Unit Manager's Role with Family Members of Clients in Complex Continuing Care Settings: An Untold Story*

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RÉSUMÉ

À ce jour, la plupart des écrits scientifiques portant sur les relations entre le personnel et les familles découlent d'études portant sur des soins de longue durée. Ils mettent essentiellement l'accent sur la perspective des familles à l'égard des facteurs qui influencent leur relation avec le personnel, et comportent peu de conclusions liées à la perspective du personnel. Nous n'avons trouvé, dans la documentation spécialisée, aucune étude portant sur les relations entre le personnel et la famille, dans des établissements de soins complexes de longue durée, où l'on partait de la perspective du personnel. Une étude qualitative fondée sur l'approche de la théorie ancrée a été menée afin d'étudier les relations entre le personnel et les familles dans un établissement de soins complexes de longue durée. Les résultats présentés dans cet article permettent de mettre en lumière le rôle du gestionnaire d'unité. Les données ont été recueillies au moyen d'entrevues approfondies menées auprès de neuf gestionnaires d'unité et d'un groupe de discussion composé de cinq gestionnaires d'unité travaillant dans trois établissements de soins complexes de longue durée. Trois catégories, qui reflètent le rôle du gestionnaire d'unité auprès des membres de la famille des patients d'un centre de soins complexes de longue durée, ont été établies : établir un accueil positif; créer des liens et les entretenir; boucler la boucle. L'incidence des résultats de cette recherche, en matière de pratiques et de recherches à venir, est également présentée.

ABSTRACT

Most literature on staff–family relationships has come from studies of long-term care settings, has focused mainly on the families' perspectives on factors affecting their relationships with staff, and has included scant findings from the staff's perspective. No studies that examined staff–family relationships in complex continuing care (CCC) environments from the perspective of staff were found in the literature. A qualitative study that draws on a grounded theory approach was conducted to explore staff–family relationships in CCC, and the findings presented in this article illuminate the unit manager's role. Data were collected through in-depth interviews with nine unit managers and a follow-up focus group with five unit managers who work in three CCC facilities. Three categories reflecting the unit manager's role with family members of clients in CCC settings were derived: establishing supportive entry; building and preserving relationships; and closing the loop. Implications of the findings for practice and future research are presented.

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Introduction

Complex and continuing care (CCC) settings have a unique population of clients, many of whom have experienced life-altering events such as an acquired brain injury or a stroke. They are usually admitted to a CCC unit following an acute care episode for a variety of complex medical conditions, and have limited potential for returning to their homes. In CCC settings, the quality of care that clients receive can be seen as dependent on not only individual staff and/or family but also on the staff–family relationship. While there are technological competencies required for staff to practise in these settings, the skills of interpersonal engagement plus the development and sustainability of positive relationships with family members of clients are the predominant hallmarks of the practice setting. The expectations of staff at all levels – including health care aides, personal support workers, registered practical nurses, registered nurses, advanced practice nurses, as well as unit managers – to build and maintain supportive relationships with clients' family members are becoming increasingly more explicit in CCC settings. However, there is a paucity of literature on how staff build and maintain such relationships in these settings. The purpose of this qualitative study was to explore – from the perspective of staff – how staff–family relationships are built and maintained in CCC settings.

While there were no CCC studies, a few studies have been conducted in long-term care (LTC) settings to explore staff–family relationships, which are discussed next. While not all families wish to be involved in their relative's care (Bauer & Nay, 2003; Ward-Griffin, Bol, Hay, & Dashnay, 2003), several studies have shown that families often continue to and/or wish to be part of their relative's care within institutionalized settings (Kellett, 1999a, 1999b; Ross, Rosenthal, & Dawson, 1997; Sandberg, Lundh, & Nolan, 2001). This involvement requires them to establish relationships with staff that work in the facility. From the perspective of family members, how they relate to staff in LTC is influenced by staff ability to meet their expectations (Friedemann, Montgomery, Rice, & Farrell, 1999). These expectations include (1) working closely with staff and feeling as if they are part of the team (Gladstone & Wexler, 2000); (2) having their knowledge of their relatives and their experiences valued by staff (Duncan & Morgan, 1994; Friedemann et al., 1999); (3) wanting their relative to be treated as a unique individual (Bowers, 1988); and (4) seeing the development of "emotional bonds" between their relative and staff (Duncan & Morgan, 1994). Other factors that affect staff–family relationships centre on expectations of caregiving roles: (1) differing perceptions that nurses and families have of each other's roles on the unit (Levine & Zuckerman, 1999); (2) role overlap (Schwartz & Vogel, 1990); (3) rigid role definition (Duncan & Morgan, 1994); or (4) staff perceptions that families interfere with care (George & Maddox, 1989 noted in Friedemann, Montgomery, Rice, & Farrell, 1997). Organizational or unit deterrents are lack of privacy during family visits, lack of consistency in staffing, and unit policies that prevent family involvement (Specht et al., 2000).

More recently, some interest has developed in understanding the types of staff–family relationships in LTC. Gladstone and Wexler (2002b) identified five types of staff–family relationships in LTC settings: friendly, collegial, professional, distant, and tense. According to their study, participating in care decisions, sharing experiences, and establishing trust contribute to positive relationships with family members. Four types of relationships emerged from the study of Ward-Griffin et al. (2003): conventional, competitive, collaborative, and "carative." Some studies suggested that when families are involved in the client's care, staff appear more satisfied (Karner, Montgomery, Dobbs, & Wittmaier, 1998), and have a low rate of staff burnout and fatigue, as well as increased personal job satisfaction (Anderson, Hobson, Steiner, & Rodel, 1992). But other studies (e.g., Hertzberg, Ekman, & Axelsson, 2003) indicated that staff see families as demanding and time consuming. Conflicts between staff and families have been shown to have a negative impact on family members (Gladstone & Wexler, 2002b), staff (Cohen-Mansfield, 1995), and client outcomes (McGilton, 2001). Therefore, it is important to understand in depth how staff build and maintain relationships with family members in all settings.

The purpose of our study was to understand how staff – health care aides, registered practical nurses, registered nurses, unit managers, and advanced practice nurses – develop and maintain relationships

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with family members of clients in CCC settings. The research questions were – from the perspective of staff – how they develop and maintain relationships with family members, and what influences ways in which these relationships develop. This qualitative study draws on a grounded theory approach informed by Glaser and Strauss (1967) as well as Strauss and Corbin (1998). Grounded theory helps to interpret, predict, and explain social processes of a situation from the perspectives of multiple persons involved in the situation. Grounded theory approach "has been especially useful for the study of setting and social relations that have not previously been the explicit focus of attention" (Kushner & Morrow, 2003, p. 33).

This paper summarizes our findings on the unit manager's role in staff–family relationships. This understanding is important, given unit managers' pivotal position at both the micro and macro levels in CCC facilities.

Setting and Sample

This study was conducted at three non-profit health care facilities located in an urban area in Ontario. All three facilities were large and ranged from 150 to 400 CCC beds. The number of clients on each CCC unit varied from 40 to 70, and their diagnoses included end stage renal disease, diabetes, HIV, stroke, brain injury, CHF, COPD, MS, ALS, and dementia.

A purposive sample of nine unit managers participated in individual interviews and five in a focus group discussion. The study participants were all women, were on average 47 years old (range: 32–54 years), and were primarily Anglo-Canadian, and included one Indo-Canadian and one African-Canadian. On average, they had 18 years of experience in nursing (range: 3–29 years) and close to 11 years in CCC settings (range: 2–18 years). Five of the managers had a B.Sc.N. preparation, and four had advanced nursing preparation. On average, they had approximately 50 staff (regulated and unregulated care providers) reporting to them.

Data Collection and Analysis

Once permission was obtained from the Research and Ethics Review Boards of each facility, one of the co-principal investigators (co-PIs) met individually with the directors and unit managers at each facility to explain the study. A few days later the research assistant (RA) called the unit managers to invite them to participate in the study. Upon their agreement to be interviewed, a time and place of convenience for each participant was decided.

The RA was a master's-prepared nurse practitioner with previous experience in working with research teams engaging in qualitative research projects. She participated in several simulated interviews with the co-PIs as part of the training for this study. The RA also met with the co-PIs after completing each of the first three in-depth, face-to-face interviews to discuss her experience in conducting the interviews and to receive feedback on her interview style and format. The RA used semi-structured, open-ended interview questions, some of which are presented in Table 1. During interviews, she attended closely to participant responses and asked questions to elicit depth and clarity of data. Individual interviews lasted for 45 to 60 minutes. At the completion of individual interviews, a focus group was also conducted with five unit managers. Of these, four had participated in the in-depth individual interviews. The fifth had been at the CCC facility only for six months and was invited to participate in the focus group discussion (even though she had not participated in the individual interviews), in order to broaden the range of participant employment in the particular CCC facility.

Table 1: Sample interview questions

What is it like working with families on this unit?
Tell me what your most positive (negative) relationship was like. What personal characteristics (both on your side and the client/family members' side) contributed to such a positive (negative) experience? What organizational factors contributed to this situation?
In general, what kinds of things make establishing relationships with family members easier (harder) for you? Can you explain how these things make it easier (harder) for you to establish relationships with family members?
What kinds of things do family members want from you? What do you do that helps family members the most (least)? What kinds of things do you think family members find the most (least) helpful in their relationship with you?
To what extent do you feel supported in relating to families? Where does the support come from?

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The purpose of the focus group was to confirm or disconfirm the preliminary interpretation of the data as well to further develop the relational properties and dimensions. The one-hour focus-group session was conducted by two members of the research team; while one member led the discussion, introduced topics, asked for clarification, and encouraged all participants' feedback and comments, the other took notes of the group process and kept track of who said what. The two research team members met after the focus group session to discuss the content and process and to note initial impressions of the focus group discussion.

All individual and focus group discussions were conducted with informed consent, were tape-recorded, and were transcribed verbatim. Each transcript was checked with the corresponding tape for accuracy and completeness. Code numbers were assigned to all participants and each of the sites and units. Only the research team had access to the name/code book and demographic data. Data collection, data analysis, and sampling were carried out simultaneously. Each transcript was read in its entirety by three designated members of the research team. The team made notations directly in the margins on the transcripts. Then the whole team met to discuss and reach consensus on the interpretation of the data. Each interview was coded using line-by-line open coding (Strauss & Corbin, 1998). Analysis of the first transcripts picked up key words and phrases suggesting that unit managers' roles with family members varied, depending on the family members' needs. For example, unit mangers used phrases such as "supporting families in transitions" and "supporting families through their adjustment to CCC" to describe their relationships at the beginning. Unit managers used new phrases such as "once they have been on the unit for awhile" and "being proactive in maintaining relationships," which reflected additional roles of the unit manager after the initial entry period to the unit. Properties and dimensions of categories were developed through axial coding (Strauss & Corbin). For example, within the category "establishing supportive entry" the properties "clarifying expectations" and "acting as a conduit" were revealed. Three main categories were identified, and the final integration of properties was done through selective coding.

Sampling purposively helped to capture a range of experiences (such as length of experience as a unit manager in CCC or at the particular facility) needed to address study questions and ensure that findings are relevant beyond the confines of the study. Further, the researchers' interpretation of individual interview data was subjected to verification during the focus groups to ensure credibility of the findings. Procedural and ethical rigor was maintained by adhering to the protocol proposed, and by ensuring that the logic of interpretation of data is auditable by maintaining reflexive records of decisions and actions.

Results

Three categories were derived from the data, each reflecting the unit managers' role with family members of clients in CCC settings: (1) establishing supportive entry, (2) building and preserving relationships, and (3) closing the loop (see Table 2).

Establishing Supportive Entry

The central properties associated with establishing supportive entry were "clarifying family members' expectations and perceptions" and "acting as a conduit for family members into the management and organizational systems of the facility."

Unit managers observed that there had been a marked increase in acuity of patients transferred from acute care to CCC settings in recent years and

Table 2: Categories and properties emerging from the data

Categories	Properties
Establishing supportive entry	Clarifying expectations and perceptions
	Acting as a conduit into the management and organizational systems
Building and preserving relationships	Listening and responding to family members' needs
	Ensuring continuity of family members' wishes
	Negotiating and balancing needs of family members and staff
Closing the loop	Dealing with unmet expectations of family members
	Making the change

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that families and clients were moving through the system quickly. These changes left little time for family to "process all that is happening to their family member." One unit manager explained,

> Patients are being discharged sooner in acute care facilities. We are getting patients and families who mostly are playing catch-up, and a lot of them are still in denial about their illness . . . families who still haven't dealt with the guilt, crisis of acknowledging it even. So, it's really very difficult. It's not like 10 years ago, it's changed.

Such changes have made the role of establishing supportive entry crucial in helping family members adjust to CCC environments. For family members, the transfer of their loved one from an acute care unit to a CCC setting results in having to change their expectations and perceptions about the diagnosis and the prognosis of their loved one's condition. From the perspective of the study participants, clarifying family members' expectations and perceptions during the entry period also involved trying to instill hope, without being too unrealistic. One manager explained,

> That way we're working with them constantly and saying, "We hear what you're saying." We're not telling them that they can't achieve it, but rather, let's just do little steps. They themselves often come to the realization they're never going to reach this goal, and then they start to verbalize that, and then it opens up a whole new avenue that you can now talk to them about their losses.

During the initial period in a CCC setting, family members also experienced ambiguity about the new clinical setting and their role in it, which created anxiety, stress, and conflict. According to unit managers, clarifying expectations and perceptions about the new setting and the services offered there prior to the client's discharge from acute care could assist families with the transition and help to decrease distress. For example, services such as physiotherapy tend to be minimized to the clients if there is no significant change in their functional or cognitive status. But families may not be informed prior to their loved one's transfer about the type of setting or about reduction in services, and conflicts can result. In order to address such concerns, unit managers have taken steps that include "visiting all potential clients before they are discharged from acute care units." Another manager commented about her attempt to address similar concerns:

> We've tried in many ways to link with the acute care setting to help the staff there understand who we are and what we provide, but there's always changes happening there, so of course there's always the potential the wrong information will be shared.

The entry period involving family members coming to terms with diagnosis, prognosis, new goals for themselves, and their relative who is receiving care at the facility, was lengthy. According to participants, the entry period took one to six months, depending on the frequency of and length of their visits to the unit, among other factors: "While some family members are there every day, others are able to visit only on weekends." Accordingly, unit managers employed a variety of communication strategies to connect with family members during entry period. These strategies included e-mailing, making phone calls, and posting unit managers' availability on the unit. Even if brief, such approaches demonstrated unit managers' interest in connecting with new family members and opened up a space for communication.

Participants also observed the need of family members to know "who was in charge" and saw the unit managers as key in meeting this need:

> It's like the families are waiting. Even though staff are doing the orientation, they are sort of waiting for the manager to come by and just introduce themselves. Families have an expectation of knowing who is in charge, a connection to the organization.

This perception was related to unit managers' role as a conduit into the facility's management and organizational systems. One unit manager commented on the importance of this aspect of her role: "Family members coming to these organizations and not knowing who to turn to for help or who to go to for answers and how to navigate the system." To this end, another unit manager spoke of "sitting down as soon as they come in, letting them know who is who and where your office is." Unit managers' awareness of and central role in the facility was helpful in sending or redirecting family members in a timely manner to others (such as chaplaincy or client relations) within the organization who could better address particular needs of the clients and their family members, as well as facilitate the exchange between them. Unit managers in the study spoke of their skills and preparation, and the experience of dealing with various levels of the facility within a complex health care system so that they could be a "conduit into the system." One manager said,

> I always try to coach family members and redirect them to where they needed to go to find their answers and sit in with them for the first little while as they express their concerns. If they've got a concern . . . then I facilitate the exchange.

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Establishing supportive entry facilitated the development of family–staff relationships during the rest of their stay in the setting.

Building and Preserving Relationships

Participants unanimously agreed on the importance of building and preserving relationships between staff and clients' family members. Based on unit managers' experiences, ''bad'' relations were difficult to repair, so there was an incentive for them to preserve ''positive'' staff–family relationships and to encourage their staff to do so as well. They felt that family members were also more willing to tolerate the shortcomings of staff if they already had a ''good'' relationship with them. The key properties associated with building and preserving supportive relationships included ''listening and responding to the family members' needs and concerns,'' ''ensuring continuity of their wishes,'' and ''negotiating and balancing care needs between family members and staff.''

Listening and responding to family members' needs was a priority for all managers in the study. They felt that clients' family members also were going through a difficult time and as such, in need of staff attention:

> Because their loved one may not be able to speak, so that [family members] are the ones that have the burden of all the changes that are going on in their life ... they may be here day in and day out that we have to think about as much as the patient.

Participants clarified that listening to family members also involved looking beyond the complaint to begin to understand that family members were seeking help and/or answers:

> What we try and do is simply focus on the situation ... sometimes they won't come out and tell us you know, the family member is not getting better. It's more a case of, you know, my family member didn't get up ... didn't get put back to bed, or we were late doing something, or whatever.

> Just taking that extra minute and listen to somebody makes such an incredible difference .... It is just trying to keep that in front of your mind ... even when families are angry ... it's just trying to remember it's not at you, it's at life, it's at God, it's at whatever, but ... we're the ones that hear it.

While listening was a key aspect of building and preserving staff–family relationships, responding to family members within a reasonable time was also important. Listening and responding to family members' needs and concerns also meant demonstrating honesty and open communication, which included acknowledging mistakes:

> Like you know, hey we messed up, that shouldn't have happened, you're absolutely right ... I think some people out there can accept a mistake and forgive a mistake.

However, some respondents felt such an approach was not always easy, because ''sometimes families can't let go of the history, but neither do staff.'' Unit managers responded to such situations by directing the two parties to focus on the client's needs. As one unit manager stated, ''When we put clients' needs in the middle, everything else is not that important.''

According to participants, ensuring continuity of family members' wishes was important in preserving positive relationships with family members. One unit manager said,

> Because of the kind of patients that we have ... they are here for so long it's really important to try to work together with these families, because they are not going away, or we hope they aren't going away. And often the families know the patient much better than the staff, so we get to know the family members. They can help us in finding [what really matters] for patients. It's really rewarding. If a relative asks me for something ... a lot of things are doable; it's just a matter of finding out and accessing the assistance and support to do that ... if it works, then we need to continue doing it.

Ensuring continuity of the family wishes often involved notifying as many staff as possible. For this purpose, unit managers in the study employed several strategies such as having formal and informal meetings with staff, posting notes in the communication book/binder, and posting care plans at the bedside. One manager spoke about current plans to develop a worksheet to ensure continuity of family wishes when employing agency staff. Information continuity was important for both continuity of care for the client and for preserving staff–family relationships.

Unit managers in the study also described the need to negotiate between the care concerns of family members and of staff in an attempt to preserve staff–family relationships. While staff were perceived to be interested in being fair to all clients, family members were more interested in meeting the unique needs of their relative. At times family were seen as adamant about a particular routine for their relative, despite its impact on other clients. For example, if their relative usually took a bath at 8:30 a.m., they wanted to continue this routine, despite the concern that a staff could not be freed for this purpose during breakfast

time on the unit. When family members "continue to complain about staff, regardless of all they do, staff become very frustrated and approach me to intervene." In such situations, unit managers were able to negotiate a balance between concerns of families and staff. Unit managers spoke of meeting with staff to listen to their interpretation of the situation, and to provide them with another point of view in order to come up with ideas and suggestions together to see "how we can best help this family." Through unit managers' actions, staff were able to see other ways of being with, thinking through, and working with family members to balance care concerns of the clients. The role of the unit manager here is to negotiate a win/win situation, supporting both staff and family members, so that the staff–family relationship is preserved.

Closing the Loop

Closing the loop was characterized by two properties: "dealing with unmet expectations" and "making the change." When family members complained about their relative's unmet needs, unit managers picked up the missing pieces in ways that varied from apologizing to rectifying what was not done. Unit managers in the study described the link between their administrative positions and "closing the loop" in the following way: family members as well as staff saw the unit managers as having the power to deal with any unmet needs and to make changes to address the situation. One unit manager said,

> I often get the feeling from families that when they look at the nurse managers, they see us as having answers to all problems: ... we can fix everything, we can make everything right, we have all the answers. And that can be a tough position to be in.

While study participants also perceived that their position enabled them to "close the loop" and address unmet needs and concerns that staff could not, they also felt that it was important to convey to staff and family that unit managers did not have solutions or easy answers to every problem.

For many unit managers, their role often included "dealing with unmet expectations" that resulted when staff had insufficient time to listen to family concerns or promptly respond to family needs, which in turn appeared to be related to shortage of staff or use of agency staff on units. One manager stated, "I hate to tell [family members] that we have only four people on the floor ... two that have to take care of basically 30 to 40 patients who all need some sort of care and medications and everything." Other reasons for inability of staff to deal with family concerns were lack of required equipment or resources on the unit. Some unit managers felt that in working in such conditions, "we are setting staff up for failure."

When relationships between family members and staff were strained and negotiating care was not working, unit managers took over in an attempt to diffuse the situation and get the issue resolved. They worked more unilaterally with the family member, even though this was not their preferred role.

In "making the change," unit managers spoke about ensuring continuity of care for the client and arranging further training and skill-development for staff. One manager elaborated, "My personal kind of wish list would be to do something organization wide to put some system in place so that staff does not feel that powerless." Other focus group participants spoke about the need for units, programs, and organizations to not only have their vision, mission, values, and beliefs written and posted but also to inform staff at all levels about how to put these ideals and principles into practice:

> I'd like to see organizational principles that would just make sense. It should say you know, how do they turn that into action because it's not nouns, it's verbs, ... like care, courtesy, positive attitude, enthusiasm. But how do you translate it from a word into action, so that you know it when you're doing?

Unit managers in the study spoke about their role in "making the change," which sometimes required anticipating, identifying, and responding to issues on the units. This response included development, implementation, and evaluation of new unit policies or initiatives. The unit managers felt that they were in a position to recognize the need and opportunity for change towards advancement of care to clients and families and to facilitate change through their leadership and role modelling.

Discussion

The findings from the study add to our knowledge of staff–family relationships in CCC in several ways. It was apparent that the quality of support provided by unit managers partially determined quality of staff–family relationship. In this study, unit managers' support was directed primarily towards establishing supportive entry to CCC, building and preserving relationships, and closing the loop.

In recent years, the health care system has experienced increased consumer expectations, rapid processing of patients through a maze of settings, demand for cost containment, and diminished personnel resources. These changes – combined with increase

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in technological care, longevity, and number of patients in LTC and CCC settings – affect the way institutionalized care is provided. The process of establishing supportive entry when family members arrive on the unit is consistent with findings from a recent synthesis of current research on families and chronic illness by Knafl and Gilliss (2002) and a review of studies on staff–families partnerships in long-term care (Bauer & Nay, 2003), and from nurses' perspective in a study by Gladstone and Wexler (2002a). In a review of descriptive studies in the pediatric literature, Knafl and Gilliss (2002) found that the time around diagnosis was especially difficult for families. Likewise, Meacham and Brandriet's (1997) study findings on family members' experiences of the transition phase demonstrated that once a relative was admitted to a long-term care facility, family members felt guilt, conflict, and uncertainty. These investigators concluded that interventions directed toward supporting family members' adaptation were crucial. Gladstone and Wexler (2002a) found that when nurses first met with family members, they tried to reach out to them without being intrusive. Nurses also spent time listening to families' feelings of guilt about their relative's move to the facility. In our study, the unit manager's role of clarifying expectations and acting as a conduit into the facilities' organizational systems appears to assist in establishing supportive entry for family members. However, unit managers' workload made it difficult to provide supportive entry.

Preserving staff–family relationships was a theme in several other studies. For example, Horvath and colleagues (1994) found that the unit manager's role in acute care facilities included preserving client–family/staff relationships, in ways such as listening, negotiating, and responding to families' needs. Bauer and Nay (2003) found in LTC environments that all stakeholders benefit from family involvement in care that had been negotiated with the staff. According to Bowers (1988), a primary concern of families of clients in the nursing home was maintenance of a client's unique individuality and idiosyncratic needs. Ensuring that continuity of family wishes are known to all staff was seen to be the responsibility of the unit managers in our study. While staff appeared to be seeking equal and fair treatment to all clients, families were more concerned with meeting the unique individuality and idiosyncratic needs of their own family member. Unit mangers in the study often responded in a manner that brought a fair resolution to the situation.

Unit managers had a central role in closing the loop on the concerns expressed by family members, and employed a number of strategies to do so. Foner (1995) noted that family members found it difficult and distressing when their needs and concerns were disregarded or ignored by staff. According to Foner (1994), family members have a sense of urgency that is not necessarily shared by staff. Family complaints in the nursing home were often directed at the staff who provided most of the direct care. In our study, unit managers were perceived as having the most influence and were approached by unsatisfied family members, who expected the unit manager to pick up the missing pieces and make the change.

Our study findings suggested that unit managers were involved in role modelling for staff how to best help families in time of need. These findings are consistent with findings from Ward-Griffin et al. (2003) in that the mentorship of nursing leaders was important in fostering family-centred care. The support that family as well as staff received was conditioned by unit managers' leadership capacity. Effective leadership capacities that have been identified in LTC environments include communicating effectively and showing personal concern (Buelow, Winburn, & Hutcherson, 1999), being empathic and dependable with staff (McGilton, 2003), and listening effectively and being persistent and honest (Samuelson, 2002). Glasscock and Hales (1998, p. 37) observed, "The administrator is expected to take charge, be a responsible role model, and a competent mentor." In the Cardin (1995) study conducted on 49 intensive care units in Los Angeles, nurses ($n = 454$) and physicians ($n = 110$) perceived that the nurse manager's leadership characteristics and skills were important in meeting family members' needs. Nurse managers' leadership behaviours and practices explained 23 per cent of the variance in meeting family needs. Unit managers in our study affirmed that these leadership skills were important attributes in their work. In all three categories, the unit managers' capacity to communicate effectively was duly noted. Managers spoke about the need to listen and respond to family members' wishes and expectations, that required them to be empathic and good listeners. They were called on to establish supportive entry, that required them to be effective communicators. Managers' effective communication skills and strategies also helped to motivate staff to achieve excellence in practice.

Extrinsic factors, such as time allotted to care for families and degree of collegial and administrative support, were found to define the type of relationship that developed between families and staff (Ward-Griffin et al., 2003). Nurses who were part of a collaborative or carative relationship with families reported the importance of administrative support. Unit managers were called on to develop policies to

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create a family-centred care milieu or to ensure that adequate time and resources were spent cultivating positive family–nurse relationships. According to Montgomery (1983), staff attitudes towards family members were related to the care policies in each institution that influenced the extent to which families were involved. Similarly, Gladstone and Wexler (2002a) found that structural characteristics of the facility – such as institutional policies on family involvement, the work culture, including the type of support that RNs expect to receive from supervisors after a family complaint – shape the family–staff relationship. In our study also, extrinsic factors such as lack of adequate time, decrease in staff to client ratio, and lack of clear policies and guidance on how to enact family-centred care influenced staff–family relationships.

Limitations

This study is limited to the perspectives of unit managers in CCC settings in an urban area in Ontario, Canada. Perspectives of unit managers in LTC settings or CCC settings in different geographical locations may be somewhat different. While we have attempted to explore unit managers' view on their role with family members of clients in CCC settings, incorporating client and family perspectives on the topic would have allowed us to understand to what extent these findings are relevant to them. For example, a few studies (Shuttlesworth, Rubin, & Duffy, 1982; Schwartz & Vogel, 1990) found differences in expectations, roles, and responsibilities between family members and staff. Family members' perception of how unit managers build and maintain supportive relationships in CCC settings can be an area for future inquiry.

Implications

Study findings suggest several implications for practice and future research.

Implications for Practice

Although the findings serve as a beginning effort to understand staff–family relationships in CCC settings, they also shed some light into working with family members of clients in CCC settings and, also possibly, those in LTC, where clients also live out their remaining days. In order to provide the best care possible to their clients in CCC settings, staff need to be cognizant of the importance of building and maintaining supportive relationships with their clients' family members. To this end, administrators of such facilities can play a big role and therefore need to reflect critically on their practices related to working with families. The period of entry to CCC settings can be confusing and difficult for clients' families. Establishing supportive entry appears to be key in building and maintaining supportive relationships with them. Open, honest, empathic, ongoing communication with family members as well as timely responses to their concerns facilitate the maintenence of staff–family relationships. In addition, these strategies appear to lessen unit managers' time spent in dealing with unmet needs and complaints.

Implications for Research

Currently we are analyzing study data from our interviews with advanced practice nurses, registered nurses, registered practical nurses, and health care aides to understand their perspectives on staff–family relationships in CCC settings. Our preliminary analyses suggest that there is overlap in the roles and responsibilities of staff, which is causing confusion to both staff and family members of clients. The ultimate aim of our research is to develop a model of family–staff partnership where family members will know whom to turn to for answers to their needs, which in turn may facilitate better relationships as well as clearer delineations of roles and responsibilities among staff. Future research will involve testing the model of family–staff relationships and its links to desirable client, family, and staff outcomes. Further, little is known about facilities without unit managers. Similarly, who provides this link when the unit managers' span of control is too large, is an area for further inquiry.

Conclusion

This paper provides an initial discussion on unit managers' role with family members of clients in CCC settings, an important area of nursing that is not yet well explored. Unit managers' role in establishing supportive entry quite possibly facilitated the process of building and maintenance of staff–family relationships. Unit managers' role in closing the loop was directed at addressing family members' unmet need, which appear to be related to the first two roles mentioned here. Effective leadership roles and capacities appear to facilitate supportive staff–family relationships in CCC environments, and the unit managers' pivotal position in this endeavour must be recognized and supported.

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