



NEW MODELS OF CARE IN RESIDENTIAL LONG-TERM CARE

Tri-focal Model of Care Implementation: Perspectives of Residents and Family

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Key words

Aged care, long-term care, model of care, nursing, person-centered care, qualitative, residential aged care facility

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Accepted October 3, 2016

doi: 10.1111/jnu.12269

Abstract

Purpose: To explore residents’ and family members’ perceptions of partnership-centered long-term care (LTC) associated with implementation of the Tri-focal Model of Care. The Model promotes partnership-centered care, evidence-based practice, and a positive environment. Its implementation is supported by a specifically designed education program.

Methods: The Model was implemented over approximately 12 months in seven LTC facilities in Victoria, Australia. A qualitative exploratory-descriptive approach was used. Data were collected using individual and focus group interviews with residents and family members prior to and following implementation of the Model. Data were analyzed thematically.

Findings: Prior to implementation of the Model, residents described experiencing a sense of disempowerment, and emphasized the importance of communication, engagement, and being a partner in the staff–resident care relationship. Following implementation, residents reported experiencing improved partnership approaches to care, although there were factors that impacted on having a good experience. Family members described a desire to remain involved in the resident’s life by establishing good communication and rapport with staff. They acknowledged this was important for partnership-centered care. Following implementation, they described experiencing a partnership with staff, giving them confidence to assist staff and be included in decisions about the resident.

Conclusions: The Tri-focal Model of Care can enable residents, family members, and staff to be partners in resident care in LTC settings.

Clinical Relevance: With an ageing population, an increasing demand for complex, individualized LTC exists. Delivery of high-quality LTC requires a strategy to implement a partnership-centered approach, involving residents, family members, and staff.

The advent of consumer-focused care is having a profound effect on service delivery in health care. The shift to individual patient- and resident-centered approaches has, in part, been driven by government policy and standards for care (Australian Commission on Safety and Quality in Health Care, 2012; National Health Service Executive, 2000; Victorian Department of Human Services, 2003). In Australia, for example, the National Safety and Quality Health Service Standards, against which health services are measured for accreditation purposes, include a standard for “Partnering with Consumers” (Australian Commission on Safety and Quality in Health Care, 2012). This standard requires consumer involvement in service planning, measurement, and evaluation, and is intended to ensure health services are responsive to consumer input and need.

This shift has also been a key driver in promoting consumer participation in care decisions. In the United States, patient engagement is enshrined in law for the Centers for Medicare and Medicaid Services. The U.S. Patient-Centered Outcomes Research Institute was created through law to fund research to assist consumers to make informed decisions about their health care. Similarly, in Europe, the Picker Institute was established in 2000 as a not-for-profit organization to capture the experiences of consumers and identify areas of priority for delivery of high-quality care.

Alongside this shift, many countries are experiencing changing demographics, resulting from increased life expectancy, with a corresponding larger older population and a relatively smaller working population, rising costs, and expectations for quality care provision. The ageing phenomenon is placing pressure on publicly funded health and social services, including long-term care (LTC; Taylor, 2011). Thus, health system performance is under considerable pressure and scrutiny, mainly due to the demands of an ageing population, rising costs, and expectations for quality in care provision.

The World Health Organization (WHO, 2015) identified population ageing as one of the major public health challenges. Additional challenges to aged care provision include changing societal models with a reduction in family carers, increasing expectations for well-coordinated care services, and changes in technology (Organisation for Economic Co-operation and Development, 2011). Older people living in LTC are a highly dependent and frail population requiring complex, individualized care. Increased demand for aged care services combined with community expectations for high-quality LTC has led to a need for targeted education to promote capacity building among the LTC workforce (Ansell, Davey, & Vu, 2012; Cook & Halsaw, 2011).

To deliver LTC in accordance with best practice, models of care need to combine teaching, clinical care, research, and service delivery (Barnett, 2014). Barnett describes education of the multidisciplinary workforce and students as a defining feature of such models. Teaching comprises that delivered through university partnerships, and clinical teaching and supervision initiated within the practice setting itself. Such models ensure high-quality care through integration of evidence-based practice and person-centered care.

The LTC sector in many countries is under pressure to adopt person-centered care policies and practice. A concept analysis of person-centered care identified key attributes as: recognition of personhood, evidence of a therapeutic relationship, respect for individuality of the person, care that reflects professional ethical standards, identification and reinforcement of the individual's strengths, acknowledgement of the person's lived world, and empowerment of the person to make his or her own health decisions (Slater, 2006). The Institute for Patient- and Family-Centred Care (n.d.) in Europe defines person-centered care as: “An approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.” Petriwskyj and colleagues (2014) published a metasynthesis of quantitative evidence for family involvement in decision making for people with dementia living in residential LTC. The findings revealed the complex and varying levels of involvement of family in decision making, and as a consequence the authors called for greater consideration to be given to collaborative decision making between staff and family members.

In recognition of the importance of the role of family in the care of an older person residing in an LTC facility, Mass and colleagues (2004) developed and tested an intervention, the Family Involvement in Care intervention, to promote negotiated partnerships between staff and family. The intervention is composed of four components: (a) orientation of family members to the facility and the partnership role; (b) education of family members regarding how they may be involved in care; (c) development of a formal partnership agreement; and (d) evaluation and renegotiation of the agreement. Among family members of the same generation as the resident, the intervention was statistically significantly associated with reduced sense of loss and captivity, increased satisfaction with physical care provided, and reduced decline in satisfaction with activities for residents. Further, perceptions of the relationships between family, staff, and residents were more positive following the intervention. This work highlights the potential for interventions designed to promote partnerships

between staff and families to result in positive outcomes.

In 2008, the Tri-focal Model of Care was developed by a team of researchers and educators in collaboration with aged care clinicians to provide a “whole of organization” approach to building staff capacity to meet increasingly complex care needs of older people residing in LTC residential facilities (O’Connell, Ostaszkiwicz, Sukkar, & Plymat, 2008; see also the Center for Innovation and Education in Aged Care). This Model is intended to produce culture change that fosters a learning environment to support workforce and student development to deliver quality LTC in residential facilities. The Model is underpinned by the teaching nursing home literature (Barnett, 2014), according to which the nexus between teaching, research, and practice provides the foundation for high-quality care, and it is philosophically grounded in three core concepts: (a) evidence-based practice, (b) positive environment, and (c) partnership-centered care. The concept of partnership-centered care, as espoused by Nolan, Davies, Brown, Keady, and Nolan (2004), extends the notion of person-centered care, highlighting the importance of the relationship of mutual respect, trust, and collaboration between the resident, his or her family, and staff to optimize the well-being of the older person (O’Connell et al., 2008).

Based on best available evidence (including systematic reviews [e.g., Chang-Quan et al., 2010; Milne, Potter, Vivanti, & Avenell, 2009], evidence-based practice guidelines [e.g., Department of Health and Ageing, 2012; Substance Abuse and Mental Health Services Administration, 2011], and other published research), a nine-module education program was developed to facilitate implementation of the Model. Three modules address the philosophical underpinnings of the Model as well as leadership, change management, collegiality, and teamwork in LTC, and six modules address aspects of care, including challenging behaviors, continence, depression, medications, mobility, and nutrition and hydration. Presentation of the education modules is designed to suit a range of education levels, and the content is relevant to, and intended to be accessed and used by, all categories of staff as well as family members and residents. In this way, the same information is available to all stakeholders within facilities and a common understanding of the core principles of the Model (partnership-centered care, evidence-based practice, and a positive environment) is established. While the Model was designed to be used in residential LTC, much of the content of the educational modules is transferrable across other settings in which older people are cared for. When instigating substantive organizational change, such as implementing

a model of care, it is important to understand stakeholder perspectives as an intrinsic part of the evaluation.

Method

Aims

This article is based on the findings of a larger study that evaluated the outcomes of implementing the Tri-focal Model of Care in the LTC setting. The aim of this article is to report residents’ and family members’ perceptions of partnership-centered care in association with implementation of the Model.

Design

A pre- and postqualitative exploratory-descriptive design was used to determine if perceptions changed in association with implementation of the Model (Lincoln & Guba, 1986; Patton, 2002). The Tri-focal Model of Care principles were introduced and integrated through the education program, which was delivered over approximately 12 months. Experienced educators delivered the modules within the respective LTC facilities using interactive meetings with staff, including nurses, personal care workers, allied health professionals, catering, and cleaning staff. During this 12-month period, educators facilitated staff in the adoption of a partnership approach to care and the use of evidence to inform practice. Qualitative interviews were undertaken with residents and family members prior to implementation and following completion of implementation of the education program.

Sample and Setting

Tri-focal Model of Care was implemented in seven purposively selected LTC facilities in Victoria, Australia, including one private and six publicly funded facilities, of which two were rural and five were metropolitan facilities. Residents had varying levels of care requirements, including dementia-specific needs. In total, approximately 311 older people resided in the seven LTC facilities.

Selection criteria. We specifically selected facilities from which the managers had expressed interest in implementing the Model. Further, facilities were purposefully selected to ensure a mix of public, private, metropolitan, and rural facilities were included. Residents who were cognitively unimpaired (as determined by the registered nurse in charge), able to give informed consent, able to communicate in English, and available while the researchers were present in the facility were invited to participate.

Procedure

Ethical considerations. Prior to commencement, the study was approved by the Human Research Ethics Committees at each healthcare organization and the university.

Data collection. Data were collected from consenting cognitively intact residents and unmatched family members using individual and focus group interviews. Family members were invited to participate via a letter sent by the facility manager. Nursing staff provided the researchers with a list of residents who were deemed to be suitable for inclusion. These residents were initially approached in person by the researchers and provided with a brief overview of the study and the Participant Information and Consent Form. Researchers returned at a later time to establish residents' interest in participating and to arrange interview times with those consenting to participate.

Interview questions varied depending on the participant group and across pre- and postintervention time frames. The individual and focus group interviews explored perceptions of care practices in the facility, the care environment, and relationships and communication among key stakeholders. Examples of the interview questions are illustrated in Tables S1 and S2 (available with the online article). Additional questions in the postintervention focus group and individual interviews explored perceived changes following the intervention. All interviewers were experienced researchers and members of the investigative team. At least two researchers facilitated each focus group using an interview guide. A total of 33 focus group and individual interviews (17 individual interviews with residents, 12 individual interviews, and four focus groups with family members) were conducted during the pre-intervention period (January–June 2013), which included 17 residents and 34 family members. The demographic characteristics of the residents and family members are reported in Tables S3 and S4 (available with the online article). During the postintervention period (February–July 2014), in total, 22 focus group and individual interviews were conducted (12 individual interviews with residents, 7 individual interviews, and three focus groups with family members), which included 12 residents and 13 family members. Interviews were up to 45 min in duration, were audio recorded and transcribed verbatim, and identifying information was removed prior to analysis.

Data analysis. Interview data were analyzed using thematic analysis procedures recommended by Grbich (2013). Data were reduced into meaningful groupings

using block and file (identifies context through reading large sections of data), concept mapping (allows identification of concepts through a broad review of data), and segmentation (closely examines fragmented data groups to elicit key words and concepts) methods. All three approaches allowed categorization, linking, and interpretation of aspects, and enabled key themes to emerge from the data (Grbich, 2013). To stay true to the data, we used an audit trail linking all themes, subthemes, and codes to actual quotes. We constantly referred to the transcripts and specific quotes in the process of categorization and theming. Data from pre- and postimplementation focus groups within resident and family member groupings were compared.

Rigor

In addition to upholding key principles of qualitative research (i.e., credibility, fittingness, auditability, confirmability), there was also a particular focus on triangulation to ensure the rigor of the study (Patton, 2002) through the use of source and analyst triangulation. In this study, source triangulation was achieved by recruiting participants from public and private LTC facilities from rural and metropolitan locations, with data collected pre- and postimplementation of the Model. Analyst triangulation was achieved by the data being analyzed separately for each group (residents and family members) and independently by two members of the study team. They then came together to reach consensus on the coding and to subsequently group the codes into the most consistently reported and salient set of issues for each group. Following this process, another team member discussed and critiqued the emergent findings and compared them with those from the extant literature.

Findings

Analysis of the data revealed that for residents and family members the move to LTC was a decision made out of necessity, and as a consequence being empowered, maintaining control, and communication were key aspects of the partnership-centered care they desired.

Residents' Perceptions Prior to Implementation of the Model

Residents indicated that in LTC everything was “decided” for them; often they were “told” what to do, and this left them feeling “very annoyed.” Emerging from resident interview data prior to implementation of the Model were three major themes that represented

residents' perceptions of partnership-centered care in LTC: disempowerment, communication and engagement, and a partner in care.

Disempowerment. It was perceived that LTC promoted dependence and reliance on staff: "Well, I've been out once or twice, and it's a little bit difficult because you've got to have a nurse. They won't let you go out without a nurse." However, despite feeling disempowered, some residents clung to elements of control. They negotiated with management, "... fought ..." for "... freedom ..." or chose not to be "regulated." One resident described the importance of freedom: "I'm allowed to go out here as long as I'm home by seven at night. My word [freedom], that's everything."

Communication and engagement. Communication and engagement were important for some residents and although "... it's difficult to make friends [in here]," they sought companionships with staff and other residents, and to maintain external friendships. One resident acknowledged that not all staff were a source of companionship: "Some of the staff are lovely, they come and have a chat to you. Some of them are a bit cross and you keep clear of them." Residents spoke about communicating with some staff where language was a barrier to engagement. One resident explained: "... I don't have much conversation with them. I'll sometimes ask them what country they come from and so on."

It was evident that fostering relationships with other residents relied on opportunities to meet, and while this could be difficult, some residents relished occasions to meet other residents. For one resident, meal times provided the perfect occasion for engagement: "Oh yes, it's nice being able to go up there [to the dining room] ... I can't always do it ... but it's nice and we meet some nice people." For others, communicating and engaging with other residents required some commonality. One resident explained: "Now they [three other residents] are nice ladies but they haven't done anything in their life like I've done. So once we get past the weather and the plants outside the window, we can't discuss many other things." Maintaining the connections outside LTC was a vital component of communication and engagement for some residents, and these "external" connections were either family ("I've got a very supportive family, and that is the backbone of my life") or friends ("We [external friends] still meet every 3 months ... [it's] very important. Yes, I like that").

As a platform for communication and engagement, residents discussed a desire for more meaningful activities in the facility. Perceptions of existing activities ranged from "... not enough social activities ..." or "... not

enough mental stimulation" to "Loads of activity yes, a bit overwhelming at times" A key factor in residents' desire for activities was reliance on staff to facilitate this process. As one resident explained, "... Well, the only thing is you have to be aware of all the activities that go on because they're [staff] not good at saying, do you want to go?"

A partner in care. From residents' responses, positive perceptions of staff, including being known by staff, related to positive perceptions of the care they received. Overall, staff were described as "... absolutely fantastic" and "... working very hard" Residents' perceptions of staff appeared to be intrinsically linked to feeling that they were looked after, as one resident stated: "They [staff] are lovely, there's no doubt about it. They think the world of everybody, treat everybody the same and that's what I like." However, residents indicated that staff did not really know them, that is, their life before moving into LTC: "They haven't asked me about my life before and I haven't said anything. I think they just take us as we come and look after us."

In contrast to the positive perceptions of staff, the residents' assessment of the care they received varied. This was described as "alright," "satisfactory," and "reasonable," indicating a mediocre assessment of care: "I think what they're doing [care provision] is satisfactory to me and I can't think of anything that I need. I get what I want regarding showers and bed made, washing done." When asked about any changes in care they desired, indifference was evident in one resident's comment: "I don't have any objections. Not really [any changes] ... Not that it could make much difference."

Residents' Perceptions Following Implementation of the Model

Following implementation of the Model, residents' perceptions of partnership-centered care revealed three major themes: a dual reality of LTC, a partnership approach to care, and issues affecting a good experience. There was an overall understanding of living in LTC and the perceived work pressures staff were under. Residents highlighted more of a partnership approach to care, while still indicating areas for further improvement.

Dual reality of LTC. Although residents acknowledged missing some aspects of home life, there was an understanding and resigned acceptance of life in LTC: "Well, it's just like my own home. It is at the moment. You've got to make it that way." There was renewed satisfaction with staff and the care provided: "I think the staff are very caring. I think they're certainly excellent in

the way in which they carry out their duties so I haven't got any complaints there."

A partnership approach to care. Residents perceived that their preferences were being considered. These preferences related to their care ("... Well, it [care] really is brilliant the way we're taken care of ... the way they focus on what you've asked for. They do a brilliant job from that perspective"); activities ("They don't force you to go. I feel I'm happier here sometimes than to go to some of the things that are on"); and general well-being ("Yes, they come and ask me—they know I'm always awake early, and they usually come in and say, 'now do you want to get up or do you want to have a lay in—it's your choice'"). In contrast, although some residents felt that choice was still lacking, especially with activities, there was a recognition that it might be difficult to meet everyone's choice in this regard:

I'd say it would be pretty awkward trying to accommodate people doing the things [activities] that they choose ... It would be very hard for each one to put forward his ideas or wants or needs and everybody else accept it.

In addition, there was an understanding of staff's work pressures and the often task-orientated nature of their work, implying that this understanding was necessary in partnership-centered care. One resident expressed frustration at having to wait for staff, but at the same time acknowledged the strain staff were under: "I'm not an impatient person, but you do get a bit sick of, day after day, waiting and waiting and waiting. They're [staff] stressed out too by knowing that you're there waiting." As a partner in care, there appeared to be solidarity with staff, and their workload was presented as a reason for any delays in care. Residents commented on the "strain" staff were under: "You get some [days] where you feel you've been shunted around and I think generally it is because the staff have got too many things on their plate. I really do, so they can only do so—too much." For one resident this worried him: "There are times it has worried me, not as far as the care of me is concerned but I feel that the staff are under a strain."

Issues affecting a good experience. Residents highlighted two key issues that affected a good experience in LTC: staff's lack of knowledge about residents' life history and perceived staff shortages. Residents felt it was important for staff to know their past history, but this was still not commonly discussed between residents and staff, nor translated into personal care. However, although one resident mentioned that staff never asked

about the family, this did not detract from the care provided: "No, they've never really queried me on my family I don't think, but yeah they look after us." For another resident, the longevity of some staff in the facility enabled this level of engagement:

Well, some of them do [know about history], because they've been here for a long time and then they realise who I am, but they seldom ask you about ... your life and where you're from ...

Lack of staff was something many commented on, and despite the perceived impact on residents, their concern for staff in this regard was often mentioned: "It's got some drawbacks here and there. I think it's understaffed in places. I think they're overworked. I really can see that standing out ..."

Family Members' Perceptions Prior to Implementation of the Model

When an older person moves into LTC, the role that a family member has in the care relationship changes and for family members in this study, this change left them feeling "excluded." They wanted to be "involved" in the older person's care and life in LTC, including when decisions were made. Therefore, they sought to be "included" through being an "advocate" for the older person. Analysis of the interviews with family members prior to the implementation of the Tri-focal Model of Care revealed three major themes that represented their perceptions of partnership-centered care in LTC: a desire to retain control, communication and rapport with staff, and elements of partnership care.

A desire to retain control. Overwhelmingly, family members sought to retain the control they had in the older person's life prior to LTC. They wanted more than just to visit: "What we found is that we have to be involved, rather than just visit we actually have to be involved in her care." The desire for involvement was non-negotiable because they saw staff as not having the time to spend with residents. One family member stated,

I feel as though I have to be here because no one's going to pick up on her pain and no one's going to take the time to feed her as I will ... they [staff] haven't got the time.

Family members recounted times when staff did not listen to them regarding aspects of an older person's care, leaving them feeling "fobbed ... off." One family member felt that the medical model of care did not allow for involvement.

Because they're [staff] not used to a third party. They deal with the person involved and as far as they're concerned they've got blinkers [metaphor for being unreceptive to other influences] on, there's nobody else in their [older person] life, like I'm talking about the medical model So they do not include anyone else in that [decision] I'm the one that needs to know, I'm the one that makes the decisions.

Consequently, this family member saw their role as an "advocate" and this meant they could retain some element of control in the older person's life through their active presence in the facility. These family members were regular visitors to the facility and sought to ensure they were included in all decisions related to the older person: "You have to be here to advocate on their behalf."

Communication and rapport with staff. For family members, having good communication and rapport with staff was important when their loved one was in LTC. It ensured shared decision making and good communication between all parties. However, it was acknowledged that this was difficult at times. In desiring to retain control, family members highlighted the challenges they experienced in communicating and building rapport with some staff. They noted it was most important to have a good rapport with the facility manager. One family member described "a heated argument" with the nurse in charge. After a series of staff changes in the manager role at one facility, one family member commented,

With the new [nurse] manager that's come in, [I] have a very good rapport with her It's monumental, it's everything. So now I don't feel like I have to keep drumming the drum, I can relax a little bit

In contrast, another relatively new family member in the facility had a different experience in developing a positive relationship with the new manager and this led to a feeling of vulnerability:

I haven't been able to communicate with [manager]. I feel there's a barrier that I haven't been able to get through it takes you time to get used to everything. So I'm vulnerable and I may be taking it too personally.

Although family members understood that having a good rapport with staff was important, they felt a lack of respect from some staff:

I had been her primary carer for nearly 24 hours a day for three years and all of a sudden my opinion was—this is how I perceived it all of a sudden my opinion was worth nothing and they were medical people or in the health industry and they know better.

Others expressed frustration and the ". . . great difficulty being heard." This did leave one family member very stressed: ". . . I get a thousand times stressed out because I've not got that communication, which I need. . . ." In desiring to retain control and have positive communication and rapport with staff, family members were faced with the dilemma of not expressing any concerns, or doing so and risking losing rapport with staff. As one family member deliberated,

Well, I was worried for him anyway, but then I thought if I cause too much trouble it may backfire. I won't have the rapport that I have now and I won't be able to get the things that he needs.

Elements of partnership-centered care. Perceptions of partnership-centered care and how this was currently manifested in the facility was discussed by all participants, and it was clear they felt that ". . . family should be a little more involved. . ." Overall, their responses suggested three important elements of partnership-centered care that would benefit residents: working with each other, continuity of care, and the importance of good care and carers. For one family member (a retired registered nurse), working together reflected integration of care: ". . . integrated care is very important. Family, staff, patient together."

Continuity of care was seen as important for building a bond: ". . . I think they should try to use the same staff . . . put the same carers . . . with the same residents so a bond is built up." However, their experience of lack of continuity of care was also revealed: "If you raise it with that one [staff member] it won't be her next morning doing it. They're always different, there's not a lot of continuity." In contemplating their perceptions of partnership-centered care, it was important for family members to know that residents were well cared for: "These people [staff] are so good to her [resident] and she just loves them and I love them for making her feel good." One family member relished the complete care staff gave:

When you can't be here, the fact that somebody will give them a hug or what have you . . . there's a book she keeps, it's about her family. I know that they read that to her. That to me is a nice touch

Family Members' Perceptions Following Implementation of the Model

Family members' perceptions of partnership-centered care were also sought following implementation of the Model, and this highlighted two major themes: partnership through communication and taking control.

Partnership through communication. Responses indicated that family members saw evidence of the impact of the Tri-focal Model of Care in the facility, and this showed improved communication between staff and families: “Yes, I think it [the Model] has assisted the staff and also the nursing unit manager to adjust their responses to our concerns.” One family member described this change as related to communication, engagement, and aspects of the care:

Being here every day, I notice how things work, and yes, I do think they have improved in the last 12 months, definitely ... I think the staff are a little bit more attentive, a bit more tuned in to how they do things. They're very approachable, so if I think I'd like it to be done a little bit differently, they're always happy to change it over to—and they're open to suggestion, happy to talk with you ... They're more open, I find ... that the level of care has lifted.

Another family member saw the benefits of focusing on all the stakeholders' perspective as is done in the Model: “... We want the best for dad, or our loved one. But then thinking about the resident's perspective, plus the staff perspective, plus the unit manager's perspective, or the department manager's perspective, was good... .” They spoke of more positive communication and aspects of partnership. Staff were said to be “approachable,” and others spoke of “the improvement in ... relationships with all the staff,” which one family member solely attributed to the Model:

But there's a real openness in terms of what's going on, an openness about issues, an openness about improving, and my assumption is the fact that this Model has been running during this year has made a difference ... whereas before, they [staff] were a little bit defensive.

Also mentioned was the connection family members felt staff now had with some residents. They felt staff now “try to be more engaging [with residents] in passing.” One family member spoke of his father who could not communicate with staff:

We have now got the staff to at least ... look at him ... some of them wave, or smile, or some might even say hello and that is a significant improvement to what it has been. I think that's directly related to Tri-focal.

Taking control. Family members emphasized the need to be involved in residents' care: “it's important in an organisation like this that family members do participate, because nobody knows the resident as well as family members, so we'll see things that the nursing

staff can't.” Consequently, they felt confident to assist staff as needed and even insist on some aspects of care:

We had to insist and we finally got it, we got dad down to the physiotherapy room, we got him down there once. They said it wasn't really appropriate for him, but we got him down there and with a bit of a push and a shove verbally, it got achieved, the result.

Discussion

In 2006, Bauer argued that a new model of care was required, where staff worked collaboratively with families “as a legitimate and necessary part” of their role (Bauer, 2006, p. 45). In 2008, the Tri-focal Model of Care was developed and included the concept of partnership-centered care to address the recommendations arising from research in this field. The findings of this study provide an important insight into residents' and family members' perspectives of partnership-centered care in association with implementation of the Tri-focal Model of Care and suggest a transition towards a partnership-centered approach to care was occurring as a result of implementation of the Model.

Prior to implementation of the Model, themes that emerged from residents' interviews were consistent with findings reported in existing literature. Disempowerment, perceptions of loss of choice, and exclusion from decision making were associated with a perceived loss of power and control. These findings may, in part, relate to staff concerns and their duty of care to protect residents from harm, leading to a risk-averse environment. Acknowledging tension between promoting resident autonomy and resident protection, a recent report from the Agency for Healthcare Research and Quality states “nursing homes must find a balance between preserving person-centeredness and resident safety while ensuring safety, quality of care, and quality of life for residents” (Simmons et al., 2016, p. vi).

Resident participants highlighted the importance of communication and engagement, factors that have been previously identified as problematic for residents in LTC, with reports of communication between residents and staff being brief, infrequent, and focused primarily on physical care (Edwards, 2003; Ellis & Rawson, 2015; Oliver & Redfern, 1991). Additionally, building relationships with other residents has been identified as a challenge for older people residing in LTC facilities (Lee, Woo, & Mackenzie, 2002).

Following implementation of the Tri-focal Model of Care, the themes that emerged from interviews with residents presented a somewhat different picture with

respect to: acceptance of LTC being home, despite still missing their previous home; acknowledgement that staff were attempting to address residents' preferences and an appreciation by residents for staffs' level of busyness; and the importance, to a resident's experience, of staff genuinely "knowing" the person and the person's life story, as well as having sufficient numbers of staff to provide quality care. In relation to aspects of care that residents considered important to their experience of partnering with staff, the findings of this study are congruent with the Eight Picker Principles of Patient-Centred Care (Picker Institute Europe, 2016). The principles considered central to an individual's experience of care are: respect for the person's values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; continuity and transition; and access to care.

Prior to implementation of the Model, family members articulated the importance of retaining a sense of control in relation to the older person's life within the facility and acting as an advocate on the older person's behalf. They also highlighted the need for a positive relationship with staff that went hand in hand with open communication. Family members also expressed a desire for families to work together with staff, to enable continuity in care so that relationships between staff and residents could be established and maintained, and the comfort for family members that was derived from knowing the staff were providing good quality care.

Following implementation of the Model, family members' description of their interactions with staff and involvement in residents' care provided the strongest indication of change towards partnership-centered care. They described more open communication between family members and staff and a marked change in the way that staff listened and attempted to consider and account for individual needs. Family members reinforced the importance for them to have some control in relation to the care of the older person, highlighted how they could contribute to care because they knew the older person better than staff, and described feeling more able to assert themselves with staff in advocating for the older person. The significance of family involvement in the care of older people in LTC settings is widely acknowledged (Petriwskyj et al., 2014). Specifically, importance of family in promoting resident well-being has been identified (Haesler, Bauer, & Nay, 2007). Additionally, the importance of accommodating the perspectives of stakeholders (the older person, family, and formal caregiver) involved in the daily life of the

older person has been identified (Nolan, Davies, & Grant, 2001).

In interpreting the findings of this study, the limitations need to be considered. While the sample sizes were relatively small for both resident and family member groups, saturation of data was achieved. Additionally, as far as possible, an attempt was made to capture the views of the same participants at the two time points. It was difficult to achieve this because most residents that participated at baseline were deceased at the time of the follow-up interviews, over 12 months later. Family members of deceased residents were not contacted for follow-up interviews. Further, it is possible that baseline interviews influenced participant responses in the follow-up interviews. However, 12 months had elapsed before the follow-up interviews were conducted, and it is unlikely the participants remembered the questions asked at baseline. Additionally, for the reasons described above, few participants participated in both the baseline and follow-up interviews. Finally, given the amount of time that elapsed between the baseline and follow-up interviews, the passage of time may have resulted in changes in residents' and family members' perceptions, and thus, changes in perceptions may not be entirely attributable to the Model.

Conclusions and Implications

There is increasing recognition of the importance of genuine partnerships between health professionals and consumers of health services. As such, models of care that promote consumer engagement and partnerships between staff, residents, and their families provide a mechanism through which the roles, communication strategies, and processes to realize true partnerships can be established. The findings of this study highlight not only the desire for authentic partnerships from the perspective of residents of LTC facilities and their families, but also the potential for models that promote partnership-centered care to provide the foundations for such a relationship. Education programs directed towards assisting all stakeholders to understand the value and nature of partnership-centered care are important in facilitating the process towards adoption of this approach to care. Arising from this study are clear implications for nursing practice in that the Tri-focal Model of Care has the potential to foster partnership approaches to care of the older person, build staff capacity to meet residents' needs, and have positive engagement with family members, which may improve care environments and practices in LTC facilities. From a policy perspective, it may be useful for LTC accreditation standards to include a standard related to partnership-centered care, along with guidelines for

achieving this approach to LTC. Further research is required to understand how such an approach to care can be nurtured and sustained. Based on our findings, further research is being conducted to ascertain family members' perspectives on the relevance and usefulness of the content of the Model to ensure that they can actively participate as partners in the care of residents in LTC facilities. In addition, in recognizing the importance of quality care for older people wherever they receive health care, we plan to adapt the Model for other settings such as in acute care. To conclude, the findings of this study suggest that implementation of a model of care that adopts a partnership-centered care approach has the potential to result in improved communication and interpersonal relationships among residents, family members, and LTC staff.

Acknowledgments

Implementation of the Tri-focal Model of Care was funded through the Teaching and Research Aged Care Services initiative of the Commonwealth Government of Australia. Development of the Model was funded by the JO & JR Wicking Trust.

Clinical Resources

- Centre for Innovation and Education in Aged Care—website for the Tri-focal Model of Care nine module education program: <https://blogs.deakin.edu.au/cieac-online/sample-page/programs/online-program/>
- Patient Centred Outcomes Research Institute: <http://www.pcori.org/about-us>
- The Picker Institute: <http://www.pickereurope.org>

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Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher's web site:

Table S1. Pre-Implementation Sample Interview Questions

Table S2. Post-Implementation Sample Interview Questions

Table S3. Residents' Demographic Characteristics ($n = 17$)

Table S4. Family Members' Demographic Characteristics ($n = 38$)