Partnership between staff and family in long-term care facility: a hybrid concept analysis

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ABSTRACT

Purpose: The purpose of this study was to examine the attributes and verify the definition of the partnership concept using the hybrid model.

Methods: A hybrid model was used to develop the concept of partnership. The hybrid model consists of three phases: theoretical, fieldwork and final analytical. In the theoretical phase, a working definition of partnership was developed by an extensive review with 35 studies. The fieldwork phase comprised seven focused-group interviews with 35 participants consisted of 25 facility staff and 10 family caregivers in long-term care facilities. The final analytical phase compared and interpreted the findings from the first and second phases in order to clarify the concept of partnership.

Results: The concept of partnership was found to have two dimensions: interpersonal and environmental dimensions. The seven attributes emerged from this study. They included relationship, information sharing, shared decision-making, professional competence, negotiation, involvement in care, shared responsibility.

Conclusions: The partnership between family and staff in long-term care facilities was defined as an ongoing and dynamic process associated with interpersonal and environmental factors. Based on the results, it can be suggested that the development of a tool for measuring partnership and an effective program for enhancing to establish a collaborative relationship.

Introduction

The number of older adults who require long-term care (LTC) has increased rapidly with the increase in the ageing population. Within a culture of care that prioritizes caring by family members at home, caregivers experience physical, emotional, and social problems and despair (Jang & Yi, 2017). Despite somewhat negative perception of LTC facilities (Kwon & Tae, 2014), this heavy care burden has led to a steady increase in the institutionalization of older person, and the number of residents in LTC facilities in Korea reached 345,000 in 2016 (National Health Insurance Corporation, 2017).

Admission older adults to a LTC facility does not signify the termination of family care. While families often expect the burden of caring to be reduced due to the older adults’ entry into the facility, the families still have the caregiving burden (Majerovitz, 2007) and are confused about the changing role of caregiving (Chang & Schneider, 2010; Kwon & Tae, 2014; Mast, 2013). In addition, the family still wants to maintain a meaningful relationship with the older adult even after entering the facility and to continue to involve in care of the older adult (Bauer et al., 2003; Hagen, 2001). The families of older adult residents may provide important information on the life history, habits, preferences, and care needs of residents (Robison et al., 2007; Utley-Smith et al., 2009), so the family’s involvement in care is crucial for the well-being of the older adult residents (Bauer, 2007). Therefore, the family of resident should be regarded as a partner who expresses the preferences and expectations of the resident and participates in the care, not the passive watchers (Choi & Bang, 2013).

Since the concept of partnership was declared in 1978 by the World Health Organization as a key element of the goals for all people’s health (World Health Organization, 1978), it focuses on improving the health status and health-care ability of the patients, and is used in cooperation with the health-care providers (Choi & Bang, 2013).

In Western countries, since Casey (1988) proposed the partnership nursing model, research on partnerships not only in hospitals but also in community practice has been actively conducted, noting that collaborative relationships between health-care providers and patients have a positive impact on patients’ health (Lee, 1998). Previous researches on partnerships included exploring the meaning of partnerships and analysing concepts such as negotiation, equality of care, involvement in care (Casey, 1995; Dowling...
et al., 2004; Espezel & Canam, 2003; Lee, 2007), partnership models (Courtney et al., 1996; Farrell, 1992), and family involvement (Coyne & Cowley, 2007; Power & Frank, 2008). In addition, family involvement in care in facility has a positive effect on the older adult, the family and the facility staff (Pillemer et al., 2003; Robison et al., 2007) and is an important factor in ensuring the quality of life of the older adult resident. Various nursing interventions are applied to prevent role conflicts and to build cooperative relationships among the family members and staff members (Specht et al., 2000) and the concept of partnership between them is emphasized (Haesler et al., 2010).

Despite the necessity and importance of partnerships are widely known and emphasized abroad, studies on partnerships are insufficient in Korea. Most are limited to exploratory research on partnerships in hospital settings for nurses and families of hospitalized children (Bae & Lee, 2017; Choi & Kim, 2014). Research on this has not been actively conducted in various fields such as long-term care facilities and community. On the other hand, there is a study that conducted a concept analysis as a part of the tool development process for the partnership among the parents of hospitalized children and nurses in Korea (Choi & Bang, 2013). However, there are limitations in applying the results to the formation of partnerships with residents’ families and facility staff.

In other words, in a hospital setting, the family stays as a guardian for a limited length of stay and participates in the treatment and care of the patient. In contrast, in a facility setting, the family does not reside during their stay, but rather visits the facility and participates in caring for the resident. So the partnerships with families and health-care providers in hospital and institutional settings can be seen as being formed through different dynamics in different contexts. Therefore, in order to have a clear understanding of the partnership of the family and staff in the facility, it is necessary to consider the context that affects the formation of the partnership. Applying the meaning of the concept used in the existing literature as it may not be able to reflect the actual situation of the facility.

In order to promote positive outcomes in the health status of the older adults in the facility and to increase the family’s adaptation to daily life after entering the facility, various efforts are needed to form a partnership between the family and the facility staff. First of all, the establishment of a conceptual definition of the partnership between staff member and family member is essential. This is not only a basic data for intervention program and policy development for partnership building but also a direct contribution to the development of tools that can assess the partnership between resident’s families and staff member.

Therefore, the purpose of this study was to examine the attributes and verify the definition of the partnership concept between staff members and residents’ family members in LTC facilities, using the hybrid model (Schwartz-Barcott & Kim, 2000).

Methods
Study design
This study was performed to concept analysis with a hybrid model by Schwartz-Barcott and Kim (2000) that determine the dimensions, attributes, and indicators of partnerships between staff members and residents’ family members in LTC facilities.

Study procedure
To develop a concept of partnership in LTC facilities, this study was performed to analysis using the hybrid model (Schwartz-Barcott & Kim, 2000). This model is a way to create, develop, and expand concepts, especially widely used to clarify of concept in the field of nursing. The hybrid model combines the inductive and deductive approaches and integrates theoretical analysis with empirical investigations. This model comprises three phases: theoretical, fieldwork, and final analytical phase (Figure 1). The theoretical phase begins with the selection of a concept of interest in the field of practice. Then, the literature is searched and reviewed to formulate the working definition. The fieldwork phase is undertaken to verify the concept of empirically using qualitative methods. The final analytical phase consists of a conceptual analysis of the findings from the two phases to identify attributes of the concept. Through this model, the concept is refined and new and more comprehensive definitions emerged, and at times quite different definitions from the initial ones (Schwartz-Barcott & Kim, 2000).

Theoretical phase
For a theoretical analysis of partnership in LTC facilities, the literature was systematic reviewed. Search terms used were (famil* OR staff*) AND (partnership OR partner OR collaboration OR cooperation) AND

![Figure 1. Hybrid model of concept analysis of partnership.](image-url)
"nursing homes" OR "long-term care facility") were searched. A search was performed in these databases; Korean articles in the KoreaMed, KMbase, Research Information Sharing Service (RISS), Koreanstudies Information Service System (KISS), and National Digital Science Library (NDSL), and foreign articles in the PubMed, Excerpta Medica database (EMBASE), PsycINFO, Cumulative Index to Nursing and Allied Health Literature (CINAHL) database, and Cochrane Library. The articles published from 1980 to 2016 were included in the search, based on the previous study (Gallant et al., 2002) that considered the 1980s as the period during which the concept of partnership in nurse-client emerged. Only articles written in English and Korean. Two researchers undertook the literature search independently and yielded 2,442 articles; after duplicates were removed, 1,302 articles were left for review. Following a review of titles and abstracts, 1,246 articles determined to be unrelated to the topic were excluded, remaining 56 articles. The full text of these articles was reviewed, and 25 articles were excluded for not meeting the selection criteria. Four additional hand-searched articles identified during the process of reviewing the articles’ full text were included. Finally, 35 articles were included in this study (Figure 2).

The articles were analysed systematically to determine the working definition and attributes of the partnership in LTC facilities. The antecedents, attributes, and consequences presented in each article are as shown in Table I.

Fieldwork phase

To confirm the attributes of the concept determined in the theoretical analytic phase, focus groups interviews were conducted with staff members and residents’ family members. The study participants consisted of individuals who could communicate without assistance and provided voluntary consent to participate in the study based on a full understanding of the study purpose. The detailed inclusion criteria were as follows:

- Staff who have worked at the current LTC facility for three or more months and were capable of adequately providing their experiences of working with residents and their family members.
- Resident’s family members were relatives of older adult who have resided in current facility for three or more months, were primary caregivers of their older adult, and visited them at the facility most frequently.

For the focus group interview, a researcher with extensive experience in qualitative studies drafted the interview questions based on the attributes of the concept as determined in the theoretical analytic phase. The interview questions were as follows: “What do you think is role of residents’ family in facility?”, “How do you feel about family members participating in residential care?”, “What do you think about the nursing home staff and residents’ family partnership?”, “What do you think is helpful (or necessary) when establishing partnership between staff and family?” and “What bothers you in establishing partnership between staff and family?”

Data were collected from May 2016 to August 2016 and the interviews were conducted in a quiet conference room or visiting room in facility and lasted approximately for 90 minutes. Data were collected until data saturation had occurred and no new information could be obtained. Finally, there were 35 participants (25 staff members in five groups and 10 family members in two groups). Of the staff participants, 24 were female, the average age was 52.8 years, and the average working period was 5.1 years. Of the family members participants, 7 were female, the average age was 52.6 years, and the average duration of institutionalization was 2.9 years. The general characteristics of participants are shown in Table II.

To ensure the trustworthiness of data, in-depth interviews were conducted with one or two participants from each staff and family group, and we received feedback from peers to establish the validity of the analysis and interpretation. In addition, purposive sampling was used to facilitate transferability of the inquiry, and the interview data transcribed within 24 hours of finishing each interview to ensure that no data were missing or distorted (Anney, 2014; Lincoln & Guba, 1985).

The interviews were transcribed verbatim and analysed according to the qualitative content analysis using the qualitative computer software program ‘MAXQDA12’ (VERBI Software GmbH, Berlin, Germany). Qualitative content analysis is a research method that has been widely used to analyse the meaning of extensive and complex text-based data (HSieh & Shannon, 2005). The details of this analytical
Table I. Antecedents, Attributes and Consequences of partnership in Literature Review.

| Authors                               | Antecedents                                      | Attributes                                                                                     | Consequences                                                                 |
|---------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| Dupuis et al., 2016                   | None                                             | Connecting and committing, creating a safe space, valuing diverse perspectives, establishing and maintaining open communication, conducting regular critical reflection and dialogue | Resident: improved equality                                                  |
| Bauer et al., 2014                    | Staff attitudes, mutual cooperation, meaningful engagement, shared expectation | Building trust, involvement, keeping the family happy                                          | Resident: maintaining the health and well-being Family: satisfaction of facility Staff: having confidence to provide good care |
| Choi & Bang, 2013                      | None                                             | Reciprocity, professional knowledge & skill, sensitivity, collaboration, communication, shared information, cautiousness | None                                                                          |
| Park & Jang, 2010                      | Mutual respect                                    | Sharing information, sharing power, autonomy, sharing decision making                         | Resident: enhance participant’s adherence, health status, and the quality of life |
| Cowdell, 2009                          | None                                             | Sharing information, sharing the care, developing supportive relationships, making it work    |                                                                                |
| Haswell-Elkins et al., 2009           | None                                             | Gaining two-way understanding, supporting the empowerment                                     | Achieving greater wellness                                                  |
| Utley-Smith et al., 2009              | None                                             | Interaction, communication                                                                   | Improved quality of care for residents                                       |
| McVeigh et al., 2009                   | None                                             | Opening lines of communication, acknowledging, providing support                             | Family: improved satisfaction of facility                                     |
| Alice Lau et al., 2008                 | Beliefs, experiences about institutionalization, role relationship expectation                 | Institutional social penetration: self-disclosure, evaluation of care, penetration strategies  | Resident: no resistance towards institutionalization                            |
| Wiggins, 2008                         | Shared value, skill in relationships and communication, interpersonal skill, the presence of support, sharing and a conductive environment | Shared responsibility, information, decision making, communication, trust, respect, reciprocity | Patients, family, physician, nurse: positively impact on safety, quality of care, satisfaction, outcomes and job fulfilment |
| Haesler et al., 2006                   | None                                             | Collaboration, positive communication, sharing information, sharing power and control         | Increasing family involvement in resident care                                 |
| Hook, 2006                            | Professional staff values, knowledge and skills in relationship building, communication, clinical competence, introspection Environment: safe, time, leadership support, interdisciplinary relationship | Professional competency, communication, patient participation, relationship, shared knowledge, shared power, patient autonomy, shared decision-making | Empowerment: enhanced self-management, improved health care utilization, improved health outcomes |
| Bidmead & Cowley, 2005                 | Model of health visiting, organizational and professional support, practitioners’ qualities and skills | A genuine and trusting relationship, honest and open communication and listening, praise and encouragement, reciprocity, empathy, sharing and respect for the other’s expertise, working together with negotiation of goals, plans, and boundaries, participation and involvement, support and advocacy, information giving, enabling choice and equity | Client: feel enabled and empowered, gain knowledge and self-esteem, change attitudes and behaviour Parents: perceive themselves as more capable, more supported, family, relationship improved and child behaviour better Practitioner: more job satisfaction, less stress, greater role clarity Child: improved quality of life Professional: improved academic achievement and functional life skills |
| Blue-Banning et al., 2004              | None                                             | Communication, commitment, equality, skills, trusts, respect                                |                                                                               |
| Bauer et al., 2003                     | Visiting nursing home                             | Establishing and maintenance of relationships, Be involved in care, collaborative with nursing home staff, be involved on decision-making processes, share in the responsibility of caring, shared understanding of responsibility for each task | Resident: adaptation of facility Family: emotional support, social contact, relief of guilt, be satisfied with a resident’s care Staff: ameliorate the associated distress |
| Gallant et al., 2002                   | Democratic, value cooperation, commitment to shared responsibility, open and respectful, basic interpersonal skills | Structure: relationship Process: power sharing, negotiation                                  | Empowerment                                                                  |
| Gwyther, 2001                          | None                                             | Relationship, involvement, communication                                                     | Adaptation of facility transition                                             |
| Janzen, 2001                           | None                                             | Monitoring care, communication, collaboration, relationship                                  | Promote good quality care, acceptable quality of life for the resident        |
| McQueen, 2000                          | None                                             | Mutual and unilateral relationship, empathetic understanding, genuineness, unconditional positive regard | Patient focused care                                                         |

(Continued)
Table I. (Continued).

| Authors          | Antecedents | Attributes                                                                 | Consequences                                                                 |
|------------------|-------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| Norris, 2000     | None        | Personal interactions, responsibility, mutual respect                      | Avoid conflict, provide high quality of care                                   |
| Owen et al., 2000| None        | Sharing information, seeking information, adult relations                   | Improved quality of care                                                      |
| Specht et al.,   | None        | Negotiation and involvement in care                                          | Improved perception of caregiving role and knowledge of Alzheimers’ role       |
| Lee, 1999        | Belief, intention, adequate facility | Negotiation, equality of care between parents and nurses, involvement of families in care | Nurse’s role change in a supervisory role                                      |
| Pillemer et al., | None        | Relationship, communication, cooperation, work together, understanding differences in values | Resident: improved quality of life Family-staff: reduce conflict               |
| Friedemann et al.| Extensive education of staff, the subsequent willingness of staff | Involvement, interactions                                                      | None                                                                          |
| Courtney et al., | None        | Negotiated sharing of power, agree to be involved as active participants     | Enhance the capacity of the partners                                           |
| Leahey & Harper-Jaques, 1996 | Beliefs, values | Reciprocity, non-hierarchical relationship, respect each as expert, aware of resourced and strengths, simultaneously feedback process | None                                                                          |
| Taylor, 1996     | None        | Open lines of communication, participation, providing information           | Parent: enabled to discuss their role and negotiate fully in the care of their child |
| Harvath et al.,  | None        | Blending local and cosmopolitan knowledge, unique information and nurses’ knowledge and skills | Resident: tailored care, individualization care, improving care quality empowerment |
| Wade, 1995       | None        | Relationship, reciprocity, sharing, equality, respect, participation        | Child: become more independent Family: have the responsibility for care         |
| Farrell, 1992    | Commitment of healthcare workers | Relationship of equality, share knowledge and teach the skill, acknowledge the unique of nursing care | None                                                                          |
| Stower, 1992     | None        | Family centred care, parent participation, negotiation, respecting the wishes |                                                                               |
| Opie, 1991       | Recognition of the limits, organization of formal services, reorientation, focus on prevention services, integration of males into caring work | Equal relationship, sharing power and responsibility, participated in decision making | A cost saving                                                                 |
| Casey, 1988      | None        | Relationship, negotiation, respect for the wishes of the family              | Child: the child learn self-care until he is independent and considered mature |
| Teasdale, 1987   | Change attitudes of nurse and patient | An equal relationship, involved in care, choice including negotiation, shared information |                                                                               |

procedure are as follows: First, coding was performed by repeatedly reading transcribed data to identify meaningful words, phrases, and sentences. Second, the codes are sorted into subcategories by comparing the differences and similarities between codes. Finally, subcategories are organized into categories depending on the relationships between subcategories.

**Final analytical phase**

In the final analytic phase, this study emerged the final attributes and definition of partnership in LTC facilities via comparing the findings through a literature review and the focus group interviews.

**Ethical considerations**

Data were collected after obtaining approval from the Institutional Review Board at the researcher’s affiliated university (IRB No. HYI-16-036-2). Participants were explained the purpose of the study and were informed that the interviews would be recorded and that they could withdraw from the study at any time without negative consequences. Only those who voluntarily participated were asked to interview after giving written consent.

**Results**

**Theoretical phase**

**Definition of partnership in the other academic field**

A partnership is defined as a “relationship between individuals or groups that is characterized by mutual cooperation and responsibility, as for the achievement of a specified goal” (American Heritage Dictionary, 2006). Partnerships are prominent in a variety of fields, particularly economics, sociology, and education. In economics, partnership is described as the fundamental belief or assumption of primarily cooperative behaviour (Boardman & Vining, 2012). In the social sector, partners share a common vision, present
opportunities to achieve multiple organizational benefits that include the development of a positive corporate culture and the opportunity to build reputational capital (McDonald, 2014). In the educational field, partnership is defined as comprehensive service activities that share various resources to achieve common goals (Cho & Kim, 2013).

**Definition of partnership in nursing**

In the nursing field, the concept of partnership has emerged since the World Health Organization (WHO) declared it as a key element of the goal to be achieved health for all individuals (World Health Organization, 1978). Traditionally, the relationship between healthcare professionals and patients was hierarchical. Because healthcare professionals have abundant knowledge about the patients’ diseases, it was common for healthcare professionals to determine overall treatment procedures, and patients would comply with these established treatment plans. However, due to the social change that regards the patient as a health service consumer, the patients are perceived as actively managing their own health (McQueen, 2000). Moreover, health-care professionals, including nurses, have been viewed as care partners who enhance residents’ ability to manage their own health, rather than health-care providers or decision makers (Gallant et al., 2002). Accordingly, this shift in perspective regarding these roles has increased awareness of the importance of cooperative relationships between patients and health-care professionals. Consequently, the concept of partnership has been emphasized in the nursing field because collaboration with patients is perceived to be an important factor in improving patients’ health conditions and health-care abilities (Choi & Bang, 2013). In the nursing field, partnership is defined as the improvement of a patient’s health-care ability through collaboration with the patient.

**Partnership-related concepts**

Concepts that are used interchangeably with partnership include alliance/therapeutic alliance; participation; empowerment; patient-, client-, or family-centred care; individualized care; patient involvement; physician–client relationship; interpersonal relationship; supportive relationship; and sharing. Of these, sharing, participation, and relationship considered as one of the attributes to explain the partnership (Bidmead & Cowley, 2005; Dupuis et al., 2016; Gallant et al., 2002; Hook, 2006). Addition, patient- and family-centred care emphasize family strengths and encourages family choice and control over decisions regarding services, while intervention effects based on family-centred care are assessed according to improvements in family members' sense of personal control and self-efficacy (McCormack, 2004). Consequently, these concepts focus more closely on family empowerment than the interaction between family members and professionals. On the other hand, because empowerment entails development of the ability to take care of oneself, it could be considered an outcome of partnership, rather than a similar concept (Bidmead & Cowley, 2005; Choi & Bang, 2013; Gallant et al., 2002; Hook, 2006), and can, therefore, be distinguished from the concept of partnership.
Table III. Category, Subcategory, and Codes Obtained Among Staff in the Fieldwork Phase.

| Category                                      | Subcategory                                      | Codes                                                   | A sample of participants’ statements                                                                                                                                                                                                 |
|-----------------------------------------------|--------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Relationship building through communication   | Open communication                              | Open mind, Communication, Relationship                   | “If we have listen to first, a cooperative relationship naturally will be maintained”                                                                                                                                                        |
|                                               | Building mutual understanding and trust          | Trust relationship, Mutual understanding, Cooperation   | “Cooperation is not achieved until trust is formed. I don’t believe each other here, and if I don’t understand, cooperation seems difficult. When trust builds, everything becomes easier from then on.”                                               |
| Provision of information about the status of  | Need to be aware of the older adult’s condition | Not knowing the condition of the older adults, Not knowing the condition change, Lack of understanding of status change | “The relationship is well formed and understanding is improved only when they are aware of their parents’ status.”                                                                                                                       |
| the resident                                   | Provide opportunities for questions about the   | Check your questions, Encourage to ask questions, Creating a comfortable atmosphere | “They asked a question that they were interested in, but when they understood it, their facial expression certainly changed, and from then on, little change has come.”                                          |
|                                               | older adult’s condition                          |                                                         |                                                                                                                                                                                                                                           |
| Cooperative interaction in problem solving    | Relationships seeking help from one another for | Support, Mutual help, Close cooperation                  | “As long as older adult is here, we will seek help from his/her caregiver, and we will also ask he/she to help us.”                                                                                                                        |
|                                               | the care of the older adults                     |                                                         |                                                                                                                                                                                                                                           |
|                                               | Find solutions together through decision         | Decision support, Finding a solution                     | “We are grateful to those caregivers who gather together to discuss, think together, and seek solutions together when residents have a problem.”                                                                                                           |
| Provision of high-quality care                | Show with care rather than words                 | Respect for demands, Individualized care                 | “Basically, we have to be good at caring. I think showing them as care rather than words is the way to build trust.”                                                                                                                    |
|                                               | Providing of safe care                           | Fall prevention, Fracture prevention, Injury prevention  | “Older adults have fallen accidents. There may be safety accidents. When safety accidents happen, most of the trust you have built up so far is broken.”                                                                                |
| Coordination of role and expectations at the  | Lack of awareness of the role of the facility    | Don’t know the role, The thinking that everything is possible here | “A nursing home is not a hospital. Even if we have a nurse, they need to go to the hospital for treatment if necessary, but the family should do to us at the nursing home. This is how it’s like this.”                     |
| facility                                       | Excessive expectations for caring for facilities | Wanted 1:1 care, Please take care of everything, Excessive demands | “They’re starting to demand a lot from our nursing homes for services for the older adult that they couldn’t actually do.”                                                                                                                   |
| Participation in emotional and physical care   | Participation in care to understand the staff’s | Meal help, walk, Difficulties in changing diapers       | “The last time family helped their mother with meals, they said that we had a lot of trouble. I think I can find out the difficulties and cooperate well.”                                                                               |
|                                               | difficulties                                     |                                                         |                                                                                                                                                                                                                                           |
|                                               | Participation in care makes older adult more     | Participation, stability, adaptation, positive,         | “Occasionally, they come to stabilize their parents, and see if there is anything uncomfortable, and then the older adult naturally stay in a nursing home in a more peaceful state, and in this case, they can cooperate, and it is good for us.” |
|                                               | stable                                          |                                                                |                                                                                                                                                                                                                                           |
| The role of family members present at the     | Indifference to care after admission to the     | Not coming, Even if the contact does not answer, Leave it alone | “Family comes often only for the first time, and if we contact an emergency, they won’t answer the phone. And sometimes they get rather angry. Why take us to the hospital …”                                                                                           |
| facility                                       | facility                                        |                                                         |                                                                                                                                                                                                                                           |
|                                               | Transfer responsibility for care to facilities   | Defer decision, Watcher role, Lack of interest, Non-cooperative on request | “I think that their role (family) has been transferred to a nursing home.”                                                                                                                                                                   |

Attributes of partnerships in LTC facilities

The attributes of partnership in LTC facilities were extracted seven elements from the literature review: relationship, information sharing, sharing of decision-making, professional competence, negotiation, involvement in care, and shared responsibility (Table III). As the first element, relationship is the most crucial and fundamental aspect of a partnership (Wiggins, 2008). Particularly, a trusted relationship not only allows family members to talk to nursing home staff about their concerns and fears of residents’ care but also facilitates the establishment of realistic care-related goals (Wiggins, 2008). As the second element, information sharing is based on the perceptions of both staff and family members as important resources in resident care. In other words, staff members possess professional nursing knowledge and clinical experience of elderly care, while family members provide unique information about their relative, such as habits, preferences, and care needs (Gallant et al., 2002; Robison et al., 2007). Therefore, information sharing through mutual interaction is a major attribute of partnership, and integrating nursing knowledge and individual patient information is required for effective and sensitive care (Holman & Lorig, 2000). Consequently, information sharing contributes to the
provision of individualized and optimal care services for residents. The third element, shared decision-making is a process in which staff and family members find solutions together, rather than alone when faced with problems or decisions regarding the resident. Additionally, the family member is recognized as a partner playing an active rather than passive role in healthcare (McQueen, 2000). The fourth element, professional competence refers to professional knowledge and skills that can be applied to clinical practice (Wiggins, 2008). This includes the ability to provide care that meets individuals’ specific needs, identification of patients’ conditions, provision of appropriate responses, and the ability to provide education for patients’ empowerment. As the fifth element, negotiation refers to choosing care for resident when care plans are established and discussing the family roles in resident care with staff members (Hook, 2006). This is a premise that it is possible to negotiate goals, plans and scopes in providing care to the residents (Bidmead & Cowley, 2005). This can be clarified the expectations and roles of each other and helping family members to actively participate in decision-making (Choi & Bang, 2013). As the sixth element, involvement in care refers to the process in which both family and staff members serve as joint care providers in emotionally supporting and helping older adults to adapt to facilities (Coyne & Cowley, 2007). Since equal authority is required for effective involvement, trust in the ability of the other caregiving partner and mutual respect are fundamental (Gallant et al., 2002). As the final element, shared responsibility refers to sharing common caregiving goals and a sincere interest in the resident’s condition by both parties. Considering common goals as important and commitment to the resident are fundamental for active responsibility sharing.

Antecedents, consequences, and working definition of partnerships in LTC facilities

The antecedents of partnership examined via the literature review in the theoretical phase included “trust in institutional care” and “willingness to be involved as active participants.” Consequences of partnership affected family, staff members, and the residents. In other words, effects on family members included increases in empowerment in care and satisfaction with the nursing home and reductions in conflicts with staff (Bidmead & Cowley, 2005; Gallant et al., 2002; Hook, 2006). The effects on staff members included increase in job satisfaction, reductions in conflict and stress, and improvement in care quality (Bidmead & Cowley, 2005). The effects on residents included maintenance of well-being and health and improvement in the quality of life (Dupuis et al., 2016).

The working definition of partnership in LTC is to focus on a cooperative relationship that is an ongoing dynamic process. It also involves sharing of professional nursing knowledge, skills, and information regarding the patient’s condition as well as shared decision-making through appropriate role negotiation, the involvement of both parties in caregiving, and shared responsibility.

Fieldwork phase

In the fieldwork phase, the dimensions and attributes of the partnership between staff members and residents’ family members in LTC facilities were identified via interviews. The staff members with seven attributes and family members with six attributes were identified. The attributes identified via interviews with staff members included relationship building through communication, provision of information about the status of the resident, cooperative interaction in problem-solving, provision of high-quality care, coordination of role expectations at the facility, participation in emotional and physical care, and the role of family members present at the facility (Table III). The attributes identified via interviews with family members included mutual respect and equal relationships, seeking information about care, decision-making support, provision of care with dignity and consistency, recognition of care limitations at the facility, and care cooperation at the facility (Table IV).

Final analytical phase

In the final analytical phase, the findings from the theoretical and fieldwork phases were analysed comprehensively to identify attributes and indicators of the partnership between staff members and residents’ family members in LTC facilities. The features of each of the seven attributes as identified in the literature review are presented in Table V.

Ultimately, two dimensions (interpersonal factor and environmental factor), seven attributes, and 30 indicators were identified (Table VI). Interpersonal factor referred to the personal aspects of staff and family members and was classified into four attributes (relationship, information sharing, shared decision-making, and professional competence) with 20 indicators. Environmental factor referred to environmental or systematic aspects and was classified into three attributes (negotiation, involvement in care, and shared responsibility) with 10 indicators.

Discussion

In this study, two dimensions (interpersonal and environment), seven attributes, and 30 indicators were identified for the partnership between staff members and residents’ family members in LTC facilities.
### Table IV. Category, Subcategory, and Codes Obtained Among Family Members in the Fieldwork Phase.

| Category                        | Subcategory                      | Codes                          | A sample of participants’ statements                                                                 |
|---------------------------------|----------------------------------|--------------------------------|------------------------------------------------------------------------------------------------------|
| Mutual respect and equal        | Equal relationship to each other  | Equality, relationship,       | “I think it’s important for each other to think equally. We rather noticed that the employees didn’t think so.” |
|       relationships              | A mutually respectful relationship| Horizontal relationship        |                                                                                                      |
| Seeking information about       | Timely information provided      | Tell me what I need, Notify   | “Mom is not eating these days or she is telling me to come.” Thank you for saying something like this.   |
|       Care                       |                                 | when problems occur           |                                                                                                      |
| Decision-making support         | Tell me about the situation      | Providing information on      | “In order for the family to make a decision, they have to tell the status exactly. If you tell us the basis of judgment based on experience, we can do better judgment and it helps.” |
|                                 |                                  | status, Provide the basis for  |                                                                                                      |
|                                 |                                  | judgement, Provide accurate   |                                                                                                      |
|                                 | Help with judgement              | Sharing experience, Give time,| Even if you know, it’s hard to make a decision. It would be much more helpful to tell us what to do and what others were like. |
| Provision of care with          | Consistent care                  | Care by the same staff at all | “I come here suddenly. They’re not surprised that I came suddenly, but they always do the same. The caregiver’s face is always bright …” |
|       dignity and consistency    |                                  | times, Care by familiar staff,|                                                                                                      |
|                                 |                                  | it is the same even if I visit  |                                                                                                      |
|                                 |                                  | unexpectedly                    |                                                                                                      |
|                                 | Care with dignity of the residents| Maintaining dignity, Privacy,| “My mom is a dementia patient. I am thankful to see that staffs are covering all the doors even when they dress my mom up. I didn’t do that at home ….” |
|                                 |                                  | Understand resident status     |                                                                                                      |
| Recognition of the limitations  | Personalized care is difficult   | Group life, Having a fixed    | “There’s a fixed time here. Since she has lived in a group, they have time to change diapers, so I’d like her to change it if it’s uncomfortable, but they can’t do it here. I understand. It’s a group life.” |
|       of care at the facility    | due to group life                | time, Need to respect          |                                                                                                      |
|                                 | Can’t be like caring at home     | individual demands            |                                                                                                      |
|                                 | Pretend not to know, Admit the   | Can’t be the same as my heart  | “If it’s the best, there are some things you don’t like, but you have to pretend you don’t know. Wouldn’t be exactly the same as at home.” |
|                                 | situation                        |                                |                                                                                                      |
| Care coordination at the        | Cooperate if requested.          | Do not decline on request,    | “if you ask for cooperation, we’ll do it quickly, and that’s the best thing.”                        |
|       facility                  |                                  | Respond quickly on request,    |                                                                                                      |
|                                 |                                  | Don’t miss a call from the     |                                                                                                      |
|                                 | It’s good for each other to do   | Passive participation, Respect  | “I think participating in the care first might make the caregiver uncomfortable. From their point of view, they have their own way.” |
|                                 | what you’re told to do without    | for the caregiving method, Do  |                                                                                                      |
|                                 | taking action                    | not take action                |                                                                                                      |
Table V. Dimensions and Attributes of Partnership in Literature Review and Field Study.

| Dimensions          | Attributes in literature review                  | Attributes in field study          | Staff                          | Family caregivers          |
|---------------------|-------------------------------------------------|-----------------------------------|-------------------------------|----------------------------|
| Interpersonal factor| Relationship building through communication      | Mutual respect and equal relationships |                              |                            |
|                     | Information sharing                              | Provision of information about the status of the resident | Seeking information about care |                            |
|                     | Shared decision-making                           | Cooperative interaction in problem solving | Decision-making support       |                            |
|                     | Professional competence                          | Provision of high-quality care      | Provision of care with dignity and consistency |                            |
| Environmental factor| Negotiation                                      | Coordination of role and expectations at the facility | Recognition of the limitations of care at the facility |                            |
|                     | Involvement in care                              | Participation in emotional and physical care | Care cooperation at the facility |                            |
|                     | Shared responsibility                            | The role of family members present at the facility | None                          |                            |

In 77% of previous studies, relationships have been identified as an attribute of partnerships (Hook, 2006). In this study, equal, mutual respectful and cooperative relationships were identified as major attributes of partnerships. Interpersonal relationship skills were identified as an antecedent (Wiggins, 2008). Communication, mutual understanding and empathy which were included as indicators in the present study were also chosen as attributes or subcategories in previous studies (Bidmead & Cowley, 2005; Choi & Bang, 2013; Dupuis et al., 2016). This is consistent with Choi and Bang (2013) posited that when partnership is perceived as an ongoing, dynamic process, its attributes and antecedents could be implied and duplicated. Additionally, encouraging family facility visits and creating a welcoming atmosphere during these visits have been found to positively affect the establishment of relationships with staff members and produce a feeling of trust regarding the safety and security of facility care. This is consistent with Bauer and Rhonda (2011) study indicating that a welcoming atmosphere for family visits played an important role in establishing constructive relationships, as it facilitated interaction between staff and family members.

Information sharing is an attribute based on the mutual perception that both staff and family members possess unique and valuable knowledge and experiences. Effective information sharing is an

Table VI. Dimensions, Attributes, and Indicators of Partnership in Final Analytical Phase.

| Dimension          | Attributes                                                                 | Indicators                                                                 |
|--------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Interpersonal factor| 1. Relationship                                                            | 1. Equal relationship                                                      |
|                    | 2. Mutually respectful relationship                                         | 8. Respect of other partner’s knowledge and care experience                |
|                    | 3. Cooperative relationship                                                 | 9. Provision of information regarding the older adults before entering facilities |
|                    | 4. Mutual understanding and empathy                                         | 10. Provision of information regarding the older adults after entering facilities |
|                    | 5. Open communication                                                      | 11. Sharing of coping strategies                                           |
|                    | 6. Encouraging family members to visit facilities                          |                                                                            |
|                    | 7. Welcoming environment for family members’ facility visits               |                                                                            |
| Environment factor  | 2. Information sharing                                                     | 12. Finding solutions together                                             |
|                    | 3. Shared decision-making                                                  | 13. Participation in the decision-making process                           |
|                    | 4. Professional competence                                                 | 14. Decision-making support                                                |
|                    | 5. Negotiation                                                             | 15. Confidence in the information provided for decision-making            |
|                    | 6. Involvement in care                                                     | 16. Provision of safe care                                                 |
|                    | 7. Shared responsibility                                                   | 17. Provision of care to maintain patients’ dignity                        |
|                    |                                                                           | 18. Provision of consistent care                                           |
|                    |                                                                           | 19. Fulfilment of individuals’ special needs                               |
|                    |                                                                           | 20. Education regarding care provision                                     |
|                    |                                                                           | 21. Recognition of basic care in facility                                 |
|                    |                                                                           | 22. Awareness of basic family roles                                       |
|                    |                                                                           | 23. Respect for family’s needs                                            |
|                    |                                                                           | 24. Discussion regarding role scope                                       |
|                    |                                                                           | 25. Provision of opportunities to involve family in care                   |
|                    |                                                                           | 26. Positive support for family members involved in care                  |
|                    |                                                                           | 27. Appreciation of the value of caring                                   |
|                    |                                                                           | 28. Sharing common care-related goals                                      |
|                    |                                                                           | 29. Common interest in the older adults’ condition                        |
|                    |                                                                           | 30. Active cooperation when requested                                      |
important resource in providing individualized care for older adults in LTC facilities and affects family members' participation in care (Specht et al., 2000). In other words, since mutual respect and acceptance of family members as important caregiving resources strongly affect partnership building, it is necessary to educate staff and family members to improve their awareness. Therefore, plans for effective information sharing should be considered.

Professional competence refers to the provision of safe, consistent care while maintaining patients' dignity, and previous studies have identified the concepts of professional knowledge and skills as attributes (Blue-Banning et al., 2004; Choi & Bang, 2013; Hook, 2006; Wiggins, 2008). Because the articles reviewed in the theoretical phase examined mainly acute hospital settings or children, knowledge and skills regarding diseases and treatment were emphasized; however, safety measures related to falls, a dignified end-of-life care, and the provision of consistent care were emphasized in the fieldwork phase. Specifically, the provision of consistent care referred to care services provided by a familiar person without frequent changes in caregivers. This is considered important in caring for older patients with dementia and could reflect the characteristics and culture of LTC facilities. Moreover, professional competence was included in the interpersonal domain in the present study; however, continuing education is required to enhance staff members' competence (McWilliam et al., 2009) and should be supported in LTC facilities. This demonstrates that the two dimensions identified in this study were organically connected and supports the finding that partnership is an ongoing, dynamic process.

Shared responsibility refers to sharing common goals concerning care and a sincere interest in the patient's status. In the fieldwork phase, "the role of family members exists at the facility" was identified as an attribute for staff members, but no attributes reflecting shared responsibility were observed for family members. Staff considered both staff and family members responsible for care, while family members considered only staff members to be responsible. This could explain family members' lack of attributes for shared responsibility.

Despite partnership being a practical concept, previous studies have reviewed its concept in the literature. However, this study used a hybrid model that involving theoretical and fieldwork analyses, providing a concept of partnership that accounted for cultural differences in clinical practice. Therefore, the results of the study enhanced the understanding of partnerships from a nursing perspective. Moreover, the attributes identified in the study could be used in the development of tools to evaluate the partnership between staff members and residents' family members in LTC facilities.

Conclusion
The partnership between staff members and resident's family members in LTC facilities is an ongoing, dynamic process involving the combination of interpersonal factor and environment factor. In other words, it could be defined as a cooperative relationship that involves sharing of professional nursing knowledge, skills, and information regarding the resident's condition as well as shared decision-making through appropriate role negotiation, the involvement of both parties in caregiving, and shared responsibility.

The attributes identified in this study could be used in the development of tools to evaluate the partnership between staff members and residents' family members in LTC facilities. In addition, the results could provide basic data for developing and assessing nursing interventions to enhance cooperative relationships.

Acknowledgments
The authors would like to thank all participants of this study.

Disclosure statement
No potential conflict of interest was reported by the author.

Funding
This work was supported by the National Research Foundation of Korea (NRF) grant funded by the Korea government (NRF-2015R1C1A2A01053766).

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Ethical approval
This study was approved by the institutional review board (HYI-16-036-2) at Hanyang University.

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