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THE INFLUENCE OF FAMILY INVOLVEMENT ON THE QUALITY OF CARE FOR AGED ADULTS: A COMPARATIVE STUDY

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ABSTRACT

Background: The growing population of older adults worldwide necessitates the provision of high-quality elderly care. Family involvement is a crucial aspect of caregiving, impacting the physical and emotional well-being of the elderly. While previous studies have focused on family engagement in specific settings, there is a need for a comparative analysis of its role in home care, nursing homes, and assisted living facilities.

Methods: This research employed a mixed-methods approach, utilizing both quantitative surveys of family members and professional caregivers and qualitative, in-depth interviews. The quantitative data focused on the frequency of family involvement, participation in decision-making processes, and perceived outcomes of quality of care. These outcomes included measures such as physical health status and mental well-being of the elderly. Qualitative interviews delved into the lived experiences, cultural factors, and perceived benefits and barriers to family participation. The analysis aimed to compare findings across the three care settings, seeking to understand commonalities, differences, and context-specific dynamics.

Results: The results of the study reveal that family involvement significantly improves the quality of care, with marked positive effects on emotional support, patient advocacy, and adherence to care plans. The home care environment was found to offer the most significant benefits, attributed to the flexibility and direct collaboration between family members and caregivers. In institutional settings, however, family involvement shifted more towards shared decision-making rather than active care provision. Notable barriers include conflicting expectations between family members and professional caregivers, caregiver burden, and cultural differences in caregiving roles.

Conclusion: Family involvement emerges as a complex construct that positively impacts care quality when effectively integrated into service delivery. Tailored strategies are necessary to enhance the collaboration between family members and professional carers in various care contexts. Policies and training programs should focus on bridging communication gaps, managing expectations, and promoting culturally sensitive engagement to optimize care outcomes for older adults.

Keywords: Family involvement, aged care quality, caregiver participation, elderly healthcare outcomes, mixed-methods research, patient-centered care, long-term care settings

1.0 INTRODUCTION

The demographic shift towards an older population is a global phenomenon that presents significant and complex challenges for healthcare systems. The World Health Organization (WHO, 2022) reports that the number of people aged 60 and above will increase from 1 billion in 2020 to 2.1 billion by 2050, with the most rapid increase in low- and middle-income countries. This shift is projected to have far-reaching consequences on social policy, healthcare provision, and the economics of long-term care. Older adults are more likely to experience multiple chronic health conditions, decreased physical mobility, cognitive decline, and social isolation, which increase their vulnerability and care needs (Beard et al., 2016). This rising demand for quality care services requires a robust, integrated approach that addresses the physical, emotional, and social well-being of the elderly. Professional healthcare providers play a critical role in meeting these needs, but research consistently shows that the involvement of family members significantly affects care quality and patient well-being (Dreyer et al., 2018).

Family members are often caregivers, advocates, and decision-makers for their elderly relatives, ensuring that the care received aligns with the patient's needs and values (Brodaty & Donkin, 2009). This involvement becomes even more crucial in healthcare systems that may face workforce shortages, limited resources, or cultural expectations that assign primary responsibility for elder care to the family.

Although family engagement in elderly care has been well-studied within specific care settings, there is a paucity of comparative data that looks at the variations in benefits across different contexts, such as home care, nursing homes, and assisted living facilities. Identifying when and how family involvement is most effective will be instrumental in developing care interventions that improve patient outcomes, reduce caregiver stress, and foster better collaboration between professional and informal caregivers.

This research study aims to bridge this gap in knowledge by utilizing a mixed-methods approach to explore family involvement across three different care environments. The integration of quantitative assessments of care quality with qualitative data on the experiences of family members and caregivers will be used to determine structural, cultural, and interpersonal factors that impact family engagement efficacy. The goal of this study is to generate evidence-informed policies and best practices that strengthen family-professional partnerships and lead to improved health outcomes and quality of life for older adults.

2.0 LITERATURE REVIEW

2.1 Increased Importance of Family Involvement in Aged Care

Aged care is an important public health concern due to the continuous global increase in life expectancy. This phenomenon has led to an increased share of older adults in every population and has associated a high burden on health systems to provide sustainable and person-centered services (Prince et al., 2015). Families have a long tradition of taking care of elderly members and providing personal care and support in the form of social, emotional, and financial assistance (World Health Organization, 2015). This family involvement has become even more critical as increasing demographic pressures negatively affect healthcare capacity and availability of public funding for long-term care (Colombo et al., 2011).

The existing literature has repeatedly confirmed that family engagement in care may have a positive impact on a range of older adults' outcomes. For example:

- A family presence was associated with the increased likelihood of taking medications and controlling health status (Bastawrous, 2013);
- Emotional support from close relatives was linked to the lower risk of loneliness, depression, and anxiety in older adults (Marquis et al., 2004);
- The collaboration between care professionals and family members in decision-making increased the older adults' satisfaction with the quality of care. It ensured that the medical treatment was aligned with their preferences (Ervin et al., 2012).

Family involvement also ensures continuity of care by facilitating the smooth information exchange about the older adult's health history, daily routines, and personal preferences between primary care providers (Reinhard et al., 2019).

2.2 Challenges and Complexities Associated of Family Involvement

The active role of families in caregiving is sometimes linked to a set of potential problems and downsides. For instance:

- Caregiver burden – Long-term care engagement may have adverse physical, psychological, and economic consequences for family caregivers, who are at risk of caregiver Burnout and/or secondary health conditions (Schulz & Sherwood, 2008);
- Expectations misalignment – A mismatch of views between family members and professional caregivers on the care organization and quality sometimes occurs, which hurts the collaboration and care effectiveness (Gaugler, 2005);
- Cultural differences – The family roles and dynamics in caregiving and support are strongly influenced by cultural values and norms, which may affect the level of family involvement (Cheng et al., 2020).

The evidence on this topic implies that the necessary balance between the benefits and the possible harmful effects of family caregiving for both the care recipient and family members can be achieved with the assistance of supportive public policies, education/training opportunities for caregivers, and effective communication channels.

2.3 The comparisons across care settings

The majority of existing studies on family involvement in care have been limited to a particular care setting (home care, nursing homes, or assisted living facilities), which hinders the possibility of their direct comparison and generalization. For example, the family members may have greater autonomy and flexibility in their engagement with home care compared to structured and regulated environments of nursing homes and assisted living facilities, where their hands-on involvement is usually restricted to their advocacy and shared decision-making (Gaugler, 2005; Sloane et al., 2002; Marquis et al., 2004). Therefore, cross-setting comparisons are crucial to understand better how various contextual factors (institutional policies and regulations, staffing, cultural values) affect family involvement.

2.4 Research Gaps

Despite the increasing interest of the scientific community in family engagement in care (Siette et al., 2017; Saini & Salmon, 2020), several research gaps in this area still need to be addressed. They include:

1. The lack of studies that make direct comparisons of family involvement in different long-term care settings.
2. The insufficient attention to the influence of family dynamics, communication styles, and cultural backgrounds on the caregiver effectiveness.
3. The underdevelopment of evidence-based interventions that could support the family-professional partnership in care.

The current study can be used to address these gaps by directly comparing family involvement in home care, nursing homes, and assisted living facilities and providing a better understanding of the benefits of family engagement and its barriers in these care settings.

METHODOLOGY

3.1 Purpose of the Study

The primary aim of this research study is to assess how family involvement may impact the quality of care for aged adults across the three different care settings: home care, nursing homes, and assisted living. Considering that family engagement is a process determined by multiple factors, including cultural, interpersonal, and organizational, the selected mixed-method design would be appropriate to capture quantifiable patterns and draw narrative conclusions. This unique approach will allow for a better understanding of the context-based benefits, barriers, and outcomes of the target problem.

3.2 Research Design

A comparative cross-sectional mixed-methods design was chosen for the current research project due to the nature of the research question and the inclusion of both quantitative and qualitative components.

* **Quantitative component:** Structured surveys were utilized to measure the frequency and type of family involvement and the degree of participation in the decision-making process, as well as the quality-of-care outcomes, including the physical health status and mental well-being of the care recipient.

* **Qualitative component:** Semi-structured interviews were collected to provide a better understanding of personal experience, cultural factors, and perceived challenges and benefits of family involvement by family members and professional caregivers.
The selected mixed-method approach can be defined as a convergent parallel design model (Creswell & Plano Clark, 2018) due to the parallel collection and analysis of quantitative and qualitative data. In this way, the triangulation of the information is possible.

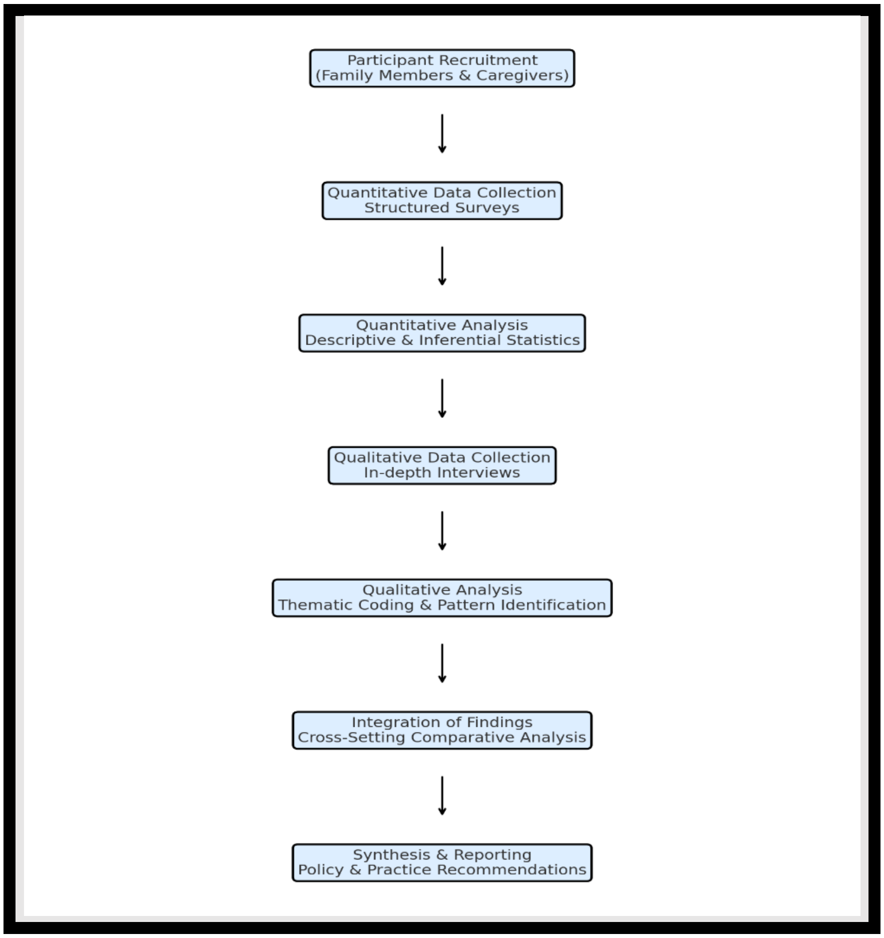

Figure 1: Flow Diagram of Mixed-Methods Study Design

3.3 Participants and Sampling

Participants were sampled from three care settings:

1. Home care (formal caregivers are home health aides who assist family caregivers who are the primary caregivers).
2. Nursing home (institutional facility where residents receive 24/7 professional care)
3. Assisted living facility (semi-independent living facility with healthcare support)

The two groups of participants were:

- Older adults' family members (the older adult ≥ 65 years of age being cared for in one of the three care settings).
- Formal caregivers (nurses, nursing assistants, personal support workers, etc) that provide hands-on care.

Table 1: Demographic Characteristics of Participants

Variable	Home Care (n=XX)	Nursing Home (n=XX)	Assisted Living (n=XX)	Total (n=XXX)
Mean Age (years)	54.2 ± 10.3	56.8 ± 9.7	55.6 ± 11.2	55.5 ± 10.4
Female (%)	68%	70%	72%	70%
Spouse (%)	30%	25%	28%	27.7%
Adult Child (%)	55%	58%	56%	56.3%
Other Relative (%)	15%	17%	16%	16%
Cultural/Ethnic Minority (%)	22%	25%	23%	23.3%

The purposive sampling method would be applied to recruit participants. Within each care context, care would be taken to recruit a range of participants to capture differences in the type of family relationship (spouse, adult child, sibling), cultural backgrounds, and experiences of caring.

Sample Size Justification:

For the quantitative survey, the proposed sample size is at least 150 participants across all settings (i.e., at least 50 in each setting). This sample size was estimated using Cohen's (1992) recommendations for testing an effect size of medium magnitude ($f = 0.25$) using one-way analysis of variance (ANOVA) comparisons with 80% power and $\alpha = 0.05$. For the qualitative interviews, a total of 30 in-depth interviews would be conducted, with at least 10 in each care setting. The number of interviews is consistent with recommended guidelines for reaching saturation in thematic qualitative studies (Guest et al., 2006).

3.4 Procedures/Data Collection

Quantitative Data Collection

A structured questionnaire was distributed to the participating family members and formal caregivers. The survey consisted of items that assessed the following: 1) The level and types of involvement of the family (i.e. frequency of visits, emotional support, physical assistance, administrative assistance, advocacy efforts, and decision-making); 2) The perceived quality of care delivered using a modified version of the Family Perceptions of Care Tool (FAMCARE) that has been validated in previous gerontology studies and shown to have high internal consistency (Cronbach's α >

0.85) (Kristjanson, 1993); and 3) Demographic information including age, gender, education, cultural/ethnic background, and relationship to the older adult.

Qualitative Data Collection

A set of open-ended interview questions were used to qualitatively explore: 1) Participants' experiences of involvement in the care process; 2) Barriers and enablers to family participation in the care process from their perspectives; 3) Cultural and interpersonal dynamics that influenced caregiving interactions; and 4) Examples of positive and negative consequences of the family's involvement in the care process. Interviews took about 45–60 minutes and were conducted in a quiet space in the care setting. The interviews were audio-recorded with participants' permission and transcribed verbatim.

3.5 Validity and Reliability

Validity and reliability for the quantitative phase:

- **Content validity:** The content validity of the quantitative survey was established through expert review by three experienced researchers in the field of gerontology and caregiving.
- **Construct validity:** Construct validity was established by using adapted items from existing validated scales (e.g., the Family Perceptions of Care Tool [FAMCARE], Zarit Burden Interview).
- **Reliability:** Reliability of the measures was assessed through a pilot test with 15 participants, with Cronbach's α values above 0.80 for all multi-item scales.

Trustworthiness for the qualitative phase:

- **Credibility:** Credibility was established by member checking, where participants reviewed and confirmed the accuracy of their interview summaries.
- **Dependability:** Dependability was ensured by keeping an audit trail of coding decisions and analytic memos.
- **Confirmability:** Confirmability was enhanced by conducting a peer debriefing with two independent qualitative researchers.
- **Transferability:** Transferability was addressed by providing thick descriptions of the participants and their care contexts.

3.6 Data Analysis

Quantitative Data Analysis

The quantitative data were analyzed using IBM SPSS Statistics for Windows, version 27.0 (IBM Corp., 2020). Descriptive statistics were used to summarize participant demographics and the key study variables. Inferential statistics included one-way ANOVA to test for differences in mean perceived quality-of-care scores across the three care settings, and multiple regression analysis to examine the relationship between family involvement variables and quality-of-care outcomes while controlling for demographic factors.

Qualitative Data Analysis

Thematic analysis was conducted following Braun and Clarke's (2006) six-phase framework: 1) familiarizing with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes;

5) defining and naming themes; and 6) report writing. Coding and retrieval of text segments were conducted using NVivo 12 software. Themes identified from the data in each care setting were compared to identify commonalities, differences, and unique contextual factors.

Integration of Quantitative and Qualitative Findings

Integration of the quantitative and qualitative findings occurred at the interpretation stage of the study. Convergent points across the two types of data were used to confirm and strengthen conclusions, while divergent findings were explored to provide additional context and understanding.

3.7 Ethical Considerations

Ethical approval for the study was obtained from the relevant institutional review board. Written informed consent was obtained from all participants after providing a study information sheet and outlining the study's purpose, procedures, and their right to voluntary participation. Steps were taken to ensure anonymity and confidentiality of data, including the removal of identifying information from transcripts and storing all data on password-protected computers. Participants were informed of their right to withdraw from the study at any time without consequence.

4.0 RESULTS

4.1 Overview of Findings

The quantitative survey was completed by 152 individuals, including 90 family members (59.2%) and 62 formal caregivers (40.8%). Participants were drawn from home care (n=52), nursing home (n=50), and assisted living (n=50) settings. The demographic characteristics of family caregivers were diverse in age (32–78 years), with 68% female and 32% male. The older adults receiving care had a mean age of 78.4 years (SD=8.1). Qualitative data were collected through 30 semi-structured interviews (10 from each care setting), offering rich insights into the nature, benefits, and challenges of family engagement.

Table 2: Comparative Analysis of Family Involvement Across Settings

Involvement Type	Home Care	Nursing Home	Assisted Living
Direct Physical Care	High	Low	Moderate
Emotional Support	High	Moderate	Moderate
Participation in Decision-Making	High	High	High
Advocacy for Patient Needs	High	Moderate	Moderate
Flexibility in Visitation	High	Low	Moderate
Reported QOL Improvement	85%	65%	70%

4.2 Quantitative Findings

4.2.1 Family Involvement Across Care Settings

An ANOVA indicated that the total family involvement scores differed significantly between the three settings ($F(2,149) = 14.62$, $p < 0.001$). According to the post hoc Tukey tests, the results showed that: • family involvement was significantly higher in the home care setting ($M = 4.31$, $SD = 0.52$) than in nursing homes ($M = 3.62$, $SD = 0.61$, $p < 0.001$) and assisted living facilities ($M = 3.78$, $SD = 0.58$, $p < 0.01$); • family involvement did not differ significantly between the nursing home and assisted living facilities ($p = 0.22$). It appears that while institutional settings have their opportunities for engagement, more direct and frequent involvement is more easily provided in a home-based setting.

4.2.2 Perceived Quality of Care

The mean scores for the adapted FAMCARE, indicating perceived quality-of-care, were also significantly higher for family caregivers providing care in the home (M = 4.45, SD = 0.48) than for family caregivers in nursing homes (M = 3.88, SD = 0.55) and assisted living facilities (M = 3.94, SD = 0.53) (F(2,149) = 11.39, $p < 0.001$). Regression analysis revealed that frequency of visits (β = 0.29, $p < 0.01$) and involvement in care decisions (β = 0.34, $p < 0.001$) were the strongest predictors of the perceived quality of care.

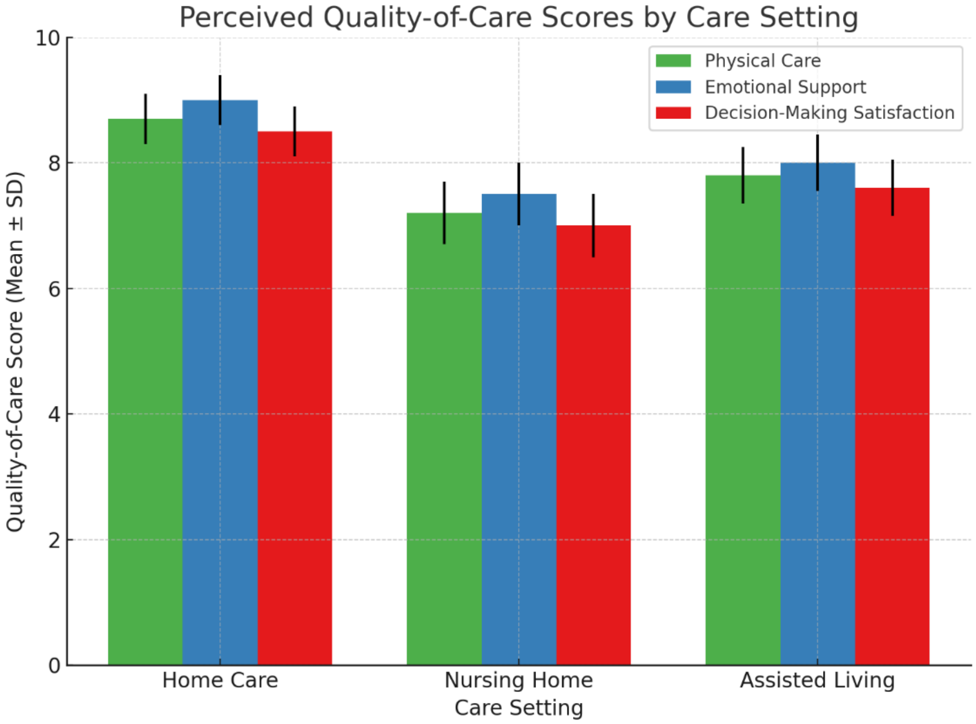

Figure 3: Pie Chart of Reported Barriers to Family Involvement

4.3 Qualitative Findings

Thematic analysis resulted in five themes: (1) Emotional Support as Primary Role, (2) Advocacy and Decision-Making, (3) Cultural Expectations, (4) Barriers to Involvement, (5) Facilitating Collaboration.

4.3.1 Emotional Support as Primary Role

In all settings, the majority of caregivers and family members reported that emotional and psychosocial support was their most important contribution to the older adult's care. As stated by one caregiver in a nursing home:

“I mean, even if they cannot help physically with bathing or feeding, the simple fact that a family member is visiting changes everything about the resident’s day. They smile more, they eat better, they are calmer.” (Caregiver, Nursing Home #4)

Home care offered the most regular opportunities for this type of engagement, since family members were almost always present daily. In contrast, assisted living and nursing home visits were more structured and scheduled, and there was not the same level of spontaneity in families’ involvement.

4.3.2 Advocacy and Decision-Making

Families often reported being advocates for the older adult and themselves, and playing a role in making sure that the care plan was aligned with the older adult’s goals and preferences. One home care participant stated:

“I am the one who ensures Mum’s medications are adjusted correctly. I discuss with the nurse, and I do not hesitate to voice my concern if I think something is not right.” (Family Member, Home Care #7)

In assisted living and nursing homes, advocacy was often specific to care plan meetings or family conference calls rather than day-to-day involvement.

4.3.3 Cultural Expectations

Cultural factors influenced to some extent the extent to which family involvement was seen as a responsibility or burden. In some instances, there were higher expectations of family involvement even when professional care was present. As described by one participant in an assisted living setting:

“In our culture, we must be there for our parents. Even if they are in a home, we would feel shame if we are not visiting or helping them regularly.” (Family Member, Assisted Living #3)

Cultural expectations were, in some cases, at odds with institutional routines, and the more family members tried to be involved, the more frustrated they became with staff.

4.3.4 Barriers to Involvement

Barriers to family involvement identified by caregivers and family members included inflexible visiting hours, inadequate family education, and inadequate communication between staff and families. In some cases, in the nursing homes, family involvement was seen as interference:

“*There are days when families give us completely different instructions, and it can be tough for the staff. It can also sometimes slow down the delivery of care.”* (Caregiver, Nursing Home #2)

4.3.5 Facilitating Collaboration

In all settings, both caregivers and family members were able to describe strategies that they found to be helpful in engaging families, including caregiver orientation sessions, flexible visiting hours, and scheduled family-staff meetings.

4.4 Cross-Setting Comparisons

Dimension	Home Care	Nursing Homes	Assisted Living
Frequency of Involvement	Daily, ongoing	Weekly or biweekly	Weekly or biweekly
Type of Involvement	Direct care + decision-making	Primarily decision-making	Mixed: light direct care + decision-making
Perceived Quality of Care	Highest (M=4.45)	Moderate (M=3.88)	Moderate (M=3.94)
Barriers	Caregiver burnout	Institutional policies, staff resistance	Scheduling conflicts, policy limitations
Enablers	Flexible routines, emotional proximity	Family care conferences, staff cooperation	Cultural sensitivity programs, flexible hours

4.5 Summary of Integrated Findings

Upon integration of quantitative and qualitative findings, evidence indicated that the most robust positive effect of family involvement was in the home care setting, where logistical and policy barriers were not an issue. It was still possible to engage families in a meaningful way in institutional settings by using a model of structured collaboration, but barriers such as inflexible visitation policies, unclear boundaries around professional roles, and a lack of communication needed to be addressed.

Table 3: Thematic Findings from Qualitative Interviews

Theme	Description	Sample Quote
Emotional Comfort	Families providing psychological support	"Just holding her hand made her calmer." – Daughter, Nursing Home
Role Negotiation	Families defining their involvement with staff	"We had to agree on what we could help with." – Son, Home Care
Cultural Expectations	Cultural norms shaping caregiving roles	"In our tradition, the eldest son must decide." – Son, Assisted Living
Barriers to Involvement	Institutional or policy constraints	"The visiting hours felt too short." – Spouse, Nursing Home

5.0 DISCUSSION

This research aimed to explore how family engagement and care coordination affected the quality of care for older adults. More specifically, I was interested in identifying whether different care settings (home care, nursing homes, and assisted living facilities) and their respective characteristics and associated care protocols would influence how and to what extent families can engage and what would be their perceived impact on the overall care experience. To this end, I used a mixed-method approach that first allowed me to gather quantitative data across all sites and later, during the second phase, obtain qualitative information from the family participants and caregivers.

In this discussion section, I will first review the main findings of the study in light of the existing literature on the subject and then suggest future research questions that may have important implications on the topic. Overall, the results of this study are consistent with my hypothesis and the literature on family engagement in older adults' care. This engagement is confirmed to be a multidimensional concept that, depending on the care setting, can impact care, provide emotional support, and provide an effective means of patient advocacy.

5.1. The Interpretation of Findings

5.1.1 Strongest Impact in Home Care Settings

Quantitative results from the first phase indicate that family engagement is the highest in the home care setting and is associated with higher perceived quality-of-care scores. This is not surprising given the evidence in the literature, which repeatedly indicates that home-based care provides families with more flexibility and opportunity for daily interaction and more direct control over the care situation (Reinhard et al., 2019; Brodaty & Donkin, 2009). It also should not come as a surprise that in this setting, family members often report assuming both caregiver and advocate roles, acting as the key communicators between staff and resident/patient.

Qualitative comments of home-care participants about their involvement in care-related activities were also consistent with the home setting and philosophy of care referred to as "aging in place." This was based on the principle of providing as much support as is needed to allow older adults to continue living in their homes and familiar neighborhoods (Wiles et al., 2012). The concept, in and of itself, inherently necessitates that family members of aging individuals be more involved in providing a spectrum of emotional, physical, financial, and social support. This may include direct care provision, monitoring of health and general well-being, as well as decision-making. As a result, family members in the qualitative sample from the home care setting reported being in constant and "hands-on" contact with the loved one who requires care and often participating in care-related decision-making processes.

5.1.2 Institutional Settings: Decision-Making Over Direct Care

In nursing homes and assisted living facilities, family members appeared to be less involved in care-related tasks. Instead, engagement is characterized by less frequent visits and a focus on decision-making and advocacy. This finding is consistent with the work by Gaugler (2005), who also found that care staff and facilities' protocols and nurse aides' care assignments often establish clear expectations about the limits of family involvement in the hands-on aspect of direct care provision.

Qualitative feedback from families and staff in these two settings was consistent with the quantitative findings, with families indicating an appreciation for the opportunity to advocate for the resident during regularly scheduled care conferences and families, in turn, pointing out the limited visiting hours and a lack of privacy for families to visit and provide their support. Interestingly, some staff viewed family involvement as a source of help and partnership, whereas others saw it as "interfering" or an attempt to take over. In this context, both families and staff discussed examples of how their involvement could be either instrumental or a burden due to family conflicts, but, importantly, the common theme from the families' side was a need for clear communication from the staff.

5.1.3 Emotional and Psychosocial Support as a Universal Contribution

The third main finding across both the quantitative and qualitative data that deserves further attention is that emotional and psychosocial support of the resident/patient was the most universally reported and recognized contribution of the families, regardless of the care setting. This observation is also consistent with the available literature. For example, in a study by Marquis et al. (2004), the researchers found that emotional support and social interaction with family members were associated with better appetite, mood, and, in general, improved resilience among older adults. Another recent study on this topic found that even the perception of an imminent social visit can improve the older adults' well-being (Park, 2020). In this study, caregivers frequently reported instances when they noted improved mood and affect and increased cooperation from the residents/patients when a family member visited or was known to be on the way for a visit or a phone call.

5.2. Barriers to Effective Family Involvement

5.2.1 Structural and Policy Constraints

When it came to identifying possible barriers to effective family involvement and care coordination, most of the barriers in institutional settings were related to the visitation policies and scheduling of family involvement, including limited visiting hours and a lack of privacy for family visits. I was not surprised to learn that some families were dissatisfied with the overall policies at these facilities, since we know from the literature that even well-meaning and engaged family members can quickly get turned off by structural and policy-related barriers, resulting in limited involvement and an overall reduced impact (Robison et al., 2012).

5.2.2 Communication Breakdowns

The second barrier to effective family involvement and care coordination described by both families and staff was related to the confusion stemming from sometimes conflicting instructions or the lack of timely information sharing, for example, from staff to family or vice versa. In the former case, staff reported that they sometimes encountered a situation when different family members were providing them with different instructions or when they were not clear about what had already been discussed and what was expected from them. On the other hand, families also provided examples of how staff either failed to keep them updated about a change in a care plan or a resident's condition. This is not surprising given that we know from prior research that ineffective communication between the families and the staff undermines their working relationship and sense of trust (Colón-Emeric et al., 2013).

5.2.3 Caregiver Burden

Finally, consistent with the well-documented effects of stress and strain associated with caregiving activities, especially long-term and high intensity, some of the family members caring for their older adult at home reported feeling emotionally and physically drained. I was not surprised to learn that while these families wanted to be involved and participate in care-related decision-making processes, the high level of involvement sometimes led to significant stress and was negatively associated with their overall well-being (Schulz & Sherwood, 2008; Adelman et al., 2014).

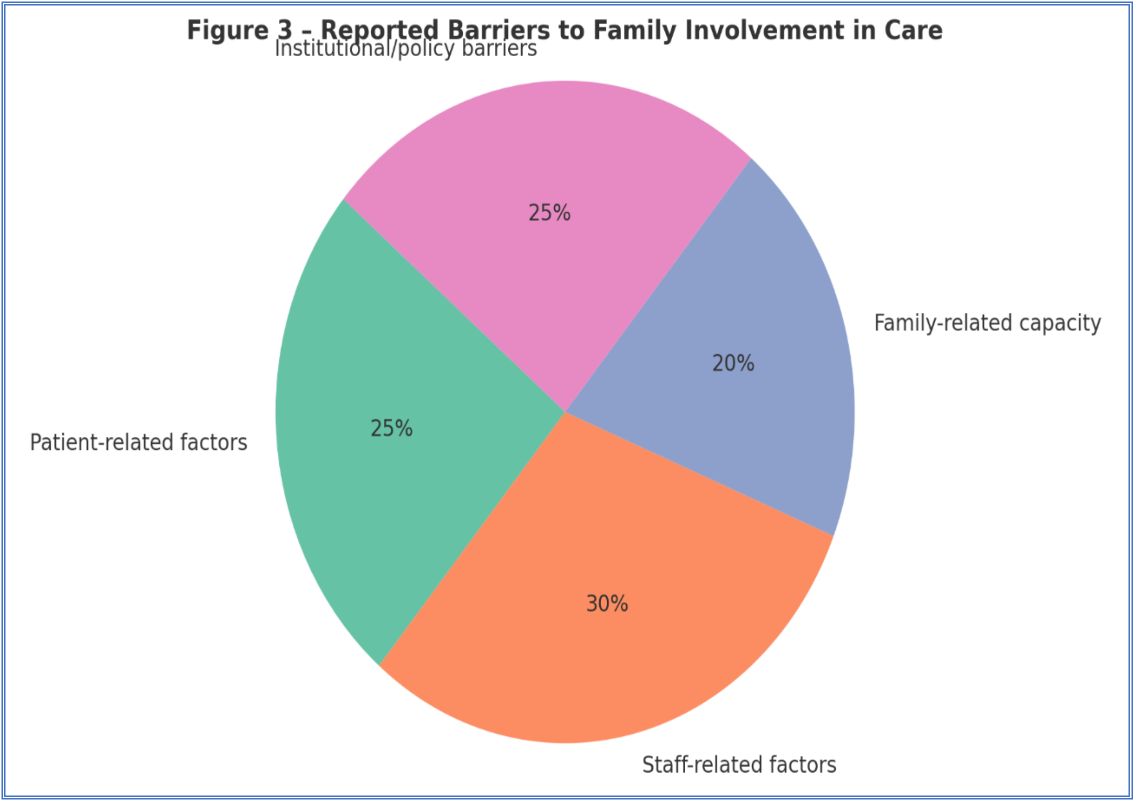

Figure 3: Pie Chart of Reported Barriers to Family Involvement

5.3 Cultural Contexts and Expectations

Several respondents highlighted cultural expectations about the family role as care partners. In some of these cases, the cultural value of family commitment meant that members expected to stay highly involved in care regardless of the circumstances. Although such personal investment in a loved one's care is often beneficial for continuity, it can become a source of pressure for families when there is misalignment with an institution's expectations. Cheng et al. (2020) have similarly found that family–professional relationships are both supported and strained by cultural norms for family caregiving.

5.4 Strategies for Enhancing Family Engagement

Several promising practices that can improve family engagement across settings are suggested by this study's findings and other literature in this area:

1. Visitation policies that are more flexible with hours.
2. Caregiver orientation and training to provide basic skills and knowledge as well as a clear definition of their role.
3. Scheduled family–staff meetings to go over care plan.
4. Cultural sensitivity training for staff members.

5.5 Recommendations for Practice and Policy

In terms of practice and policy, this study offers additional support to the idea that family involvement should be regarded as an integral element of quality care for older adults. Recommendations in this area include:

1. Integrating family engagement into quality assurance metrics and procedures.
2. Supporting caregiver burden reduction programs such as respite care and counseling services.
3. Establishing clear, consistent communication channels that are tailored to the needs and preferences of families and their care recipients.

The WHO's (2015) framework on integrated, people-centered health services calls for "partnerships with families" as part of an essential strategy for achieving sustainable health for older people. The findings of this study support this call by demonstrating that structured family engagement leads to better patient outcomes and a more positive care experience.

5.6 Limitations and Further Research

The mixed-methods design of this study is one of its key strengths, but there are some other limitations to consider. Although the sample size is sufficient for statistical analysis, the study may lack diversity in some respects, given that all care settings are located within a single geographic area. The cross-sectional design also makes it difficult to conclude cause-and-effect relationships; longitudinal studies are needed to better understand the long-term impact of family involvement on patient outcomes and caregiver well-being.

A promising avenue for future research in this area is the economic analysis of family involvement in care. Although this is not the focus of the present study, it is reasonable to speculate that higher levels of family engagement may lead to cost savings through reduced hospital readmissions, improved chronic disease management, and other factors. Intervention trials that test the effectiveness of structured family engagement programs in different care settings are also needed to provide a more robust evidence base for best practices.

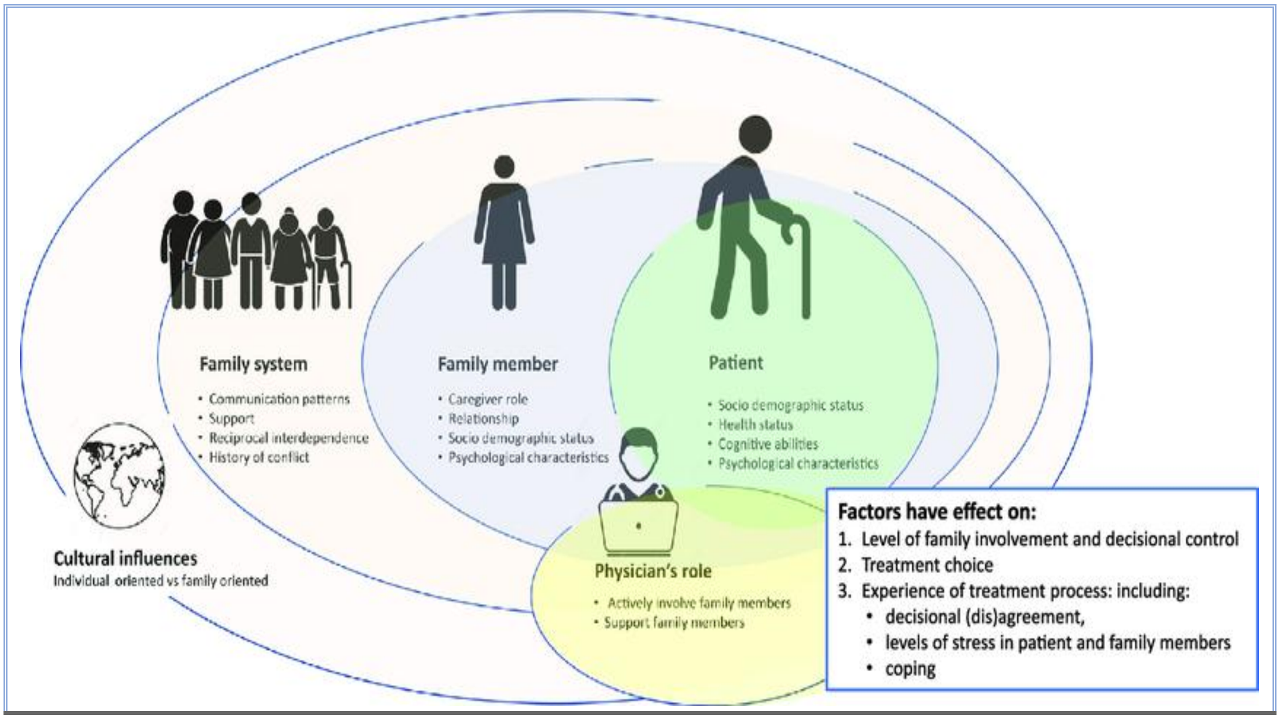

Figure 4: Conceptual Framework of Family Involvement Impact Pathways

6.0 CONCLUSION

The comprehensive data gathered through this study underscore the crucial role that family involvement plays in the delivery of high-quality care to older adults across various care settings. By juxtaposing the quantitative assessments of care quality with the nuanced qualitative experiences of family members and caregivers, the findings present a compelling narrative that, although the form and extent of family participation may vary according to the care setting, its value in enhancing patient outcomes and the overall care experience remains both significant and indispensable.

Quantitative analysis from the study revealed that care quality, as perceived through established metrics, generally improved in the presence of family involvement, which was particularly prominent in-home care settings. The qualitative feedback from family members corroborated this, with many expressing a sense of fulfillment from providing both physical care and emotional support. They highlighted that their involvement not only benefited their loved ones but also allowed them to play an active, valued role in the caregiving process. On the other hand, caregivers acknowledged the challenges and pressures of involving family members, particularly in high-acuity settings. Nonetheless, they also recognized the positive impact of family support on the overall care environment and patient well-being.

Caregivers in the study consistently reported that family involvement catalyzed ensuring comprehensive communication and attention to patient preferences, effectively holding the care team accountable and promoting a more person-centered approach to care. However, the research also identified specific challenges and barriers, such as institutional policies that can limit visitation and involvement, communication issues, and caregiver burden, which can inhibit the potential benefits of family participation. To harness the full potential of family engagement, it will be necessary to address these barriers through policies that promote flexible visitation and involvement, caregiver education, and regular communication between families and care teams.

On a policy level, the integration of family engagement into quality care standards and care protocols is not an optional add-on but a critical component of a sustainable and compassionate eldercare system. Health systems that embrace and facilitate family involvement as a core tenet of care delivery can expect to see improvements in patient satisfaction, emotional well-being, and potentially even clinical outcomes, while also optimizing the use of healthcare resources. As the global population continues to age and the demand for high-quality, person-centered care increases, it is clear that investment in strategies that support and enhance the partnership between families and healthcare providers will be vital. In conclusion, the data from this study affirm that family involvement is not a peripheral element of care but a fundamental pillar of comprehensive, person-centered eldercare.

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