al Gerontologist, 32:309–323, 2009
ight © Taylor & Francis Group, LLC
0731-7115 print/1545-2301 online
10.1080/07317110902895952

Routledge
Taylor & Francis Group

Aged Care Residential Facility and Family Interface: A Training Program for Staff

TAMMY BERMAN TISHER, BSc, MA, MAPS, VAFT
Alma Family Therapy Centre, North Caulfield, Victoria, Australia

UZANNE DEAN, BA(Hons), MA, PhD, FAPS, MVAPP, MPPAA
onash University and Victoria University–St. Albans, Melbourne, Victoria, Australia

MIRIAM TISHER, BA(Hons), MA, PhD, MAPS, VAFT
Alma Family Therapy Centre, North Caulfield, Victoria, Australia

An important dimension of long-term residential care is the ongoing relationship between nursing staff and residents' families. This article reports an innovative attempt to train staff in an Australian Federal Government accredited aged care facility in Melbourne, Australia. A series of four in-service workshops for staff were designed, conducted on two occasions for 26 participants, and evaluated for 18 participants. Results showed that after the workshops, participants felt more appreciated and less blamed by family members and more satisfied with their conversations with family members. Central critical factors in format and content of training included role playing, group dynamics, facilitators' acknowledgment and containment of staff vulnerabilities, and staff need for recognition, value, and appreciation and increased awareness of their own behavior.

KEYWORDS training, aged care, staff, residents' families

wth of the elderly population in Western countries has brought the llenges of long-term residential care to the forefront of concern. One of most important aspects of long-term residential care is family involvet and caregiving, where a relative provides some ongoing support and

Address correspondence to Miriam Tisher, Clinical Psychologist and Family Therapist, Family Therapy Centre, 403 Alma Road, North Caulfield, Victoria 3161, Australia. ail: miriamtisher@almafamilytherapy.com

assistance to an older family member due to various limitations of that person (Bass & Noelker, 1997). However, there is minimal literature concerning the interface between nursing staff in long-term care facilities and family members of residents who live there (Looman, Noelker, Schur, Whitlatch, & Ejaz, 2002). The present research was designed to explore the factors relating to training needs and attitudes of nursing staff, in the context of evaluating training workshops on strategies for working with residents' families.

The elderly often enter a residential facility as their capacities to manage activities of daily living have become compromised due to physical, cognitive, or behavioral limitations. Families often continue to provide hands-on care and remain emotionally involved with their relative after placement (Zarit & Whitlatch, 1992). Conflicts between family members and staff can arise (Vinton, Mazza, & Kim, 1994). The family's life-long relationships "enter the home" when the resident is admitted, and this includes values, conflicts, legacies, and loyalties (Ginsberg-McEwan & Robinson, 2001). Similarly, nursing home staff approach residents and residents' families with their own values about older adults and about care, loyalties, conflicts, and legacies.

Research has identified issues faced by families when a family member enters care, such as feelings of guilt and anger for handing over their relative to others, changes of familiar family roles, loss of the emotional support and wisdom their relative would have usually provided in the past, fear of their relative dying or of his or her rejection and anger, lack of information about institutional, medical, and nursing care, and fear of asking questions and of financial burdens (Ginsberg-McEwan & Robinson, 2001). Research has also shown that family members experience stress in negotiating relationships with the facility staff (Gladstone & Wexler, 2000; Hertzberg & Ekman, 1996; Whitlatch, Feinberg, & Stevens, 1999). Studies in the United States have reported that residents' family members often fail to behave in a respectful manner toward nursing staff, and do not value their care of their relative, so that staff feel unappreciated (Heiselman & Noelker, 1991). Vinton et al. (1994) studied aggressive behaviours directed at nursing home staff by residents' family members. They concluded that, to resolve conflict, there needs to be an understanding by staff of the purpose of specific aggressive behaviors.

A small body of literature exists on training methods regarding resident care in the elder care setting, where evaluation of training has occurred. Training methods include lectures, group exercises, role plays, discussions, experiential activities, videos and case studies. Evaluation methods have included pre and post training questionnaires, mail questionnaires, various scales, tests of knowledge, case vignettes and assessments of residents' behaviors (Aylward, Stolee, Keat, & Johncox, 2003; Braun, Cheang, & Shigeta, 2005; Thulessius, Petersson, Petersson, & Hakansson, 2002). All these studies report on educating staff in aged care facilities to work better

with residents rather than with residents' families. Some authors have noted that increasing knowledge does not necessarily translate into behavior change in practice (Aylward et al, 2003; Stolee et al., 2005).

Studies relevant to improving the relationship between aged care nursing staff and residents' families include Heiselman and Noelker (1991), Pillemer, Heheman, Albright, and Henderson (1998), and Pillemer, Suitor, Henderson, Meador, Schultz, Robinson, and Hegeman (2003). These authors developed and reported on programs working with both staff and residents' families, either at the same time or using parallel workshops. However, no literature has been identified reporting specific training programs for staff in aged care facilities to improve their relationships with families of residents.

A major part of the care of residents in aged care facilities in Australia is provided by nursing staff such as personal care attendants (PCAs), who are unlikely to have had any formal training or prior experience in working with the elderly and their families. The job is physically and emotionally demanding, and at the low end of the pay scale. In addition, the demands of the job leave little time for PCAs to develop their interpersonal skills, or to get to know the residents and their relatives as unique individuals. While qualified nurses are also employed, it should be noted that not all nursing degree training programs in Australia pay attention to family dynamics and relations, to culture and families, or to family counselling theories and techniques.

This paper describes an innovative attempt to train staff in a Federal Government accredited aged care facility in Melbourne, Australia. The Home comprised 70 beds and its residents included those with low and high care classifications. The initiative for the training program came from the Chief Executive Officer of the Home.

Because there were no published reports of appropriate training programs, it was decided to establish and pilot a program. A series of workshops for staff were designed, conducted and evaluated, using the authors' experience of training groups such as doctors and bearing in mind reports of relevant content (e.g., communication skills, reducing blame) suggested by writers such as Vinton et al. (1994) and Looman et al. (2002).

Negotiations with the Home established that staff would be permitted to attend four workshops, each of 90 minutes duration, during their working hours. An implication of this agreement was that the Home would fund replacement staff to cover minimum staffing requirements for the residents.

Objectives for each workshop were set up on the basis of family therapy or systems theory training literature. Main objectives are outlined in Table 1.

A recognized training challenge was the likely mix of participants, including PCAs and more senior nurses, their supervisors. Accordingly, the first workshop sought to affirm participants' existing strengths and

TABLE 1 Workshop Objectives

Workshop	1	2	3	4
Main Objectives	Affirm participants' existing strengths and skills. Identify skills to be acquired. Develop language for communicating care to residents and families.	Develop empathy for experiences associated with older age, reflection and validation skills.	Develop empathy for experience of having family member in aged care facility. Use reframing as communication strategy.	Practice reflection, validation, and reframing using role plays and experience being a family member in role.

encourage them to identify skills they needed. These objectives were aimed to maximise a sense of interest, relevance and respect between participants. Labelling language for communication was based on narrative ideas in communication (Osis & Stout, 2001). In the second and third workshops, empathy was a key focus, and participants were encouraged to develop reflection and validation skills (Geldard & Geldard, 2005) and taught reframing as a communication skill (Bepko, 1984). The final workshop focused on role plays to practice these skills and to experience being a family member. Training methods also involved informal group discussions of case examples and experiential activities in pairs. The program was designed to maximize opportunities for participants to actively engage in learning and to interact with each other and the facilitator.

METHODS

Measures

Reports in the literature identify numerous difficulties in evaluating programs for improving staff care of residents in nursing homes (Bourgeois, Dijkstra, Burgio, & Allen, 2004). However, as there are no reports of training of aged care staff in working with family members of residents, there were no precedents for evaluation of such programs. Consequently, three evaluation measures were developed, bearing in mind the principles set out by Lieff and Silver (2001), and piloted.

Pre and post self-ratings relating to communication with family members

On a 5-point Likert scale ranging from 1 (not at all) to 5 (very much), participants were asked, before and after the workshop series, to rate (a) how they generally *felt whilst having conversations with family members,* (i) *appreciated*, (ii) *helpful*, (iii)) *understood*, (iv) *confident*, and (v) *pleased with the conversation;* (b) how they thought *family members felt in terms of being* (i) *understood* and (ii) *pleased with conversations with the staff member;* (c) their *overall skill when communicating with residents' family members and* (d) whether they *felt blamed or criticized when residents' family members communicated a concern.* A 5-point Likert scale questionnaire was also used post workshops to investigate participants' satisfaction with and usefulness of the workshops.

Case vignettes

Case vignettes as assessment tools test applications of learning rather than reports about learning (Tisher & Jackson, 2003). The case vignette presented to participants before and after the workshop training was: *Dora, the daughter of a resident at [the] Home, visits her mother regularly. Before moving to [the Home] her mother used to live with her until things became too difficult and she could no longer manage. Dora came up to you today and said "When my mother presses the bell you take too long to come and she wets herself".* Participants were asked: *What do you reply to Dora?* and *What do you think made Dora say this?* They were then asked to rate on a 5-point Likert scale how satisfied they were with their responses and how satisfied they thought Dora might be with their responses. Responses to the case vignette were scored on a scale of 1 to 5 against criteria based on evidence of specific communication strategies taught in the workshops, namely, *empathy, reflection, reframing, validation* and *evidence of empathy for the family member in the vignette upon hearing their (the participant's) response.*

Responses to the self ratings and to the case vignette were analyzed quantitatively, using paired two-tailed *t*-tests with the significance level set at $p = .05$.

Open-ended questions

Open-ended questions were asked about participants' experiences of the training and responses were analyzed using qualitative analysis methods. Questions related to participants' experience of the workshops, what they learned, most useful activities and why. Responses were recorded verbatim, then divided into units of meaning which were subsequently grouped into common emergent themes, using matrices of tables. These emergent

themes were re-grouped several times until a higher order group of dominant themes was established (Miles & Huberman, 1994). Evaluation was conducted by an independent person, a post graduate psychology student who was not the person who conducted the workshops. Participants' data were de-identified.

Participants

Four groups, with six to eight participants in each group, completed the series of training workshops. Eighteen of the 26 participants in the workshops completed both pre- and post-training data collection. The 18 participants ranged in age from 24 to 60 years, with a mean age of 48 years. Of the 18 participants, 1 was male.

Although the workshop series was devised for nursing staff, only 10 participants were qualified nurses and three were personal care assistants (PCAs). The remaining five included three activity staff and two administrators. Years of experience working in aged care ranged from 1 to 25 years, with a mean of 10 years. Participants worked between 18 and 40 hours per week, with a mean of 31 hours per week.

Participants did not attend all workshops in their series and on many occasions were late, citing work demands and absenteeism from work as reasons. Additional factors influencing the workshops were building renovations necessitating change of room, constraints around privacy, noise intrusion and an unexpected mix of attendees with different professional backgrounds, such as administrators, which affected confidentiality of resident care discussion. Differences in English language fluency due to diverse ethnic backgrounds were also relevant.

FINDINGS

Quantitative Analyses

Results for pre and post self ratings and case vignette responses are presented in Table 2.

Table 2 indicates that the training had no statistically significant effect on most self ratings. However, significant increases in scores were reported in *feeling appreciated by families* ($t[17] = -3.06$, $p = .007$), *feeling pleased with conversations with families* ($t[17] = -2.68$, $p = .016$) and in *family members were pleased with conversations with staff member*, ($t[17] = -2.72$, $p = .015$). On other self-rating dimensions the mean scores tended to be higher but the differences were not significant. Responses to the case vignette indicated that *reflection* was the only variable with a (non-significant) increase in mean scores, ($t[17] = -0.81$, $p = .430$). They also showed (non-significant) decreases in mean scores for participants feeling *satisfied with*

TABLE 2 Comparison of Variables Before and After the Workshop Series: The *t*-Statistic, Degrees of Freedom, and Significance Level

Variable rated	N	Mean before	Mean after	*t*	Df	Significance (2-tailed)
Feeling appreciated by family	18	3.72	4.17	−3.06	17	.007*
Feeling helpful to family	18	4.17	4.22	−0.27	17	.790
Feeling understood by family	18	3.89	4.22	−1.68	17	.111
Feeling confident with family	18	4.22	4.33	−0.62	17	.542
Pleased in conversations with family	18	3.89	4.33	−2.68	17	.016*
Whether residents' families felt understood in conversations	18	3.89	4.28	−1.94	17	.069
Whether residents' families felt pleased with conversations	18	3.61	4.00	−2.72	17	.015*
Own skill in communication	18	4.17	4.28	−.81	17	.430
Whether felt blamed or criticized when family members voice concern	17	2.53	2.47	.18	16	.859
Vignette: empathy for family	18	0.05	0.05	.00	17	1.000
Vignette: reflecting feelings of family	18	0.22	0.33	−.81	17	.430
Vignette: reframing family concern	18	0.78	0.72	.44	17	.668
Vignette: validation of family	18	1.00	0.94	1.00	17	.331
Vignette: empathy for family member with their response to vignette	18	0.89	0.89	.00	17	1.000
Vignette: total	18	3.39	3.39	.00	17	1.000
Vignette: satisfaction with own response	18	3.94	3.83	.49	17	.631
Vignette: satisfaction for family member with their response	17	3.24	2.88	1.00	16	.332

*significant at $p = .05$.

TABLE 3 Mean and Standard Deviation Scores for Participants' Ratings of Aspects of the Workshop Series

Aspects of the workshops	Mean (*SD*)
The overall content of the sessions was helpful to me.	3.39 (1.23)
I felt comfortable with the structure of the sessions.	3.94 (0.99)
I've been thinking about my behavior or responses when communicating with families.	3.61 (1.34)
The activities were useful to me.	3.56 (1.25)
I felt comfortable in the group.	4.39 (0.70)
I thought about the sessions during the week.	3.06 (1.55)
I learned some things from the workshops.	3.50 (1.34)
The evaluation forms and process were simple.	4.50 (0.79)

their response ($t[17] = 0.49$, $p = .631$) and whether *they thought the family member in the vignette felt satisfied with their response* ($t[16] = 1.00$, $p = .332$).

Table 3 sets out mean and standard deviation scores of participants' ratings (1 to 5) of aspects of the workshop series.

Table 3 shows that participants often rated 'satisfactory' or 'very satisfactory' on all aspects of the workshops.

Qualitative Analyses

Emergent common themes relating to participants' identification of the most useful workshop activity and reasons why are presented in Table 4.

Fifteen of the 18 participants reported that the role plays and their analysis were the most useful activity. The reasons were grouped into three higher order themes, using content analysis. Quotations illustrating each theme are presented in italics. (a) general experiential learning: *"because it made it more realistic and I was able to experience it,"* and *"because we get to act out a real situation,"* (b) empathy for residents' families: *"I could see things from the other person's point of view"* and *"because it makes it easier to understand the residents' families"* and (c) empathy for staff: *"because it opened my eyes to what the staff really do put up with from the families."*

Five participants reported that the group discussion was the most useful activity in terms of (a) being able to share thoughts, ideas and feelings: *"brainstorming approaches to problems or difficult families"* and *"hearing other staff perceptions/reactions on communicating with families"* and (b) feeling comfortable in the group: *"because I felt comfortable in the group."*

Table 5 presents the dominant common themes when participants listed three or four important things that they learned from the workshops.

Dominant common themes included a) communication strategies: *"to listen to what the person is telling you, to let them take the time to tell you what they want," "playing a daughter identified which staff actions would make me feel good, so I could learn better communication with the family,"* (b) empathy for family members: *"understanding the families' shortcomings and anguish about their parents," "to get the feeling of how the family feels when they ask you something or complain,"* (c) awareness of one's own behavior: *"staying calm, don't get into the cycle,"* (d) reinforcement of general knowledge:, *"to build on more than I know, to be educated more"* and (e) team building: *"more communication within the staff regarding a situation."*

TABLE 4 Reporting of the Most Useful Activity in the Workshop Series and the Themes in the Reasons Why it was the Most Useful Activity

Most useful activity	Themes in the reasons reported for the most useful activity	Number of participants citing
Role play & analysis	Experiential learning – general	6
	Empathy for residents' families	6
	Empathy for other staff	3
The discussion	Sharing thoughts, ideas, and feelings	3
	Comfort in the group	2
Do not know		3

TABLE 5 Reporting Themes of What Was Learned from the Workshop Series

Themes in reporting what was learned from the workshops	Number of responses
Communication strategies	10
Empathy for family members	10
Awareness of one's own behavior	8
Reinforced general knowledge	5
Team building	3
Nothing new	4*

*Observation: two of the four participants who reported nothing new also reported that they had learned something new.

TABLE 6 Reporting Themes of the Meaning of the Workshop Series for the Participants

Themes in reporting of the meaning of the workshops	Number of responses
Experiential learning	12
Focus for staff support and expression	8
Disappointing	4

The common themes concerning what the workshops meant to participants are shown in Table 6.

Common themes included: (a) experiential learning: *"a way in which to improve our skills in dealing with people and putting myself in the situation, if it was my parents, how would I feel?"*; (b) a focus for staff support and expression: *"a chance to discuss issues and general problems"* and (c) disappointing: *"I don't think I gained as much as I thought I would."*

Main themes identified by participants who listed three main things important to them when communicating with residents' families are presented in Table 7.

TABLE 7 Reporting of the Higher Order Themes of What Participants Identified as Important To Them When Communicating with Residents' Families

Higher order themes of what staff identified as important to them when communicating with residents families	Number of responses before the workshop	Number of responses after the workshop
A focus on families'/residents' needs	14	16
A focus on mutual needs	15	13
A focus on staff needs	8	10
Important communication processes	16	19
Active communication skills	6	11
Professional conduct	7	4
Empathy	3	4

TABLE 8 Reporting Themes of How the Workshops Could Be Improved

Themes of how the workshops could be improved	Number of responses
Provide more strategies	13
Structure and content of the teaching	
More concrete strategies	
Provide more sessions	2
Alter dynamics of facilitator and group	2
Nothing/Don't know	5

The four main common themes included (a) a focus on families'/ residents' needs: *"for them to feel understood and at ease with me,"* and "to *enable families to feel that they are part of the decision making process,"* (b) a focus on mutual needs: *"come to the agreement that we both want the same thing if it is in the resident's best interest and care;"* (c) a focus on staff needs: *"I want them to understand me, for me to be understood"* and *"their loved one is not the only person at [the Home] and there are 68 other people we have to care for and they understand we are not their parents children, we are here to do a job, but they have to take responsibility for their parents"* and (d) important communication processes, grouped into three sub-themes: (i) active communication skills: *"clear and concise speech, nothing too over the top and eye contact"* (ii) Professional conduct: *"follow up is very important and prove to them you do for credibility so they can come to you in the future"* and (iii) empathy, *"they feel that I empathise with them."*

Table 8 indicates dominant themes on how the workshops could be improved.

The common themes emerging included (a) provide more strategies, analyzed into two sub-themes: (i) structure and content of the teaching: *"to have more feedback," "the content of the sessions should have been different for more experienced people;"* (ii) concrete strategies for working with families: *"more role plays with various situations to be discussed, more specific examples should have been covered"* and *"to learn more how not to be affected by the family members when they are aggressive, so I am not affected by them as a person,"* (b) provide more sessions: *"maybe having a few more sessions a year;"* (c) alter dynamics of facilitator and group: *"there should have had a mix of experienced and not experienced people in the group so they could share with others,"* and (d) *nothing/don't know.*

DISCUSSION

Among the quantitative findings, it was revealed that participants felt more appreciated by family members after the workshops. Staff reported being more satisfied with their conversations with family members and believed

that family members also felt more satisfied with their conversations. Participants felt less blamed or criticized by family members when they voiced an issue or concern. This suggests that, overall, participants gained a new understanding of families and perhaps more empathy for their concerns and for the position of being a relative. This is consistent with prior research working in a parallel way with both residents' families and nursing staff (Pillemer et al., 1998; Pillemer et al., 2003) which reported changes in participants, including new understanding and insights, a decrease in hostile perceptions, and behavior changes. The results also support the view of Looman et al. (2002) that appreciation and acknowledgement of staff efforts by residents' family members is important to nursing staff. The results may also suggest that when staff members feel more appreciated by family members, they feel more able to have cooperative conversations and feel more empathy. The above can lead to staff forming better and more cooperative relationships with family members, which may improve their working life.

Responses to the case vignette showed little change. One explanation for this could be that participants may have been resistant to behavioural change, a finding also reported by Stolee et al. (2005) who investigated factors associated with the effectiveness of education in long term care. Another explanation is that, although not significant, participants tended to be less satisfied with their vignette response after the workshops, as well as less satisfied with their response to the family member in the vignette after the workshops. This may indicate that participants were exposed to, and became more reflective upon, their behavior and attitude toward family members, identified elsewhere as a theme of learning from the workshops. This may have resulted in participants becoming more sensitive and empathic to families, but not yet experienced enough to implement new communication skills. This is consistent with previous findings that education not only promotes competence but also sensitivity, such that successful education can result in increased awareness of one's hitherto unrecognized difficulties (Thulesius et al., 2002). Use of the case vignette as an evaluation method tests what participants would do rather than how they think about the situation (Tisher & Jackson, 2003). A critical factor in training is the balance between affirming strengths and developing knowledge about gaps in capacity. It may be that the case vignette method addresses such gaps.

A major challenge for training in the long-term care setting is the transfer of knowledge into practice, wherein learners gain new knowledge and acquire new skills, but have difficulty when implementing the new learning. In their review of effectiveness of education in long term care, Aylward et al. (2003) found that in almost all the studies in which knowledge and behaviour changes were evaluated, staff showed improvements in knowledge but no improvement in behavior. Both Aylward et al. (2003) and Stolee et al. (2005) have suggested that organizational and systemic factors may account for the difficulties in the transfer of knowledge into practice.

This type of training probably needs to be followed by a shift in the organizational culture to support staff in managing their workloads and the emotional burdens they carry, to provide time for staff to share experiences with each other, and to encourage each other to develop more cooperative relationships with families.

Participants generally were satisfied with the workshops. Most participants found the role play and its analysis the most useful activity. Through role play they were able to experience and observe different situations, and feel empathy both for family members and other staff members. This is consistent with the findings of other researchers who used role play in their training (Braun et al., 2005).

In the qualitative content analysis of responses to the open ended questions, three main themes which emerged from the workshops were improved communication strategies, empathy for family members, and awareness of one's own behavior. Participants also reported that a focus on family needs, staff needs and mutual needs were central to them when communicating with residents' families.

The findings showed that experiential learning and a focus on staff support and expression of feelings was important in the workshops. This is consistent with prior research (Braun et al., 2005), which reported that when participants are able to share their stories and others can relate to the situations, the experience made their learning real, validating the purpose and meaning of their work, and improving knowledge, positive attitudes and practice.

Participants suggested improvements to the content and format of the workshops, especially the provision of more concrete and practical strategies for working with families. The staff had not originally been consulted about the content of the workshop series. It is recommended, before content is decided, that a brainstorming session with staff, as outlined by Heiselman and Noelker (1991), be conducted to clarify needs of staff in general, and what they hope to achieve after completing the training. Participants also requested more role play, a written summary of each session, more sessions, and repeatedly identified the value of the group dynamic in sharing of experiences.

Some of the feedback included comments of a personal nature about caring. In the long-term care setting, staff build on their own personal resources and family background to cope with challenging situations, as there is often a lack of training in emotional issues, and especially in working with residents' families. Staff react and cope differently with emotional aspects of their work. Some may distance themselves from it and others may become emotionally involved and take things personally, depending on their life experience. The workshops included discussions around family dynamics, both personal and about residents and their families, but it is recommended to go into more depth about family issues and about possible

reasons why family members behave the way they do with their relative. This is consistent with Looman et al.'s (2002) suggestion of family dynamics as a topic for inservice training.

The present research has illuminated the importance of critical factors in training staff concerning relationships with residents' families in the long-term care setting. First, certain factors emerged as particularly salient in the format of the training. The majority of staff identified role playing as a valuable training tool and the importance of the group for bonding and support. This is consistent with the conclusion of Braun et al. (2005), who reported on an active learning model for workers in elder care. Hence, group dynamics and a setting for the training, whereby participants feel comfortable with each other, and are in an environment conducive to learning and expressing oneself, are critical to training aged care staff.

Second, a number of central factors in the content of such training were identified by the research. One salient factor was the facilitator's acknowledgment and containment of the staff's vulnerabilities and their need to be validated. Furthermore, there was a need for staff to be recognized, valued and appreciated, consistent with the findings of Looman et al. (2002). Another important factor consisted of staff becoming more aware of their own behaviour, as found by Thulesius et al. (2002). Central to all training is transferring knowledge into practice, making it concrete and developing skills, also reported in the review by Aylward et al. (2003). This emerged in the reflections of participants upon their training experience.

The critical factors identified above are largely in line with those found in the small body of research in training aged care staff in working with residents. The factors involving the venue for training, staff's vulnerability and their need for validation are newly highlighted and especially worthy of further study.

Limitations of this study include its small sample size, new evaluation measures being piloted, outcomes not tested through a randomised control design, and no tracking of longer-term outcomes. Participants came from unexpectedly diverse occupational and cultural backgrounds, and English language skills competence was inconsistent, which may have affected both the response of some participants to the training and evaluation, and their communication with residents and families. The workshop series being required by management of the care facility may have affected participants' motivation and interest in the content and evaluation. Interpersonal conflicts between staff members may have made some participants reluctant to engage openly in the discussions. For example, it may have been difficult for some staff to admit vulnerability in front of their supervisees and/or supervisors. This may point to a constraint of in-house training programs generally. Finally, the fact that this particular study was confined to a single setting makes its applicability to other facilities tentative.

Validation of the measures piloted here appears warranted. More research is also required to examine the effects of the critical factors identified in this research, in particular the ones that are newly highlighted. The value of training staff in residential aged care facilities to work with families of residents has been affirmed, training challenges have been noted, innovative and established training programs and evaluation measures have been reported and reviewed, and the complex interface of different staff, values and organizational factors has been illuminated.

REFERENCES

Aylward, S., Stolee, P., Keat, N., & Johncox, V. (2003). Effectiveness of continuing education in long-term care: A literature review. *The Gerontologist, 43*(2), 259.

Bass, D. M., & Noelker, L. S. (1997). Family caregiving: A focus for aging research and intervention. In K. Ferrara (Ed.), *Gerontology: Perspectives and issues* (2nd ed., pp. 243–264). New York: Springer.

Bepko, R. A. (1984). Strategic therapy with a "nasty" patient. *Clinical Gerontologist, 3*(2), 5–10.

Bourgeois, M. S., Dijkstra, K., Burgio, L. D., & Allen, R. S. (2004). Communication skills training for nursing aides of residents with dementia: the impact of measuring performance. *Clinical Gerontologist, 27*(1/2), 119–138.

Braun, K. L., Cheang, M., & Shigeta, D. (2005). Increasing knowledge, skills, and empathy among direct care workers in elder care: A preliminary study of an active-learning model. *The Gerontologist, 45*(1), 118–124.

Geldard, D., & Geldard, K. (Eds.). (2005). *Basic personal counselling. A training manual for counsellors.* Sydney: Pearson Education.

Ginsberg-McEwan, E., & Robinson, A. (2001). Understanding and helping the family. In D. K. Conn, N. Herrmann, A. Kaye, D. Rewilak, & B. Schogt (Eds.), *Practical psychiatry in the long term care facility: A handbook for staff,* (pp. 259–270). Toronto: Hogrefe & Huber.

Gladstone, J., & Wexler, E. (2000). A family perspective of family/staff interaction in long term care facilities. *Geriatric Nursing, 21,* 16–19.

Heiselman, T., & Noelker, L. S. (1991). Enhancing mutual respect among nursing assistants, residents, and residents' families. *Gerontologist, 30,* 49–53.

Hertzberg, A., & Ekman, S. L. (1996). How the relatives of elderly patients in institutional care perceive staff. *Scandinavian Journal of Caring Sciences, 10,* 205–211.

Lieff, S., & Silver, I. (2001). Planning mental health education programs for long term care. In D. K. Conn, N. Herrmann, A. Kaye, D. Rewilak, & B. Schogt (Eds.), *Practical psychiatry in the long term care facility: A handbook for staff* (pp. 239–248). Toronto: Hogrefe & Huber.

Looman, W. J., Noelker, L. S., Schur, D., Whitlatch, C. J., & Ejaz, F. K. (2002). Impact of family members on nurse assistants: What helps, what hurts. *American Journal of Alzheimer's Disease and Other Dementias, 17*(6), 350–356.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (2nd ed). Thousand Oaks, CA: Sage.

Osis, M. & Stout, L. (2001). Using narrative therapy with older adults. In G. Kenyon & P. G. Clark (Eds.), *Narrative gerontology: Theory, research and practice* (pp. 273–290). New York, Springer Publishing:

Pillemer, K., Hegeman, C. R., Albright, B., & Henderson, C. (1998). Building bridges between families and nursing home staff: The Partners in Caregiving Program. *The Gerontologist, 38*(4), 499–503.

Pillemer, K., Suitor, J. J., Henderson, C. R., Meador, R., Schultz, L., Robinson, J., & Hegeman, C. (2003). A cooperative communication intervention for nursing home staff and family members of residents. *The Gerontologist, 43*, 96.

Stolee, P., Esbaugh, J., Aylward, S., Cathers, T., Harvey, D. P., Hillier, et al. (2005). Factors associated with the effectiveness of continuing education in long-term care. *The Gerontologist, 45*(3), 399.

Thulesius, H., Petersson, C., Petersson, K., & Hakansson, A. (2002). Learner-centred education in end-of-life care improved well being in home care staff: A prospective controlled study. *Palliative Medicine, 16*(4), 347–354.

Tisher, M., & Jackson, L. (2003). Courses in family therapy for general practitioners: Identifying learning objectives. *Australian and New Zealand Journal of Family Therapy, 24*(3), 121–131.

Vinton, L., Mazza, N., & Kim, Y. (1994). Aggressive behaviour directed as nursing home personnel by residents' family members. *The Gerontologist, 34*(4), 528–533.

Whitlatch, C. J., Feinberg, L. F., & Stevens, E. J. (1999). Predictors of institutionalization for person's with Alzheimer's disease and the impact on family care givers. *Journal of Mental Health and Aging, 5*, 275–288.

Zarit, S. H., & Whitlatch, C. J. (1992). Institutional placement: Phases of the transition. *The Gerontologist, 32*, 665–672.