

# Family Involvement in the Care of Hospitalized Elderly Patients

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## Abstract

Family participation in caregiving to elderly inpatients is likely to improve the quality of care to older patients. This qualitative design study applied semi-structured interviews to elicit experiences from nurses, families, and patients on the notion of family participation in the care of elderly patients in two general teaching hospitals in Iran. Data were gathered using individual interviews, field notes, and participant observations. Interviews were recorded, transcribed verbatim, and analyzed using manifest and latent content analysis. The following main themes emerged through the data analysis process: (a) safety and quality in patient care and (b) unplanned and unstructured patient care participation. The study concludes that family involvement in caregiving to elderly patients is important, yet the participation should be based upon a planned and structured framework to ensure a safe and satisfying experience for patients, families, and health care team.

## Keywords

elderly care, family participation, nursing, family caregiver

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## Introduction

Despite the advances in medical sciences, the majority of the elderly population suffer from a range of physical and mental disabilities, particularly in the last years of their lives (Ebersol & Touhy, 2006). Consequently, elderly patients consume the majority of health care resources in most societies (Jasmine, 2007; Moons, Arnauts, & Delooz, 2003). Due to significant alterations in physical and mental functioning, the health care needs of elderly patients differ from those of other age groups. Older patients are more likely to suffer from hospital-acquired complications, such as pressure ulcer, fall, functional incontinence, dehydration, and nutritional deficit (Li, 2005) requiring more complicated care when admitted to health care facilities. Nevertheless, older patients are often marginalized in health care systems and their distinctive health care needs are neglected. A specialized care system is often not available for elderly patients (Flatley & Bridges, 2008), they are admitted to general hospital wards and, regardless of their condition, are subjected to the same procedures as other age groups. The specific care needs of elderly patients on the one hand, and increased nursing workload on the other, have resulted in significant unmet health care needs for older patients in many acute care settings (Li, Stewart, Imle, Archbold, & Felper, 2000; Lindhardt, Bolmsjö, & Hallberg, 2006; Lyytinen, Liippo, Routasalo, & Arve, 2002).

Involving the family in patient care can help ease the experience of hospitalization and reduce the potential complications for elderly patients (Li, 2005). A family member who holds valuable information concerning the patient may stay in hospital, work collaboratively with the health care team, and participate in caregiving for the patient (Li et al., 2000). Families' expectations and acts in hospital are mainly formed based on their feelings, roles, and previous experiences (Lindhardt et al., 2006). They feel responsible for protecting their patient and ensuring that they receive sufficient care. Li (2005) studied the perspectives of nurses, patients, and families on strategies that families used when caregiving to an elderly patient in acute care settings in the United States. The emerged strategies included carrying on, modification, starting new, sharing, and arranging care for the patient (Li, 2005).

Although studies from different parts of the world support involvement of the family in caregiving to inpatients including the elderly (Li, 2005; Lindhardt, Nyberg, & Hallberg, 2008; Molazem, Ahmadi, Mohammadi, & Bolandparvaz, 2011), caregiving can be a very demanding and stressful experience. In a phenomenological study by Lindhardt et al. (2006), family members who participated in caregiving to elderly inpatients perceived hospitalization as an emotionally and physically stressful experience (Lindhardt et al., 2006). Lindhardt, Hallberg, and Poulsen (2008) investigated

the perspectives of nurses on the involvement of the family in the care of older patients in Denmark. The analysis of interviews with six nurses and two assistant nurses suggested that nurses had conflicting attitudes towards involving the family in caregiving activities, in practice and theory (Lindhardt, Hallberg, & Poulsen, 2008). Understanding how to best use family resources in the care of elderly patients helps improve the quality of care for older patients and promotes the satisfaction of both patients and families (Lindhardt, Nyberg et al., 2008).

With the population of 75 million, Iran is one of the most populated countries in the world (Taheri, 2011). The health care system of Iran is highly centralized. Health policies are mainly designed at the national level by the Ministry of Health and Medical Education and implemented by medical universities locally. The president of a medical university is the highest health authority in each province and responsible for public health, health care provision in public facilities, and medical education in the province. Public health care services are provided through referral system and include *primary*, secondary, and tertiary care levels. More than 90% of the population is covered by at least one type of health insurance, yet almost 55% of health expenditure is paid out of the pocket (Mehrdad, 2009).

In every society, cultural norms influence the extent to which families are involved in patient care (Newman, Lawless, & Gelo, 2007). In Iranian culture, the family is expected to provide support and care for an ill family member and the expectations are particularly high when an elderly family member is admitted to a hospital (Hafizi, 2005; Li et al., 2000). Families themselves are also keen to stay with their patient in the hospital to ensure the best possible care and experience for the patient (Molazem et al., 2011). Although families' participation in caregiving to elderly patients is a common practice in Iran, the roles, experiences, and expectations of those involved in the process have not been adequately studied in the context. This study aimed to bridge the gap by exploring the notion of family participation in caregiving to elderly patients in acute care settings in Iran.

## Method

This qualitative study aimed to explore the notion of family participation in the care of elderly inpatients in Iran. The study received ethics approval from Tehran University of Medical Sciences. Potential participants were invited to the study after they received information about the purpose and objectives of the research and those who gave informed consent and agreed on the recording of the interviews were recruited to the study. The confidentiality of the interviews and anonymity of the participants were assured.

Participants were composed of elderly patients and their family members who had stayed in hospital for at least 2 days and registered nurses who had experience of looking after elderly patients for a minimum of 6 months. Elderly was defined as age 65 years and older. Participants were recruited over 3 months from two teaching hospitals in Tehran and they were selected using purposeful sampling method to assure triangulation. Severely ill patients or those with cognitive impairments were excluded from the study. Decision on cognitive impairment of the patients was made based on a short interview with their family caregivers and the main question was how impaired the family caregiver believed their patient was (Harvey, 2009). Except for a nurse, all those invited agreed to participate in the study. Overall, six family members, 10 nurses and five elderly patients were interviewed.

Semi-structured interviews were used to capture in-depth experiences of participants about family involvement in the care of elderly patients. The researchers developed an understanding of the phenomenon by building rapport and trust with study participants through their long and constant presence in the study field. The triangulation of the data provided the researchers with rich information on different aspects of family participation in caregiving activities. All interviews were conducted in hospital and lasted from 30 to 60 min. The interview times were scheduled based upon a mutual agreement between the participants and the researchers. The main questions asked from family members included "what do you do for your patient in the hospital?" and "why do you think your stay in the hospital is important?" The following main questions were asked from nurse participants: "how do you involve family in the care of elderly patients?" and "how does family involvement affect elderly patients' health outcomes?". The two main questions asked from elderly patients included "why is your family member staying in the hospital?" and "what do they do for you?". Clarifying and probing questions were used throughout the interviews to bring out the depth in the experiences. At the end of each interview, the researcher summarized the content to ensure that the participant's perspective was correctly understood. *As is common in qualitative research*, the criterion to halt the interviews was to reach data saturation (Burns & Grove, 1997).

All the interviews were recorded and transcribed verbatim by the principle researcher and analyzed using manifest and latent content analysis to allow understanding of both objective and subjective (obvious and hidden) concepts. In view of that, the transcriptions were reviewed several times to yield a general understanding of the notion of family participation in caregiving to elderly patients. The meaning units were underlined and highlighted as sentences or paragraphs, from which the initial codes were generated. The initial

codes were then reviewed and categorized based on meaning similarity, resulting in development of the study themes and subthemes.

In addition to the interviews, field notes also provided data to the study, helped the researchers gain a broader view on the phenomenon and were useful in interpretation of the findings. Further, family involvement in caregiving to elderly patients was observed by the principle researcher in four different shifts and each observation lasted from 90 to 120 min. Being a passive observer, the researcher did not disturb any patient care or engage in any interactions with nurses, patients, or families.

## Results

The following main themes and accompanying subthemes were identified from the data obtained:

### *Safety and Quality in Patient Care*

There was a perception that the presence of the family in hospital and their involvement in the care of elderly patients contributed to quality patient care by safeguarding the patient, advocating for their individual care needs, bridging the gaps in care provision, facilitating the continuity of patient care, enhancing the patient–provider relationship, and releasing nurses’ time to more important care activities.

*Safeguarding the Patient and Advocating for Their Needs.* The family acted as a safeguard and protected the patient from unnecessary care interventions. They felt responsibility to monitor the quality of provided care to ensure that their patient was receiving appropriate and safe care.

My mom is not able to walk to the bathroom. The nurse said, “We have to insert a urine catheter”, but I stopped them and said, “No, it would hurt her. I’ll get her a bedpan when she needs and let you know how much she has peed.” (Ashraf, family member)

One of the patients had a fall the other day . . . I am terrified to leave my dad alone here. (Mina, family member)

The family actively participated in identifying and communicating patient needs, stood up for the patient, and appealed about the shortcomings of care. They reminded the health care team of delays or denials in care and reported the defects in a timely manner, imposing obligations on the health care team to improve the quality of care services.

On one occasion I reminded the nurse to commence fluid for my patient. She (nurse) said, "Ok, right away". Well, when your patient does not eat properly, they (nurses) must start intravenous fluid . . . Whenever I note my patient care is delayed, I remind nurses and they attend to it. (Mina, family member)

They had discharged me from the hospital, but my son said, "They haven't reviewed your radiography results yet, how did they discharge you?" He then talked to the doctor and doctor agreed I stay in the hospital for a few more days. (Raheleh, patient)

My mom had been allocated a room near to the toilets, she was feeling very cold. I complained about it and they (nurses) changed it as soon as another room became available. (Hassan, family member)

Families who care and protect their members appeal about the shortcomings. Definitely, this helps improve the quality of care provided to patients. (Raziyeh, nurse)

*Bridging the Gap in Care Provision.* Factors, such as the complexity of elderly care, nurse shortages and workload issues contributed to unmet care needs for patients, necessitating involvement of the family in the care of elderly patients. Nurses often spent a considerable amount of time on providing routine care to patients, such as checking vital signs, administering medication, changing dressings, and documentation while they placed less priority on other aspects of care, such as patients' personal care, nutrition, ambulation, and patient education. To compensate for the gap, the family felt they needed to get involved in patient care and assist the patient with personal care activities, such as showering, feeding, and changing bed linens.

When I don't have time, I ask patients' relatives to help out. (Rahman, nurse)

Sometimes I note some patients' meals are being left on the tables untouched. When I ask why they haven't had their meal yet, they say (other patients): "her family caregiver is not here". (Sakineh, nurse)

Nurses believed that elderly patients often become anxious and stressed out when they are admitted to hospital. The presence of a family member at the bedside helps reduce the patient's anxiety and positively affects clinical outcomes in elderly patients, such as vital signs and the need for pain relievers.

Some patients' blood pressures go up in the absence of their family. Like, this patient's daughter was here yesterday and she was Ok; her blood glucose level and

blood pressure were normal, but now that her daughter is gone, her vital signs have changed a bit and I can notice it. (Sakineh, nurse)

Patients who are very unwell and anxious, we allow their family to stay with them in hospital. In some cases, we even call them ourselves and ask them to come and stay with their patient. Actually, I've noticed patients who have a family member with them they seem to be more relaxed and less anxious . . . their recovery goes well. (Sima, nurse manager)

In situations where nurses failed to meet the psychological needs of elderly patients, the family members accompanying the patients filled in the gaps by providing constant emotional and psychological support helping the patients to handle their situation properly.

My mom feels lonely in the hospital. She is terrified of needles . . . it is good for her I stay in the hospital. (Fatimah, family member)

Besides emotional and psychological support, the family supported their patients physically and financially. They accelerated health-care process through providing required medicines and medical supplies.

*Facilitating the Continuity of Patient Care.* Collectively, patients, families, and nurses believed that hospitalization was a stressful and overwhelming experience for elderly patients and their family caregivers, which could be relieved by the patient, family, and the health care team working collaboratively together. There was a belief that family plays a substantial role in easing care transition from home to hospital by supporting the patient's wishes and providing the health care team with the necessary information about the patient. In addition, during their stay in hospital, the family received useful information about the patient and learnt new skills that they could use at home after the patient was discharged from the hospital.

We educate their (patients) family to be mindful so their patient does not get bed sore at home. (Raziyeh, nurse)

*Promoting the Patient–Provider Relationship.* The workload issues and lack of appropriate training in elderly care were perceived as impediments hindering the nurse–patient relationship. Cognitive and physical impairments of elderly patients also contributed to the challenge. Presence of a family member at the patient's bedside was believed to be particularly useful in facilitating the patient–provider communication.

Unfortunately, the nurse–patient communication, particularly for elderly patients, is fairly poor and it is a big barrier to effective care. (Sakineh, nurse)

Lack of competency in the Persian language coupled with the cultural barrier of feeling uncomfortable when communicating with authorities hindered elderly patients from communicating their needs effectively to the health care team. They felt more comfortable asking for assistance from their family members than hospital staff.

I am so scared of falling when I go to the bathroom, (I) feel more comfortable when my daughter is here. I can't ask for anyone's help except for my daughter. (Agdas, patient)

She (patient) never complains, even if you give her nothing (food) for ten days. (Mina, family member)

By explaining the purpose of treatments to patients and helping them relax and gain comfort and trust, families increased patient collaboration with the health care team and improved patient compliance with the treatment regimen.

Sometimes they (patients) refuse treatments like changing dressings, so we have to ask their family to explain the procedure to the patient and convince them to cooperate. (Rahman, nurse)

She wouldn't let them examine her or take her medicines if I was not here (hospital) . . . She listens to me. (Family member, Ashraf)

**Releasing Nurses' Time to More Important Care Activities.** Family participation in the elderly care mainly included showering, feeding, and changing the patient's gown, the patient-care activities that take a significant amount of nurses' time. By participating in patient-care activities and taking over some of the nurses' responsibilities, the family released nurses' time to focus on more vital care activities.

We have kind of fewer issues with elderly patients who have a family member with them; they make our job a lot easier. (Zahra, nurse)

### ***Unplanned and Unstructured Patient Care Participation***

Although analysis of the interviews suggests that the presence of *family members at patients' bedside provides many great benefits*, the second main theme emerged from data indicates that overall family participation in elderly



patient care was undertaken in an unorganized and unplanned manner. This theme included the subthemes of “conflicting role expectations” and “being involved in potentially unsafe and stressful caregiving activities”.

**Conflicting Role Expectations.** Patients, families, and nurses expressed positive attitudes towards involving the family in caregiving to elderly patients, however, gaps in patient care, at times, resulted from lack of clarity in the roles and responsibilities and also the failure of nursing staff to effectively manage and coordinate family participation in caregiving.

It depends on the sympatheticity of the family. Sometimes the family is at patient’s bedside, but the patient’s clothes and linens are not clean or the patient has got bedsores, as they haven’t been out of bed for a long time. (Sakineh, nurse)

Some family members say they don’t know what and how to do things and some say they are not in good health themselves to be able to help out much. (Raziyeh, nurse)

Family members reported that they were left alone with physically demanding care activities, such as showering the patient and moving them in and out of bed. Expressing their dissatisfaction with the matter, families believed that nurses should lend a hand to family caregivers in carrying out patient-care activities, particularly manual handling of patients.

I cannot shower her (the patient) by myself. None of hospital staff assists me. I have to ask one of my brothers or sisters to come over and help me out. (Fahimeh, family member)

In situations where there was shortage of advanced medical devices for patient monitoring, family members were used as alternatives to inform the health care team of changes in the patient’s condition, for example, when *vital signs went above or below a certain limit, or the infusion bag was empty*. These responsibilities were believed to place extra stress and strain on the family caregiver.

Once the monitor went off, I got so terrified and called the nurse. She said, “the battery has run out of charge”. (Mina, family member)

Admitting the shortcomings in the health care system, nurse participants suggested that family involvement in patient care and the expectations of staff need to be clearly discussed with the family caregiver and adequate education and supervision provided.

Sometimes I ask a family member if they have changed patient position and they say “yes”, but the reality is they don’t know which areas are more prone to pressure ulcer . . . they need appropriate education and monitoring . . . nurses need to be effectively involved in the process and coordinate family’s participation in patient care. (Zahra, nurse)

Nevertheless, nurses believed that the supervision and coordination of family participation in caregiving activities was another challenge for already busy nurses. Due to the nature of shift work, nurses found that it was difficult to effectively manage family participation in patient care. Training of the family was perceived to be particularly challenging when different family members were involved in patient care. Nurses also expressed their dissatisfaction with family caregivers who acted independently without following the professional advice of nurses on care provision, disrupting the patient-care process due to lack of sufficient knowledge and skills. Some family members, on the other hand, conveyed their reluctance to become forcefully involved in caregiving activities and believed that patient care should be the sole responsibility of the health care team.

They (the family) argue that patient care is our (nurses) job and say “what you (nurses) are doing here!.” (Sakineh, nurse)

*Being Involved in Potentially Unsafe and Stressful Caregiving Activities.* By participating in patient care, families intended to ease the patient journey, assure quality care, and promote the patient-provider relationship, yet families’ involvement in acute care settings followed no rules or policies. Nurses involved family members in specialized patient care, which could be potentially unsafe for the patient, such as administering medications, changing dressings, suctioning, and nasogastric tube feeding.

Families help out with giving medicines, as some elderly patients cannot take their medicines themselves . . . for patients who have NG tubes (nasogastric tubes), we (nurses) teach their family caregiver to crush and dissolve the medicine. Then either we or they, themselves, give them to the patient. (Susan, nurse)

This patient has a family caregiver so we are kind of less concerned. We have taught him (the family member) to gavage feed and suction the patient . . . he no longer calls us...knows when to suction. (Susan, nurse)

Lack of sufficient training and supervision by the health care staff, at times, resulted in families performing unsafe practices, jeopardizing the patient health as well as leaving the family caregiver with a feeling of guilt, worthlessness, and failure.

They asked me to clean her bedsore site. I didn't know I should not use tissue for it... They (nurses) blamed me for leaving the tissue on the bedsore site. (Mina, family member)

## Discussion

Family participation in the care of elderly inpatients is increasingly being addressed and explored in the literature, although the effectiveness of family involvement in patient care has not been yet examined using an appropriate study design. The current study was carried out with the aim of exploring the notion of family involvement in the care of elderly patients in acute care settings. Analysis of the interviews with patients, families, and nurses reflected both promoting and hindering effects of family participation in caregiving activities. Two main themes emerged from data analysis: (a) safety and quality in patient care; and (b) unplanned and unstructured patient-care participation.

### *Safety and Quality in Patient Care*

The findings of this study provided further evidence that hospitalization is often a stressful experience for elderly patients. They commonly experience feelings of fear, stress, loneliness, and lack of trust, and therefore, need to be well supported throughout the hospitalization process (Huckstadt, 2002). In the current study, emotional and psychological support emerged as the main reason why the family wanted to stay with their elderly patient in hospital. Nurses, patients, and families consistently commented that the presence of a family caregiver at patient bedside provided the patient with emotional support and eased the process of hospitalization for the patient. These findings are consistent with the results of previous studies suggesting that the family is present in the hospital due to the special needs of elderly patients for emotional and psychological support and because the family doubts that these needs will be fully met by hospital staff (Lyytinen et al., 2002). By being present in the hospital and providing care and support from different aspects, families help maintain familiar routines for patients, which are considered an important aspect of the elderly care, facilitating an easier care transition from home to an acute care setting (Molazem et al., 2011).

Nurses and families similarly commented that elderly patients were not receiving optimal care for a range of reasons, such as poor nurse-to-patient staffing ratios, the task-oriented health care system, and the failure of nursing staff to meet patients' individual care needs. By being present in the hospital, the family was able to identify and act upon the shortcomings of the health care system and felt responsibilities to fill up the gap in care provision. Confirming the findings of Li et al. (2000), family caregivers believed that in

circumstances where there was nurse shortage or the quality of health care services was poor and could not be trusted, they needed to bear more responsibilities for the patient. Hence, families chose to stay in hospital to remedy the shortcomings and fulfill the unmet patient care needs. The culmination of these findings and other studies (Khademi, Abedi, & Alimahamadi, 2007; Molazem et al., 2011) may suggest that the health care system in Iran is failing to deliver a satisfactory level of care to elderly patients and has implications for the health care policy makers to promote education and training in geriatric nursing.

During their stay in hospital, families had witnessed various unsafe practices on their or other patients, compelling them to take more responsibility in protecting their patient. Similar to previous reports, in current study, families felt responsible for ensuring that their patients' health care needs were sufficiently addressed by the health care team and the patient was receiving an appropriate and adequate level of care and treatment. They advised the staff on delays in care provision and participated in the monitoring of their patients and timely reporting of incidents. The controlling and evaluating role of the family has been previously documented in the literature (Li, 2005; Li et al., 2000).

Also confirming previous research (Huckstadt, 2002; McCabe, 2004), our findings reflected a poor nurse–patient relationship. Cognitive and functional declines in the elderly, ineffective previous attempts to communicate, and lack of competency in speaking Persian language—the official language of Iran—were some identified barriers hindering elderly patients from communicating their needs effectively with the health care team. Further, gender and modesty were common cultural impediments to an effective patient–provider communication. These barriers tend to be common in the Middle Eastern culture where patients are more likely to feel disempowered to express their dissatisfaction or voice complaints about health care systems. Patients usually feel embarrassed to take staff's time and attempt to avoid being labeled as “difficult” (Gholizadeh, Salamonson, DiGiacomo, & Davidson, 2009; Macdonald, 2007). Expectedly, elderly patients, in current study, were reluctant to ask for help from hospital staff and felt more comfortable to ask for assistance of their family members.

Likewise, nurses found it difficult to communicate effectively with patients due to cognitive and functional deficits in older patients. Further, the high workload hindered effective communication between nurses and elderly patients. Reasonable nurse–patient staffing ratios and adequate training of the health care team on elderly care, which also includes strategies to promote communication between nurses and patients are likely to improve the quality of care for older patients (Stewart et al., 2000).

During the course of hospital stay, families were exposed to useful patient information and learnt new skills that they could apply at home. The obtained knowledge and skills to facilitate a smooth patient-care transition from hospital to home setting. Thus, nurses can use the unique opportunity to work collaboratively with patients and families to develop and implement a comprehensive discharge plan based on patients' specific needs and family resources (Li, 2005). Yet, inconsistent with the results of a study by Li et al. (2000), in the current study, there was no mention of nurses using the knowledge and skills of family caregivers to improve the quality of care for elderly patients. Li et al. (2000) reported that families applied strategies to increase patient trust and collaboration with the health care team and provided the health care staff with valuable information concerning the patient's condition, which helped establish a care partnership between formal and informal caregivers in acute care settings (Li et al., 2000).

### *Unplanned and Unstructured Patient Care Participation*

Although family participation in the care of elderly patients was overall perceived as beneficial by study participants, some conflicting role expectations between nurses and family caregivers were identified. This was particularly evident in provision of personal patient care, in that nurses expected family members who stayed with the patient in the hospital to take responsibilities in providing personal care to their patients, such as bathing, changing soiled linens, feeding, and helping out with patient ambulation. It is noted that in the health care system of Iran, the registered nurse is not often clinically involved in patients' personal care and it is the responsibility of the nurse's assistant to deliver this aspect of patient care (The Iranian Nursing Organization, 2012). Yet, due to a shortage of nurse assistants and their negligence in the hospitals where this study took place, family members were expected to provide personal patient care. This was not particularly welcomed by families who held a view that nurses should complete the entire patient care. The existence of role conflict and role ambiguity resulted in inconsistency in care provision among nurses, family caregivers, and nurse assistants, creating a potential for the patient care to be compromised. This finding is consistent with previous research in Iran, suggesting that nurses possess unenthusiastic attitudes towards providing personal care to patients (Hamadanizadeh, Mottahedian Tabrizi, Sarhangi, & Zigheimat, 2008). Similar to nurses in other countries, Iranian nurses are rather distant from basic and initial care provision since they desire to be promoted and officially recognized (Nolan, Brown, Davies, Nolan, & Keady, 2006). Yet, patient personal care and nutrition play an important part in the holistic nursing (Crisp & Taylor, 2009) and deserve

greater recognition in nursing education and elderly care. There is also an implication for developing clear role descriptions for registered nurses and nurse assistants.

The scope of family involvement in caregiving activities needs to be also clearly defined. Globally, health care systems lack a structured and well-planned approach as to how best to involve families in caregiving activities in acute care settings (Li et al., 2000) and this topic remains almost untapped in Iran. Molazem et al. (2010) suggest that in circumstances where the health care team fail to meet patients' care needs, involving the family in caregiving activities seems necessary, however, the authors suggest that the main role of family caregivers should remain emotional and psychological support (Molazem, Ahmadi, Mohammad, & Bolandparvaz, 2008). Although this approach could remedy the shortcomings in health care, some families may not wish to become engaged in patient care, yet they continue to feel responsible for the patient to ensure that their patient's care needs are adequately met by health care team (Lindhardt, Nyberg et al., 2008). Therefore, the involvement of families in care needs to be based upon their desire to become involved (Halm & Titler, 1990) and it should be mutually negotiated among the patient, family, and health care team. Involving the family in caregiving to inpatients regardless of their desire or aptitude may raise some ethical issues and needs to be clearly addressed and defined in health care systems.

Families reported being left by themselves to accomplish physically demanding patient-care activities, such as manual handling of the patient, without their ability being assessed or an adequate training provided, resulting in experiences of strain, stress, and dissatisfaction by the family caregivers. The burden of caregiving to elderly patients or patients with chronic health condition has widely been documented in the literature (Li, 2005; Lindhardt, Hallberg, et al., 2008). The stress and strain of new caregiving responsibilities in an acute care setting can add up to the burden of already overwhelmed family caregivers resulting in caregiver burnout (Li, 2005; Lindhardt, Hallberg, et al., 2008; Molazem et al., 2011). The family caregivers, in current study, perceived their role as rather supportive and supplementary than taking over some roles of nursing staff, a finding that supports previous research. Families value being involved in decision makings, becoming engaged in patient discharge plan, and receiving information and education regarding patient care which they can apply after discharge at home (Abedi, Mostafavidarani, & Riji, 2010; Lindhardt, Nyberg, et al., 2008). This is of paramount importance when it concerns frail and vulnerable elderly patients, who might be incompetent or reluctant to participate in decision-makings related to their care and prefer their family to become

involved in the care process (Bridges, Flatley, & Meyer, 2010; Lindhardt, Hallberg et al., 2008). Thus, it is important that family involvement in patient care and decision-makings to be individually negotiated with the patient and family. Effective participation of patients and families in health care process, has been shown, helps relieve anxiety in the patients and families (Bridges et al., 2010). In our study, there was no mention of family involvement in decision-makings related to the elderly patient care, possibly because it is not a common practice in Iran. It can also be related to the fact that nurses often lack authority to develop patient-care plans in this country. In developed health care systems, patient involvement in decision making regarding their care is an established patient right (Crisp & Taylor, 2009), however, family caregivers' involvement in these decisions needs to be clearly defined and evaluated.

In our study, excerpts from both nurses and families indicated that family members became, at times, involved in specialized nursing care, such as suctioning and NG tube feeding of patients in the hospital setting. This type of family participation in care in acute care settings have not been frequently mentioned in the literature (Halm & Titler, 1990). A study by Halm and Tiltler (1990) reported of family members being involved in suctioning and Hickman line care with guidance from nursing staff (Halm & Titler, 1990). Nurses, in the current study, believed that adequate training and supervision of family caregivers was difficult, particularly when different family members became involved in patient care. Family members who did not receive sufficient training on delegated tasks and were not aware of hazards jeopardized both the patient's and their own health. Molazem et al. (2009) suggest that the family might not fully understand patient health care needs or be able to provide the quality and/or quantity of care required, risking the patient's safety and adding to the stress of caregiving (Molazem et al., 2008; Molazem et al., 2011). Family participation in patient care needs to be implemented with adequate training and monitoring to ensure safety for the patient and a positive experience for the caregiver (Molazem et al., 2008).

We found that family involvement in caregiving to elderly patients in acute care settings followed no rules and the level of participation varied significantly depending upon the attitudes and expectations of the nurse. On one end of the spectrum, some nurses hardly ever involved families in the patient-care process. On the other end, the family became involved in caregiving tasks beyond their skills and abilities. These findings are somewhat consistent with those reported previously by Lindhardt, Hallberg, and Poulsen (2008) who found that nurses possessed mixed attitudes and varying expectations about family participation in caregiving to inpatients. Overall, effective involvement of family in patient care was perceived to be

a time-consuming process and nurses often considered engaging the family in patient personal care only (Lindhardt, Nyberg et al., 2008). Yet, nurses believed that if family involvement in caregiving to elderly inpatients is implemented in a structured and appropriate manner and includes adequate training and supervision, it helps improve the quality of patient care in acute care settings as well as facilitating continuity of care for elderly patients after discharge from hospital.

## Conclusion

Understanding the process that the family undertakes over the course of their stay in an acute care unit is important to inform strategies to promote the collaboration of patients, families, and nurses, which in turn improves patient outcomes as well as ensures a safe and satisfying experience for the family caregiver. For an effective use of family resources in caregiving to elderly patients, family involvement in patient care needs to be based upon a planned and structured framework. The framework should take into consideration patient health care needs and the dignity, safety, and preferences of both the patient and family. The caregiver's legal rights and responsibilities also need to be addressed. The findings of this study should inspire and inform further research, which applies more appropriate study designs to enable improved evaluation of the effectiveness of family participation in enhancing patient outcomes.

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