Health Care Aides' Struggle to Build and Maintain Relationships with Families in Complex Continuing Care Settings*

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RÉSUMÉ

La recherche sur les relations entre les aides-soignants (AS) et les familles des clients est menée principalement dans le milieu des soins de longue durée, et elle offre peu de résultats sur la perception des AS. Sur la base des résultats d'une étude qualitative plus étendue à l'aide d'une méthode basée sur une théorie reposant sur les faits, le présent article traite des relations AS-famille dans le cadre de soins continus complexes (SCC). Des entrevues individuelles approfondies avec huit AS et un groupe de suivi avec les AS de trois établissements de SCC ont été analysées. L'établissement de relations avec les familles nécessitait « être présent pour eux et leurs parents », tout en maintenant des relations comprenant le fait d'avoir à « faire face à une déception ». Parmi les facteurs influençant l'établissement et le maintien de relations AS-famille, il faut noter « avoir des membres d'un groupe de soutien », « avoir des ressources disponibles » et « établir une structure hiérarchique dans l'équipe des soins de santé ». Les résultats soulignent l'importance de réduire l'unité et les facteurs organisationnels qui dérangent les relations AS-famille.

ABSTRACT

Research on the relationships between health care aides (HCAs) and families of clients has been situated mainly in long-term care settings and includes scant findings about the perceptions of HCAs. Based on the findings of a larger qualitative study using a grounded theory approach, this paper addresses the topic of HCA–family relationships in complex continuing care (CCC). In-depth individual interviews with eight HCAs and a follow-up focus group with HCAs from three CCC facilities were analysed. Building relationships with families entailed ''being there for them and their relatives'', while maintaining relationships involved ''dealing with disappointments''. Factors influencing building and maintaining HCA–family relationships included ''having supportive team members'', ''having resources available'', and ''functioning within care-team hierarchies''. The findings highlight the importance of minimizing the unit and organizational factors that disrupt HCA–family relationships.

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Research demonstrates the important role of nursing staff in preserving the identity of the client through sensitive, nurturing, and individualized care (Bowers, 1988; Keefe & Fancey, 2000). Such care can be delivered only in a collaborative partnership among the client, her/his family members, and staff (Janzen, 2001). Several studies (such as Gladstone & Wexler, 2002; Ward-Griffin, Bol, Hay, & Dashnay, 2003) explore nursing staff's perceptions of relationships with family members in long-term care (LTC) and in complex continuing care (CCC) settings. However, studies focusing on the relationship between nurse aides (referred to as *health care aides* [HCAs] in the Canadian context) and family members are sparse, despite the more proximal role of HCAs in delivering care in CCC and LTC settings. This paper presents the findings of a grounded theory–based qualitative study on the importance of the role of HCAs in developing and maintaining supportive relationships with family members of clients in CCC facilities. This study is part of a larger study that explored staff's perspectives (HCAs, registered practical nurses [RPNs], registered nurses [RNs], advanced practice nurses, and unit managers) on how they developed and maintained relationships with family members of clients in CCC settings. Presented first is a brief summary of literature on staff–family relationships in LTC and CCC.

Literature Review

Several researchers have explored family members' appraisals of developing relationships with staff in LTC. Factors that affected these relationships centred around families' attitudes, behaviours, and expectations in relation to their role in LTC settings. Family members tended to develop relationships with staff when (a) their attitudes were welcoming, friendly, and compassionate (Lau & McKenzie, 1996); (b) they were able to reassure and console families during difficult times (Laitinen & Isola, 1996); (c) they demonstrated empathic awareness (Sandberg, Nolan, & Lundh, 2002); (d) they took the initiative to approach families to talk (Li, 2004); and (e) they promoted learning (Friedemann, Montgomery, Maiberger, & Smith, 1997). Family members also perceived that relationships developed more easily when they were expected to be part of the team with staff, rather than just to take on services that staff did not provide (Boise & White, 2004). As well, most family members expected to contribute to the care of their relatives by providing information about biographical background and individual care needs (Bowers, 1988).

A few researchers have investigated staff members' perception of the development and/or maintenance of staff–family relationships in LTC settings. Gladstone and Wexler (2002), for example, found that registered nursing staff who encouraged families to participate by making care decisions and sharing their experiences with staff built positive relationships with family. Other factors that contributed to effective relationships between registered staff and family members of clients in LTC included staff members' willingness to embrace the expertise and perceptions of family members and families' having perspectives similar to those of professional caregivers on how care should be delivered and how involved family members should be (Ward-Griffin et al., 2003). Gaugler and Ewen's (2005) study in LTC indicated that nurse aides (HCAs) who reported better-quality relationships with clients also tended to indicate a more positive perception of family members. However, no studies explored the HCAs' perceptions of their relationships with family members in CCC, nor did any examine how individual, unit, and organizational characteristics influenced such relationships.

Research Questions

The research questions addressed in the larger study are (a) How do staff develop and maintain relationships with family members of clients in CCC settings? and (b) What factors influence the way in which these relationships develop? This qualitative study is based on a grounded theory approach informed by Strauss and Corbin (1998). Grounded theory helps to interpret, predict, and explain the social processes of a situation from the perspectives of multiple persons involved in the situation (Strauss & Corbin, 1998).

Method

Setting and Sample

The study was conducted at three conveniently selected not-for-profit CCC facilities, which ranged from 150 to 400 CCC beds. CCC facilities may be designated as indefinite-stay destinations because most clients remain for an extended time, much like those in LTC facilities. The three units selected for this study, one within each facility, had between 40 and 70 beds. The clients' admitting diagnoses included end-stage renal disease, diabetes, stroke, brain injury, congestive heart failure and dementia. RNs, RPNs, and HCAs worked on these units.

Twelve HCAs from three CCC units were selected, based on their willingness to participate in the study. Eight HCAs participated in individual interviews and four attended a focus group discussion. Of the 12 participants, 11 were female and 1 was male.

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The participants' average age was 46.6 years (range 32–60 years); average length of experience in nursing was 10.2 years (range 5–17 years); and average length of experience in CCC settings was 5 years (range 2–8 years). Ten participants had obtained their HCA certification in Canada; two had an RPN certification but worked as HCAs. All participants worked day and evening shifts. The average staffing for the three units included one HCA for eight clients, with one RN or RPN supervising. These supervisors were in charge of overseeing some of the administrative and clinical activities on the unit and provided support to the HCAs.

Data Generation and Analysis

With permission from the Research Ethics Boards of the facilities, the co-principal investigator (KM) met with unit managers to explain the study. Next, the research assistant (RA), who was a nurse with a master's degree, attended unit meetings to explain the purpose of the study to potential participants. Those HCAs who were interested in the study approached the RA after the meeting. After consent was obtained, each interview was conducted by the RA at a time and location convenient for the participants, using semi-structured, open-ended interview questions, some of which are presented in Table 1. Based on the participants' responses during the interview, the RA further explored issues important to them and asked questions to elicit depth and clarity of data. Interviews took 45 to 60 minutes and were tape-recorded. Data collection and analysis were carried out simultaneously, and individual interviews continued until the point of saturation of conceptual information. Following the individual interviews, a focus group (60 minutes in length) was conducted to clarify gaps in the emerging ideas and to validate preliminary interpretation of the data.

All interviews and the focus group discussion were transcribed verbatim by a professional transcriptionist. Identifying information was removed, and all participants and all sites were assigned code numbers. Each investigator read the transcripts separately and identified repeated phrases or concepts using a "constant comparison" technique. An analysis of the transcripts produced key words and phrases that suggested HCAs' role in establishing relationships with family members as well as maintaining these relationships over time. Next, properties and dimensions of categories were developed. During team meetings, subcategories were compared for similarities and differences, through which categories were identified and the final integration of properties was completed.

Table 1: Sample interview questions

What is it like working with families on this unit?
Tell to 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 kind 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?

Results

The HCA's role in *building* relationships with families was described as "being there for them and their relatives", while *maintaining* relationships involved "dealing with disappointments". Factors influencing HCA–family relationships included "having supportive team members", "having resources available", and "working within care-team hierarchies". These themes were consistent across interviews with staff at the three facilities.

Building Relationships

HCAs' building relationships with families consisted of "being there for the family" and "being there for the client".

Being There for the Family

All participants spoke about the idea of "being there" for families who were looking for support, comfort, reassurance, and encouragement. HCAs spoke about listening to families express their concerns and issues without repercussions and without judging them and about showing empathy, care, and understanding. Participants described a number of strategies that they used to get to know the family and to be there for them, including: (a) calling family members by their preferred names, (b) greeting them when they arrived on the unit, (c) explaining procedures and care plans, (d) providing information about the client, (e) being polite, and (f) learning about the individual family members' lives. In the words of two HCAs:

> We get to know them by first names. I'll be very polite, you know. We start off by calling them

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> by their last name, but they end up always saying, ''No, call me by my first name.''
>
> The best way to build a relationship with the families is when they first come in, introduce yourself, you know, explain a bit about what you're gonna do here for them if you happen to be their nurse. Get to know them.

HCAs also spoke about attempting to place themselves in the families' ''shoes''. By doing so, they got to know family members of clients well and often felt close to them. The participants felt this strategy enabled them to convey a sense of understanding that helped them to work more effectively with the family and the client.

Being There for the Client

To be truly available to and present with family members, HCAs felt they needed to be there for the client. Being there for the client involved knowing the client, being responsive to the particularities of her/his needs, preventing annoyances by knowing what made the client happy, sad, satisfied, or content, and knowing how to comfort her/him. Often coming from a family member, this information helped HCAs to tailor care to the individuality of the client. The following remarks by participants highlight these ideas:

> We know them ... and [we know] how to make them happy.
>
> Even the professional staff members ask, ''How did you get him to calm down? What did you say to him?''
>
> I have one client every day: I go in and I bring him an egg because he only gets one egg and he loves eggs, so I get ... one person that can't stand eggs and they give him every day. I take the egg from there over to him.
>
> Sometimes I'm talking to my client and I'll be singing a song and ... most of the clients, some of them talk, some don't. They still hear.... And I probably sing a song and you see the light in their eyes; they keep quiet for a while and that moves me, you know.

According to the participants, acknowledgement of their attempts to be responsive to the particularities of the clients ''makes things feel lighter''. Families were also likely to respect HCAs when they perceived HCAs as providing individualized and respectful care to their relatives.

Maintaining Relationships

Maintaining positive relationships with the family was primarily influenced by how well HCAs were able to deal with family members' disappointments.

Dealing with Disappointments

Despite HCAs' attempts to maintain positive relationships with family members, HCAs could not always control the multitude of factors that influenced staff–family relationships. A diverse range of circumstances can lead to conflicts, tensions, and disputes among clients, family members, and staff because care is provided by an entire organization. For instance, study participants noted that clients' clothes might not be returned from the laundry, nourishment might not always be provided in a timely manner, or communication from one shift to the next might not always occur. Such events often made family members feel disappointed with care. HCAs in the study reported dealing with these disappointments (and restoring connections with family members) by renegotiating families' care expectations and by anticipating families' needs in an attempt to prevent further frustrations.

When family members experienced disappointments, HCAs listened to their concerns and attempted to address their concerns as best as possible. When HCAs felt unable to provide care exactly as family members requested, they attempted to renegotiate care expectations with them. For example, one participant referred to a particular situation in the following manner:

> The family member may tell you to do this and do that for my mom, my sister, whoever ... because this is the way it's always been done. You would say to them, ''OK we're going to try it.... [W]e will try it ...'', and you would try to show them, tell them the reason why it doesn't work. And you try to reach them half way.... [T]hen you try to do more so it is as close as possible to what they're accustomed to.

Dealing with disappointments also involved the HCAs' acknowledging family members' emotions or responses without making accusations or becoming defensive. This, along with demonstrating empathy towards the family members, helped to diffuse their anger or distress and promote a sense of partnership. Another strategy HCAs used to prevent further disappointments was anticipating and meeting family members' needs and wishes prior to their arrival on the unit. For example, HCAs provided family members with information about changes in their relative's condition before they had an opportunity to find out for themselves. Thus one HCA noted that, if a client had fallen and sustained a cut or bruise, she would make sure to inform the family members about this prior to or immediately upon their arrival on the unit. Being strategic about maintaining the relationship by being honest and gently sharing information about their relative's

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change in status made it easier for HCAs to avoid families' being disappointed later on.

Factors Influencing the Development and Maintenance of Relationships

The development and maintenance of relationships with family members were influenced by having supportive team members, having resources available, and functioning within the care team hierarchy.

Having Supportive Team Members

Participants unanimously agreed that "good" teamwork and support from colleagues made a difference in their ability to establish and maintain relationships with families. For example, one HCA spoke about how she could rely on her team to get her clients ready before their family arrived on the unit, so that they would not be disappointed. Not all the HCAs who were interviewed had the same experience, as timely help was not always available.

In addition to the support from colleagues, HCAs also relied on their immediate supervisors. This was especially important when HCAs provided care to clients whose families were not easy to work with. Supervisors who listened and called staff meetings to deal with family issues were revered. One HCA told a story about her immediate supervisor, an RN, who said, "Yesterday, such and such thing happened, and let's clear it up today." In another situation, the RN followed through on an HCA's request by phoning the family. Support from the team and supervisors to work out a solution for a problem in a timely manner was considered important to building and maintaining positive relationships with family members.

Conversely, staff conflicts negatively influenced HCA–family relationship development and maintenance. Participants said that some staff interpreted being there for the client and their family as "spoiling" them. Such different views were noted as leading to staff conflicts. This was especially the case when families and clients expected the same care from all staff and felt disappointed or complained when it was not delivered. One HCA in the focus group explained that her colleagues were not pleased with her attempts to do "little extras" for her clients, such as getting an extra drink. She commented that they would say to her, "Why did you do so much. . . . [Y]ou are spoiling the client and the families." In response, another focus group participant noted, "Certainly, it's not spoiling. You just meet all their needs."

Having Resources Available

Another factor that contributed to HCAs' difficulties in developing and maintaining relationships with families was a lack of resources and of services on their units. The opportunity to communicate with the family and hear their stories was vital to the development of relationships; however, sometimes lacking resources and services and having to spend the time and work required to address this issue made it difficult to provide client care. One participant noted this concern in the following manner: "We tend to sometimes not get enough linen, which really hinders [being] able to do our job, because if you haven't got the linen to wash a person, you're in trouble."

Resources not being available on the unit at the right time was noted as a source of frustration for many HCAs, who were then perceived by family members as not "being there" or "caring enough" for clients. This contributed to strained relationships with family members.

Another resource that was in great demand was having translators available. Working in a facility where families and clients spoke different languages than the HCAs was frustrating because this hindered their ability to build a relationship with families and to maintain it. The importance of having a translator during interactions with families and clients was highlighted by one HCA:

> We have a lot of people who do not speak English that come in here and it's like if you can't understand them, it's difficult to do your job, because you try to explain to them that you want to wash them . . . and you try to even use your hand, you know, put your hand before your face kinda swirl and say, "I'm going to wash you," and they're like, "I don't know what you're talking about."

Translator services were not available in any of the facilities that were approached for this study; therefore, the participants attempted to communicate with clients and their relatives using hand signals and gestures. When necessary, housekeepers or staff members from different units were called in to translate among family members, clients, and staff.

Functioning within Care Team Hierarchies

Within the context of the organization, the care team hierarchy was one of the central factors that influenced HCAs' development and maintenance of relationships with family members. HCAs viewed their lack of decision-making authority and input regarding client and family care with frustration, especially given that HCAs had the most contact with clients and their families, and therefore, a better familiarity with their needs. The participants spoke of situations where they knew the information the families were asking for, but only the RN had the authority to communicate this information

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to the family. These hierarchies made it difficult for HCAs to be responsive to families' and clients' needs. As one HCA stated on behalf of her peers, "We often wish we were something other than a HCA", so as to be able to provide the information required. Another HCA gave a poignant example of her frustration with not being able to provide immediate relief for her clients in the following manner:

> Sometimes when they [the clients] are in pain and you want a RN to come right away to give them something, but you have to go and look and search [for an RN]. . . . [S]ometimes you feel kind of blocked to help that client.

The inability to respond to client and family needs in a timely manner led to family members' being frustrated with the perceived "lack of responsiveness" on the part of HCAs. Participants noted that family members often asked HCAs, "How come you work on this floor and you don't know?" The power imbalance within the care team was especially evident in the family-and-client care meetings that were held on the units, when HCAs were not invited to participate. One HCA stated,

> We are the ones who are mostly with the client because of our work. . . . [W]e're there when things happen . . . and sometimes we might not remember to tell the RN what happened . . . and then there is a family conference and it is another RN. . . . [I]t would be nice if you get plain workers (HCAs), at least one, to go to this conference.

Participants felt disempowered when they were unable to have input into the care of their clients. The power imbalance in the care team was also reflected in how some family members treated HCAs. For example, one focus group participant commented, "We don't get treated like everyone else." Another said, "Some people . . . treat you like you're not a person, you're just a thing." Participants felt that some families did not even acknowledge them when in the same room. One HCA noted, "We pretty much just grin and bear a lot of it with the ones that are very difficult." These concerns by and large affected how HCAs maintained relationships with family members of clients.

Discussion

Given the important role that HCAs play in caring for clients and their families in CCC settings, it is important that we pay particular attention to how they build and maintain relationships with families and to the factors that influence their ability to develop and sustain those relationships. A model that emerged from our analysis of data on the family–HCA relationship is provided below (Figure 1).

The importance of the client–HCA relationship in relation to the family–HCA relationship cannot be underestimated. The current study findings indicate that HCAs' relationships with families are built on a stronger foundation if they are able to comfort the client and be responsive to her/his needs. Gaugler and Ewen (2005) also found that the strongest predictor of staff members' attitudes towards families was their perceived closeness with clients. Gladstone and Wexler (2002) reported similar results, in that RNs' ability to establish relationships with family members in LTC was driven by establishing trust. Laitinen and Isola (1996) indicated that families participated more in their relative's care when the staff's attitudes and personal characteristics were welcoming. In this study, those HCAs who could appropriately reassure and console families during difficult periods were highly valued by families, as were those who were able to use empathy.

An important finding of our study pertains to its focus on how HCAs *maintained* relationships with family members of clients. Previous work has focused mainly on the *development* of the relationship (Gaugler & Ewen, 2005; Gladstone & Wexler, 2002; Laitinen & Isola, 1996; Sandberg, Nolan, & Lundh, 2002). Our study found that maintaining relationships with families involved preventing and/or dealing with disappointments, which was not always easy to do. In CCC, caregiving roles that HCAs undertake are often similar to the roles that family members have fulfilled either at home or in a previous acute-care setting (Duncan & Morgan, 1994). Because of this overlap, in CCC settings, there is a potential for conflict over care expectations and care delivery. Family members appear to see their main functions in relation to

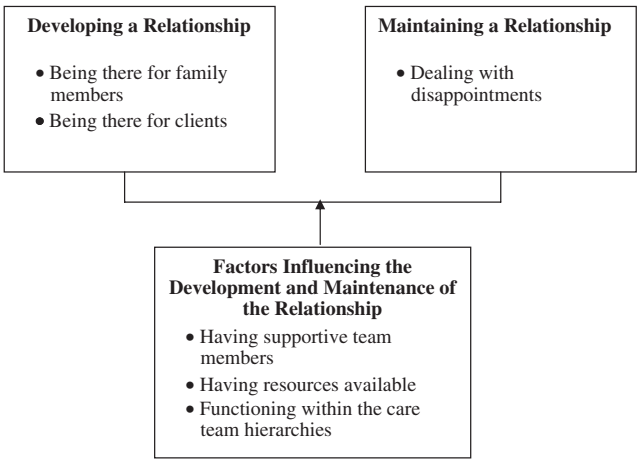

Figure 1: Emerging model explaining health care aides' perception of developing and maintaining relationships with family members

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their relative as monitoring the quality and effectiveness of the care, helping staff to understand their relative's personal care needs, and providing a biographical background (Bowers, 1988). Staff members often see their role as delivering the best care to the client based on following dependable routines for the sake of efficiency (Janzen, 2001). In the present study, HCAs spoke of doing their best to balance the needs and knowledge that family members bring to patient care with the HCAs' plans to provide efficient quality care. By using empathy, by listening and by being honest, HCAs were able to renegotiate the family's care expectations so that both parties in the relationship were satisfied. Evidence indicates that resident care may be optimized when communication between families and staff is consistently effective and working relationships are strong (Robison et al., 2007).

Another important finding of our study is the interconnectedness of the factors that influence family–staff relationships. Lack of teamwork, lack of or ineffective resources and services, and care-team hierarchies created barriers to both building and maintaining relationships in CCC environments. Facility policies regarding practice sometimes hindered collaborative relationships between HCAs and family members. Families in LTC environments look for support, comfort, and encouragement for themselves, but due to time pressures and overwhelming workloads, HCAs are unable to spend the time necessary for substantive or meaningful discussions with family members (Pillemer, 1996; Ryan & Scullion, 2000). Similar results were found in the present study. Staff did not have time to spend with family members because they were looking for supplies or trying to find translators. Without adequate resources and supplies, HCAs spent a considerable amount of time dealing with these issues and the resulting family disappointments; this meant that being there for families and clients became secondary. Further, without the necessary support from team members and supervisors, developing and maintaining relationships with family members becomes a challenge for HCAs. Future models of care focused on developing partnerships between staff and family members need to include enhancement of interactional skills for supervisors and administrative facilitators, while examining the facility procedures that have a negative impact on staff–family interactions (Robison et al., 2007).

The care-team hierarchy can impede the development of HCA–family relationships. HCAs in the present study felt that they were at the bottom of the nursing hierarchy. The findings of this study are similar to those of McWilliam, Ward-Griffin, Sweetland, Sutherland, and O'Halloran (2001), who analysed the everyday experience of in-home care, with particular attention to the enactment of empowerment in the care partnership. They found that mandated, centralized authority for decision making and traditions of professional status undermined the full exercise of knowledge, status, and authority by those lower in the hierarchy, and that the system assigned greater power to those with the least first-hand knowledge of the client. Likewise in this study, HCAs, who had the greatest first-hand knowledge of the client and family were sometimes ignored or not valued. HCAs often felt that they could provide the family members with information, but because of assigned limits to their practice, they had to rely on the RN to discuss certain topics with the family. These inequities and practice regulations limited their ability to be there for families, and, therefore, the relationships between HCAs and family members suffered.

Limitations of the Study

A number of study limitations need to be recognized. Our study participants and their practice settings were located in an urban area in Ontario, which might be characterized by systematic differences from facilities in which other HCAs work. Also, incorporating client and family perspectives on the topic would have allowed us to understand to what extent these findings were relevant to them. Finally, no observations were done to verify the behaviours HCAs reported using to develop and maintain relationships with families of clients (since the purpose of the study was to understand the topic from the perspective of the HCAs).

Implications for Practice

Relationship development between HCAs and family members in CCC settings should be encouraged. Their current efforts in this regard should be explored, acknowledged, and supported. Additional relational skills to support their work around being empathic and honest, taking the initiative to approach families, and being dependable with them – as well as dealing in a sensitive way with the anger, anxiety, frustration, and guilt expressed by family members regarding care – must be discussed as part of continuous learning and critical reflective practice. For example, anger and anxiety can usually be reframed as expressions of concern and frustration at loss of hopes and expectations for a relative in CCC, and, perhaps, complaints and loss of patience with staff can be reframed as a sign of powerlessness in the new care setting.

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Additional training in working with families might include role-playing real life scenarios, through which HCAs can learn more effective strategies to deal with diverse situations and prevent future conflicts. Staff members' willingness to embrace these relational and conflict resolution skills are highly influenced by the policies, procedures, and culture of the unit. When task performance is emphasized, relationships often are neglected (Bowers, 1988). Thus, supervisors need to model effective relational skills and provide positive reinforcement when HCAs use these behaviours with families. Supervisors must also be advocates for minimizing unit and organizational factors that negatively affect HCAs' relationships with families. Senior administrators as well as immediate supervisors must pay attention to resolving concerns with a lack of resources that hinders caregiving. For example, translators are becoming a fundamental need in CCC facilities in urban settings, due to the increasing cultural diversity of the clients in such settings.

The strengths of all team members should be recognized and appreciated by everyone in the team. Secrest, Iorio, and Martz (2005) proposed that, in order to reduce hostility and disrespect towards each other, informal and/or formal communication forums should be held to discuss the value of each team member's roles. By listening to HCAs' perspectives on relationships with peers on the unit, administrators can determine whether the team could benefit from mentoring or team-building activities. Actively involving HCAs in decision-making activities might reduce their experience of frustration and perceived lack of control. Relevant and timely information should be provided to family members, and team discussions on what each member can do to ensure this occurs are essential. HCAs may have the most informed understanding of the clients' and family members' needs, and they should, therefore, be invited to attend family conferences to share these insights. Mentoring HCAs to engage actively in care planning within such team conferences, encouraging discussions between HCAs and RNs, and listening to and honouring the knowledge that HCAs bring to the situation are key to enhancing individualized care for clients and families.

Conclusion

This paper explored HCAs' perceptions of their struggle to build and maintain relationships with family members of clients in CCC. Findings revealed that HCAs attempted to deliver family-centred care by being there for families and clients and by dealing with families' disappointments. HCAs' work in this regard was influenced by the presence of supportive team members, including their supervisors, by having resources and services on the unit, and by the health care team hierarchy. Such influences speak to the importance of establishing a climate of openness, respect for the role of each member of the health care team, and collaboration within the team. Fostering egalitarian team relationships, where each staff member's feedback for improving care is valued, will minimize the impact of hierarchical decision-making authority on the relationship between HCA and family members.

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