Revised
2006
Supplement
Enclosed

July 2002

Nursing Best Practice Guideline
Shaping the future of Nursing

supporting and strengthening families through expected & unexpected life events

RNAO

Registered Nurses Association of Ontario

L'Association des infirmières et infirmiers autorisés de l'Ontario

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Greetings from Doris Grinspun
Executive Director
Registered Nurses Association of Ontario

It is with great excitement that the Registered Nurses Association of Ontario (RNAO) disseminates this nursing best practice guideline to you. Evidence-based practice supports the excellence in service that nurses are committed to deliver in our day-to-day practice.

We offer our endless thanks to the many institutions and individuals that are making RNAO's vision for Nursing Best Practice Guidelines (NBPGs) a reality. The Ontario Ministry of Health and Long-Term Care recognized RNAO's ability to lead this project and is providing multi-year funding. Tazim Virani --NBPG project director-- with her fearless determination and skills, is moving the project forward faster and stronger than ever imagined. The nursing community, with its commitment and passion for excellence in nursing care, is providing the knowledge and countless hours essential to the creation and evaluation of each guideline. Employers have responded enthusiastically to the request for proposals (RFP), and are opening their organizations to pilot test the NBPGs.

Now comes the true test in this phenomenal journey: will nurses utilize the guidelines in their day-to-day practice?

Successful uptake of these NBPGs requires a concerted effort of four groups: nurses themselves, other health-care colleagues, nurse educators in academic and practice settings, and employers. After lodging these guidelines into their minds and hearts, knowledgeable and skillful nurses and nursing students need healthy and supportive work environments to help bring these guidelines to life.

We ask that you share this NBPG, and others, with members of the interdisciplinary team. There is much to learn from one another. Together, we can ensure that Ontarians receive the best possible care every time they come in contact with us. Let's make them the real winners of this important effort!

RNAO will continue to work hard at developing and evaluating future guidelines. We wish you the best for a successful implementation!

Doris Grinspun, RN, MScN, PhD (candidate)

Executive Director
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How to Use this Document

This nursing best practice guideline is a comprehensive document providing resources necessary for the support of evidence-based nursing practice. The document needs to be reviewed and applied, based on the specific needs of the organization or practice setting, as well as the needs and wishes of the client. Guidelines should not be applied in a "cookbook" fashion but used as a tool to assist in decision making for individualized client care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care.

Nurses, other health care professionals and administrators who are leading and facilitating practice changes will find this document valuable for the development of policies, procedures, protocols, educational programs, assessment and documentation tools, etc. It is recommended that this nursing best practice guideline be used as a resource tool. Nurses providing direct client care will benefit from reviewing the recommendations, the evidence in support of the recommendations and the process that was used to develop the guidelines. However, it is highly recommended that practice settings adapt these guidelines in formats that would be user-friendly for daily use.

Organizations wishing to use the guideline may decide to do so in a number of ways:

- Assess current nursing and health care practices using the recommendations in the guideline.
- Identify recommendations that will address recognized needs or gaps in services.
- Systematically develop a plan to implement the recommendations using associated tools and resources.

Implementation resources will be made available through the RNAO website to assist individuals and organizations to implement best practice guidelines. RNAO is interested in hearing how you have implemented this guideline. Please contact us to share your story.

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Nursing Best Practice Guideline

Supporting and Strengthening Families Through Expected and Unexpected Life Events

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Acknowledgement

The Registered Nurses Association of Ontario wishes to acknowledge the following individuals and organizations for their contribution in reviewing this nursing best practice guideline, and providing valuable feedback:

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The nursing best practice guideline: **Supporting and Strengthening Families Through Expected and Unexpected Life Events** is available on the RNAO website at www.rnao.org

RNAO sincerely acknowledges the leadership and dedication of the researchers who have directed the evaluation phase of the Nursing Best Practice Guidelines Project. The Evaluation Team is comprised of:

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RNAO also wishes to acknowledge the following organizations in Barrie, Ontario for their role in pilot testing this guideline:

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summary of recommendations

The RNAO Consensus Panel (2000) for this nursing best practice guideline formulated a framework based on the best practice guideline process. The framework is called "Flower (Em)power" and is depicted in Figure 1 on the following page:

This framework depicts a comprehensive and perennial approach to best practices in this area. At the core of the flower is the ***nurse-family partnership***. Without a genuine partnership, the four petals of the flower are unable to blossom and are of limited value to the family through expected and unexpected life events. The four petals are:

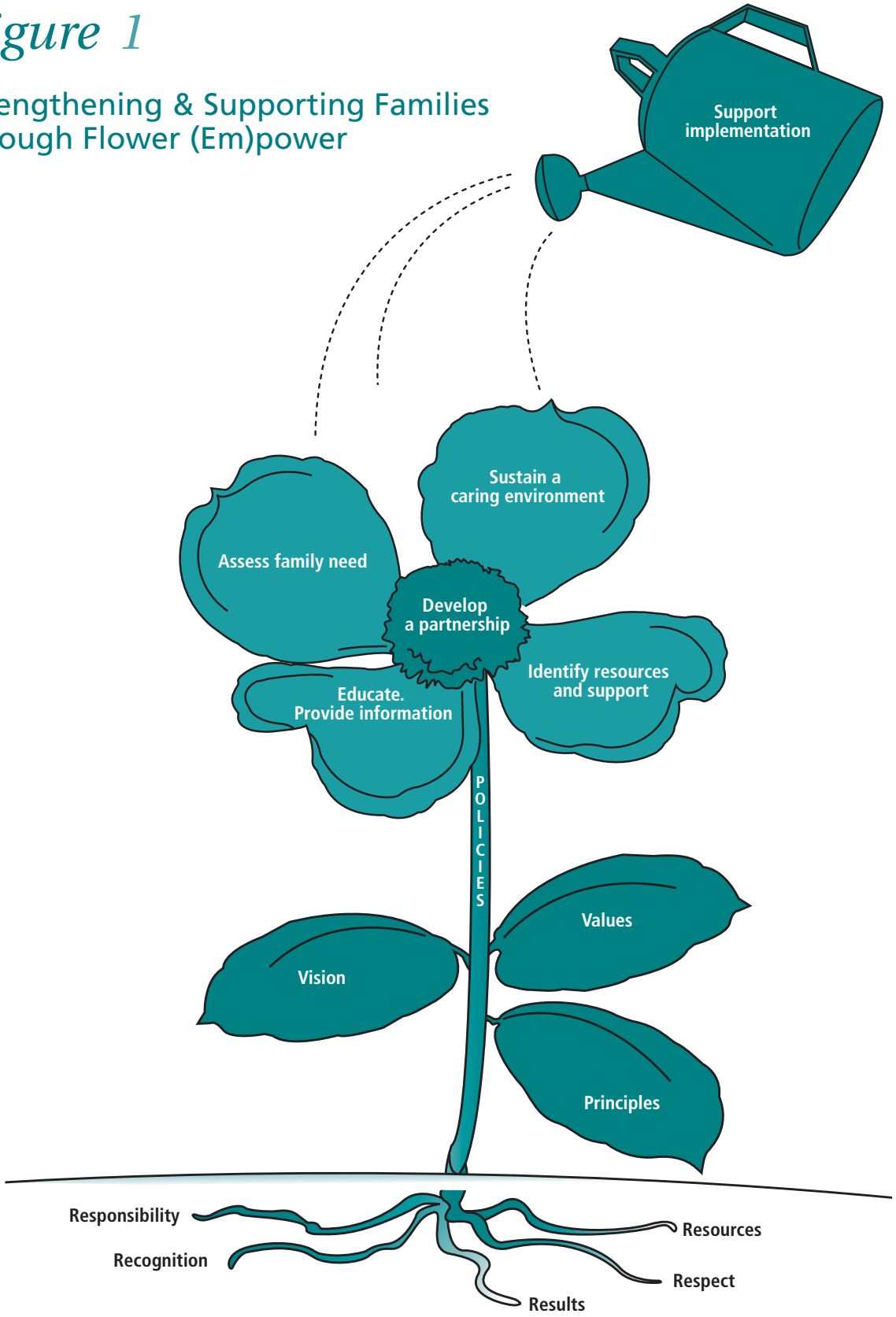
- Assess family need;
- Sustain a caring environment;
- Identify resources and support; and
- Educate and provide information.

Sustaining a caring environment represents different interrelated components of promoting family health. The stem of the flower symbolizes the ***advocacy activities and policy*** changes needed to ensure that the nursing activities that support and strengthen families can grow and flourish. The leaves of the flower - ***vision, values and principles*** - are the source of a burgeoning model of Supporting and Strengthening Families. The roots of the flower symbolize how this best practice model is grounded in the following five axioms: responsibility, resources, respect, results and recognition. The Supporting and Strengthening Families Flower flourishes under conditions where support is provided for implementation of best practices.

See Appendix D for a perforated pocket card containing the Strengthening and Supporting Families Flower (Em)power chart. The card displays the flower of empowerment on one side, and key questions that nurses can consider when implementing family-centred approach into their practice.

Figure 1

Strengthening & Supporting Families through Flower (Em)power



The following recommendations grow out of the "Flower (Em)power" framework (Figure I):

Recommendation 1

Develop a genuine partnership with families by:

- Recognizing the family's assessment of the situation as essential;
- Acknowledging and respecting the important role of family in health care situations;
- Determining the desired degree of family involvement; and
- Negotiating the roles of both nurse and family within the partnership.

Recommendation 2

Assess individuals in the context of the family (as they define it) to identify whether assistance is required by the nurse to strengthen and support the family. While a family assessment should include information in the following areas, it should be tailored to address the uniqueness of each family through examining:

- Family structure;
- Environmental data;
- Family strengths; and
- Family supports.

Recommendation 3

Identify resources and supports to assist families address the life event, whether this is expected or unexpected. Resources should be identified within the following three categories:

- Intrafamilial;
- Interfamilial; and
- Extrafamilial.

Recommendation 4

Educate and provide information to nurses, families, policy-makers and the public to assist families to manage expected or unexpected life events.

Recommendation 5

Sustain a caring workplace environment conducive to family-centred practice by:

- Ensuring that nursing staff are oriented to family-centred care, including family assessment;
- Ensuring that nurses have the awareness and ability to effectively access resources; and
- Providing ongoing opportunities for professional development for nursing staff, including knowledge and skills regarding family-centred care.

Recommendation 6

Support the implementation of family-centred practice in the workplace by:

- Ensuring appropriate staffing levels, assignments, and staffing categories;
- Implementing family-centred practices and policies;
- Creating and maintaining physical work environments that are conducive to promoting family involvement; and
- Developing employee assistance programs promoting family health.

Recommendation 7

Advocate for changes in public policy by:

- Lobbying for public discussion on family caregiving and the development of a public position on what level of caregiving is reasonable to expect from family caregivers, and at what point the public might expect the health care system to step in to provide care;
- Lobbying for public education about the value and legitimacy of the role of family caregivers;
- Lobbying for a full range of adequate and effective respite care programs which facilitate family caregiving;
- Lobbying for consistency in funding, availability, and delivery of respite care programs across Ontario;
- Lobbying for the funding of research projects that examine family as the recipients of care, caregiving and respite care, family as caregivers, and the application of lessons learned from this research into public policy and program development; and.
- Lobbying for mechanisms within organizations for families to dialogue with one another in an open forum.

Recommendation 8

Nursing best practice guidelines can be successfully implemented only if there are adequate planning, resources, organizational and administrative support, as well as the appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- An assessment of organizational readiness and barriers to education;
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process;
- Dedication of a qualified individual to provide the support needed for the education and implementation process;
- Ongoing opportunities for discussion and education to reinforce the importance of best practices; and

- Opportunities for reflection on personal and organizational experience in implementing guidelines.

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *"Toolkit: Implementation of Clinical Practice Guidelines"*, based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO nursing best practice guideline on *Supporting and Strengthening Families Through Expected and Unexpected Life Events.*

Responsibility for Guideline Development

The Registered Nurses Association of Ontario (RNAO), with funding from the Ontario Ministry of Health and Long-Term Care, has embarked on a multi-year project of nursing best practice guideline development, pilot implementation, evaluation, and dissemination. "Strengthening and Supporting Families through Expected and Unexpected Life Events" is one of seven (7) nursing best practice guidelines that were developed in the second cycle of the project. This guideline was developed by a panel of Registered Nurses and Registered Practical Nurses convened by the RNAO and conducting its work independent of any bias or influence from the Ministry of Health and Long-Term Care.

Purpose and Scope

Focusing on the family is an integral component of nursing practice. The guideline development panel acknowledges that most nurses already have relevant knowledge and skills to care for families. However, this guideline was developed to promote and facilitate continuing education, reflection and reaffirmation of the importance of caring for families. The intent of the guideline is to further build upon, improve and deepen nurses' knowledge and skills towards meeting the needs of families.

This best practice guideline is intended for nurses working in all health care sectors. The overall goal of the guideline is to assist nurses in promoting family health through interventions and supports provided during expected as well as unexpected life events. Expected life events may include birth, school, adolescence, aging, and death, while unexpected life events may include trauma/accidents, chronic illness, developmental delay and disability. The guideline also includes recommendations for connecting nurses with families, in order to be able to assist families during these events. Lastly, this guideline includes recommendations for nurses and other health care providers to advocate for changes in the health care system.

The nursing best practice guideline focuses its recommendations on:	
Practice Recommendations	directed at the nurse and nursing practice.
Education Recommendations	directed at the competencies required for practice.
Organization & Policy Recommendations	directed at the practice settings and the environment to facilitate nurses' practice.

This guideline contains recommendations for Registered Nurses (RNs) and Registered Practical Nurses (RPNs). It is acknowledged that effective patient/client care depends on a coordinated interdisciplinary approach incorporating ongoing communication between health professionals and patients/clients, ever mindful of the personal preferences and unique needs of each individual patient/client.

Guideline Development Process

A panel of nurses with expertise in caring for families from practice, research, policy and academic sectors was established by RNAO. The panel undertook the following steps in developing this nursing best practice guideline:

- Defined the scope of the guideline;
- Conducted an extensive literature search;
- Articulated values that are the underpinnings of working with families (this work was supported by the literature);
- Reviewed articles comprising of research, theoretical papers, and other discussion papers. Evidence to support the values was identified and specific actions pertaining to nursing was gathered; and
- Identified themes from the literature that led to the development of recommendations in three key areas.

An initial draft of the RNAO "Supporting and Strengthening Families Through Expected and Unexpected Life Events" nursing best practice guideline was reviewed by representative stakeholders and their feedback was incorporated. The stakeholders reviewing this guideline included clients, their families, staff nurses, various formal groups and organizations, and are acknowledged at the front of this document. This guideline was further refined after an eight-month pilot implementation phase in selected practice settings in Ontario. Practice settings for RNAO nursing best practice guidelines are identified through a "request for proposal" process. The guideline was further refined taking into consideration the pilot site feedback and evaluation results.

Definition of Terms

Acute Care Setting: An institution providing services to clients with acute needs (physical and psychological). Rehabilitation and palliative care can be a part of the acute care setting.

Clinical Practice Guidelines or Best Practice Guidelines: "Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical (practice) circumstances" (Field & Lohr, 1990, p. 8). Clinical Practice Guidelines or Best Practice Guidelines are developed using the best available research findings and where research gaps are present, consensus processes.

Community Setting: The care setting is in a community-based building (gathering place) or in the client's home. Services are provided by either Community Health Nurses (Public Health) or Home Health Nurses. Examples of community settings are a hospice, public health unit, school, church, or temple.

Consensus: A process for making policy decisions, not a scientific method for creating new knowledge. At its best, consensus development merely makes the best use of available information, be that scientific data or the collective wisdom of the participants (Black et al., 1999).

Education Recommendations: Statements of educational requirements and educational approaches/strategies for the introduction, implementation and sustainability of the best practice guideline.

Evidence: "An observation or fact or organized body of information offered to support or justify inferences or beliefs in the demonstration of some proposition or matter at issue" (Madjar & Walton, 2001, p.28).

Expected Life Events: Life events that are likely to happen. These can include, but are not limited to parenthood, retirement, birth, and death.

Extrafamilial Resources: Those resources that exist or occur outside the family, such as government or community.

Family: Being unique and whomever the person defines as being family. Family members can include, but are not limited to parents, children, siblings, neighbours, and significant people in the community.

Formal Groups or Organizations: Support and resources provided by a professional organization (Skemp Kelley, Pringle Specht & Maas, 2000). Formal groups or organizations can include nurses, home support workers, long-term care facilities, respite or support groups.

Informal Support: Support and resources provided by persons associated with the person receiving care. Persons providing informal support can include, but are not limited to family, friends, members of a church or synagogue, neighbours.

Interdisciplinary Care: A process where health care professionals representing expertise from various health care disciplines participate in supporting clients and their families in the care process.

Interfamilial Resources: Those resources that exist or occur among or involving several families.

Intrafamilial Resources: Those resources that exist or occur within the family.

Long-term Care Facility: Residential setting for the provision of long-term care services including medical, nursing, rehabilitative, attendant, activity and social support services along with nutrition and shelter (Health Services Restructuring Commission, 1997).

Meta-analysis: Use of statistical methods to summarize the results of independent studies, can provide more precise estimates of the effects of health care than those derived from the individual studies included in a review (Clarke & Oxman, 1999).

Organization & Policy Recommendations: Statements of conditions required for a practice setting, that enable the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader government or societal level.

Practice Recommendations: Statements of best practice directed at the practice of health care professionals that are ideally evidence-based.

Respite: Planned, temporary relief for the primary caregiver through the provision of substitute care (Gottlieb & Johnson, 2000).

Stakeholder: An individual, group, or organization with a vested interest in the decisions and actions of organizations who may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem. Stakeholders can be of various types, and can be divided into opponents, supporters, and neutrals (Ontario Public Health Association, 1996).

Systematic Review: Application of a rigourous scientific approach to the preparation of a review article (National Health and Medical Research Centre, 1998). Systematic reviews establish where the effects of health care are consistent and research results can be applied across populations, settings, and differences in treatment (e.g. dose); and where effects may vary significantly. The use of explicit, systematic methods in reviews limits bias (systematic errors) and reduces chance effects, thus providing more reliable results upon which to draw conclusions and make decisions (Clarke & Oxman, 1999).

Unexpected Life Events: Life events that are not expected to happen. These can include, but are not limited to chronic illness, hospitalization, physical and/or mental trauma, move to a long-term care facility.

Background Context

The family plays an integral role in promoting and maintaining health of family members, as well as providing physical and emotional support. This nursing best practice guideline was developed to increase nurses' awareness to the role and needs of the family and to facilitate the development of partnerships with the family and health care team.

Since the early days of the nursing profession, nurses have consistently identified the importance of family in relation to health (Thalman Boyd, 1996). Focusing on the family is an integral component of nursing practice, as health and illness behaviours are learned within the context of the family. Families are affected when one or more members experience related health issues. The family is a significant factor in the health and well-being of individuals, and promotion, maintenance and restoration of families are important to society's survival (Harmon Hanson & Thalman Boyd, 1996).

The concept of family is value-laden, and has varied over time in response to changes in predominant ideologies, values and social trends (Fast & Keating, 2000; Wass, 2000). Family definitions tend to be described according to structural criteria (what they look like) or functional criteria (what they do) (Fast & Keating, 2000). An example of a structural definition is:

> A now-married couple (with or without never-married sons and/or daughters of either or both spouses), a couple living common-law (with or without never-married sons and/or daughters of either or both partners), or a lone parent of any marital status, with at least one never-married son or daughter in the same dwelling (Statistics Canada, 1994).

A functional definition of the family by the Vanier Institute of the Family is as follows:

> Family is defined as any combination of two or more persons who are bound together over time by ties of mutual consent, birth, and/or adoption/placement and who together, assume responsibilities for variable combinations (for such things as) physical maintenance and care of group members (Vanier Institute of the Family, 1994).

Over the past three decades there have been significant changes in the family environment, such as smaller families, increased diversity and more complex family relationships (Fast & Keating, 2000). Individuals construct their own definition of family regardless of how a

researcher or policy-maker defines it (Fast & Keating, 2000). Therefore, for the purpose of this guideline, the family is defined as:

Being unique and whomever the individual identifies as being family.

Families have strengths and require support as they undergo expected and unexpected life events. Throughout the life cycle, expected changes are experienced by all families (Rankin, 1989). Developmental changes in a family such as transition to parenthood, being middle-aged parents, retirement and death, come in stages during which a period of disequilibrium occurs and adjustments are made (Kelly Martell, 1996). An important nursing role is to assist families and their individual members move toward completion of individual and family developmental tasks throughout the lifespan (Friedman, 1992; Miller, Hornbrook, Archbold & Stewart, 1996).

When unexpected life events occur and a family member is at home or hospitalized with health care needs, the family experiences numerous complex demands (McDonald, Stetz & Compton, 1996). Recent trends within the health care system have resulted in an increased need for awareness of the significance of the family when providing caregiving. Restructuring of health care systems and the resulting budget cuts to health care organizations have resulted in the expectation for families to assist in caregiving when a family member is hospitalized (Marshall, 1994). The increasing proportion of older people with disabilities and chronic illness, and technological advancements that enable medical treatments to be performed at home that were once only done in the hospital, have also dramatically changed the nature of home care (Ward-Griffin & McKeever, 2000). These trends have resulted in an increased reliance on family and friends to meet the needs of the frail, ill or disabled (Fast & Keating, 2000).

Women form the majority of home care personnel, such as visiting nurses, therapists and personal support workers (Martin Matthews, 1992). Females also provide the majority of the caregiving of older family members (Aronson, 1991; Canadian Study of Health and Aging, 1994) with wives and daughters predominating. This persistent differential representation of women providing both paid and unpaid care in the home means that shifts in the delivery of health care from institution to the household tend to affect women to a greater degree than men (Gregor, 1999; McKeever, 1994).

Interpretation of Evidence:

Evidence-based practice has been defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of patients" (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996, p.71). In order to ensure that current best evidence is used in the development of clinical guidelines, the methods of identification and interpretation of relevant evidence need to be critically appraised (Cluzeau, Littlejohns, Grimshaw, Feder & Moran, 1999). Generally, "the gold standard" is given to evidence derived from the randomized controlled trial (RCT), either in isolation or preferably in a systematic review or meta-analysis (Sweeney, 1998). In considering evidence, however, Berg (1997) cautions nurses to not deny the less quantifiable aspects of nursing work.

In developing this guideline, the development panel drew their evidence from a variety of sources (as discussed in the Background Context). The evidence was based on not only RCTs, but also on a number of qualitative sources, including studies that provided in-depth descriptions of family and nurse perceptions of their interactions with one another, and information about the relevance and helpfulness of nursing interventions involving families in care. Expert consensus was also utilized in this guideline when no other more scientifically formalized knowledge was available. In this way, patterns of knowing, including empirics, ethics, personal knowing and aesthetics, were captured (Carper, 1978).

Vision, Values and Principles

The development panel was guided by the "5 R's" to promote health in expected and unexpected life events:

Respect:	A high regard for the uniqueness of families.
Recognition:	The continuous acknowledgement of the value of the role of families and of nurses.
Resources:	Awareness of the need to gain access to sources of support to relieve difficulty and/or recover strengths.
Responsibility:	The accountability on the part of families and nurses.
Results:	The need to monitor outcomes and evaluate nursing practices.

The panel then developed the following vision for supporting and strengthening families, believing that *"in a perfect world"*:

- Families would be supported across the care continuum in a caring, consistent, timely and effective manner.
- Families' needs and strengths would be recognized and the need for supports would be anticipated.
- Families would have access to timely and comprehensive information.
- Families would be able to choose from a full range of respite care and support services which would be delivered consistently across Ontario in a flexible, culturally-sensitive, and affordable manner.
- Families would be comprehensively supported by nurses and other care providers because resources would be available to allow this to take place.
- Families would say their needs were met and they were supported and strengthened through the care experience.

And lastly, the panel developed the following ***Values & Principles*** for supporting and strengthening families:

- We believe that it is important for nurses to recognize their own assumptions and values about families and cultural beliefs, and adjust their care accordingly.
- We believe that families and family relationships are unique and diverse, and that they may change over time.
- We believe families should be given sufficient information to make informed decisions.
- We believe that families have expert knowledge and skills that help them determine their own needs and respond to expected and unexpected life events.
- We believe that partnerships with families are built upon mutual trust, honesty, and collaboration. We suggest, however, that families should participate in care only to the extent that they want to or as much as they are able.
- We believe that the use of partnerships as a primary means of supporting and strengthening families increases the likelihood that nurses will follow a family-centred approach to care.
- We believe families should be supported in their choices.
- We understand that family members and the client may have different and conflicting needs.
- We believe that nurses should support family situations in accordance with the College of Nurses of Ontario's Ethical Framework for Registered Nurses and Registered Practical Nurses (College of Nurses of Ontario, 1999).

Practice Recommendations

A. The Nurse-Family Partnership

Building a nurse-family partnership is central to strengthening and supporting families (Skemp Kelley et al., 2000; Ward-Griffin & McKeever, 2000). This partnership begins to develop immediately on contact with the family, and evolves as the nurse-family relationship and the persons within the relationship change over time (Friedemann, Montgomery, Maiberger & Smith, 1997; Hoskins Noll et al., 1996; Magliano et al.,1998a; Magliano et al., 1998b; Ward-Griffin & McKeever, 2000; Ward-Griffin, 2001).

To develop genuine partnerships there must be respect, trust, positive and open communication, listening, and mutual informing between the nurse and the family (Friedemann et al., 1997; Magliano et al., 1998a; McDonald et al.,1996). A partnership implies that both the nurse and the family contribute to the care of the client (Ward-Griffin & McKeever, 2000; Ward-Griffin, 2001). As stated by a family member, "I now expect the professionals who support my family to come to the table as equals; equally valued… and equally responsible" (Fisher, 1995, p.4).

Recommendation 1

Develop a genuine partnership with families by:

- Recognizing the family's assessment of the situation as essential;
- Acknowledging and respecting the important role of family in health care situations;
- Determining the desired degree of family involvement; and
- Negotiating the roles of both nurse and family within the partnership.

Discussion of Evidence

Although the literature strongly supports the importance of recognizing the experiential, specific knowledge of the family, and their desire to act as full partners in the care of their family member, little attention has been given to the relationships between formal (professional) and informal (family) caregivers. As a result, families and nurses need to discuss their mutual concerns about the adequacy of resources to provide care (Ward-Griffin & McKeever, 2000; Ward-Griffin, 2001). Friedman (1992) and Hertzberg & Ekman (1996) agree that when families pass on their responsibilities for the physical care of a family member to others, this does not necessarily relieve their sense of burden, and one way of reducing this discomfort is to involve the family more in the care of a loved one.

Friedman (1992) and McDonald et al. (1996) confirm that families are a resource as well as a recipient of nursing service, as they bring knowledge, skills and experience to the relationship. Nurses should encourage families to share their experience (McCubbin & McCubbin, 1993). It is essential to incorporate cultural beliefs and concerns shared by family members into the plan of care (Davidhizar & Giger, 1998), and recognize the infinite variety and lack of stereotype in families from various ethnic groups (Wright & Leahey, 1994). In addition, it is important to understand that the differences in family beliefs and values in families will affect the nurse-family partnership.

Hupcey (1999) cautions that families should always have the right to choose their level of participation in the relationship, and the family should be recognized as an active partner in providing care if they choose (Friedemann et al., 1997; Hertzberg & Ekman, 1996). Most families seek more cooperation on the part of professionals (Friedemann et al., 1997) and want to be involved in team discussions (McDonald et al., 1996) and problem-solving (Grant, 1999). Skemp Kelley et al. (2000) cite the need to assist the family to find meaningful and satisfactory caregiving roles.

B. Assessing Need

Family assessments are critical in identifying how the family has been affected by the expected or unexpected life event. A family assessment is an exploration between the nurse and family to gain insight into the family's perspective of the event, their strengths and need for support (Neabel, Fothergill-Bourbonnais, & Dunning, 2000). This perspective provides an understanding of how the quality of health of the family is intertwined with the health of its members (Lapp, Diemert, & Enestvedt, 1993). Through a complete assessment, the nurse plays a pivotal role in assisting families adjust to the expected or unexpected life event. Based on the findings in the literature, as well as expert opinion, the guideline development panel offers the following recommendation:

Recommendation 2

Assess individuals in the context of the family (as they define it) to identify whether assistance is required by the nurse to strengthen and support the family. While a family assessment should include information in the following areas, it should be tailored to address the uniqueness of each family through examining:

- Family structure;
- Environmental data;
- Family strengths; and
- Family supports.

Discussion of Evidence

The literature confirms that the assessment process is a critical component in exploring the overall health of the individual and family. Key components of an assessment and intervention framework of family nursing include listening to the family, engaging in a participatory dialogue between the nurse and family members, recognizing patterns and collaboratively identifying action and positive change (Neabel et al., 2000). This data is gathered over time through direct questioning of family members, observations, and use of the nurse's knowledge and expertise.

When assessing a family, it is important to remember that each family is unique and that the assessment process is a continually evolving process of data collection as family needs change. The family's characteristics, prior experiences, developmental level and personal resources will all interact with the environment to influence the manner in which families contend with expected and unexpected life events (Stover, Vaughan-Cole, O'Neill Conger, Abegglen, & McCoy, 1998).

Many approaches, techniques and models can be used to assess families (Harmon Hanson, 1996). Some examples of family assessment models and approaches (see Appendix A) are the Friedman Family Assessment Model (Friedman, 1992), Calgary Family Assessment Model (Wright & Leahy, 1994), and the McGill Model/Developmental Health Model (Feeley & Gottlieb, 1998). The guideline development panel cautions that no one assessment model will address every family's and nurse's need in every situation. However, based on a comparison of family assessment models and tools, it is clear that a family assessment should explore and address the key areas of family structure, environmental data, family strengths, and family support (Feeley & Gottlieb, 1998; Friedman, 1992; Laitinen, 1993; Lynn McHale & Smith, 1993; McCubbin & McCubbin, 1993; Skemp Kelley et al., 2000; Ward Griffin & McKeever, 2000; Wright & Leahey, 1994).

Family structure includes gathering information on the family's composition, culture/ethnicity, spiritual identification, economic status, lifestyle, health behaviours, developmental stage, power and role structure within the family, how the family communicates and who should be contacted. The environmental data explores the type and characteristics of the home as well as the community's characteristics such as access to health care, recreation, school, and environmental hazards. Family strengths identify the family's health beliefs and values. Other strengths that should be assessed are the family's fundamental values, coping mechanisms, problem solving strategies, resources and capabilities. Family supports are another area that should be assessed. Family supports examine the types of supports the family requires during

the expected or unexpected life event. Issues that should be assessed include the family's appraisal of the stressor, their concerns, vulnerability, information needs and the degree of involvement the family wants in caregiving and decision making processes. (Appendix B includes questions that can be explored in each of these areas).

Wright & Leahey (1999) identify that the most common reason offered by nurses for not routinely assessing and involving families in their practice is because "they don't have time". They propose that a 15-minute family interview can be purposeful, effective, informative, and even therapeutic for family members. Key components of a 15-minute family interview include therapeutic discussions and questions, identifying who makes up the family unit, and identifying family and individual strengths.

To gather data about the family, Wright & Leahey (1999) suggest that the nurse needs to actively seek out opportunities to engage in purposeful discussions with family members. This can be achieved through inviting family to accompany the patient to the unit, clinic or hospital. Family can be routinely included in the admission procedure. During the patient orientation, family can routinely be invited to ask questions and participate.

To learn more about the family unit and structure, nurses can ask questions in relation to the ages and current health of the household family members. Once this information has been collected, the nurse can assess external family structure information by asking such questions as "who outside of your immediate family is an important resource or stress for you?" (Wright & Leahey, 1999). To assess how the client and family have managed health problems in the past, nurses can ask the family to describe routines at home. Lastly, nurses should consult families and clients about their ideas and concerns in relation to treatments and discharge (Wright & Leahey, 1999).

In the 15-minute interview, Wright and Leahey (1999) identify questions that address important themes such as sharing of information, expectations and challenges of the life event, and the most pressing concerns/problems that need to be assessed. Laforet-Fliesser & Ford-Gilboe (1996) also identify five broad questions that can be explored with families to assist nurses in identifying how best to support families. (Examples of these questions can be found in Appendix B).

C. Providing Information, Accessing Resources and Supporting Family Resources

The guideline development panel believes that families play a crucial role in the quality of care. If support and guidance are provided, enhanced quality of life is achieved both for the patient and their families. As a trusted professional, the nurse is in a unique position to guide the family to access the supports they require throughout the continuum of care.

Recommendation 3

Identify resources and supports to assist families address the life event, whether this is expected or unexpected. Resources should be identified within the following three categories:

- Intrafamilial;
- Interfamilial; and
- Extrafamilial.

Discussion of Evidence

The literature noted that families who access resources will gain a sense of control (which helps relieve stress and caregiver burden), and will reduce mental health problems (e.g. depression) often associated with family caregivers (Bourgeois, Schulz & Burgio, 1996; Gottlieb & Johnson, 2000; Ostwald, Hepburn, Caron, Burns & Mantell,1999). By recognizing and identifying these resources which can be classified as intrafamilial, interfamilial and extrafamilial, nurses can guide families to gain access to these means, recognizing that they may require a multifocal approach encompassing all three areas (Bourgeois et al., 1996).

Intrafamilial: Nurses can support families in recognizing their strengths and building upon them; in times of stress each family copes in their unique way. During assessment, individual coping mechanisms should be identified:

- Spirituality e.g. prayer, formalized religion (Hawkins, 1996; Magliano et al.,1998a);
- Individual counseling (Bourgeois et al., 1996);
- Cultural strengths (Fast & Keating, 2000); and
- Implementing self-care strategies e.g. personal journal, accepting help, acknowledging need for rest and revitalization (McDonald et al., 1996).

Interfamilial: It is important to assist patients and their families to access the services of support groups (Bourgeois et al., 1996; Hawkins, 1996; McDonald et al., 1996; Wysocki et al., 1997) and informal networks. Some resources families can consider are:

- Support groups unique to the family's needs e.g. Alzheimer Support Group (Bourgeois et al., 1996);
- Newsletters e.g. Bone Marrow Transplant Newsletter (McDonald et al., 1996);
- Organized educational programs for families related to specific skills training (Bourgeois et al., 1996; McDonald et al., 1996; Wysocki et al., 1997); and
- Friends or families to help with housekeeping, dietary needs, transportation and companionship (Dokken & Sydnor-Greenberg, 1998).

Extrafamilial: Nurses can act as advocates, coordinating and facilitating access to care, and can provide information on:

- Community resources and programs e.g. home care and respite care (Bourgeois et al., 1996; Dokken & Sydnor-Greenberg, 1998; Gottlieb & Johnson, 2000; Hawkins, 1996; Laitinen, 1993).
- Guides to local community resources e.g. Community Service book; and
- Educational and skill training programs (Hawkins, 1996, Magliano et al., 1998a, McDonald et al., 1996).

D. Educating Nurses, Family, Policy-Makers and the Public

Ongoing education for ***all*** parties involved (nurses, family, policy-makers and public) is key in supporting families. For *nurses*, this education is an essential component of understanding their role in facilitating family coping. Education would assist nurses to acknowledge the family's unique role in the client/patient's life, helps acknowledge the nurse's bias (e.g. cultural, spiritual) and helps assess the family's ability to cope using recognized assessment tools. Education is a life-long expectation for nursing practice. (See Education Recommendations for a discussion of the competencies required for nursing practice in family-centred care).

Education for *families and clients* supports coping by providing disease-specific information, information relating to coping and skill development, and information on how to maneuver the health care system. Providing information and education is an important step in involving families in the care of their family members, as they are not always involved in the care to the extent they want to be (Laitinen,1993).

Lastly, education for *policy-makers and the public* is essential in family coping with expected and unexpected life events; nurses must educate policy-makers and the public on issues, which impact on care (see Organization & Policy Recommendations).

Recommendation 4

Educate and provide information to nurses, families, policy-makers and the public to assist families to manage expected or unexpected life events.

Discussion of Evidence

The literature indicates that some practice settings are not supportive of the notion that families and nurses require education to heighten awareness of the need for family involvement (Friedemann et al.,1997), even though it is broadly known through research that nurses involved in specialty areas need to have enhanced educational activities (Bromberg & Higginson, 1996; Kovach & Meyer-Arnold, 1996; Wehtje-Winslow & Carter, 1999). As relationships among health care providers and families have changed over time, nurses need to be prepared to adapt care to families' needs and their preferred style of interaction. Dixon (1996) agrees that education will facilitate this adaptation.

Education around the role of families in care giving is another important area of support. As Health Care Reforms continue to be implemented, the impact on the family is great. Some families want more control and involvement in the care of their family member, while others feel that institutions have to take more responsibility in care issues. Skemp Kelley et al. (2000) discuss a negotiated partnership in health care issues. Support programs involving educational components have been researched and indications are that supports need to be made available at an early stage to families (Magliano et al., 1998a). Families need to be aware of the options open to them, and of the expectations of the health care system (Dokken & Sydnor-Greenberg 1998; Mayer et al., 1990; McDonald et al., 1996). Disease-specific education programs, such as behaviour management for caregivers of dementia sufferers, can decrease the burden of care for the caregivers (Buckwalter et al., 1999), and evaluation of education programs is necessary to assess their effectiveness and validity (Bauman, Drotar, Leventhal, Perrin & Pless, 1997; Briggs & Thompson, 2000).

Changing visiting policy in institutions, which limit access, will positively impact families coping with life events (Giganti, 1998). Further research to guide decision-making about policies and funding issues to support caregivers is essential (Fast & Keating, 2000).

Education Recommendations

A focus on family-centred care should be incorporated into all levels of nursing curricula. Close examination of the definition of family-centred care by Dunst, Trivette & Deal (1994) reveals a number of beliefs that emphasize a participatory, highly responsive approach to working with families. Major emphasis should be placed on:

- Creating opportunities for families to become more competent and independent;
- Strengthening families by building on their strengths and natural resources rather than supplanting their social support networks with professional "expert" service; and
- Enhancing the family's acquisition of a wide variety of competencies and resources.

Focusing on the family (not the patient), on family capacities (not deficits), and on promotion of growth-producing behaviour (not treatment of problems) contrasts with a more traditional approach to nursing. Reconceptualizing the relationship between the nurse and family as one of sharing responsibility and mutual problem solving requires a shift in how professionals interact with families. Professional educational programs could, in part, assist with this shift and expansion in the roles nurses play in working with families.

An orientation to family-centred care should include family assessment (family structure, environmental data, identification of family strengths, supports and needs, family developmental stage and family history) and the vision, values, and principles of supporting and strengthening families. In addition, it is important to ensure nursing staff have the awareness and ability to effectively access resources (intrafamilial, interfamilial, and extrafamilial) and current information and research on family-centred care.

By providing opportunities for professional development, organizations are enabling nurses to:

- Enhance knowledge and skills around family-centred care (i.e. effective communication and conflict management skills, negotiation, advocacy, etc.).
- Access a variety of professional development activities (i.e. internal workshops and inservices or external courses and workshops), through reimbursement or payment for professional development activities and flexible scheduling etc.

Recommendation 5

Sustain a caring workplace environment conducive to family-centred practice by:

- Ensuring that nursing staff are oriented to family-centred care, including family assessment;
- Ensuring that nurses have the awareness and ability to effectively access resources; and
- Providing ongoing opportunities for professional development for nursing staff, including knowledge and skills regarding family-centred care.

Organization & Policy Recommendations

Promoting a Caring Environment

Many of the recommendations in this guideline are predicated by caring and supportive workplace/environment policies. If practice settings are not conducive to supporting and strengthening families, it will be difficult for the nurses to enact the range of best practice activities being recommended in this document. The guideline development panel feels strongly that practice settings have a responsibility to the person receiving care, their family, and to their employees. This involves creating, promoting and sustaining practice settings that are caring environments, centred on a philosophy of supporting and strengthening families. Employers in all sectors need to develop employee assistance programs promoting family health.

Recommendation 6

Support the implementation of family-centred practice in the workplace by:

- Ensuring appropriate staffing levels, assignments, and staffing categories;
- Implementing family-centred practices and policies;
- Creating and maintaining physical work environments that are conducive to promoting family involvement; and
- Developing employee assistance programs promoting family health.

Discussion of Evidence

The literature supports the concept of ensuring *appropriate staffing levels* (e.g. permanent full-time and part-time positions), staff mix, care delivery models and resources that promote continuity and consistency of caregiver to allow nurses to support families (Kirk, 1998; Ward-Griffin & McKeever, 2000). Allocation of adequate and appropriate staff and a care delivery

model that facilitates consistency and continuity of care would provide sufficient time for meaningful opportunities for interactions of nurses with patient/clients and family members that support and strengthen the family through the care experience.

Family-centred practices and policies (e.g. open visitation policies including hours, number of family members and flexibility regarding who is considered family) foster and maintain patient and family involvement in planning, decision-making and provision of care, as a core activity of the organization (Friedemann et al., 1997; Giganti, 1998; Powers, Goldstein, Plank, Thomas & Conkright, 2000). Family-centred values are integrated into the mission, vision and values of practice settings, and nursing staff, through orientation, experience and assimilation, incorporate these values in their practice.

Family-centred care is also supported by *creating and maintaining physical work environments* (e.g. a home-like atmosphere at the bedside and in waiting rooms), that can accommodate family members (Giganti,1998; Hertzberg & Ekman, 1996).

Employee assistance programs (e.g. flexible scheduling, time off, support groups and on-site day care) are additional supports to family-centred practice (Hawkins, 1996).

Advocacy

Many of the recommendations offered in this guideline are dependent on the availability of adequate funding for health care in Ontario, as well as the appropriate allocation of funding by health care organizations. If adequate public funding is not available, nurses will have neither the time nor the capacity to carry out the range of best practice activities recommended in this guideline. To ensure adequate support for family-centred practice, nurses must advocate for changes to public policy. Advocacy, or the act of promoting for a particular policy or position, is a well-recognized strategy for change. While advocacy has historically been thought of as a political approach, and out of the normal range of activities for health professionals, it is increasingly recognized by professional associations, health provider organizations and policy-makers that health professionals in particular (and all citizens generally) must advocate for changes that they feel are needed in Ontario's health care arena.

Over the past few decades Health Care Reforms across Canada have shifted the burden of responsibility for caregiving from hospitals and institutions, where formal caregivers provide care, to home and communities, where families are expected to provide care (Fast & Keating,

2000). These changes, the result of a significant shift in policy directions, have had a profound impact on clients of all ages, and their families. Nurses, as caregivers to clients and families, are also deeply affected by these changes. Heavy workloads, stressful work environments and limited resources inevitably affect the lives of nurses and their patients.

The guideline development panel strongly supports the recommendation that nurses must take an active role in advocating for health policy and health care funding changes that ensure adequate resources and appropriate staffing levels for nurses in all parts of Ontario's health care continuum. Nurses must take every opportunity to present their views on health care policy to administrators, policy-makers, politicians, provider associations and union leaders.

Recommendation 7:

Advocate for changes in public policy by:

- Lobbying for public discussion on family caregiving and the development of a public position on what level of caregiving is reasonable to expect from family caregivers, and at what point the public might expect the health care system to step in to provide care;
- Lobbying for public education about the value and legitimacy of the role of family caregivers;
- Lobbying for a full range of adequate and effective respite care programs which facilitate family caregiving;
- Lobbying for consistency in funding, availability, and delivery of respite care programs across Ontario;
- Lobbying for the funding of research projects that examine family as the recipients of care, caregiving and respite care, family as caregivers, and the application of lessons learned from this research into public policy and program development; and
- Lobbying for mechanisms within organizations for families to dialogue with one another in an open forum.

Discussion of Evidence

Lewis (1999) proposes that nurses advocate for:

- A public discussion on family caregiving;
- The development of a public position on what level of caregiving is reasonable to expect from family caregivers; and

- Confirmation of when the public might expect the health care system to step in to provide care.

The literature also supports the role of the nurses as an advocate for:

- Public education about the value and legitimacy of the role of family caregivers (CareWatch Phoneline, 1999; Laitinen, 1993);
- A full range of adequate and effective respite care programs which facilitate family caregiving (Beisecker, Wright, Chrisman, & Ashworth,1996; Community Care Access Centre, 1999; Hoskins Noll et al., 1996; Laitinen, 1993);
- Consistency in the funding, availability, and delivery of respite care programs in communities across Ontario (Beisecker et al., 1996; Bourgeois et al., 1996; CareWatch Phoneline, 1999; Hanson, Tetley & Clarke, 1999); and
- The funding of research projects that examine family caregiving and respite care, and the application of lessons learned from this research into public policy and program development (Fast & Keating, 2000; Lewis, 1998).

Recommendation 8

Nursing best practice guidelines can only be successfully implemented if there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- An assessment of organizational readiness and barriers to education;
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process;
- Dedication of a qualified individual to provide the support needed for the education and implementation process;
- Ongoing opportunities for discussion and education to reinforce the importance of best practices; and
- Opportunities for reflection on personal and organizational experience in implementing guidelines.

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *"Toolkit: Implementation of Clinical Practice Guidelines"*, based on available evidence, theoretical perspectives and consensus (See Appendix C). The Toolkit is recommended for guiding the implementation of the RNAO nursing best practice guideline on *Supporting and Strengthening Families Through Expected and Unexpected Life Events.*

Evaluation & Monitoring

Organizations implementing the recommendations in this nursing best practice guideline are recommended to consider how the implementation and its impact will be monitored and evaluated. The following table, based on a framework outlined in the RNAO Toolkit: Implementation of Clinical Practice Guidelines (2002), illustrates some indicators for monitoring and evaluation:

	Structure	Process	Outcome
Objectives	• To evaluate the supports available in the organization that allow for nurses to practice family-centred care with their clients.	• To evaluate changes in practice that lead towards a nurse-family partnership.	• To evaluate the impact of implementation of the recommendations.
Organization/ Unit	• Review of guideline recommendations by organizational committee(s) responsible for policies/ procedures. • Organizational mission that supports family-centred care and the nurse-family partnership.	• Modification to policies and procedures consistent with the values of family-centred care.	• Enhanced practice of family-centred care. • Staff satisfaction.
Provider	• Commitment to ensure continuity of family-centred care. • Per cent of nurses attending education sessions (orientation, professional development opportunities) on family-centred care. • Per cent of non-nursing staff attending education sessions (orientation, professional development activities) on family-centred care.	• Nurses' self-assessed knowledge of the importance of: ◦ Family-centred care. ◦ The nurse-family partnership. ◦ Documenting the family's understanding of a situation, rather than the nurse's judgement of the client. • Per cent of nurses self-reporting: ◦ Adequate assessment of a family's desire to be an active partner in the care of a family member. ◦ Development and adequate documentation of the family-centred care plan. ◦ Sharing family's concern with other members of the health care team.	• Nursing and non-nursing staff report active involvement in implementation process. • Per cent of clients/families with family assessment recorded on chart
Client			• Improved client-family satisfaction. • Families report being included as full partners in the care plan, feel they are being listened to.
Financial costs	• Adequate financial resources for staffing to provide family-centred care • Nursing turnover costs.	• Costs for education and other interventions.	• Overall resource utilization.

Process For Update/Review of Guideline

The Registered Nurses Association of Ontario proposes to update the nursing best practice guideline as follows:

1. Following dissemination, each nursing best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area, every three years following the last set of revisions.

2. During the three-year period between development and revision, RNAO Nursing Best Practice Guidelines project staff will regularly monitor for new systematic reviews and randomized controlled trials (RCTs) in the topic area.

3. Based on the results of the monitor, project staff may recommend an earlier revision period. Appropriate consultation with a team of members comprising of original panel members and other specialists in the field will help inform the decision to review and revise the guideline earlier than the three-year milestone.

4. Three months prior to the three-year review milestone, the project staff will commence the planning of the review process as follows:
   a) Invite specialists in the field to participate in the Review Team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.
   b) Compile feedback received, questions encountered during the dissemination phase as well as other comments and experiences of implementation sites.
   c) Compile new clinical practice guidelines in the field, systematic reviews, meta-analysis papers, technical reviews, randomized controlled trial research, and other relevant literature.
   d) Develop detailed work plan with target dates and deliverables.

The revised guideline will undergo dissemination based on established structures and processes.

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Appendix A

Components of Family Assessment Models and Tools

Friedman Family Assessment (Friedman, 1992)	**Calgary Family Assessment Model** (Wright & Leahy, 1994)	**Resiliency Model of Family Stress, Adjustment & Adaptation** (McCubbin & McCubbin, 1993)	**McGill Model** (Feeley & Gottlieb, 1998; Conference Proceedings from: A Professional Approach to Nursing Practice: The McGill Model (1985).	**Family Involvement in Care** (Skemp Kelley, L., Pringle Specht, J.K., & Maas, M.L., 2000)
• Identifying data. • Developmental stage and history of family. • Environmental data. • Family structure. • Family functions. • Family coping.	• Developmental stage and history of family. • Structural. • Developmental. • Functional.	• Adjustment phase. • Adaptation phase.	• The family as the subsystem. • Health as the focus of work. • Learning as the process through which health behaviours are acquired.	• Identifying data. • Person with Alzheimer's disease. • Family members. • Formal care provider.

Appendix B

Sample Questions for Key Areas of Family Assessment

Family Structure

Identifying data (Names, ages, addresses - Who is the primary person to contact? Does the family have any transportation difficulties?).

Composition (Family Unit - Could you tell me who is in the family? Is there anyone else who is not related that you think of as family? How close is the family?).

Culture/ethnicity (Knowledge and customs of family - Could you tell me about the family's cultural background? Does ethnicity influence the family's health beliefs? Are there any ethnic customs the family gains strength from or may need assistance with?).

Spiritual identification (Characteristic values of a person which may or may not be a religious affiliation - Are your spiritual beliefs a resource for family members? Is there anyone that can be contacted to assist the family with their spiritual needs?).

Economic status (Income of family - Who is (are) the breadwinner(s) in the family? Is the family able to meet current and future needs? What type of work?).

Lifestyle and health behaviours (Nutrition, drugs and alcohol, smoking, activity and rest).

Developmental stage (Family's present developmental stage and developmental stage history [e.g. births, retirement, aging parents, deaths], extent to which the family is fulfilling the developmental tasks appropriate for their developmental stage).

Power and role structures (Who makes what decisions? Are family members satisfied with how decisions are made and who makes them? What positions and roles do each of the family members fulfill? Is there any role conflict? How are family tasks divided up?).

Communication (Family's ability to interact with one another-Are family members able to communicate openly with one another? Is conflict openly expressed and discussed? Do family members respect one another?).

Environmental Data

Home characteristics (Type of characteristics of the home - Can you describe your home? Do you own or rent? Do you consider your home adequate for your needs?).

Community characteristics (Describe your neighbourhood/community, e.g. rural or urban, schools, recreation, access to health care, crime rate, environmental hazards, etc.?).

Family Strengths

Health patterns (Family's health beliefs, values and behaviours - How does the family assess their present health status? What present health problem(s) does the family identify?).

Values (Family's fundamental ideas, opinions, and assumptions - What values/beliefs does the family have that have assisted them in adapting successfully or unsuccessfully?).

Coping mechanisms (Ability to adapt to stress and maintain emotional well-being and stability of its members - How has the family coped with past crises? What helped the most and the least? What strengths does the family have to assist in coping? Do family members differ in their ways of coping?).

Problem solving (Family's ability to organize a stressor into manageable components and to identify courses of action to solve it effectively - How has the family resolved problems in the past? What resources have they used?).

Family Resources and Capabilities (Resources the family use to assist adapting to the stressor - What intra, inter and extrafamilial resources are the family using and require information on?).

Family Secrets

Family appraisal of the stressor (What is the family's estimate of the strength and duration of the stressor?).

Major concerns (What are the family's major concerns?).

Adapted from: Feeley & Gottlieb, 1998; Friedman, 1992; Laitinen, 1993; Lynn McHale & Smith, 1993; McCubbin & McCubbin, 1993; Skemp Kelley et al., 2000; Ward-Griffin & McKeever, 2000; Wright & Leahey, 1994.

Examples of General Questions to guide the family assessment and interview:

1. Who of your family and friends would you like us to share information with and who not?
   (Identifies alliances, resources and conflictual relationships)
2. How can we be most helpful to you and your family or friends during the hospitalization?
   (Clarifies expectations, increased collaboration)
3. What has been most/least helpful to you in past hospitalizations or health visits?
   (Identifies past strengths, problems to avoid and successes to repeat)
4. What is the greatest challenge facing your family right now?
   (Indicates actual/potential suffering, roles, and beliefs)
5. What do you need to best prepare you/your family member for discharge?
   (Assists with early discharge planning)
6. Who do you believe is suffering the most in your family at this time?
   (Identifies which family member requires the greatest support and intervention)
7. What is the one question you would most like to have answered right now?
   (Explores the most pressing issue or concern)
8. How have I been most helpful to you in this family meeting? How could I improve?
   (Demonstrates a willingness to learn from families and work collaboratively)

   (Adapted from Wright & Leahey, 1999).

Laforet-Fliesser & Ford-Gilboe (1996) identify five broad questions that can be explored with families to assist nurses in implementing a family assessment:

1. What is the family working on or dealing with?
2. How is the family going about it?
3. What does the family want or what is it working toward?
4. What resources is the family using and what other resources could be mobilized?
5. What aspects of the broader context of family life might explain the family's present health behaviour or situation?

Appendix C

Toolkit: Implementation of Clinical Practice Guidelines

Best practice guidelines can only be successfully implemented if there are: adequate planning, resources, organizational and administrative support as well as appropriate facilitation. In this light, RNAO, through a panel of nurses, researchers and administrators has developed a "Toolkit: Implementation of Clinical Practice Guidelines" based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of any clinical practice guideline in a health care organization.

The "Toolkit" provides step-by-step directions to individuals and groups involved in planning, coordinating and facilitating the guideline implementation. Specifically, the "Toolkit" addresses the following key steps:

1. Identifying a well-developed, evidence-based clinical practice guideline.
2. Identification, assessment and engagement of stakeholders.
3. Assessment of environmental readiness for guideline implementation.
4. Identifying and planning evidence-based implementation strategies.
5. Planning and implementing evaluation.
6. Identifying and securing required resources for implementation.

Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The "Toolkit" is one key resource for managing this process.

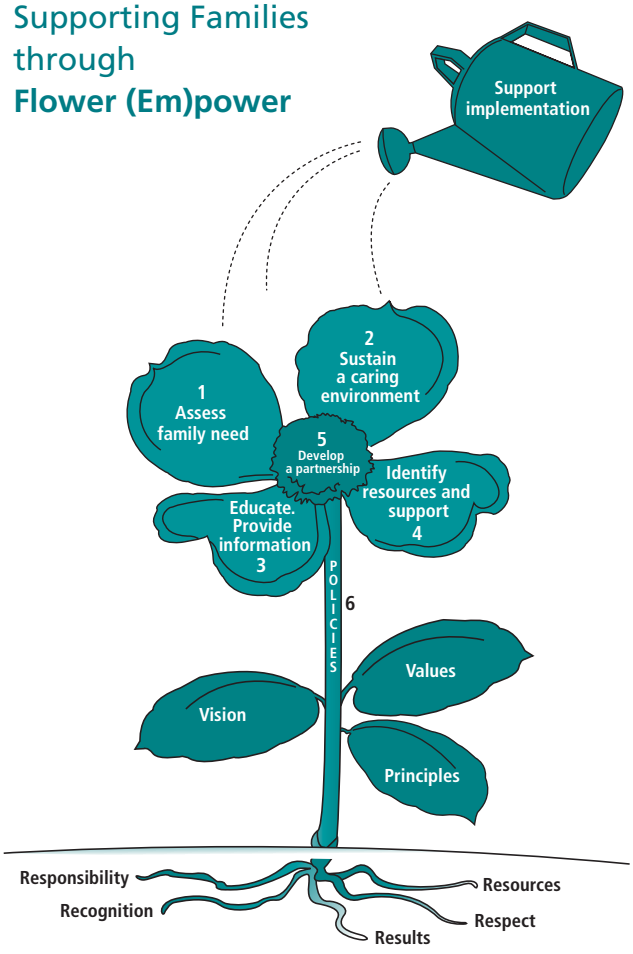
The "Toolkit" is available through the Registered Nurses Association of Ontario. The document is available in a bound format for a nominal fee, and is also available free of charge off the RNAO website. For more information, an order form or to download the "Toolkit", please visit the RNAO website at www.rnao.org.

Appendix D

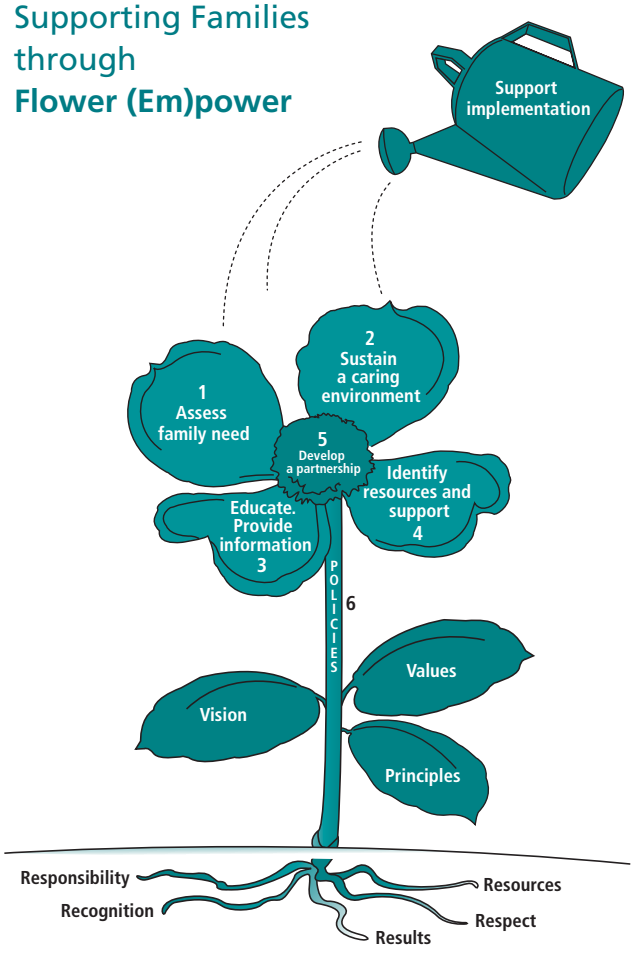
The Flower (Em)Power Pocket Card

Attached are two pocket cards that can be removed, reproduced and/or laminated, that display the flower of empowerment on one side, and key questions that nurses can consider when implementing/incorporating a family-centred care approach into their practice, on the other.

Strengthening & Supporting Families through **Flower (Em)power**



Strengthening & Supporting Families through **Flower (Em)power**



1. Is a family assessment completed over time examining the family structure, strengths, and areas of support?
2. How am I demonstrating family-centred care?
3. What reciprocal learning has taken place?
4. Are there adequate resources and support to meet the needs of the family?
5. How is the family involved in the client's care?
6. How am I advocating for family-centred practice?

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1. Is a family assessment completed over time examining the family structure, strengths, and areas of support?
2. How am I demonstrating family-centred care?
3. What reciprocal learning has taken place?
4. Are there adequate resources and support to meet the needs of the family?
5. How is the family involved in the client's care?
6. How am I advocating for family-centred practice?

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March 2006

Nursing Best Practice Guideline

Shaping the future of Nursing

supporting and strengthening families through expected and unexpected life events

supplement

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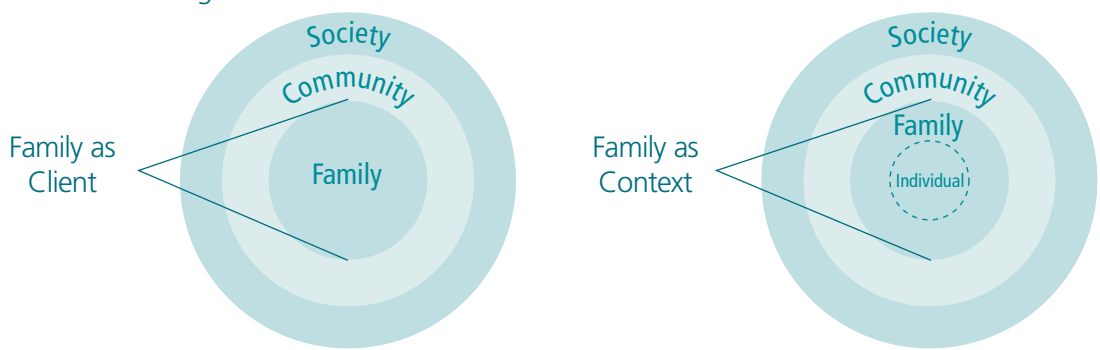
Supplement Integration

This supplement to the nursing best practice guideline *Supporting and Strengthening Families Through Expected and Unexpected Life Events* is the result of a three year scheduled revision of the guideline. Additional material has been provided in an attempt to provide the reader with current evidence to support nursing practice. Similar to the original guideline publication, this document needs to be reviewed and applied, based on the specific needs of the organization or practice setting/environment, as well as the needs and wishes of the client/family. This supplement should be used in conjunction with the guideline as a tool to assist in decision making for individualized care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care to families.

Family nursing is a multi-faceted specialty of nursing. It requires nurses to not only care for the individual within the family group (family as context), but to also nurse the family as the unit of care (family as client). Refer to Figure 1. In addition, the term "family as partner" has tended to focus on family members who provide care to other members – whether they act or feel as partners in care is debatable (Ward-Griffin & McKeever, 2000). The concept of "family-centred nursing" needs to be examined further in order to move beyond the family caregiver model and to embrace an empowering partnership with the family. The aim of this approach to family nursing practice is to promote the health of the family.

Figure 1



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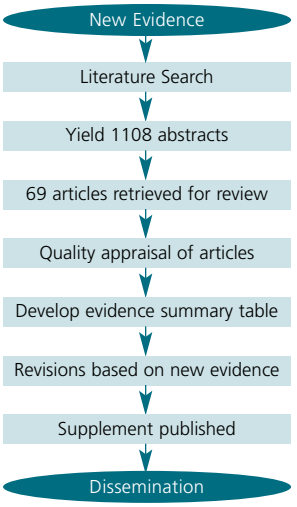
NURSING BEST PRACTICE GUIDELINES PROGRAM

Revision Process

The Registered Nurses' Association of Ontario (RNAO) has made a commitment to ensure that this guideline is based on the best available evidence. In order to meet this commitment, a monitoring and revision process has been established for each guideline every three years. The revision panel members (experts from a variety of practice settings) are given a mandate to review the guideline focusing on the recommendations and the original scope of the guideline. The revision panel for the *Supporting and Strengthening Families Through Expected and Unexpected Life Events* guideline consists of original panel members, representatives of organizations who have had experience implementing the guideline, and other recommended experts.

The revision panel reflected on the "Flower (Em)power" Framework and the components of the nurse-family partnership; advocacy activities and policy; founded on the vision, values and principles of respect, recognition, resources, responsibility and results. The framework was used to structure the review/revision discussions to ensure consistency of approach with the original guideline.



Definitions:

The following definition is added to those in the "Definition of Terms" section starting on page 15 of the guideline.

Empowering Partnership:

An empowering partnership between a nurse and a family is a collaborative relationship built on mutual respect and trust, as well as the sharing of knowledge, skills and experience. Ultimately, families and nurses are empowered to grow and learn together as partners in the promotion of the health of the family.

Summary of Evidence

The following content reflects the evidence reviewed that either supports the original recommendations, or provides evidence for revisions. Through the review process, no recommendations were added or deleted, however a number of recommendations were reworded to reflect new knowledge.

changed
✓ unchanged
\+ additional information

Recommendation 1

Develop an empowering partnership with families by:

- Recognizing the family's assessment of the situation as essential;
- Acknowledging and respecting the important role of family in health care situations;
- Determining the desired degree of family involvement; and
- Negotiating the roles of both nurse and family within the partnership.

The wording of this recommendation has been revised to reflect the concept of "an empowering partnership" which incorporates the previous concept of "genuine partnership" – really knowing about the family and supporting the "here and now" of the person. The Developmental Model of Health and Nursing (DMHN) supports the concept of empowering partnerships, as the model emphasizes health as a process and the capacities all families have, including their potential for growth and change. Health is seen as a social process that is shaped by the social context of family life, including social and political realities that may restrict individual and family choices for health. The nurse is viewed as a partner in the family process of developing health (Ford-Gilboe, 2002). An empowering partnership is seen as a collaborative relationship built on mutual respect and trust, as well as the sharing of knowledge, skills and experience.

Central to an empowering partnership is the negotiation of roles and an appreciation of the types of knowledge and authority that both nurses and families bring to the relationship. Being able to understand the difference between "power with" and "power over" approaches in a relationship will assist nurses to develop more empowering negotiating strategies within families. Exploring the intrinsic factors that shape different types of family relationships, reviewing empowering negotiating strategies and reflecting on specific experiences with families will help nurses develop positive relationships that are flexible enough to promote a genuine sharing of both authority and expertise (Ward-Griffin et al., 2003).

Additional Literature Supports

Allen & Warner, 2002; Astedt-Kurki, Tarkka, Paavilainen & Lehti, 2002; Ballard-Reisch & Letner, 2003; Clark & Dunbar, 2003; Ford-Gilboe, 2002; Gill, 2001; Holden, Harrison & Johnson, 2002; Hong, Callister & Schwartz, 2003; Hopia, Tomlinson, Paavilainen & Astedt-Kurki, 2005; Knafi & Deatrick, 2003; Kristjanson, 2004; Kuupelomäki, 2002; Legrow & Rossen, 2005; Mok, Chan, Chan & Yeung, 2002; Sharpe, Butow, Smith, McConnell & Clarke, 2005; Ward-Griffin, Bol, Hay & Dashnay, 2003; Ward-Griffin, Schofield, Vost & Castsworth-Puspoky, 2005

Recommendation 2

Assess family in the context of the event(s) to identify whether assistance is required by the nurse to strengthen and support the family. While a family assessment should include information in the following areas, it should be tailored to address the uniqueness of each family through examining:

- Family perceptions of the event(s);
- Family structure;
- Environmental conditions; and
- Family strengths.

The wording of the recommendation has been revised to more closely align with the concepts of assessing family in the context of their perceptions of the event and family as the unit of care (family as client).

Ward-Griffin et al. (2005) conducted a descriptive study exploring the perspectives of individuals caring for a family member with mental illness, with particular attention to the family perspectives of the experience in relation to housing, quality of supports, and formal care services and to identify potential solutions to difficulties encountered by families. The researchers found that these families were part of a "circle of care", offering support to their members with mental illness in order to promote their independence, but at the same time trying to protect them from the realities of the system. Inadequate and inappropriate resources and supports pushed families into a cycle of caregiving that compromised their health and that of their family member.

Revisions to the Appendix that supports this recommendation are included on page 7 of this supplement.

Additional Literature Supports

Allen & Warner, 2002; Astedt-Kurki et al., 2002; Ballard-Reisch & Letner, 2003; Callahan, 2003; Ford-Gilboe, 2002; Gill, 2001; Holden et al., 2002; Hong et al., 2003; Hopia et al., 2005; Knafi & Deatrick, 2003; Kristjanson, 2004; Mok et al., 2002; Sharpe et al., 2005; Ward-Griffin et al., 2005

Recommendation 3

Identify resources and supports to assist families to address the life event, whether this is expected or unexpected. Resources should be identified within the following three categories:

- Intrafamilial;
- Interfamilial; and
- Extrafamilial.

Sharpe et al. (2005) explored the available support and unmet needs of people with advanced cancer, their family caregivers and their health care professionals. Findings from this study indicate that individuals with advanced cancer tended to underestimate the level of support that they received or needed. Health care professionals identified greater levels of need than the individual and family caregivers reported, but still underestimated the support needs of the person and their family. Opportunities need to be made available for individuals and family caregivers to discuss the life event they are experiencing and the needs they perceive. Providing opportunities for families to identify their needs and access resources to address these needs will have a positive impact on family strengths.

An ethnographic study conducted by Gill (2001) found that nurses supported breastfeeding mothers by providing information and interpersonal support. Breastfeeding mothers identified their support needs as information, encouragement and interpersonal support. The conclusion of this study was that nurses have a positive impact on breastfeeding mothers (and families), but the resources and support offered must be the kind the mothers (families) want.

Family members provide support to the ill family member, and have needs of support from health professionals. Family members whose own need for support is not met are less able to maintain their supportive role, and are more likely to experience mental and physical health problems (Kristjanson, 2004). Resources and supports identified to support the

family, in a review by Kristjanson (2004), included information giving, practical assistance with physical care requirements, facilitating emotional support and family communication and assistance with financial burdens of care. These key areas of support need intersect with the categories of intrafamilial, interfamilial and extrafamilial resources.

The revised Appendix on page 7 supports this recommendation in relation to assessing intra, inter and extrafamilial resources.

Additional Literature Supports

Ford-Gilboe, 2002; Gill, 2001; Holden et al., 2002; Hong et al., 2003; Hopia et al., 2005; Knafi & Deatrick, 2003; Kristjanson, 2004; Kuuppelomäki, 2002; Petrie, Logan & DeGrasse, 2001; Scott et al, 2003; Sharpe et al., 2005; Taainila, Syrjala, Kokkonen & Jarvelin, 2002; Thyen, Sperner, Morfield, Meyer & Ravens-Sieberer, 2003

Recommendation 4

Educate nurses, families, policy-makers and the public to respond to expected or unexpected life events within the family.

The wording of this recommendation has been revised to reflect the inclusion of nurses, families, policy-makers and the public in education and information exchange.

Partnership approaches to care have the potential to achieve effective, quality health care. Empowering and optimizing existing human potential by providing new ways to respond to expected or unexpected life events can be effective at the personal and organizational level. Providing knowledge and structures that allow all involved in care to respond to the family's needs empowers the family and allows for transfer of authority. Organizations and systems with cultures that foster empowering care partnerships are able to de-centre the professional in relationships with clients and de-centre the organization in relation to all involved in care (McWilliam et al., 2003).

Additional Literature Supports

Allen & Warner, 2002; Gill, 2001; Holden et al., 2002; Hong et al., 2003; Hopia et al., 2005; Kristjanson, 2004; McWilliam et al., 2003; Mok et al, 2002; Petrie et al., 2001; Taainila et al., 2002; Thyen et al., 2003

Recommendation 5

Sustain a caring workplace environment conducive to family-centred practice by:

- Ensuring that nursing staff are oriented to the values and assessment of family-centred care;
- Ensuring that nurses have the knowledge, skill and judgement to implement family-centred care; and
- Providing ongoing opportunities for professional development for nursing staff.

The wording of this recommendation has been revised to reflect an increased focus on skill development and application to family-centred practice.

The skill of facilitation is to be included as an outcome in an orientation to family-centred care (Guideline - pg 29). Gill (2001) and Ford-Gilboe (2002) have identified that individuals and families expect encouragement and support from nurses in relation to responding to life events. Families engage in health work on their own as they learn from the life events that they encounter. However, nurses facilitate this learning when assistance has been sought to support the family efforts to manage a particular situation (Ford-Gilboe, 2002).

Skill development that supports the emergence of relationship-centred care is essential as interactions amongst people are the foundation of any therapeutic activity. These relationships exist at many levels, including those between patients, their families, staff from all disciplines and the wider community. These relationships are the medium for exchanging information, feelings and concerns needed for a better understanding of the life event (Nolan et al., 2004).

Additional Literature Supports

Bruce et al., 2002; Ford-Gilboe, 2002; Gill, 2001; Holden et al., 2002; Hong et al., 2003; Hopia et al., 2005; Knafl & Deatrick, 2003, Kristjanson, 2004; Nolan, Davies, Brown, Keady & Nolan, 2004

Recommendation 6

Support the implementation of interdisciplinary family-centred practice in the workplace by:

- Ensuring appropriate resources (e.g., time, staffing);
- Developing and implementing family-centred practices and policies;
- Creating and maintaining environments that are conducive to family-centred care; and
- Developing programs that promote work life balance for employees.

The wording of this recommendation has been revised to reflect new knowledge regarding the implementation of family-centred practice.

Family-centred practice requires resources of time and staffing. Kristjanson, 2004 describes the importance of having time allocated for communication exchange with individuals and families. Health care professional may limit their information sharing with patients and families because of the pace of their busy work schedules. When information is provided, it is often shared in the hallway, over the phone or in public spaces with limited privacy. By not allocating time and space for family discussions and sharing of information, workplaces convey a message that this exchange is not important.

The findings of a feminist narrative study (Ward-Griffin et al., 2006) suggest that female health professionals who assume familial caregiving responsibilities continually negotiate the boundaries between their professional and personal caring work. Although they use a variety of strategies to manage their caregiving demands, many women experienced a blurring of professional/personal boundaries, resulting in feelings of isolation, tension, and extreme physical and mental exhaustion. These findings suggest that women who are double-duty caregivers, especially those with limited time, finances, or other tangible supports, may experience negative impacts on their health. Having programs available for employees that promote work life balance demonstrates a commitment to interdisciplinary family-centred practice.

Additional Literature Supports

Bruce et al., 2002; Gill, 2001; Hong et al., 2003; Hopia et al., 2005; Knafl & Deatrick, 2003; Kristjanson, 2004; Legrow & Rossen, 2005; Mok et al., 2002; Ward-Griffin, C., Brown, J. B., Vandervoort, A., McNair, S., & Dashnay, I., 2006

Recommendation 7

Advocate for changes in public policy by:

- Lobbying for public discussion on family caregiving and the development of a public position on what level of caregiving is reasonable to expect from families;
- Lobbying for public education about the value and legitimacy of the role of family caregivers and how multiple family members respond to life events;
- Lobbying for a full range of adequate and effective programs for family members who are involved in caregiving and other life events within the family;
- Lobbying for consistency in funding, availability and delivery of respite care programs and other supports for families across Ontario;
- Lobbying for the funding of research projects that examine family as the providers and recipients of care, and the application of lessons learned from this research into public policy and program development; and
- Lobbying for mechanisms within organizations for families to dialogue with one another in an open forum.

The wording of this recommendation has been revised to reflect the need for advocacy activities beyond a focus on family caregivers/caregiving.

In their study of the perspectives of individuals caring for a family member with mental illness, Ward-Griffin et al. (2005) identified the need for nurses to build trusting and respectful collaborations with families and to take action through advocacy for policy and service changes in various sectors at the local, municipal and federal government. There are opportunities for nurses to strengthen and support families in informing policy, for example, through the mental health reform process. Lobbying for public policies that support the broader determinants of health, such as affordable housing, via provincial and national family support organizations are further advocacy opportunities.

The application of lessons learned from research into public policy and program development is critical. Although

the process of research dissemination and utilization is complex, it is determined by numerous intervening variables related to the innovation (research evidence), organization, environment and individual (Dobbins et al., 2002).

Additional Literature Supports
Dobbins, Ciliska, Cockerill, Barnsley & DiCenso, 2002; Ford-Gilboe, 2002; Gill, 2001; Holden et al., 2002; Hong et al., 2003; Hopia et al., 2005; Knafl & Deatrick, 2003; Kristjanson, 2004; Ward-Griffin et al., 2005

Recommendation 8

Nursing best practice guidelines can only be successfully implemented if there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- An assessment of organizational readiness and barriers to education;
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process;
- Dedication of a qualified individual to provide the support needed for the education and implementation process;
- Ongoing opportunities for discussion and education to reinforce the importance of best practices; and
- Opportunities for reflection on personal and organizational experience in implementing guidelines.

✓

Additional Literature Supports
Dobbins, Davies, Danseco, Edwards & Virani, 2005; Graham, Harrison, Brouwers, Davies, & Dunn, 2002

Implementation Strategies

The Registered Nurses' Association of Ontario and the guideline panel have compiled a list of implementation strategies to assist health care organizations or health care disciplines who are interested in implementing this guideline. A summary of these strategies follows:

- Provide organizational support such as having the structures in place to facilitate family-centred practices. For example, having an organizational philosophy and vision that reflects the value of best practices through policies and procedures. Develop new assessment and documentation tools (Davies & Edwards, 2004).
- Identify and support designated best practice champions on each unit to promote and support implementation. Celebrate milestones and achievements, acknowledging work well done (Davies & Edwards, 2004).
- Establish a process to facilitate the cultivation of positive family-nurse relationships. This process may include adequate time and resources, documentation of family care transactions, and family-centred care as a component of staff performance reviews. These approaches may help to sustain a family-centred approach to care and to achieve partnerships between families and nurses (Ward-Griffin et al., 2003).
- Organizations implementing this guideline should adopt a range of self-learning, group learning, mentorship and reinforcement strategies that will over time, build the knowledge and confidence of nurses in providing family-centred care. Mentorship of nursing staff leaders may help to foster family-centred practices (Ward-Griffin et al., 2003).

Research Gaps and Implications

In order to assist nurses in the provision of family-centred care, additional research in the following areas would benefit practice:

- How to determine the desired degree of family involvement in care;
- Strategies for providing nurses with the skills required to negotiate roles within the partnership;
- Key components of a comprehensive assessment of the "event";
- Children's needs for support when an adult member of their family is the focus of the "event";
- Effective strategies nurses use in transferring knowledge that has meaning for the family; and
- Requirements for specific types of support, public policy etc. related to certain life events.

Appendices

The review/revision process did not identify a need for any additional appendices; however significant revisions have been made to Appendix B, which has been replaced with the following revised content.

Appendix B (Revised):

In conducting a family assessment, the nurse engages in a partnership with the family to assess their perception of, and their capacity to address, the life event.

Sample Questions for Key Areas of Family Assessment

FAMILY PERCEPTIONS OF THE EVENT(S)

- **Family appraisal of the event:** What is the family's perception of the event? Is it expected or unexpected? What is the family's estimate of the strength and duration of the event?
- **Major concerns:** What are the family's major concerns?

FAMILY STRUCTURE

- **Identifying data:** Names, ages, addresses. Who is the primary person to contact? Does the family have any transportation difficulties?
- **Composition:** Family Unit - Could you tell me who is in the family? Is there anyone else who is not related that you think of as family? How close is the family? Who lives with you? Are there any family pets? Is there anything else you would like to add?
- **Culture/ethnicity:** Knowledge and customs of family - Could you tell me about the family's cultural background? Does ethnicity influence the family's health beliefs? Are there any ethnic customs the family gains strength from or may need assistance with?
- **Spiritual identification:** Characteristic values of a person which may or may not be a religious affiliation - Are your spiritual beliefs a resource for family members? Is there anyone that can be contacted to assist the family with their spiritual needs?
- **Sexual identification:** The sexual orientation with which a family member identifies or is identified - Some people who are facing an experience similar to your family are concerned about their sexual abilities and their sexual partners. It may be helpful for us to discuss any questions or concerns you may have.
- **Economic status:** Income of family - Who is (are) the breadwinner(s) in the family? Is the family able to meet current and future needs? What type of work are family members involved in?
- **Lifestyle and health behaviours:** Nutrition, drugs and alcohol, smoking, activity and rest.
- **Developmental stage:** Family's present developmental stage and developmental stage history [e.g., births, retirement, aging parents, deaths], extent to which the family is fulfilling the developmental tasks appropriate for their developmental stage.
- **Power and role structures**: Who makes what decisions? Are family members satisfied with how decisions are made and who makes them? What positions and roles do each of the family members fulfill? Is there any role conflict? How are family tasks divided up?
- **Communication:** Family's ability to interact with one another - What languages do you speak at home or with your family members? Are family members able to communicate openly with one another? Is conflict openly expressed and discussed? Do family members respect one another?

ENVIRONMENTAL CONDITIONS

- **Home characteristics:** Type of characteristics of the home - Can you describe your home? Do you own or rent? Do you consider your home adequate for your needs?
- **Community characteristics:** Describe your neighbourhood/community, e.g., rural or urban, schools, recreation, access to healthcare, crime rate, environmental hazards, etc.

FAMILY STRENGTHS

- **Health patterns:** Family's health beliefs, values and behaviours - How does the family assess their present health status? What are your present family health issues?
- **Values:** Family's fundamental ideas, opinions, and assumptions - What values/beliefs does the family have that have assisted them in adapting successfully or unsuccessfully?
- **Coping mechanisms:** Ability to adapt to the life event and maintain emotional well-being and stability of its members - How has the family responded to past life events? What helped the most and the least? What strengths does the family have to assist with their response? Do family members differ in their ways of responding?
- **Problem solving:** Family's ability to organize a life event into manageable components and to identify courses of action to solve it effectively. How has the family resolved problems in the past? What resources have they used?
- **Family Resources and Supports:** Resources the family uses to assist in adapting to the life event – What internal *(inter, intra)* and external *(extra)* resources or supports is your family using?

Examples of General Questions to guide the family assessment and interview (Guideline - pg 45) remain unchanged.

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Citation:
Registered Nurses' Association of Ontario (2006). *Supporting and Strengthening Families Through Expected and Unexpected Life Events.* (rev. suppl.) Toronto, Canada: Registered Nurses' Association of Ontario.

July 2002

Nursing Best Practice Guideline

supporting and strengthening families through expected and unexpected life events

This project is funded by the Ontario Ministry of Health and Long-Term Care

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L'Association des infirmières et infirmiers autorisés de l'Ontario