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Quality of care for residents who reside in the Aging in Place facilities in Hawaii: A family member perspective

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Abstract

Family members of residents living in long-term care facilities are important contributors to the evaluation of long-term care, leading to improved care. The aim of this study was to explore family perceptions of care and satisfaction from community-based long-term care settings in Hawaii that promoted resident-centred care through the promotion of ageing in place policies. This study builds upon a prior family satisfaction study conducted in Aoteoroa New Zealand. Eighty-two family member participants completed a 31-item Family Satisfaction Scale and answered one overall satisfaction question. The Spearman's correlation demonstrated a positive and significant correlation ($p < 0.001$) between each of the domains of family satisfaction and the overall satisfaction rating. Nursing care was most strongly correlated to overall satisfaction, followed by individual patient support, family involvement, activities, cleanliness, meals, resident safety, and finally medical attention. Overall, the family members were satisfied or very satisfied with the quality of care in the Aging in Place facilities which was comparable to the work undertaken in aged care facilities in Aotearoa New Zealand. Nursing care plays a critical role in family satisfaction. The components of nursing care and how this informs family satisfaction needs to be further explored.

Keywords / Ngā kupu matua:
aged residential care/kāinga noho manaaki kaumātua; family perspectives/ngā whakaaro o ngā whānau; long-term care/ngā manaakitanga wā-roa; older adult/ngā pakeke taikaumātua; patient-centered care/ngā manaakitanga hāngai ki te tūroro; quality of care/te kounga o te manaakitanga

Te Reo Māori translation

Te kounga o ngā manaakitanga hunga e kaumātua haere nei i ō rātou ake kāinga noho i Hawai'i: He tirohanga nā tētahi mema whānau

Ngā ariā matua

He mea taketake ngā mema whānau o te hunga noho i ngā kāinga manaaki wā roa, mō te aromātainga i aua manaakitanga wā roa, he mea hoki e piki ai te taurimatanga mō rātou. Ko te whāinga o tēnei rangahau he tūhura i ngā whakaaro o ngā whānau mō te taurima, me te hari o te tangata mō aua mahi, i tētahi kāinga taurima wā-roa i Hawai'i, e whakatairanga nei i te tiakitanga hāngai ki te hunga noho, mā te whakatairanga kaupapa here mō te kaumātua haere i tōu whare ake. Ka whai tēnei rangahau i tētahi rangahau mō te hari o te whānau i kawea i Aotearoa. Waru tekau mā rua ngā mema whānau i urupare mai, mā te whakakī i tētahi uiuinga 31 ōna tohu mō Te Inenga Hari ā-Whānau, me tā rātou whakautu i tētahi pātai kotahi mō te hari whānui tonu. Nā te ine pānga Spearman i tautohu tētahi ine pānga takatika, hira tonu ($p < 0.001$) i waenga i ia rohenga o te hari o te ngākau, me te hari o te whānau. Ko te take i kaha rawa te pā ki te hari nui tonu ko te taurimatanga tapuhi, whai i muri ko te tautoko ā-whānau i te tūroro takitahi, te whāinga wāhi o te whānau, ngā ngohe, te mā, ngā kai, te haumaru tangata, ā, ko te taurimatanga tākuta te whakamutunga. Mō te nuinga, i te hari, i te tino hari rānei ngā mema whānau mō te kounga o ngā manaakitanga i ngā kāinga e kaumātua haere nei te tangata i tōna whare ake, ā, ka taea

tēnei te whakarite ki ngā mahi i kawea i ngā whare manaaki kaumātua tūturu i Aotearoa. He mea taketake te taurimatanga tapuhi mō te hari o te whānau. Ko ngā kōwae o te taurimatanga tapuhi, he pēhea hoki e pā ai ki te hari ā-whānau, tētahi mea tika kia tūhuratia.

Introduction

The world's population is growing at a rapid rate. By 2050, the population is expected to reach 9.7 billion people (United Nations Department of Economic & Social Affairs, 2019), with more than two billion people aged 60 years or over (Lara et al., 2017); an estimated 22% of the world's population. Demographically, this is one of the most profound changes in human history (Kalfoss, 2017). As the number of older adults continues to grow, so does the need for long-term care. Notable changes have been seen in the long-term care industry over the last decade, particularly with rising residents' acuity and dependency (Silvestre et al., 2015). For this reason, the provision of good care has become even more important to protect the vulnerable cohort such as those living in long-term care.

Including the family members in care decisions of long-term care residents is part of the ideology of resident-centred care (Law et al., 2017; Li et al., 2016; Yeung & Rodgers, 2017). Obtaining the family member perspective on the quality of care has many positive benefits, including improving the care for one's own family member. For organisations, it can help with quality improvement measures (McVeigh et al., 2009; Yeung & Rodgers, 2017). It can also assist other families in making good decisions about placement (Shippee et al., 2017) and promote resident-centred care (Hamann, 2014), which is known to increase the quality of life for long-term care residents (Yeung & Rodgers, 2017). For this reason, it is important to include long-term care residents' family members in the evaluation of care.

While there is a strong indication to understand family involvement and their satisfaction with long-term care support, a search of the literature revealed few studies on this topic. Of the articles found, the majority were on family satisfaction with end-of-life care (Nadin et al., 2017; Ong et al., 2016; Zimmerman et al., 2015). There were also three studies conducted in the nursing home setting (Li et al., 2016; Shippee et al., 2017; Williams et al., 2016), and one study (Law et al., 2017) which was specific to dementia care. There was only one recent study found that was conducted in a long-term care home setting, in which the researchers evaluated family member satisfaction of care from a non-hospice standpoint (Yeung & Rodgers, 2017).

In the Yeung and Rodgers' study (2017), the quality of care was assessed in two care homes in Aotearoa New Zealand that emphasised resident-centred care. Aside from examining quality of care and overall satisfaction from the residents, their study also used a care satisfaction measure developed by the care homes to examine family satisfaction with the care provided by the facilities. While resident and family satisfaction has become a key attribute to measure the quality of care provided, this practice is still limited in Hawaii. Given the care measure for family satisfaction by Yeung and Rodgers covered many of the core elements concerning care home facilities (for example, Boldy et al., 2015; Kinley et al., 2018), this study has built upon their work to focus specifically on the long-term care residents' family members to show the importance of family satisfaction with care. By cross-referencing the results from Aotearoa New Zealand, it will inform how service delivery and provision of care in long-term care facilities in Hawaii can be enhanced.

Background

Resident-centred care is a topic of interest in the healthcare industry especially within the long-term care sector, and this type of care is the opposite of what has been traditionally seen in nursing homes (Castle & Ferguson, 2010). The concept of resident-centred care is a type of care in which a person's values and preferences of care-provision are at the forefront of the decision-making process (Desrosiers et al., 2014). There has been a tendency for healthcare organisations to be disease-centred or system-centred (Entwistle & Watt, 2013), and nursing homes have predominantly used a decision-making model that uses a top-down approach (Castle & Ferguson, 2010). Resident-centred care uses a bottom-up approach in which the residents' preferences are driving the care decisions. Research has indicated that resident-centred care is positively affiliated with a better quality of life (Grubman, 2015; Hermer et al., 2018; Palmer et al., 2018; Poey et al., 2017; Zimmerman et al., 2016).

An important contributing factor that promotes resident-centred care is the involvement of the residents' family members in the evaluation of care. While the most important stakeholder is undoubtedly the resident themselves, it is not always possible for a resident to evaluate their own quality of care. This is especially the case for those diagnosed with dementia or some type of cognitive impairment (Shippee et al., 2017). Long-term care residents' family members have been used primarily as proxies for cognitively impaired residents when evaluating care, however, family members' evaluations are beneficial and have merit on their own (Levin & Kane, 2006; Shippee et al., 2017).

While resident-centred care may be interpreted as resident-focused only (Kinley et al., 2018), relationships among the care staff, nurses, management, the residents, and their families are vital to provide a holistic care model (McCormack & McCance, 2017; Yeung & Rodgers, 2017). Having different stakeholder groups' perceptions of the quality of care can be beneficial to care-provider organisations (Yeung & Rodgers, 2017).

To cater to the needs of vulnerable residents, a high level of support delivered by a skilled and caring workforce is required to minimise any adverse effects on the health and wellbeing of residents due to the impact of institutionalisation. The dominant cultural narrative of care homes remains negative as older people have been reported to be fearful of losing their independence with no privacy and dignity (Bornstein & Laguirand, 2009; Prince & Butler, 2007). Hence, more emphasis has been placed to move away from a formal medical model of care to resident-centred care that recognises and supports older people's autonomy and self-determination in care home facilities (Yeung & Rodgers, 2017; Zimmerman et al., 2014).

Ageing in place is a term used to refer to older adults ageing in their own home. This philosophy has also impacted the long-term care industry. The World Health Organisation (2004), defined ageing in place is as:

> *Meeting the desire and ability of people, through the provision of appropriate services and assistance, to remain living relatively independently in the community in his or her current home or an appropriate level of housing. Aging in place is designed to prevent or delay more traumatic moves to a dependent facility, such as a nursing home (p. 9).*

In Hawaii, long-term care for older adults consists of both long-term care agencies and facilities. Most residential care occurs in the skilled or intermediate nursing facilities or adult residential care homes (Suzuki, 2015). Aging in Place facilities (AIPs) became a formal part of Hawaii's long-term care industry in 2018 through the development of a non-profit organisation that sets the standards of care for the AIP facilities (Aging in Place, 2018). The residents are renters in these facilities and as such they fall outside the Hawaii State Department of Health's system of annual inspection. To mitigate the lack of oversight, the Hawaii Platinum Group established the requirement that all AIP residents have registered nurse case managers employed by case management companies who are required to assess each resident monthly and provide 24/7 on-call services for the safety of the residents (Aging in Place, 2018). Given the AIPs do not come under government control, it remains a critical health policy issue on how quality care in these homes is assessed and monitored to ensure inclusive and dignified practice.

The current study sought to explore family perceptions of care and satisfaction from community-based long-term care settings in Hawaii that promoted resident-centred care through the promotion of aging in place policies.

Methods

Study design

The study used a quantitative, correlational design collecting data using the Family Satisfaction Scale (FSS) from family members of residents in Aging in Place facilities in Hawaii. The FSS was originally developed by an aged residential care operator as an auditing tool and consequently for a collaborative project with the operator in Aotearoa New Zealand to explore the use of a resident-directed approach in aged care facilities (Yeung & Rodgers, 2017). The FSS includes eight domains: 1) family involvement; 2) individual patient support; 3) nursing care; 4) medical attention; 5) activities; 6) cleanliness; 7) meals; and 8) resident safety; with a total of 31 items (Yeung & Rodgers, 2017). Additionally, each participant rated an overall satisfaction statement as follows: "In general, I am satisfied with the home" (Yeung & Rodgers, 2017). Each item and the overall satisfaction statement were rated on a six-point

Likert scale as follows: 1 = *very dissatisfied*, 2 = *dissatisfied*, 3 = *neutral*, 4 = *satisfied*, 5 = *very satisfied*, and 6 = *don't know* (Yeung & Rodgers, 2017). The family member participants filled out the 31-item scale and the overall satisfaction rating. To keep the survey short to increase participation (Shippee et al., 2018) no socio-demographic data was collected.

Participants

Each of the 35 AIP managers in Hawaii were emailed an invitation letter to hand out to the residents' designated family members or legal guardians. The designated family members were those who were most involved in the residents' care and medical decisions. The designated family members needed to be 18 years old or older, and the residents needed to reside in the AIP group homes during the period August 2018 to August 2019. Only one unique family member could participate per AIP resident. The letter directed the family members to contact the researchers. Initial phone contact from the researchers introduced the study to family members, the requirements to participate, and their rights to refuse participation or drop out of the study. The name of the AIP was not recorded, which allayed some participants' concern of potential retribution.

Participants had a choice to receive the surveys via mail or email. All participants who preferred to use email received their consent and survey forms through DocuSign which provided a secure method of sending documents electronically. All mailed surveys included a return self-addressed stamped envelope. Of 172 eligible participants, 85 agreed to participate and 82 returned the survey. Fifty-three surveys were returned through email and 29 surveys returned through regular mail.

While no demographic data was collected, the managers of the AIP facilities reported that their residents were predominantly Asian females over the age of 70 years old followed by Asian males over 70 years old. Caucasian females and Caucasian males, both over 70 years old, are the next racial groups serviced in the AIPs. These trends are in alignment with the United States Census Bureau's 2021 report, which states that Hawaii's largest racial group are Asians (37.6%) followed by Caucasians (25.5%) (United States Census Bureau, 2021).

Ethics approval through the Institutional Review Board (IRB) was received by Grand Canyon University in Phoenix, Arizona (IRB-2019-1284).

Analysis

Handling of missing data

Eighty surveys were fully completed. Just two surveys had missing data totalling four items out of a possible 2624 available items (82 participants x 32 items each). Because a missing data rate of 5% or less would have little effect on the data (Dong & Peng, 2013; Schafer, 1999), the researchers opted to remove the four items and proceed with the analysis.

Handling of 'don't know' responses

There were eight surveys that had "don't know" responses that were handled through a process called available item averaging. With available item averaging, the researchers created scale scores for each participant by averaging the items that were available and disregarded the don't know responses (Schafer & Graham, 2002; Young, 2012). According to Young (2012), this method reduces respondent scale average bias since one would expect scale items to be highly correlated anyway.

Analysis procedure

The ordinal data were approximated to continuous by assigning numerical values to all the scores collected from the participants. The numerical values assigned were as follows: 1 = *very dissatisfied*; 2 = *dissatisfied*, 3 = *neutral*, 4 = *satisfied*, and 5 = *very satisfied* (see above for *don't know* responses). The numerical values were entered into an IBM SPSS (version 25) Data Editor Spreadsheet. Scale scores (means) were then calculated for each of the eight domains from the FSS. The scale scores included one score for the entire group of participants per domain. The mean was also calculated for the entire group of participants for the overall satisfaction rating. A descriptive statistics analysis was conducted to include the mean and standard deviation for all items on the FSS. The alpha level was set to 0.05 and a Spearman's correlational analysis was performed for all items on the FSS. The Spearman's correlation was selected because the data were not normally distributed. This provided the researchers with 31 correlation coefficients; the 31 items on the FSS correlated with the overall satisfaction question. The Cronbach Alphas were also computed to compare with those of Yeung and Rodgers (2017) and to examine the reliability of the FSS.

Results

In Table 1, the Cronbach's alphas (α) are provided for both the Yeung and Rodgers (2017) study and the current study. The results demonstrate the internal reliability of the FSS instrument on two separate occasions.

In Table 2, the FSS domains and scale items are listed as well as the means and standard deviations for all items within the scale and for the overall satisfaction rating. The Spearman's rank correlation coefficients are also displayed. This information is presented for both the current study and the Yeung and Rodgers (2017) study. For the current study, eight scale scores (means) are also presented (one score for the entire group of participants per domain). The scale scores demonstrate strong internal consistency of the FSS and the homogeneity of the items within the scale.

Table 1: Cronbach Alphas (α) for Family Satisfaction Scale

Domain	Number of Items	α current study	α Yeung & Rodgers study*
Family Involvement	9	0.90	0.83
Individual patient support	4	0.80	0.93
Nursing Care	4	0.83	0.92
Medical attention	4	0.92	0.88
Activities	3	0.92	0.91
Cleanliness	3	0.92	0.84
Meals	2	0.93	0.84
Resident safety	2	0.92	0.96

Note. Reprinted from Yeung and Rodgers (2017, p. 33)

Table 2: Analysis of the family satisfaction scale showing the mean item score and correlation (Rho) to the overall satisfaction score. The results of the correlation for each item from Yeung and Rodgers (2017) are also shown (shaded).

Domain	Abbreviated Items	Mean (SD)	*rho*	Mean (SD)	*rho*
		Current study		Yeung & Rodgers (2017)	
Family Involvement	The way greeted when phoning the nursing home	4.65(0.53)	0.68***	4.46 (0.69)	0.40**
	The way treated when visiting the nursing home	4.74(0.47)	0.62***	4.42 (0.61)	0.59**
	How concerns of your family member are dealt with	4.55(0.59)	0.70***	4.02 (0.81)	0.57**
	How family member's financial matters are dealt with	4.35(0.69)	0.61***	4.28(0.78)	0.30**
	Assistance to deal with paperwork on family member's care	4.41(0.75)	0.52***	4.15(0.74)	0.28*
	Process available to make complaints	4.26(0.71)	0.44***	4.20(0.95)	0.52**
	How complaints are dealt with	4.00(0.80)	0.32**	4.14(1.17)	0.44**
	Knowing who to contact for support	4.65(0.55)	0.55***	4.19(0.70)	0.66**
	Organisation's understanding of the needs of older people	4.54(0.65)	0.82***	4.11(0.76)	0.69**
	Scale score for domain	4.46(0.48)	0.74***	---	0.54**
Individual patient support	Family member's likes and dislikes taken into account in care	4.54(0.59)	0.68***	4.10(0.80)	0.51**
	Freedom of movement family member has within the nursing home	4.55(0.59)	0.52***	4.28(0.65)	0.57**
	Staff support family member to get dressed and personal presentation	4.70(0.51)	0.57***	4.23(0.74)	0.49**
	Family member's rights are met and respected overall	4.66(0.53)	0.70***	4.25(0.71)	0.59**
	Scale score for domain	4.61(0.44)	0.76***	---	0.62**

Nursing care	Availability of the Registered Nurse if needed	4.18(0.81)	0.56***	4.32(0.66)	0.48**
	Politeness and courtesy of the care staff to residents	4.66(0.55)	0.73***	4.40(0.64)	0.57**
	Your involvement as family in nursing and care related decisions	4.55(0.57)	0.68***	4.18(0.67)	0.52**
	Overall impression of the nursing care your family member receives	4.62(0.56)	0.81***	4.27(0.66)	0.64**
	Scale score for domain	4.51(.52)	0.78***	---	0.62**
Medical attention	Medical attention your family member receives from doctor	4.35(0.85)	0.44***	4.22(0.68)	0.59**
	Your involvement as family in medical and health related decisions	4.52(0.59)	0.55***	4.17(0.73)	0.51**
	Explanations and information the doctor gives your about your family member	4.34(0.79)	0.46***	4.07(0.91)	0.33**
	Overall impression of the medical care your family member receives	4.44(0.65)	0.54***	4.18(0.61)	0.42**
	Scale score for domain	4.41(.65)	0.50***	---	0.50**
Activities	Range and variety of recreational activities provided by the nursing home	3.73(0.99)	0.64***	3.87(1.03)	0.54**
	Staff support to be involved in activities or therapies	4.01(0.95)	0.65***	3.98(1.04)	0.45**
	Access your family member has to grounds and facilities	4.17(0.84)	0.60***	4.37(0.88)	0.40**
	Scale score for domain	3.97(.86)	0.67***	---	0.54**
Cleanliness	Overall cleanliness of the nursing home	4.66(0.53)	0.53***	4.05(0.94)	0.65**
	Cleanliness of the linen in the nursing home	4.68(0.49)	0.59***	4.31(0.60)	0.63**
	Laundering and maintenance of your family member's clothing	4.61(0.56)	0.69***	4.10(0.80)	0.51**
	Scale score for domain	4.65(.49)	0.65***	---	0.66**
Meals	Impression of the general quality of meals provided	4.50(0.65)	0.69***	4.13(0.87)	0.51**
	Catering for medical/cultural dietary needs	4.44(0.72)	0.74***	4.22(0.95)	0.34**
	Scale score for domain	4.46(.67)	0.73***	---	0.52**
Resident safety	Security of your family member within the nursing home	4.69(0.46)	0.64***	4.33(0.57)	0.54**
	Safety of your family member within the nursing home	4.61(0.49)	0.61***	4.29(0.65)	0.64**
	Scale score for domain	4.65(.46)	0.65***	---	0.62**
Overall satisfaction	**Satisfied with the home in general**	**4.65(0.48)**	**---**	4.19(0.79)	---

*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$

Overall, the family members were satisfied with the care provided in the AIPs in Hawaii with all family members scoring the overall satisfaction as either 4 (*satisfied*) or 5 (*very satisfied*). The results showed that the eight domains, represented by the scale scores on the FSS, were positively and significantly correlated with the overall satisfaction variable. The domains nursing care (*rho* = .78, $p < .001$) and individual patient support (*rho* = .76, $p < .001$) received the highest scores. This was followed by family involvement (*rho* = .74, $p < .001$) and meals (*rho* = .73, $p < .001$). The lowest score was medical attention (*rho* = .50, $p < .001$), followed by cleanliness (*rho* = .65, $p < .001$), resident safety (*rho* = .65, $p < .001$), and activities (*rho* = .67, $p < .001$). The use of correlational analysis between the eight domains and overall satisfaction supports the predictive validity of the FSS, which is similar to the results from Yeung and Rodgers (2017). This shows that there were strong correlations between domains, with higher level of family satisfaction in each of the eight domains associated with higher level of overall satisfaction of the home in general.

Discussion

For this study, all eight domains on the FSS contributed to the family members' satisfaction with care in the AIPs. All of the domains were positively and significantly correlated with the family members' overall satisfaction. These results are in alignment with the literature on the topic of family satisfaction with long-term care (Shippee et al., 2017; Yeung & Rodgers, 2017). However, because of the limited number of studies conducted on this topic, this study adds valuable data to the literature.

The first domain on the FSS is *family involvement*. In order to promote family involvement in the long-term care setting, good staff-family relationships are important as well as good communication. Research has indicated that constructive relationships between the staff and the families promoted a better environment to provide care (Yeung & Rodgers, 2017). Involving the long-term care residents' family members in their loved ones' care, has been shown to increase the family members' satisfaction with care in the long-term care setting (Shippee et al., 2017; Yeung & Rodgers, 2017). Effective communication is an integral component of good staff-family relationships. In fact, good communication between staff and family members is central to the provision of quality of care, and it leads to improved family satisfaction and reduced complaints (Majerovitz et al., 2009).

The domain *individual patient support* pertained to the ability of the organisation to provide individualised and supportive care to its residents and whether the care was provided in a respectful and dignified manner. Being treated with dignity is one of the most important contributors to long-term care residents' quality of life (Yeung & Rodgers, 2017). The experience of being treated with dignity involves care that is compassionate and person-centred (Thompson et al., 2016). Dignity is also a top priority in nursing and in the care of the older people (Crisp et al., 2017; Yeung & Rodgers, 2017). Because time constraints, lack of resources, and task-oriented work culture have been shown to have a negative impact on providing dignity-conserving care (Thompson et al., 2016), it is possible that a smaller long-term care setting (such as the AIPs) would have the opposite effect. In a small group setting, there is a smaller staff-to-resident ratio. This might have influenced the family members' evaluations regarding the individual patient support domain.

The domain *nursing care* had the highest correlation with family satisfaction of care in the AIPs. Within the literature, a higher quality of care has been associated with higher family satisfaction (Shippee et al., 2017; Yeung & Rodgers, 2017). The findings from this study align with prior studies in that quality nursing care is instrumental for family members to be satisfied with the care. While nursing care received the highest rating for this study, the domain *medical attention* received the lowest. This might be related to several things. In a small group home setting, medical doctors do not routinely visit patients at the home. The residents are escorted to their doctors' appointments from family members and/or caregivers. For this reason, it is not surprising that medical attention was not as highly correlated to the overall satisfaction of the home as the other domains were.

The domain *activities* pertained to the range and variety of activities provided at the facility. Prior research has indicated the importance of activities for family member satisfaction (Yeung & Rodgers, 2017). Inactivity and social isolation can have detrimental effects on long-term care residents. Inactivity can lead to strength loss, depression, and sleep cycle disturbances (Lorenz et al., 2012), while those who participate in meaningful activities have greater psychological and physical well-being (Mansbach et al., 2017). Participation in activities can also enhance the long-term care residents' social connections with other residents as well as the staff members which can reduce the experiences of loneliness (Bogati & Pirret, 2021). For this reason, it is understandable why family members rated activities as being important to their overall satisfaction with the care provided in the AIPs.

The domains *cleanliness*, *meals*, and *resident safety* were also positively and significantly correlated with the family members' overall satisfaction. Cleanliness of the facility, as well as the linens and residents' clothing, are important for family members. Within the literature, the cleanliness of long-term care facilities contributed to the family members' satisfaction with the care (Shippee et al., 2017; Yeung & Rodgers, 2017). Family members also consider *meals* to be important in their overall satisfaction. Meals that are catered to the individuals' dietary needs enhance family satisfaction with care (Shippee et al., 2017; Yeung & Rodgers, 2017). Lastly, the domain *resident safety* pertained to the residents' safety and security at the facility. For this study,

resident safety was related to the family members' satisfaction with care in the AIPs. Literature supports the importance of resident safety for family members to be satisfied with the care (Shippee et al., 2017; Yeung & Rodgers, 2017).

Family involvement, individual patient support, nursing care, medical attention, activities, cleanliness, meals, and resident safety are all important contributors to family satisfaction with long-term care. While the literature demonstrates the importance of obtaining the family members' assessment of care, there is a paucity of research on the topic, especially in the community-based long-term care setting. This study has added to the literature on the topic of family satisfaction with long-term care. The measure of family satisfaction is part of a resident-centred approach, which has been shown to improve the residents' quality of life. It also assists organisations with quality improvement measures by offering other stakeholder perspectives regarding the care. In the long-term care setting, family satisfaction is complementary to, but different from, the residents' evaluations of their quality of life (Shippee et al., 2017). Family members have high expectations regarding the care provided which can provide protection for the long-term care residents.

This study has built upon the work by Yeung and Rodgers (2017), and the findings support their conclusions and provide additional evidence of the importance of soliciting the family members' evaluations of care in the long-term care setting. The FSS was selected for the study, because it included the domains of family satisfaction that have been shown to promote satisfaction among long-term care residents' family members. The survey instrument worked well and the researchers were able to gain 82 family members' evaluations of care in the AIPs in Hawaii. The survey instrument provided strong indicative results of the importance of the domains used to evaluate family members' perceptions of care in the AIPs in Hawaii.

Limitations of the study

The cross-sectional nature of the research study was a limitation of this study as the quality of care in the AIPs might have changed over time and the results might not have reflected those changes. The smaller sample size was also a limitation. The sample sought was 97 participants but only 82 family members participated; hence, we could only undertake criterion-related validity but not construct validity, which requires a larger sample size to perform confirmatory factor analysis. Additionally, many demographic factors, that could have informed the results of this study, were not accounted for. Lastly, while a quantitative design worked well for this study, future researchers should consider adding additional open questions at the end of the survey, regarding the domains assessed, which could contribute valuable qualitative data and provide a more in-depth assessment of the quality of care provided in the AIPs.

Implications and recommendations for practice, policy, and research

The future implications of this study are as follows: 1) the possibility that more healthcare organisations use family members in the evaluation of care; 2) that more studies are conducted using the family member perspective regarding the quality of care; and 3) that healthcare organisations design facilities that are more resident-centred. This might include smaller settings that allow ageing in place for its residents. It is recommended that future researchers conduct more studies on family satisfaction with long-term care to include all long-term care settings. While this recommendation includes all research methods and designs, a qualitative study is highly recommended. It is also recommended that a larger sample size be used as compared to this study (n = 82). Examining the effect that different demographic and relational factors have on family satisfaction with long-term care would be beneficial as well. For future researchers who use the FSS, it is recommended that missing or don't know responses greater than 5% should be described and discussed within the findings.

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