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An Examination of Conflict Management among Family Caregivers of Residents in Long
Term Care Facilities: A Mixed-Methods Study

by

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Abstract

Family-staff conflict in long term care (LTC) is a daily reality that has adverse outcomes for residents, staff and families. However, to date it has not been empirically evaluated from the family caregiver's perspective. Multiple barriers exist in examining conflict, including its sensitive nature, which may have precluded such study, as well as lack of theoretical integration. In order to examine family-staff conflict and its management in LTC, this study has merged two independent bodies of literature, that of family caregiving in LTC and organizational behaviour literature on conflict, namely the theory of cooperation and competition (Deutsch, 1949). Through the application of a theoretical approach, the objective of the study was to examine the predictors and outcomes of conflict and its management in 107 family caregivers in LTC using self-report measures. Family caregivers experienced multiple conflicts with staff concerning a range of care-related issues, and primarily reported the use of cooperative conflict management, which was positively related to trust, communication, power and sense of community (SOC). Family caregivers' trust in staff was identified as the main predictor of competitive conflict management, whereas family caregivers' perceptions of power in LTC and SOC predicted cooperative conflict management. Cooperative conflict management mediated the relationship between frequency of conflict and satisfaction with care, meaning that conflict management is the mechanism by which conflict and satisfaction are linked in this family caregiver sample. Another aim was to gain a greater understanding of family caregivers who experience conflict most frequently, as these families have been identified to require a disproportionate amount of limited LTC resources and may be at greatest risk of adverse outcomes. Ten family caregivers

completed comprehensive interviews concerning their experience of conflict with staff and conflict management in LTC. These 'high conflict' family caregivers described employing primarily competitive conflict management, as well as engaging in a variety of other strategies to address conflicts with staff. The implications of the conflict management strategies reported by family caregivers for key caregiver outcomes (i.e., satisfaction with care and caregiver burden) and recommendations for intervention in family-staff conflicts are discussed.

Keywords: Long term care, nursing home, family, caregiving, conflict, conflict management

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List of Abbreviations

AHS	Alberta Health Services
BSCS	Brief Sense of Community Scale
BSI-18	Brief Symptom Inventory - 18
FICS	Frequency of Interpersonal Conflict Scale
FPCT	Family Perception of Care Tool
HC	High Conflict
ICS	Intragroup Conflict Scale
LC	Low Conflict
LPN	Licensed Practical Nurse
LTC	Long Term Care
NA	Nursing assistant/aide
OTI	Organization Trust Inventory
RN	Registered Nurse
SOC	Sense of Community
UTI	Urinary Tract Infection
ZBI	Zarit Burden Inventory (ZBI)

Chapter 1. Introduction

Over the course of our lives, there is a high likelihood that each of us will either provide and/or receive care at least once. According to the General Social Survey (Sinha, 2013), one in two Canadians provided care to a family member or a close friend with a disability. More specifically, 3.8 million Canadians aged 45 years and over reported providing unpaid care to an older adult, with 12% of these Canadians caring for an older adult residing in a long-term care (LTC) facility¹ (Turner & Findlay, 2012). The role of a caregiver is one that we are increasingly more likely to undertake in the course of our lives as the "greying" of Canada continues and the baby boomer cohort (those born between 1946 and 1965 that account for approximately a third of the Canadian population; Statistics Canada, 2011) ages.

Health Canada predicts that by 2041, six percent of Canadians will be aged 85 years and older (Health Canada, 2002). Although these 1.6 million individuals are expected to follow the current trend of older adults living longer and being less disabled than previous generations, the overall number of individuals requiring LTC services—particularly for those who are physically and cognitively impaired—is expected to rise substantially. Currently, one in five individuals in Canada aged 85 years and older resides in a LTC facility with projections suggesting that 320,000 older adults may require LTC by 2041 due to increasing functional and medical frailty (McGregor & Ronald, 2011). This is a notable increase from the current 200,000 LTC beds available across Canada (Statistics Canada, 2008), requiring an expansion in the capacity of an

¹ The term LTC is used in Canada to represent a range of services that provide indefinite care to individuals that may include home, supportive and facility care (Banerjee, 2007). This document uses the term LTC to denote nursing homes and dementia units providing care to older adults.

already strained LTC system. These estimates have been described as conservative (McGregor & Ronald, 2011). This expansion will require increased appropriate involvement of family members in care to offset the current challenges in LTC in meeting the needs of older adults, which underscores the importance of research that involves families in LTC and increases understanding of family caregivers' experiences. It is estimated that by 2038, family caregivers will be contributing 107 million hours of unpaid care per year to LTC in Canada (Alzheimer Society of Canada, 2011).

In addition to the growing number of families and older adults that will require LTC services, newer philosophies of care and provincial licensing guidelines for LTC in Canada are emphasizing the involvement of family caregivers in institutional care. The most esteemed models of care in LTC currently advocate a person-centred philosophy of care that has resulted in a significant culture change in LTC from previously espoused medical models of care (Koren, 2010). According to the Alzheimer's Society of Canada (2011) person-centred care "recognizes that individuals have unique values, personal history, and personality and that each person has an equal right to dignity, respect, and to participate fully in their environment" (p.4). It is emphasized that person-centred care is meant to be incorporated in all aspects of care within LTC, and values partnerships between staff, residents, and their families that ultimately contribute to improved outcomes and enhanced quality of life and care for residents (Alzheimer's Society of Canada, 2011). This model supports design and delivery of services that are "integrated, collaborative, and mutually respectful of all persons involved including the

person with dementia, family members, caregivers, and staff"² (p.4). Whereas medical models of care require residents and family caregivers to fit into the routines and practices prescribed by health professionals, a significant component of person-centred care is including and involving family caregivers, along with residents, in decision-making and care provision that is flexible in discovering the best way to meet care needs (Boise & White, 2004; Health Innovation Network, 2016). The inclusion of families as part of person-centred care is consistent with the findings that successful resident outcomes are unattainable without family caregivers' assistance in LTC (Abrahamson, Sutor, & Pillemer, 2009). However, LTC facilities—and staff in particular—have been reported to rarely receive the full benefit of family caregivers' knowledge and assistance in resident care due to challenges related to family involvement in LTC, development of constructive family-staff relationships, and, arguably, due to family-staff conflicts (Abrahamson, Anderson, Anderson, Sutor, & Pillemer, 2010). Therefore, although there is a theoretical acceptance of the person-centred family focused model, the practical application of it has produced significant challenges and there is a dearth of research exploring how it can be realized in everyday practice. In fact, the American Geriatrics Society Expert Panel on Person-Centered Care (2016) reported in their review of the definition and key characteristics of person-centred care, that person-centred care may remain aspirational in nature.

Additional emphasis on family caregiver issues in LTC has been placed by provincial licensing guidelines that require family caregivers to be invited to participate

² Initial publications on person-centred care were focused on persons with dementia. However, person-centred care philosophy in LTC extends beyond provision of services to persons with dementia to include all older adults.

in care conferences, which consist of the development and reviews of a resident's care plan, as well as encouragement for LTC facilities to establish Family Councils where families can voice their concerns about resident care (BC Ministry of Health, 2009; BC Ministry of Health, 2012). According to a report by the Alberta Continuing Care Epidemiological Studies group (ACCES; Strain, Maxwell, Wanless & Gilbert, 2011), the importance of family caregivers' involvement in the day-to-day functioning of LTC homes was recognized, as was the support that they required to maintain their involvement and the need to explicitly address expectations for their involvement. However, integrating families in LTC and supporting their involvement has been suggested as a frequent source of family-staff conflict in LTC, as will be reviewed below.

The deleterious consequences of conflict between staff and family in LTC have been noted, including adverse outcomes for residents, families, and staff (Gaugler, 2005a; Haesler, Bauer, & Nay, 2007). However, there is a dearth of studies examining conflict in LTC in general and particularly from family caregivers' perspectives. To date, a small number of studies have explored conflict between staff and residents (Small & Montoro-Rodriguez, 2006) and staff's opinions about conflict with families (Abrahamson et al., 2009; Hertzberg, Ekman, & Axelsson, 2003; Utley-Smith et al., 2009). Chen and colleagues (2007), using the large representative Partners in Caregiving data set of 932 family caregivers, reported that family caregiver depression was significantly associated with their perceptions of family-staff conflict, suggesting that families may be specifically adversely impacted by the occurrence of conflict with staff. However, family members' perceptions of conflict and conflict management in LTC remain largely unknown. This is unsurprising given that, in general, the role of families in LTC is a relatively under-

researched area compared to the understanding of the role of families providing care to older adults in the community (Bauer, Fetherstonhaugh, Tarzia, & Chenco., 2014; Baumbusch & Phinney, 2014). There is a smaller body of research that specifically examines the involvement of families in the institutional LTC context that is largely qualitative in nature and focuses on family adaptation to and involvement in LTC (Haesler, Bauer, & Nay, 2010). Despite the lack of a robust literature, research that addresses family-staff relationships (including family-staff conflict), predictors of conflict and barriers to care partnerships has been deemed important for the design and delivery of LTC services (Abrahamson et al., 2009).

The present study sought to address the need to empirically examine family staff conflict by exploring the nature of family-staff conflict and its management from the family caregiver's perspective. Using a mixed methods research design, the goals of the study were to: (a) explore the nature of family-staff conflicts, (b) examine the type of conflict management strategies used by families, (c) examine family-staff conflict and its management in the context of broader conflict theory, (d) examine predictors of conflict management, (e) examine the outcomes of conflict and conflict management, and (f) understand the types of conflict and conflict management strategies among family caregivers who experience high levels of conflict.

The introduction is organized as follows: first, conflict and conflict management theory will be outlined; second, the literature on family caregiving and involvement in LTC will be reviewed; and third, the limited available literature related to family-staff conflict will be described.

Theories of Conflict and Conflict Management

As aforementioned, there is a significant lack of empirical evaluation of family-staff conflict and conflict management among family members in LTC. The field of family caregiving in LTC could significantly benefit from the application of established theories of conflict and conflict management, from fields such as industrial-organizational psychology, in order to gain a greater understanding of family-staff conflict and its management in LTC.

Traditional views of conflict hold that conflict is disruptive and dysfunctional (Almost, 2006). Positive dynamics and consequences of conflict have been noted, such as increased creativity, innovation, and productivity, which are largely dependent on conflict being managed effectively (Almost, 2006; Deutsch & Coleman, 2000; Kolb & Putnam, 1992). It has been noted that a certain degree of conflict may be essential to stimulate discussion, uncover differences in views, and to bring about change (Cowling, Stanworth, Bennett, Curran, & Lyons, 1988; Way, Black, & Curtis., 2002). Therefore, it is currently held that conflict is a “multidimensional construct, with both constructive and destructive effects depending on the type of conflict, the task at hand, and how the conflict is managed” (Almost, 2006, p. 447). Conflict literature to date has focused on both defining the type of conflict (including its antecedents and consequences) and examining how conflict is managed, in separate, albeit complementary, lines of research.

Tri-partite classification of conflict. One prominent line of research has focused on classifying conflict by delineating interpersonal from task-related aspects of conflict. The most advanced conflict classification is the tri-partite classification, which

includes relationship, task, and process conflicts. *Relationship* conflict refers to a disagreement resulting from interpersonal incompatibilities, including personality clashes, annoyance, tension, and animosity (Behfar, Peterson, Mannix, & Trochim, 2008; Jehn, 1995). This type of conflict can be highly counterproductive by removing the focus from establishing goals and consistently leads to adverse outcomes that harm team functioning such as dissatisfaction and decreased performance (Jehn, 1997). *Task* conflict refers to a disagreement over differences in ideas, opinions, and viewpoints related to a mutual task (Amason & Sapienza, 1997). This type of conflict can lead to both negative (e.g., dissatisfaction; Baron, 1990) and positive effects (e.g., improved productivity and creativity; Simons & Peterson, 2000) for the involved parties, depending on context (e.g., task complexity). *Process* conflict refers to disagreements in dividing and delegating responsibility and deciding how to accomplish tasks (Jehn, 1997). Therefore, whereas task conflict focuses on the content and goals of a task, process conflict focuses on how tasks should be accomplished (Jehn, 1997). Notably, the more diverse the values of individuals involved, the more likely it is that process conflict will occur (Jehn, 1995), which would be consistent with the diversity of values in care-orientations between families and staff in LTC. In terms of team outcomes, process conflict has been associated with reduced satisfaction and performance (Jehn, 1997). Moreover, when tasks are well defined and straightforward, individuals have little need to challenge one another and express their own opinions, which reduces the likelihood of task and process conflicts (Pelled, Eisenhardt, & Xin, 1999). Given the ambiguity of family and staff roles, and differing opinions and preferences in LTC, it is probable that task and process conflicts may be particularly common in LTC. Furthermore, the

seminal aspect in the evaluation of values and goals is perception. Regardless of whether values and goals are actually incompatible, it is the perceived incompatibility between family caregivers and staff that creates opportunity for conflict (Almost, 2006). Therefore, this suggests that it is the family caregivers' perceptions that matter more than objective factors (e.g., facility care orientation, staff orientation).

Although differential predictors of the three types of conflict on outcomes have been proposed (Jehn, 1997), nothing has been published in the literature about these different types of conflict in LTC. Furthermore, it has been suggested that these conflicts may not be mutually exclusive and that it is possible for different types of conflict to transform into another type (Jehn, 1997). For example, during a task-related conflict a family caregiver might begin to dislike a staff member and attribute the conflict to a personality issue, spurring a relationship conflict.

The dynamics of the individuals involved can serve to ameliorate or exacerbate the impact of conflict on group outcomes (Jehn & Bendersky, 2003). For example, when task conflict occurs among individuals who trust one another, the conflict is more likely to result in positive effects than when trust is low (Simons & Peterson, 2000). Research suggests that moderate levels of task conflict are constructive (Jehn, 1995), because they stimulate discussion of ideas and improve quality through constructive criticisms. In fact, absence of task conflict has been suggested as a detriment to group growth and innovation, whereas high levels of task conflict can negatively affect task completion (Jehn, 1997).

However, in the context of LTC it is unclear whether task conflict would result in beneficial effects, as families may not have adequate venues to discuss the conflict with

staff in order to create beneficial outcomes. Similarly, task conflict may be of greater benefit in environments where conflict norms encourage expression of doubts and opinions without fear of retribution or dislike by other team members. Edmondson (1999) reported that, without such norms of open communication, team members who express a divergent perspective may feel interpersonally threatened, may be made to feel incompetent, and could be accused of hindering progress toward a goal. This parallels the experience of family caregivers who express fear of retribution from staff toward the resident if they disclose their opinions (Hertzberg & Ekman, 1996).

Moreover, task conflict may be harmful when teams are performing straightforward, routine, and mundane tasks (Jehn, 1995). Jehn indicated that team performance was poor when task conflict occurred during routine tasks that are familiar and have a highly predictable outcome that does not benefit from further discussion, debate or consideration of alternate viewpoints. However, when tasks are complex, discussing discrepant viewpoints about a task, engaging in problem-solving, and overcoming conflict could optimize team effectiveness in meeting their goals in contrast to avoiding such discussions (Jehn, 1994; Jehn, Northcraft, & Neale, 1999). In fact, it remains unclear whether different conflict types reliably lead to beneficial outcomes for the involved parties, or whether all types of conflicts possess both negative and positive outcomes. For example, in a meta-analysis conducted by De Dreu and Weingart (2003a), the authors concluded that both relationship and task conflict relate negatively to team performance and satisfaction, with reported correlational relationships being similar in magnitude for relationship ($r = -.22, p < .05$) and task conflict ($r = -.23, p < .05$). A contingency approach has been advanced that suggests possible moderators of the

relationship between task conflict and team outcomes, that amplify and suppress the positive and negative effects of the conflict-outcome relationship, as well as differentially ameliorate and exacerbate positive and negative effects (i.e., Ameliorators decrease negative effects and increase positive effects; De Dreu & Weingart, 2003a; Jehn & Bendersky, 2003)

Overall, the historical consideration of conflict as solely a negative process that should be avoided has been replaced by the view that conflict can also lead to positive outcomes. In part, the outcome—including the value that can be obtained from a conflict experience—depends on the manner in which conflict is managed (Jehn, 1997). Therefore, it is of interest to understand how family caregivers manage conflict and whether different management strategies can impact their outcomes.

Conflict management. Conflict management is defined as preferences for communication, patterned responses, and behavioural strategies that individuals who are involved in a conflict intend to do as well as what they actually do (De Dreu, Evers, Beersma, Kluwer, & Nauta, 2001; Montoro-Rodriguez & Small, 2006; Van de Vliert, 1997). Notably, conflict management has a significant impact on the amount of conflict in an environment (Almost, 2006). Conflict management strategies can serve to ameliorate or exacerbate the impact of conflict on group outcomes, and such strategies largely determine whether the conflict impedes or facilitates and strengthens functioning of individuals within an environment (Behfar et al., 2008; De Dreu, 2010). Therefore, if conflict is to be productive rather than dysfunctional, understanding how family members approach conflict in LTC is critical (Almost, 2006).

Two prominent theories of conflict management are the *theory of cooperation and competition* (Deutsch, 1949; 2014) and the *dual concern theory* (Pruitt & Rubin, 1986; see De Dreu, 2010 for a review), with the former being the focus of this work.

The theory of cooperation and competition originated from Social Interdependence Theory (see review by Johnson, 2003; Johnson & Johnson, 2005), which posits that conflict is unlikely to occur when individuals are independent because their actions have a low likelihood of affecting the goal pursuits of the other individual. However, when individuals are interdependent, perceptions of cooperation and competition between individuals or within an environment become relevant to how parties interact because the actions of one individual will likely affect the goal pursuits of the other (Deutsch, 1949; Tjosvold, 1985). According to the theory of cooperation and competition, conflict management strategies depend on the extent and the manner in which an individual perceives their goals to be interdependent with another individual or group. When goals are perceived as mutual and positively related (i.e., individuals involved sink or swim together), individuals are likely to select cooperation and joint problem-solving strategies to address conflicts. Conversely, if the individuals perceive their goals to be separate, or negatively related (i.e., one sinks while the other swims), competitive strategies are more likely to occur (i.e., forcing, withdrawal). In addition to positive and negative interdependence, Deutsch additionally characterized two types of actions that individuals can take-- effective and bungling actions that improve and worsen an individual's chances of obtaining a goal, respectively (Deutsch, 2014).

To illustrate the above concepts, let us consider two students (student 1 and 2) in a class. If student 1 and 2 are working on a team project toward a single grade, their

goal orientation would be considered positively interdependent because the work of one student would impact the grade of the other student. Therefore, when encountering a conflict they would be more likely to behave cooperatively because their goal of a good grade is based on both of the students' performances. Alternately, if the teacher announced that the work of each student would be graded separately on the project and only one student could receive an A, this situation would create a negative interdependence as Student 1 may hope that Student 2 had a bad day, did not put in the work, or would score poorly for some reason. When encountering a conflict, Student 1 may act competitively to manage the conflict in order to increase his/her chances to attain the A grade. In the first scenario, anything that detracts from the overall team performance may be considered a bungling action, such as a student not completing their assigned portion of the task or losing the assignment, whereas an effective action would consist of any actions that are beneficial to the overall grade (e.g., the student doing additional research toward the assignment, assisting the other student with their portion of the assignment, etc.).

De Dreu (2010) noted that individuals with a prosocial orientation are more likely to emphasize mutual goals resulting in negotiation and problem-solving strategies, whereas those with an individualistic or competitive orientation are more likely to emphasize negative linkages between theirs and others' goals resulting in struggle and withdrawal. Evidence also suggests that positively linked goals induce prosocial motivation and foster cooperation, whereas negatively linked goals induce proself motivation and foster competition (De Dreu, 2010). Given the increasing emphasis on family and staff collaboration in LTC that would theoretically promote positively linked

goals, it was of interest to examine whether families perceive interdependence with staff in attaining resident quality care (e.g., whether families perceive themselves as dependent on staff to attain the goal of providing quality care to the resident). Moreover, the use of conflict management approaches may be associated with family member outcomes. Tjosvold's (2008a) review of the conflict management literature indicated that a cooperative approach to conflict management is often associated with higher team effectiveness than is a competitive approach, identifying conflict management as a key variable of interest in modifying the effects of conflict in an environment.

Debate exists over whether there is a conflict management *style* based on individual dispositions, that is stable over time and situations (Rahim, 1992, as cited in Friedman, Tidd, Currall, & Tsai, 2000; Thomas, 1976), or whether these approaches are *strategies* or *intentions* that are matched to the circumstances of a situation or the type of relationship (Knapp, Putnam, & Davis, 1988, Pruitt, 1983). There is evidence both for situational determinants of conflict management, such as the type of conflict and the relationship involved (Graziano, Jensen-Campbell, & Hair, 1996; Sternberg & Soriano, 1984) as well as dispositional determinants such as agreeableness and prosocial orientations (De Dreu & Van Lange, 1995; Graziano et al., 1996). It is suggested that dispositional styles of conflict management can be seen over longer periods of time, whereas situational determinants dominate in specific situations (Kenrick & Funder, 1991). Also important in conflict is the perceived resolution potential for a conflict situation by the involved parties. Greater perceived resolution potential is related to greater constructive effects of conflict (e.g., improved performance and satisfaction) as well as decreased negative effects of conflict (Jehn, 1997).

Grounded in Deutsch's theory, the author of this study perceives conflict between family caregivers and staff as largely inevitable given the interdependent nature of their roles in attaining their goals (e.g., quality resident care) in LTC (Deutsch, 2000; Tjosvold, 2008). The conflict itself is not perceived as the focal concern, but instead family caregivers' management of the conflict in determining whether the incidence of conflict has a positive or negative outcome (Tjosvold, 2008). Specifically, according to Deutsch's theory, whether a collaborative or competitive approach to conflict resolution is undertaken will determine the course and outcome for the involved individuals (Deutsch, 2014). Therefore understanding family caregiver characteristics that are related to the use of collaborative or competitive conflict management approaches is of importance in understanding how to foster beneficial conflict management and family outcomes. Theoretically, trust (Lewicki & Wiethoff, 2000; Lewicki & Tomlinson, 2014), power (Coleman, 2000; 2014) and communication (Krauss & Morsella, 2000; 2014) are key and foundational variables in the occurrence of conflict as well as its management (Deutsch, 2000, 2014). Within the sparse family-staff conflict literature, as will be described below, family expectations of LTC (Vinton, Mazza, & Kim, 1998), communication with staff (Haesler et al.2007) and sense of community (SOC; Petrovic-Poljak and Konnert, 2013) have been asserted to be associated with conflict and important in the LTC environment. Resultantly, these five seminal variables present themselves as the most prominent candidates for having influence on conflict management.

Family Caregiving in Long Term Care

Family involvement following relocation to LTC. As noted previously, family caregivers account for the largest, and growing, unpaid workforce in Canada, and provide the majority of the physical and socio-emotional care to older adults living in the community, which may or may not be supplemented by community health services such as home care (Fast, 2015; Peter, 2013). Although most older adults will live out their final years in the community, a subset will, along with their families, experience a relocation to a LTC facility. Unsurprisingly, admission of a care recipient to a LTC facility does not terminate family involvement in care (Haesler et al., 2010). In fact, many families maintain frequent involvement following relocation to LTC (Baumbusch & Phinney, 2014; Cohen et al., 2014; Gaugler, 2005a).

The relocation to a LTC facility does not solely involve a physical change of location of the care-recipient but an overall change in the daily lives and roles of the care recipient and the family. Certain caregiver stressors, such as physical exertion and limits to leisure time, decrease following relocation of the care recipient; however, other stressors can increase, that can result in an unchanged level of caregiver burden (Keefe & Fancey, 2000). These new stressors include family caregiver's modifying previous care roles and assuming new roles, such as those of an advocate and monitor of care (Baumbusch & Phinney, 2014; Gaugler, Anderson, Zarit, & Pearlin, 2004; Haesler et al., 2010). Moreover, transition from caring in the community to caring in LTC involves negotiation of new role expectations with several parties, including the resident, other

family members, and front-line, professional and managerial staff³ (Abrahamson, Anderson, Anderson, Sutor, & Pillemer, 2010). Families find negotiations with nursing staff concerning residents' care particularly challenging because there is a lack of clear expectations for family involvement in LTC, which are rarely if ever articulated, resulting in role ambiguity, meaning that families are unsure as to what they can or cannot do in LTC (Haesler et al., 2007; 2010). Therefore, families experience a change in their caring role from the community, where they are typically considered "caregivers" to being viewed as "visitors" or outsiders in the LTC setting by staff and administration (Holmgren, Emami, Eriksson, & Eriksson, 2013). As families are uncertain about what their role in the residents' care is, while simultaneously adjusting to relinquishing control of direct care to nursing staff and often having differing views as to what constitutes quality care, the potential for family-staff conflicts in LTC is high.

Collaboration and competition between family members and staff: Sources of family-staff conflicts. Disparities exist between family members and staff in terms of their opinions regarding who provides what care and what constitutes quality care (Haesler et al., 2010). Results from qualitative research studies indicate that families tend to emphasize individualized care (i.e., care tasks that maintain resident's personal identity and dignity) by trying to differentiate the resident as a unique individual with idiosyncratic needs who is distinct from other residents, that is in contrast to the uniformity of care provision that is frequently practiced by staff (Bauer & Nay, 2003;

³ Front-line staff refers to any staff members who directly interface with families on a regular basis including administrative (e.g., administrative assistants, unit clerks) and nursing staff (e.g., Nursing Aides/Attendants [NA], Health Care Aides [HCA], Licensed Practical Nurses [LPNs] and Registered Nurses [RN]). Professional staff includes social workers, occupational therapists, physiotherapists, and physicians in this document. Managerial staff includes floor/unit managers and facility directors.

Friedeman, Montgomery, Maiberger, & Smith, 1997, Haesler et al., 2010). Family members' satisfaction with care has been noted to depend on their perceptions of staff's ability to promote individualized care and to maintain residents' emotional well-being, in addition to providing efficient direct physical care (Bauer, Fetherstonhaugh, Tarzia, & Chenco, 2014; Friedmann et al., 1997; Haesler et al., 2010). Unfortunately, the family's focus on personalized care is frequently overlooked as members of nursing staff, who largely follow the medical model of care, are primarily preoccupied with routine physical caregiving and efficiency due to issues of understaffing, work overload and the expectations of their employers (Gaugler, 2005a; Haesler et al., 2010). To this end, staff are faced with negotiating the expectations of both families and their employers, within their set of abilities (Abrahamson et al., 2009). Abrahamson and her colleagues (2009) noted that these expectations are often incompatible, with staff noncompliance with family members' expectations potentially resulting in interpersonal conflict and dissatisfaction with care, whereas noncompliance with employers potentially resulting in job loss or reduction in pay.

Therefore, the perceived disparity in care orientations is a frequent source of conflict between family members and staff, as each attempts to maintain control over caregiving duties (Bauer & Nay, 2003). Families and staff also differ in which aspects of care they see as important. Families view issues of privacy and boredom as particularly important whereas staff do not perceive them to be significant concerns (Lindgren & Murphy, 2002). In addition, families and staff have disparate views on the degree of relevance and importance they place on the information families possess about residents. Research indicates that staff believe that certain information possessed by

families refers to residents' pre-morbid past (i.e., prior to cognitive and physical decline) in the absence of knowledge of care-recipients' present preferences, which staff believe that they possess (Abrahamson et al., 2009; Hertzberg et al., 2003). Therefore, staff report that families' requests represent their own needs rather than the residents', which contributes to staff's perceptions of family requests as irrelevant (Hertzberg et al., 2003). However, family members do bring knowledge of resident history and care preferences that are particularly important in circumstances where the resident is cognitively impaired (Abrahamson et al., 2009; Rowles & High, 1996). Austin and her colleagues (2009) reported that these different, and at times opposing, views between staff and families in regard to what constitutes care that is in the best interest of the resident creates a "chasm" (p.373) between the two parties and contributes to an "us versus them" mentality, that can lead to family-staff conflict.

The journey from "us vs. them" to "we": The development of family-staff relationships. Research indicates that family caregivers believe that the quality of care that the residents receive is compromised if their roles and actions as family caregivers are not supported by staff (Haesler et al., 2010; Kellet, 1999). Therefore, family caregivers perceive that the quality of care provided to the resident is dependent on their participation in care provision in LTC (Bauer & Nay, 2003; Haesler et al., 2010). They view optimal involvement as one that allows them to collaborate with staff and share the responsibility for the care of the resident and to be readily involved in decision-making processes (Bauer & Nay, 2003; Robinson & Thornes, 1984; Ross, Rosenthal, & Dawson, 1997). If family caregivers do not perceive themselves as an integrated part of the nursing team or if their needs and opinions are disregarded by

staff, dissatisfaction with the quality of care provided and significant distress may result (Gaugler, 2005a; Haesler et al., 2010). Family perceptions of exclusion from residents' care have been associated with increased levels of caregiver burden and strain, as well as overall well-being (Bramble, Moyle, & Mc Allister, 2009; Westin, Ohm, & Danielson, 2009).

Several authors have recommended a collaborative partnership between families and staff rather than a competitive approach (Bauer et al., 2014; Dijkstra, 2007; Kemp, Ball, Perkins, Hollingsworth, & Lepore, 2009; Legault & Ducharme, 2009; Majerovitz, Molloy, & Rudder, 2009). The existing literature on family involvement has well established the importance of fostering good family-staff relationships, with benefits noted by residents (Gaugler, 2006; Wilson, Davies, & Nolan, 2009), staff (Bauer et al., 2014; Moyle, Skinner, Rowe, & Gork, 2003; Utley-Smith et al., 2009) and family members (Bauer & Nay, 2003; Bauer et al., 2014; Haesler et al., 2007, 2010; Legault & Ducharme, 2009). Despite identified benefits of collaboration in providing care, research indicates that nursing staff and families continue to experience ongoing strains.

Moreover, family caregivers' position in care is often viewed as secondary following institutionalization, whereby the formally trained nursing staff assume the position of primary or "expert" carers who possess current knowledge of the resident, reducing and restricting the family members' role to an informal one, resulting in significant frustration for families (Holmgren et al, 2013; Levine & Zuckerman, 2000). Family involvement in LTC may be viewed by staff as interference with routines in the facility, in light of time constraints and work overload (Bauer et al., 2014; Hewison, 1995; Holmgren et al., 2013), as well as an attempt to usurp staff roles and boundaries

(i.e., questioning nursing ability), increasing potential for conflict (Bauer et al., 2014). In their study of family and staff perceptions of the role of families in LTC, Ryan and Scullion (2000) reported that staff were hesitant to trust family caregivers due to professional responsibility and accountability, preferring to maintain professional control over resident care. Shuttlesworth, Rubin, and Duffy (1982) reported that the quality of family-staff relationships may depend upon the clarity of the division of tasks, and the degree to which the institution and staff encourage and support involvement of the family in various aspects of care. The findings of this study remain relevant today and the manner in which these goals can be attained remain elusive, as the establishment of collaborative relationships between families and staff in LTC continues to be a significant goal (Haesler et al., 2007, 2010) and one consistent with person-centred care ideals (Alzheimer Society of Canada, 2011). However, programs that have been created to promote communication and collaboration between families and staff, by focusing directly on the quality of the family-staff relationship—such as the Family Involvement in Care intervention (Maas et al., 2004) and the Partners in Caregiving intervention (Robison et al., 2007)—have resulted in limited effects on family-staff conflicts (Maas et al., 2004; Robison et al., 2007).

Importantly, the diversity of family members in LTC needs to be recognized- they have varying levels of commitments, abilities, and interests in caring for the residents. In a Canadian study, Reid and Chappell (2015) concluded that optimal family involvement in the context of the provision of person-centred care differs by the family member considered and depends on the degree to which family caregivers consider their own involvement to be important. Family members can engage in various levels of care

across different domains including physical (e.g., feeding, bathing), social (i.e., attending or leading social or recreation activities such as a birthday party or bingo), emotional (e.g., listening, holding hands, hugging), spiritual (i.e., attending worship), monitoring/overseeing (e.g., observing resident interactions with staff, checking residents for signs of abuse), and advocacy (e.g., attending council meetings, making suggestions to management, assuming role of system "watchdogs") (Baumbusch & Phinney; 2014; Cohen et al., 2014).

The influence of the LTC context on family-staff relationships. Long-term care services in Canada are chronically underfunded and understaffed (Banerjee, 2007, Hirdes, 2002). This results in limited qualified full-time clerical and nursing staff, and a strong reliance on casual, part-time staff, particularly in the evenings and on weekends, which constitute popular times when families visit (Hertzberg et al., 2003; Registered Nurses' Association of Ontario, 2007). The nature of the work for nursing staff is physically and psychologically demanding (Zhang, Punnett, Mawn, & Gore, 2016). Some evidence suggests that LTC provides unfavourable working conditions, including low control and support (Liang, Hsieh, Lin & Chen, 2014), and limited training and heavy workloads (Alper & Domnitz, 2017). The level of burden related to the work has been reported to contribute to consistently high nursing staff turnover-with the workforce turnover rates being deemed to be of critical proportions (Alper & Domnitz, 2017). According to the 2004 National Nursing Home Survey in the U.S., the annualized staff turnover rate was the highest among nursing attendants at 74.5%, followed by registered nurses at 56.1%, and licensed practical nurses at 51.0% (Donoghue, 2010). Although comparable Canadian statistics are not currently available, Rondeau and

Wagar (2016) reported that nurse turnover in LTC is frequent and costly in Canada. Nursing attendants are the most numerous and visible in the nursing home, and are tasked with the provision of direct basic care to residents and assisting them in daily activities, including bathing, feeding, dressing, and toileting. Therefore, the staff who are assigned the most personal tasks, and perhaps those that carry the greatest emotional salience for family members—as well as who have the most direct and frequent contact with family members—are the ones who experience the greatest rates of staff turnover (Abrahamson, Pillemer, Sechrist, & Sutor, 2011). A large-scale examination of family-staff conflicts from the staff's perspective conducted by Abrahamson and her colleagues (2009), indicated that family-staff conflict led to increased staff burnout and reduced work satisfaction, both factors that are deemed important in retention of staff in LTC. High staff turnover and limited administrative support have been noted as significant barriers to the development of trusting family-staff relationships and maintenance of open communication between families and staff (Bauer & Nay, 2003). Notably, perceived time pressure to complete duties was positively related to greater staff endorsement of conflict with family caregivers (Abrahamson et al., 2009), however, arduous workloads are a daily reality. Moreover, staff have reported that negative interactions with families have made them want to quit their positions (Utley-Smith et al., 2009).

Thus, due to staff time constraints, high workloads, and a lack of training in family-focused care (as well as low priority given to family members) little opportunity may be available to establish positive relationships (Hertzberg et al., 2003). Families show awareness of these organizational factors, often acknowledging that these are

beyond staff's control, but nonetheless perceive them as obstacles to constructive relationships, and often report that they want greater and better contact with staff, that they are often not listened to or taken seriously, and feel ignored or misunderstood by staff (Bauer et al., 2014; Haesler et al., 2007, 2010; Hertzberg et al., 2003; Marzialli, Shulman, & Damianakis, 2006; McGilton & Boscart, 2007).

Nursing staff with high workloads are less likely to engage in positive communication with families (Abrahamson et al., 2010; Bauer, 2006). In fact, Bowers, Luring, and Jacobson (2001) found that nursing staff engaged in multiple avoidance strategies to avoid communication with family caregivers in an effort to complete mandated tasks within given time limits, with greater level of perceived role burden being related to greater avoidance of communication (Abrahamson et al., 2010). The author's master thesis research study indicated that almost a third of front-line nursing staff reported that they did not regularly interact with families due to avoidance of communication (Petrovic-Poljak & Konnert, 2011, unpublished data). In particular, neither staff nor family members in LTC receive education or training regarding the experiences and roles of the other to enhance understanding or develop helpful communication strategies (Levine & Zuckerman, 2000). Studies suggest that staff are often left to their own devices to engage in perspective taking and development of empathy for families, often based on their own personal experience and resulting in inconsistent results (Bauer, 2006).

Notably, staff have been reported to judge families based on their perceived involvement in resident care. Port (2004) reported that because many caregiving tasks that continue to be performed by family members tend to occur outside of the LTC

facility (e.g., financial management) or are conducted privately away from the staff's view (e.g., on weekends or in the evenings), staff may underestimate family's involvement in care. Although staff report that family caregivers can be a valuable resource in providing care, when they show interest in the resident and help out with tasks around the LTC facility (e.g., feeding, interacting with residents), often they are viewed as demanding, disruptive and time consuming (Bauer et al., 2014; Haesler et al., 2010; Hertzberg et al., 2003; Kemp et al., 2009). Staff have been reported to be critical of families' involvement in care and were more forthcoming about the challenges they presented, including lacking understanding of the residents' current physical and mental health needs and appropriate care, and disputing their care decisions (Bauer et al., 2014).

It has been suggested that development of trusting relationships between families and staff, in place of the superficial and strained relationships that commonly occur, can actually increase the time that staff have to provide care instead of consuming it by beneficially involving family members (Hertzberg et al., 2003; Sandberg, Lundh, & Nolan, 2001). Staff have echoed this in their positive views of family involvement by having families help with some of their work duties and assist with organized activities, however, staff reported that an investment of time is required to develop positive relationships with family members (Bauer et al., 2014).

Communication between families and staff. Communication difficulties between families and staff have been frequently cited in the literature (Haesler et al., 2007, 2010), with families reporting dissatisfaction with the quality and amount of communication that they receive from staff (Bramble, Moyle, & McAllister, 2009). In the

conflict literature, all aspects of communication, including style, verbal, non-verbal and a lack of communication, have been implicated in leading to conflict (Almost, 2006). As previously noted, lack of training in communicating with family members and lack of protected time for communication between family and staff may compromise the quality of communications. In their qualitative study that included interviews and focus groups with 27 staff and 15 family members at five LTC facilities, Bauer and his colleagues reported that communication was the key ingredient for the formation of constructive family-staff relationships (Bauer et al., 2014). Communication was perceived as essential to building trust between families and staff, maintaining positive involvement, and "keeping families happy". Seminal to the development of trust by families was the approachability of staff and having the ability to discuss the resident (Bauer et al., 2014). In another qualitative analysis, Majerovitz and her colleagues (2009) reported that when family-staff relationships lacked communication and trust, families felt criticized by staff that in turn led to increased feelings of guilt and distress.

Family expectations of LTC. The research literature has frequent anecdotal references to family's expectations in LTC as "unrealistic" (Bauer, 2006; Bauer et al., 2014). However, if the quality of care fails to meet families' expectations or the expectations are not considered reasonable by staff, dissatisfaction with care and conflict often result (Abrahamson et al., 2010; Dobrof, 1981; Vinton & Mazza, 1994). Nursing staff view many family expectations, including individualized care, as unrealistic and find family complaints trivial at times (Bauer et al., 2014; Bowers, 1988; Karner, Montgomery, Dobbs, & Wittmaier, 1998). According to Vinton and her colleagues' (1998) survey of social workers in LTC, the respondents indicated that in most cases of

formally reported conflicts family caregivers were difficult to please, took issue with patient care practices, and were unrealistic in terms of expectations about what staff should do for the resident. Often, family caregivers' expectations for their relative cannot be met by the LTC facility due to understaffing or a lack of resources (Allen, Nelson, Netting & Cox, 2007). Staff have also reported that families expectations can reflect their guilt over their care decision to relocate the resident to LTC (Bauer et al., 2014). When staff perceive that families' expectations match their own, the frequency of family-staff conflicts that they report decreases (Abrahamson et al., 2010). Given that families' expectations are often cited but seldom examined empirically, it would be of interest to examine how family expectations relate to conflict and conflict management strategies employed by family caregivers.

Family-staff conflicts in LTC: What do we currently know? Conflict between nursing staff and families has been labeled as an “institutional reality” for almost 20 years (Pillemer, Hegeman, Albright, & Henderson, 1998). Conflict potential appears to stem from the fact that family involvement in LTC can be challenging for both family members and staff (Bauer & Nay, 2003). Several factors that might contribute to the potential for family-staff conflicts have been noted including: (a) competition in care between staff and families, (b) failure of staff to recognize family caregivers' expertise, (c) overlap between family and staff roles, (d) rigid definition of roles, (e) disparities in care orientations and priorities, (f) factors regarding institutional organizational structure, (g) the mental and emotional status of residents and families, (h) staff perceived as incompetent by families, (i) family conflicts, (j) poor communication and relationships between staff and families, (k) intergenerational tensions, and (l) negative behaviours

(e.g., yelling) engaged in by staff (Abrahamson et al., 2009; Allen et al., 2007; Duncan & Morgan, 1994; Haesler et al., 2010; Marziali et al., 2006; Small & Montoro-Rodriguez, 2006).

Family and resident factors. Several additional factors may be pertinent to the potential for family-staff conflict in LTC. These include family caregiver's gender, age, and relationship to resident, resident's functional status, resident's veteran status, family conflict, and sense of community.

Gender. Staff have reported that male caregivers are more "easygoing" and less stringent about how care was carried out, whereas female caregivers visited more regularly and frequently and had higher standards of care (Hertzberg et al., 2003). In two studies examining aggressive behaviour toward staff, (Vinton & Mazza, 1994; Vinton et al., 1998), daughters and wives of residents were the most frequent perpetrators of aggressive acts toward staff, followed by husbands and sons. It is unclear whether conflict is related to gender, or perhaps to visitation frequency and involvement, as female caregivers report the greatest involvement in LTC (Gaugler, 2005a).

Age. In previous studies, staff have reported that younger family caregivers were more challenging to work with than older ones (Hertzberg et al., 2003). Generational differences may be present in that younger family members may be more aware of what they can ask for and may be better informed, which may increase their likelihood of requests from staff and demands. This is consistent with Vinton and colleagues' (1998) findings regarding aggressive acts toward staff: Approximately one half (51.4%) were adult child caregivers and one-fourth (25.8%) were spouses.

Resident's functional status. Resident dependency is a factor that may affect the relative position of staff and families in regard to their roles in caring. Greater resident dependency gives staff greater control over care and affects how staff interact with residents, which may be accompanied by abusive and patronizing communicative behaviour (Bergstrom & Nussbaum, 1996; Small & Montoro-Rodriguez, 2006). This has been particularly noted when residents suffer from dementia or high levels of functional impairment and are most vulnerable (Gaugler, 2005; Small & Montoro-Rodriguez, 2006). Indeed, families may strive to exert greater control and monitoring of resident care with increased resident vulnerability (Davies & Nolan, 2006). Thus, examining residents' diagnoses of dementia, as well as functionality in terms of activities of daily living, may be important resident-level factors to consider in how families approach conflict management.

Elderly veterans. With the accumulation of research studies examining caregiving in LTC, it has been noted that subgroups of family caregivers should be studied, including family caregivers of elderly veterans (Gaugler, 2005a). Importantly, there is evidence that LTC facilities that specialize in providing care to elderly veterans are lower on cohesion and higher on conflict, despite providing higher quality care than non-veteran facilities (Moos & Lemke, 1994). Several factors may be unique to these family caregivers including the severity of an elderly veteran's condition (e.g., PTSD) and its effects on the caregiver (Manguno-Mire et al., 2007; Settersten, 2006; Sokoloff, 1999), the duration of the caregiving career (Rosenman, Brocque, & Tilse, 2008), relational difficulties in veteran families (e.g., disturbed intimate relationships, increased conflict and aggression, reduced cohesion; Catani, 2010; Dekel, Goldblatt, Keidar, Solomon, &

Polliack, 2005; Monson, Taft, & Fredman, 2009), and sentiments of deservedness and entitlement (Struthers, 2007). Family caregivers of veterans have strong perceptions of discipline, responsibility for care and may possess a strong belief in self-reliance and a resultant desire to maintain personal control over caregiving in LTC (Dorfman, Holmes, & Berlin, 1998). These proposed unique factors may contribute to greater experiences of conflict as well as poorer conflict management in LTC.

Family conflict. Nelson (2000) noted that families bring long-standing family dysfunctions into the LTC context. These pre-existing conflicts can be exacerbated following LTC placement (Vinton & Mazza, 1994). Families of older adults with mental and physical impairments experience higher rates of family conflict, with as many as 40% of caregivers experiencing serious conflict with a family member (Strawbridge & Wallhagen, 1991).

In caregiving situations, there is often one family member who assumes primary responsibility for the care recipient (e.g., hands on care), with other family members providing substantial assistance (e.g., emotional support, financial support; Gaugler, Mendiondo, Smith, & Schmitt, 2003). Through the process of caregiving and changing roles within the family, disruptions in interpersonal relationships among family members can occur which can result in family conflicts (Scharlach, Li, & Dalvi, 2006). Family conflicts can occur when a family member is unwilling to provide the expected amount of help, provides insufficient social or emotional support, when there are perceived inequities related to caregiving roles, or when there is disagreement about the appropriate type and amount of support for care-recipients (Pruchno, Burant, & Peters, 1997; Scharlach et al., 2006).

Family conflict can have deleterious effects on individual family members and the care-recipient. For example, families who experience conflict or dysfunction provide less care to the resident (Lieberman & Fisher, 1999) and provide less social and emotional support to the family member with primary care responsibilities (Gaugler, et al., 2003; Weihs, Fisher, & Baird, 2002). Family conflict has been associated with greater anger, depression, greater caregiver burden, poorer mental health, and a lower sense of competence among family members both in the community (Semple, 1992; Strawbridge & Wallhagen, 1991) and in LTC (Gaugler, Zarit, & Pearlin, 1999).

Moreover, family conflict management has been implicated in mental health outcomes (Fisher & Lieberman, 1996). Specifically, conflict avoidance predicted anxiety and depression, and was related to greater caregiver burden, in adult child caregivers of elders with dementia (Fisher & Lieberman, 1996), whereas, in another study, denial and avoidance were not related to distress (Mitrani, Vaughan, McCabe, & Feaster, 2008). However, successful management of family conflict may have protective impact against caregiver distress and result in greater care provided to the care-recipient (Lieberman and Fisher, 1999; Mitrani et al., 2008).

In addition to the adverse effects on the caregiver, family conflict can impact conflict with staff in another manner. Family members might perceive the expression of hostility or anger toward the resident (e.g., parent or spouse) or other family members as unacceptable; however, expressing hostility toward staff providing care may be perceived as acceptable or even as an indicator of caring (Iecovich, 2000; Vinton & Mazza, 1994).

Sense of community. Sense of community (SOC) refers to a feeling of belonging, having influence, having needs met, and having an emotional connection to individuals in a community (McMillan & Chavis, 1986). This construct evaluates the extent to which people feel connected to, supported in, and effective in their functions as a community member. Of note, a perceived SOC is important in sustaining harmonious relations in communities, is predictive of collaborative behaviour, and enhances participation (Chavis & Pretty, 1999; Chavis & Wandersman, 1990). Petrovic-Poljak and Konnert (2013) reported that family caregivers in LTC with higher perceived SOC were more satisfied with care and experienced less conflict with staff. Because SOC is closely aligned with collaborative values and mutual regard for community members, including perception of shared goals, it is plausible that family caregivers who have a higher SOC might possess conflict management styles that are cooperative in nature.

Family responses to family-staff conflict. Most of the literature concerning family-staff conflict in LTC includes staff's reports of conflict, their management of it and their attitudes toward families (Pang & Chair, 2007; Utley-Smith et al., 2009). There is very limited information about family caregivers' responses to conflict or their management of it.

Unfortunately, aggressive behaviour directed at staff by families is not a rarity (Vinton & Mazza, 1994). In Vinton and colleagues' (1998) survey of 70 facilities, facility administrators reported 1,193 acts of verbal aggression and 13 acts of physical aggression over a period of six months. The most frequently cited cause of conflict in this study was dissatisfaction over how the specific and overall care needs of residents were being met, followed by theft of residents' possessions and financial disputes.

Notably, for 56.8% of episodes of aggressive behaviour the family member had a prior incident of aggressive behaviour. Some instances of aggressive behaviour involved multiple family members (e.g., three family members of one resident were aggressive toward staff). In regard to the target of the aggressive behaviour, in 36% of the cases it was nurses, followed by social workers (26%), and nursing aides (20%). Furthermore, an average of 3.1 interventions were used in each case involving aggression, with partial resolution occurring in the majority of cases (61.3%) and only 17% being completely resolved.

The second way that families respond to conflict can be gleaned from anecdotal evidence and staff reports. Staff have mentioned that families may see more shortcomings in the care of the residents than they articulate (Hertzberg et al., 2003). Families have been noted to be cautious or vague in their communication especially when they wanted to question something pertaining to care or wanted a request to be fulfilled (Hertzberg et al., 2003). This has been attributed to family's anxiety of being labeled as "difficult" and fear of retribution (Bauer, 2006; Nelson, 2000). These concerns may be more evident among older caregivers who may be less likely to challenge the authority of staff (Almost, 2006).

"Problem" family caregivers. Family caregivers who make frequent requests of staff, question or complain about the care provided, want preferential treatment for the resident or do not follow staff instructions are often labeled by staff as "problem" or "demanding" family caregivers (Bauer, 2006; Baumbusch & Phinney, 2014; Utley-Smith et al., 2009). These family caregivers are often avoided and their requests and expectations are not taken seriously (Bauer, 2006; Hertzberg et al., 2003). By

distancing themselves from family caregivers through avoidance, staff may be creating an ineffective feedback loop, whereby families become more demanding with increased requests for attention and information (Utley-Smith et al., 2009). However, studies have reported that nursing staff do not feel that they have adequate skills to manage these families and that other professionals, such as social workers, have the appropriate training (Hertzberg et al., 2003). Unfortunately, such negative perceptions of family members by staff may affect resident care. Gaugler (2005b) reported that staff who had more positive attitudes toward family caregivers were more likely to have positive perceptions of residents. Therefore, both families and residents can be impacted by family caregivers who are perceived as problematic by staff. As these families account for the majority of complaints in LTC (Vinton & Mazza, 1998), it is of particular interest to examine what types of conflicts they encounter and how they manage such conflicts. Thus, the qualitative analyses in the present study focused on conflict and conflict management in high conflict families.

Rationale, Contribution and Significance of the Study

Research emphasizes that involvement of families in everyday care is “one of the best guarantees of a resident’s well-being” (Haesler et al., 2007, p. 385) by improving psychosocial outcomes and decreasing mortality, playing a pivotal role in the provision of holistic person-centred care (Gaugler, 2005a; Kiely, Simon, Jones, & Morris, 2000; Zimmerman, Gruber-Baldini, Hebel, Sloane & Magaziner, 2002). Moreover, family involvement results in decreased family stress and may significantly contribute to caregiver well-being (Bramble, Moyle, & McAllister, 2009; Gaugler et al., 2004; Westin, Ohn, & Danielson, 2009). However, there is often confusion about how families can be

integrated into care routines in LTC. All too often, family caregivers are faced with barriers such as lack of encouragement from LTC staff or poor interpersonal relationships with staff, ultimately culminating in conflict between family caregivers and staff (Haesler et al., 2007, 2010).

The role of family in LTC has changed significantly in recent years. Historically, LTC was part of the medical model, whereby family caregivers were considered mere visitors. Newer holistic models of LTC place a greater focus on family-staff collaboration, emphasizing family involvement as an essential component of quality of care (Gaugler, 2005a). For example, the Eden Alternative, which provides enhanced opportunities for family involvement, resulted in improved satisfaction from greater communication and interaction among families, staff and residents (Roshier & Robinson, 2005). As mentioned, inclusion of families in LTC is important for person-centred care (Boise & White, 2004), and some have increased this goal to integrate family-focused care in LTC (Maas et al., 2004; Robison et al., 2007; Ward-Griffin, Bol, Hay, & Dashnay, 2003), with family members determining whether they want to participate or not. However, although new models of care have been accepted theoretically, the actual translation of these models of care in everyday practices in LTC has been limited (Haesler et al., 2007). As family caregivers strive for their positions as collaborators, it is likely that conflicts between families and staff will increase, as negotiations of partnerships are a dynamic process that involves considerable conflict (Ward-Griffin & McKeever, 2000).

Many of the potential sources of family-staff conflict are interrelated and likely cumulative; however, many of the factors that contribute to conflict are anecdotal (i.e.,

offered through the opinions of LTC staff) without being empirically evaluated, or have been attained through studies that only included nursing staff as participants. Additionally, given the lack of information regarding the manner in which family members manage conflict, it is imperative that an empirical examination of conflict management strategies employed by family caregivers is conducted, as well as how these strategies may affect their caregiving outcomes, including burden and satisfaction with care.

To date, family-staff conflict has not been informed by the broader literature on conflict and conflict management; however, it is a natural fit for several reasons. Firstly, families and staff are interdependent on each other for providing quality care to residents and this is an essential requirement for conflict (Deutsch & Coleman, 2000; Haesler et al., 2007). As in work environments, staff and family members in LTC must work as a team, establish roles and responsibilities, and work as collaborators and not competitors in providing care (Dijkstra, 2007; Kemp et al., 2009; Legault & Ducharme, 2009; Majerovitz et al., 2009). Interdependence can lead to conflict due to individuals' different perspectives and viewpoints that need to be reconciled in order for the team to function and achieve its goals (Beersma, Conlon, & Hollenbeck, 2008; Jehn, Greer, & Rupert, 2008).

Secondly, family-staff relationships have been noted to be riddled both with instances of cooperation and competition in care (Haesler et al., 2010) and it is of interest to examine whether similar modes of behaviour are applied to management of family-staff conflicts, as is advanced in Deutsch's theory (1949; 2014) of conflict management.

Thirdly, trust, power, and communication—deemed as essential factors in determining adaptive conflict management (Deutsch, 2010; 2014)—have been put forth by the qualitative literature as key factors impacting family-staff relationships in LTC. Researchers have reported that when family caregivers develop a sense of trust and security about their role in LTC they are more likely to engage with staff in positive ways (Wilson, Davies & Nolan, 2009). Similarly, open communication has been reported to improve the quality of family-staff relationships by both families and staff by promoting helpful behaviours (Bauer et al., 2014, Baumbusch & Phinney, 2014).

Fourthly, inappropriate management of conflict due to inadequate conflict management skills may have deleterious effects on the quality of care provided in LTC (Montoro-Rodriguez & Small, 2006), as is suggested in the broader conflict literature (Behfar et al., 2008; De Dreu, 2010). Conflict can cause a series of adverse outcomes for staff and families, including anger, fear, threats to self-esteem, decreased cognitive resources, stress, psychosomatic complaints, depression, and anxiety (Danna & Griffin, 1999; McEwen, 1998; Quick, Quick, Nelson, & Hurrell, 1997). Moreover, family-staff conflict contributes to staff overload, increased absenteeism and staff turnover, which are significant areas of concerns given workforce shortages in LTC (Abrahamson et al., 2010). Also, specific conflict management strategies may impact family caregiver outcomes both positively and negatively. Studies of nursing staff in LTC show that use of avoidance and confrontational coping predicted mood disturbance (Healy & McKay, 2000), mental distress (Tyler & Cushway, 1995), emotional exhaustion (Ceslowitz, 1989), decreased psychological morale (Montoro-Rodriguez & Small, 2006), and job depersonalization (Montoro-Rodriguez & Small, 2006), whereas cooperative and active

coping strategies may prevent burnout (Ceslowitz, 1989; Jansen, Kerkstra, Abu-Saad, & Van Der Zee, 1996) and were associated with higher feelings of job accomplishment (Montoro-Rodriguez & Small, 2006). As the broader conflict literature indicates, effective conflict management can promote improved adjustment and competence and can strengthen the relationship with the other party (Tjosvold, 1997).

Finally, “the experience of conflict is not just a function of external conditions, but also the conflict management styles that people bring to bear on problems” (Friedman et al., 2000, p.32). Individuals who are less able to manage conflicts effectively are likely to experience an accumulation of conflicts, producing a highly conflict-laden environment (Friedman et al., 2000). For example, Friedman and his colleagues (2000) reported that individuals who use collaborative strategies produce an environment with less conflict whereas individuals who use avoidant or dominating strategies produce environments with more conflict. Moreover, an individual’s ability to manage conflicts can determine whether they perceive their environment as supportive or adversarial. This provides further evidence for the importance of investigating conflict management strategies, as well as correlates of such strategies including family and resident factors that may affect them. This represents an initial step towards identifying family caregivers at risk of poor conflict management and potentially implementing conflict management skills training that could complement programs currently in place for improving family involvement in LTC.

Furthermore, it needs to be reiterated that family-staff conflicts occur in a LTC environment that is characterized by understaffed and underfunded facilities, high staff turnover and burn-out, increasing morbidity of residents and higher care needs, and

decreased specialized expertise of nursing staff (Gaugler, 2005a; Montoro-Rodriguez & Small, 2006). Unfortunately, although much of the literature is based on data from the United States, data specific to the Canadian context also suggests that it is unlikely that these challenges in LTC will change in the near future. Compared to previous decades, a greater proportion of residents in LTC in Canada require a higher level of care (Ontario Long Term Care Association, 2016; Registered Nurses Association of Ontario, 2007). Approximately 80% of residents are deemed complex, which creates higher demands on staff for greater support for daily activities and for specialized care for complex health conditions and dementia (Ontario Long Term Care Association, 2016). In Canada, staffing standards for LTC are determined by provincial governments. Currently, all provinces show a gap between the actual staffing standards (both in terms of number and skill level), the recommended staffing standards and the demands in LTC facilities (Harrington et al., 2012). This gap has been deemed problematic, as poor quality of resident care in Canada has been associated with inadequate staffing and poor skills mix (Spilsbury et al., 2011). For example, the Registered Nurses Association of Ontario (RNAO) has made recommendations to the provincial government outlining the percentages required of each type of staff member in LTC facilities in order to have the sufficient number of appropriately educated and trained staff, including regulated professionals and personal support workers, as well as management in sufficient number "to provide effective, safe and culturally competent care" (RNAO, 2007, p. 4). The RNAO had developed recommendations that included health care aides (HCAs) providing 55% of resident care, LPNs providing 25% of care, and RNs providing 20% of care. However, these numbers were much higher in terms of the percentage of care

that was provided by regulated staff (e.g., LPNs were found to provide 13% and RNs 11%, with the remaining 75% provided by HCAs). This is further complicated by increased staff turnover which is costly for LTC organizations, detrimental to the well-being and productivity of staff and can adversely impact resident care quality (Duffield et al., 2009). Therefore, it is important to gain a greater understanding of how families manage conflicts within this context in order to optimize the support and resources that can be provided to them in LTC.

Overall, there is a dearth of research in the area of family-staff conflicts in LTC, in particular from the point of view of family caregivers. Furthermore, as indicated, the research currently available is not guided by models of conflict or conflict management that have been investigated in other contexts (e.g., work, other institutional settings). In addition, the current literature is largely qualitative in nature and although these studies have enhanced our understanding of family-staff relationships, quantitative studies can begin to investigate conflict and correlates of conflict in larger samples, that can consider causal explanations of conflict and related phenomena, as well as allow for generalizability of the findings and development of interventions.

This study used a mixed-methods sequential explanatory design (Hanson, Creswell, Clark, Petska & Creswell, 2005). Quantitative data were collected and analyzed and, from these data, family caregivers who reported the highest levels of conflict were interviewed to augment and extend the quantitative data. As previously noted, studies concerning family-staff conflict in LTC (Vinton & Mazza, 1994, 1998) indicate that most conflict-related issues in LTC result from a small number of family caregivers who repeatedly engage in conflicts with staff. These family caregivers require

a disproportionate amount of staff resources to manage the conflicts, and are resultantly of greatest clinical interest (Vinton & Mazza, 1998). High conflict family caregivers would be the natural first target for any conflict management interventions.

This study focused on the following research questions and hypotheses, organized below according to the aims of the study, with questions A to C being addressed by the quantitative data and question D addressed by qualitative data:

A) To describe family-staff conflict, conflict management strategies, and experience of conflict:

1. What types of conflicts are most commonly reported by family caregivers?
2. What conflict management strategies are most commonly reported by family caregivers?
3. Do family caregivers believe that they can resolve their conflicts with staff effectively?
4. Are family caregivers satisfied with their own ways and staff's ways of managing conflict?
5. Are family caregivers knowledgeable about established organizational policies concerning management of family-staff conflicts?

B) To explore Deutsch's (1949, 2014) theory of conflict management as applied to family-staff conflict:

6. Is dependence on staff to provide quality resident care and family's perceived dependence of staff on them related to cooperative and competitive conflict management?

Hypothesis: Family caregivers who report greater dependence on staff will report higher use of cooperative conflict management and lower use of competitive conflict management.

7. Are cooperative and competitive conflict management related to frequency of conflict, stress related to conflict, and conflict outcomes (resolution of conflict vs. ongoing conflict)?

Hypotheses: (a) Family caregivers who report greater use of cooperative conflict management will report lower frequency of conflict, lower stress related to conflict, and will report greater likelihood of having resolved their conflicts with staff; (b) Family caregivers who report competitive conflict management will report higher frequencies of conflict, greater stress related to conflict, and will report greater likelihood of having currently ongoing conflict with staff.

8. Are cooperative and competitive conflict management related to power, trust, and communication among family caregivers in LTC?

Hypotheses: (a) Greater family endorsement of cooperative conflict management will be related to higher power, greater trust, and better communication; (b) Greater endorsement of competitive conflict management will be related to reduced power, lower trust, and poorer communication that is consistent with Deutsch's (1949, 2014) theory and the conflict management literature.

9. Do sense of community, family expectations, and family conflict predict conflict management above and beyond trust, communication, and power?

Hypotheses: Sense of community will predict conflict management beyond trust,

communication, and power. No predictions were made for family expectations and family conflict.

10. Do cooperative conflict management and competitive conflict management relate to family caregiver outcomes, including satisfaction with care, family involvement, caregiver burden, and psychological distress?

Hypotheses: (a) Cooperative conflict management will relate to higher satisfaction with care, and lower caregiver burden, and psychological distress; (b) Competitive conflict management will relate to lower satisfaction with care and higher psychological distress. No hypotheses were made concerning family involvement.

11. Do cooperative and competitive conflict management mediate the relationship between frequency of conflict and satisfaction with care?

Hypothesis: Both conflict management strategies will mediate the influence of frequency of conflict on satisfaction with care, with cooperative management having a positive influence, and competitive management having a negative influence.

C) To compare family caregivers who experience low and high frequencies of conflict.

12. How are high conflict family caregivers different from low conflict families in terms of demographic and caregiving characteristics? Do they experience different outcomes in terms of psychological distress and caregiver burden?

Hypothesis: Based on previous research it was hypothesized that high conflict family caregivers would more likely be female, adult children of residents, with greater psychological distress and reported caregiver burden.

D) To explore conflict experiences of family caregivers who experience high frequencies of family-staff conflict, including the nature of the family-staff conflict, how family caregivers manage conflict, how they perceive staff's approach to managing conflict and the outcomes of conflict.

Chapter 2. Methodology

The explanatory sequential design is a two phase mixed methods approach that includes an initial quantitative phase which is followed up on with a second qualitative phase to explain the initial results in greater depth (Creswell & Plano Clark, 2011). The follow-up explanation variant, implemented in this study, gave priority to the quantitative portion of the study while using the qualitative phase to explain and elaborate upon the quantitative results (Creswell & Plano Clark, 2011). This approach was used because it lends itself well to research questions that are more quantitative in nature and permits the further exploration of extreme scores (Creswell & Plano Clark, 2011). In the present study, the differences observed between family caregivers that were high and those that were low in terms of frequency of conflict were followed up with structured interviews of high conflict family caregivers to gain a greater understanding of their experience with and management of conflict. The steps of this approach consisted of: (a) design and collection of quantitative data from all recruited family caregivers, (b) using quantitative results to guide the structure of the qualitative portion of study (i.e., purposeful sampling procedures and the data collection protocols followed directly from the quantitative results by using all participants' scores on the Frequency of Interpersonal Conflict Scale to identify high conflict family caregivers for the interview), (c) collection and analysis of qualitative data, and (d) interpretation of the extent to which qualitative results explained and added insight into the quantitative results and to the overall purpose of the study (Creswell & Plano Clark, 2011).

Participants

The study sample consisted of 107 self-identifying family caregivers (one per resident) of older adults residing in LTC facilities. Family caregivers included individuals of any relation as well as friends. The sample consisted of a wide representation of relationships to the resident. To the author's knowledge, there were no comparable studies to conduct a power analysis at the time of study development. As such, a convenience sample was employed, as is most common in this area of research.

Family caregivers were required to have proficient English language skills and adequate visual and auditory functioning in order to complete the study protocol. All participants were community-dwelling individuals whose cognitive abilities were not compromised based on self-report and the author's observations.

Participants' mean age was 63.51 years ($SD=9.92$; range=23-87 years), with an average of 14.81 years ($SD=3.10$; range=6-31 years) of education. The majority of the sample was female (77.57%) and, in terms of relation to the residents, was composed primarily of daughters (56.07%), other relatives (14.95%; including sisters, brothers, daughters-/sons-/brothers-in-law, nieces, and granddaughters), sons (13.08%) and wives (10.28%). Additional family caregiver demographics are presented in Table 1 and 2.

With respect to residents, 57.01% were male and 73.83% were diagnosed with dementia according to family caregivers' reports. Residents' mean age was 88.98 years ($SD=6.68$; range=58-101 years), and 42.99% were veterans.

Table 1.

Family Members' Personal and Caregiving Demographics (N=107)

Demographic Variable	Mean	SD	Range
Family caregiver age ^a	63.51	9.92	23.00-87.00
Family caregiver education ^a	14.81	3.10	6.00-31.00
Resident age ^a	88.98	6.68	58.00-101.00
Total duration of caregiving ^b	104.02	100.66	11.00-696.00
Number of people currently caring for	1.59	1.17	1.00-8.00
Duration of stay in current LTC facility ^b	23.32	22.88	1.00-118.00
Duration of institutionalization ^b	28.47	26.32	1.00-132.00
Number of LTC facilities residents resided in	1.55	.68	1.00-3.00
Number of family members involved in care	2.33	1.23	1.00-5.00
Number of visits per week	3.04	3.00	.06-21.00
Duration of visit ^c	2.32	1.77	.42-9.25

Note: LTC= long term care.

^a variable measured in years; ^b variable measured in months; ^c variable measured in hours.

Table 2.

Demographic Information for Family Members (N=107)

Demographic	Frequency	Percentage of Sample (%)
Gender		
Male	24	22.43
Female	83	77.57
Race		
Caucasian	103	96.26
Asian	2	1.87
South Asian	1	.93
Black	1	.93
Marital Status		
Single	14	13.08
Married	75	70.09
Widowed	6	5.61
Divorced	9	8.41
Separated	3	2.80
Employment Status		
Full Time	27	25.23
Part Time	20	18.69
Retired	59	55.14
Unemployed	1	.93
Average Net Yearly Income		
< \$10,000	1	.93
\$10,000-\$19,000	2	1.87
\$20,000-\$29,000	9	8.41
\$30,000-\$39,000	13	12.15
\$40,000-\$49,000	8	7.48
\$50,000-\$59,000	9	8.41
\$60,000-\$69,000	9	8.41
\$70,000-\$79,000	7	6.54
\$80,000-\$89,000	7	6.54
\$90,000+	29	27.10
Undisclosed	13	12.15
Satisfaction of Financial Needs		
Very Well	38	35.51
Adequately	51	47.66
Not Very Well	11	10.28
Very Inadequate	4	3.74
Don't Know	3	2.80
Relationship to Resident		
Wife	11	10.28
Husband	3	2.80

Daughter	60	56.07
Son	14	13.08
Other relative	16	14.95
Friend	3	2.80

Note: Percentages may not add up to 100% as they are rounded to one decimal place.

Recruitment and Study Setting

Participant recruitment occurred between October 2013 and August 2015 in Calgary, Alberta. Initially, family caregivers were recruited at three Carewest sites, the largest government-funded provider of specialized LTC, rehabilitative and recovery services for adults in Calgary, and a wholly-owned subsidiary of Alberta Health Services. In consultation with the site directors, the following methods were used to recruit participants sequentially at each site (i.e., one site at a time): (a) facility-wide mail outs of information flyers explaining the project and inviting residents' family caregivers to participate, (b) recruitment posters placed in public areas in the LTC facilities (see Appendix A), and (c) an on-site recruitment booth. The recruitment booth contained a tri-fold poster board, handouts for interested family caregivers, and the author present to answer questions about the study in a public space in the facility (e.g., by the front door, by the entrance of the auditorium during social events). When adequate response rates were not attained (i.e., rate of recruitment decreased to the point where no further family caregivers were recruited from the participant LTC facilities) recruitment was extended to other LTC facilities in Calgary. Thirty-nine facilities were approached with recruitment posters and, of these, eight agreed to participate. The 11 LTC facilities ranged in size from 25 to 221 beds, and included public/government (5), non-profit (1), faith-based (1), and for-profit (4) facilities. The majority of respondents were from public/government facilities (77.57%), followed by non-profit (14.02%), for-profit (6.54%) and faith-based facilities (1.87%).

Procedure: Phase I (Quantitative)

This study was approved by the Conjoint Health Research Ethics Board at the University of Calgary (REB12-0172). Family caregivers who chose to participate received a full description of the study and informed consent was obtained by the author (see Appendix B). Family caregivers were interviewed individually at a location that was convenient for them to ensure their comfort and privacy (i.e., the LTC facility, their homes, or the university). The protocol was administered to participants in one sitting, ranging from 45 minutes to 125 minutes in duration. If the caregiver became fatigued or expressed a desire to continue at a later time, a second interview was offered, with less than 5% of the participants requiring two sessions. For elderly caregivers, cards with enlarged text representing the various Likert-type scale designations were used to facilitate understanding, clarity, and accuracy of responses. Upon completion of each individual interview, caregiver protocols were stored in a locked filing cabinet at the University of Calgary. The first 10 participants were treated as pilot participants to check for clarity, organization, content, problematic questions, and ease of administration (including potential participant fatigue). The interviewer invited each participant to provide feedback and suggestions about the study protocol and relevant feedback were integrated into the revised protocol (e.g., modification of a question for clarity). Due to the minimal changes resulting from the pilot period, the 10 pilot participants were retained in the overall sample.

Measures

The protocol consisted of a semi-structured interview with self-report measures (True/False or Likert-type formats) and open-ended questions. The measures employed in the

study have either been employed with family caregivers in previous studies or have been currently adapted for use in the LTC context (See Appendix C for a list of measures). Some measures contained reverse-coded items to cross-check answer validity (e.g., Conflict with Staff scale, Communication with Staff scale).

Family caregiver measures.

Demographic information. The demographics form (see Appendix D) included general participant demographics (e.g., age, gender), caregiving-related information (e.g., duration of caregiving, duration of institutionalization, frequency of visits) and information about the resident (e.g., age, gender, presence/absence of dementia).

Previous experience in long term care. This questionnaire (see Appendix E) was constructed to ascertain previous experiences that participants may have had with LTC apart from the present facility. It consists of 5 questions examining the presence/absence of previous experience in LTC facilities, the types of previous experience, the overall nature of previous experience (ratings ranged from 1 [*negative*] to 5 [*positive*], with higher scores indicating more positive experiences), the influence of previous experience on current feelings about LTC facilities (ratings ranged from 1 [*not at all*] to 5 [*very much so*], with higher scores indicating greater influence). Each of the 5 questions were individually scored.

Resident's level of independence. Katz Basic Activities of Daily Living Scale (Katz, Down, Cash, & Grotz, 1970; see Appendix F) is a 7-item measure that assesses a resident's level of independence using a dichotomous Yes/No rating. A participant's responses on the scale were added, with higher scores indicating a greater level of independence in activities of daily living, whereas lower scores indicated greater levels

of dependence on others. This measure is one of the most commonly used tools to assess basic activities of daily living among residents in LTC, and is particularly suited to identifying severe and stable degrees of disability (Mlinac & Feng, 2016).

Conflict and conflict management measures.

Frequency of conflict. The Frequency of Interpersonal Conflict Scale (FICS; Pillemer & Moore, 1989; see Appendix G) assesses the frequency (*never, once a month, a few times a month, a few times a week, or every day*) of conflicts with staff over the following seven domains: personal care, meals/food, administrative rules, laundry/clothing, resident's appearance, toileting and attentiveness to needs. The measure was scored by calculating the mean response (i.e., the sum of responses was divided by the number of items). The scale has an internal reliability ranging from 0.79 to 0.86 and has been used in studies examining communication between staff and families of residents in LTC (Abrahamson et al., 2009; Pillemer et al., 2003) and family-staff interventions (Zimmerman et al., 2013). Higher scores indicated greater frequency of conflict with staff.

Conflict with staff. The Conflict with Staff measure is a subscale of the Family Perceptions of Caregiving Role scale (FPCR; Maas & Buckwalter, 1990; see Appendix H), an 81-item self-report measure of family stress associated with the institutionalization of a relative. The Conflict with Staff subscale is composed of 10-items rated on a Likert -type scale ranging from 1 (*strongly agree*) to 7 (*strongly disagree*) with higher scores representing higher stress associated with family-staff conflict. The measure was scored by calculating the mean response (i.e., the sum of responses was divided by the number of items). Unlike the items on the FICS which specifically elicit

responses about the frequency of conflict with staff in areas of resident care, the items on this measure elicited subtle information about family-staff conflict as outlined in the literature. This included: (a) having to be careful about making suggestions/requests about the resident's care so that staff would not think the family is interfering (1 item), (b) feeling like an outsider/not having control in the resident's care/being allowed to approve care (3 items), (c) thinking staff ignore family directions/do not reach consensus on resident care (2 items), (d) thinking staff have the say about care/inability to control care (2 items), and (e) agreeing on what is important or trivial in care and rules/routines versus individualized care (2 items). Cronbach's α was .78 and was related to important family caregiver outcomes, including SOC and satisfaction with care (Petrovic-Poljak & Konnert, 2013). It was also the measure of choice in evaluation research of family caregiving in LTC (Maas et al., 2004; Zimmerman et al. 2013).

The Intragroup Conflict Scale (ICS; Jehn & Mannix, 2001; see Appendix I) was used to examine the type of conflict occurring in LTC facilities. This measure combined items from the Intragroup Conflict Scale (Jehn, 1995) with process conflict items from Shah and Jehn (1993), as used by Jehn and Mannix (2001) in a longitudinal evaluation of conflict types. A total of nine items (3 each) assessed relationship, task and process conflict on a 5-point Likert-type scale ranging from 1 (*none*) to 5 (*a great deal*). In this study, the items were adapted to family caregivers and staff as the focal group, and the general term "task" was replaced with "resident care". The measure is made up of 3 factors (Jehn & Mannix, 2001): (a) *Relationship* conflict (e.g., How much relationship tension is there between family caregivers and staff?), (b) *Task* conflict (e.g., How often do family caregivers and staff have conflicting opinions on how to provide care to a

resident?); and, (c) *Process conflict* (e.g., How much conflict is there between family caregivers and staff about who is responsible for what in providing care for the resident?). The measure has shown excellent internal consistency, with Cronbach's α for relationship, task and process conflict ranging from .93 to .94 in previous research (Jehn & Mannix, 2001). The measure was scored by calculating the mean response (i.e., the sum of responses was divided by the number of items). Higher scores indicated greater severity of conflict.

Conflict management. A measure of cooperative and competitive conflict management was employed to examine conflict management (Alper, Tjosvold, & Law, 2000; Tjosvold, Poon, & Yu, 2005; see Appendix J). Five items assessed cooperative conflict management and four items assessed competitive conflict management using a 7-point Likert-type scale ranging from *Strongly Disagree* to *Strongly Agree*. The factor structure of these scales has been supported in factor-analytic research (e.g., Alper, Tjosvold, & Law, 1998; Tjosvold et al. 2005). As this measure has not been previously used in LTC research, the items were amended to include the term *staff* in place of the term *others* in the wording of items. A sample cooperative conflict management item is "I encourage a 'we are in it together' attitude as we (staff and I) negotiate our differences." A sample of a competitive conflict item is "I demand that staff agree to my position." The measure was scored by calculating the mean response separately for cooperative and competitive conflict management (i.e., the sum of responses was divided by the number of items). Higher scores indicated greater endorsement of the conflict management strategy.

Goal interdependence. Two questions, developed for this study and evaluated with a 5-point Likert -type scale ranging from 1 (*not at all*) to 5 (*extremely*), examined the extent of family caregivers' perception of staff's dependence on them (e.g., "To what extent do you feel that staff depend on you in order to provide quality care to your loved one?"), and their dependence on staff (e.g., "To what extent do you feel that you depend on staff in order to provide quality care to your loved one?"). Each item was scored separately with higher scores indicating greater interdependence.

Conflict Questionnaire. A series of individual questions (see Appendix K) were developed for the purposes of this study to obtain information about family caregivers' perceived abilities to manage conflicts effectively (4 items), their satisfaction with their own and staff's conflict management (6 items) and their knowledge of the appropriate processes to manage conflicts at the facility (3 items). Each item was scored separately.

Predictors.

Trust. The Organizational Trust Inventory (OTI; Nyhan & Marlowe, 1997; see Appendix L) is a 12-item scale that measures an individual's level of trust in his or her supervisor/coworker and in his or her work organization as a whole. It requires participants to complete sentence stems using a 7-point Likert-type scale ranging from 1 (*nearly zero*) to 7 (*near 100%*). The OTI consists of three dimensions that measure the belief that an individual or group makes good-faith efforts to behave in accordance with any commitments (Dimension 1), is honest in negotiations (Dimension 2); and does not take excessive advantage of another (Dimension 3). In the absence of any measures of trust for use in LTC by families and staff, the OTI was revised to suit the context of the study by changing the terms *supervisor* and *organization* to *staff* and *nursing home*,

respectively. For example, the item "When my *supervisor* tells me something, my level of confidence that I can rely on what they tell me is ____." was revised to "When *staff* tells me something, my level of confidence that I can rely on what they tell me is ____." Nyhan and Marlowe (1997) reported excellent internal consistencies ($\alpha=.92-.96$) across diverse student and employee samples and adequate convergent validity with the Job Stress Questionnaire (Caplan et al., 1975, as cited in Nyhan and Marlowe, 1997), the Job Satisfaction Survey (Spector, 1985, as cited in Nyhan and Marlowe, 1997) and the Affective Commitment Scale (Meyer & Allen, 1984, as cited in Nyhan and Marlowe, 1997) across samples ranging in age and educational attainment. The measure was scored by calculating the mean response across items (i.e., the sum of responses was divided by the number of items). Higher scores on this measure represent higher levels of trust in staff.

Power. Family Perceptions of Power scale (see Appendix M) was developed for this study to examine family caregivers' perceptions of influence over different aspects of LTC life including the pursuit of own goals, staff, overall environment, and the quality of care provided. In the absence of measures to assess this construct, a 4-item instrument with items rated on a 5-point Likert type scale ranging from 1 (*not at all*) to 5 (*extremely*) was developed. The measure was based on Deutsch's conceptualization of power (1973) as a relational concept between a person and his or her environment and included: (a) *environmental power*, referring to the degree to which an individual can favourably influence his or her overall environment (1 item); (b) *relationship power*, referring to the degree to which the person can favourably influence another person (1 item); and (c) *personal power*, the degree to which a person is able to satisfy his or her

own desires, goals, or needs (2 items). The items were reviewed by the author's research supervisor and pilot participants for clarity and content. The measure was scored by calculating the mean response across items (i.e., the sum of responses was divided by the number of items). Higher scores on the measure indicated higher levels of perceived power in LTC by family caregivers.

Expectations. Family Caregiver Expectations (Tornatore & Grant, 2002; see Appendix N) is a 14-item scale using 5-point Likert-type responses ranging from 1 (*not at all*) to 5 (*a great deal*) that measures what family caregivers anticipated LTC would be like before they institutionalized their relative. This is currently the only available measure of family caregiver expectations, and was used in large-scale study of caregiver burden with 276 family caregivers of residents with dementia (Tornatore & Grant, 2002). The measure has acceptable internal consistency ($\alpha=.74$) and was inversely correlated with caregiver burden (Tornatore & Grant, 2002). The measure was scored by calculating the mean response across items (i.e., the sum of responses was divided by the number of items). Higher scores on the measure indicated greater family expectations.

Communication. The communication measure consisted of the staff's communication with residents' families, a 6-item scale from the Nursing Home Stressors Scale (Whitlatch, Schur, Noelker, Ejaz, & Looman, 2001; see Appendix O). This measure has shown acceptable internal consistency ($\alpha=.73$; Petrovic-Poljak & Konnert, 2013). Five communication items were added based on the author's previous work (Petrovic-Poljak & Konnert, 2013), available literature and questions employed as part of Health Quality Council of Alberta's Long Term Care Survey (Health Quality Council of

Alberta, 2011), to capture additional aspects of communication including expression of concerns and comprehension of communication. Participants were asked to rate each of the 11 items on a 5-point scale ranging from 1 (*hardly ever*) to 5 (*all of the time*). The measure was scored by calculating the mean response across items (i.e., the sum of responses was divided by the number of items). Higher scores indicated greater quality of family-staff communication as perceived by family caregivers.

Sense of community. The Brief Sense of Community Scale (BSCS; Peterson, Speer, & McMillan, 2008; see Appendix P) is an 8-item measure of SOC that is derived from the Sense of Community Index developed by McMillan and Chavis (1986) and is based on their model of SOC. Respondents rated each item on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher scores indicating greater SOC. The measure consists of four subscales, consistent with McMillan and Chavis' model. The BSCS has shown acceptable to excellent internal consistency. Cronbach's α for the overall scale was .92, for Membership .94, for Influence .77, for Needs Fulfillment .86, and for Emotional Connection .87 (Petrovic-Poljak & Konnert, 2013).

Family conflict. The Family Conflict Scales (Gaugler et al., 1999; Semple, 1992; see Appendix Q) measure three dimensions of family conflict, as follows: (a) conflict that arises from disagreements over the type or level of care that is needed for the resident, (b) conflict that arises from disagreements between the family caregiver's perceptions of the appropriateness of other family members' interactions and involvement with the resident, and (c) conflict that arises from disagreements around family members' attitudes and behaviours toward the caregiver and his/her performance in the caregiving role. The measure contains 12

items (four items for each dimension) that are rated by participants on a 4-point Likert-type scale ranging from 1 (*no disagreement*) to 4 (*quite a bit of disagreement*), with higher scores indicating higher levels of family conflict. The measure has excellent internal consistency, with Cronbach's α ranging from .80 to .90 (Gaugler et al., 1999; Pearlin, Mullan, Semple, & Skaff, 1990; Semple, 1992). The measure was scored by calculating the mean response across items (i.e., the sum of responses was divided by the number of items), with higher scores indicating greater severity of family conflict.

Psychological distress. The Brief Symptom Inventory (BSI-18; Derogatis, 2000) is an 18-item measure of psychological distress experienced during the past 7 days. The measure consists of an overall distress scale (Global Severity Index) and three symptom subscales: Anxiety, Depression, and Somatization. Participants rated each item on a 5-point Likert type scale ranging from 0 (*not at all*) to 4 (*extremely*). Cronbach's α ranged from .74 (Somatization) to .89 (Global Severity Index; Petrovic-Poljak & Konnert, 2013). The BSI-18 has been extensively validated in medical and community populations and has been employed with older adults (Manguno-Mire et al., 2007; Petkus et al., 2010). Higher scores on the BSI-18 represent higher severity of psychological distress.

Subjective rating of overall health. Participants were asked to rate their health as either *excellent*, *good*, *fair*, or *poor* in response to the question "How do you rate your health at the present time?". This single-item self-assessment of health has shown excellent agreement with physicians' assessments of general health status, and is a well-established predictor of mortality (Idler & Benyamini, 1997; Maddox & Douglas, 1972). Higher scores indicated poorer health.

Family involvement. The Family Involvement Questionnaire (Maas et al., 2000; see Appendix R) examined whether family caregivers took part in 29 different activities on a monthly basis by responding with a *Yes* or *No* to each item. The activities ranged from social activities (e.g., "Attended social or recreational activities at the nursing home with your relative."), personalized/ emotional (e.g., "Reminisced about the past with your relative."), physical care (e.g., "Groomed your relative's hair or nails."), and monitoring (e.g., "Overseen staff interactions with your relative."). To score this measure, item responses were summed, with higher scores indicating greater family involvement in LTC.

Family outcome measures.

Satisfaction with care. The Family Perception of Care Tool (FPCT; Maas & Buckwalter, 1990; see Appendix S) is a 51-item self-report questionnaire measuring family caregiver satisfaction with the care of their relative. Satisfaction is measured in four areas: (a) staff consideration of family and resident, (b) management effectiveness, (c) physical care, and (d) activities. Family caregivers rated the items on a 7-point Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Item scores were summed to form a total FPCT score and four subscale scores. Overall, FPCT has excellent internal consistency. Cronbach's α were .95 for the Total Scale, .97 for Physical Care, .87 for Activities, .88 for Management, and .85 for Consideration (Petrovic-Poljak & Konnert, 2013). As the FPCT was originally developed for family caregivers of residents with dementia, the items that contained the words *Alzheimer's Dementia* were re-worded to exclude the term. FPCT has been used as the primary

index of satisfaction with care in studies of family caregivers in LTC (Zimmerman et al., 2013), including evaluations of family-staff interventions (Maas et al., 2004).

Caregiver burden. The Zarit Burden Interview (ZBI; Zarit, Reever, & Bach-Peterson, 1980; see Appendix T) is the most well-established measure of family caregiver burden. In the present study, a 7-item short form of the ZBI that is appropriate for use in LTC was used (Gaugler, Mittelman, Hepburn, & Newcomer, 2010).

Participants rated each item on a 5-point Likert-type scale ranging from 0 (*never*) to 4 (*nearly always*), with higher scores indicating greater caregiver burden.

Procedure: Phase II (Qualitative)

Family caregivers, whose scores on the Frequency of Interpersonal Conflict Scale (FICS) were 1.5 SD above the mean, were identified as High Conflict family caregivers. This cut off was selected to identify individuals highest in terms of frequency of conflict in the overall sample and to identify enough participants to invite to complete the interview portion of the study. The first 10 family caregivers who met the cut off on the FICS were approached by the researcher, with all 10 family caregivers approached agreeing to take part. Participant attrition from Phase I to Phase II was a concern. So, rather than waiting until all the quantitative data were obtained, qualitative data collection began approximately mid-way through Phase I recruitment. The 10 family caregivers identified remained the family caregivers with the highest frequencies of conflict at the end of Phase I data collection. Interviews were conducted until data saturation was attained and no new data or themes were observed by the author who was the sole interviewer (Fusch & Ness, 2015). The interviewer's observations of each participant were recorded during the interviews to capture the non-verbal aspects of the

interview. During data collection both rich (quality; detailed and nuanced) and thick (quantity; comprehensive) data were collected to aid in saturation (Dibley, 2011).

The qualitative sample consisted of 10 family caregivers with a mean age of 59.90 years ($SD=8.53$; range=47-71 years), with an average of 15.30 years ($SD=1.84$; range=13.00-18.00 years) of education. The entire sample was female and, in terms of relation to the residents, was composed of 7 daughters, 1 wife, 1 sister and 1 granddaughter. Additional family caregiver demographics are presented in Table 3.

The interviews were conducted at a place selected by the participant in order to optimize participant comfort in disclosure. Settings included a private room in the LTC facility (3 participants), the author's office at the University of Calgary (4 participants), and participants' homes (3 participants). All interviews were conducted in person, with a single interviewer present. Audio recordings of the data were collected at the time of the interview, and participants provided additional consent for this portion of data collection (see Appendix U). All participants agreed to audio recordings of the interviews.

The questions included in the interview (see Appendix V) were developed to establish the scope of the three most significant instances of family-staff conflict identified by family caregivers, the antecedents and consequences of those incidents, as well as how both family caregivers and staff managed the conflict. The same questions were presented to each family caregiver, with follow-up questions used when appropriate for elaboration and clarification.

Table 3.

High Conflict Family Caregivers' Personal and Caregiving Demographics (n=10)

Demographic Variable	Mean	SD	Range
Family caregiver age ^a	59.90	8.53	47.00-71.00
Family caregiver education ^a	15.00	1.84	13.00-18.00
Resident age ^a	87.70	12.28	58.00-101.00
Total duration of caregiving ^b	168.00	192.75	36.00-696.00
Number of people currently providing care to ^b	1.70	1.06	1.00-4.00
Duration of stay in current LTC facility ^b	19.70	18.02	1.50-52.00
Duration of institutionalization ^b	23.10	17.45	1.50-53.00
Number of LTC facilities	1.50	.53	1.00-2.00
Number of family members involved in care	1.90	.88	1.00-3.00
Number of visits per week	4.40	3.81	.50-14.00
Duration of visit ^c	2.13	1.03	.50-4.25

Note: LTC= long term care.

^a variable measured in years; ^b variable measured in months; ^c variable measured in hours.

Data Analysis: Phase I (Quantitative)

All of the data collected were entered and analyzed using the Statistical Package for the Social Sciences 23 (SPSS 23). The data were initially screened for out-of-range values as well as missing values. The missing values were identified as random, and were not subject to any additional treatments, with pairwise deletion used during analysis. Analysis of outliers was conducted and the identified outliers were observed to represent true values that were not anomalous or invalid but represented true reported values by participants. For this reason, and preservation of sample size, outliers were retained in the data. Details of the tests of assumptions, descriptive, and inferential statistics conducted can be reviewed in Chapter 3: Results. The demographic information and family caregivers' answers to individual items on measures were analyzed using frequency counts and calculation of means and standard deviations. Inferential statistics consisted of bivariate correlations using the Pearson correlation coefficient, hierarchical linear regressions, and mediation analysis. Mediation analysis was conducted using the PROCESS extension for SPSS 23 developed by Andrew Hayes (2012). Group comparisons were conducted using Fischer's Exact test, Chi square test of independence, and independent samples t-test.

Data Analysis: Phase II (Qualitative)

The data were prepared for analysis through transcription. Two professional transcriptionists were employed for the direct verbatim transcription of the audio recordings of interviews into text. To ensure accuracy of recording, the transcription was validated against the audio recording. The data analysis procedure consisted of: (a)

initial reading through the data transcripts and writing memos, (b) coding the interview data by segmenting and labeling the text in NVIVO 11 using the thematic procedure outlined by Braun and Clarke (2006), (c) developing the individual codes, (d) aggregating similar codes together to develop themes, (e) verifying and modifying the themes developed by the initial rater with a second rater (Creswell & Plano Clark, 2011). Notably, codes and themes were generated based on the answers to interview questions in the data transcript; however, any instances of behaviour, emotion or cognition related to managing conflict within the data transcript were coded as part of conflict management (i.e., even though the data may not have appeared directly in response to how the participant managed conflict). Once the initial themes were developed the first and second coder independently coded several transcripts. Discrepancies in the coding were discussed over multiple meetings until consensus was achieved on themes pertaining to types of family-staff conflict, family caregivers' conflict management, staff's conflict management, and family-staff conflict outcomes. Both splitting and lumping of themes was discussed by the two coders until agreement was attained. For the remaining interview questions, the full range of responses was used in data analysis (e.g., consequences to staff, family caregivers, residents). An overall thematic narrative of the key themes that accounted for the interview data was developed and is presented in Chapter 4.

Data Interpretation

Following the initial quantitative and qualitative analyses, the interpretation phase integrated the two sources of data. In the case of this study, the qualitative data were used to expand upon the knowledge acquired during the quantitative phase, specifically

to extend the initial findings regarding the nature of family-staff conflicts, family caregivers' ways of managing conflicts, and understanding of barriers and enablers to positive outcomes, as reported by High Conflict family caregivers. The synthesis of the quantitative and qualitative findings can be found in Chapter 5: Discussion.

Chapter 3. Quantitative Results

Tests of Assumptions

In examining the assumptions for the use of parametric tests, namely Pearson's correlation coefficient, hierarchical linear regression, Fisher's exact test, chi-square test of independence, and independent samples t-test, the assumptions of interval data, homogeneity of variance (using Levene's test of homogeneity of variance), and independence were met. However, the assumption of normal distribution of data was largely unmet based on visual inspection of the data including histograms and P-P plots, as well as skewness and kurtosis statistics for the majority of the variables. Results of the Kolmogorov-Smirnov and Shapiro-Wilk tests were also considered and were significant suggesting non-normal distributions for the examined variables. Given the moderate size of the study sample, tests of skewness and kurtosis, as well as the Kolmogorov-Smirnov and Shapiro-Wilk tests, were more likely to be significant even if the distribution in question was not much different from a normal distribution (Field, 2009). The skewness of distributions is consistent with what would be known about the distribution of the variables (e.g., duration of institutionalization would be expected to have a greater concentration of scores at lower ends of the distribution since the average number of years that an older adult resides in LTC is approximately 6 months to 2 years). Recommended examination of outliers (to address skewness) revealed extreme scores on some measures (i.e., duration of caregiving, duration of institutionalization, years of education), that represent a minority of family caregivers that are of particular research interest due to their extensive involvement with caregiving and LTC. Therefore, the removal of extreme scores, which in this case present true

values, is problematic theoretically and practically (i.e., removal of extreme cases would remove participants who are of greatest research interest and would reduce sample size). Transforming the data to attain normality was deemed inappropriate due to the importance of preserving the scaling of the measures for data interpretation (Field, 2009). To compensate for the issue of non-normality a bootstrapping procedure (Efron & Tibshirani, 1993, as cited in Field, 2009) was employed, and the confidence intervals generated from bootstrapping are reported along with the p values in order to garner greater support for the significance tests. Typically normality in the data allows one to infer that the sampling distribution is normal and to calculate the probability of a particular test statistic occurring. However, in situations where normality cannot be assumed, bootstrapping allows one to estimate the properties of the sampling distribution from the sample data (Field, 2009). The collected (i.e., sample) data are treated as a population from which smaller samples are taken (i.e., bootstrap samples), and the statistics of interest are calculated with each sample (Field, 2009). Therefore by taking many samples the sampling distribution can be estimated. The standard deviation of this sampling distribution allows for the estimation of the standard error of the statistic, which in turn allows confidence intervals and significance tests to be computed (Field, 2009). All reported bootstrapped confidence intervals (95%) were computed using SPSS and were based on 1000 samples.

Internal Consistency of Measures

According to Cicchetti's (1994) guidelines, Cronbach's α for all measures used in this study were *acceptable*, ranging from *fair* ($>.70$) to *excellent* ($>.90$). Internal consistency reliabilities (Cronbach's α) are provided in Table 4.

Table 4.

Internal Consistency of Measures for Family Caregiver Sample (N= 107)

Measure	Cronbach's α
Brief Sense of Community Scale (BSCS)	.92
Expectations	.84
Organizational Trust Inventory Revised (OTI-R)	.97
Power	.87
Communication with Staff	.84
Frequency of Interpersonal Conflict Scale (FICS)	.84
Conflict with Staff Scale	.87
Intragroup Conflict Scale	.93
Relationship	.86
Task	.90
Process	.94
Conflict Management Scale	
Cooperation	.81
Competition	.71
Katz Activities of Daily Living Scale	.79
Brief Symptom Inventory 18 (BSI-18)	.91
Family Conflict Scale	.93
Zarit Burden Inventory (ZBI)	.92

Note. In some instances, respondents declined to answer a question. Three caregivers did not complete all of the measures, with the measures differing because of study termination, death of family member and relocation. As a result the total sample size varies from 104 to 107 depending on the specific question, unless otherwise noted.

Sample Characteristics, Caregiving Demographics, Physical and Mental Health

The sample consisted of 107 family caregivers with a mean age of 63.51 years ($SD=9.92$; range=23-87 years), and an average of 14.81 years of education ($SD=3.10$; range=6-31 years). The majority of the sample was female (77.57%) and, in terms of relation to the residents, was composed primarily of daughters (56.07%). Family caregivers reported caregiving for the residents in the community and LTC, on average, for 104.02 weeks ($SD=100.66$; range=11.00-696.00 weeks). Family caregivers spent an average of 7.05 hours of visitation at the LTC facility per week. The majority (76.64%) did not hire additional private caregivers (e.g., personal companions) to care for the residents in the LTC facility. Additional family caregiver demographics are provided in Table 1 and Table 2.

With respect to residents, 57% were male and 73.83% were diagnosed with dementia according to family caregivers' reports. Their mean age was 88.98 years ($SD=6.68$; range=58-101 years) and 43.00% were veterans. Residents had a mean stay of 23.32 ($SD=22.88$; range=1.00-118.00 weeks) weeks in the present LTC facility.

Furthermore, family caregivers reported being, on average, in *good* physical health ($M=1.87$; $SD=.75$). In regard to mental health, the Global Severity Index ($M=8.23$; $SD=9.81$) of the BSI-18 was within the normal range (Derogatis, 2000).

Previous Experience with LTC

Family caregivers' responses to questions about their previous LTC experience are provided in Table 5. The majority of family caregivers reported having previous experience with LTC (86.79%) prior to the current LTC facility. The source of previous experience was varied, with the majority (97.82%) reporting personal experience (i.e.,

caring or visiting someone in a LTC facility), speaking to a friend or relative (80.43%) and receiving information from the media (79.35%; i.e., newspapers, television programs, Internet, documentaries). Interestingly, almost a quarter of the sample had professional experience in LTC including volunteering, working in administrative/clerical roles, and being a nurse or a nursing attendant. When asked about the nature of their experience more than half of the sample (58.70%) reported their previous experience to be negative. The majority indicated that their previous experience had affected their level of concern about their relative's care in the current LTC facility (82.6%).

Table 5.
Family Members' Previous LTC Experience

Question	Response Frequency	Percentage of Family Caregivers (%)
Previous experience in LTC ^a		
Yes	92	86.79
No	14	13.21
Source of experience ^b		
Personal	90	97.82
Heard/Received information		
Friend/Relative	74	80.43
Co-worker	44	47.83
Media	73	79.35
Professional experience	21	22.82
Nature of previous experience in LTC ^b		
Negative	23	25.00
Somewhat Negative	31	33.70
Neutral	14	15.22
Somewhat Positive	12	13.04
Positive	12	13.04
Previous experience impact on concern about the resident in current LTC facility ^b		
Not at all	16	17.39
Slightly	12	13.04
Somewhat	25	27.17
Moderately	19	20.65
Very much so	20	21.74

Note. LTC= Long term care.

Personal experience includes caring for or visiting someone in a LTC facility other than the recruitment facility. Professional experience included paid employment (e.g., administration, nursing) and volunteering.

Percentages may not add to 100% due to rounding to two decimal places.

^a N=106

^b n=92

Interdependence in Resident Care

Family caregivers reported greater dependence on staff to attain the goal of quality resident care, than staff being dependent on them (refer to Table 6 for participants' complete responses). However, the majority reported staff being dependent on them to an extent, with less than a fifth of the sample reporting no staff dependence on families. None of the participants reported that they do not depend on staff for providing care, however, 2.83% reported that they only rely on staff *slightly* and another 6.60% indicated that they rely on staff *somewhat*.

Description of Conflict, Conflict Management Strategies and Family Caregivers' Experience of Conflict

What types of conflicts are most commonly reported by family caregivers?

Responses on the Conflict with Staff Scale ($M=3.52$; $SD=1.22$; range=1.10-6.50; Maas & Buckwalter, 1990) suggests an overall low level of stress related to conflict with staff. Similarly low rates of conflict were observed on the Intragroup Conflict Scale (ICS; Jehn & Mannix, 2001) for relationship ($M=1.86$; $SD=.97$; range=1.00-4.67), task ($M=2.02$; $SD=.90$; range=1.00-4.33), and process conflict ($M=1.91$; $SD=.87$; range=1.00-4.00). To examine what types of conflict were most frequently reported by family caregivers, frequency analysis of the Frequency of Interpersonal Conflict Scale (FICS, Pillemer & Moore, 1989) was completed. Participants' responses are presented in Table 7. An examination of the response frequencies on the FICS indicated that just over a half of the sample (50.94%-66.04%) reported *never* becoming involved in conflicts with staff across most of the conflict domains examined, with the exception of personal care (41.51%) and attentiveness to residents' needs (37.74%; *Note: Conflicts*

Table 6.
Goal Interdependence in Resident Care (N=106)

	Response Frequency	Percentage of family caregivers (%)
Staff dependent on family caregiver		
Not at all	18	16.98
Slightly	18	16.98
Somewhat	26	24.53
Moderately	38	35.85
Extremely	6	5.66
Family caregiver dependent on staff		
Not at all	0	0.00
Slightly	3	2.83
Somewhat	7	6.60
Moderately	27	25.47
Extremely	69	65.09

Note. Percentages may not add to 100% due to rounding to two decimal places.

Table 7.
Frequency of Family-Staff Conflict Reported by Family Caregivers (N=106)

Type of conflict	Frequency of conflict				
	Never	Once a month	A few times a month	A few times a week	Every day
Personal Care	41.51	32.08	15.09	10.38	0.94
Meals/Food	58.49	18.87	14.15	5.66	2.83
Administrative Rules	66.04	25.47	5.66	2.83	0.00
Laundry/Clothing	50.94	30.19	16.98	1.89	0.00
Appearance	58.49	24.52	12.26	4.72	0.00
Toileting	53.77	20.75	16.04	8.49	0.94
Attentiveness to needs	37.74	29.25	22.64	5.66	4.72

Note. Percent (%) of participants' responses as reported on the Frequency of Interpersonal Conflict Scale (FICS).

Percentages may not add to 100% due to rounding to two decimal places.

occurring at a frequency of less than once per month were classified as *never* based on the FICS Likert scale). In terms of conflicts with staff related to attentiveness to residents' needs, the majority (62.27%) reported at least monthly occurrence of such conflict, ranging from once a month to daily. Approximately 20% to 30% of participants encountered various conflicts across domains on a monthly basis. In terms of conflicts that occurred a *few times per week*, conflicts concerning personal care were most often reported, followed by conflicts related to toileting. Conflicts related to attentiveness to needs and meals/food were most frequently reported as occurring on a daily basis.

What conflict management strategies are most commonly reported by family caregivers? Results from the cooperative and competitive conflict management scale (Alper et al., 2000; Tjosvold et al., 2005) indicate that 97% of the participants reported primary use of cooperative (i.e., working with staff toward a common goal) conflict management strategies ($M=5.78$; $SD=.10$; range=1.00-7.00) when managing family-staff conflicts, as compared to competitive (i.e., an "us" vs. "them" approach) management strategies ($M=2.49$; $SD=.11$; range=1.00-5.75).

Do family caregivers believe that they can resolve their conflicts with staff effectively? To explore whether family caregivers believe that they can resolve their conflicts with staff effectively, frequency analyses of participants' responses to specific conflict-related questions were examined. Likert scale responses were collated into three categories such that agreement (*Yes*) includes participants who indicated that they *somewhat agree*, *agree*, or *strongly agree*, and disagreement (*No*) included *somewhat disagree*, *disagree*, and *strongly disagree*. Participants' responses are provided in Table 8. The majority reported resolving most of their conflicts with staff

Table 8.
Family Caregivers' Responses to Conflict Resolution Questions (N=104)

Question	Response Frequency	Percentage of Family Caregivers (%)
Most conflicts with staff have been resolved		
Yes	85	81.73
No	16	15.38
Unsure	3	2.88
Can effectively resolve conflict with staff		
Yes	83	79.81
No	11	10.58
Unsure	10	9.62
Conflict with staff is ongoing		
Yes	25	24.04
No	75	72.11
Unsure	4	3.85
Anticipate having conflict with staff in the future		
Yes	38	36.54
No	51	49.04
Unsure	15	14.42

Note. Percentages may not add to 100% due to rounding to two decimal places.

(81.73%) and perceived themselves as able to effectively resolve conflicts (79.81%).

Almost a quarter of the sample reported ongoing conflict with staff (24.04%), and more than a third anticipated future conflict with staff (36.54%).

Are family caregivers' satisfied with their own and staff's conflict

management? To examine whether family caregivers were satisfied with their own as well as staff's ways of managing conflicts, frequency analysis of relevant conflict-related questions was undertaken. Participants' responses are provided in Table 9. The majority reported being satisfied with the way that conflict was handled overall by the facility (73.08%), by staff (76.92%) and with their own conflict management (83.65%). Based on family caregivers' reports, a higher percentage of participants reported being dissatisfied with staff's conflict management (11.54%) than their own (5.77%). The majority of the sample (74.04%) indicated satisfaction with the outcomes of family-staff conflicts that they have experienced, as well as satisfaction with the overall process of managing family-staff conflicts as supported by the facility (e.g., conflict policies, management's response to conflict; 66.35%). Approximately 15% of participants consistently reported being dissatisfied with conflict management and conflict outcomes. When asked whether family caregivers thought that their feedback about conflicts was being heard by staff at the LTC facility, the majority of the sample indicated feeling heard at least somewhat.

Table 9.

<i>Family Caregivers' Satisfaction with Conflict Management in LTC (N=104)</i>		
Question	Response Frequency	Percentage of Family Caregivers (%)
Satisfaction with how the conflict situation was handled		
Yes	76	73.08
No	16	15.38
Neither	12	11.54
Satisfaction with own conflict management		
Yes	87	83.65
No	6	5.77
Neither	11	10.58
Satisfaction with staff's conflict management		
Yes	80	76.92
No	12	11.54
Neither	12	11.54
Satisfaction with the outcome of family staff conflict		
Yes	77	74.04
No	15	14.42
Neither	12	11.54
Satisfaction with the facility's support in managing family staff conflicts		
Yes	69	66.35
No	17	16.34
Neither	18	17.31
My feedback about conflict with staff is being heard by staff ^a		
Very much so	15	14.71
Moderately	40	39.22
Somewhat	28	27.45
Slightly	8	7.84
Not at all	11	10.78

Note. Percentages may not add to 100% due to rounding to two decimal places.

^an=102

Are family caregivers knowledgeable about established organizational policies concerning management of family-staff conflicts? Family caregivers responses to questions regarding knowledge of organizational processes are presented in Table 10. In regard to clarity of the processes for managing conflicts with staff in the LTC facility, the majority of the sample indicated that the processes were at least *somewhat* clear and more than a quarter of the sample indicated *not at all* (27.88%). Almost a fifth of the sample (18.27%) indicated not knowing what they are supposed to do in order to manage conflicts according to facility-based policies. When asked about knowing the relevant procedures and policies regarding conflict management in the LTC facility, 63.45% indicated at least some knowledge, with 36.54% reporting no knowledge.

Examination of Cooperative and Competitive Conflict Management

Descriptive statistics for all the measures administered to family caregivers are presented in Table 11. The following bivariate correlational analyses were conducted using Pearson's *r* coefficient. In addition, the relationships observed with Pearson's *r* coefficient were cross validated with Spearman's *rho* analyses, with all relationships of interest preserving magnitude and direction between the parametric and nonparametric analyses.

Is dependence on staff to provide quality resident care and family's perceived dependence of staff on them related to cooperative and competitive conflict management? Although family caregivers' perception of staff's dependence on them in providing resident care was inversely related to family caregivers' level of dependence on staff, $r=-.23$, $p=.007$, CI [$-.30,-.03$], this measure

Table 10.
Family Caregivers' Knowledge of Institutional Conflict Management Policies
 (N=104)

Question	Response Frequency	Percentage of Family Caregivers (%)
Are the processes for managing disagreements/conflicts with staff in this nursing home clear?		
Not at all	29	27.88
Slightly	11	10.58
Somewhat	28	26.92
Moderately	25	24.04
Extremely	11	10.58
Do you feel that you know what you are supposed to do in order to manage disagreements/conflicts with staff in this nursing home?		
Not at all	19	18.27
Slightly	19	18.27
Somewhat	24	23.08
Moderately	27	25.96
Extremely	15	14.42
Do you know the relevant procedures and policies regarding managing disagreements/conflicts in this nursing home?		
Not at all	38	36.54
Slightly	16	15.38
Somewhat	22	21.15
Moderately	19	18.27
Extremely	9	8.65

Note. Percentages may not add to 100% due to rounding to two decimal places.

Table 11.

Means, Standard Deviations, and Ranges of Family Caregiver Measures (N=107)

Measure (possible range)	Mean	SD	Range
Brief Sense of Community Scale (1-5)	3.56	.83	1.63-5.00
Dependence 1 (1-5)	2.96	1.20	1.00-5.00
Dependence 2 (1-5)	4.53	.75	2.00-5.00
Expectations (1-5)	3.39	.76	1.27-4.82
Organizational Trust Inventory Revised (1-7)	4.92	1.07	1.92-7.00
Power (1-5)	3.31	.94	1.00-5.00
Communication (1-5)	4.01	.60	2.00-5.00
Frequency of Interpersonal Conflict Scale (1-5)	1.78	.69	1.00-3.86
Conflict with Staff Scale (1-7)	3.52	1.22	1.10-6.50
ICS Relationship Conflict (1-5)	1.86	.87	1.00-4.67
ICS Task Conflict (1-5)	2.02	.90	1.00-4.33
ICS Process Conflict (1-5)	1.91	.87	1.00-4.00
Conflict Management Cooperative (1-7)	5.78	1.00	1.00-7.00
Conflict Management Competitive (1-7)	2.49	1.12	1.00-5.75
Katz Activities of Daily Living (7-14)	11.82	1.98	7.00-14.00
Brief Symptom Inventory 18 Global Severity Index (0-72)	8.23	9.81	0.00-45.00
Family Perception of Care Tool Total (1-7)	4.81	.90	2.80-6.71
Physical Health (1-4)	1.87	.75	1.00-4.00
Zarit Burden Interview (0-4)	1.17	.91	0.00-4.00
Family Conflict (1-4)	1.70	.78	1.00-3.75
Family Involvement (0-58)	39.49	4.61	31.00-51.00

Note. ICS=Intragroup Conflict Scale

was not related to cooperative, $r=.06$, $p=.28$, CI [-.17,.27], or competitive conflict management, $r=.09$, $p=.18$, CI [-.12, .27]. As predicted by Deutsch's (1949; 2014) theory of cooperation and competition, family caregivers who have greater dependence on staff to provide resident care reported greater use of cooperative conflict management, $r=.24$, $p=.007$, CI [-.00,.47].

Are cooperative and competitive conflict management related to frequency of conflict, stress related to conflict, and conflict-related outcomes? Family caregivers who reported greater use of cooperative conflict management reported lower frequency of conflict ($r=-.37$, $p=.001$, CI[-.53, -.18]), and stress related to family-staff conflict ($r=-.57$, $p=.001$, CI[-.69, -.47]). Although competitive conflict management was not related to the frequency of conflict ($r=.13$, $p=.09$, CI[-.06, .32]), its greater endorsement was associated with greater stress related to conflict ($r=.35$, $p=.001$, CI[.17,.52]). Greater endorsement of cooperative conflict management was also associated with greater resolution of conflicts with staff ($r=.28$, $p=.002$, CI[.10, .48]), lower endorsement of ongoing conflict with staff ($r=-.36$, $p=.001$, CI[-.54, -.18]), greater perceived ability to effectively deal with conflicts in the future ($r=.55$, $p=.001$, CI[.37, .71]), and lower anticipation of future conflicts ($r=-.37$, $p=.001$, CI[-.53,-.20]). Greater use of competitive conflict management was related to greater endorsement of ongoing conflict with staff ($r=.18$, $p=.04$, CI[.00,.10]).

Is greater family endorsement of cooperative conflict management related to higher perceptions of power, trust, and better communication? Is greater endorsement of competitive conflict management related to lower family caregiver perceptions of power, trust, and poorer communication? All

correlations can be reviewed in Table 12. Greater endorsement of cooperative conflict management was related to better communication ($r=.45$, $p=.001$, $CI[.27,.61]$), greater power ($r=.46$, $p=.001$, $CI[.31,.58]$), greater trust in staff ($r=.41$, $p=.001$, $CI[.27, .56]$), and higher SOC ($r=.53$, $p=.001$, $CI[.41,.63]$). Conversely, greater endorsement of competitive conflict management was related to less power ($r=-.19$, $p=.03$, $CI[-.40, .03]$), reduced trust ($r=-.30$, $p=.001$, $CI[-.45,-.15]$), and lower SOC ($r=-.18$, $p=.04$, $CI[-.39,.03]$). Neither family conflict nor family expectations were related to cooperative or competitive conflict management; for this reason these two variables were excluded from the hierarchical linear regression analyses discussed below.

Do sense of community, family expectations and family conflict predict conflict management above and beyond trust, communication, and power?

Based on the previous lack of significant relationships between family expectations, family conflict and cooperative and competitive management, this question was revised. Prior to conducting a hierarchical multiple regression, relevant assumptions were considered. A sample of 107 was deemed adequate given that four independent variables were included in the analysis (Tabachnick & Fidell, 2001). The assumption of singularity was additionally met because all of the independent variables were independent and not a combination of other independent variables. In Table 12, the correlations reveal that independent variables are correlated, with the highest

Table 12.

Relationships Between Cooperative and Competitive Conflict Management and Key Theoretically and Empirically Derived Variables

Measure	1	2	3	4	5	6	7	8
1. Cooperative CM	-	-.23*	.45***	.46***	.41***	.09	.05	.53***
2. Competitive CM		-	-.13	-.19*	-.30***	-.13	.04	-.18*
3. Communication			-	.61***	.77***	.14	.02	.64***
4. Power				-	.64***	.10	.05	.71***
5. Trust					-	.06	-.13	.63***
6. Expectations						-	.31***	.23**
7. Family Conflict							-	-.06
8. SOC								-

Note. CM: Conflict management; SOC: Sense of community

* $p < .05$, ** $p < .01$, *** $p < .001$

correlation observed between Communication and Trust; however, none would be considered very highly correlated (e.g., correlations above 0.80 or 0.90; Field, 2009). Additionally, the collinearity statistics, Tolerance and VIF, were within acceptable limits (i.e., VIF <10, and Tolerance >0.20 were employed as cutoffs; Field, 2009). Assumptions of homoscedasticity and independence of errors were also met.

Two 2-stage hierarchical linear regressions were conducted, with one having cooperative conflict management as its outcome variable and the other with competitive conflict management as the outcome variable. In model 1, the three independent variables identified by Deutsch as seminal in contributing to conflict management, trust, power, and communication were entered. In Model 2, SOC was additionally entered.

The first hierarchical regression predicting cooperative conflict management (Table 13) shows that in the first model entered, trust, power, and communication, contributed significantly to the regression model $F(3,100) = 11.14, p < .001$, and accounted for 25.1% of the variance in predicting cooperative conflict management, with power being the main predictor. The second model with the addition of SOC, explained an additional 5.3% of the variation in cooperative conflict management, for a total of 30.4%, and this change in R^2 was significant, $\Delta F(1,99) = 7.65, p = .007$. SOC was the main predictor in this model.

The second hierarchical regression predicting competitive conflict management (Table 14) shows that in the first model including trust, power, and communication was significant $F(3,100) = 4.23, p = .007$, and accounted for 11.30% of the variance in competitive conflict management with trust being the main predictor. The second model, with the addition of SOC, remained significant $F(4,99) = 3.17, p = .017$, and accounted for

11.40% of the variance in predicting competitive conflict management, with trust being the main predictor. There was no significant increase in the amount of variance explained by the second model, $\Delta F = (1,99) = .12, p = .73$.

Do cooperative conflict management and competitive conflict management relate to family caregiver outcomes, including satisfaction with care, family involvement, caregiver burden, and psychological distress? Family caregivers who reported higher use of cooperative conflict management reported less psychological distress ($r = -.17, p = .04, CI[-.49, -.03]$), less caregiver burden ($r = -.23, p = 0.01, CI[-.42, -.02]$) and greater satisfaction with care ($r = .50, p = .001, CI[.36, .64]$). Higher endorsement of competitive conflict management was related to lower satisfaction with care ($r = -.30, p = .001, CI[-.46, -.13]$). Neither cooperative ($r = .13, p = .09, CI[-.06, .31]$) nor competitive ($r = -.14, p = 0.77, CI[-.34, .04]$) conflict management was related to family involvement.

Table 13.
*Summary of Hierarchical Regression Analysis for Variables Predicting
 Cooperative Conflict Management*

Variables Entered	<i>B</i>	<i>SE (B)</i>	β	<i>t</i>	R^2	ΔR^2
Model 1					.25	.25
Trust	.02	.18	.02	.16		
Power	.29	.13	.28	.24*		
Communication	.44	.38	.26	1.88		
Model 2					.30	.05
Trust	-.02	.13	-.02	-.17		
Power	.12	.13	.11	.89		
Communication	.28	.23	.17	1.19		
SOC	.43	.15	.36	2.77***		

Note: SOC= Sense of community

* $p < .05$, ** $p < .01$, *** $p < .001$

Table 14.
*Summary of Hierarchical Regression Analysis for Variables Predicting
 Competitive Conflict Management*

Variables Entered	<i>B</i>	<i>SE (B)</i>	β	<i>t</i>	R^2	ΔR^2
Model 1					.11	.11
Trust	-.48	.16	-.46	-2.98***		
Power	-.04	.15	-.04	-.29		
Communication	.46	.28	.25	1.63		
Model 2					.11	.00
Trust	-.47	.16	-.46	-2.90**		
Power	-.02	.17	-.01	-.09		
Communication	.49	.30	.26	1.66		
SOC	-.07	.20	-.05	-.35		

Note: SOC= Sense of community
 * $p < .05$, ** $p < .01$, *** $p < .001$

Do cooperative and competitive conflict management mediate the

relationship between frequency of conflict and satisfaction with care? The

significance of the mediated effect of cooperative and competitive conflict management was tested using a bootstrapping method. Hayes (2012) developed an SPSS macro (PROCESS) that estimates parameters and significance levels involving mediation and moderation. The accuracy and power of this approach to detect mediation effects has been reported in simulation studies (Williams & MacKinnon, 2008). PROCESS estimates the 95% confidence interval of the indirect effect of the exogenous predictor (i.e., frequency of conflict) on the final criterion (i.e., satisfaction with care) by comparing the observed indirect effect against a bootstrapped distribution, that is constructed from 5,000 parallel data sets. The bootstrapping method constructed each simulated parallel data set by sampling randomly from the observed data set with replacement. When the confidence interval does not include zero, it indicates that the indirect effect is significantly different than zero, that means that the mediation effect is statistically significant (Hayes, 2012).

Figure 1 contains unstandardized path coefficients involving the direct effects of frequency of conflict on cooperative and competitive conflict management (the proposed mediating variables) and the direct effects of the proposed mediating variables on satisfaction with care. The test of cooperative conflict management as a mediator between frequency of conflict and satisfaction with care was supported, $b = .13$, $SE = .05$, 95% CI $[-.24, -.05]$. The test of mediation involving competitive conflict management was $-.02$, and was not statistically significant, 95% CI $[-.09, .00]$. This latter test violated

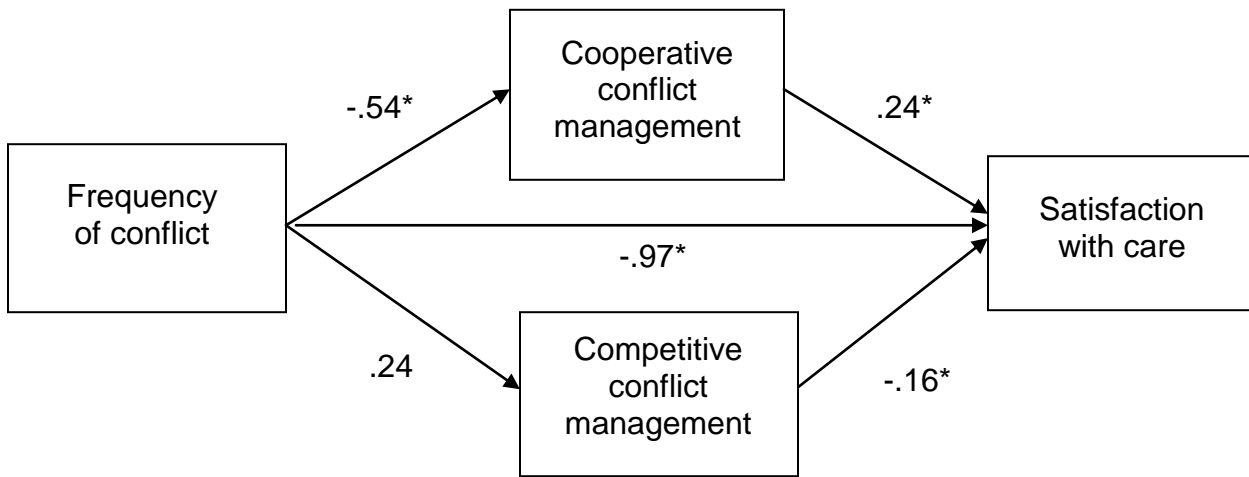


Figure 1. Cooperative and competitive management used as mediators in the relationship between frequency of family-staff conflicts and satisfaction with care. Unstandardized path coefficients marked with an asterisk are associated with bootstrap confidence intervals that do not include zero and are considered significant ($p < .05$).

the mediational hypothesis, as frequency of conflict was not a significant predictor of competitive conflict management, $b=.24$, $SE= .15$, $p=.12$.

How are high conflict families different from low conflict families in terms of demographic and caregiving characteristics? Do they experience different outcomes in terms of psychological distress and caregiver burden? High and low conflict family caregivers were identified using 1 SD

above (e.g., identifying High Conflict family caregivers [HC]) and below (e.g., identifying Low Conflict family caregivers [LC]) participants' mean scores on the Frequency of Interpersonal Conflict Scale (Pillemer & Moore, 1989), that led to the identification of 25 LC and 23 HC family caregivers. Comparisons between groups were performed using Fisher's exact test, chi-square test of independence and independent samples t-tests.

According to Fisher's exact test there was no significant association between gender and HC or LC family caregiver group, $p=.062$; however, this comparison was approaching significance, suggesting that with a larger sample size women are more likely to be in the HC group. No statistically significant association between employment (full-time, part-time, retired, unemployed) and level of conflict was observed $\chi (3)=1.15$ $p=.76$. Similarly no statistically significant associations between group and relationship to resident (spousal, adult child, and other) were observed, $\chi(2)=3.54$, $p=.17$. In terms of resident demographics, no statistically significant associations were demonstrated between group and whether the resident was a veteran [$\chi (1)=.10$, $p=.75$] or diagnosed with dementia [$\chi (1)=.42$, $p=.52$].

Independent t-test analyses for comparisons between LC and HC families are summarized in Table 15. No statistically significant differences were observed between

HC and LC family caregivers in terms of duration of caregiving or stay in the LTC facility; however, HC family caregivers reported more negative previous experiences in LTC than LC family caregivers, that was statistically significant $t(45) = -3.57, p = .001$.

High Conflict family caregivers visited the LTC facility 3.51 times per week as compared to 1.77 times for LC family caregivers, a difference that was statistically significant, $t(46) = -2.58, p = .013$. Low conflict family caregivers reported greater involvement in LTC than HC family caregivers, with this difference being statistically significant $t(46) = 3.52, p = .001$. LC families additionally reported a greater dependence on staff in attaining quality care for the resident when compared to HC families.

High Conflict family caregivers reported higher psychological distress than LC family caregivers, that was statistically significant [$t(45) = -2.23, p = .03$]. They also reported higher caregiver burden than LC family caregivers, that was also statistically significant $t(45) = 3.57, p = .001$. No differences in physical health or residents' level of dependency were statistically significant. High conflict family caregivers reported higher severity of relationship, task, and process conflict than LC, all of which were statistically significant, as can be seen in Table 15.

Table 15.*Independent Samples T-tests Between High (n=23) and Low Conflict (n=25) Family Caregivers*

Variable	Groups				T	df
	Low Conflict		High Conflict			
	M	SD	M	SD		
Age	66.83	10.35	61.87	7.77	1.85	45
Education	14.82	3.09	14.43	2.22	.49	46
Duration of caregiving	81.32	43.05	108.48	138.46	-.93	46
Duration of stay in facility	27.92	22.00	20.11	17.43	1.36	46
Previous experience in LTC	3.24	1.58	1.95	.95	-3.57***	45
Number of visits per week	1.77	1.36	3.51	3.06	-2.51*	29.82
Resident dependency	11.64	2.23	11.87	2.18	-.36	46
Dependence on staff	4.68	.69	4.13	.97	2.25*	39.49
ICS Relationship conflict	1.33	.38	2.78	.98	-.6.38***	25.31
ICS Task conflict	1.35	.52	2.87	.76	-.7.89***	43
ICS Process conflict	1.35	.50	2.78	.78	-.7.24***	33.15
Psychological distress (BSI-18)	7.28	8.10	13.18	10.00	-2.23*	45
Family involvement	41.44	3.91	37.22	4.40	3.52***	46
Caregiver burden (ZBI)	.87	.88	1.85	.99	-3.57***	45
Family conflict	1.60	.76	1.85	.84	-1.07	45

Note. LTC=Long term care; ICS=Intragroup Conflict Scale; BSI-18=Brief Symptom Inventory-18; ZBI=Zarit Burden Interview

Ranges and score interpretations for all measures included are provided in Chapter 2 on pp. 47-57. In general, for all of the variables included, higher scores indicate increases in that variable, with the exception of Physical Health (higher scores indicate poorer health) and Previous Experience in LTC (higher scores indicate increasingly positive experience).

^aHigh Conflict $n=21$; Low Conflict $n=24$

* $p < .05$, ** $p < .01$, *** $p < .001$

Chapter 4: Qualitative Results

An overview of the themes and participants' responses to interview questions can be seen in Appendix W.

What is the Nature of Family-Staff Conflict?

Severity and significance of conflict situations. Ten participants reported on 24 family-staff conflicts which were rated as somewhat (n=1), moderately (n=11), and extremely (n=12) severe. Most participants cited multiple co-occurring and/or sequential conflicts that contributed to the overall severity of the conflict episode. As one participant described (Participant 370):

Just because there was three – at least three or four things going on there. Five even, if I count the Zoloft. Like, there's just a number of things kind of going on at the same time, and... it could've been quite severe, you know. It kind of was severe, I guess, emotionally and just getting everything on track again in that sense...you know it's not life threatening when your pinky toe falls off, but it's just the whole kind of thing that went with it.

Participants also indicated that it mattered more whether the issue was perceived as severe by the resident than by the family caregiver, suggesting that the perceptions were inextricably linked:

I don't think it's extremely severe that people go in and out of my dad's room although it is upsetting to him so he would say something different I'm sure. He'd say very severe... so, it's not that for me that bothers me as much except that it bothers my dad and therefore it bothers me (Participant 468).

Moreover, severity was elevated when residents were negatively affected or there was a potential for harm:

I think it's extremely severe. It potentially could not only end his life, but in a very painful way. And I have visions of him lying there in the night with a broken hip and nobody coming..."Your dad never complains, your dad's always so polite, your dad's so gentle. He's such a gentleman." They love that about him, because there are some that are very loud and demanding and whatever. And I don't-- I think in some ways that works well for my dad. On the other hand, I think the

squeaky wheel gets the oil and I think at times he gets ignored because of that. That's kind of a Catch 22 in a way... But the fact that he won't yell if he needs something or speak up or complain or, you know, kind of, put-- makes him a bit of a victim as well. (Participant 844)

When asked why the conflicts were significant, half of the participants reported because of the occurrence of or propensity for harm to the resident, either from too much or not enough medication (Participant 900), having a fall and experiencing a serious injury against a hard surface (Participant 370 and 844), violence between residents (Participant 625, 844, and 468) and accusing staff of contributing to residents' deaths (Participant 625). Participants were concerned that some of the conflict episodes could have not only led to adverse outcomes for the resident in terms of physical and emotional harm, but could have been fatal.

Themes of hopelessness, powerlessness and vulnerability arose in the context of the significance of the discussed conflict episodes. Participants described feelings of hopelessness because of beliefs that even relocation from the current facility would not result in improved care for the resident:

They keep telling me you can always – if you're unhappy, you can move your mother. And I'm going, yeah – where am I going to move her? 'Cause Alberta Health, I have talked to them a couple of times 'cause I've been so concerned about my mother, and they say, 'Well, you know, it's really the same. Some are a little worse, some are a little better, but really it's about the same everywhere you go.' (Participant 625)

Relatedly, participants discussed residents having high degrees of vulnerability and families lacking power in changing staff perceptions:

Well, it was all traumatic 'cause [crying] you know, it's somebody that you love that is so vulnerable, that you still see as a person, a viable person and they don't see them as people either. They just see them as people with dementia or not even people with dementia. They don't even see them as people anymore. They don't care. (Participant 795)

When describing family-staff conflicts, participants previously encountered similar issues and suspected that these issues were representative of LTC problems in general (i.e., were not limited to the current facility). In addition to experiencing feelings of helplessness and lack of power, as previously noted, participants described "having to push to be validated and understood" (Participant 671) on resident care issues and feeling unwelcome at the facility:

...obviously the staff is not used to or comfortable with having family members around and, you know, they want to let me know that I really wasn't welcome there. I mean s-specifically I think if I stopped to have dinner with her [mother] and fed her so that they didn't have to, I think that would be fine but they definitely didn't want me around. And two of the other family members..told me to, 'Don't say anything'. They said, 'If you say anything, you know, your mom will get the worst care.' (Participant 795)

Participants' concerns generalized from the specific issue that they encountered with staff to all other aspects of care in the facility, including developing concerns about staff's overall demeanour toward families and residents (e.g., avoidant, unwilling to help). Given the continuous nature of conflict that some participants encountered, Participant 625 described that it led to a loss of "innocence" that staff do their best and indicated that "something needs to change":

...I guess I've lost some innocence there – I like to believe people try to do their best, you know. And from what I've seen, that's not always the case. It's not. I'm sorry, I'm not buying it anymore, you know... What is – I mean, you see these things on the TV all the time, but even that – they come on the TV, and what does Alberta Health say? 'Well, we're sorry we didn't meet expectations, and we're going to do an investigation – thorough investigation.' It's the same line every time. And what comes out of it? You never hear anything back, and have any changes been made? You never hear anything back. And it seems to be the same stuff over and over again. These places are not held accountable. So, I don't know. I don't know what my next steps are going to be. That's where I'm at right now. 'Cause I think something has to change.

The scope of care issues that participants reported conflicts about was all-encompassing including end-of-life care issues. A participant who experienced a series of conflicts with staff surrounding her father's end-of-life care expressed sadness and continued wonder about what her father's last interactions with staff were like, illustrating the depth of impact such conflicts can have on family caregivers:

The end-of-life care and support package. And the fact that they left it in plain view of my father and I -- what did they even say to him when they left it? What was the circumstance? Like, I would really appreciate talking to the person -- that's accountability, talking to the person who left it there and what was going through their mind? Did they say anything to my father about that? Did they tell him he was at end-of-life and what did they share with him? And-and if they had, it wasn't their place to share it; it was my place. (Participant 477)

Participants described an ongoing emotional impact of the conflict episodes as they expressed emotion in their speech while recalling events that occurred as far as a year or more prior to the interview.

Most family-staff conflicts occurred and evolved over the course of weeks and months, with some conflicts lasting over a year, including repeated conflicts with the same staff member. Participants reported a mix of isolated and re-occurring incidents, with the latter being more common-place. When conflicts were time-limited, participants attributed this to their influence, either because they effectively dealt with the incident to affect change or because they were physically present to ensure that it does not re-occur, as described by Participant 650, "Well, this was an isolated incident because I caught them....the thing is that I have a caregiver at lunch and if there isn't one, I go in. Or at supper. So, again, that takes the burden off them." The same participant further described that she was unsure whether issues recurred when she was absent from the LTC facility, and that her repeated experience with conflicts has taught her to be selective which conflicts she engages in:

So, when I've been there, now, who knows what goes on-then when I'm not there. I mean I know that because I'm there other wives who leave before their husband eats..They don't see things that I see, you know. I see bickering in the hall and-and I say, "Is that gonna affect me? No, okay so this is when I let go. (Participant 650)

Participant 844 attained a successful resolution of a conflict regarding her father's toileting needs, but encountered a similar issue with other staff leading to re-addressing the issue and becoming increasingly frustrated over time:

Yeah, with other temporary workers. ..even when I'm there and I mean I know they're not doing it 'cause I've been there and I'll say, 'Oh. He's gotta go to the washroom,' so they'll come. And I've been there and seen it--'cause I'll help and then I mean I'll do what I gotta do if I have to pull his pants down and put him on the drawer if he has to go, I'll do it.

In summary, participants reported that resident's perceived level of severity of an incident and potential for harm determined severity. The degree of concern and significance of the events discussed centered on resident safety, with families providing vivid recall of situations where residents were at risk due to care issues. Significance was accompanied by strong emotions including hopelessness, lack of control/helplessness and high perceived degree of vulnerability. Participants spoke about the ongoing and repetitive nature of conflicts, and their manners of adapting to the situations in hopes of affecting change regarding the care issue they encountered.

Types of family-staff conflicts. Participants described numerous types of conflicts with staff, surrounding various care-related issues including personal care (e.g., resident left undressed), food, medication (e.g., not being administered medication as prescribed), toileting (e.g., responsiveness to toileting needs), end-of-life care (e.g., how much care to provide), recognition of resident's agency (e.g., staff leaving an end-of-life-care binder in the living resident's room), and having their own knowledge and opinions recognized. Four key themes emerged when analyzing participants' responses

about the origin of family-staff conflicts that included (a) *they didn't listen to me*, (b) *staff are not attentive to the resident*, (c) *staff are not doing their job*, and (d) *the quality of care is suffering*. Each of these themes and relevant subthemes will be discussed in turn below. These themes overlap in terms of the care-related issues that they concern, with the issues outlined above representing the range of the various issues that contributed to family-staff conflict. However, the discussed themes go beyond the care-issue to capture the aspects of the family-staff dynamic that incited and propagated conflict. Moreover, each conflict incorporated one or more of the four themes, particularly over the course of the conflict episode, which spanned from days to months.

The first theme *they didn't listen to me* captured participants' experiences of conflict with staff in situations where staff did not respond to their requests, leaving them feeling unheard. Participants described a wide range of situations such as asking staff to stop arguing amongst themselves in front of residents, reporting observations about a resident that could be consistent with a missed fall or an untreated urinary tract infection (UTI), asking for clarification about when and how something would happen without receiving a clear response, asking to stay during a staff-resident care interaction, staff not following written instructions left by a family caregiver in resident's room, or not being called when an emergency occurred as requested.

Participant 671, who reported having a history of seeking medical care for her grandmother who suffered from frequent UTIs, described sharing her observations about her grandmother's changing state (e.g., pain, screaming, malodorous urine) with staff and feeling invalidated as her requests for a urine test were denied. Notably, her perceived invalidation by staff led to her escalating the issue to the Registered Nurse

(RN) and eventually taking charge of the situation by taking her grandmother outside of the LTC facility to receive the tests she requested. The participant stated "so I was left feeling kind of unvalidated, if you will, and maybe that my grandma's health care and concern was just kind of non-important," which suggest that feeling unheard during the conflict was linked to feeling that her concern and the resident's health were unimportant. This was in sharp contrast to the level of importance she placed on the medical situation: "if it's being dismissed could eventually even kill her. Right? Which we've been close to. Because it's been put off and ignored."

Participant 906, who was a pharmacist by profession, had an ongoing conflict with staff regarding her mother's medication but reported being repeatedly dismissed by staff which contributed to an exacerbation of her mother's hypertension: "...the doctor did phone me. He didn't say he's going to try anything. He said, 'Well, we've got some room with this other medication,' and I'm thinking, why didn't you listen to me in the first place and we could've avoided all this?" She reported feeling "irritated" that her opinion was not taken into account at an earlier point in the discussion regarding her mother's medication history and inappropriate medication administration.

Overall, when participants believed that their concerns were not acknowledged and validated by staff, conflicts escalated in severity. Participants believed that they possessed knowledge that was beneficial to resident care and important for staff to consider, including the resident's preferences, known symptoms of infection or health decline and/or relevant treatments for a condition based on personal caregiving history with the resident. In this sample, family caregivers' initial opinions were validated when staff obtained further information about the resident following their request (e.g.,

accessed resident's medical records, received consultation from the resident's physicians within or outside of the facility), which contributed to further frustration and added weight to the degree of importance they placed in their opinion about the resident relative to staff.

The second theme *staff are not attentive to the resident* captured participants' experiences of conflict with staff during situations that require staff to provide care in a timely manner, to provide additional attention or surveillance to the resident, and to demonstrate knowledge of the resident's needs. Participants believed that staff did what was convenient for them such as using incontinence products and catheters instead of toileting residents in the washroom (e.g., Participant 477: "it's out of convenience for the staff as opposed to his well-being"), and not responding to fall alarms or leaving alarms inactivated. Participants also indicated that staff may ignore residents' calls:

I heard this going off and I thought, 'What, the hell is that going off,' you know, because he isn't the only one. And, I heard it when I came right into the house... there where the nurse's station was, right. Oh, when I got there, it's dad and he was saying, 'I have to go to the bathroom, I have to go to the bathroom, there's just nobody's coming, I've been hollering.' You know, and I realized they could be busy with somebody else but they were sitting, talking. You see that really bugs me because I could hear the alarm, they must've been able to hear it. (Participant 844)

Additionally, this participant, whose father was at risk for falls and was using a motion sensor alarm, noted that his alarm was off during previous visits and had approached staff about this matter. However, she described that the staff did not believe her when she approached them, which led to repeated arguments regarding the details of her father's falls and how they could have been prevented:

You know, it happened like three or four times they phoned me and said, 'Well, your dad had a fall.' 'Well, when did he fall?' 'Well I don't know, but one in the morning, we were doing rounds and found him on the floor.'...And, I said, 'Well

wasn't this alarm on?' 'Oh yeah.' 'Well if this alarm was on, there should've been beeps on that phone'....It's really too bad, I know they need a break, but at two o'clock in the morning, how busy can they really be that that alarm is beeping to get up and go? I mean I know he falls, he's gonna fall...that's why he...wears the pants with the hip protectors on....Because some of the girls will say, 'Well, I don't know, he must've. We checked him and then about half an hour later, we went and he was on the floor.' But, where the others will say, 'Oh no, we checked him and he was you know--' So, you don't know, well did you check him or didn't you check him and you're just saying that because you don't want me pissed off? (Participant 844)

In addition, participants reported conflicts concerning staff not attending to information about the resident. For example, Participant 844 described casual and new staff trying to get her father to ambulate in a manner in which he was unable to due to inadequate knowledge of his physical limitations. She reported overhearing her father voicing his limitations to staff and addressing this issue with staff on his behalf:

...I would also come down and I can hear them in the bathroom with him. They're saying 'stand up, stand up'. They don't care, the new staff. He can't stand up himself....he kept saying, 'I can't, I can't.' 'Yes you can. Yes you can.' He said, 'I can't.' I can hear him, eh. Then I walked in and she was right by the toilet... I said, 'No, he can't stand.' She said, 'No he can stand.' I said, 'There's nothing for him to grab on to. He can't stand and transfer himself to the toilet.' I said, 'What you have to do, you have to wheel his chair up to there, he holds on.' 'Well I didn't know.' ... I'm thinking, well why don't they know? They should be told that when there's a new person that comes on. Even if they're just a temporary, they should. All the-- all the girl has to say is 'Okay, Mr. *Smith* he can't stand by himself, push him up to the rail, he'll hold on, push him on the commode.' Does that take long? (Participant 844).

Participants also reported having arguments with staff regarding lack of attention and curiosity about the resident's changing condition. Participant 370, whose father became agitated and was placed "immediately" on medication, wanted contributing factors to her father's presentation to be considered by staff:

They're ready to give him risperidone and some kind of drug if he's showing some kind of agitation and aggression towards himself, but they don't really look as to why. Why is that? Is that how he normally acts? Well, no. Well then, what do you think is bothering him? You know? Like, they don't seem to have time for that, I guess....but my concern was like, 'Why am I telling you guys this? Why

didn't anybody notice his toenail was off? You know, you guys, why don't – do you not check ears? Or, you know, is that never done? Or...' and then the urine infection again, like, they just don't seem to notice anything. (Participant 370)

Another participant experienced a series of conflicts with staff resulting from a single situation that she alerted the staff to (i.e., her paid caregiver was unable to attend to her husband one day). She arrived later than her usual visitation time to find out that her husband had not been attended to by the nursing staff (e.g., had not received his lunch, and was thirsty and soiled). She was upset with staff and asked staff to join her in the resident's room:

So she came and I said, 'We need to change this T-shirt. I'll help you but we need to change it.' I said, 'You know, this shows me that nobody's been in here looking at him because this doesn't happen in 20 minutes'...It was all over him...the drool..And if you put a face cloth or something there and then change it in an hour, he doesn't get it on himself. ...So I got another T-shirt out, and we got him changed and the caregiver said to me, 'Is that to your liking Mrs. *Smith*. Are you happy with that?' And I said to her, 'Don't you ever say that to me again ever, ever. I pay you people to come in and take care of him. I know that this was not caused in 20 minutes. He was so thirsty, he could drink the tap dry. Unforgivable, don't ever talk to me like that.' (Participant 650)

In sum, participants expressed concerns about staff's lack of attentiveness to residents' needs and their lack of knowledge about the specific care needs of individual residents, both of which were a significant source of conflict.

The third theme *staff are not doing their job* consists of family-staff conflicts that were incited by participants' perceptions that staff were not fulfilling their designated duties either in the context of providing resident care or addressing a family request or concern. One prominent area of resident care where participants reported staff not fulfilling their duties was toileting, citing a lack of availability of staff and a perceived refusal to toilet residents. For example, a Participant 671 illustrated observing and overhearing others ask for toileting:

To me when I sit and I hear staff or not staff but a family person or a resident, excuse me, say 'I need to go to the washroom,' and now especially around let's say meal times, they're told basically to soil in their pants because meal times are not a time in which that they can take people to be toileted because they need to take two people and there isn't enough staff, right? ...like even just yesterday there was a resident who said she needed to go to the washroom and being told that now is not a good time for you to go to the washroom so you'll have to wait. (Participant 671)

Some participants described having understanding for the time it takes staff to address toileting needs because they encounter competing demands. Participants suggested that they will get involved in providing some physical assistance to staff around care tasks but recognized a limit to the extent of their role:

Why should he wait for 10 minutes and do it in his pants if he has to go and I'm-- nobody's available. I take him in there, hold on dad, rip his pants down and put him on the commode, shove him on. And then I-I say, 'Okay, he's on the toilet and he, you know, to be wiped or whatever'. I haven't got to the wiping part yet...I don't feel that that is my job. I mean I-I used to change my mom, I used to change her diaper and clean her up and everything and you know... (Participant 844)

Participants reported feeling "used" by staff when taking on responsibility for resident care because they believed that staff faltered on their duties. Although participants suggested that they wanted to help, they did not view it as their duty to attend wholly to the resident's activities of daily living, which they perceived as staff's responsibility.

Another prominent area of conflict was staff not providing medication to residents as prescribed. For example, Participant 795 discovered that the licensed practical nurse (LPN) that was attending to her mother would mark off on the medication card that she had administered all the medication for the duration of her shift prior to dispensing the medication. As she was at the facility for several hours per day, and had a private caregiver as well, she observed that no medication was administered even though it

was recorded as such. This observation created additional concern for her as she described:

'My God' I said, 'Has she given anything? Did she get her blood thinner and her other medication this morning?' 'Cause then I was thinking she didn't get anything, but they said they would speak to her....And then sometimes I just starting going -- 'cause I was -- I think I was getting more worried and more worried. And I -- So, I started going earlier in the morning and a couple times when we would get her up to do physio, I ... would find her Pantoloc in the chair or in her lap... so then I would give it to her and they said, 'Oh, well she-she's spitting it out or she won't swallow it.'

In addition, staff were reported to engage in unprofessional behaviour as described by Participant 625:

...some healthcare aides sleeping on the job – caught them sleeping all the time they have a couch down there, they're sleeping on the couch...Talking back to the LPNs and recreational therapists, yeah, fights amongst the staff like, with talking back to the managers essentially. No respect for the managers. Refusing to do what the LPNs ask them to do, and neglecting obvious resident needs. Like, you see somebody that's all wet – their pants are all, you know – and you say, can somebody please change this person? 'Oh, we're busy.' and walking away. You know, that kind of thing.

This description paints a negative view of staff, which was echoed by other participants who did not believe that staff possessed the motivation, skills or care required to fulfill their duties. This attitude regarding staff was tied to concerns about resident care and escalation of conflict, with family caregivers exercising a perceived right to point out staff's missteps.

Some participants expressed sympathy and understanding for staff by identifying the challenges of their roles, the staffing shortages and the significant demands placed on staff. For example, Participant 844 said,

I know they need their breaks, and they can't be running every five minutes. But, if they can't do their jobs they shouldn't be here. I mean, I couldn't do what they do. I'm not saying, you know, I mean I have a lot of respect for those girls because they put up with a lot of crap from the residents. They do.

In summary, participants were critical of staff's conduct and how they approached their care duties with residents, which contributed to instances of conflict. Areas of care where conflicts were reported as resulting from staff inadequately completing their duties included toileting, medication and communication with families. Participants were vocal about staff's mistakes in care, as well as omissions, frequently citing suggestions or alternate codes of conduct that staff could have demonstrated.

The fourth conflict theme generated was *the quality of care is suffering*, whereby participants experienced conflict with staff while navigating issues, concerns and disagreements regarding medication, resident's agency, end-of-life care, space limitations/room size, resident-to-resident aggression, falls, and care expectations. Participants described encountering care issues a number of times prior to them escalating to conflicts. For example, Participant 844, who reported staff employing inadequate fall prevention measures, indicated that the issue was ongoing over a two year period and was complicated by multiple factors, including a shortage of fall detectors at the facility, lack of attentiveness to her father, and lack of adequate staffing.

With regard to medication, participants expressed concerns about the specific use of certain medications (e.g., Seroquel) for behavioural management, and sought alternate methods to manage resident behaviour (e.g., modifying the environment, getting a greater understanding of resident needs; Participant 900), as well as disagreements about the actual administration of medications (e.g., type of medication and frequency, Participants 906 and 795). A participant, who is a pharmacist by profession, illustrated her medication-related conflicts with staff,

...when my mom told me that they give her all her – all her medication at the breakfast table just before they eat. And, one of those medications was

Synthroid, and this is a real thing with me because it should be taken at least half an hour before any food or food will deactivate it. And I mentioned that to the nurse and she said, *'Oh no that doesn't matter anymore.'* And so...I don't believe that. I can't believe something I've learned to the contrary, not – and it doesn't matter what she tells me, um...in fact, she said to *me 'I don't know why I'm telling you these things because you'll probably go and do what you want anyway,'* and I said "that's right I will". (Participant 906)

She similarly reported that her mother was receiving the wrong medication for her blood pressure but felt that her concerns were consistently not taken seriously by staff.

Furthermore, participants encountered conflicts with staff related to supporting resident's agency. Participant 477 described that her father experienced post-stroke speech difficulties; however, her father communicated his want to live and improve his ability to communicate. During a visit, she reported that staff did not take his limitations into account and did not highlight his agency:

I'd gone in there and he was sitting in his chair and there was somebody feeding him because he had to be fed because he was having trouble with his hand and stuff and, um, he was trying -- you know, he was happy to see me and he was trying to say something. And the -- the aide who was feeding him said -- you know what she said to me? She said, 'Oh, don't -- don't mind him, he's just making noises.' It's my father. I said, 'No, he's not just making noises, it may sound like noises to you, but he's aware of what's going on. He's trying to articulate, he's trying to speak and say something.' (Participant 477)

This participant reported a similar concern for the way that her father and family were treated during his end-of-life care. During a visit she identified an end-of-life support package inside their father's room. She described:

I just was shocked...I couldn't believe it...'cause it's there in full view. I don't know how long it had been sitting there, but my dad was, you know, he's still mobile. He was in his wheelchair at that time. He can move around a bit, right. What's just the chances that he -- not that he doesn't -- shouldn't be aware- but that's part of the problem. He wasn't. He was never involved in the conversation about end-of-life. It was like this big secret, and yet -- So all this stuff was happening to him, but he wasn't involved in any of the decision making. (Participant 477)

Notably, she approached front line staff and the unit manager to find out who had placed the package in his room and why, without receiving any clarification. She

described feeling a lack of power in the situation, which was exacerbated following her father's passing when she felt that she was rushed in saying goodbye and received a number of requests from staff (e.g., completing her father's affairs within 24 hours of his passing), in the absence of support. Her experience, consistent with other participants' reports, illustrated the additive nature of conflicts experienced with staff concerning a single care issue.

In summary, participants' conflicts with staff frequently centered around poor perceptions of the quality of care that was provided to residents in key areas that had either direct impact on resident's well being (e.g., resident safety) or concerned an emotionally challenging time (e.g., end-of-life). Some participants described being explicit in their expectations without being able to obtain the responses that they sought from staff. This will in turn be discussed as part of the strategies that family caregivers used to manage conflicts with staff to varying degrees of success.

How Do Family Caregivers Manage Conflict with Staff in LTC?

Participants described varied ways of managing conflicts with staff both within a single conflict incident and across different conflicts. These themes included *being confrontational*, *being present*, *being careful*, *getting support*, *demonstrating personal/professional knowledge*, *questioning staff's knowledge* and *trying to work with staff on the issue*. Each of the themes described below was discussed by more than four participants .

Being confrontational. All participants reported addressing at least one of their conflicts with staff in a confrontational manner, encompassing aggressive, competitive, and direct communication and actions. As participants recounted the conflict episodes,

they were observed to be bewildered, sarcastic, angry and frustrated. Participants differed in the extent to which they were aware of their confrontational approach, with some explicitly noting the value of using this approach to manage conflict, to others eschewing aggressive and direct approaches but nonetheless acting in an aggressive manner based on their narrative.

Participant 650, who notably reported having more authority in the LTC facility as a family caregiver than front-line staff, described being consistently direct with staff when she was dissatisfied with their conduct. She described readily saying to nursing aides (NAs), "Why did you do that?" and "What are you doing?" while taking control of the care-related situation. For example, she described her reaction to a NA, who "grabbed" her husband's wheelchair without communicating with him first, "I said, 'Please don't talk to me anymore about it. He's upset. I'm upset. Now you're upset because I'm upset with you.'" She approached the RN to manage the conflict because she believed that further approaching the conflict with the NA would be futile:

Participant 650: The nurse is the one that needed to know what was going on and what happened. And I needed to go express my anger with someone else.

Interviewer: Is this what you wanted to do to speak to the nurse about it?

Participant 650: No, I wanted to get a gun. But yes, I- I needed to speak to the nurse about it and make sure that she understood that this ain't the way you do it....It was no use to continue talking to the caregiver. She was denying that she had pulled the chair back and I told her, 'Excuse me do you think I'm blind?'

She described frequently engaging in confrontations with staff when she perceived care that she was dissatisfied with, including with temporary staff:

...Or one caregiver that hardly ever works there, I don't know where she came from. But I said to her, you know, 'If I could go out and buy you common sense and bring it back to you, I would.' And she says, 'What does that mean?'

Notably, she did not show concern for expressing her dissatisfaction with staff directly or being verbally aggressive toward staff.

Participant 900, who supported both her mother and sister in LTC, described that being confrontational and aggressive was necessary to be taken seriously and have her concerns addressed in a timely manner. While managing a conflict related to the quality of food that her sister was receiving, she described using a confrontational approach:

I said, 'Oh, whoopee, but, would you eat it, it was awful.' And he was a little bit upset because I was quite curt with him and quite, you know, I wasn't nice about it. Because I found that every time I have been nice, nothing's come of it, when I get nasty then it starts to come- [laughing]- then they start to realize, 'Hey, she means business.'

Similarly Participant 671 considered her confrontational approach as a necessary part of her advocacy for her grandmother's medical care:

...Speaking with the RN, we kind of got into a bit of an argument about the fact that I felt like I wasn't being validated with my concern about her UTI. And her telling me, you know, like, 'Look, I know how to do my job.' And I reiterated back to her, 'It's not about me trying to tell you how to do your job. I don't want your job, I don't want anyone's job in this care facility, I have enough to take care of, but my job is to advocate for my grandmother when something is wrong, and to get it straightened away to the best of my ability. So if she has an infection, then I need to advocate to get her medicine, because that's what I said I would do.'... 'If the care facility isn't gonna do it, then I don't have a problem to step up to advocate. If it means I need to take her out of here to the hospital, to a different doctor, to get what she needs, then I will do that. Because I don't want it on my head that she needed some type of medical care and I did nothing. And it's the demise of my grandmother's life because I chose to do nothing.'

Moreover, participants obtained evidence to confront staff with such as photos or names of staff. Participant 900 described sending her husband to attend to her sister while she was ill, and instructed him to take pictures that she could use as evidence if needed:

I say to him, 'And while you're there, take some pictures. I want this all documented because anything that's got -- involves bruising and stuff, I want that documented.' I did that with my mother too. And it does help. It, trust me when--it

helps. They seem to resolve the situation a little bit better if they know you've got pictures. But if you go along without the pictures or the names, trying -- when I went -- the little journey that I went through with my mom and my sister, trying to get them into the system when they first-came to live with us, that was -- we got jerked around and finally, I just said, 'I want your name and I want your supervisor's name, and I want their supervisor's name.' 'Well, I'm not going to give it to you.' I said, 'Yes, you are. I want it, give it to me.' And I said, 'If there's anything that goes wrong I'm going to talk to them and you're going to get it.' So, okay fine, and everything was resolved all of a sudden. Everything was resolved once I had names and pictures and you name it.

When asked why she believed that this approach was effective, she responded:

I don't know, they're scared I guess. They don't want to be reported to the government or whatever. But as soon as I threaten I wanted the names of them, their supervisors and their supervisors ... they don't like people who [laughs] do that I guess. I don't know. But I -- that's the only way it seems-- to get resolved.

Other participants also threatened reporting staff to various management (e.g., clinical/unit managers, directors,) and external sources (e.g., Alberta Health Services). For example, Participant 671 described an instance of threatening staff that she will contact managerial staff when she found herself locked out of the LTC facility:

And as I was walking past the woman at the big computer screen, I said, 'Gee, you know you're sitting right here. You couldn't come and buzz me in.' She said, 'Can't you see I'm busy working here?' I said, 'Could you not hear me ringing the buzzer and beating on the glass asking for someone to let me in?' She said, 'I'm busy. I'm working here so no, I couldn't come and let you in.'... I said, 'Oh, I'll be reporting that to the directors. So mark my words that you're being busy sitting behind that computer screen is noted.'

Participants also described seeking immediate response from staff in light of a conflict situation. For example, Participant 844 described confronting staff about ignoring her father's requests and instructing staff how to respond:

You know, I just I went back up and I said, 'Did you hear dad's alarm going off?' 'Oh yeah, but he opens it and closes it and everything, so we didn't bother.' I said, 'he was in the bathroom, he had to go to the bathroom.' I said, 'if he did try to do it himself, he could've smacked his head and that would've been you know on the toilet.' Then I said, 'Now, he's done it in his pants.' So I said, 'So, now I guess you're gonna have to come and change him, aren't you?' Just like that. Well they were a little bit, you know, 'Well yeah, we'll get there in a minute.' I said,

'No'. I said, 'He needs to be changed now. You are not doing anything. You're not busy with someone else. He needs to be changed now.' And they could tell I was getting a little pissed, eh, so then they went and did it. They changed him.

Participants also mentioned openly defying staff's instruction, and escalating the degree of confrontation to attain their goal. For example, Participant 795 described being asked by two NAs to leave her mother's room while they provided direct care:

...I said, 'Oh no I'm just going to stay with my Mom' and she said, '*Organization* has a policy that we do not work with family in the room.' And then I kinda got irritated and I said, 'Yes, well I have a policy that I am not leaving when my mom is asking me not to leave.' And I said, Alberta Health Services has a full transparency policy supposedly.' And she said that they had nothing to do with the Alberta Health Services. And I said, 'Well, that's who I pay to stay here is Alberta Health Services,' and I said, 'I'm not leaving the room.' And I didn't leave when she was quite put out with me...Well, I said to her...'Do you have anything to be embarrassed about how you treat my mother?' And she said, 'No.' And I said, 'Do you have anything to hide about how you treat my mother?' She said, 'No.' And I said, 'Is there any injuries or bruises or bedsores that you're trying to hide?'... She said 'No.' And I said, 'Then why would you care?' I said, 'I looked after my mother.' I said, 'She's been living with me. She's-she's new here. She's scared to be here and she wants me to stay. So why would you feel bad that I'm here?' ...they didn't speak to me the rest of the time, so I mean the rest of the evening and so they weren't happy with me.

As evident in this quote, participants were aware of negative outcomes of confrontational conflict management, including termination of communication and feeling unwelcome in the LTC facility.

In summary, all participants reported using confrontational conflict management. Some reported using this approach more consistently when encountering conflicts with staff, citing it as an effective way to attain a response from staff and to effect change. Notably, participants who held this view described a history of being confrontational with staff either in other LTC facilities or engaging in multiple conflicts with staff (Participant 900, 650, and 671). Some participants reported unhelpful outcomes including feeling unwelcome and negatively impacting communication with staff.

Being present at the LTC facility. Four participants described that following conflict with staff they tried to be more frequently present at the facility, either to monitor staff or to work along them to attain the desired care outcome. For example, Participant 370 described reciprocating staff's willingness to document her father's fall by trying to be helpful:

...I went out and got the glasses fixed to make sure at least those were comfortable and he could see properly and that kind of thing... I was there probably three hours yesterday, and Saturday also for a bit, you know, probably a couple hours anyways. Two or three hours. So, trying to kind of be there to have eyes just so that maybe they don't have to all the time...

However, her intention was twofold as she indicated when asked what she did to manage the conflict, "I guess being there – well, again, like I just, you know, you don't really trust that they're actually doing what they say".

Another family caregiver (Participant 650) indicated that the strategy of being present at the facility was also used to make her presence known as an advocate, "So, they're aware that I'm there a lot and so that makes it better for my husband than for a lot of the other ones. I don't care who you are, you need an advocate." The sentiment that family presence made it known that the resident was not alone at the facility, was shared by families as an approach to send a message to staff that care was monitored.

In addition to overseeing how staff conduct themselves with residents, participants reported being present to provide care themselves (e.g., feeding the resident, providing medication, dressing), often taking on duties that they had disagreements with staff over. Participant 795 described being present in order to administer medication that she believed staff was not giving her, despite feeling uncomfortable going into the facility due to ongoing active conflicts with staff. She highlighted the importance of her presence and having a proxy in her absence:

...I felt like I should be there because then I knew I could make sure she got the medication because it wasn't — she wasn't getting it and I — and I also thought that's probably what's been happening all along is she wasn't getting it and that's why she's deteriorated quickly and the coughing up blood. Which isn't that pleasant for anybody to see, right? Never mind — and my mom, it was scaring her too, right? And so I thought if I get there and I would still have *private caregiver* there, but I thought if I can't get there, at least, then give her the medication. And then, I thought, there are some days, like, sometimes I have to go to meetings and things that I couldn't be there. So I thought if I really explain then they really understand the importance of the medication, they will make more effort to make sure she gets it.

Although some participants reported having a regular visitation routine so that staff would be aware that they would be present at certain times of the day to oversee resident-staff interactions (e.g., Participant 650), Participant 844 described using her visits to check in on staff, by keeping a random schedule of visits:

Participant 844: Yes, and I don't wanna say much. You don't wanna say too much to them because then I feel they wanna take it out on him. Maybe I'm wrong, but I have kinda seen, you know, little things when you come unexpectedly, because I never come at one certain time though. I may pop in in the morning, I may pop in the afternoon, I may pop in at night, sorta thing.

Interviewer: And, have you done that in response to this incident?

Participant 844: Yes. And, I do it a lot now. Like I do — they can tell you, I'm here — They never know when I'm coming.

Overall, participants increased their presence in LTC facilities to assist staff, to monitor their activities, and to increase their visibility as a family caregiver when managing conflicts. Participants described having greater power as a result of their presence when addressing issues with staff by having more knowledge about what occurred during care episodes.

Being careful or on guard. Seven participants described a conscious effort not to express emotion (i.e., being upset, angry, etc.) when managing conflicts with staff,

due to fears of how their reactions would be received by staff and what repercussions could follow. Participant 468 described restraining her emotional reaction:

And then I come in and see my dad and see his knees all scraped up. And I tried to hunt somebody down to — so I have — I have managed, despite what I'm feeling inside, to always try to be as calm and diplomatic as I can. I-I think sometimes I can be very direct.

However, she described that maintaining a cool demeanor was important as the alternate could have repercussions, "there's always that fear that if you complain too loudly, because the caretakers complained to me about family members who complained. And they-they don't say very nice things about them. And so, I know that attitude." Participants were concerned that if they came across as "more forceful" and "upset" in their interactions with staff that it would impact how staff would treat the resident and them (Participant 468, Participant 844, Participant 795),

Well, because I-I was-I mean a part of me wanted to tell her-tell her off but the other part of me knows my mom is there with them, very vulnerable when I'm not there, so I tried to handle it, you know. I thought I tried to handle in a professional, kind, calm manner. (Participant 795)

In summary, participants' concerns about how they appeared to staff translated to family caregivers not being as direct in their communication with staff during conflict episodes, and relying on passive strategies to express their dissatisfaction.

Getting support to manage the conflict. All participants reported garnering support to navigate conflict with staff. Additional support included family members of other residents at the facility, other staff at the facility (e.g., front-line staff, management), consulting with professionals external to the facility (i.e., doctors, organizations such as AHS), and involving another family member from their own family.

Participants described connecting with family members of other residents to "compare notes" on an issue, to "check in," and obtain support. Turning to trusted members of staff to speak to and even receive "a hug" from was commonly mentioned. It appeared that these staff members served a similar role as that of the other families at the facility, as a sounding board for the participants during periods of significant stress.

Apart from approaching known or trusted staff, participants frequently cited approaching front-line staff as their initial step in conflict management. Staff approached included RNs, LPNs, and NAs, with RNs and LPNs being most commonly approached due to their level of authority in LTC.

Participant 650 illustrated this approach as she described becoming progressively angrier while engaged in a conflict with a NA, at which point she recognized that she needed to speak to the nurse on duty for assistance. When asked why she chose to speak to the nurse, she said:

Well, the nurse is the one that's head over the caregivers. The nurse is the one that needed to know what was going on and what happened. And I needed to go express my anger with someone else.... I explained to her- I said, 'I'm so mad, like, I am ready to vibrate myself.' She sent me downstairs and she said, 'I'll go in and I'll get him to calm down, and I'll talk with her'. I said, 'Okay,' so I went downstairs. She decides, the caregiver, to come down and confront me and say she didn't do all that.... But yes, I- I needed to speak to the nurse about it and make sure that she understood that- this ain't the way you do it... It was no use to continue talking to the caregiver. '

This perceived authority that RNs and LPNs hold over the immediate front-line NAs resonated across participants, making them the first point of contact to manage conflict. Some participants were instructed by management to only approach RNs and not to manage conflicts with other front-line staff (Participant 650 and 795).

In addition, all participants reported seeking to speak with staff who held authority over care practices and front-line staff. Participants contacted floor/unit managers, social workers, and directors, in person and by telephone. However, participants mentioned variable confidence that they could be of assistance in affecting change. Some participants described being confident with the support of the manager or director:

I feel that the situation is definitely going to be rectified. The director indicated to me with her demeanor that she was thoroughly not impressed on a couple of different points. One being that I never should have had to probably ring that doorbell more than once. that there was staff just right around the corner that suddenly now were running after I entered the building, right. (Participant 671)

Conversely, other participants described that managers and directors were not aware of what transpires between family caregivers and staff on the units. Participant 370 escalated her conflict to a case conference with management and staff (case conferences and meetings were also reported by other participants), and was "not very confident" about the director's effectiveness in assisting her to navigate the conflict:

I felt – that's kind of what I expected, and I didn't want to blow up the care conference, I wanted to kind of go through a few items...just kind of looked at her like, 'okay now what are you going to do?' [laugh]...she just said her little spiel and that was all. She wasn't committing to being better, or doing something differently, or blah, blah, blah, really... Well it's like, you know, 'oh we'll have a meeting about that, oh yes we'll have to look at that, oh well I can't say why that wasn't looked at'...you know, or [laugh]...it was just very...'nothing's going to change here but I'll nod and smile at you and pretend I'm answering your question;', is kind of what it seemed like to me. So, I wasn't really impressed with that at all.

Furthermore, participants described seeking support from medical professionals and organizations external to the facility, in order to obtain consultation on a medical opinion (i.e., medication issues, presence/absence of an infection), to receive validation for their concerns, and to enlist the help of someone to speak on their behalf.

Participants mentioned being direct with staff when seeking external professional assistance. Participant 900 described turning to an external organization to assist with her ongoing conflict with staff regarding the amount of medication her sister was receiving:

I shook her and touched her face and stuff, because her head was right down to her waist sitting in this chair. That's when I called the Alberta Board for Patient Abuse or whatever it is. I called them and explained to them what happened and there was the big kerfuffle. They had come here and talked to the facility here. They talked to the social worker that was here.

An organization commonly contacted by participants was Alberta Health Services either via telephone for additional information or for organized meetings to discuss the nature of the conflict.

Lastly, two participants described obtaining help from male family members (e.g., husband, son) by having them accompany them to the facility to speak with staff or to a meeting. Reportedly, these participants felt that men were more likely to be effective in obtaining a response from staff (Participant 900, 906).

Demonstrating personal/professional knowledge. Seven participants described managing conflicts by emphasizing the importance and validity of the resident-specific and/or care-related knowledge they possessed, espousing an 'I know what I am talking about' attitude. Some participants additionally took on an educational approach by using their knowledge to show or teach staff how to address a resident-related concern. This theme also included participants' tendencies to raise concerns to staff in order to increase their awareness of the issue.

Participants described trying to convey their expertise in knowing the resident, including symptoms of illness, communication strategies, and likes and dislikes, among

other unique knowledge. For example, Participant 671 recounted multiple arguments with staff regarding the assessment and treatment of her grandmother's UTI, based on previous years of managing her grandmother's frequent UTIs:

I felt frustrated and unvalidated. Like, my grandma has kind of been inadvertently in my care for almost four years. So, through that time, I have spent countless hours with her. Often on weekends from nine in the morning until four or five, six o'clock in the afternoon I would spend with my grandma and then weekdays from nine in the morning until 2:30, I would spend with my grandma at her old care facility so I spend a lot of time with her. I feel that I can advocate for her—you know, with preciseness. And when I go to staff and I bring up something that I've noticed with my grandma, I really wish that they wouldn't undermine it as being, I'm over-reactive or that what I'm talking to them about isn't really something of any kind of importance to them, but just take it as, you know, maybe we should monitor her.

She further described sharing her observations of her grandmother with staff and concerns that she may be perceived as telling them to do their job:

... why is the staff in this care facility isn't noticing the same things as what I'm noticing? I don't want to seem like I'm trying to tell staff how to do their job, but sometimes when I'm approaching them and I'm sharing with them, that's how I feel... I'm the family member and I'm going to them with something that they obviously should've noticed, and I'm not trying to demean them by, you know, 'Oh, you stupid idiot' type of demeanor or anything, but, you know, like, 'Oh, did you notice?' Right? Like, I mean, how can you not bend down on one knee to swap out her catheter or to empty out her catheter and not notice that it has a smell?

In addition to having personal knowledge about the residents, participants raised their professional knowledge when managing conflicts with staff to bolster their arguments, challenge staff, and attain their care goal. Participant 906 encountered a number of conflicts related to medication administration, that she found particularly challenging as a pharmacist and described the contended issues as "well known facts in the medical community":

I'm angry at the place. I hate going there. And then my next encounter was when my mom told me that they give her all her medication at the breakfast table just before they eat. And, one of those medications was Synthroid, and this is a real

thing with me because it should be taken at least half an hour before any food or food will deactivate it. And I mentioned that to the nurse and she said, 'Oh no that doesn't matter anymore.' And so...I don't believe that. I can't believe something I've learned to the contrary, and it doesn't matter what she tells me...in fact, she said to me 'I don't know why I'm telling you these things because you'll probably go and do what you want anyway,' and I said 'that's right I will'.

Moreover, participants managed conflicts by demonstrating to staff how to perform a care task such as how to administer a medication, educating staff about the importance of providing a specific medication (e.g., eye drops), placing dentures, with emphasis placed on teaching new and temporary/casual staff members. For example, Participant 795 described ongoing medication-related conflicts that she attributed to staff not understanding the importance of her mother's medications to her well-being and not knowing how to appropriately administer it. She spoke about teaching staff how to best administer medication to her mother:

But I thought if I explained to her about the bleeding ulcer then maybe she'll -- Because she would always take her medications but you had to put it in her mouth. Like, you have to put in her hand that she could see it and she would put it in her mouth. And you had to give her a cup. And they would give her medic-- they would give her a cup with a straw. And then she couldn't suck enough water in to swallow the pills. So I tried to explain to them too. You have to give her a cup with no straw and no lid. And she wouldn't drink cold fluids, so if they gave her ice water or cold juice, she wouldn't drink it. It has to be lukewarm. So I tried to explain all that, but I thought it must be getting complicated. [laughs] It's too complicated.

In addition to providing verbal instructions, families reported providing written instructions to staff in the form of signs placed in the resident's room. Participant 844 illustrated providing step-by-step written instructions to reduce the likelihood of direct confrontations regarding her father's care:

I put a big note, 'Please put *John's* running shoes' tape that to the mirror, and then about the tube in I put, 'And, please look at the tube it will tell you how much to put on otherwise it gets stuck'. So, I put three strips and I circled three in that. I put a mark on it. So, maybe they think I'm being a smart ass or something, eh. And, I said, 'that's all he needs'.

Apart from sharing knowledge, participants described raising care-related issues with staff so as not to initiate a conflict but to ensure staff awareness of the issue to be addressed either by staff or by staff and family. Family caregivers described placing value on providing feedback to staff when encountering issues as a way of developing change that they could not effect on their own. Participant 625, who facilitated a family group, described developing a written document that outlined families' concerns about resident care, that was submitted to management. She recounted having "families commit to being diligent and timely in bringing issues to *facility's* attention", and encouraged them to provide suggestions and to share information gathered from other facilities. Participants described raising their concerns with staff to effect change at the organizational level (e.g., more frequent family complaints may result in nursing staff communicating complaints to management), and for other residents and their families in LTC:

...that they need to know that this is not okay and that somebody else should not have to go through this, so, they need to be aware that this is not a good system you don't do that....my view in speaking to her was to make sure it doesn't happen again to-to have some stricter guidelines around their policies when it comes to end-of-life. (Participant 477)

Participants described negative outcomes related to raising concerns including feeling unheard and being viewed as "complainers". As experienced by Participant 671 and Participant 906:

I have bugged them and bugged them and explained to them and told them....Bugging, to me, means that you bring it up several times. You keep on bringing it up until it's resolved. So that's what I've done. I thought it might get me somewhere. Like, let's get rid of this lady and shut her up and let's investigate. Let's do something for my mom. (Participant 906)

In summary, participants perceived sharing information and knowledge with staff as a method of increasing awareness of problems and their solutions, with hopes of generating a mutual discussion of the issues. However, families reported varied levels of success in using these methods to manage conflicts as potential adverse consequences arose, such as being labeled as a "complainer" or feeling unheard, that then escalated the conflict situations without resolution.

Questioning staff's knowledge. As the above approaches imply, participants reported varying degrees of confidence in staff's training and skill levels to provide the level of care they believed that residents required. These concerns included lack of training in mental health, dementia, identification of infections, dignified treatment of residents, administration of medication, as well as a lack of knowledge about individual residents (e.g., resident's medical, physical, and emotional needs). Participants perceived staff's lack of knowledge as directly contributing to the conflict situation and described confronting staff during conflict incidents about their perceived lack of knowledge. For example, Participant 370 described lacking trust in how staff approach resident-related situations and questioning their approaches to care:

...it's just comical almost, like even after he was throwing up the one LPN was saying, 'Well, would you like a coffee?' [laugh] Like, I don't know – do people usually want coffee after they've thrown up?...I guess that's kind of one of the things. I'm concerned that they're not, I don't know. Do they have no protocol, or...?

Participants described such instances as "scary", "horrific", "negligent", and being "disgusted, amazed, and floored" in response. For example, Participant 477 recalled expressing her disbelief to a staff member whom she believed mistreated her father by denying his ability to engage with her, "You just don't know enough, you should not be

in this position. You should not be doing this if you don't understand that these are human beings and still have capacity." Participant 650 similarly expressed her dissatisfaction to a staff member during a conflict related to staff closing the resident's door and turning off the music in his room:

Well what I tell them is I say, '*John* has PTSD, which obviously you're not aware of because if you were, you wouldn't close his door, and the music helps relax him. So I don't know who shuts it off on the TV.'...Their response is, 'Oh, we know about PTSD.' And I said, 'Well you don't or you wouldn't shut the door.'

Participants most frequently reported concerns about temporary/casual staff, particularly regarding their knowledge about the resident:

But when you have caregivers that are from any agency or fill in, they don't know the person. They're supposed to read the profile... They don't read the profile. When you have somebody that comes in and says to you, '*John* can walk to the washroom, cant he?' And I looked at her and say, 'You didn't read about him, did you?' 'Yeah', I said 'then you know he's a two-man person to get into bed and he has to wear pants, and he can't walk. So I think you better go back and read it, okay?' (Participant 844)

Participants were observed to diminish staff's training in response to frustration in managing ongoing care-related issues. For example, Participant 795 described her frustration with staff after multiple conflict episodes related to medication administration:

And she was very kind but I don't think she understood the importance. That was what I thought. The LPNs, I thought they must take a two-week course of no value and they don't really understand medications or the importance of certain medications.

Notably, participants reported escalating their concerns about front-line staff's level of training to managerial staff, with requests for further education and training, or performing the care duties themselves. For example, Participant 844 described:

You know and I just said -- I-I went to *Jane* [floor manager]. And, I said, you know, I said, 'These girls should be trained better.' She said, 'It's not their fault.' I said, 'I-I feel bad getting pissed at them.'

This participant indicated that her concerns about staff's knowledge impacted the manner in which she managed care-related conflicts by directly demonstrating to the staff member how she wanted the task to be executed:

I was just like- I was just 'Oh I got thanking Jesus Christ, you don't know what I do to myself, you don't know what the f- you are doing, why are you here?' sort of thing. I was like- I was just so- but I just-I counted to ten and I went in there and I said, 'Jesus, well he doesn't-no, he can't stand.' I was very calm but you know I thought it's not gonna help to get -- that was one of the time that I just say, 'Ok, this is how you do it.' and 'Oh', she said, 'I didn't know that.'

Overall, seven participants described questioning staff's knowledge openly when managing conflict episodes, either directly with the staff member as part of confrontation or raising it with managerial staff. Participants identified areas of inadequate knowledge and skill, made suggestions for staff to enhance their knowledge through identified training opportunities (e.g., bringing experts into the facility for workshops) and provided direct instructions to staff.

Trying to work with staff to resolve the issue. All of the participants described attempts to work with staff to resolve care-related issues. However, participants remained skeptical whether staff was genuine with them (in their intentions and actions), and/or was going to fulfill their end of the mutually decided upon plans when managing conflict episodes. Some participants described being distrustful, suspicious, doubtful and wary while managing the conflict with staff. For example, Participant 370 described trying to piece together information concerning a potential fall her father may have had. However, due to previous conflicts with staff regarding care-related issues not being documented, she remained suspicious of staff's reports on her father's condition:

So, I popped it back together and put the shade on, but they were like, 'Well, no one said anything to us.' Like, nobody said anything, so that, you know, it just wasn't even in their mind that he would've fallen, right? So, and I guess I had mentioned it to the first – the LPN initially, so when she came down with the other

one I said, you know, 'I think he could've fallen, he's got kind of a scrape on his nose, and the lampshade's not right, and his glasses are all bent up.' And it's like, 'Oh well maybe he just scratched his nose,' [scoff] and stuff like that, and I'm like...whatever...Well, it just kind of like 'Well nobody told me that.' Like, 'The staff would've said something,' you know. And I just said, 'Well, you would hope that they would've said something,' you know. Didn't really get a response from that, but...So, I was just kind of thinking – and then as I got home, I was thinking more and more. It's like, well he didn't sleep on his glasses [laugh], he must've fallen, right?

Participant 468 echoed these concerns by suggesting that her attempts to work with staff on an issue were being impacted by staff avoidance and lack of clear answers,

Too busy. It's almost like when you come in-- and I know this is an exaggeration, but it's almost like they scatter and hide. And if they see you or if they know that you're trying to hunt somebody down to get information or ask the nurse something. It's like, can't find her, you know. Can't find them, whoever. And everybody you ask shrugs their shoulders, 'Don't know, don't know. Wasn't here. Didn't hear whe-- .' If I ask the nurse, 'Oh, that was yesterday. Oh, let me see if there's something in the book. Well, nothing's written about it in the book.' So all these unanswered questions.

Participants believed that the willingness to work together was one-sided at times, thinking that staff did not want to share information with them, or were "hiding behind confidentiality", with avoidance of family caregivers and limited disclosure being construed as ominous (Participants 477, 625, and 844). Moreover, instances of feeling invalidated by staff when seeking to work together also increased suspiciousness about the quality of the shared information and validity of care decisions:

I consulted with the care attendant who indicated to me, she seemed like she was fine, didn't seem to think that there was any issues. But with my visiting my grandma, she was having spasms, she was chanting in pain and elevated screams which were very concerning -- to myself and my children. So again, I approached staff with my concern that I thought that my grandmother may have a urinary infection and wanted to know if they would possibly do a culture swab for her to look at ruling it out as a yes or a no. And they said no. That they didn't think that was warranted and so that they weren't gonna do it. So I was left feeling kind of unvalidated, if you will, and maybe that my grandma's health care and concern was just kind of non-important. Um, so I left a message for the RN. The RN called me and said that she'd spoken to my grandmother who had indicated that she had some pain. But they were going to just administer

morphine to help with the pain and that was the end of the conversation... So I indicated to the RN that maybe I should come and take my grandma to the hospital where they would provide a test which could rule it out other, you know, being a yes or a no to this UTI. So she said she'd talk to the doctor about it then the doctor actually contacted me and said that, you know, they don't wanna waste money. (Participant 671)

Despite the challenges with staff recounted by participants, six participants did report instances of working collaboratively with staff to manage a resident-related issue. These instances of collaboration occurred in situations where staff was responsive to family caregivers (e.g., initiating a follow up sheet following a fall-related concern).

Participant 625 also emphasized a collaborative approach when dealing with management of the LTC facility on behalf of the family group. She advanced a reciprocal approach between families and staff to managing identified issues,

... we kept saying, 'We're not telling you what to do, don't take it that way,' but, you know, lots of us are from the professional communities and you go to a manager and they want to know some ideas. I said, 'Just take these as ideas, take it or leave it,' but, we're always going to try and provide some suggestions. Like, you know, did you consider this/consider that. I says, you're probably are, you know, already on top of it but we're always going to do that and don't take it – and she was fine with that. So, we always provide suggestions and we also like, provide, what can we do, right. The question, what can we do? What can we do to help? So, we're there to help as well. Not just to criticize. So, so you know, the care manager was working on some of this stuff.

She underscored that a family caregiver's role was not solely to criticize but to offer help to staff in effecting change and provide praise. She suggested that family caregivers needed to allow time for issues to be addressed by staff and to accept constructive criticism from staff.

Overall all of the instances of collaborative approaches to conflict management contained an element of wariness and mistrust. Participants described trying to work through care-related issues with front-line staff, management and physicians, to variable success, either because of the way that staff responded to them or due to previous

issues with staff. Participants became easily suspicious of staff if they did not receive the information that they sought, experienced avoidance or if their opinions were not supported by staff.

Additional themes. Other themes described by family caregivers, at lower frequencies (e.g., reported by 3 participants or less) included, bringing up an issue with staff and "dropping it" (i.e., families perceiving that there is "no point" to further fighting), obtaining more information on the issue from staff who are not involved in the conflict (e.g., finding staff members who would divulge information deemed confidential by other staff), filling out feedback and complaint forms, having a meeting with staff to discuss the issue, telling the resident to address the issue and using reward and praise to improve their relationship with staff and meet their care goal. Some families additionally indicated avoidant approaches to managing conflict, stating "what's the point in talking to staff" about an issue and indicated that they should not have to manage conflicts with staff in LTC (i.e., viewing the conflicts as unnecessary and not a part of their role).

What barriers and enablers did family caregivers encounter when managing conflict with staff?

Participants recognized both barriers and enablers to managing conflicts with staff in LTC. Barriers included not having ready access to staff with influence (e.g., managerial staff), communication issues with staff, becoming upset with staff and staff-related issues (e.g., staff not being equipped or trained to deal with situations).

In regard to access to staff, participants reported not knowing who to turn to as well as having difficulty identifying and locating appropriate staff to manage the conflict with. This was particularly an issue for participants who were primarily present at the

facility in the evenings and on the weekends, when managerial staff was unavailable.

The access to staff issue may have contributed to inability to immediately address issues and additional frustration, as Participant 477 described:

Well, the immediacy, I guess... there's just that lack of -- you know, trying to get hold of people, trying to arrange times where you can speak about things like this, it's few and far in between.

Communication was a commonly identified barrier to conflict management.

Participants reported challenges in having to communicate with multiple staff members (e.g., being passed from one staff member to another), getting someone to listen to them, lack of validation when speaking, being instructed not to speak with staff (i.e., managerial staff asking them not to address conflicts directly with front-line staff), lack of consistent relaying of information between staff members, lack of transparency in communication, and staff being argumentative. For example, Participant 477 expressed her challenges when posing questions to staff, which was further exacerbated by limited access to staff:

Oh well, not getting- being able to get in touch with people when I needed to. And unwillingness to discuss certain things like... who actually did put this here? Why don't you have things set up on weekends to help family members? Why wasn't I alerted that he was being treated like he had days to live? And, why didn't you tell me that?

Staff's level of English proficiency was commonly described as an impediment to clear and effective communication, as participants reported lacking confidence that staff could comprehend their comments, questions and concerns, and would in turn, have difficulty communicating with the resident. Participant 370 described her personal challenges with staff understanding her:

This person has said to me, 'Well we all speak English here'. I didn't really say anything at the time, but I mean yes – maybe they do have a grasp of some English, but if you go outside the routine sentences that you would use in that

kind of an environment, I don't think there is an understanding for a lot of people there...Well, when you're trying to explain what you think had happened, they just, um...I don't think they really, like, they catch it, but it's hard for them to explain it even back to you, I guess, as to what happened....it makes it difficult, and when they're trying to tell me what's going on they – a lot of times I find it hard to really follow. I'm not even sure what they're saying sometimes, but you don't want to continually go, *pardon?* or whatever. They're always going *he* for *she* and *she* for *he* and – and all sorts of things, and it's kind of hard to follow...I usually just kind of suck it up, and if I can't quite catch it, I'll have to ask somebody tomorrow, I guess. [laugh]

Lack of acknowledgment and validation when communicating with staff was also noted by participants as a barrier. This ranged from being noticed and paid attention to, with Participant 906 describing, "Getting someone to pay attention to me, to listen to me, to – to even ask me a question. That would be helpful." As well as being validated for what families shared with staff, as Participant 671 described:

The validation...Right? With-with my grandmother and just feeling like, you know, it's a battle whenever I go to them and I say that I think that there's a problem...I just feel that they just think that well, you're just family and maybe you do -- because you don't have a medical field degree, that you can't possibly really have the information that could be valid and supported as being accurate.

When discussing factors that enabled conflict management, participant outlined both family- and staff-based characteristics and actions. Family-based factors included acknowledging staff efforts, forming relationships with staff, going to management, threatening to obtain assessments and treatments outside of the facility, having time to be at the LTC facility, being patient, being a man, being persistent and insistent, focusing on a main issue to avoid "burnout", hiring a private caregiver, bringing own experience and knowledge, and prayer.

A couple of participants emphasized their own professional and personal knowledge as significant aids when managing conflict with staff, including having

specific training in conflict management. Participant 477 described how her own course work was beneficial to her but felt disheartened for other families in a similar situation:

My own experience, like, my palliative care training and, you know, level coursework I've done in -- on a daily basis. I'm in the social work and advocacy and I'm just -- I don't wanna let things slip under the carpet, you know, I'm going to get things addressed, but even then, that's actually brought that, it emphasized to me the importance of that, because if I'm having difficulty and I have that skill set -- what are people doing who are 80 years old themselves, have a spouse that's going through this, how are they dealing with it without some of that background and some of that strength to, you know, advocate and, you know, change things for the better. So that's a bit heartbreaking I got to say the whole experience was really upsetting.

Participants mentioned the importance of staff acknowledgment when managing conflicts. Participant 625, with her experience of years of conflicts with staff as a family caregiver and group facilitator, in addition to previous training in facilitation and conflict management, described that such acknowledgment was seminal to conflict management:

Well I tried to acknowledge that, you know, thanked them for bringing Alberta Health in to help answer my questions -- I tried to acknowledge as much as possible. Because I think they tend to be, and this new management is 100 times worse [laugh], very defensive, right. They tend to automatically go to the defensive, right? So if you can acknowledge some things that they're doing right or some things that you appreciate, it might help bring some of the back down a bit -- the tone down a little bit, you know [laugh]...So I always try to acknowledge something when I'm talking to them, you know. And I, you know, thank them some time during the conversation about, well I really appreciate you bringing somebody in over the long weekend 'cause I was really concerned about that, and I do appreciate that. You know, so. I'll say, even though I'm really -- I seem -- you can read it on me, I'm really agitated, you know. I want you to know that I really do appreciate you doing that because I realize that's a cost to you.

However, she noted that it can be challenging to communicate the acknowledgment when you are emotionally involved in the conflict. As well, she cautioned that staff can become focused on only hearing the positive feedback that families provide, leading to ignorance of the main issue, thereby suggesting potential negative effects:

..that can backfire because I know with this. it was the previous executive director, with her you had be careful because she would only hear the positives and forget all about what you were actually there to discuss [laugh] the – you know? [laugh] So you have to be careful with that as well. She would hear just all the positives – oh aren't we doing just such a good job [laugh], you know, and it's like, yes but – you know, there's always room for improvement...So, you have to be careful with that, but yeah I – I think it is generally good to try and acknowledge...(Participant 625)

She further encouraged families to form relationships with staff to help them gain more information about the facility and conflicts. However, she acknowledged that relationships cannot be formed with every staff member but that families could select a "good one" that they could approach, trust and speak to when they find themselves in a conflict:

...it kind of helped trying to develop relationships with people, you know? It was helpful because then you will open up and trust. Um, you can't do it with everybody because there's just so many of them and such turnover, but, um, that's the advice I give. You know, try and find somebody that you can talk to, you know? (Participant 625)

Although participants reported a significantly lower number of staff-related enablers, they mentioned that it was helpful to have trust in a staff member, when staff provided a solution, staff attending to the resident during the incident, and staff's communication approach with families, with the latter being the enabling factor most frequently mentioned. Participants described being attended to, listened to, and perceiving a genuine attitude was helpful:

...what really helped the most and made me feel better was being able to go in and talk to *Jane* [floor manager] for her to say, 'Sit down.' And, not just to say, 'Yeah, okay I'll deal with it,' and kinda shove you. 'Sit down,' and she says, 'We'll talk about it.' I think that's what you know helped...

She [nursing attendant] just kind of listened and when she realized what had to be done, she did it...Because then I knew that the next time she came on, she would know what she was doing and I wouldn't have to worry about my dad falling and injuring himself...It's just her attitude. She just said 'I'm very sorry.' she said, 'I just didn't know.' and just you know that-the way she said, she sounded

very sincere and you know and then she said we've done everything and like I said then I knew for sure when I came the next time a couple of weeks later she was on again... She was a 100%. easy to ,you know, to accept, she didn't take it as criticisms but just an explanation and she dealt with it, whereas they were saying, 'I've worked here long enough and I know what I'm doing and I don't need you to tell me.'...Yeah. And it made me feel-I went home and I was complete, I felt really good...I think some of the staff that have been here a long time, they don't like being told...'Cause they think well they've got their own way of doing things and this is how they're gonna do it. (Participant 844)

Overall, participants were generally focused on identified barriers to conflict management, which they predominantly attributed to organizational and staff influences. Most of the enablers were deemed to result from their own actions, with some acknowledgment of staff-based influences that were limited to specific staff members.

What concerns did family caregivers report when managing conflicts with staff?

Participants reported a number of concerns while trying to manage conflicts with staff, which included concerns about resident's well-being, retribution, adversely impacting their relationship with staff, not being heard, understood or taken seriously, and whether staff was able to do what was asked of them.

Participants expressed concerns about residents' health and safety that were consistent with what the conflict was about (e.g., medication, blood pressure, fall, etc.), and mentioned the concern as the force behind direct approaches of conflict management (e.g., repeated pursuing of an issue, confrontation). Half of the participants reported concerns about retribution, which they described as concerns that staff would take their frustration with families (as a result of raising issues with staff and/or being involved in a conflict) out on the residents. Participants underscored residents' vulnerability because many lacked the ability to ambulate and/or communicate. For example, Participant 650 described regularly checking for bruises on her husband's body, and being continuously present to monitor any mistreatment:

Well, the concerns are, that when you're not there, that this caregiver doesn't take it out on your husband because you've been so vocal about the situation. That's one of my big concerns. And he's not mobile in any way, so they can take it out. I don't ever see any bruises or anything. And God help them if they did, but that's a big concern...and they know- I'm there all the time...Because I-- they never know when I'm coming in.

Other participants were concerned that the resident would be given a poorer quality of care or that staff would be "neglectful", as illustrated by Participant 795, "Well, I think my concern was always my mom because I thought, 'Oh my God. They may -- if they don't like me or, yeah, they'll treat my mom poorly-they'll give her poor care'."

Participants reported concerns that their relationship with staff would be adversely impacted following conflict episodes, including being disliked by staff (Participant 795) and being perceived as "bossy" (Participant 468, 795, 844). Changes in staff's perceptions of family caregivers when raising care issues was a source of worry, as described by Participant 468:

...there's always that concern about if - if you - they think that you're a b - - - h, then will that affect my dad's care? Um will they be even more uh -- communicate less with me? I mean, it's bad enough now. There are a couple of them who are quite talkative with me and will tell me. But for the most part, they- they steer clear..I think there were concerns, yeah, about that if I get too squeaky... I have had times like that, when a major incident has happened. And they can see by the look on my face that I'm -- I want answers and I -- and I'm not happy about what's happened with my dad. Um, yeah, then they-they avoid and I-- and I get the cold shoulder and I get the whining and crying. And if I do happen to corner one of them to get-- try to get questions and I-I get the reverse. Where I end up listening to their-their issues...

Do family caregivers find their conflict management effective?

The majority (7) of participants described being effective in managing at least one of their described conflicts. Conversely, four participants described being ineffective, and another five reported being unsure about the effectiveness of their conflict management in at least one situation.

Participants who reported their conflict management as effective resolved the conflict or received increased attention from staff, spoke to staff (RNs and managers), and were hopeful that staff learned something from the conflict that would assist the resident and others in the facility (Participants 370, 671, and 795). One participant mentioned being aware of her "conflict style" ("compromiser"; Participant 625), noting that she just needed "a little bit" from staff and that she was willing to meet them halfway, however, she indicated that "it's like pulling frickin' teeth to get just a little something". Notably, she reported that this awareness and knowledge of her conflict management assisted her in managing conflicts at the facility.

The majority of participants indicated that the most effective aspect of their conflict management was raising the issue directly with staff and increasing awareness that an issue exists by voicing their concern and bringing it to staff's attention. Participant 650 described approaching staff even when it was unpleasant for her to do so, but was an important part of her role as a "wife and advocate":

Being able to talk to the nurse and feeling like they will go and talk even though I have said something I don't like. They will go and they have to because they have to write something 'cause I approached them about it. Um, and then I-I watch to see if I feel they've listened.

Participant 844, whose phone calls to her father's unit went unanswered that led to her making phone calls from her neighbour's home, indicated that making staff aware that she knew that they were avoiding her was seminal in being able to address this communication barrier with them:

I wanted them just to know that, you know, yeah okay, you could see my phone call coming up...If I have to go somewhere else, I'm gonna do it. You know, it was, it just kind of was letting them know like I know what you do and I know what's going on. And I just want you to know that I know... 'Cause for the next while it seemed when I phoned, the phone was answered. You know, maybe I'd phone once and it wasn't then I'd phone back in ten minutes and was answered.

Moreover, family caregivers reported being persistent and insistent as key to having effective conflict management. Participant 671 illustrated the level of insistence that families described as required to attain their goals, taking on a "not taking no for an answer" approach:

When I became really insistent with her [RN], that I thought that my grandmother had a UTI... Well, I just kept telling her that, you know, 'Well, if you believe that she actually doesn't have a UTI, how about you do the test and humor me with the fact that you do the test and it comes back negative. And then, you know what? Then I guess I was wrong. But I honestly don't feel at this point that I am wrong, so if you could please just do it to verify one of us is right and one of us is wrong and we could just move forward and not that I'm gonna now, you know, smear it in your face when it comes back positive, that I told you so, but humor me.' Right? So at that point then she said, 'Okay, fine then, you know, I'll test and see.' And then she tested and she called me back and said that her cell count was out of whack and that they were going to send a urinary culture off to the lab. And then it came back that she needed antibiotic...I didn't back down from her, and I think that she kind of knew that there was a point where either she did the test, or I was going to take my grandma, right to the hospital to get further testing. Right? And I had indicated that. Like, either do it or I'm gonna take her.

Restraining their emotional reactions by being calm and polite was seen as important with families reporting their overall demeanour playing a role in the effectiveness of their conflict management. Participant 844 mentioned how expressing sympathy for staff and adopting a pleasant demeanour helped her feel heard by staff and feel better about her reputation at the LTC facility:

I said, 'I understand that you guys are understaffed and everything and you do get busy.' I said, 'I understand that.' I said, 'I couldn't do what you do. I really couldn't because I wouldn't have the patience.'... 'But, when girls are doing nothing, there's no education.' I said 'there's no reason why this can't be addressed.'... 'I feel bad.' I said, "you know, like, seems like I'm always b - - - hing about something and everything.' I said, 'Like, you know, w-what can I do?' Sort of thing. It maybe made me feel better 'cause I felt like such a b - - - h, complaining [laughs]. But, I find you get a lot more with some honey than you get with-- with the vinegar.

Similarly, Participant 625 described the importance of maintaining a cooperative approach. However, she also mentioned being criticized for her approach to conflict management by other family caregivers at the facility who urged her to escalate:

You get criticisms which makes you think. Some people think I should've been tougher or more assertive/aggressive. Um, possibly. But I also, my own belief, is that, well first of all I'm just not that type of person, but also my own belief is that if you're – it's a fine line. If you're too aggressive, then they're going to cooper – you know, you try and do it as nicely as possible [laughs]... you're trying to get something from somebody. You're trying to get cooperation. To be really in-your-face aggressive, I don't think gets you there. But, again, that's just my own personal belief.

In terms of what was unhelpful, participants reported being confrontational, creating relationship strain with staff, and speaking up, challenging and querying staff. Six participants said that being confrontational was unhelpful, with the majority indicating that "getting upset", "being curt" and/or "agitated" toward staff was the most detrimental. When participants reflected on their actions, they reported wanting to have acted differently in the situation but having difficulty doing so and being "caught in the moment" (Participant 795).

With regard to relationship strain, participants were concerned about how their actions during conflict episodes impacted staff's opinion of them. Participant 370 described the type of reputation she believed she gained by repeatedly raising issues with staff:

I'm not sure, but just by pointing it out when they didn't find everything – I guess it – is one thing I guess that crosses your mind. I mean, it wasn't one thing, it was one, two, three, four, [laugh] you know? It was like, at what point do they, you know, start to think, 'Well, we've gotta get rid of this woman 'cause she's bothering us on a daily basis.' [laugh] ... I don't know what they write down. See, if it's not written down, then it's not in their reports, right? So, maybe it doesn't matter to them. I don't know.

Although participants reported that raising issues with staff was helpful, a third of the participants interviewed reported that questioning staff's actions may have deterred from effectively managing conflict. Participant 477 described her beliefs that raising issues was viewed negatively, even though she received support from the facility director:

Well, I think anytime you speak up and challenge anything, it's not necessarily taken favourably. Even if you're diplomatic about it...I can remember even saying to *Jane* [facility director], you know, 'I'm only-- I'm saying this because I really believe that if you don't speak up, things won't change and things don't improve. You know. It's -- it's important that I bring this to your attention.' I mean she- she agreed.

Overall, the majority of the sample reported their conflict management as effective. The aspects of conflict management that were noted as ineffective concerned their use of confrontational conflict management strategies, that were commonly employed by the participants in this sample.

Staff Conflict Management

Participants described staff engaging in a wide range of conflict management strategies. Almost all (9) participants reported staff working with them on the care issue, followed by the majority (7-8 participants) reporting staff deferring the issue, being avoidant or passive, being confrontational or defensive, and "not doing anything". Additional themes included staff demonstrating authority or power and accommodating families.

Participants reported various manners in which staff worked with them on an issue by accepting and validating what they were saying, acknowledging and addressing the issue that was raised, organizing a meeting for the key parties to discuss the issue, providing an apology, following up with families, and providing explanations to

foster families' understanding. Participants also described staff as confrontational and defensive when managing issues with them including expressing anger, denying the presence of an issue, and being abrupt. Staff was additionally described as accommodating by following family caregiver's instruction (i.e., became compliant to family caregiver's requests following probing or escalation), moving a staff member to a different ward, and saying that they will look into a matter for them.

Conversely, participants reported staff being avoidant and passive when managing conflicts, by not responding to families, including not speaking to them, saying "I don't know", not returning calls, and avoiding accountability. Another approach that was differentiated from avoidance, was staff deferring the issue, which consisted of families being passed on from one staff member to another to deal with an issue (e.g., told to speak to a different staff member), being "put off", and being deferred to a doctor, a manager, or director, or to a case conference meeting. Participants also described staff demonstrating their power and authority when engaging in a conflict by being dismissive of their concerns, denying their requests, instructing family caregivers to only speak to managerial staff, questioning what family caregivers had to say, reporting family caregivers to management, enforcing a rule for family caregivers to follow, and demonstrating that their knowledge and power are superior.

In terms of effectiveness of staff's conflict management, the majority of participants interviewed (9) indicated that staff was ineffective in managing the conflict situation. They cited a number of approaches that were ineffective in managing conflict, such as staff being confrontational, denying the presence of an issue, and being unaware of what was going on. Defensiveness, sarcasm, and "nonchalant" demeanours

were described as unhelpful and were noted to escalate conflict. Participant 468 described her dislike of "the defensive attitude of, 'How dare you hold me responsible? It's not my fault, so don't take it over to me. It's not my responsibility,' when trying to manage conflicts with staff. Participant 650 mentioned that staff's tone in communicating and their demeanour escalated her conflict management to managerial level, when staff said "you're late" to her when she arrived to the facility, and "is that to your liking?" when she asked staff to change the resident's clothes.

Participants reported that staff would deny the issue, minimize its significance, and were avoidant of conflict management. For example, Participant 844 described the lack of interest in wanting to address her concerns, "It was just like an attitude -- 'Well, these things happen. They all have falls sort of thing. They didn't really feel like they wanted to address it.'" Repeated denial of the issue was mentioned to result in further escalation of conflict and confrontation between the parties, as illustrated by Participant 650, "Oh, by keep coming at me and trying to talk circles like, that she didn't do that. When I'm sitting there watching it, you know. Trying to cover her ass, but it wasn't working."

Participants also reported that staff lacked knowledge about care issues and were, resultantly, unable to effectively address it in the moment. For example, Participant 625 illustrated the challenges she experienced while being provided an update following resident-to-resident aggression,

Because the poor girl I'm sure was told to just downplay it, and it was obvious [laugh] that I think – if I had to look back, she probably – it was obvious she was uncomfortable saying what she was saying. And didn't know any information. And, why did they have her call? You know, without any information, and that just – yeah, made it worse. So they put her in a bad – in a difficult position, which – and I didn't blame her, like I say, I didn't blame her, I said, you know, it's not your

fault nobody left you enough information [laugh] you know. I think that something that serious, maybe the care manager should have called and, or, you know, offered a meeting.

Five family caregivers described staff as effective in conflict management for at least one of the conflict episodes that they discussed. Helpful approaches included receiving support from staff, having meetings and developing action plans, paying more attention to the resident and actively working on the family-staff relationship. Receiving support from staff was most frequently cited by participants which included speaking to the doctor or with managerial staff, speaking to staff members who had an open and amiable demeanour, and staff offering help, acknowledgment and saying "sorry". Participants mentioned that speaking to staff in managerial positions who were new to the facility as helpful because they were not "tired of whining and complaining" (Participant 650). Participant 844 reported that receiving support from managerial staff in addressing the conflict with a NA was helpful,

I guess 'cause she just sat down and we talked. She says, 'Well come on in have a chair and you know close the door.' And, we sat to talk and we knew what was going on and you know everything. And she said, 'I'll address it.' And, she did address it. I know she did address it. I know they had a meeting you know 'cause it was a sign on the board, this meeting with *Jane* and staff from blah, blah, blah sorta thing, eh. So, I mean she does, she tries to -- I saw her the other day and she said, 'Well, hi, how are you?' I said, 'Fine.'...Yeah, it was-- it was effective 'cause at least if they knew it was coming from her, and she's the manager sort of thing, up the floor. So, it kind of, she's got a little bit higher, you know. So, they think they were on their p's and q's for a bit.

Participants also reported receiving support from front-line staff who immediately intervened in the situation, which they described helpful in addressing the issue and in calming them down:

Well the nurse sending me down to have a cup of tea. Sending me away from the situation and settling my husband down. Which wasn't going to work with me, because I'm supposed to be his guardian--his advocate and I let him down. So with me being there, he would still be agitated and upset. And she got somebody

else to come in and wash him down and get him cooled off and put a new t-shirt on. And- so I feel the nurse knew how to handle it. (Participant 650)

Staff's demeanour was noted as important in establishing trust with families and de-escalating conflict situations, as a family group facilitator described an RN who attended the family group meetings at the facility,

I think what was working with *Jane* was that she was very open. So, she did develop trust with the families, she acknowledged when things weren't working, and she had an answer or a plan at least of, this is what we're going to try, give us a couple of weeks, you know, we're doing this in-service training, we're doing, you know. She had an answer for things. So, I think families feel, I mean all you can do is try. At least you're trying. They trusted her, that she was trying her best. And she was an RN and very knowledgeable, and she was open, and she wasn't afraid to talk to us.

Although participants saw meetings as helpful in effectively managing conflicts, two participants reported lacking notice that the meetings would occur. The lack of notice and the attendance of several staff members contributed to family caregivers feeling unprepared and outnumbered. For example, Participant 795 described her experience:

...had they given me notice that 'Oh, we're gonna have a meeting tomorrow or Monday with regards to, you know, the incident or you know we've had some complaints obviously about some of the staff has complained about you or we can bring up, you know, any issues you have. So I think the meeting idea is a good idea. It's just -- I wasn't prepared for it and it kind of threw me off guard.

Participant 671 highlighted the benefit of being able to address her relationships with staff during a meeting:

There was one kind of inadvertent one when I had a meeting with the RN and I had a meeting with the floor manager just to kind of make sure that there was no uneasy feelings from me towards the RN and from the RN back to me and-and at which point I indicated to the floor manager that, "No", I mean, "I will still go to her and say --" And when I have a concern, you know, and however that resolves-will be however it resolves. I.e. I go to here and I say, "I believe my grandma has a UTI" -you know, right? "Can you test her?" She says, "No." I'm just going to say, "Okay, fine, and then I-- at which point then I'll just take my grandma elsewhere in order to get her tested." ...Well, I think in some senses, it was helpful because

of the fact that we walked away knowing that there was no hardships felt on either side of the board, so that she feels like she can contact me and say, "Oh, I have a concern or I have a question about your grandma." Knowing that my door is open 24 hours a day. If you need to call me and ask me something about my grandma, by all means, call me. Right? You-you-you know, and I can feel like I can still go to her with a concern and it may or may not be addressed to the level that is of my satisfaction but if it's not, I don't have a problem to go outside of the care facility to get that to happen.

In sum, the majority of participants perceived staff's conflict management as ineffective, frequently citing that the staff did not do "anything". Power dynamics were highlighted in discussions of staff's conflict management, as participants were acutely aware of staff's greater authority in the facility during conflict episodes. Therefore, staff approaches that reduced the power differential were deemed to be effective in managing conflicts whereas those that increased the power differential escalated conflicts.

Outcomes of Family-Staff Conflict

Participants reported a number of negative and positive outcomes of the conflicts they experienced with staff, with negative outcomes being more frequently reported than positive outcomes.

Negative outcomes of conflict. Participants described a wide range of negative outcomes including feeling invalidated, escalating the conflict, staff not speaking to them, and staff calling family caregivers abusive. The most frequently cited negative outcomes consisted of emotional reactions, loss of trust in staff, and feeling unwelcome at the facility.

Specifically, participants described feeling angry, frustrated, helpless, hopeless, guilty, and even "traumatized" as a result of managing conflicts with staff. Anger was the most commonly described emotion throughout the interviews and present at different

points of the conflict episode. For example, Participant 625 described how her anger impacted how she related to staff over time:

Because I'm always fighting. I'm always fighting for her to get the right pill. Fighting for her to get more – more of the right pill ...and I hate going there. I hate even going there, because I get there and I get so mad because I'm thinking of all these things that they're so...nonchalant about it, I guess.

Another family caregiver (Participant 906) described anger and helplessness in response to having a lack of knowledge in how to approach the situation:

...so I feel that what any further dealing about this situation is not gonna do anything. So, it's left me feeling kind of angry and frustrated, and I really don't know what to do. I don't know who to ask, or who to talk to anymore.

Having a sense of hopelessness and helplessness was shared by several participants.

Participant 468 described the negative sequelae to feeling helpless:

...when you feel helpless and hopeless to making a change, I think it's a survival instinct to stuff it down because it's crazy making and there's sleeplessness and you almost have to cut yourself off and become numb and, you know, and it does surface at times but I mean, you could drive yourself crazy with worry about the potential and what could happen...

Similarly Participant 477 provided insight into how much of the conflict was seen as under staff's control by families,

...you feel so helpless, and you know like, like I said before as much as you know and as much as you're trying to make things improve, it just-- it just seems to get lost. You know, like it's just the system, the way they do things is, it's just-- if that takes precedence over anything else over the well being of the people and their family. And, um, I -- so I know I'm limited.

Participants differed in the degree of helplessness they experienced in attempting to manage conflicts, ranging from specific situation-limited to being felt across situations, as mentioned by Participant 906, "cause I can't seem to get anywhere. It's like I'm banging my head against the door and it's not opening."

A common outcome of conflict was loss of trust in staff to act in the best interests of the residents. Notably, violations of family caregiver's trust were generalized across

care tasks and projected into future concerns, with participants reporting becoming suspicious of "everything" after relatively minor challenges encountered with staff (e.g., staff being unable to state when the doctor is coming). For example, Participant 906 had a conflict with staff regarding her mother's blood pressure medication but then indicated, "so then I worry about any medication they're giving her".

One family caregiver (Participant 650) recommended having a "secret caregiver" system akin to the secret shopper system to record the interactions in the facility. Some participants (Participant 844 and 650) did observe improved interactions but continued to doubt what occurred in their absence, or with staff that was not permanent (e.g., Participant 468, "I think they genuinely do care about my dad...I see that they talk to him respectfully, and, now again, that's when I'm there").

Some participants did not have trust in managerial staff because they did not believe that managers knew what was occurring on the wards with the front-line staff and the quality of care provided. Concern was expressed that staff "cover" for each other and focus on protecting their jobs, which further impacted trust. Even when participants had a degree of trust in a specific staff member, they continued to express concern: "She, obviously, has too much going on and can't keep up with what's going on. I think she probably means well but is over- overrun with issues." (Participant 795). Overall, greater trust was reported for regularly scheduled staff and staff that family caregivers had relationships with, when compared to temporary, weekend and night staff. However, participants indicated that a single positive relationship could modify attitudes about trust:

I don't trust them, yeah, to do the best thing for my mom. I guess now they're doing it, but at least I know now I can bring up some issues with the nurse and

she is paying attention to me, and she will give her input or do some of the things that are proactive, I guess. I mean, she's really – she really changed her attitude. I've changed mine, too. (Participant 906)

Residents' progressing cognitive deterioration posed a further challenge in determining who to trust when it came to issues in LTC. For example, Participant 844 recounted a conversation with her father who has been diagnosed with dementia:

I said, "What happened there?" He said, "Well somebody scratched me." And, right away they said, "No, no, he probably just scratched." Right away you know, "No, that didn't happen." You know they think well he's just you know thinking that happened. And, I mean I know my dad has dementia, so who do I believe them or him?

Following instances of conflict with staff, participants reported feeling unwelcome in the LTC facility. Participant 671 recounted that staff was "reluctant" to let her into the facility, whereas Participant 795 reported that she felt that staff became aware of her as a problem, as if she was being "watched": "Now I'm an issue there that they were already aware of me, whereas people would come and go to visit somebody."

Positive outcomes of conflict. Participants reported positive outcomes of family-staff conflicts at a lower frequency than negative outcomes. Positive outcomes consisted of receiving feedback from staff, staff paying greater attention to families' concerns, reassurance, and development of documents by a family group that outlined family and staff's roles and responsibilities. The most commonly reported positive outcomes consisted of attaining a practical goal that was a part of the conflict (e.g., gaining access to the facility, receiving better quality food, administering a requested medication) and feeling grateful toward staff (e.g., for providing care, providing a novel solution to the issue, making a contribution).

Change in the opinion of the LTC facility

Participants reported having a changed opinion of the facility following conflict with staff. They described that their initial expectations of the facility were unmet, as Participant 906 succinctly stated, "they're [staff] not doing what they said they would do". Specifically, participants expected that better care would be provided and that they would have open communication with staff:

I didn't think they were very good, but now I believe, yeah – they are worse than I actually thought 'cause I did think mom was fairly safe at least. I thought she was at least safe there, maybe not clean, not always fed, but at least safe. And now I realize that that's not necessarily the case. So, yeah, it really, you know, any little bit of naivety that I had like, gone! (Participant 625)

A couple of participants said that they were taking on staff's responsibilities because their care expectations were unmet. For example, Participant 671 described how her role expectations were violated:

My opinion on the care facility has changed somewhat because I just don't feel like I need to be doing staffs' job. I am a family member, I don't have a problem maintaining that title, but if I have to feel like I need to switch on a regular basis from being family member to care facility aid or RN or emergency nurse, I don't think that that should be a part of my bucket list, to come to visit my grandmother in this care facility. 'Cause why are we paying \$1600 a month for my grandmother to be here, right?

Participant 795 who experienced a shorter-stay in LTC reported that families were unwelcome and that her opinion shifted toward the preconceived negative notions she had about LTC (i.e., from the media):

Like in the news you hear-you hear about, you know, the lack of care for the seniors and that they don't get their diapers changed and-and they have bedsores and they don't want families to know what's going on and-and I thought, 'Oh my God, it's true'. They don't want family around. I definitely felt like they didn't.

On the positive end, one family caregiver (Participant 844) pointed out that despite the conflicts that she had, the LTC facility that her father resided in continued to be one of the best in the city, and she maintained a positive opinion of the facility. However, her opinion was in the minority, as the majority of participants (i.e., 8 out of 10) indicated that their opinion of the facility had negatively changed.

Changes to Family Caregiver's Role

Approximately half of the participants reported changes to their role in the LTC facility following conflict with staff. Some reported an increased need for involvement in the facility and becoming an advocate, whereas others reported a need to keep a "lower profile" and diminishing their advocacy role.

Participants described increasing their involvement in the facility, whether through increased frequency or duration of visitation or greater involvement in care tasks, beyond what they had anticipated or would have preferred as part of their role. This involvement was provided out of perceived necessity as they reported issues with trust in staff. For example, Participant 906 highlighted the lack of trust in staff that accompanied her increased involvement:

I'm becoming an advocate. I'm becoming more involved than I ever thought I would be. I mean, I assume that they would give the medications properly. I never thought for a minute they wouldn't. I assumed that they'd be competent enough to – to see. I mean, after she'd been there three months the nurse says, 'Oh, I haven't even seen her back.' [scoff and a laugh] I'm thinking, what?!

Participants consistently reported that they did not anticipate the increased involvement apart from one family caregiver who was more involved due to challenges experienced at a previous facility (Participant 468),

Well, only, um, no, not really, because I guess, even from day one my dad had a bad start at *LTC facility*. Which was even more horrific than the treatment here.

Uh, so I think early on, I knew that I had to be-- stay very involved and to have a companion every day. For two hours a day he gets a companion. So, to try and keep tabs on what's happening. Is there anything new? Any new marks, any, you know-- so I guess, being more diligent than I really would like to be, have to be, feel I have to be.

Notably, participants were more attentive to and vigilant about care issues that the conflict with staff was about (e.g., fall alarm, UTI) and were more sensitive to physical changes in the resident, when compared to prior to the conflict.

The one family caregiver in the sample (Participant 625) who was a facilitator of a family group reported having to leave her role the year prior due to the negative physical and emotional toll it took on her. She reported having difficulty abstaining from the role due to the ongoing want to be involved and advocate based on her perceived significance of the issues that families encountered, despite being told by management to limit her activities.

Change in Quality of Care

When participants were asked whether the conflict contributed to change in resident's quality of care, the majority indicated that it did not, and one participant indicated that the care worsened. Participants mentioned concerns that staff neglected the residents in their absence (Participant 468 and 844), and that some staff were not genuine in their interactions. However, some participants indicated transient or ongoing changes to the attentiveness of the resident (e.g., checking a wound, providing medication regularly; Participant 906 and 795) and attaining greater education for staff about PTSD (Participant 650). Despite the positive changes reported, families remained wary and maintained a dissatisfied view of the care change. For example, Participant 650 appeared to be pleased with her success in bringing in an education opportunity

that provided staff training on managing PTSD, but her satisfaction was bungled by several concomitant issues:

Well, I feel that because I pushed for more knowledge of PTSD and of course the caregivers aren't obligated to go. They are asked to go. It's optional which I don't think is right. The only thing is- is there supposed to be on the floor caring for people, and now we're in a meeting, and it's only about 25 to 30 minutes that they're there. So you have to cover a lot if you're at the presenter in that time. But they do give them paperwork. But I'm sorry to say that some of them either can't read or don't read. So, you know, that's my fine line about that. But at least I kept nagging and they do get somebody in about the PTSD.

Changes to the Family-Staff Relationship

Participants described a range of responses when asked whether they experienced changes in their relationship with staff following a conflict. Four participants indicated that they did not experience any changes or were unsure whether any changes ensued. Participants reported that some staff became sheepish or more agreeable, whereas others reported improved relationships with staff by using verbal and material reward with the hope to improve the quality of their relationship and the care provided. For example, Participant 650 discussed this approach:

I'm very kind to them. I bring them in fruit. I bring them in baking. I bring them in oranges and I shouldn't have to. But my theory is, that if you're kind to your employees, your employees work harder. Even when I worked if a boss thanked you a lot, or if he made you feel special, you work harder. And that's the theory I use-- I use there.

Similarly, Participant 906 told a staff member that she was "a fantastic nurse" even though she did not believe so but sought to improve the relationship. She spoke about being successful in this regard by increasing the staff member's attentiveness to her mother and improving the NA's demeanour toward her:

She's really nice to me. She talks to me when I go up there. She will come up and say, 'Well we've done this for your mother today, and we've done that,' and on and on... I guess I feel that I've gotten the nurse to – she's understanding more. And, just the fact that I can talk to her and have her respect, me talking to

her, and I'm not talking to her in a put-down way or anything like that, um, I'm just expressing my concerns. And I'm getting more feedback from her.

A more direct approach to addressing relationships with staff was described by Participant 795, who sought to "clear the air" with the RN that she had a conflict with. She openly said to the RN that she would still approach her if she had a concern, and that she hoped that the RN would reciprocate, in order to re-establish their relationship post-conflict.

Three family caregivers reported a "mixed bag" appraisal of their relationships with staff, by reporting being avoided, disliked, or irritating staff when speaking to them, but also identifying staff members with whom they maintained a positive relationship. Participant 468 described the importance and the challenge of maintaining a positive relationship with staff:

I try as hard as it -- I try to maintain a good relationship and be friendly and, you know, open... I don't want them to see me as a complaining b - - - h, you know. But I think they do see me as somebody who's very concerned about my father's care and very protective of my father and I think that's why they aren't avoiding me now, the few that know who I am, who've kind of developed a relationship. I think see me as safe and I always tell those ones how appreciative I am of-- I let them know how much I am thankful for what they do for my dad. Uh - but so in general then there's some that you just - they don't come around. They seem to be a more aloof, they don't want to develop a relationship. They say very little and know very little, shrug their shoulders, don't speak in English enough to communicate well or I'm not sure what it is why they're more standoffish.

The need for family caregivers to be validated by staff for their concerns, that they are coming from a place of care and filial piety, appeared across several interviews, with one participant who had a negative appraisal of staff at the facility reporting a single identified positive interaction over the course of her mother's stay in LTC (Participant 795):

...the one nurse who was a Chinese nurse but, see I think it -- some of it is cultural too -- 'cause some cultures appreciate that people look after their parents

more than other cultures. And she stopped me when I was leaving and said -- and said she was going to say a prayer for us. [tearful] And she -- and she -- and I thanked her and she said, "It's so nice that you're here every day with your mom." And she said, "You know, some people, they don't see any family." And she said, "It's so nice that you're concerned about your mom's care." So that made me feel good.. I was glad she said that. Because by then, you know, like, I felt uncomfortable going in there 'cause, again, there's been so many incidences, with different staff...

The majority of participants reported that their relationships worsened following conflict with staff due to a loss of trust and respect, disliking specific staff members, staff avoiding them and being identified as an "issue" by staff. Participants recounted attempts to communicate with staff and having to "hunt them down" due to increased avoidance:

There have been times on and off, where-- and again, [laughs] the red-headed nurse again, when I would question her to ask as much as she talked to me, was friendly and I thought, 'Oh, that's great. We have a good rapport and then I can talk to her about things.' But when I would go to her with my concerns, then I would get a cold shoulder from her. And at the end, it was like she was dodging me too. So you get that feeling, they see you, you know, and then instead of early on, it was coming over, 'Oh, you know, how are things?' And then they didn't wanna hear how are things anymore. So, it's like, avoiding you. You could almost see where they see you come in through the corner of their eye and they will pretend they don't see you and take off. You know, and become-- lose you or go into the office and close the doors and when I-- if I knock on the door and say, 'Can I talk to you for a moment?' You kind of, get daggers, like, 'Yeah, I'm really busy,' you know. 'Hurry up', you know, 'Don't interrupt me.' (Participant 468).

Although this participant reported a general increase in staff avoidance, Participant 795 described how following a single instance of conflict with a NA, that the NA would not speak to her even when she asked her a care-related question:

She went from saying, 'Hello', and stuff to not talking to me. Not even if I addressed a direct question to her, she wouldn't even answer my question about my mom. Which is what I said when I complained about her. I said, 'I couldn't care less if she hates my guts or doesn't like me or whatever.' But I said, 'I'm now worried that she's going to take it out on my mom.' So, that was when they moved her.

Staff avoidance was not limited to face-to-face communication, but extended to family phone calls to the facility. For example, Participant 844 described encountering significant difficulty contacting staff by telephone,

Well I'd phone and the phone would ring, ring, ring, ring, and ring and nobody answers and I would phone like every 15 minutes, keep phoning and it rings 25, 30 times, nobody answers. I'm sure they're looking and saying, 'Oh, it's her. Oh, God.' Right? Because the one day I phoned about five times and nobody answered. And, so I went to my neighbor's and used my neighbor's phone. I phoned, they answered on the first ring. So, it just made me feel, well you know, am I wrong or you, just because they can see who's calling and you just saw my name so you just thought you should ignore it because I was gonna b - - - h about something? You know, I mean it just kind of makes you wonder.

Being labeled as an "issue" (Participant 795) was shared by several participants who would raise their concerns to staff. Participants felt that staff did not want to interact with them and changed their demeanour toward them:

Sometimes you get the feeling it's just they're saying, 'Oh God, she's gonna b - - - h again. Here she is again.' Like that they get – you just get that feeling. They don't come out and say, 'Well Jesus you're b - - - hing a lot about this' you know. But, you just get that feeling, like they don't really wanna have anything to do with you because you b - - - h. [laughs]...They're just something. It's not that they're unfriendly. That they don't talk to you. That they don't-- it's just they seem to be different and I cannot explain. I don't know why it just feels that way. (Participant 844)

Overall, participants reported conflict negatively impacting their relationships with staff from front-line to managerial level, either as a result of experiencing conflict directly with them or from frequently mentioning care issues to them. Participants mentioned the importance of repairing negative relationships, and suggested that the onus was on them to initiate such repair, "I'd say my relationship with the Executive Director is horrible right now, which I know is not helpful, and if I do decide to go back, um, I will need to put some thought into how to repair that relationship. It's sad that it's up to me to repair that relationship" (Participant 625).

Consequences to the Resident

All but one of the participants reported both positive and negative consequences to the resident as a result of managing family-staff conflicts. However, they were cautious when reporting positive consequences indicating that they were not certain that the changes that they hoped had actually been put into effect. Positive consequences consisted of the resident receiving better food, medication, having a care plan, having fall prevention alarm turned on, greater attention being paid and care provided to the resident, and changes in type of residents accepted in the facility (e.g., aggressive). The positive outcomes described were related to families attaining what they had hoped through conflict with staff, and they attributed the positive outcome to their efforts, as illustrated below:

I guess I feel that I've gotten the nurse to – she's understanding more. And, just the fact that I can talk to her and have her respect me talking to her, and I'm not talking to her in a put-down way or anything like that, um, I'm just expressing my concerns. And I'm getting more feedback from her...And she's more attentive to my mom. She didn't need to take her blood pressure every hour. [laugh].
(Participant 906)

Some participants were more cautious when discussing positive outcomes, suggesting that the changes that they observed may be occurring only when they are present at the facility:

I think like-- like yeah, maybe they, like I said it didn't seem to change much but I have noticed that his chair alarm has been on every time that I come around, sort of thing. And, I know when I'm there that they set the alarm but I still don't know that they set it. It just makes me wonder, well when he's having these falls and then they don't know when it happened or how it happened or why it happened or, you know. It just makes me think, 'Well, you know, if that alarm went off, he should have been found in five minutes or more.' (Participant 844)

Most participants reported negative consequences, with the most common being receiving worse care than prior to conflict, including harm to the resident such as

neglect and pain. Similar to the positive consequences, some families described being unsure what negative consequences residents may have experienced, due to their inability to be present at the facility 100% of the time. As previously noted, participants suggested that staff's perceptions of them could adversely impact resident care:

If they get irritated with the family member, I think they care even less. And I mean not all the staff 'cause there are certainly -- like I said there was a couple of staff that I saw that were really good in caring with the patients. They would probably resent that I was coming and I'm-I'm sure then, like honestly I was scared not to be there all the time. Well, I think I'm sure she probably got neglected when we weren't there. (Participant 795)

In terms of harm, participants described concerns about what the resident may be experiencing because the conflict was not resolved. Participants who experienced conflicts concerning medications and access to treatment discussed the adverse consequences to residents' health as a result of staff's actions. In the case of Participant 468 who was having difficulties receiving a prompt identification of her father's falls, she described what she imagined her father went through following a fall,

Yeah severe consequence. I can only imagine how, even though he-- his short term memory is poor, I can only imagine how scary that must be for him to wake up in the middle of the night, have to go in the dark and be laying on the floor, uh, for God knows how long. In the cold with no pajamas on and-and trying to find his way around the dark. And it looks like that's exactly-- that he was crawling on the floor. That's what his knees look like, you know, and where this huge big bruise on the side and the marks across his nose. And his hands and stuff from, probably grabbing under the railing. I mean, I try to put the pieces together of how that could-- but it's gotta be damn scary, you know.

Apart from direct harm, practical consequences, such as the resident being unable to ambulate independently as a result of being unable to resolve a conflict related to space limitations was also noted (Participant 906).

Consequences to Family Caregivers

Participants reported negative consequences to themselves following conflict with staff, including emotional and physical impact, and being labeled "difficult". A single positive consequence was reported of feeling good about being able to communicate with staff about the resident's care needs (Participant 844).

More than half of the participants interviewed reported experiencing a range of emotions consequent to conflict with staff including anxiety, frustration, feeling overwhelmed, and guilt about letting the resident down. Anxiety was the most frequently described outcome, with two participants indicating disturbed sleep as a result of the conflict,

"...constant feeling of anxiety and concern and, you know, waking up in the middle of the night and wondering, 'What's he doing then?'" (Participant 468)

"And then I would just worry -- like I said I started not sleeping at nights because of that ulcer medication and because of the spitting of blood." (Participant 795)

Two participants discussed the tolls that conflict with staff and caregiving had taken on their physical health. Notably, both were caregivers to multiple members of their family (e.g., parents and siblings). Participant 900 described changes in her demeanour over time and physical health issues, which she attributed to changes in her caregiving demands:

Yeah, if you're really nice all the time, nothing happens. And I don't like being witchy but I've certainly become that way since -- since traveling with this little journey with my mom and my sister. And now my mom's gone and-and surprisingly the tension from there is gone and-and a lot of stuff, my cholesterol went down, my blood pressure went down, my insulin levels have gone down. You know, it's amazing what a toll it does take on your life. (Participant 900)

Another participant mentioned that she was hospitalized from the stress of caring for her parents and leading the family group through a series of conflicts with the facility (Participant 625).

Four participants reported having fears of being labeled as difficult by staff due to their history of conflicts with staff. Participant 625 summarized the sentiments relayed by the families:

Not just that issue, but other issues, is that there's always the concern that you're labeled 'difficult.' Kind of like, oh no [laughing]. 'Cause I am persistent – about serious things, not little things, but serious things... I don't think I'm rude but I'm persistent. So there's always the concern of being labeled difficult and, which can come back to your loved one...I think if I had to guess, I think there's a note in my file saying that I'm difficult to deal with, you know. ... Me and a couple others that are persistent and are in there often. It angers me and makes me sad because I don't want it to come back on my mom. And it angers me that they choose to have that kind of mentality rather than, let's try and improve things and there's always room for improvement, versus, you're in here complaining again, you know [laughing].

Participants reported feeling blamed for the conflict by staff, not being liked by different staff members, and feeling uncomfortable going to the facility as a result.

Consequences to Staff

The majority of participants described being unaware of any consequences to staff following the conflict episode. One participant indicated hope that there was a discussion with the staff member about how to improve their care practices around falls (Participant 370), which was the crux of the conflict. However, most were unsure that there were any resultant consequences.

The immediate consequences to staff included the termination of employment and relocation to a different unit. Participants who encountered medication-related conflicts with staff reported that the appropriate consequence for staff would have been

termination of employment, however, that was not the outcome in either case. Lastly, one participant discussed the potential long-term consequences of families raising their concerns to staff and showing understanding of the system-level limitations encountered by staff:

Like anyone with a conscience. Every time something like this comes up, it can't be good for the person's psyche. You know, if they have to work in that environment and they've got restrictions and staffing or funding or whatever or know that there's not good communication or know things that can be improved that aren't. Or there's slow to improve, yeah I-it's got to eat away at them too you know, I mean not personally like, nobody would get fired or anything like that. But no, you know, no immediate consequences but that long-term, that can't be good for staff. (Participant 477)

Were the family-staff conflicts resolved?

Participants reported both successful resolution and ongoing conflicts with staff. Interestingly, although a number of participants reported resolving conflicts, they noted that the resolution was time-limited and were doubtful of enduring change. This resulted in participants continuing to assume their advocacy roles and being vigilant regarding care-related issues (e.g., Participant 370, 671).

All of the participants reported at least one of their conflicts with staff as unresolved, describing them as an "ongoing battle" or having many "questions unanswered" and being "put off". One participant suggested that having resolution may be a target that is difficult to attain, but she described being confident in managing the issue:

I don't think any of the problems that you have in the care center is ever solved to your satisfaction. My saying with them is you can tell me nothing is perfect, and I'd say to them, "I know that but it can be better." So I just feel like I addressed it, and I said if I see more of it, I do not want the caregiver dealing with him. (Participant 650)

Summary

The sample of 10 family caregivers identified as high in terms of frequency of conflict with staff, described a variety of conflicts that were deemed as somewhat to extremely severe, and held significance to them largely due to the consequences to the resident or themselves. The conflicts ranged from isolated occurrences to spanning months, and concerned a wide-range of care-related issues. The content of the conflicts mainly concerned resident-care issues, and although four distinct themes were identified, many conflicts involved several themes overlapping as they evolved over time. Unsurprisingly, given the range of conflicts family caregivers experienced, and the duration of conflict episodes, participants engaged in a variety of conflict management strategies. Confrontational conflict management was most prominent and consistently reported across the sample. Interestingly, participants had varied awareness of using this approach, with some participants citing it as the most effective approach whereas others strived not to act in a confrontational manner. However, participants indicated that confrontational approaches were not particularly effective and contributed to negative consequences for them, the residents and for their relationships with staff.

Participants reported losing respect and trust for staff of all levels (front-line to managerial staff), as well as being more concerned and "on guard" regarding staff's actions. Participants described being increasingly concerned with minor care issues (e.g., shaving) and being unsure whether staff were noticing and following through on care needs, as well as whether there was adequate communication between staff regarding resident's needs, especially between staff on different shifts. Participants maintained concerns about the impact of conflicts with staff on the resident in terms of

retribution and family caregiver's negative reputations in LTC, and expressed difficulty navigating relationships with staff post conflict and managing staff avoidance. It is unsurprising that participants indicated that some conflicts were unresolved and for the conflicts that were identified as resolved, participants were doubtful of enduring resolution.

Chapter 5: Discussion

Bringing It All Together: What Have We Learned About Family Caregivers'

Experience of Conflict and Conflict Management

In the present study 107 family caregivers of older adults residing in LTC completed a series of self-report questionnaires, with 10 family caregivers from this sample, who were identified as experiencing relatively higher frequencies of conflict, completing comprehensive interviews. This chapter will highlight key findings and integrate the qualitative and quantitative data, review limitations to the study and, lastly, discuss future directions, including future research and implications for policy and practice.

Key Findings

Nature of family-staff conflicts. Overall, family caregivers reported relatively low frequencies of conflict on self-report measures (i.e., averaged on a monthly basis), which is consistent with previous studies employing the Frequency of Interpersonal Conflicts Scale (FICS; Pillemer et al., 2003). Conversely, High Conflict (HC) family caregivers reported conflicts several times per month. Notably, the FICS focused solely on the frequency of the conflicts with staff across a variety of care issues. However, as the qualitative data suggested, it is not so much the frequency of conflict that is relevant as is the significance and perceived severity of the conflict episodes (in terms of potential risk of harm to residents) that family caregivers use in determining its impact.

Family caregivers differentiated between conflicts that they perceived as threatening to the resident's well-being (e.g., inadequate medication administration) from minor annoyances (e.g., disagreeing with how the resident was dressed) that did

not have an adverse impact on the resident's well-being. Attentiveness to needs, personal care and toileting were reported as most frequent and pertinent conflicts across the two portions of the study. However, additional sources of conflict were raised by HC family caregivers that were not captured by the FICS, such as the full range of quality of care issues (including medication management), feeling unheard, and staff not fulfilling their duties.

Notably, attentiveness to resident's needs was the common theme across all of the conflicts discussed, and is consistent with reports from the satisfaction with care literature that identified staff attentiveness to be seminal to families (Gaugler, 2005a; Haesler et al., 2007; Law, Patterson, & Muers, 2017). In this study, attentiveness to resident's needs subsumed conflict episodes that had direct repercussions for the resident's well-being including physical safety, fall monitoring, and infection management, with the propensity for harm perceived as imminent or significant.

The care domains that were most often the source of family-staff conflict have also been tied to resident's dignity and are captured under the umbrella of individualized care, both of which are important to family caregivers in terms of satisfaction with care (Haesler et al. 2010; Law et al., 2017). This reinforces the idea that the care deemed by families as important is frequently the source of conflict. However, specifically what family caregivers consider important is likely to differ between families (Law et al., 2017). Identification of key areas of care for different family caregivers may assist in monitoring where family-staff conflict can be anticipated. For example, in this study, two areas of care provision, toileting and medication, were most often cited as the origin of conflict episodes. Among HC families who have had longer-term conflicts, family

caregivers described being particularly vigilant in how care was executed in the specific areas that were previously a source of conflict, which could provide some insight into identifying relevant care areas for intervention.

Relationship, task and process conflicts were supported in the data provided by HC family caregivers, and were all experienced to a greater degree by this subsample than by family caregivers with lower frequencies of conflict. They described relationship disagreements with staff due to interpersonal incompatibilities (i.e., not liking each other), albeit in the minority. However, participants did label staff as "good" and "bad" based on their evaluations of staff's ability to provide care and communicate during conflicts. Positive and negative evaluations of staff have been reported previously in terms of interpretations and evaluations of staff behaviour through their relationship with the resident, with families and their approach to technical tasks (Duncan & Morgan, 1994). Consistent with previous research, interpersonal conflicts may follow from previous task and process conflicts (De Dreu & Weingart, 2003a). This could be the case for the present study, as family caregivers more frequently described task conflicts as they experienced differences in ideas and opinions related to care tasks (e.g., which is most important, what should or should not be done), as well as process conflicts, in understanding what aspects of the care task are their versus the staff's responsibility (Jehn, 1997). Process conflicts were described as a significant area of frustration for families in negotiating how to accomplish tasks with staff, without offending staff but managing to meet their own care goals. The additional contribution to process conflicts may arise from family caregivers' relative unawareness what the boundaries of their and

staff's roles were in the LTC facilities. However, some family caregivers defined their own boundaries without input from staff, which escalated conflict.

Overall, HC families described engaging in multiple conflicts over the duration of their stay at the LTC facility. They described encountering care issues repeatedly and approaching multiple members of staff with the issue prior to the situation escalating to a conflict episode. The escalation was typically attributed to lack of resolution of the preceding minor episodes and was suggestive of limited attempts by staff to manage the situation with families. Staff's lack of responsiveness to initial family complaints may be costly in the long run as the initial issues may be easier to manage than the confrontations that they might escalate to.

Goal interdependence and conflict management. Deutsch (1949, 2014) asserted that there are two types of goal interdependence: (a) *positive*, where the amount of probability of goal attainment of one person is positively correlated with the goal attainment of another, and (b) *negative*, where the probability of goal attainment by one person is negatively correlated with the probability of the other's goal attainment. The former leads to cooperative relationships whereas the latter leads to competitive relationships (Deutsch, 2010). As the majority of family caregivers reported being dependent on staff for providing care, this suggested an overall positive interdependence, which is a requirement for cooperative conflict management. In other words, to work in cooperation through a conflict, family caregivers have to perceive that they and staff are dependent on one another to attain the same goal (quality resident care). This is consistent with the finding that the majority of families in the sample reported using cooperative conflict management. In addition, family caregivers who

reported greater dependence on staff to provide resident care reported higher use of cooperative conflict management, and LC family caregivers have higher dependence on staff. Notably, the dependence reported by families is of varying degrees, and some families indicated that they are rather minimally dependent on staff, which may demonstrate the presence of negative interdependence. Interestingly, HC family caregivers reported lower degrees of dependence on staff than LC family caregivers. Due to the differences in ideas about what constitutes quality care and how that care can be performed, as exemplified by interview data, families may perceive a difference with staff in the nature of the final goal and how it can be attained to such a degree that families engage in independent actions to attain care goals. For example, if a family member disagrees with staff about the role of a medication in resident's well being and does not trust staff to reliably administer a medication, she may initiate medication administration independent of staff. This scenario, described by a HC family caregiver underscored that negative interdependence is also present among families and staff in LTC.

Deutsch (1949, 2014) further proposed that asymmetries can exist with regard to the degree of interdependence in a relationship. This was evident in the present data as all family caregivers in this study reported dependence on staff for the provision of resident care, whereas the majority (83%) reported at least some degree of staff dependence on them. However, 17% indicated that staff do not depend on them at all, whereas no families indicated that they do not depend on staff, suggesting that families do not perceive the interdependence as equivalent. This makes sense when we consider that what staff do or what might happen to them might have a considerable

effect on families, but what families do or what happens to them may have little impact on staff. Moreover, staff have a known and established duty to provide 24/7 care to residents in LTC, hence are given the majority of care responsibility. Therefore, family caregivers are more dependent on staff than staff are on them, which gives greater power and influence to staff in the relationship (Deutsch, 2014).

What is interesting is the level of dependence that families perceive staff has on them, with the majority of the sample reporting staff relying on them to provide quality care to the resident. This finding supports and extends the notion that families perceive having care partnerships with staff in LTC (Law et al., 2017). Interestingly, family caregivers' perceptions of staff's dependence on them was unrelated to their use of cooperative or competitive conflict management, suggesting that their perception of reciprocal care partnerships with staff is not as salient to conflict management as is their perception of dependence on staff. It should be noted that families may not perceive staff dependence on them as positive or indicative of a partnership as HC family caregivers suggested during interviews that staff reliance on family caregivers could be construed as staff not fulfilling their duties, requiring families to contribute and take on responsibility for care of the resident. Increased family contribution to resident care following negative interactions with staff has been mentioned previously (Ejaz, Noelker, Schur, Whitlatch & Looman, 2002). In this type of situation, family caregivers' preferences for involvement are not honored and role requirements may feel imposed (Murphy et al., 2000 as cited in Zimmerman et al., 2013; Reid & Chappell, 2015). Feelings of obligation to substitute for the role of staff in routine physical care has been associated with decreased satisfaction among family caregivers (Murphy et al., 2000).

Among HC family caregivers, over-reliance on family caregivers was perceived as detrimental to the resident, and contributed to conflict. For example, a HC family caregiver described an instance of conflict when she could not visit the resident during her regular visitation time at lunch, and her husband was not fed his lunch by the time she arrived later that day.

In addition to the negative reliance that may be perceived as detrimental to the resident, staff dependence on families may counter it and be perceived as a form of "positive" staff reliance, for example, when staff approach families for information about the resident. This positive reliance would be consistent with families' reports of wanting to be recognized as experts in understanding resident care needs and preferences (Law et al., 2017; Palmer, 2012). However, HC family caregivers in this study may not have actually construed such interactions as staff reliance on them, imbuing the term "reliance" with negative connotations, such as handing over power and control in resident care.

Cooperative and competitive conflict management. As indicated above, family caregivers largely employed cooperative conflict management strategies in LTC, with the majority of the sample (97%) reporting cooperation. This finding is consistent with the LTC literature to date where family caregivers emphasize care partnerships with staff and a "we are in this together attitude" (Law et al., 2014; Majerovitz, Mollott, & Rudder, 2009), which is consistent with the positive goal interdependence in resident care as discussed above.

However, retrospective and self-serving biases as well as social desirability could contribute to an inflated endorsement of cooperative conflict management. The latter

may be less likely given the forthcoming nature of the majority of participants in disclosing verbal and non-verbal intentions and actions that were objectionable and unflattering. Self-serving biases where individuals perceive themselves as more cooperative and as less competitive than their opponent in interpersonal conflicts (Kluwer, De Dreu, & Buunk, 1998), were potentially involved. Another way of considering this finding is to return to the only other publications specific to family's behaviour in conflict with staff by Vinton and Mazza (1994, 1998), where they focused on family aggression in LTC, and reported that the majority of challenging and aggressive behaviours were demonstrated by a minority of family members, with these families being often cited as "difficult" or "problem" families. Therefore, the present study suggests that family caregivers in general are likely to engage in cooperative conflict management for most conflicts that they encounter. However, for families who engage in conflict with greater frequency, they exhibit a greater range of conflict management strategies that may include cooperative management, but also other management strategies while dealing with the same conflict or across different conflicts, dependent on the significance of the care issue. When examining interview data from HC family caregivers, all of the participants reported engaging in competitive conflict management strategies either from the outset of the conflict, or more commonly, following alternate approaches to manage the conflict with staff (e.g., approaching front-line staff, trying to teach staff). The unanimous endorsement of competitive conflict management is consistent with the negative goal interdependence demonstrated by HC families as previously mentioned. It is, however, inconsistent with the absence of a significant relationship between frequency of conflict and competitive management when the entire

sample is considered. This null finding contradicts what would have been expected and what was observed among HC families, furthering the potential role of biases in reporting conflict management.

Some HC families reported using a competitive/confrontational approach more consistently when encountering conflicts, citing it as an effective way to get staff to respond and make the changes that they requested. Notably, family members who held this view described using confrontational approaches following previous experience in LTC facilities and engaging in multiple conflicts with staff. Despite the benefits, negative consequences of using a confrontational approach were noted, as would be expected (Deutsch 2010, 2014), such as impacting communication and feeling unwelcome at the LTC facility. However, despite not wanting to be perceived as confrontational, HC families viewed their confrontational approaches as necessary to express dissatisfaction, to be heard by staff, and to effect change in LTC.

Consistent with Deutsch's assertion that "almost all conflicts are mixed motive containing both elements of cooperation and competition" (2014), HC family caregivers used cooperative conflict management as evidenced by working with staff to address care issues. However, they continued to report wariness and a degree of distrust as they cooperated with staff that stemmed from their previous conflicts. High conflict family caregivers presented concerns that staff did not possess the adequate knowledge or skills, motivation or time to complete their part of the agreed upon care duties. This finding is reminiscent of Deutsch's (2014) concept of *substitutability*, which refers to "how a person's actions can satisfy another person's intentions" (p. 5). Therefore, in order to use a cooperative approach, family caregivers would be required

to accept the activities of staff to fulfill their caregiving needs. However, for a portion of family caregivers, relinquishing control and allowing staff to provide care as a substitute for the care that they had given previously or that they believe should be provided, is a noted difficulty (Gaugler, Mittelman, Hepburn & Newcomer, 2009). Moreover, the complement to the concept of substitutability is inducibility, which refers to "the readiness to accept another's influence to do what he or she wants" (Deutsch, 2014, p.6). According to this principle, persons are willing to be helpful to another person whose actions are beneficial to them in attaining a goal (such actions are referred to as "effective"). However, when the actions are perceived as harmful ("bungling") to goal attainment, people are likely to obstruct or interfere with their occurrence. Because families perceive staff as "bungling" their actions (e.g., based on previous experience in LTC or previous conflicts with staff), staff are no longer perceived as an appropriate substitute for the family caregiver's intended actions which can contribute to use of competitive conflict management strategies or vigilance and wariness when engaging in cooperative conflict management.

Other conflict management strategies. The *demonstrating personal/professional knowledge* theme is not necessarily competitive in that HC families only insist that they are correct above and beyond staff, although competitive actions have been noted. This theme highlights the previous research that families possess unique knowledge about the resident which they attempt to contribute in care (Haesler et al., 2007; Hertzberg & Ekman, 2000; Palmer, 2012), and additionally, some families possess relevant professional knowledge given the varied educational and occupational backgrounds of the family sample (e.g., nurses, physicians, pharmacists,

and social workers). In addition to general professional knowledge, in the overall sample 22.82% of family caregivers reported having previous professional experience specifically in LTC facilities (either through volunteering or paid employment). Each of these types of knowledge can have repercussions for the family-staff relationship. Personal knowledge can contribute to having a difference in attitudes, ideas and viewpoints regarding resident care with staff that can lead to conflict, and arguably, even positively contribute through an exchange of information that can improve resident care. Professional knowledge could contribute to greater understanding of staff and closer alignment in attitudes, ideas and viewpoints, or alternately, exercising an attitude where staff are not meeting their professional standards in providing care. Both of these viewpoints were raised by participants in this study. However, based on the current limited sample of HC family caregivers, who unanimously reported feeling unacknowledged for their input into the care issues , the knowledge they possess may be underutilized in managing family-staff conflicts.

In addition, HC family caregivers also attempted to teach and instruct staff when managing a conflict, demonstrating their own personal or professional expertise in being able to attain a care goal such as transfers and medication administration. When staff were open to such exchange of information, positive conflict outcomes were noted including increased family satisfaction. However, when staff were not open to families sharing of knowledge or instruction, conflict accelerated based on family caregivers' reports (e.g., family caregivers became more insistent on their positions and/or acquired external support in order to get staff to listen and consider their input and to attain validation). Although staff ultimately hold professional responsibility, and have been

reported to be wary of involving families in care (Bauer, 2006; Ervin, Cross, & Koschel, 2013), excluding family knowledge and assistance may be unhelpful in LTC in the long term, as the number of residents is increasing in a system that is underfunded, understaffed and has a less experienced and skilled workforce than required to meet resident needs (Alper & Domnitz, 2017; McGregor & Ronald, 2011). Staff will be increasingly required to rely on families to offer support including in the form of knowledge exchange in order to meet resident care needs (McGregor & Ronald, 2011).

Perceptions of effective conflict management. The majority (81.73%) of family caregivers in the overall sample self-reported that they had effectively resolved conflicts and did not have ongoing conflicts with staff (75.96%). However, approximately 1 in 5 family caregivers reported currently ongoing conflict, having difficulties managing the conflict and being dissatisfied with how conflict was handled by the LTC facility. This is a significant proportion of the caregiving sample and underscores the importance of not only addressing family-staff conflicts, but investigating strategies for supporting families in conflict management, especially as almost half of the sample anticipated future conflicts with staff. It is notable that almost half (49%) of the sample did not anticipate experiencing any future conflicts suggesting a rather positive outlook. However, high conflict families supported the chronic nature of conflict, as many conflict episodes were described as either partially or not at all resolved. This subset of family caregivers described experiencing a series of relatively minor problems or care issues which were often left unresolved, despite their attempts to address the conflicts with multiple staff members, and often escalated to more serious confrontations with staff. Notably, even major confrontations were not entirely resolved despite managerial

intervention. These findings are in line with Vinton and Mazza's (1998) finding that the subset of family caregivers' responsible for most acts of aggression required on average of 3 or more interventions to address the conflict issue, with only the minority (17%) attaining complete resolution.

It is noteworthy that the majority of the sample was satisfied with how they and how staff managed conflict. Unsurprisingly, dissatisfaction with staff's conflict management was greater than with family caregivers' own. This finding was echoed among HC families who were largely satisfied with their own conflict management, but did note certain aspects that were ineffective (e.g., being confrontational). Families may have enhanced confidence in the effectiveness of their conflict management skills, frequently lacking awareness of how they may be perceived by staff and how they may contribute to escalating conflict episodes by evoking hostile responses from others. Individuals tend to be biased in interpersonal conflicts by perceiving themselves as more cooperative, fairer and better than others (Kramer, Newton, & Pommerenke, 1993). This self-enhancement bias has been associated with conflict escalation and is predictive of future conflict (De Dreu et al., 1995). High conflict family caregivers also criticized staff's conflict management when it contained denial, was confrontational and was not proactive. In fact, some HC family caregivers reported that staff's conflict management was only effective because of their involvement in the conflict episode, attributing the resolution to their own actions, and maintaining a competitive approach. However, proactive approaches that were consistent with cooperative conflict management such as providing families with support, scheduling meetings and developing action plans were perceived positively.

Although the majority of the sample continued to report satisfaction with the outcomes of the conflict and with the manner that the facility supported family-staff conflicts (e.g., conflict policies, management's response to conflict), almost a third reported a degree of dissatisfaction. Similar rates of endorsement on ratings of knowledge and clarity of policies concerning conflict in the LTC facilities, with about 40% reporting none to minimal knowledge. During data collection, participants were noted to say "What policies?", "I never knew there was such a thing", and "I'm not sure who to go to with it", underscoring the lack of awareness some family caregivers have about basic processes for managing conflicts at the facility. Although these comments are unsurprising from family caregivers who have not encountered any significant conflicts with staff, what is of concern is that some HC family caregivers who had experienced conflicts for months and years at the LTC facility also reported not possessing this knowledge. This suggested that policies that may be available are not currently effectively disseminated to families. For example, family orientations and handbooks to acquaint family caregivers with LTC facilities, as well as with the rights and responsibilities of families and residents (which may include respectful communication and how to make a complaint) may be available. In the context of the present study, some participants mentioned receiving such binders of information but generally indicated that the binders were either not read or were incompletely understood, as they were received upon relocation to LTC. As adaptation to LTC is an emotional and challenging process, families reported that it was not an optimal time to receive copious amounts of information as they described being "bombarded with

information", when they were prioritizing settling the resident into the facility and managing assets.

Conflict management and conflict outcomes. The results of this study suggested beneficial relationships between family caregivers' use of cooperative conflict management and lower frequency of conflict, lower stress related to conflict and decreased likelihood of having currently ongoing and future conflicts, as well as greater perceived ability to resolve and manage future conflicts. Moreover, use of cooperative conflict management was related to lower psychological distress and caregiver burden, and with greater satisfaction with care. Given the correlational nature of the data, the directionality of the relationship cannot be determined; however Deutsch's theory of cooperation and competition would suggest that the use of cooperative conflict management would have wide ranging benefits on conflict in an environment including a reduction in frequency and improved conflict outcomes (Deutsch, 2014). In fact, not only is cooperative conflict related to increased positive and decreased negative outcomes but results indicated that cooperative conflict management mediates the relationship between frequency of conflict and satisfaction with care, meaning that conflict management is the mechanism by which conflict and satisfaction are linked in this family caregiver sample. Therefore, this finding supports the assertion that it is not so much the conflict itself but the manner in which it is managed that influences satisfaction (Deutsch, 2014; Tjosvold, 2008).

Competitive conflict management, however, was unrelated to the frequency of conflict in this sample, but was associated with greater stress and greater endorsement of ongoing conflict with staff, and was a predictor of poorer satisfaction with care. Lack

of other significant relationships with competitive conflict management observed in this study may be influenced by the overall lower rate of endorsement of competitive conflict management and the limited sample size. For example, the predicted positive relationship between frequency of conflict and competitive conflict management was not observed in the overall sample, however, all HC family caregivers reported competitive conflict management on interview, even though some participants underestimated their use of competitive conflict management. High conflict family caregivers described increased use of competitive conflict management with increased incidences of conflict episodes and increased perceived severity of conflicts. Together, the qualitative and quantitative data provide support for using conflict management as a target in trying to ameliorate the negative influences of conflict on caregiver outcomes and to emphasize the establishment of cooperative relationships and environments. Reduction and removal of conflict from LTC may be unattainable targets, but educating families (and staff), and supporting cooperative management has the potential to bring about the desired outcomes of improved satisfaction with care and to ameliorate the negative consequences of conflict.

Notably, neither cooperative nor competitive conflict management was related to family conflict, family caregivers' expectations, or family involvement. In regard to family conflict, research concerning management of family conflict reported avoidance and denial as the most common conflict management strategies employed by family caregivers (Mitrani et al., 2008), neither of which are subsumed within cooperative or competitive management. Moreover, family caregivers might differentiate between intimate and non-intimate relationships when managing conflicts, with situational

characteristics and type of relationship being influential in the selection of conflict management strategies, such as potential negative outcomes (Kluwer, DeDreu & Buunk 1998; Knapp, Putnam, & Davis, 1988, Pruitt, 1983). Notably, high conflict family caregivers did not mention any instances of family conflict in their interviews. Therefore, the present study does not currently support the notion that intrafamilial conflicts are displaced and projected on LTC staff (Iecovich, 2000).

Although family caregivers' expectations about care were hypothesized to be related to conflict management given the frequency of mention of unrealistic family expectations being a barrier to constructive family-staff relationships (Haesler et al., 2007; 2010), no statistically significant relationships were observed with the variables used in this study. The Family Caregiver Expectations measure (Tornatore & Grant, 2004) was used because it is the sole available measure of family expectations in the caregiving literature to the author's knowledge. However, a review of the items (see Appendix O), as the authors intended, measures what family caregivers anticipated LTC would be like prior to resident's relocation to LTC (Tornatore & Grant, 2004). However, based on the qualitative portion of this study, the expectations discussed by HC family caregivers reflected their current expectations for care. This is understandable given that family caregivers have been involved in LTC for months to years in this sample, and shared their own changes in expectations for care over time. Additionally, family caregivers expect the quality of care to be on par with what they themselves would provide, which may be situation and carer-dependent (MacDonald, 2006). Therefore, the role of expectations in conflict and conflict management requires further examination with measurement that comprehensively captures current family caregiver expectations.

Neither conflict management approach was related to family involvement, which is interesting given the reports that HC families provided about increasing their involvement in the LTC facilities following multiple episodes of conflict and increased hostility. One reason may be inadequate statistical power to detect the relationship, or alternately that involvement may not be increased across all of the domains of family involvement (e.g., visiting, socioemotional care, physical care, advocacy, monitoring), with most HC family caregivers reporting increasing their monitoring through increased visitation frequency. Moreover, both increases and decreases to advocacy roles were reported by HC family caregivers following conflicts based on their perceived consequences of continuing to raise issues with staff and engage in conflict (i.e., family caregivers described either escalating their advocacy when they assumed responsibility to protect residents from harm, whereas others were concerned that their advocacy role could contribute to staff retribution and harm to the resident). Therefore, the absence of a relationship between conflict management and family involvement may reflect the multidimensional nature of the construct and the various types of involvement that family caregiver have in terms of commitments, abilities and interests in caring for the residents (Reid & Chappell, 2015; Strain, Maxwell, Wanless, & Gilbert, 2011).

Consistent with Deutsch's theory of cooperation and competition (2000, 2014), power, trust and communication were all positively related (e.g., based on bivariate correlational analyses) to family caregivers' use of cooperative conflict management. Importantly, sense of community was identified as a predictor of cooperative conflict management. As was predicted, competitive management was negatively related to power, trust and SOC, but was not related to family-staff communication. However,

multivariate analyses revealed trust as the sole predictor of competitive conflict management. The relationships with SOC are theoretically important given their focus on a sense of belonging of families to the facility and perception of being part of a team with staff and residents, having connection and mutual influence (McMillan & Chavis, 1986; Petrovic-Poljak & Konnert, 2013). Such sense of shared community, common ground and joint goals have been advanced as the basic norms required for cooperative relationships and constructive conflict management (Deutsch, 2014).

Trust. Trust was identified as the key predictor of competitive management in the overall sample. It was similarly the most frequently cited impediment to working together with staff through conflict episodes, as HC family caregivers' previous experiences with conflict impacted their confidence in the staff's competence and trust in staff. Trust is an essential precursor to a relationship, with it being referred to as "the glue that holds a relationship together" (p. 144, Lewicki & Tomlinson, 2014), including positive family-staff relationships (Bauer et al., 2014). When HC families reported approaching staff members whom they trusted and had positive relationships with, conflict was managed effectively without significant escalation, consistent with previous reports that when conflict occurs among individuals who trust one another positive effects are more likely to ensue, as is the use of cooperative conflict management (Lewicki & Tomlinson, 2014; Simons & Peterson, 2000). However, lack of trust results in conflict that is often destructive and competitive in nature, making resolution significantly more difficult (Lewicki & Tomlinson, 2014). With HC families describing previous conflicts and adverse experiences with staff members, a significant degree of animosity, hostility, and even pain was generated. High conflict families described not believing what staff did or

said to them, and particularly did not believe that staff would follow through on their commitments. This lack of trust contributed to HC families maintaining a wary approach even when attempting to cooperate with staff. It is thus unsurprising that trust was the main predictor of cooperative management.

High conflict families described lack of trust in staff throughout the process of conflict, including as a precursor and an outcome. Lack of trust appeared to have global influences on the conflict process, including families generalizing their concerns beyond the care issue that they were addressing as part of the conflict, by having suspicion about other care areas, and even generalizing trust issues to other staff members (including managerial level staff). Families also described distrust in staff being able to complete their duties due to inadequate skill level, negative attitude, and with some families demonstrating lack of trust in staff's motives (i.e., "covering" for each other, protecting jobs). Notably, even HC family caregivers who described examples of cooperative conflict management with staff maintained a wary stance when approaching at least one of their other described conflicts, suggesting an ongoing degree of mistrust. This lack of trust contributed to family's increased presence at the facility and decreased reliance on staff's input. For example, HC families reported maintaining a high degree of vigilance regarding care tasks that were the crux of the conflict (e.g., fall alarms), and ensuring that they or a proxy (e.g., another family member, a paid caregiver) were present during the majority of the staff-resident care interactions in order to ensure that certain tasks were completed and staff's actions were monitored.

High conflict family caregivers identified staff members that were trusted, who were typically full-time staff that they had relationships with, in contrast to casual, and

evening/weekend staff that they tended to take greater issue with. A positive finding was that family caregivers' trust in staff was bolstered when they had a single positive relationship with a staff member. This is an important consideration, as some of the facilities included in the present sample shifted staff across units in a nursing home, which could impede the formation of strong relationships with any one staff member. Moreover, even a single positive evaluation of care provision was associated with increased hopefulness and development of trust, as has been previously noted in daughter carers in LTC (Legault & Ducharme, 2009).

Power. Family caregivers' perceptions of power and SOC were the key predictors of cooperative conflict management in this study. According to Coleman (2014, p. 113) power is "a mutual interaction between the characteristics of a person and the characteristics of a situation, where the person has access to valued resources and uses them to achieve personal, relational, or environmental goals, often through using various strategies of influence." High conflict families described differing views of personal and staff's power in the LTC facility as it related to resident care, consistent with theories about power (Coleman, 2014). Some families saw staff as consistently superior to families in terms of power (i.e., being "in charge"), and described feeling helpless in being able to manage conflicts and effect change, in the absence of staff's support. Conversely, other family caregivers reported having greater power than staff in the facility referring to them as their "employees" which impacted their demeanour toward staff, and were observed to be more confrontational when managing conflicts in LTC. Yet, others saw themselves as equals who could contribute both personal and professional information to staff in order to manage conflicts, which was frequently

accompanied by increasingly cooperative conflict management. This last group demonstrated having "power with", which underscores the effectiveness of joint action and is essential to cooperative conflict management.

These different individual conceptions of power have been advanced by theory and supported by current research to impact the type of strategy people use to manage conflicts (Coleman, 2010; 2014). Interestingly, cooperative use of power through conflict was reported to generate power, and bolster sentiments of shared power (i.e., "power with").

Moreover, SOC incorporates a feeling of belonging, having influence, having needs met and having an emotional connection to individuals in a community (McMillan & Chavis, 1986). In a manner, it subsumes aspects of the power construct through its inclusion of bi-directional influence (i.e., the individual has a sense of personal control and influence over the community and the community also has some influence over the individual), and extends it by including the idea of a shared sense of purpose and commitment, which would be consistent with the finding that SOC was stronger than power as a predictor of cooperative conflict management. In fact, SOC emerged as the sole predictor among the five variables examined.

As abundantly reported in the caregiving literature, family caregivers require a sense of contribution to resident care (that is consistent with their own preference for involvement), with their own values and beliefs being acknowledged by staff in the pursuit of care goals as partners in care (Bauer & Nay, 2003; Haesler et al., 2010). To have influence, the LTC environment needs to provide opportunity and staff support for families to be involved as partners in care. If family caregivers see themselves as

recognized collaborators in care with staff, that allows them to be involved in decision-making, and a perception of sharing a common goal in providing care, a win-win cooperative approach to conflict management would result.

Communication. Although communication was not a predictor of conflict management in the overall sample, HC families described communication with staff both as an enabler and as a barrier to effective conflict management. Notably, timely communication of care issues to staff was deemed by HC families as the key to resolving conflict episodes. Family caregivers described valuing open communication that validated their concerns and made them feel understood by staff, with preference for face-to-face communication. Therefore, enabling families to have face-to-face conversations with staff in a timely manner may be a beneficial support to effective conflict management.

A range of communication strategies were described as unhelpful particularly lack of transparency and staff avoidance of communication. Families spoke negatively about having to seek out information on their own, finding information difficult to obtain and not being informed of changes in resident status or care in a timely manner. Anger, frustration and a loss of confidence in staff were described when family caregivers received conflicting reports from staff or were not provided an adequate response (e.g., said "I don't know"). Families described staff tucking away into another room when they were about to approach them, not answering their phone calls, and not reciprocating when they spoke to them. Such lack of norms for open communication may hinder beneficial outcomes of conflict, and increase the likelihood of negative outcomes, because families may not have access to alternate adequate venues to discuss issues

with staff (Edmondson, 1999). Even though families described that it was unpleasant to speak to staff at times, for example when addressing staff avoidance, families indicated that removal of such communication barriers was seminal to managing conflicts.

Additionally, staff's level of English proficiency was raised as a barrier to conflict management, as families were unsure whether staff understood their concerns and their questions, which contributed to challenges in differentiating between lack of comprehension and not fulfilling a request. Such issues were exacerbated by telephone communication due to reported increases in miscommunication. In order to counter shortages in nursing care, internationally trained registered nurses and aides are increasingly hired in Canada, following the completion of a brief registration process or bridge training programs (Government of Ontario, 2012). Although language standards have been established, they differ for the various positions in the nursing profession (e.g., RN, LPN, NA, PSW), and evidence suggests that immigrant hires differ in their speech fluency and pronunciation, which may create a hindrance in communication especially with older family caregivers and those who have limited exposure to lingual diversity (Centre for Canadian Language Benchmarks, 2002). Bauer and his colleagues (2014) reported that families disclosed that staff language fluency posed a barrier to communication, consistent with the present findings.

Reduction of misunderstandings is particularly important in the context of conflict management (Krauss & Morsella, 2014). Miscommunication has been noted to occur due to a lack of a background of shared commonality and knowledge between speakers (Krauss & Morsella, 2014). During conflict episodes, listeners interpret communication based on their preconceived notions of the speaker's intentions (Krauss & Morsella,

2014). For example, HC family caregivers described staff's interpretations of communication that were consistent with their own fears about how they were being perceived during a conflict episode (e.g., being called an "issue" was perceived as too "pushy"). Krauss and Morsella (2010, 2014) recommend that listeners focus on the speaker's intended meaning and when speaking to consider what their listeners will take their words to mean. In order to have family caregivers who are well-informed, staff should provide information at the level sought by family and in accordance to their ability to process it (e.g., reducing technical language), which could reduce misunderstandings (Way, Black, & Curtis, 2002). However, although beneficial, such considerations in communication would require consistent support in order to be implemented during family-staff conflicts in LTC.

Being labeled as a "problem." High conflict family caregivers in this sample described both concerns of being labeled by staff as a "problem", "complainer" or an "issue", and awareness of acquiring such a reputation from staff. This awareness did not result in positive outcomes as families reported further conflict episodes secondary to it, avoidance of staff, engaging in tasks outside of staff's awareness (e.g., administering medication to the resident, seeking additional medical treatments), and resulting in an even greater barrier to their relationship with staff. Studies have reported that staff label families as "demanding" and "problematic," with such labels potentially contributing to increased avoidance of these family members (Petrovic-Poljak & Konnert, 2013; Utley-Smith et al., 2009). However, it is these family members in particular who require the greatest support from staff, in terms of clarification of information and potential misunderstandings, with staff avoidance likely contributing to

exacerbation of conflict episodes and the chronicity of family-staff conflict. High conflict families described escalating their conflict management when encountering staff avoidance; they were aware that staff was avoiding them and would turn to additional family members, managerial-staff and external organizations to assist them in addressing the conflict. Families' awareness of being "known" to staff or having a reputation as a "complainer" resulted in perceptions of reduced personal efficacy to resolve conflicts with staff. These family members, as well as the staff that they interact with, should be identified for additional support and as the individuals that would most benefit from interventions that promote collaborative family-staff relationships. Therefore, an attitude shift needs to take place in terms of labeling these families "at risk" or "vulnerable" in place of the ineffective labels currently used that perpetuate conflict. An "at risk" or "vulnerable" label, is more accurate in describing these families, and could assist in connecting these family members with the appropriate resources and identifying them and the staff that they interact with for structured interventions.

Fears of retribution. High conflict families described concerns of potential retribution from staff resulting from the manner in which they managed conflict in LTC. Their concerns were that if they raised issues about the manner in which care is delivered, that the resident would be neglected by staff, would receive poorer quality of care or would be physically harmed. These fears were propagated through conversations with trusted staff, media (e.g., news reports of resident abuse in LTC) and staff behaviour (e.g., a staff member insinuating that she had done something that the family member would not approve of to a resident). Hertzberg and Ekman (1996), in their qualitative study of seven family caregivers in nursing homes, reported that

families expressed concerns about potential retribution towards residents if they expressed any criticisms to staff. Notably, families suggested that fears of retribution were more prominent when the resident was cognitively impaired and was unable to self-report substandard care. Participants in this study similarly acknowledged residents' level of physical vulnerability and inability to rely on their self-report concerning any inappropriate staff behaviour. High conflict family members were noted to either modify their behaviour in response to these fears by subduing their conflict management approach, not approaching staff with issues or becoming increasingly selective in terms of what issues they raised, or proceeding in a confrontational manner while maintaining vigilance about resident well-being (e.g., through a proxy such as a privately hired companion, regular checks for bruises). This suggests that, in general, families view themselves (and the resident) to be in a highly vulnerable position when addressing concerns and conflicts in LTC, impacting families' communication with staff and conflict management.

High conflict (HC) and low conflict (LC) family caregivers. Although previous research has identified female family caregivers as perpetrators of aggressive behaviour toward staff (Vinton & Mazza, 1994, 1998), the gender group comparison was not statistically significant in this study. The present sample had too few men overall which may have led to reduced power of the gender comparison.

High conflict family caregivers reported more negative previous experiences in LTC than LC families, a finding that was also supported by the qualitative data as families described hearing negative information from others, and having earlier negative caregiving experiences with another or with the same family member in another LTC

facility. Such previous experiences may contribute to negative expectations in care, as families described being wary of situations they had previously observed or experienced, even when they were not connected to the staff or the current LTC facility. Expectations in conflict may have been impacted as well by previous experience, as HC families described escalating issues earlier because they had learned that a more aggressive approach provides them with the immediate response that they seek from staff, with these beliefs being applied across facilities and conflict episodes.

Consistent with interview data, HC family caregivers visited the LTC facilities more frequently than LC family members. HC families described increasing the frequency of their visitation in order to "check in" on the resident, monitor care, and to take over care tasks (e.g., medication administration). However, quantitative analyses indicated that LC family caregivers were more involved in LTC than HC family caregivers based on a measure of family involvement. This finding has interesting implications in that HC families may be more present at the facility but less involved. Families report difficulties navigating their involvement in LTC (Gaugler et al., 2004), which may be further compromised following conflict episodes, with families describing trying to stay "under the radar" of staff while present at the facility. Notably the measure used examines indices of positive involvement in care, and does not include what could be perceived as bungling actions in conflict episodes (e.g., seeking out staff members to discuss care, filing complaints to staff, supervising care exchanges, etc.). Alternately, although more present, HC families may withdraw from engaging in direct care in light of concerns that staff may be inappropriately reliant on them for providing resident care, as was suggested by HC families during interviews. It would be of interest to examine to

what extent the conflict itself and its management becomes the main focus of HC family members' involvement in care and impacts their satisfaction with their own involvement in care. High conflict family caregivers indicated that they did not anticipate the degree of involvement (in terms of presence) at the facility upon relocation, and their involvement was not consistent with their own desires for involvement. Their involvement was out of perceived necessity as families reported issues with trust in staff, which may deprive them of the positive effects of other forms of involvement that they engaged in previously (e.g., emotional, social, physical, etc.), including an associated sense of generativity (e.g., "concern and activity dedicated to contributing to the welfare of others"; Grossman & Gruenewald, 2017, p. 436) and self-efficacy.

Low conflict families additionally reported a greater dependence on staff in attaining quality care for the resident when compared to HC families. This finding could be related to the possibility that LC families have better relationships with staff and better trust in staff, resulting in positive interdependence with staff.

Moreover, HC family caregivers reported higher psychological distress and caregiver burden than LC family caregivers, without any differences in physical health. This is not surprising given the negative consequences associated with repeated engagement in conflict, and underscores that HC family caregivers should receive additional support in LTC to not only assist in managing conflicts more effectively, but to reduce strain and improve their well-being. Consistent with these findings, more than half of the HC family caregivers interviewed reported experiencing a range of emotions consequent to conflict with staff such as anxiety, frustration, feeling overwhelmed, and guilt.

Study Limitations

The conclusions from this study are subject to a number of limitations. First, the non-random sampling strategy of using a convenience sample reduces the generalizability of findings, as well as the limited sample size. In order to examine the generalizability of the study findings, the present sample was compared to other family caregivers of residents in LTC in Alberta, which suggests that the family caregivers in this study are representative of family caregivers across Alberta (Strain et al., 2011; HQCA, 2015). This sample has similar demographics (including proportions, ranges and means) to two large-scale surveys⁴ of family caregivers in LTC facilities in Alberta in terms of family caregiver gender, relationship to resident, age, education, marital status, duration of resident's stay in the facility, and the number and duration of visits. The differences observed were a lower rate of family caregivers maintaining full-time employment (with the current study sample having more retirees) and having a somewhat higher (10%) proportion of male residents and age of residents (< 5 years). The employment may differ due to the time required to complete the current study in person with the researcher in place of surveys that were mailed out that may require less time. Moreover, low endorsement of frequency, severity and stress associated with conflict was observed across the measures. However, when compared to other studies employing these measures (Jehn & Mannix, 2001; Maas et al., 2000; Petrovic-Poljak & Konnert, 2013; Pillemer et al., 2003), the frequencies and severity of conflict are comparable, suggesting that this sample is consistent with other samples in the

⁴ The two surveys include the Health Quality Council of Alberta's Long Term Care Family Experience Survey (2015) and the Alberta Continuing Care Epidemiological Studies (ACCES; Strain et al., 2011). The HQCA surveyed 7,975 family caregivers in LTC facilities and ACCES surveyed 917 family caregivers.

literature in terms of conflict frequency and severity. Moreover, conflicts, conflict management and family involvement may vary by setting type (for profit, non-profit, mixed) and size. This could be due to different organizational cultures, models of care, levels of funding and staffing levels. However, the conflicts described by HC family caregivers were similar to the issues highlighted by family caregivers across Alberta who identified that meeting residents' needs, expectations regarding family involvement, staff-related issues and communication were the most significant issues and challenges in LTC facilities (Strain et al., 2011).

The second limitation consists of the use of self-report methodology and absence of real-time indices of conflict and conflict management, requiring participants to rely on their retrospective recall of conflicts with staff. This was an evident challenge, as some participants had difficulty recalling timelines or the chronology of events when discussing conflict episodes, which did not allow for a clear examination of precipitant and concomitant factors in family-staff conflict. As previous research has indicated, studying conflict empirically poses a significant challenge (Nauta & Kluwer, 2004). Conflict is a highly sensitive topic that can affect the recruitment of participants, due to fears of negative consequences of admitting to conflicts, and responses to questionnaires, through social desirability and self-serving biases (i.e., perceiving one's own conflict behaviour as more constructive and less destructive than that of the other party's behaviour; Nauta & Kluwer, 2004). These factors are particularly relevant in the LTC context where vulnerability of dependent residents and fears of retribution from staff when families leave are salient issues for family caregivers (Haesler et al., 2007).

Most studies of conflict involve self-report measures; however the validity of such questionnaires can be questionable due to social desirability (Jensen-Campbell & Graziano, 2005; Nauta & Kluwer, 2004), but remains the most readily used approach due to ease of administration and analysis. Recent research suggests the feasibility of daily diary methodology for assessing family-staff conflicts in LTC (Konnert, Speirs, & Mori, 2017), which could assist in reducing the impact of retrospective memory bias. Importantly, the authors reported family members' positive attitudes toward this method, with minimal data loss, suggesting good utility for this approach for future investigations of family-staff conflict, including interventions.

Thirdly, concerns of retribution may have contributed to another potential limitation, namely reduced saturation (i.e., the comprehensiveness of the overall data), as the participants with highest frequencies of conflict may not have participated in the study. This issue arose both during recruitment and data collection, as family caregivers reported being unable to participate in the study due to fears of staff retribution. One study site resulted in no family caregivers recruited to the study despite multiple participants approaching the author, and relayed a consistent message of fear of discussing their complaints and criticisms of staff with the author. Families voiced concerns during self-report measures and interviews as well, and requested that interviews be conducted away from the LTC facility to ensure confidentiality. The challenge of overcoming such barriers is likely a contributing factor to the lack of primary research in the area of family-staff conflicts.

Future Directions: Research and Practice

Research. Conflict is a dynamic process with multiple players (e.g., family caregivers, staff, residents). Even though the focus of the present study was on family caregivers' experiences with conflict, future studies should include staff and residents, along with family caregivers, to examine the dynamic and reciprocal nature of conflict on the multiple parties involved. Interviews with HC families provided variable perceptions of staff's conflict management and suggested that one party could evoke and escalate, or even de-escalate, the actions of the other. Moreover, this study excluded residents' opinions due to the cognitive and physical barriers, but as the conflicts concern residents it would be of interest to examine what role residents take on in family-staff conflicts. Qualitative data from the present study suggested that some residents provided feedback to their family caregivers and made requests of them in regard to care issues that incited and propagated conflicts. Therefore, future studies should examine how family and staff conflict management influence one another, and what is the role of and the outcome for residents in family-staff conflicts.

Communication is a complex construct that has been globally addressed in the LTC research literature (e.g., Majerovitz et al., 2009; Pillemer et al., 2003). However, in order to generate effective and practical interventions, specific aspects of communication that may be most detrimental to family-staff conflict management should be identified. As a result of this and previous work (Petrovic-Poljak & Konnert, 2013), staff English language proficiency and family caregiver comprehension have been identified as a barrier to effective communication and should be examined in future studies for their effect on family-staff conflict and its management.

The present study used the frequency of conflicts as the main metric of family-staff conflicts. Given that interview data suggested that families place different levels of significance on conflicts of varying frequency, it may be important in place to develop a measure of severity or significance of conflicts in addition to measuring frequency of conflict. Moreover, the scope of conflict domains on the FICS is currently limited when compared to family caregivers' descriptive reports of conflict, suggesting that this measure may be missing key conflict domains (e.g., medication management, staff's demeanour toward family caregivers, family caregivers feeling unacknowledged). Development of appropriate, psychometrically sound measures of conflict and its management for use in LTC should be seen as a priority in this area of research. It was difficult to gather appropriate measures for use in the present study that were relevant to the LTC context, contained required face validity, and were psychometrically sound. Given that the measures were appropriated from other research literatures, they may not be entirely capturing the constructs of interest, which may serve as a hindrance to the growth of research regarding family-staff conflicts in LTC.

Practice recommendations. Deutsch's well-verified theory of the effects of cooperative and competitive management was appealing for application to family-staff conflicts because it also allows insights into what can give rise to both constructive and destructive processes (Deutsch, 2014). Essentially, it provided an intellectual framework for understanding what happens during a conflict and how to intervene. As this theory has been broadly applied to various populations (Johnson & Johnson, 2005), to understand and intervene in a specific conflict requires specific knowledge about the parties involved in the conflict, the context in which the conflict occurs, and their conflict

orientations (Deutsch, 2014). This study has sought to generate knowledge about family caregivers' conflict management to complement previous studies examining staff's experience and management of conflict (Montoro-Rodriguez & Small, 2006; Small & Montoro-Rodriguez).

Each conflict situation may possess unique difficulties that may require emphasis on a different theoretical theme when compared to another; for example, a conflict situation where a family member feels powerless may draw upon renegotiation of power dynamics, whereas another might draw upon communication where a family caregiver feels unheard. Perhaps the most important implication of cooperative-competitive theory is that a cooperative orientation to conflict management facilitates constructive resolutions, whereas a competitive orientation hinders it (Deutsch, 2014), which was supported by the present study. Therefore, a theoretical approach to intervention and practice recommendations is encouraged.

Previous interventions for family caregivers and staff in LTC targeting family involvement and family-staff relationships have been reported such as the Partners in Caregiving program (PIC; Pillemer et al., 1998, 2003; Robison et al., 2007), Family Involvement in Care partnership intervention (Maas et al., 2000), among others (Gaugler, 2005c; McCallion, Toseland & Freeman, 1999; Murphy et al., 2000, as cited in Zimmerman et al., 2013; Zimmerman et al., 2013). Although these interventions had some promising outcomes such as improved family and staff communication with residents, greater empathy toward staff, improved family and staff's perceptions of one another, and reduced symptoms of depression, the interventions to-date were limited in their effectiveness due to their focus on select populations, settings and outcomes, with

limited attention given to long term follow-up and uptake in LTC. Moreover, family-staff conflict has been included as an outcome in some of the studies conducted to date (Maas et al., Pillemer et al., 1998, 2003; Robison et al., 2007; Zimmerman et al., 2013), and an atheoretical conflict resolution module was provided as part of one intervention (Pillemer et al., 1998, 2003; Robison et al., 2007). However, despite various approaches, no to minimal change in reported family-staff conflict was observed in the interventions conducted, with two studies even reporting an increase in family-staff conflicts (Pillemer et al., 2003; Zimmerman et al. 2013). Such increases in conflict may have resulted from greater awareness and willingness to report conflicts, as well as increased coordination of care with staff. Therefore, given the other beneficial outcomes observed through the interventions, it might be of value to focus on changes in family and staff's skills in conflict management and perceived effectiveness in managing conflict instead of the incidence of conflict itself which may not itself be a negative outcome.

Based on the theory of cooperation and competition (Deutsch 1949, 2014) and the results of the present study, a number of recommendations for LTC settings are outlined below. However, as previous authors have noted, there is an additional challenge of burden and hardship to the LTC facilities in terms of providing interventions to family and staff. Interventions, ideally, need to be easy to administer and brief, in light of limited time and staff resources. This poses a challenge to the implementation of recommendations in LTC, primarily when it concerns themes of conflict management, cooperation, trust, influence and communication, which not only require the acquisition of skills, practice, but also renegotiation and maintenance. Therefore, it is advised that

researchers implement interventions in consultation with administration, staff, family caregivers and residents, in order to develop the accurate "dosage" of intervention that can be sustained in the LTC environment.

1. *Reframing family staff conflict as a mutual problem.* In order to develop a cooperative orientation, family-staff conflict needs to be reframed as a mutual problem (both family caregivers' and staff's) to be solved through joint cooperative efforts (Deutsch, 2014). Practices, even when unintended, of labeling family's concerns as 'unrealistic expectations', naming family caregivers as a 'problem', and avoidance of family caregivers, place the accountability and burden of the conflict on the family caregiver which detracts from a cooperative orientation, and based on the current data, escalate conflict episodes. Reframing gives the accountability to both family and staff, which would additionally encourage that the potential solutions or approaches considered to address an issue would be acceptable and fair to both parties. Such reframing could be incorporated both in educational interventions and everyday practice. Reframing problems as mutual has been reported to be beneficial even among parties who maintain a win-lose orientation (Deutsch 2014), such as the HC family caregivers in this study.

2. *Availability of appropriate support.* It is easier to promote and maintain a cooperative orientation with the appropriate social support (individually or by becoming a part of a network of people or a member of groups), including in hostile environments (Deutsch, 2014). In the case of family caregivers, this social support can come from staff, management, other family caregivers (individually or as part of a group).

Recommendations would include having family councils and family support groups

available at the facilities. Although all families should be invited to and made aware of the presence of such resources, families who are identified as vulnerable or at risk should be explicitly invited to join. Additionally, opportunities should be made for family caregivers to have access to meetings with administration and staff in a timely manner and should be oriented to the nature of such meetings, as well as encouraged to bring their own supports (e.g., a family member). Access to managerial and staff support on weekends and in the evenings needs to be addressed by offering either a telephone service, or having a set time per week where families would have access to management and staff.

3. *Education and training.* Building knowledge and skills in cooperation and conflict management, including effective problem solving and decision-making, is important not only for family caregivers and staff, but also for the management that supports them (Marzialli, Shulman, & Damianakis, 2006). Although this study focused on family caregivers, staff should be a target of intervention as well given evidence that some staff maintain and propagate adversarial relationships with family caregivers and have limited professional training in managing family issues (Bauer, 2006; Ervin, Cross, & Koschel, 2013). Moreover, given the extent of reports by HC family caregivers about attempts to control emotional reactions, and being confrontational and aggressive, an intervention should include being aware of own tendencies of becoming emotionally upset, and how to manage such emotions (i.e., self-soothing techniques such as breathing, taking a time out).

4. *Developing and disseminating a procedure for managing conflicts.* The family caregivers in this study reported various levels of knowledge about conflict management

specific to the facility. Provision of facility-endorsed policies would be a proactive approach rather than the currently reported reactive approaches. Thus, LTC facilities would benefit from having a clear process regarding who, how, and when families should approach staff in case of an issue. Although use of feedback forms may be adequate for the majority of family caregivers with some of their concerns, having a clear process in place that is readily known and accessible to family caregivers would be of benefit for low and high conflict families alike. An established process would also benefit staff by reducing their concerns of not knowing how to manage conflicts with family caregivers and would allow for the optimization of staff resources that are spent on conflict management (Abrahamson et al., 2009).

5. *Development of cooperative norms.* Development of norms for cooperative behaviour for both family caregivers and staff in LTC, would facilitate with management of conflicts. Such norms should focus on addressing the issues in a timely manner with responsive communication and active listening (i.e., as opposed to avoidance and deferral of issues) while encouraging perspective taking between family caregivers and staff, and emphasizing the possibilities of constructive resolution of the conflict, taking responsibility for actions and making sincere apologies, seeking reconciliation following harm, seeking the other's views, sharing information, empowering the other to be an active effective participant in the cooperative problem-solving process (Deutsch, 2014). The present data contain multiple examples showing that cooperative norms are prone to violation in the heat of the conflict, as the HC family caregivers described by becoming angry and aggressive with staff and using personal attacks. In these

situations, family-staff dyads require additional support to assist in recognizing this dynamic and returning to the issue with respect toward one another.

6. *Increasing power.* As previously reported that cooperative use of power through conflict generates shared power between the involved parties, families should be provided with opportunities to demonstrate influence in decision-making and problem-solving in LTC. One way of enhancing influence would be to incorporate family caregivers' personal and professional knowledge when approaching care issues. For example, if staff encounter difficulty while providing food to residents, staff can inquire with family caregivers for suggestions and recommendations. Zimmerman and her colleagues (2013) have noted that family caregivers are an underappreciated resource in LTC, consistent with findings in this study. However, as previously noted, family involvement should be collaboratively negotiated with the family caregiver in order to take in their preferences for involvement. This should be done at admission and revisited over the course of the resident's stay as their preferences may change with time.

7. *Building trust and managing distrust.* Addressing trust between family caregivers and staff should be considered a priority in LTC, particularly given that families may arrive to the LTC facility with variable degrees of trust based on previous experiences in LTC. Previous interventions targeting family-staff relationships in LTC have focused on repairing trust between the parties. However, although trust can be rebuilt, the rebuilding process can often be lengthy and vulnerable to the multitude of issues that family-staff relationships encounter on a daily basis (Coleman, 2000). For example, although trust-building may occur with positive care interactions with staff, a single event of inconsistency or unreliability may sharply decline trust (Lewicki & Tomlinson,

2014). Therefore, research suggests that conflict management could become more effective if interventions focused on managing distrust (for a review see Lewicki & Tomlinson, 2014). This is particularly the case among HC family caregivers who hold significant distrust based on the results of the current study. Lewicki and Tomlinson recommend the following techniques for managing distrust that could be applied in the LTC setting: (a) explicitly address the behaviours that contributed to mistrust (e.g., error in care, unreliability), (b) the persons responsible for a trust violation should apologize (e.g., for harm or damage) and acknowledge responsibility for their actions, (c) cooperatively renegotiate and restate the expectations for future behaviour, (d) make an explicit agreement on expectations as to what is to be done and on deadlines for completion and feedback (e.g., asking what the family caregiver care-related benchmarks are, deciding upon a timeline to address the issue, and provide feedback), (e) agree on procedures for monitoring and verifying the other's actions (e.g., use of monitoring sheets for care plans that can be reviewed, being present during a care interaction), and (f) development of alternative options that can be invoked with further trust violations (e.g., hiring private carers, obtaining a second opinion). These interventions may be particularly useful with HC family caregivers with adequate support from managerial staff.

8. *Opportunities for two way feedback.* In order to facilitate open communication, Hertzberg and Ekman (2000) have recommended the use of pre-planned informal and formal individual conversations between family caregivers and staff, and specifically opportunities to provide two-way feedback regarding care issues and the relationship. Only one family caregiver described having a conversation with staff about their

relationship and mutually managing any "hard feelings" during a meeting with management present. Conversations about the family-staff relationships following the management of conflict episodes should be a seminal component of any managerial interventions of family-staff conflicts. Such meetings should include any front-line staff involved in the conflict episode, as front-line staff are frequently excluded from such meetings in LTC (Boise & White, 2004).

Although the above recommendations are based on the current data and would be of benefit in addressing family-staff conflict in the LTC context, the question remains—how do we make change in LTC? The two factors that may be mostly at play here are the need for change in the culture of LTC and attitudes toward LTC, and levels and type of staffing. At a societal level, there is a concern that we are not valuing the most vulnerable, particularly among the aging population, as differential amounts of resources are provided in different sectors of our health care system (e.g., pediatric care vs. end of life care). If, as a society, we do not place value on older adults and their families it will be difficult to make any of the recommended changes in LTC settings and will limit the resources that are placed in this sector of the health care system. Furthermore, the term "culture change" in LTC has become increasingly popularized, with many identifying that the LTC environment is an underserved one in terms of financial and human capital, and one that requires an entire shift in approach in order to improve the effectiveness and safety of resident care (Corazzini et al., 2014; Shier, Khodyakov, Cohen, Zimmerman, & Saliba, 2014) . Efforts focused toward discussing matters related to culture change in LTC exist, including knowledge translation, such as the Pioneer Network, that maintain a conversation between

consumers (e.g., older adults, families, future consumers), policy (e.g., regulators, policymakers, government payers), academia and education, and provider stakeholders (e.g., administrators, owners/boards). These organizations will be seminal in the gradual process of culture change that will be required to address family-staff conflict and effective interventions for high conflict families.

Although the present study has been conducted in the absence of a cost-benefit analysis, it is clear that family-staff conflicts have significant costs to residents, families and staff, based on the present study and current literature. In terms of financial costs, given that conflict has been found to be related to increased staff burnout and turnover (Abrahamson, Sutor, & Pillemer, 2009), the replacement of staff is a significant problem. Rondeau and Wagar (2016) reported that the cost of nursing staff is the most expensive line item in the budget of healthcare organizations in Canada, including LTC. In fact, excessive nurse turnover has been deemed a "major global problem" that adversely impacts most health care systems (Baumann, 2010, as cited in Rondeau & Wagar, 2016). In Canada the financial cost associated with the "loss" of one nurse has been calculated at US\$ 26,652 (Duffield et al., 2014). Although current rates of turnover in LTC in Canada are unavailable, rates in the United States suggest the annual turnover rate for RNs to be 56.1% and LPNs 51% (Donoghue, 2010). Therefore, even in the absence of the psychosocial costs, if the financial costs are just considered in terms of staff turnover and costs of replacing staff, the costs are staggering for an already starved system.

Moreover, some of the concerns reported by families underscore a progressive reduction of professional regulated staff in LTC, particularly nursing staff with advanced

degrees and specialized expertise, leaving much of the direct care provision in the domain of support staff (e.g., HCAs, NAs). These programs have limited curriculums and provide circumscribed training in caring for individuals in the LTC setting. The Government of Alberta Health Care Aide program describes that individuals can become "fully qualified" to work in a number of settings, including LTC in "just 21 weeks" (Alberta Health, 2018). The complaints by family members may reflect the potential truth that without specialized training, staff may be ill-equipped to meet the high care needs of older adult residents and their families, including increasing physical and mental morbidity, cognitive impairment and behavioural challenges (Montoro-Rodriguez & Small, 2006). Undoubtedly, the difficult nature of the work and inadequate training will continue to contribute to increased experiences of high levels of stress. However, family members and residents' expectations for care will more than likely increase with trends in person-centred care, which may not be adequately met by current staffing and funding provisions. Moreover, regulated and trained staff are required to implement any education and skills training in conflict management for staff, families and residents in LTC.

Given that staffing standards in Canada are the responsibility of each provincial government to have the appropriate number of staff and skill mix (e.g., relative percentages of regulated and non-regulated staff in LTC), in order to close the gap between the expected staffing standards and the LTC demand, policies developed by provincial governments across Canada will be required to support and promote effective change. Without policy initiatives and the involvement of policy-makers in the conversation between consumers and stakeholders, change is unlikely to occur or be

effectively maintained, particularly as it relates to levels of staffing, skill mix, and support provided for family caregivers. Currently there are unsafe resident-to-staff ratios in many LTC facilities (Harrington et al., 2012), and wide variability within and between provinces in staffing standards (e.g., ranging from 0.05 nursing hours per resident per day to more than 3 hours, may or may not require the presence of a RN 24 hours per day), with Canada reportedly having poorer staffing levels when compared to other industrialized countries (e.g., U.S., U.K., Germany, Sweden, and Norway; Harrington et al., 2012). Such inadequate staffing (and poor skills mix) have been associated with poor quality of resident care in Canada (Spilsbury, Hewitt, Stirk, & Bowman, 2011).

Relatedly, some of the family-staff conflicts described in the present study capture the dissatisfaction with the quality of care and the concern for resident safety stemming from staffing-related issues, with some families raising concerns as part of their advocacy role in LTC. Although not all families in this study sought out an advocacy role, some indicated being placed in the position of resident advocate out of necessity (e.g., potential for harm to resident). However, family caregivers' ability to advocate may be limited. Nursing staff have been noted to be in a similar advocacy role, but may have limited time due to multiple daily demands in LTC. However, provincial nursing associations (e.g., Registered Nurses Association of Ontario) have been increasingly involved in advocacy work to amend provincial policies (RNAO, 2007). Therefore, it is imperative that family caregivers, who are already in a stressful and vulnerable position, receive additional support in terms of advocacy by making the advocacy count at the policy level. In the present data and the current literature, there is an acknowledgment that policy and organizational level factors require change in order

to make the individual and team level change effective. At the community and individual level, lobbying politicians and holding governments accountable for change is the only solution for addressing the underfunding of LTC and the systemic problems in these settings.

Summary and Conclusion

According to Morton Deutsch and Peter Coleman, there are ways of "finding cooperative, win-win solutions to conflict, no matter how difficult" (Deutsch, 2000, Preface xiii). On certain occasions, family caregivers' role in family-staff conflict is impacted by their own biases and caregiving journeys, but during others, families raise a needed voice in LTC that is required to produce change and to move toward the idealized goals for improvement and growth in LTC, including person-centred care. In fact, as Molinari (2017) pointed out, the types of family-staff conflicts that are observed in LTC "reflect bureaucratic, institution-focused, insensitive, rote execution of job duties, i.e., the opposite of person-centered care", as conflicts centre around poor resident care, inadequate exchange of information and staff not fulfilling their duties. Families raise their concerns about the quality of care that residents receive and question the person-centred approach that is often advanced but not reflected in their day-to-day observations within the nursing home context (McGregor & Ronald, 2011; Zimmerman et al., 2013). However, it should be noted that although family caregivers' role as members of the caregiving team includes supporting person-centred care, not all family caregivers' activities are person-centred (i.e., there can be a mismatch between what the family caregiver wants and what the resident wants and needs; Boise & White, 2004). For example, a family member may focus on the resident's appearance insisting

on more frequent showers and wearing specific clothing, however due to cognitive and physical compromise the resident may experience showers as frightening and dressing in certain clothes a distressing battle (Boise & White, 2004).

The overarching aim of this study was to learn about family members' experiences of conflict with staff and their management of conflict in LTC. The specific intent was to apply a theoretical approach to understanding how conflict is managed by family members in LTC to a largely atheoretical and limited literature of family-staff conflicts. Through the application of a theoretical approach, the objective of the study was to examine the predictors and outcomes of conflict and its management. Another aim was to gain a greater understanding of the experience of family caregivers who experience conflict most frequently, as these families have been identified to require a disproportionate amount of limited LTC resources and may be at most risk of adverse outcomes (Vinton & Mazza, 1998).

Given that conflict is inherent in any environment in which individuals have differences in goals, needs, desires, responsibilities, perceptions and/or ideas (Almost, 2006) and that a certain degree of conflict is essential (Cowling et al., 1988), family caregivers may require education and training in conflict management in order to assist in their adjustment to LTC and to be able to manage conflict constructively. Many aspects of family caregivers' roles involve differences in opinion regarding the content, the process of care, as well as advocacy toward improved services for residents, which could place them repeatedly in conflict situations. Appropriate management of conflicts is necessary in order to maximize beneficial effects and minimize negative effects, and in order to prevent unaddressed or inappropriately managed conflicts from spiraling

(Wall & Callister, 1995). Therefore, family-staff conflicts could improve quality of resident care if properly managed (Almost, 2006).

Overall, family caregivers in LTC encounter diverse conflicts and employ mainly cooperative conflict management, with the exception of those families who encounter conflict more often, and use competitive conflict management strategies. These family caregivers engage in a number of conflict management strategies in order to effectively manage resident care issues, however, they are at risk of not only having a negative experience in LTC but in regards to caregiver burden, mental well-being, and poor relationships with staff. It is these family caregivers that most require specific and structured interventions. Families would benefit from training in cooperative management strategies in order to reduce negative consequences of conflict and promote values consistent with cooperation, to heighten cooperative goals of quality resident care, to develop open-minded discussions of conflict and foster creativity to the multitude of challenges facing LTC in the near future for residents, staff and families.

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Appendix A. Recruitment Poster

Are you a **family member** or
a **friend** of an older adult (60+)
who resides in a nursing home?



UNIVERSITY OF
CALGARY

WE NEED YOUR HELP!!!

The University of Calgary is conducting a study to gain greater understanding of the experiences of family members and their relationships with staff in nursing homes, in order to improve the experience of residents, families and staff.

We need your expertise and insights as family members and friends to make this research count and have your voice heard!

The study involves an interview and the completion of questionnaires that can be done at a time and place that is convenient for you. All inquiries and responses will remain confidential.

To obtain more information, please contact

Ana Petrovic-Poljak at 403-220-4975

Every voice counts!



The University of Calgary Conjoint Health Research Ethics Board has approved this research study.(REB 13-0172)

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Appendix B. Informed Consent Form

Informed Consent Form (Family version-Part A)

Study Title: An examination of conflict management among family caregivers in long-term care

Investigators: Ana Petrovic-Poljak, M.Sc. (Ph.D. Candidate)
(403-220-4975, apetrovi@ucalgary.ca)
Dr. Candace Konnert (Research Supervisor)
(403-220-4976, konnert@ucalgary.ca)

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Please take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

Background and Purpose of the Study

Family members and staff work together to promote residents' overall well being. At times there may be differences of opinion between staff and family members. This might include minor disagreements that pass quickly or more major issues that may be ongoing. This can be difficult for all involved. The present study seeks to gain a greater understanding of the factors that impact family and staff relationships, to understand how issues are managed, and the impact of this on family members. This information will help us develop improved ways of managing daily issues that come up in LTC, to work toward improving family-staff relationships and ultimately to improve your experience and the care provided to residents in LTC.

What would I have to do?

If you choose to participate in this study, you will be interviewed and asked to describe your experiences as a family member. You will also be asked to complete paper-and-pencil questionnaires. The researcher will obtain information about you (e.g., educational background) from you as well as general information about your caregiving experience (e.g., how long you have been a caregiver, how often you visit, etc.). The questionnaires will ask you about a variety

of things such as your well-being, involvement in the LTC facility, your satisfaction with care provided, sense of community, expectations for care, and communication with staff. Participation will require approximately 1.5 hours of your time. The interview can take place at a time and place that is most convenient for you such as at the University of Calgary or in your own home/office.. If there are questions you would prefer not to answer that will be fine.

Will my records be kept private?

Yes. All of the information collected from you as part of the study will be kept confidential and will not be shared with anyone. Only the researchers and persons associated with the study at the University of Calgary will have access to your information as part of their duties. You will be given a participant code that will be placed on all information obtained from you in place of your name. You will not be identified by name in any reports written about the study. All information obtained will be kept in a locked filing cabinet at the University of Calgary. The University of Calgary Conjoint Health Research Ethics Board will have access to the records.

What are the risks and benefits of participating?

Participation in this study does not involve risk or discomfort other than the sensitivity and personal nature of some of the questions. Foreseeable risks include potential feelings of fatigue or boredom, or feelings of worry or upset when asked questions about your caregiving experience. In the event that this occurs, we have resources that are available to you.

However, you might benefit from having an opportunity to discuss your experience. As well the results of this study will provide important information about how staff and family members can work together more effectively. This can help you to work more effectively with staff at the LTC facility. If you like, we can provide you with a summary of our results at the end of the study so that you can see how this research might help you and others.

Do I have to participate?

Your participation is entirely voluntary and you are free to withdraw your participation from the study at any time without penalty. In order to withdraw, simply notify the researcher that you wish to end your participation. If any new information becomes available that might affect your willingness to participate in the study, you will be informed as soon as possible. Whether or not you choose to participate or continue in the study will have no effect on the care your family member receives or on the attitudes of other people toward your relative or you.

Will I be paid for participating, or do I have to pay for anything?

You will not be directly reimbursed for your participation.

Signatures (written consent)

Your signature on this form indicates that you 1) understand to your satisfaction the information provided to you about your participation in this research project, and 2) agree to participate.

In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any

Appendix C. Study Constructs and Measures

Construct	Measure
Previous experience in LTC	Previous Experience in LTC questionnaire
Resident's dependence	1. Katz Basic Activities of Daily Living Scale 2. Presence/Absence of dementia
Frequency of conflict	Frequency of Interpersonal Conflict Scale (FICS)
Conflict with staff	1. Conflict with Staff subscale 2. Intragroup Conflict Scale (ICS)
Conflict management	Cooperation-Competition Scale
Goal interdependence	1. To what extent do you feel that staff depend on you in order to provide quality care to your loved one?", 2. To what extent do you feel that you depend on staff in order to provide quality care to your loved one?".
Trust	Organizational Trust Inventory (OTI)
Power	Family Perceptions of Power Scale
Expectations	Family Caregiver Expectations scale
Communication	Communication with Staff scale
Sense of community	Brief Sense of Community Scale (BSCS)
Satisfaction with care (SOC)	The Family Perception of Care Tool (FPCT)
Caregiver burden	Zarit Burden Interview (ZBI)
Psychological distress:	Brief Symptom Inventory - 18 (BSI-18)
Physical health	How would you rate your health at the present time?
Family involvement	Family Involvement Questionnaire

Appendix D. Family Caregiver and Resident Demographic Information Form

I'd like to start out by asking you some general questions about who you are. This will help me better understand the characteristics of the caregivers here at the care centre. Remember, all of the information you give me will be kept confidential.

1. Participant's gender:

- 1 Male
- 2 Female

2. Participant's ethnicity

- 1 Caucasian
- 2 Asian (please specify): _____
- 3 Native Canadian
- 4 South Asian
- 5 Black
- 6 Other (please specify): _____

3. What is your date of birth?

- 1 Day _____
- 2 Month _____
- 3 Year _____
- 4 Age _____ yrs

4. What is your current marital status?

- 1 Single
- 2 Married
- 3 Widowed
- 4 Divorced
- 5 Separated

5. Total years of education: _____ yrs

6. What is your current employment status?

- 1 Full time
- 2 Part time
- 3 Homemaker
- 4 Retired
- 5 Unemployed

7. What is your average family net yearly income:

- 1 Less than \$10,000
- 2 \$10,000 to \$19,000
- 3 \$20,000 to \$29,000
- 4 \$30,000 to \$39,000
- 5 \$40,000 to \$49,000
- 6 \$50,000 to \$59,000

- 7 \$60,000 to \$69,000
- 8 \$70,000 to \$79,000
- 9 \$80,000 to \$89,000
- 10 \$90,000 and above
- 11 Undisclosed

8. In general, how well does your income and investments currently satisfy your need?

- 1 Very well
- 2 Adequately
- 3 Not very well
- 4 Very inadequate
- 5 Don't know

Now I would like to ask you some questions about your caregiving experience.

9. What is your relationship to the resident?

- 1 Wife
- 2 Husband
- 3 Daughter
- 4 Son
- 5 Daughter-in-law
- 6 Son-in-law
- 7 Other (please specify): _____

10. Resident's gender

- 1 Male
- 2 Female

11. Resident's DOB:

- 1 Day _____
- 2 Month _____
- 3 Year _____
- 4 Age _____ yrs

12. Is the resident a veteran?

- 1 Yes
- 2 No

13. If veteran:

- 1 WWII
- 2 Korean War
- 3 Other _____

14. Has the resident been diagnosed with dementia?

- 1 Yes
- 2 No

15. Did you live with the resident prior to placement?

1 Yes

2 No

16. How long have you been a caregiver to your relative: _____month

17. How long has your relative been institutionalized (include any facility)? _____ months/yrs

18. How long were you a caregiver to your relative prior to placement in a nursing home: _____months (Q16-Q17)

19. What facility does your relative currently reside in: _____

20. How long has your relative been at this facility: _____months/years

21. How many facilities has your relative been in: _____

22. How many people are you currently caring for in a caregiving capacity? _____

23. How many family members are involved in caring for your relative: _____

24. How often do you visit your relative: _____

25. How long is your typical visit with your relative: _____

26. Does your relative have a private caregiver

1 Yes

2 No

27. DAL

1 Yes

2 No

Appendix E. Previous Experience in Long Term Care

1. Have you had previous experience with nursing homes or long term care, prior to coming to this nursing home?

- 1 Yes
- 2 No

2. Where do these experiences come from: (select all that apply)

- 1. Personal experience (such as caring for someone in a nursing home)
- 2. Hearing information from a close friend/relative
- 3. Hearing information from an acquaintance
- 4. Hearing information from a coworker
- 5. Professional Experience (such as working in a nursing home)
- 6. Media (news on TV, newspapers)
- 7. Other. Please specify:

If you had a previous experience of any kind:

3. How would you describe the nature of your experience, in general?

- 1 Negative
- 2 Somewhat Negative
- 3 Neutral
- 4 Somewhat Positive
- 5 Positive

4. To what extent do you feel that these experiences have affected the level of concern that you have about your relative's care in this nursing home?

- 1 Not at all
- 2 Slightly
- 3 Somewhat
- 4 Moderately
- 5 Very much so

Appendix F. Katz Basic Activities of Daily Living Scale

Please indicate whether your family member who resides in this nursing home is independent (i.e., able to do on his/her own) regarding the following tasks. Please place a checkmark under the appropriate response (Yes or No).

	Independent	
	Yes	No
1. Bathing (sponge bath, tub bath, or shower) Receives either no assistance or assistance in bathing only one part of body.		
2. Dressing - Gets clothes and dresses without any assistance except for tying shoes.		
3. Toileting - Goes to toilet room, uses toilet, arranges clothes, and returns without any assistance (may use cane or walker for support and may use bedpan/urinal at night).		
4. Transferring - Moves in and out of bed and chair without assistance (may use cane or walker).		
5. Continence - Controls bowel and bladder completely by self (without occasional "accidents").		
6. Feeding - Feeds self without assistance (except for help with cutting meat or buttering bread)		
7. Operates telephone on own initiative (able to dial well-known numbers and answer the telephone when available)		

Appendix G. Frequency of Interpersonal Conflict Scale (FICS)

How often have you experienced disagreements or conflicts with staff over the following items at this nursing home? Please circle the response that most closely matches your experience.

1. Resident's Personal care				
Never	Once a month	A few times a month	A few times a week	Every day
2. Meals/Food				
Never	Once a month	A few times a month	A few times a week	Every day
3. Administrative rules				
Never	Once a month	A few times a month	A few times a week	Every day
4. Laundry/Clothing				
Never	Once a month	A few times a month	A few times a week	Every day
5. Resident's Appearance				
Never	Once a month	A few times a month	A few times a week	Every day
6. Toileting				
Never	Once a month	A few times a month	A few times a week	Every day
7. Attentiveness to needs				
Never	Once a month	A few times a month	A few times a week	Every day

Appendix H. Conflict with Staff Scale

Each of the statements in this questionnaire describes something about your role in the care of your family member. You are asked to indicate your feelings about each statement in terms of the extent to which you agree or disagree. Please tell me the extent that you agree OR disagree with these statements. A rating of 1 means that you "strongly disagree"; a rating of 7 means that you "strongly agree" with the statement. Circle the number for each statement that best indicates the extent you agree or disagree.

1. I feel like I have to be careful about how I make suggestions or requests about my relative's care so that staff will think that I am interfering.						
1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
2. I feel like an outsider in the care of my relative.						
1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
3. I feel that I have control over the care my relative receives.						
1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
4. Staff listen to my directions for my relative's care, but ignore them if they choose.						
1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
5. It is clear that staff have the real say about what care will be provided and how.						
1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
6. Things that I see as important in my relative's care staff often see as trivial or inconvenient.						
1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
7. Staff are most concerned about rules, routines and efficiency while I am most concerned about my relative as an individual.						
1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
8. No major changes are made in the care of my relative without my approval.						
1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

9. When family and staff have different ideas about care the disagreements are negotiated and resolved.						
1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree
10. I feel sorrow over my inability to control how my loved one is cared for.						
1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Appendix I. Intragroup Conflict Scale (ICS)

Please read the following items and circle the number that best represents how you feel about the issues in this nursing home.

1. How much relationship tension is there between family members and staff in this nursing home?				
1 None	2	3	4	5 A great deal
2. How often do family members or staff get angry while working together in this nursing home?				
1 None	2	3	4	5 A great deal
3. How much emotional conflict is there between family members and staff in this nursing home?				
1 None	2	3	4	5 A great deal
4. How much conflict of ideas is there between family members and staff in this nursing home?				
1 None	2	3	4	5 A great deal
5. How frequently do family members and staff have disagreements about tasks pertaining to the care of the resident in this nursing home?				
1 None	2	3	4	5 A great deal
6. How often do family members and staff have conflicting opinions about the care of the resident in this nursing home?				
1 None	2	3	4	5 A great deal
7. How often are there disagreements about who should do what between family members and staff in the care of the resident at this nursing home?				
1 None	2	3	4	5 A great deal
8. How much conflict is there between family members and staff about who is responsible for what aspects of the resident's care?				
1 None	2	3	4	5 A great deal
9. How often do family members and staff disagree about how resources are distributed at this nursing home, for example, how many staff members are available for each shift, the number of activities provided for residents, etc.?				
1 None	2	3	4	5 A great deal

Appendix J. Cooperative and Competitive Conflict Management

Please place a checkmark in the appropriate box. When engaged in a disagreement/conflict with a staff member at this nursing home:

	Strongly disagree	Dis-agree	Slightly disagree	Neutral	Slightly agree	Agree	Strongly agree
I encourage a 'we are in it together' attitude as we (staff and I) negotiate our differences.							
I demand that staff agree to my position.							
I seek a solution that will be good for all of us (staff and me).							
I want staff to make compromises but I do not want to make compromises.							
I treat conflict as a mutual (mine and staff's) problem to solve.							
I treat conflict with staff as a win-lose contest.							
I work so that to the extent possible we (staff and I) all get what we really want.							
I state my position strongly to staff to get my way.							
I combine the best of positions to make an effective decision.							

Appendix K. Conflict Questionnaire

Please read the following statements and select the response that most accurately reflects your experience here in this nursing home:

1. I have resolved most of my disagreements/conflicts with staff.

- 1-Strongly disagree
- 2-Disagree
- 3-Somewhat disagree
- 4-Neither agree or disagree
- 5-Somewhat agree
- 6-Agree
- 7-Strongly agree

2. Most of my disagreements/conflicts with staff are currently ongoing.

- 1-Strongly disagree
- 2-Disagree
- 3-Somewhat disagree
- 4-Neither agree or disagree
- 5-Somewhat agree
- 6-Agree
- 7-Strongly agree

3. I will be able to effectively resolve disagreements/conflicts with staff at this nursing home in the future.

- 1-Strongly disagree
- 2-Disagree
- 3-Somewhat disagree
- 4-Neither agree or disagree
- 5-Somewhat agree
- 6-Agree
- 7-Strongly agree

4. I anticipate that I will continue to have disagreements/conflicts with staff at this nursing home in the future.

- 1-Strongly disagree
- 2-Disagree
- 3-Somewhat disagree
- 4-Neither agree or disagree
- 5-Somewhat agree
- 6-Agree
- 7-Strongly agree

5. To what degree are you satisfied with the manner that disagreements/conflicts play out between you and staff at this nursing home?

- 1- Completely dissatisfied
- 2- Mostly dissatisfied
- 3-Somewhat dissatisfied
- 4-Neither satisfied or dissatisfied
- 5-Somewhat satisfied
- 6-Mostly satisfied
- 7-Completely satisfied

6. To what degree are you satisfied with the manner in which you handle disagreements/conflicts with staff at this nursing home?

- 1- Completely dissatisfied
- 2- Mostly dissatisfied
- 3-Somewhat dissatisfied
- 4-Neither satisfied or dissatisfied
- 5-Somewhat satisfied
- 6-Mostly satisfied
- 7-Completely satisfied

7. To what degree are you satisfied with the manner that staff handles disagreements/conflicts with you at this nursing home?

- 1- Completely dissatisfied
- 2- Mostly dissatisfied
- 3-Somewhat dissatisfied
- 4-Neither satisfied or dissatisfied
- 5-Somewhat satisfied
- 6-Mostly satisfied
- 7-Completely satisfied

8. To what degree are you satisfied with the outcomes of the disagreements/conflicts that you have experienced with staff?

- 1- Completely dissatisfied
- 2- Mostly dissatisfied
- 3-Somewhat dissatisfied
- 4-Neither satisfied or dissatisfied
- 5-Somewhat satisfied
- 6-Mostly satisfied
- 7-Completely satisfied

9. To what degree are you satisfied with the facility's support (e.g., having policies in place, managerial involvement) in managing family-staff disagreements/conflicts in this nursing home?

- 1- Completely dissatisfied
- 2- Mostly dissatisfied
- 3-Somewhat dissatisfied

- 4-Neither satisfied or dissatisfied
- 5-Somewhat satisfied
- 6-Mostly satisfied
- 7-Completely satisfied

10. Are the processes for managing disagreements/conflicts with staff in this nursing home clear?

- 1- Not at all
- 2-Slightly
- 3-Somewhat
- 4-Moderately
- 5-Extremely

11. Do you feel that you know what you are supposed to do in order to manage disagreements/conflicts with staff in this nursing home?

- 1- Not at all
- 2-Slightly
- 3-Somewhat
- 4-Moderately
- 5-Extremely

12. Do you know the relevant procedures and policies regarding managing disagreements/conflicts in this nursing home?

- 1- Not at all
- 2-Slightly
- 3-Somewhat
- 4-Moderately
- 5-Extremely

13. Do you think that your feedback about disagreements/conflicts with staff is being heard?

- 1- Not at all
- 2-Slightly
- 3-Somewhat
- 4-Moderately
- 5-Extremely

Appendix L. Organizational Trust Inventory (OTI)

SCALE						
1 nearly zero	2 very low	3 low	4 50-50	5 high	6 very high	7 near 100%

Please read the following statements, and select the number from the scale above that is closest to your opinion and write the number in the blank at the end of the statement.

1. My level of confidence that staff are technically competent in the critical elements of their jobs is _____.
2. My level of confidence that staff will make well thought out decisions about their job is _____.
3. My level of confidence that staff will follow through on requests is _____.
4. My level of confidence that staff has an acceptable level of understanding their job is _____.
5. My level of confidence that staff will be able to do their job in an acceptable manner is _____.
6. When staff tells me something, my level of confidence that I can rely on what they tell me is _____.
7. My confidence in staff to do their job without causing other concerns for me is _____.
8. My level of confidence that staff will think through what they are doing on the job is _____.
9. My level of confidence that this nursing home will treat me fairly is _____.
10. The level of trust between staff and family members in this nursing home is _____.
11. The level of trust between the staff I interact with on a regular basis and myself is _____.
12. The degree to which staff and families can depend on each other in this nursing home is _____.

Appendix M: Family Perceptions of Power

Please read the following items and circle the answer that most applies to you.

1.	To what extent do you feel that you are able to influence staff members in this nursing home?				
	Not at all 1	Slightly 2	Somewhat 3	Moderately 4	Extremely 5
2.	To what extent do you feel that you are able to fulfill your own pursuits as a family member in this nursing home?				
	Not at all 1	Slightly 2	Somewhat 3	Moderately 4	Extremely 5
3.	To what extent do you feel that you are able to influence the overall environment of this nursing home?				
	Not at all 1	Slightly 2	Somewhat 3	Moderately 4	Extremely 5
4.	To what extent do you feel that you are able to influence the quality of care that your loved one receives in this nursing home?				
	Not at all 1	Slightly 2	Somewhat 3	Moderately 4	Extremely 5

Appendix N: Family Caregiver Expectations

Here is a list of statements about the services your relative may be receiving. For each statement, tell me to what extent you believed or understood the statement to be true since your relative moved into this nursing home.

To what extent did you believe or understand that.....

	1 not at all	2 a little bit	3 some- what	4 quite a bit	5 a great deal
A program of activities would be offered in which your relative could participate easily.	1	2	3	4	5
Your relative would have opportunities to participate in everyday activities that (he/she) has always done, such as gardening, making beds, and preparing meals.	1	2	3	4	5
Your relative would get plenty of exercise.	1	2	3	4	5
Staff members would seek input to solve any problems they encounter with the care of your relative.	1	2	3	4	5
Opportunities would be provided to include family members in planned social activities in the facility.	1	2	3	4	5
You would be regularly informed about changes in the facility.	1	2	3	4	5
Your relative would have privacy in (his/her) own (room/apartment).	1	2	3	4	5
Staff would help you learn more about your relative's condition by offering reading material, information, and opportunities to discuss questions you may have.	1	2	3	4	5
Your relative would not be bothered by unnecessary noises or people.	1	2	3	4	5
Family members would be made comfortable visiting with their relatives in the facility.	1	2	3	4	5
Your relative would be living in a home-like environment.	1	2	3	4	5

Appendix O: Communication with Staff

Please use the following scale to answer the questions listed below:

1-*Never*

2- *Hardly ever*

3- *Some of the time*

4- *Most of the time*

5-*All of the time*

In the last 6 months, how often did staff at this nursing home:

- _____ Greet you when you visit?
- _____ Seem glad to see you?
- _____ Seem interested in learning more about your relative by talking with you?
- _____ Have all the information they need to care for your relative properly?
- _____ Respond to your questions promptly?
- _____ Act rude or unpleasant?
- _____ Explain things in a way that was easy for you to understand?
- _____ Try to discourage you from asking questions about your family member?

In the last 6 months, how often did you:

- _____ Talk to any staff about concerns that you have about the care of your family member in the nursing home?
- _____ Stop yourself from talking to any staff about your concerns?
- _____ Fear that if you expressed your concerns to staff that they would take it out on your family member?

Appendix Q. Family Conflict Scale

Family members don't always see eye to eye when it comes to their relative who is ill. How much disagreement have you had with anyone in your family concerning any of the following issues:

1. The seriousness of your relative's memory problem?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement
2. The need to watch out for your relative's safety?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement
3. What things your relative is able to do for him/herself?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement
4. Whether your relative should be placed in a nursing home?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement

Family members may differ among themselves in the way they deal with a relative who is ill. Thinking of all your relatives, how much disagreement have you had with anyone in your family because of the following issues? How much disagreement have you had with anyone in your family because they:

5. Don't spend enough time with your relative?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement
6. Don't do their share in caring for your relative?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement
7. Don't show enough respect or sensitivity toward your relative?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement
8. Lack patience in dealing with your relative?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement

I've just asked you how your relatives act toward your relative. Now I'd like to ask how they act toward you. Again, thinking of all your relatives, how much disagreement have you had with anyone in your family because of the following issues? How much disagreement have you had with anyone in your family because they:

9. Don't visit or telephone you enough?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement
10. Don't give you enough help?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement
11. Don't show enough appreciation for your work as a caregiver?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement
12. Give you unwanted advice?			
1 No disagreement	2 Just a little disagreement	3 Some disagreement	4 Quite a bit of disagreement

Appendix R. Family Involvement Questionnaire

This questionnaire asks some questions about the activities you do with or for your relative/friend in this nursing home. There are no right or wrong answers to these questions. Please circle your response.

1. In the past month how many times have you visited your relative (friend) in the nursing home? _____ times. What about in the past week? _____ times.
2. When you visit the nursing home, how long do you usually stay? _____ minutes

In the past month have you:			
3.	Talked to your relative in person or on the phone	YES	NO
4.	Sent letters or card to your relative	YES	NO
5.	Provided food, reading materials, treats or gifts to your relative	YES	NO
6.	Reminisced about the past with your relative	YES	NO
7.	Provided emotional support to your relative (listening, holding hands, hugging)	YES	NO
8.	Attended social or recreation activities at the nursing home with your relative	YES	NO
9.	Attended social or recreation activities outside the nursing home with your relative	YES	NO
10.	Led activities at the nursing home or helped out with other residents	YES	NO
11.	Groomed your relative's hair or nails	YES	NO
12.	Cared for your relative's skin or assisted with bathing	YES	NO
13.	Walked with your relative or assisted with exercises	YES	NO
14.	Fed your relative or assisted with feeding	YES	NO
15.	Assisted your relative with toileting	YES	NO
16.	Assisted your relative with dressing or choosing clothes to wear	YES	NO
17.	Provided clothing, supplies, or equipment for your relative	YES	NO
18.	Laundered your relative's clothes	YES	NO
19.	Cleaned, straightened or decorated your relative's room	YES	NO
20.	Transported or accompanied your relative to appointments outside the nursing home	YES	NO
21.	Managed your relative's financial affairs or paid bills	YES	NO
22.	Overseen the quality of your relative's care at the nursing home	YES	NO
23.	Overseen the condition of your relative	YES	NO
24.	Overseen staff interactions with your relatives	YES	NO
25.	Talked with nursing home staff about your relative's care or condition in person or on the phone	YES	NO
26.	Talked with physicians (doctors) or dentists about your relative's care or condition in person or on the phone	YES	NO
27.	Provided information about your relative to nursing home staff	YES	NO
28.	Attended care conferences (meetings) at the nursing home	YES	NO

29.	Given suggestions to nursing home staff on ways to care for your relative	YES	NO
30.	Directed the nursing home staff on ways to care for your relative	YES	NO
31.	Made decisions about treatments or care your relative gets at the nursing home	YES	NO

Appendix S. The Family Perception of Care Tool (FPCT)

Each of the statements in this questionnaire describes something about your family member's care or living environment. You are asked to indicate your own feelings about each statement in terms of the extent to which you agree or disagree. Highest agreement = 7 and highest disagreement = 1. Circle the number for each statement that best describes the extent to which you agree or disagree.

	<u>Strongly</u> <u>Disagree</u>						<u>Strongly</u> <u>Agree</u>
1. I feel reassured about my family member's care after I visit.	1	2	3	4	5	6	7
2. I could feel more welcomed by staff when I visit my family member.	1	2	3	4	5	6	7
3. Staff listen to the problems or concerns I have about my family member.	1	2	3	4	5	6	7
4. Staff are patient with my family member.	1	2	3	4	5	6	7
5. Staff are caring in their interactions with my family member.	1	2	3	4	5	6	7
6. Staff show affection through use of touch with my family member.	1	2	3	4	5	6	7
7. Staff tend to treat my family member as a child.	1	2	3	4	5	6	7
8. Staff provide for the privacy of my family member.	1	2	3	4	5	6	7
9. Staff appear to be knowledgeable about problems and disorders affecting older adults.	1	2	3	4	5	6	7
10. Staff solicit my help in providing care for my family member.	1	2	3	4	5	6	7
11. Staff provide support to help me deal with my feelings about my family member's situation.	1	2	3	4	5	6	7
12. Other residents on the unit get upset with my family member's behavior and sometimes treat him or her with unkindness.	1	2	3	4	5	6	7

	<u>Strongly</u> <u>Disagree</u>				<u>Strongly</u> <u>Agree</u>		
13. My family member is allowed to move about freely if she or he is physically able.	1	2	3	4	5	6	7
14. My family member gets enough exercise.	1	2	3	4	5	6	7
15. My family member should be encouraged to participate in more activities that help maintain abilities.	1	2	3	4	5	6	7
16. Enough activities are provided for my family member.	1	2	3	4	5	6	7

I AM SATISFIED WITH THE CARE MY FAMILY MEMBER RECEIVES:

17. In general.	1	2	3	4	5	6	7
18. From nursing staff.	1	2	3	4	5	6	7
19. From the physician.	1	2	3	4	5	6	7
20. From the social worker.	1	2	3	4	5	6	7
21. From the recreation staff.	1	2	3	4	5	6	7
22. From the dietician.	1	2	3	4	5	6	7
23. From physical therapy.	1	2	3	4	5	6	7
24. From occupational therapy.	1	2	3	4	5	6	7
25. From speech therapy.	1	2	3	4	5	6	7

I AM SATISFIED WITH THE FOLLOWING ASPECTS OF MY FAMILY MEMBER'S ENVIRONMENT:

	<u>Strongly</u> <u>Disagree</u>				<u>Strongly</u> <u>Agree</u>		
26. Cleanliness.	1	2	3	4	5	6	7
27. Freedom from unpleasant odors.	1	2	3	4	5	6	7
28. Noise level.	1	2	3	4	5	6	7
29. Attractiveness of decor.	1	2	3	4	5	6	7
30. Safety for residents.	1	2	3	4	5	6	7
31. Opportunity for physical exercise.	1	2	3	4	5	6	7
32. Number of staff resources to provide care.	1	2	3	4	5	6	7
33. Opportunities for my family member to enjoy the outdoors and other diversions.	1	2	3	4	5	6	7
34. Adequate equipment resources to provide care.	1	2	3	4	5	6	7

- | | | | | | | | |
|---|---|---|---|---|---|---|---|
| 35. Protection of my family member's personal belongings. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 36. My role in providing my relative's care. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

MY FAMILY MEMBER'S CARE COULD BE BETTER IN REGARD TO:

- | | | | | | | | |
|---|---|---|---|---|---|---|---|
| 37. Grooming and hygiene. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 38. Medications used. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 39. Use of restraints. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 40. Sensory stimulation (e.g., artwork, music, colors). | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 41. Use of self care abilities. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 42. Bowel and bladder function. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 43. Control of behavior. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 44. My input into the care provided. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

	<u>Strongly Disagree</u>				<u>Strongly Agree</u>		
45. I always feel informed about my family member's condition.	1	2	3	4	5	6	7
46. I feel that this living arrangement is the best that it could be for my family member.	1	2	3	4	5	6	7
47. My family member's personal belongings are sometimes taken/or used by other residents.	1	2	3	4	5	6	7
48. Staff sometimes talk too loud to my family member.	1	2	3	4	5	6	7
49. Staff too often get angry and/or speak sharply to my family member.	1	2	3	4	5	6	7
50. Staff do the best they can but are often too busy to give my family member the attention he or she should have.	1	2	3	4	5	6	7
51. If more resources were available, staff could provide care that would be more beneficial for my family member.	1	2	3	4	5	6	7

Appendix T. Zarit Burden Interview (ZBI)

Do you feel:

1. That because of the time you spend with your relative you don't have enough time for yourself?				
Not at all	A little	Moderately	Quite a bit	Extremely
2. Stressed between caring for your relative and trying to meet other responsibilities for your family or work?				
Not at all	A little	Moderately	Quite a bit	Extremely
3. Strained when you are around your relative?				
Not at all	A little	Moderately	Quite a bit	Extremely
4. Your health has suffered because of your involvement with your relative?				
Not at all	A little	Moderately	Quite a bit	Extremely
5. Your social life has suffered because you are caring for your relative?				
Not at all	A little	Moderately	Quite a bit	Extremely
6. You have lost control of your life since your relative's illness?				
Not at all	A little	Moderately	Quite a bit	Extremely
7. Overall, how burdened do you feel in caring for your relative?				
Not at all	A little	Moderately	Quite a bit	Extremely



Appendix U. Informed Consent Form for Interview

Informed Consent Form (Family version-Part B)

Study Title: An examination of conflict management among family caregivers in long-term care

Investigators: Ana Petrovic-Poljak, M.Sc. (Ph.D. Candidate)
(403-220-4975, apetrovi@ucalgary.ca)
Dr. Candace Konnert (Research Supervisor)
(403-220-4976, konnert@ucalgary.ca)

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Please take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

Background and Purpose of the Study

Family members and staff work together to promote residents' overall well being. At times there may be differences of opinion between staff and family members. This might include minor disagreements that pass quickly or more major issues that may be ongoing. This can be difficult for all involved. The present study seeks to gain a greater understanding of the factors that impact family and staff relationships, to understand how issues are managed, and the impact of this on family members. This information will help us develop improved ways of managing daily issues that come up in LTC, to work toward improving family-staff relationships and ultimately to improve your experience and the care provided to residents in LTC. The purpose of this part of the study is to gain a more detailed understanding of some of the issues that have come up in your experience as a family member at this LTC facility.

What would I have to do?

If you choose to participate in this part of the study, you will be interviewed and asked to describe your experiences as a family member. You will be asked to discuss your experiences with staff at this facility, in particular about the times when perhaps you did not see "eye to eye" with staff, or had something come up that you were concerned about. You will be asked open-ended questions about any issues you may have encountered with staff, how such issues were

handled and what you see as the outcomes of the issues. Participation will require approximately 1 hour of your time. The interview can take place in a private room at the LTC facility, at the University of Calgary, or in your own home and will be scheduled at a time that is convenient for you.

If there are questions you would prefer not to answer that will be fine. You should know that the information you give us will be kept confidential and will not be shared with anyone you know, including your family member or staff at this facility.

Audio Recording of Study Activities

Interviews may be recorded using audio recording to assist with the accuracy of your responses. You have the right to refuse the audio recording of the entire interview and/or parts of the interview. This will not impact your ability to participate in the study. Please select one of the following options:

I consent to audio recording: Yes _____ No _____

Will my records be kept private?

Yes. All of the information collected from you as part of the study will be kept confidential. Only the researchers and persons associated with the study at the University of Calgary will have access to your information as part of their duties. Other persons, including your family members and staff and management at this long term care facility will not have access to any of your individual responses (both written and audio recorded). You will be given a number code that will be placed on all information obtained from you, including the audio recording, in place of your name. You will not be identified by name in any reports written about the study. All information obtained will be kept in a locked filing cabinet at the University of Calgary. Audio recordings will be stored on the researchers' computer at the University of Calgary and will be password protected. The University of Calgary Conjoint Health Research Ethics Board will have access to the records.

What are the risks and benefits of participating?

Participation in this study does not involve risk or discomfort other than the sensitivity and personal nature of some of the questions. Foreseeable risks include potential feelings of fatigue or boredom, or feelings of worry or upset when asked questions about your caregiving experience. In the event that this occurs, we have resources that are available to you. However, you might benefit from having an opportunity to discuss your experience. As well the results of this study will provide important information about how staff and family members can work together more effectively. This can help you to work more effectively with staff at the LTC facility. If you like, we can provide you with a summary of our results at the end of the study so that you can see how this research might help you and others.

Do I have to participate?

Your participation is entirely voluntary and you are free to withdraw your participation from the study at any time without penalty. In order to withdraw, simply notify the researcher that you wish to end your participation. If any new information becomes available that might affect your

willingness to participate in the study, you will be informed as soon as possible. Whether or not you choose to participate or continue in the study will have no effect on the care your family member receives or on the attitudes of other people toward your relative or you.

Will I be paid for participating, or do I have to pay for anything?

You will not be directly reimbursed for your participation.

Signatures (written consent)

Your signature on this form indicates that you 1) understand to your satisfaction the information provided to you about your participation in this research project, and 2) agree to participate.

In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your or your relative's care at Carewest. If you have further questions concerning matters related to this research, please contact: Ana Petrovic-Poljak (403) 220-4975 or Dr. Candace Konnert (403) 220-4976.

If you have any questions concerning your rights as a possible participant in this research, or research in general, please contact the Chair of the Conjoint Health Research Ethics Board, University of Calgary at (403) 220-7990.

_____	_____
Participant's Name	Signature and Date
_____	_____
Investigator/Delegate's Name	Signature and Date
_____	_____
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study. A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix V. Interview Questions

I'm interested in knowing more about your experiences with staff at this facility, in particular about the times when perhaps you did not see "eye to eye" with staff, or had something come up that you were concerned about or disagreed with staff about. If there have been several times that this happened, please choose the one that you think was the most serious, perhaps the one that stands out most in your mind. You will have the opportunity to discuss other instances at a later time (e.g., up to three incidents will be discussed).

1. Please describe what happened in as much detail as possible. (GOAL: Description of incident)

Probes:

- When did this happen?
- Who was involved?
- How long did this go on? Is it still going on? If not, when did it end?
- How did you feel about this incident?
- In your opinion, what is the severity of this conflict situation?

1-Not at all	1-Not at all	1-Not at all
2-Only a little	2-Only a little	2-Only a little
3-Somewhat	3-Somewhat	3-Somewhat
4-Moderately	4-Moderately	4-Moderately
5-Extremely	5-Extremely	5-Extremely

2. What were the circumstances that led up to the conflict? (GOAL: Description of antecedents to incident)

Probes:

- When did it start?
- What happened next?
- What did you do?
- What did the staff do?
- What did the resident do? [include follow-up of anyone who was involved]
- How did you feel?

3. a) What did you do to manage/address the problem? (GOAL: Conflict management and family's perception of staff)

- Why did you choose to do that?
- How did you feel?
- Is this what you wanted to do? If not, what did you want to do? Why didn't you do that?
- In your opinion, was this effective in addressing the problem? Why or why not?
- Was there anything that you did or said that helped the situation? If so, why did you find this helpful?
- Was there anything you did or said that made it worse? If so, why do you feel that this made it worse?

b) What did the staff do to address the problem?

- How did this make you feel?

- In your opinion, was this effective in addressing the problem? Why or why not?
 - Was there anything that staff did or said that helped the situation? If so, why did you find this helpful?
 - Was there anything that staff did or said that made the situation worse? If so, why do you feel that this made it worse?
4. What was the eventual outcome? (GOAL: Understanding outcomes, enablers, and facilitators)
- Do you feel that the problem was resolved to your satisfaction? Why or why not?
 - What were the barriers you faced in resolving the problem?
 - What were your concerns as you tried to solve the problem?
 - What were the enablers (e.g., things that helped you) you encountered in resolving the problem?
 - Have there been any consequences to you? To others (staff, your loved one)? If so, what were they?
 - Did anything change? Did the quality of your loved one's care change? Did your role in the LTC facility change? Did your relationship with the staff member change? Did your opinion of this facility change?
 - Do you think that this situation had any positive outcomes for your loved one's care? If so, what were they?
 - Do you think that this situation had any negative outcomes for your loved one's care? If so, what were they?
 - Looking back, would you do anything differently?
6. What made this incident significant for you?
- Is this an ongoing/recurring problem or an isolated incident?

Appendix W. Qualitative Analysis: Theme overview (n=10)

Interview Question	Themes	Subthemes
Conflict severity	Somewhat moderately, extremely	Repeat incidents Resident's perception of severity Harm to resident
Significance of conflict episode	Propensity for harm Hopelessness Powerlessness Resident's vulnerability Lack of validation and understanding Feeling unwelcome Negative appraisals of staff Emotional impact Repeated incidents	With the same staff member, re-occurring care issues, different incidents
Types of conflicts	They didn't listen to me Staff are not attentive to the resident Staff are not doing their job The quality of care is suffering	
Types of conflict management	Being confrontational	Direct communication Voicing discontent Aggressive

	Necessary approach to be effective
	Collecting evidence
	Threatening to report to supervisors/regulating bodies
	Seeking immediate response/demands from staff
	Defying staff's instructions
	Negative outcomes associated with confrontational approach
	Don't want to be aggressive
Being present	Monitoring staff
	Working alongside staff in providing direct-care
	Make presence known/ resident not alone
	To provide care and relieve demands on staff
	Regular visit schedule to establish presence
	Irregular visit schedule to "check in"
Being careful	Holding back emotions
	Fear of repercussion of actions
	Staff complain about family caregivers
Getting support	Family members of other residents
	Own family members
	Front-line staff
	Managerial staff/staff with power to effect change
	Consulting with external organizations and professionals
Demonstrating personal/professional	I know what I am talking about
	Personal knowledge about the resident

knowledge	Professional knowledge about care issues Teaching staff how to conduct a care-related task Raising concerns to staff to increase awareness of issue Negative outcomes- unheard, "complainers"
Questioning staff's knowledge	Lack of training in mental health, dementia, identification of infections, dignified treatment of residents, and administration of medication Lack of knowledge about individual residents Lack of trust in approaches to care Temporary/casual staff lacking knowledge about the resident Requests for further training & education
Trying to work with staff on the issue	Is staff genuine/honest Can staff fulfill their end of the bargain Lacking trust/suspicious of staff One-sided working toward resolution Collaborating on a solution Staff responsive to families Providing suggestions to staff
Additional themes	Bringing up an issue with staff and "dropping it" Getting more information on the issue from staff who are not involved in the conflict Filling out feedback and complaint forms Having a meeting with staff to discuss the issue Telling the resident to address the issue

		Focusing on improving relationships with staff
		"What's the point in talking to staff"
		Shouldn't have to deal with conflict
		Using reward and praise with staff to meet their goals
Barriers to conflict management	Not having ready access to staff with influence	Managerial staff not readily available
		Reduced access to staff on weekends and evenings
		Not knowing who to approach with the issue
		Cannot address issue immediately
	Communication issues with staff	Communication with multiple staff (e.g., being passed from one staff member to another)
		Getting someone to listen
		Lack of acknowledgment and validation
		Being instructed not to speak with staff
		Lack of consistent relaying of information between staff
		Lack of transparency in communication
		Staff being argumentative
		Staff's English proficiency
		Communicating over the telephone with staff
	Becoming upset with staff	
	Staff-related issues	Staff not being equipped or trained to deal with situations
Enablers to conflict management	Family-based factors	Acknowledging staff efforts

		Forming relationships with staff
		Going to management
		Making threats to obtain assessments and treatments outside of the facility
		Having time to be at the LTC facility
		Being patient
		Being a man
		Being persistent and insistent
		Focusing on a main issue to avoid "burnout"
		Hiring a private caregiver
		Bringing own experience and knowledge
		Prayer
	Staff-based factors	Trust in a staff member
		When staff provide a solution
		Staff attending to the resident during the incident
		Staff's communication approach with families
Concerns when managing conflict	Resident's well-being	
	Retribution	
	Adversely impacting relationship with staff	
	Not being heard, understood or taken seriously	
	Whether staff are able to do what was asked of them	
Effective to conflict	Raising the issue directly with staff	Decreasing avoidance

management		Approaching staff even when it is unpleasant
	Being persistent and insistent	
	Being calm and polite	
Ineffective	Being confrontational	
	Creating relationship strain with staff	
	Speaking up, challenging and querying staff	
Staff's conflict management	Working with family members on the issue	Accepting and validating what families were saying acknowledging and addressing the issue that was raised organizing a meeting
		Providing an apology
		Following up
		Providing explanations to foster families' understanding
	Deferring the issue	Families being passed on from one staff member to another
		Being "put off"
		Deferred to a doctor, a manager, a director, or a case conference meeting.
	Being avoidant or passive	Not speaking to family caregivers
		Saying "I don't know"
		Not returning calls
		Avoiding accountability.
	Being confrontational or defensive	Expressing anger
		Denying the presence of an issue
		Being abrupt

	"Not doing anything"	
	Demonstrating authority or power	Being dismissive of families' concerns Denying requests Instructing family caregivers to only speak to managerial staff Questioning what families had to say Reporting family caregivers to management Enforcing a rule Demonstrating that staff knowledge and power are superior
	Accommodating families	Following a family caregiver's instruction Moving a staff member to a different ward Looking into a matter for families
Ineffective Staff Conflict Management	Being confrontational	Defensiveness, sarcasm and "nonchalant" demeanours
	Denying the presence of an issue	
	Being unaware of what was going on	Staff lacked knowledge about an issue Unable to effectively address it in the moment.
Effective Staff Conflict management	Receiving support from staff	Speaking to the doctor or with managerial staff Speaking to staff who had an open and amiable demeanour Staff offering help, acknowledgment Saying "sorry"
	Having meetings and developing action plans	

	Paying more attention to the resident	
	Actively working on the family-staff relationship.	
Negative outcomes	Feeling invalidated	
	Escalating the conflict	
	Staff not speaking to them	
	Staff calling family members abusive	
	Emotional reactions	Angry, frustrated, helpless, hopeless, guilty, "traumatized"
	Loss of trust	
	Feeling unwelcome at the facility	
Positive outcomes	Receiving feedback from staff	
	Staff paying greater attention to families' concerns	
	Staff providing reassurance	
	Document that outlines family caregivers' and staff's roles and responsibilities	
	Attaining a practical goal that was a part of the conflict	
	Feeling grateful toward staff	
Change in opinion of facility	Unmet expectations	Taking on care responsibilities

	Loss of trust and respect	
Changes in role	Increased visitation and involvement	
Change in quality of care	Care worsened	Neglect Staff disingenuous
	Care improved	Increased attentiveness Education for staff Weary of change/change is transient
Changes to family-staff relationship	None/Unsure	
	Yes	Staff more sheepish/agreeable Using material and verbal reward "Clearing the air" with staff member Avoided by staff in person/telephone Irritating staff Have positive relationships with some staff Need for validation of concerns Lack of respect and trust Family caregiver identified as an "issue" Disliking staff Need to repair relationships with staff
Consequences to the resident	Positive	Unsure if changes have been put into effect Unsure if changes are only limited to when the family caregiver is present Receiving better food, medication Having a care plan

		Having fall prevention alarm turned on
		Greater attention being paid and care provided to the resident
		Changes in type of residents accepted in the facility
	Negative	Care worse than prior to conflict
		Harm/neglect/pain to resident
		Unsure
		Staff take out their frustration with the family caregiver on the resident
		Adverse consequences to residents health
		Because conflict is not resolved (e.g., can't ambulate, continued falls, etc.)
Consequences to family caregiver	Positive	Feeling good about being able to communicate with staff about the resident's care needs
	Negative	Emotional (e.g., anxiety, frustration, feeling overwhelmed, and guilt)
		Physical toll
		Labeled as "difficult"
		Blamed for the conflict by staff
		Not liked by different staff members
		Uncomfortable going to the facility as a result
Consequences to staff	Unaware of any	
		Hope that there was a discussion with the staff member

	Termination of employment	
	Relocation to a different unit	
	Potential long-term consequences of families raising their concerns to staff	
Was the conflict resolved	Yes	Resolution is time-limited
		Doubtful of lasting change
	No, unresolved	Resolution is an unattainable target

Appendix X. Site Comparison

Means and standard deviations for key study variables in LTC facilities with more than 10 participants

Variable	Facility A (n=46)		LTC facility Facility B (n=31)		Facility C (n=15)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Frequency of conflict	1.82	.74	1.71	.69	1.81	.50
Cooperative CM	6.02	.61	5.63	1.36	5.53	1.01
Competitive CM	2.29	.93	2.75	1.35	2.30	1.18
Trust	4.93	1.01	4.94	1.01	4.97	1.01
Power	3.40	.87	3.08	1.01	3.43	1.02
Communication	4.00	.62	3.94	.65	4.13	.43
Sense of community	3.62	.75	3.36	.85	3.72	1.00
Satisfaction with care	5.01	.86	4.52	.86	4.86	.87
Caregiver burden	1.23	.87	1.07	.97	1.07	.77

Note: CM= competitive management