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## Health care providers' perceptions of family caregivers' involvement in consultations within a geriatric hospital setting

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## ABSTRACT

This study explored health professionals' (HPs') experiences of interacting with family care-givers (FCs), and the strategies they employ during these interactions. Qualitative methods involved audio-taped and transcribed in-depth semi-structured interviews with 21 HPs (doctors, nurses) from the geriatric wards of two tertiary hospitals. Framework methods were used to analyze data. Seven main themes emerged: Variation in family behaviours; FCs face many challenges; Psychosocial factors influence FCs' behaviours; Attitudes, competing responsibilities and lack of resources influencing HPs' strategies and behaviours; Strategies employed by HPs to improve communication; HPs' self-care strategies; Impact of interactions on HPs and the healthcare system. Inter-relationships between the themes were then integrated into a three-part model. This study offered insights into HPs' perspectives, experiences, and behaviours in geriatric consultations where FCs are present. Findings emphasised the need for HP training programs to improve communication and collaboration between HPs, patients, and FCs.

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## Introduction

In Australia, as in many Western countries, the population is aging. Between 2009 and 2014, the number of people aged 65 years and over in Australia increased by 565,600 (20%) to reach 3.5 million people.<sup>1</sup> Similarly, in the US, the proportion of Americans aged 65 and older is projected to increase from 15 to 24% by 2060.<sup>2</sup> Aging is often associated with multi-morbidity, however there can be considerable diversity in morbidity and functional capacity across age groups. Frailty, rather than chronological age, is now considered the factor most determinant of geriatric status.<sup>3</sup>

Care for geriatric patients is complex due to co-morbidities and an often poor prognosis. Family caregivers in our society play a critical role in the care of their elderly relatives, in terms of the quality of the care they provide and the cost savings provided by their care.<sup>4</sup> In 2015 there were 2.7 million unpaid carers in Australia.<sup>5</sup> The

replacement value of their care was \$60.3 billion – over \$1 billion per week.<sup>6</sup>

Family Caregivers (FCs) (e.g. a patient's spouse, adult children, siblings) undertake many important caregiving tasks, including more technical tasks. They may provide emotional support, provide information (e.g. medical history), advocate for the patient, act as memory aids, provide logistical and practical support (e.g., dressing wounds and monitoring medication)<sup>7</sup> and actively participate in medical decision-making.<sup>8</sup> Their role usually increases as the patient's health, frailty, and cognitive impairment deteriorates.<sup>7,8</sup>

Prior studies found that many FCs feel ill-equipped for their roles as carers when the patient's health and functioning have deteriorated,<sup>9</sup> which can affect their wellbeing and health.<sup>7,10–12</sup> FCs want to be involved in caring for their loved one, and there have been recent calls from consumers in the literature for better support from HPs to empower them in this role.<sup>13</sup> However, the experience of seeing their aging relative vulnerable, suffering, and possibly approaching death, can, however, be extremely stressful for FCs,<sup>14</sup> and they may need support and care themselves.

Good communication and partnerships between patients, FCs and HPs can assist FCs, increase their involvement in care, improve their understanding of their roles and responsibilities, and decrease patient and FC distress and dissatisfaction, resulting in

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decreased complaints and litigation against hospitals.<sup>15–17</sup> For these reasons, the National Academy of Medicine (NAM) in the US, and others, have concluded that the involvement of families is key to achieving a high quality, high value health system that achieves positive outcomes.<sup>18</sup> Geriatric guidelines and models of care also promote family-centred care (FCC).<sup>19</sup>

There is no consensus definition of FCC, however there are commonly accepted principles and concept analyses of FCC,<sup>20</sup> which emphasise welcoming FC presence and participation in care, a respectful partnership between HPs, FCs and patients, provision of tailored information and support to FCs and respect for FC choices.<sup>20</sup> Recommendations to enhance involvement of FC within the hospital setting and a review of the evidence base to support family-centred care have been developed for the Intensive Care setting<sup>21</sup> and a useful model of engagement with FCs in the delirium setting has recently been proposed.<sup>19</sup>

While studies suggest that HPs view FCs' involvement in consultations as beneficial,<sup>22–24</sup> both doctors and nurses report that family-centred care is not always easy to adopt or optimal in the geriatric acute care setting.<sup>25</sup> HPs are time-poor<sup>26</sup> and are not usually compensated for attending to FCs' needs.<sup>15</sup> Acute care hospital settings are often busy and noisy and lack privacy and space for families to stay with their relatives,<sup>16</sup> making communication more difficult.<sup>24,27</sup> While nurses are expected to attend to concerns, provide emotional support, and deliver clarification when approached by FCs, they often report feeling ill-equipped in providing this level of support, largely due to low confidence or lack of appropriate training.<sup>25</sup>

For example, at times HPs have difficulty responding to conflicting expectations of patients and families,<sup>28</sup> particularly when FCs are experienced as dominant, demanding, or have unrealistic expectations of staff.<sup>29</sup> Doctors express concerns that FCs' involvement may intrude on their relationship with the patient and compromise patient autonomy.<sup>10,27</sup> Nurses report struggling with providing emotional support, clarifying medical care, and managing FCs who express strong negative emotions or behave aggressively.<sup>28,30</sup> Despite these reported challenges, clinical guidance supporting HPs in effectively communicating with and involving FCs, while growing, is still limited.<sup>31</sup>

Research examining the experiences and perspectives of HPs toward FCs within geriatric hospital settings may assist in developing effective training and guidelines for HPs when interacting with FCs, but remains sparse,<sup>32</sup> with most research focussing on patients' and FCs' perspectives.<sup>26,33</sup> This study therefore aimed to explore: 1) HPs' experiences and attitudes regarding FCs' involvement in key interactions and decision-making and 2) the strategies that HPs employ to overcome challenges when interacting with FCs.

## Method

### Design

This study was a cross-sectional qualitative study, designed to increase understanding of the meaning staff give to their experiences of working with family members.<sup>34,35</sup> Qualitative research is appropriate when there is insufficient understanding of a specific topic or when the phenomenon can best be described through rich narrative and detailed examples.<sup>36</sup>

### Study setting

The study was conducted within the Geriatric Medicine departments of two metropolitan tertiary referral hospitals in Australia. Their focus is on the management of common geriatric syndromes

such as dementia, delirium, falls, urinary incontinence, polypharmacy, and frailty.

### Recruitment

HPs with > 1 year of experience in aged care were eligible to participate in the study. The study rationale and procedures were presented by members of the research team, to all geriatric doctors and nurses working in participating centres, during face-to-face staff meetings. Copies of the information sheet and consent form were provided at that meeting to all interested staff. Consecutive interested HPs provided their contact details to research staff either at the meeting or via email. Research staff then phoned these staff within a week to explain more about the study, confirm consent and arrange an interview time. Recruitment continued until data saturation was achieved.

### Procedure

Participants completed a questionnaire eliciting demographic and professional characteristics, and an open-ended question where they were asked to identify the three top professional challenges (in Geriatric care) for which they would like additional training. Semi-structured interviews, piloted with two health professionals, (see Table 1) were then conducted in person with each participant in the workplace, by DK (a trained qualitative researcher), exploring their experiences and attitudes to FC involvement in patient care. Interviews ranged in length from 35 to 50 minutes. No repeat interviews were conducted. All interviews were audiotaped and transcribed for analysis.

Several techniques were employed to promote rigour in the study. First, purposive sampling of senior and junior nurses and doctors working in a geriatric hospital setting enabled the researchers to capture a diverse range of perspectives and viewpoints.<sup>37</sup> Member-checking was employed to ensure that the results and interpretations accurately reflected participant perspectives. Member checking involves presenting interpreted data to the persons from whom the data were originally obtained, and asking them to comment on the familiarity, face validity and accuracy of the material presented. It is seen by some researchers as the most important step in establishing the credibility of findings.<sup>38</sup> The researchers met weekly to discuss and resolve differences of interpretation during the data col-

**Table 1**  
Interview schedule.

1. What is your experience of family members (FM) who are involved in the care of their geriatric relatives?
  - How do things change when a FM is present compared to if the patient is alone?
2. Are there any factors that impact the communication between health professionals (HP) and FM?
  - What are the differences in FMs' involvement when patients are cognitive competent vs incompetent?
3. What roles have you observed family members play in consultations and family meetings? What roles do you think FM should play?
4. Can you describe your experiences when making decisions in a consultation in which FM is included?
  - Benefits and challenges
  - When and why are family more (or less) involved in the decision-making?
  - What supports or hinders family members from participating in decision-making?
5. Can you describe your experiences (if any) which have been challenging when interacting with FMs?
  - How do such situations affect you?
  - What strategies do you use in such challenging interactions?
6. Finally, is there anything else about family involvement in the patient medical care that we haven't touched on?

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