatives' functioning while in hospital. One nurse noted, "the families, most of them want to be there. And they help." When families were hesitant to jump in to assist their relative with functional activities, nurses explained that they gave families reassurance by saying "it's okay to be involved." Another participant outlined an experience of including a family in their relative's care to help support their functioning while in hospital. "If the family wants to be involved in the care, I'm in there like a dirty shirt [involving families in care]... because they are an integral part of the care for that patient".

Nurses explained that they directed families on how to safely assist their relatives with physical activities. To support a client's functional abilities, one nurse described how she provided instructions to a family member about how to perform activities with range of motion by "allowing the families to here, lift their arms or do this a little bit to help their functioning level there while they're in bed." Nurses gave families information on how to help their relatives perform functional activities by telling families "it's good if you take them [older relatives] for a walk" and by encouraging families to instruct their relatives to "dangle their feet" while in bed to encourage their movement and mobility. Nurses also gave families instructions on how to "help walk the patient to the bathroom" and how to "help the patient move" in bed to encourage their mobility and to prevent skin breakdown and pressure ulcers.

Participants felt that teaching families how to support their relatives' functional abilities while in hospital was important so that families had the knowledge and skills needed to continue to support their relatives after being discharged from hospital. Participants identified that families could acquire a great deal of knowledge from nurses

about how to promote older adults' independence while preserving their relatives' functional abilities before they are discharged home. One participant outlined why teaching families about FFC in hospital is important for their relatives after discharge:

It would be helpful to teach them so when they're discharged, this is how to push up on the bed, don't pull up on the walker... or having equipment at home, what equipment to have, being able to show them and demonstrate it while their loved one is in the hospital, how to do it.

### **Families Constrained Function-Focused-Care**

The second major theme illustrates that participants also perceived families as constraining FFC. This theme contrasts sharply with the first major theme where participants viewed families as facilitating FFC. The dissimilarity highlights how nurses viewed families as double-edged swords as families were noted to both support and hinder FFC for older adults in acute care settings. Participants outlined that some families constrained FFC when their emotions of fear and burnout prevented them from being involved in their relatives' care. Nurses also identified that family members' insufficient knowledge on physical activity and on how to support their relatives' functioning in hospital hindered FFC. Participants perceived that's families constrained FFC in two ways: a) families' emotions constrained them from being involved in their relatives' care; and, b) families had insufficient knowledge about how to support their relatives' physical needs.

#### **Families' emotions constrained FFC by impeding their involvement in care.**

This sub-theme captures that participants believed families' emotions impeded FFC by preventing them from being involved in their relatives' care. Nurses described "fear" and

“burnout” as limiting family involvement in older adult care. Participants identified that families often view their relatives as “vulnerable while hospitalized” because they have “gone downhill physically, mentally or emotionally. They're suffering in some way.” Nurses perceived that some families were frightened when their relatives were hospitalized, and asserted that families’ fear prevented their involvement in their relatives’ care. One nurse stated, “fear is often of the unknown. They just don't know what's going to happen or what the plan is or why we're doing things the way we do them.”

Families were described by nurses as being fearful of making a mistake if they were to help their relatives with physical activities including walking, toileting and range of motion exercises. Nurses identified families’ fear of making a mistake as limiting families from supporting their relatives’ physical functioning while in hospital. One nurse identified that families’ fears prevent them from supporting their relatives’ physical functioning: “I think a lot of them [families] are reluctant to do anything. They’re afraid of making a mistake.” When families were fearful of assisting their relatives with physical activities including walking, nurses identified that they provided families with “reassurance” and answered their questions to help “take that fear away” and to get them involved.

Participants suggested that when families experienced feelings of being burned out, it constrained FFC. Nurses perceived that when some families were “unable to cope” with their relatives at home, families wanted to “just get rid of them” by leaving them at the emergency department for nurses to care for. One nurse summarized this experience: “A lot of the times, it’s the family that is burned out. A lot of them don’t know what

avenues to go to ... where do we put them [older adults] ... so they bring them to the hospital.” Another nurse explained that older relatives are often brought to hospital on weekends and holidays to be cared for by nurses because their families are feeling burned out and need a break as caregivers: “I do see a lot of dumping off on Friday afternoons at the emergency department for the weekend because they [families] just need a break. They need a break from caring for their loved one.” Participants identified that when families felt emotionally burned out from caring for their relatives at home, they became absent when their relative was hospitalized. Participants perceived this absence as constraining FFC because nurses had to figure out their clients’ functional abilities and health status without having access to information from families.

**Families lack knowledge about how to support their relatives in FFC.** In this sub-theme, participants described families’ limited knowledge about nursing interventions and rationales used in FFC as a barrier. Nurses suggested that when families had insufficient knowledge about how to support their relatives physical functioning in hospital, their level of support and involvement with care varied. Participants perceived families as either assisting their hospitalized relatives too much or too little and believed this to be harmful by hindering older adults from maintaining their functional abilities. As one nurse stated:

The families, it’s one extreme to the other. It’s either they over-help, and they’re feeding people who don’t need to be fed. Let them feed themselves because part of their rehab is feeding themselves. Or, they don’t do anything... It’s trying to get them the happy medium, so that they are helping them participate in their care... so that we can get them home.

Participants also viewed families' limited understanding of the rationales behind nursing interventions used in FFC as a barrier. They explained that families who lacked this knowledge put their relatives at risk of experiencing functional decline. Instead of supporting their relatives' functioning in hospital, nurses noted that some families would discourage their relatives who were in pain or who had a history of falling from participating in activities including getting out of bed and walking. Participants identified that when families lacked knowledge about how to support their relatives' functioning in hospital, they were more likely to prevent their relatives from participating in activities. One nurse described how the lack of knowledge by families interfered with nurses' delivery of FFC:

I don't know how many times I will have a son or daughter or grandson or granddaughter come to me and say, "I don't think he should be out of bed. He's too unsteady. He should stay in bed... it's too unsafe for him to get out of bed" and they're not realizing that the longer the patient stays in bed the higher the risk of pneumonia, the higher the risk of skin breakdown, the higher the risk of losing their mobility.

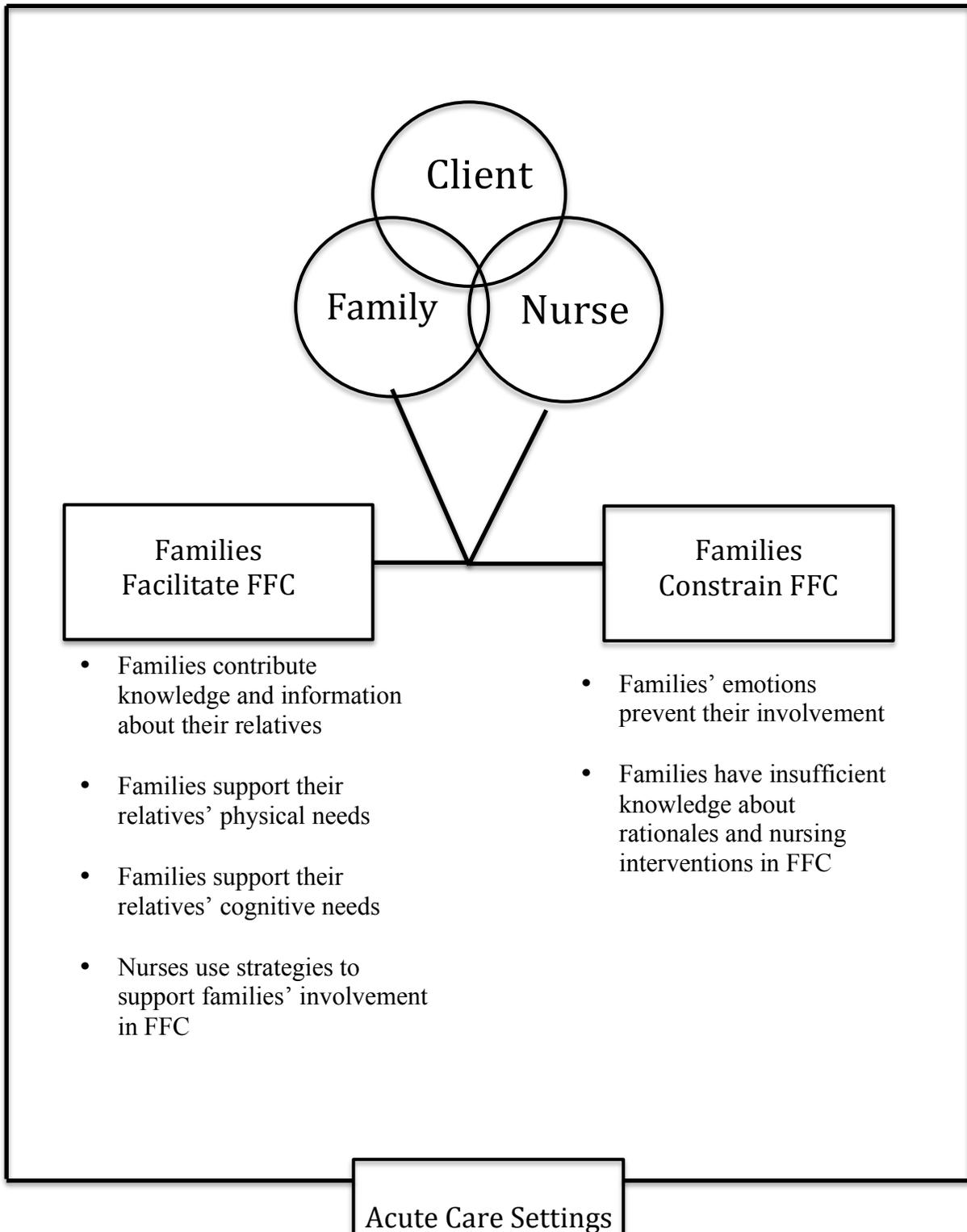
### **Summary**

From the focus-group interviews, two major themes characterized participants' perspectives: 1) families facilitated FFC; and, 2) families constrained FFC. Nurses identified that families played an important role in FFC when they contributed knowledge and information about their relatives' functional abilities and health status with nurses and when they supported their relatives' physical and cognitive functioning. Nurses also described the role they can play in providing families with education and support to

encourage their involvement in older adult care. Nurses perceived that it was challenging to provide care to older adults when families experienced emotions such as fear and burnout or when they had insufficient knowledge about FFC. These contrasting themes highlight that nurses in this study viewed families as double-edged swords in FFC and exemplify the tension described by nurses when working with families of older adults in FFC.

## Figure 1: Overview of Research Findings

Nurses' Perceptions of Families on Delivering Care to Older Adults



## **Chapter Five: Discussion**

This study explored nurses' perceptions of families in delivering FFC to older adults in acute care settings. In this chapter, I discuss the findings presented in chapter four by comparing and contrasting them with the existing literature on the topic. The discussion will revolve around my key study finding that nurses perceived families of older adults as double-edged swords in FFC. Nurses identified that families create tension because they either help nurses support older adults' physical and cognitive functioning or they impede nurses from delivering care that maintains older adults' functional abilities. This key theme is comprised of two major subthemes. The first subtheme explores how nurses perceive families as facilitating FFC in acute care settings when they offer nurses baseline information about their relatives' health and functional abilities and when they provide physical and cognitive support to their relatives. The second subtheme, in contrast, examines nurses' views of families as constraining FFC when families' emotions inhibit them from being involved in their relatives' care, when families lack knowledge about the benefits of physical activity, and when they prevent older adults from being active during hospitalization. The last section of the chapter will outline the study's limitations, as well as its implications for nursing practice, education and research.

### **Families Contribute Baseline Information About their Relatives**

My study shows that nurses perceive they acquire information about older adults' capabilities from families so nurses can plan care that helps to prevent older adults' functional decline. This finding concurs with those of previous studies identifying families as important sources of information for nurses when they provide them with

facts about their relatives' baseline medical history, illnesses and health conditions (Fry et al., 2014; Lindhardt et al., 2008; Nikki, Lepisto, & Paavilainen, 2012). An important finding from my study is that nurses view families as facilitating FFC when they provide information to nurses about how their relatives function at home with activities such as feeding, walking and toileting. To the best of my knowledge, this finding has not been noted in previous studies that examined nurses' perspectives on caring for older adults in acute care settings. I recommend that nurses use information from families to gain knowledge about their clients' baseline functioning in physical activities and activities of daily living. This information will help nurses to plan care for clients based on their individual abilities and to assess for changes in their patients' functioning so they can adapt their care accordingly to help prevent functional decline.

My study found that nurses view families as knowledgeable about their relatives' baseline cognitive status and as assisting nurses to recognize changes in patients' cognitive functioning that may indicate delirium. This finding is similar to those of a study completed by Flanagan & Spencer (2015) in which families reported recognizing subtle changes in older adults' cognitive functioning more easily than nurses. While the study by Flanagan & Spencer (2015) examined family members' experiences in recognizing delirium in patients in acute care settings, my study findings add to the existing literature by confirming that nurses view families as instrumental in helping nurses recognize signs of delirium. Delirium has negative consequences for the health care system and older adults that include longer hospital stays, higher hospital costs, increased risk for functional decline and mortality, reduced self-care ability, and irreversible cognitive impairment (Leslie & Inouye, 2011; Salluh et al., 2015). According

to Fox et al. (2016) signs of delirium in older adults are often not recognized by nurses. Consequently, I suggest that nurses leverage the knowledge of families who have the potential to play an important role in the recognition and management of delirium in older adults to help limit its negative consequences.

### **Families Support Their Relatives' Physical Functioning While In Hospital**

My study found that nurses see families as wanting to support their relatives with physical activities during hospitalization when they help their relatives with activities such as walking, toileting, turning in bed and feeding as well as when they encourage them to be active in hospital. According to Nikki et al. (2012) families want to be involved in their hospitalized relatives' care. Boltz et al. (2011) further note that nurses view families' involvement as important in keeping older adults functioning in hospital. My findings are congruent with existing literature noting that families help keep their relatives' functioning in hospital by motivating them to keep active and guiding them in performing physical activities (Boltz et al., 2011). In acute care settings, factors including restricted mobility related to treatments, procedures, and hospital environments, and decreased energy levels related to patient illness or injury put older adults at risk of experiencing functional decline (Fisher et al., 2011; Kortebein, 2009; Zisberg et al., 2011). Older adults may be hesitant to engage in physical activity during hospitalization because of fear of falling or because they associate being in hospital with staying in bed and resting with getting better (Boltz, Resnick, Capezuti, & Shuluk, 2014). Families help keep their relatives active in hospital by encouraging them to participate in physical activities such as walking and moving in bed (Boltz et al., 2011; Boltz et al., 2014a). Because families can provide their relatives with support, encouragement, motivation and

guidance to participate in physical activities, nurses should enable families' involvement in their relatives' care. Nurses can do so by providing families with direction and education on how to support their hospitalized relatives with functional activities that keep them active during hospitalization and prevent functional decline.

### **Families Support Their Relatives' Cognitive Functioning While In Hospital**

My study demonstrates that nurses perceive families as facilitating FFC when they provide cognitive support to their relatives in hospital. Nurses describe that families do this by reducing their relatives' confusion during episodes of delirium or dementia. This finding is comparable to that of Gallagher et al. (2014) who found that families are helpful when they provide their confused or disoriented relatives with distraction to prevent unsafe behaviours like climbing out of bed. My study found that nurses view families as helpful in limiting the use of physical and chemical restraints for older adults. When older adults are experiencing confusion or agitation because of delirium, families use distraction and re-orientation techniques with their relatives so nurses do not have to use restraints. According to Inouye, Westendorp, & Saczynski (2014), re-orientation and distraction techniques are used to keep older adults safe by managing dangerous behaviours like climbing out of bed and walking without using assistive devices when older adults are experiencing delirium. Because chemical and physical restraints are recommended as last resorts for older adults with delirium, techniques performed by families including distraction and re-orientation are preferred methods for managing unsafe behaviours in older adults with delirium (Canadian Coalition for Seniors' Mental Health, 2010). The use of restraints in older adults is associated with negative health implications including increased risk of pain, death, falls and pressure ulcer development

(Capezuti, Maislin, Strumpf, & Evans, 2002; Evans, Wood, & Lambert, 2003; Xue, Kwok, Woo, Chui, & Ho, 2014). Physical restraint use restricts a patient's ability to move freely, thus increasing their risk for experiencing functional decline (Castle & Engberg, 2009). While the intent of restraint use is to keep patients safe, nurses do not always understand its negative implications for older adults and incorrectly view the benefits of restraint use as outweighing the risks (Chuang & Huang, 2007; Curran, 2007; Lai, 2007). Although further research is needed to examine how families can help nurses to reduce the use of restraints for older adults, I suggest that nurses use families as a safe alternative to restraint use when older adults are experiencing delirium in acute care settings. Nurses can encourage families to re-direct and distract their older relatives from engaging in unsafe behaviours so nurses do not have to use restraints that limit their ability to move freely. Families can also help nurses to re-orientate their older relatives when they are confused to help minimize their fear and to keep them safe.

My study identifies that nurses perceive families as providing psychological support to their relatives by meeting their emotional needs, keeping their minds busy, and encouraging them to keep their bodies active during hospitalization. This finding adds to existing literature indicating that nurses believe older adults' emotions influence their willingness to participate in physical activities (Boltz et al., 2011). Older adults who are perceived to be lonely or depressed during hospitalization are thought to be withdrawn and reluctant to participate in physical activities (Boltz et al., 2011). Furthermore, nurses and other care staff identify that when older adults have a fear of falling, they feel anxious engaging in physical activities such as walking, so they remain in bed (Boltz et al., 2011; Boltz et al., 2014a). Families have a desire to provide psychological support to

their relatives while in hospital and they do this by keeping their spirits up, offering them company and companionship and by giving them reassurance to minimize their fear of falling (Boltz et al., 2014a; Lindhardt et al., 2008; Nikki et al., 2012). Because older adults' emotions such as fear and depression can negatively influence their physical activity levels, nurses should encourage families to provide psychological support to their relatives in hospital. Families can provide psychological support to their older relatives by reassuring and encouraging them in performing physical activities like walking to minimize their fear of falling. Families can also provide their relatives with companionship to keep their relatives' spirits up and to motivate them to be physically active during hospitalization to prevent their functional decline.

### **Nurses Implement Strategies to Support Family Involvement in FFC**

Nurses note that when families want to be involved in their relatives' care during hospitalization, nurses may provide families with reassurance, direction and education to support their involvement. My study identified that nurses provide families with instructions so they can support their relatives during hospitalization and at home after discharge. This finding is similar to that of Burket, Hippensteel, Penrod, & Resnick (2013), who found that families feel more prepared to support their relatives at home when they are included in older adults' care during hospitalization. In Western countries, older adults are experiencing shortened hospital stays and have high care needs when they return home (Coleman, 2003; Dunnion & Kelly, 2005; Neiterman, Wodchis, & Bourgeault, 2014). Families frequently take on the role of caregivers for older adults in acute care settings and at home (Gallagher et al., 2014). When older adults are discharged from acute care settings soon after admission, families are faced with challenges in

helping them manage at home with functional activities including walking, dressing and bathing (Neiterman et al., 2014). Families often feel unprepared to care for their relatives at home when they lack knowledge about how to support their relatives with physical activities and have insufficient knowledge about how to use assistive devices like walkers and canes (Boughton & Halliday, 2009; Neiterman et al., 2014). Nurses acknowledge that families face many challenges when their relatives are discharged from hospital. Nurses recognize the active role they play in educating families to better support their relatives during hospitalization and at home once they are discharged.

My study found that nurses view educating families about delirium as important so that families can support their relatives' physical functioning when they experience symptoms of delirium in hospital. Nurses describe using educational tools including brochures with families to provide them with information about how to help minimize older adults' risk of functional decline. This finding is consistent with existing literature that identifies brochures and other reading material as effective learning strategies for families in increasing their knowledge about delirium and functional decline in older adults (Bull, Boaz, & Jerme, 2016; Burket et al., 2013). Delirium can result in confusion, disorganized thinking and inability to concentrate when performing physical activities and may lead to functional decline in older adults (Bull et al., 2016; Krogseth, Wyller, Engedal, & Juliebo, 2013; Rudolph et al., 2010). To help families acquire knowledge about delirium and understand how to keep their relatives' active when experiencing it, nurses may play a vital role in providing families with education using different learning tools.

## **Families' Emotions Constrain FFC by Impeding their Involvement in Care**

Although nurses identify that families facilitate FFC, nurses also view them as constraining FFC when their emotions get in the way of being involved in their relatives' care. My study also identifies that nurses believe families' emotions including fear and burnout prevent them from being involved in their relatives' care during hospitalization. This finding is consistent with previous research that found that some families face many negative emotions including fear, burnout, stress and apprehension when their relatives are hospitalized (Digby & Bloomer, 2014; Giosa, Stolee, Dupuis, Mock, & Santi, 2014). Some families of older adults are overwhelmed when providing care to their relatives at home and report feeling burned out (Digby & Bloomer, 2014). My study demonstrates that nurses believe that when families feel burned out from caring for their relatives at home, they disengage from their relatives' care during hospitalization and are unavailable to provide nurses with information about their relatives' health status or functional abilities. In addition to caring for their older relatives, families often have other responsibilities including managing busy work and personal schedules which may limit their involvement in their relatives' care during hospitalization (Digby & Bloomer, 2014; Giosa et al., 2014). Nurses see families as valuable resources in caring for older adults because families provide nurses with information and help support their relatives' physical and cognitive functioning. When families are not involved in their relatives' care, nurses find it challenging because they cannot access important information from families needed to plan care for older adults and do not have families present to help support older adults physical and cognitive needs during hospitalization.

## **Families Lack Knowledge about How to Support their Relatives in FFC**

My study found that nurses view families' lack of knowledge about the benefits of physical activity during hospitalization as a barrier to FFC. Nurses note that some families discourage their relatives who are experiencing shortness of breath, pain, or fear of falling from participating in activities like walking. This is consistent with previous literature indicating that families have knowledge deficits about ageing, functional decline, and the benefits of staying active while in hospital (Boltz et al., 2011; Boltz et al., 2014a; Hall & Hoy, 2012; Higgins, Joyce, Parker, Fitzgerald, & McMillan, 2007). When families have insufficient knowledge about functional decline and the benefits of engaging in physical activity during hospitalization, they may prevent their relatives from being active. Previous studies have found that some families believe it is best to keep their relatives in bed and resting when they are ill in the hospital because they are not aware of the benefits of being physically active during hospitalization (Botlz et al., 2011; Hall & Hoy, 2012). Immobility and lack of exercise during hospitalization can result in decreased muscle tone and muscle strength and may result in older adults developing functional decline (Chambers, Moylan, & Reid, 2009; English & Paddon-Jones, 2010; Evans, 2010). My findings suggest that nurses perceive that families are challenging when they prevent nurses from supporting older adults with functional activities in hospital and when families impede older adults' functional abilities during hospitalization.

An important finding from my study is that nurses view families as constraining FFC when families either over-help their relatives with functional activities such as feeding or walking or when families do not help to support their relatives at all. Nikki et

al. (2012) found that many families have a desire to be involved in their older relatives' care during hospitalization. My findings add to the existing literature by suggesting that nurses perceive families as challenging when they prevent their relatives' from independently performing activities that they were capable of performing prior to hospitalization, thus increasing their risk for experiencing functional decline. Families often find satisfaction in providing care to their relatives during hospitalization because it makes them feel helpful and gives them a sense of purpose (Chen & Greenberg, 2004; Mitchell & Chaboyer, 2010). Some families describe that providing care to their older relatives is a way of demonstrating love and attachment (Mitchell & Chaboyer, 2010). Families may over-help their relatives with physical activities during hospitalization because they want to be helpful and this is how they show their relative that they care. Unfortunately, over-helping older adults with functional activities puts them at increased risk for developing functional decline and may result in them becoming more dependent on their relatives once discharged from hospital (Burket et al., 2013; Resnick, Galik, & Boltz, 2013).

Nurses also find it challenging when families under-help their relatives during hospitalization. Families may under-help their relatives with functional activities because they are absent from the hospital managing families and caregivers, are fearful of doing the wrong thing or do not understand the consequences of functional decline (Boltz et al., 2014a; Giosa et al., 2014; Higgins et al., 2007). My research findings suggest that families lack knowledge about the importance of maintaining older adults' functioning when they over-help them or under-help them with physical activities. Nurses can provide families with education about the importance of letting their relatives perform

physical activities for themselves whenever possible so families do not hinder their relatives from maintaining their functional abilities while in hospital.

### **Limitations of the Study**

While this study has a number of strengths, it also has some limitations. One limitation involves the sample of nurses used working in different acute care settings. According to the College of Nurses of Ontario (2015), the percentage of RNs and RPNs who work on medicine, surgery, critical care and emergency units are similar. For this study, a large proportion of participants were nurses working on general medicine units and only a small proportion of the sample represented nurses working in general surgery, critical care and emergency units. This study may have benefited from exploring the perceptions of nurses working in other acute care settings in addition to general medicine to further describe nurses' views when working with families of older adults in FFC and to make findings more generalizable to nurses working in different acute care settings.

This study was conducted using secondary data analysis. Although there are many strengths of using this approach (see research design section in methods chapter), some limitations can be noted. First, the collection of data and recruitment of participants was completed by my supervisor and her staff and I was not involved in this process. To learn about this in more detail, I had to acquire information directly from my supervisor. Secondly, data for this study came from written transcripts obtained through focus-groups discussions. Because I was not involved in conducting or observing the focus-groups, I was not able to observe participants' body language, tone of voice or emotions during the discussions. Lastly, since data used for this study were previously collected as part of a larger project with different objectives, the data were not collected to answer my specific

research question. Although the concept of families was a common theme noted within the focus-group data, there were no opportunities for me to further explore nurses' experiences with families during the discussions.

### **Implications for Nursing Practice**

Families often take on the role of caregiver for older adults at home and they want to continue to support their older relatives during hospitalization. Nurses play a key role in facilitating family involvement in older adults' care and should accommodate this when families want to help. Nurses receive important information from families about their relatives' health status and physical functioning that they can use to plan care for their clients based on their individual abilities to help prevent functional decline. Families also help nurses to detect changes in their relatives' physical and cognitive status and this allows nurses to intervene and adapt their care accordingly. Older adults often require a great deal of support to meet their physical and cognitive needs in hospital. Families can help meet their relatives' needs by assisting them with physical activities such as walking and toileting to keep them active. They can also engage in distraction and re-orientation techniques when their relatives are experiencing delirium to minimize the use of physical and chemical restraints by nurses which can harm older adults and limit their ability to move freely. Unfortunately, families can also create tension for nurses in FFC when they inhibit older adults' physical functioning in hospital. This happens when families lack knowledge about the importance of keeping older adults physically active in hospital and when they discourage their relatives from performing physical activities. I recommend that nurses facilitate family involvement in older adult care to help prevent functional decline by providing families with education and guidance about the importance of

maintaining physical functioning during hospitalization and by giving families instructions on how to perform physical activities with their relatives to help keep them moving.

### **Implications for Nursing Education**

Nurses often face challenges when working with families and this can create tension and unease within nurse-family relationships. When nurses want to avert functional decline in older adults, it becomes challenging for them when families prevent this from happening because they lack knowledge about how to support their relatives' physical functioning in hospital. To support the learning needs of families, I recommend that nurses receive education about FFC and ageing so that they can share this information with families to help advance their knowledge and to facilitate their involvement in older adult care. Teaching families how to support their older relatives may help families feel involved and ensure that nurses and families are on the same page when caring for older adults.

I also suggest that nurses receive education about conflict management and prevention as part of their nursing education and continuously throughout their nursing practice. This will help nurses to effectively manage conflict that arises between nurses, patients and families so that they can engage in effective communication and collaboration needed to deliver care to older adults. In this study, nurses identified that some families experience negative emotions including fear and burnout that can impact families' involvement in older adults' care. To help families feel empowered to be involved in their relatives' care and to meet the emotional needs of families, nurses should receive education about the emotions families experience when an older relative is

hospitalized. I also recommend that nurses have training to learn how to support families' emotional needs when their relatives are hospitalized.

### **Implications for Nursing Research**

I recommend further research studies be conducted to explore families' understanding about FFC and functional decline in older adults to identify specific areas where families lack knowledge about FFC and functional decline. In light of my study findings, further research should explore families' experiences on FFC in acute care settings. This may further our understanding of how families view nurses in FFC and provide a more comprehensive picture about barriers and facilitators for both nurses and families in working together to deliver FFC to older adults in acute care settings.

### **Conclusion**

In conclusion, this study sought to answer the following research question: What are nurses' perspectives in working with families of older adults in FFC? The study findings revealed that nurses view families as double-edged swords in FFC. Nurses described families as facilitating FFC when they provided nurses with baseline information about their relatives' health status and functional abilities and when they helped to meet their relatives' physical and cognitive needs. Nurses identified families as constraining FFC when their emotions prevented them from being involved in their relatives' care and when they lacked knowledge about the importance of physical activity in preventing functional decline.

Nurses recognize that they have an important role to play in providing families with education on how to help support their relatives' physical functioning. The study brings awareness to the challenges that nurses perceive to exist when working with

families in FFC. The study provides insight into the tensions nurses experience in providing care for older adults and raises awareness about the importance of nurse-family collaboration in acute care settings in the care of older adults.

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**APPENDIX A: Literature Review Table**

<b>Source</b>	<b>Purpose/Setting</b>	<b>Sample/Design</b>	<b>Findings</b>
Astedt-Kurki, P., Paavilainen, E., Tammentie, T. & Paunonen-Ilmonen, M. (2001).	<p>Purpose: Explore health care providers' perspective interactions with client family members</p> <p>Setting: Finnish acute care hospital (5 adult surgical units, 1 pediatric surgical unit &amp; 1 ER department)</p>	<p>Design: descriptive survey</p> <p>Participants: 320 hospital staff including nurses from 5 adult surgical units, 1 pediatric surgical unit &amp; 1 ER department</p> <p>Data Collection: Sample of 165 hospital staff. Data collected using questionnaire constructed from literature.</p>	<ul style="list-style-type: none"> <li>• Interactions were viewed as being “very important”</li> <li>• Majority of units followed a model of primary nursing</li> <li>• Hospital staff reported having interactions with families in personal and over the phone.</li> <li>• Interpersonal skills and work experience made it easier to interact with families</li> <li>• Interactions with families members was difficult when patient had a serious illness and was impeded by busy work schedules.</li> <li>• Staff behaviours, their openness and their friendliness facilitated interaction with family members</li> <li>• Family members' shyness impeded interactions between staff and families</li> </ul>
Fry, M., Gallagher, R., Chenoweth, L. & Stein-Parbury. (2014)	<p>Purpose: To explore nurses' expectations and experiences of carers and family members accompanying older adult patients.</p> <p>Setting: 550 bed metropolitan hospital in Sydney Australia</p>	<p>Design: qualitative study using exploratory design</p> <p>Participants: 27 nurses working in ER</p> <p>Data Collection: Focus groups incorporated semi-structured interviews using open ended questions and follow-up questions; audio-taped.</p>	<p>Theme 1: Importance of Time</p> <ul style="list-style-type: none"> <li>• Family members who were not frequently present were perceived as demanding and frustrating.</li> <li>• Lack of family presence limited ability of family members to provide information.</li> <li>• Nurses were frustrated and annoyed when families demanded too much time as it took away from patient care time</li> </ul> <p>Theme 2: Family/Caregiver as an informant</p> <ul style="list-style-type: none"> <li>• Family members are knowledgeable about older adults</li> <li>• Helps determine medical urgency of client</li> <li>• Nurses more understanding when families put effort into providing care for their relative</li> <li>• Information helpful for discharge planning</li> </ul> <p>Theme 3: Getting in the way</p> <ul style="list-style-type: none"> <li>• Family members could hinder</li> </ul>

			<p>client's reporting symptoms</p> <ul style="list-style-type: none"> <li>Families communicated on patient's behalf and impeded clients' rights</li> </ul>
<p>Gallagher, R. Chenoweth, L., Gallagher, P. &amp; Stein-Parbury, J. (2014).</p>	<p>Purpose: To explore the experiences and perceptions of nurses working in the emergency department when caring for older adults.</p> <p>Setting: Tertiary referral hospital in metropolitan Sydney Australia.</p>	<p>Design: Qualitative exploratory design</p> <p>Participants: 27 nurses from ED department who met inclusion criteria</p> <p>Data Collection: 4 focus groups guided by semi-structured interviews. Focus groups were audio-taped</p>	<p>Theme 1: clash of expectations between nurses and family/carers related to safety and quality of nursing care</p> <ul style="list-style-type: none"> <li>Lack of time and other priorities</li> <li>Lack of ability to provide basic nursing care</li> <li>Provision of comfort abandoned</li> <li>Families did not recognize workload management of nurses</li> <li>Nurses felt they were judged or not understood by family members</li> <li>Nurses frustrated by not meeting own care standards</li> <li>Frustrations were greatly reduced when nurses perceived family members understood their efforts and worked with them to support needs of the client</li> <li>Family members were not always aware of nurses' expectations of involvement or willingness to participate in care of older person</li> </ul> <p>Theme 2: Nurse's perceptions that family/carers could provide safety net for older persons in emergency departments to ensure safe, optimal care</p> <ul style="list-style-type: none"> <li>Family and carers were viewed as helpful resources</li> <li>Family members help to provide information and knowledge about patient</li> <li>Family members skilled in identifying changes in patient</li> <li>Family members can distract and engage patients from unsafe behaviours</li> </ul>
<p>Hall, E.O.C. &amp; Hoy, B. (2012)</p>	<p>Purpose: To explore clinical nurses' experiences of caring for older patients in a hospital setting.</p>	<p>Design: Phenomenological qualitative design using secondary data analysis</p>	<p>Main theme:</p> <ul style="list-style-type: none"> <li>Re-establishing Dignity</li> </ul> <p>Sub-Themes:</p> <ul style="list-style-type: none"> <li>Nurses felt maintaining and re-establishing dignity was</li> </ul>

	Setting: medical and geriatric ward in Denmark	Participants: 22 Registered Nurses and 7 Nursing Assistances; convenience sampling  Data Collection: Interviews	important <ul style="list-style-type: none"> <li>• Seeing the patient as a unique person</li> <li>• Supporting patient appearance</li> </ul>
Hallgrimsdottir, E.M. (2000).	Purpose: Experiences of nurses in accident and emergency units when caring for families of critically ill/injured patients and suddenly bereaved families.  Setting: Glasgow Hospital	Design: descriptive study  Participants: non-probability convenience sample of 54 RNs.  Data Collection: questionnaire	<ul style="list-style-type: none"> <li>• Information, reassurance and support were recognized as important family needs</li> <li>• A minority of participants felt they received adequate education to meet families' psychosocial needs</li> <li>• Majority of nurses found it difficult to deal with families in distress and did not feel they received enough emotional support</li> <li>• Nursing colleagues, families and friends are used by nurses for emotional support most often</li> </ul>
Lindhart, T., Rahm Hallberg, I. & Poulsen, I. (2008).	Purpose: To identify the experiences of nurses when collaborating with relatives of frail elderly patients in acute care hospitals to explore barriers and promoters for collaboration  Setting: a large Danish Hospital.	Design: Descriptive qualitative study  Participants: 8 nurses participated from acute wards; convenience sampling  Data Collection: open interviews using an interview guide; interviews were tape recorded and transcribed verbatim	Theme 1 – The coincidental encounter – the collaboration <ul style="list-style-type: none"> <li>• Discrepancy between the idea and practical level in nurses' experience of and attitude to relatives, and collaboration with them. Nurses identified with relatives' frustrations.</li> <li>• Nurses avoided contact with relatives with certain behaviours or when feeling uncertainty due to lack of knowledge about the patient</li> <li>• Other tasks were prioritized over involvement with relatives. Time pressure, workloads, work pressure and stress were all identified as constraints. The focus on medical tasks was identified. Organization of care was a barrier. Competency level and experience stood out as pre-requisite for success of collaboration with relatives.</li> </ul>

			<p>Theme 2 – Relatives – a demanding resource</p> <ul style="list-style-type: none"> <li>• Conflict between ideal and practice-related attitudes</li> <li>• Implicit code of rules for relatives appeared along with a set of role expectations that relatives should be passive recipients of information about decisions and plans made by staff.</li> </ul>
<p>Soderstrom, I.M., Benzein, E. &amp; Saveman, B.I. (2003).</p>	<p>Purpose: Explore nurses' experiences when interacting with family members in ICUs</p> <p>Setting: 2 ICU departments in Sweden</p>	<p>Design: qualitative</p> <p>Participants: 10 experienced Registered Nurses working in ICU</p> <p>Data Collection: interviews</p>	<ul style="list-style-type: none"> <li>• Nursing care of family members was essential</li> <li>• Establishing trust and openness in the relationship was most important</li> <li>• Nurses wished more family members were present when to support each other</li> <li>• Family members were a resource for nurses by providing information about patients and their families</li> <li>• More education, tools on how to assess and interact with families, professional supervision and support were requested by nurses.</li> <li>• <b>Inviting Interactions:</b> Family members were valuable; having a good relationship with families illustrates caring</li> <li>• Nurses' intuition, skills and experience affect interactions with families</li> <li>• How they "offered" themselves was important (confirming, presence, listening, answering questions, offering comfort)</li> <li>• Subsequent behaviours of nurses was impacted by how family members responded</li> <li>• Nurses who were confident with their professional role wanted to create relationships</li> <li>• Acceptance by family members occurred when nurses were perceived as competent medically and technically.</li> <li>• Honesty was a prerequisite for</li> </ul>

			<p>relationships</p> <ul style="list-style-type: none"> <li>• Establishing positive relationships allowed nurses to support family members in emotionally charged situations</li> <li>• Relationships were influenced by trust</li> <li>• <b>Non-Inviting Interactions:</b> medical and technical skills were believed to be most important nursing duties.</li> <li>• Nurses did not want family members to interfere with their work</li> <li>• Nurses felt defensive when family members watched when nurses worked with the patients</li> <li>• Nurses wanted to maintain boundaries between professional and private roles</li> <li>• Nurses did not want to illustrate feelings or show too much of themselves</li> <li>• Nurses felt ineffective in emotional demanding situations</li> <li>• Nurses distanced themselves from patients to protect themselves and avoid personal involvement</li> <li>• Nurses described feeling “hard” and believed that had lost their compassion</li> <li>• Nurses felt fear of being attacked by family members when families showed mistrust in the nurses’ professional competence</li> </ul>
<p>Stayt, L.C. (2007).</p>	<p>Purpose: Explore nurses’ experiences when caring for families of relatives in intensive care units.</p> <p>Setting: large teaching hospital in UK</p>	<p>Design: qualitative study using phenomenology</p> <p>Participants: 12 RNs working in ICU</p> <p>Data Collection: interviews</p>	<p>“Role Expectation”:</p> <ul style="list-style-type: none"> <li>• Participants did not refer to any standards of practice or guidelines</li> <li>• Lack of confidence when approaching families; fearful of saying the wrong thing; being unable to answer questions for the family appropriately</li> <li>• Practical Limitations: time constraints, inadequate resources, inadequate training, priority of care to the patient</li> <li>• Emotional limitations: confidence</li> </ul>

			<p>in skills</p> <p>“Role Conflict”- Disparity between participants’ expectations of their role and what they actually achieve – balancing care, professional versus personal</p> <p>“Role Stress” contributed to nurse stress, job strain and burnout.</p>
<p>Weman, K &amp; Fagerberg, I. (2006).</p>	<p>Purpose: to examine how factors influence nurses being able to work with family members of older adults</p> <p>Setting: Sweden; elder care unit</p>	<p>Design: qualitative study</p> <p>Participants: 314 Registered Nurses working in elder care</p> <p>Data Collection: questionnaires</p>	<p>Problems within the system: The organization was viewed as hindering relationship by:</p> <ul style="list-style-type: none"> <li>• Lack of support from management</li> <li>• Teamwork (lack of communication)</li> <li>• Physician not close enough (limited access to information)</li> <li>• Limited financial resources</li> </ul> <p>Interaction with families: Communication could be impeded by:</p> <ul style="list-style-type: none"> <li>• Language</li> <li>• Culture</li> </ul> <p>Relationships were influenced by:</p> <ul style="list-style-type: none"> <li>• Family dynamics</li> <li>• Relationship between family members and nurse</li> <li>• Family members advocating for older adult</li> <li>• Limitation of resources for families</li> <li>• Drug problems in family</li> <li>• Limited involvement by family members</li> </ul> <p>Caring in nursing work</p> <ul style="list-style-type: none"> <li>• Level of caring n nursing</li> <li>• Family judgement</li> <li>• Closeness and distance</li> <li>• Responsibility</li> <li>• Care planning and exchange of information</li> <li>• Quality of caring</li> <li>• Demands from family members</li> <li>• Receiving positive and constructive feedback</li> <li>• Being appreciated</li> </ul>

Source	Purpose/Setting	Sample/Design	Findings
<p>Haesler, E., Bauer, M. &amp; Nay, R. (2007).</p>	<p>Purpose: To explore perceptions of staff-family relationships; to explore characteristics associated with constructive relationships; To explore organizational practices most effective in developing constructive relationships between family and staff</p>	<p>Design: Systematic review.</p> <p>Participants: 32 qualitative and quantitative studies about staff-family relationships in the care of older clients in acute, sub-acute, rehabilitation, and LTC settings were used.</p> <p>Data Collection: Rigor of qualitative studies was assessed using Qualitative Assessment and Review Instrument.</p>	<p>Synthesis 1 – positive relationships with family members can be promoted through staff honouring uniqueness of resident</p> <p>Synthesis 2 – Although needs of family members vary, sharing experiences of caring for the resident, providing emotional support, and providing education have a positive impact on relationships with family members</p> <p>Synthesis 3- Positive communication between staff and family members is essential for the development of positive-family relationship.</p> <p>Synthesis 4 – Whilst families value collaboration in care, staff members sometimes have difficulties translating their own theoretical support of collaboration into practice</p> <p>Synthesis 5- Issues relating to power and control hinder the development of constructive relationships between staff and family members</p> <p>Synthesis 6 – Organizational issues including workloads, staffing models and care routines create barriers to development of constructive staff-family relationships and can impede implementation in collaborative care programs</p> <p>Synthesis 7: Interventions focused on increasing collaboration between staff and family members are most successful in promoting constructive family-staff relationships.</p>
<p>Segaric, C.A. &amp; Hall, W.A. (2015).</p>	<p><b>Research Question 1:</b> How do nurses, patients, and family members perceive their management of relationships to plan</p>	<p>Design: Qualitative study using grounded theory.</p> <p>Participants: 10 family members, 13</p>	<p>Focusing on Tasks:</p> <ul style="list-style-type: none"> <li>• During tasks interactions were minimal and guarded</li> <li>• When nurses, patients and family members experienced negative</li> </ul>

	<p>and provide patient care in the acute care hospital setting?</p> <p><b>Research Question 2:</b> How do features, including workplace conditions, affect nurses', patients', and family members' efforts to construct relationships to plan and provide patient care?</p> <p><b>Research Question 3:</b> How do personal factors affect nurses', patients', and family members' perceptions of their efforts to construct relationships to plan and provide patient care?</p> <p>Setting: acute care units across 4 community hospitals in a Western Canadian city.</p>	<p>acute care patients and 17 Registered Nurses were selected as participants using purposeful sampling. Inclusion/exclusion criteria established and used.</p> <p>Data Collection: demographic questionnaire, semi-structured audio-taped interviews, participant observation, and field notes</p>	<p>interactions, they expressed dissatisfaction about trust and respect in the relationship</p> <ul style="list-style-type: none"> <li>• Focusing on tasks, negative workplace conditions and personal factors could cause nurses, patients and family members to step back in interactions.</li> <li>• Workplace conditions requiring nurses to set work priorities resulted in nurses becoming annoyed about persistent questions from patients and family members</li> <li>• Using businesslike or impersonal approaches to care and interactions used by nurses resulted in stepping back from patients and family members.</li> </ul> <p>Getting Acquainted:</p> <ul style="list-style-type: none"> <li>• Participants could move past “just doing the job” if workplace conditions and personal factors facilitated active participation with intentions of getting to know each other better</li> </ul> <p>Establishing Rapport:</p> <ul style="list-style-type: none"> <li>• High levels of trust and reciprocity occurred with positive interpersonal dynamics, mutual support, gestures of recognition and willingness to “go the extra mile”.</li> </ul>
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## APPENDIX B: Participant Demographics Table

*Demographic and Work Related Characteristics of Focus Group Participants (n=57)*

Characteristic	n	%
<b>Sex</b>		
Female	54	94.7
Male	3	5.3
<b>Age</b>		
25-34	6	10.5
35-44	13	22.8
45-54	19	33.3
55-64	17	28.0
65 or Older	2	3.5
<b>Highest level of education in nursing</b>		
RPN Diploma	25	43.7
RN Diploma	22	38.5
Baccalaureate Degree	10	17.5
<b>Professional designation</b>		

RPN	24	42.2
RN	33	57.8
Years of Nursing Experience		
10 years or less	22	38.5
Primary area of practice		
Emergency	7	12.2
General medicine	22	38.5
General surgery	9	15.7
Intensive care	8	14
Coronary care	4	70.1
Non-critical care specialty	1	1.7
Multiple units	6	10.5
Employment status		
Full-time	44	77.1
Part-time	9	15.7
Casual	4	7.2
Hospital status		
Teaching	21	36.8
Non-teaching	36	63.2

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*Note.* n = sample size. RN = registered nurse. RPN = registered practical nurse. ICU = intensive care unit. CCU = coronary care unit.

## **APPENDIX C: Probes Used During Focus Group Interviews**

Probes to Explore Nurses' Perceptions about Families and Function-Focused Care:

1. Is it important to have families involved in care activities and decision-making?
2. How is involving patients and their families in care activities and decisions connected to preserving functional abilities?
3. How do you involve families in care activities and decision-making?
4. What strategies have been successful when involving families in helping to ensure best care is being provided to older adults?
5. What strategies have not been successful when involving families in helping to ensure best care is being provided to older adults?

**APPENDIX D: Research Ethics Board Approval Certificate**

**Certificate #:** STU 2016 -  
**031**

**Approval Period:** 03/09/16-03/09/17

5<sup>th</sup> Floor,  
Kaneff Tower

**ETHICS APPROVAL**

4700 Keele St.  
Toronto ON  
Canada M3J 1P3  
Tel 416 736 5914  
Fax 416 736-5512  
www.research.yorku.ca

**To:** **Whitney Green**  
Graduate Student of Nursing, Faculty of Liberal Arts & Professional Studies  
whitney12.g@gmail.com

**From:** Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics  
(on behalf of Denise Henriques, Chair, Human Participants Review Committee)

**Date:** Wednesday, March 09, 2016

**Title:** **Nurses' Experiences with Families of Older Adults in Delivering Function-Focused-Care in Acute Care**

**Risk Level:**  Minimal Risk  More than Minimal Risk

**Level of Review:**  Delegated Review  Full Committee Review

I am writing to inform you that this research project, "**Nurses' Experiences with Families of Older Adults in Delivering Function-Focused-Care in Acute Care**" has received ethics review and approval by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

Note that approval is granted for one year. Ongoing research – research that extends beyond one year – must be renewed prior to the expiry date.

Any changes to the approved protocol must be reviewed and approved through the amendment process by submission of an amendment application to the HPRC prior to its implementation.

Any adverse or unanticipated events in the research should be reported to the Office of Research ethics ([ore@yorku.ca](mailto:ore@yorku.ca)) as soon as possible.

For further information on researcher responsibilities as it pertains to this approved research ethics protocol, please refer to the attached document, **“RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE”**.

Should you have any questions, please feel free to contact me at: 416-736-5914 or via email at: [acollins@yorku.ca](mailto:acollins@yorku.ca).

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LLM  
Sr. Manager and Policy Advisor,  
Office of Research Ethics

## APPENDIX E: Consent Form for Focus Groups

October 31, 2012



Dear \_\_\_\_\_,

You are invited to participate in this study because you had indicated on your survey about nurses' opinions on best elder care that we could contact you.

**Study Name:** Nurses' opinions on best elder care

**Researchers:** Drs. Mary Fox, Souraya Sidani, David Ryan, Deborah Tregunno, Malini Persaud

**Sponsors:** Ontario Ministry of Health and Long-Term Care, Nursing Secretariat

**Purpose of the Research:** The purposes of this project is to (1) better understand how nurses arrived at their answers to the survey questions about the conditions they need to provide best care to older people, and (2) develop strategies to assist nurses to provide best care to older people.

**What You Will Be Asked To Do:** You will be asked to participate in one focus group session. The focus group is a follow up to a survey that you completed asking about your opinions on your work role, nursing care activities that you provide, interdisciplinary relationships, job satisfaction, intention to stay in nursing, resources available, knowledge of geriatric nursing, the quality of care older people receive, and personal and work demographics. The focus group will last about 90 minutes. The session will be held in a location that will be determined based on where participating nurses live. The session will be audio-recorded.

**Benefits of the Research and Benefits to You:** There will be no direct benefits to you. Your responses will help us better understand what nurses need to provide best care to older people. We plan to share this knowledge with policy makers and hospital administrators. We believe that your responses will help policy makers and hospital administrators develop strategies and resources to help nurses working in acute care hospitals to be able to provide the best possible care to older adults. As a token of our appreciation, you will be provided a \$75 honorarium.

**Voluntary Participation:** Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the nature of your relationship with York University either now, or in the future.

**Withdrawal from the Study:** You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer one or more questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

**Risks and Discomforts:** We do not foresee any risks or discomfort from your participation in the research.

**Confidentiality:** In the focus group, you will be asked to provide your first name only. All information you provide will be held in confidence and your name or that of your hospital will not appear in any report or publication of the research. Your information will be safely stored in a

locked facility and only research staff will have access to this information. None of this information will contain your name or that of your hospital. Mary Fox may use some of this information to train students. None of this information will contain anything that can identify you. Confidentiality will be provided to the fullest extent possible by law. If you choose to withdraw from the study all associated information collected will be immediately destroyed where possible. This project has been reviewed by the Office of Research Ethics at York University. It conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

**Questions About the Research:** If you have any questions or concerns about the study, please contact the principal investigator, Dr. Mary Fox by telephone at 416-736-2100 ext 23088 or by email [maryfox@yorku.ca](mailto:maryfox@yorku.ca). If you have any questions about this process or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5<sup>th</sup> Floor, York Research Tower, York University (telephone 416-736-5914 or e-mail [ore@yorku.ca](mailto:ore@yorku.ca)).

**Legal Rights and Signatures:** I \_\_\_\_\_ (fill in your name here), consent to participate in the study “Nurses’ opinions on best elder care” conducted by Mary Fox. I understand the nature of this study and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

\_\_\_\_\_  
**Print study participant’s name**

\_\_\_\_\_  
**Signature of participant**

\_\_\_\_\_  
**Date**

You will be given a signed copy of this consent form. Thank you for considering participating in this study.

Mary Fox RN PhD  
Principal Investigator  
Associate Professor, School of Nursing, York University  
[maryfox@yorku.ca](mailto:maryfox@yorku.ca)

**DISCLAIMER**

The College of Nurses of Ontario’s involvement in this research is limited to the provision of a mailing list. The College does not endorse or participate in this research in any manner.