Enabling professional and personal growth among home care nurses through using the Carer Support Needs Assessment Tool Intervention—An interpretive descriptive study

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Abstract

Aim: To explore nurses' experiences of supporting family caregivers in specialised home care while learning to use the Carer Support Needs Assessment Tool Intervention.

Background: The Carer Support Needs Assessment Tool Intervention can provide guidance for discussions with family caregivers in specialised home care concerning their specific support needs. Little attention has been paid to how nurses experience the use of the intervention in their everyday practice.

Design: This longitudinal study adopted an inductive qualitative approach using interpretive description.

Methods: Interviews were conducted at two time points. A total of 22 interviews took place with 12 nurses recruited from six specialised home care services. Data were analysed using interpretive description.

Results: Nurses' everyday clinical practice changed while learning to use the Carer Support Needs Assessment Tool Intervention, and they experienced professional and personal growth. Their supportive inputs shifted from being reactive towards being more proactive. Their approach changed from taking on great professional responsibility, towards a shared responsibility with family caregivers. The support altered from ad hoc contacts in the hallway, towards scheduled trustful conversations. Nurses were concerned about the amount of time and energy this kind of support might require. They pointed to the importance of holding good nursing skills to conduct this new way of having conversations.

Conclusion: Nurses' everyday clinical practice can be further developed through the use of the Carer Support Needs Assessment Tool Intervention. Nurses may develop both professionally and personally, increasing their ability to provide person-centred support.
1 | INTRODUCTION

Palliative care is often provided at home (Gomes et al., 2013) and trends analysis of European specialised palliative care shows a significant and constant prominent increase in home care services (Arias-Casais et al., 2020). This trend places the family as the unit of care and provides additional inducements for palliative care, which aims to improve the quality of life of both the patient and the family. This involves supporting the family in coping during the patient’s illness (WHO, 2017). In this work, nurses play a key role as they are often those spending most time with the family caregivers, meeting them regularly during the patient’s care (Fitch et al., 2015; Sekse et al., 2018). Studies are needed to better understand nurses’ everyday work in supporting family caregivers.

2 | BACKGROUND

The care of the patient at home is often divided between nurses and family caregivers (Pivodic et al., 2016) and family caregivers are crucial providers of care and support to the patient (Holm et al., 2015; McDonald et al., 2018; Palmer Kelly et al., 2019). Nurses are also in the unique position of being the primary link between the patient, the family caregivers and other professionals in the palliative care team (Fitch et al., 2015; Sekse et al., 2018). Hence, nurses may meet challenges in the complexity of supporting both patients and family caregivers due to their differing needs (Karlsson et al., 2017; Pottle et al., 2020). A scoping review by Wittenberg et al. (2018) showed that nurses often focus on the patient and that few actually address the family caregivers’ situation or needs. Lack of discussions about how to allocate responsibilities with family caregivers and recognition of their role can make family caregivers feel invisible and unappreciated. Such experiences may lead to consequences such as family caregivers withdrawing (Wittenberg et al., 2018).

It is well known that family caregivers report unmet support needs and insufficient knowledge of caregiving (McIlfatrick et al., 2018; Sklenarova et al., 2015). Family caregivers are often the primary caregiver and provide more care and support than other family caregivers (Pinquart & Sörensen, 2011). Nurses play an important role both in helping them to be able to care for the patient and directly supporting the family caregivers, to preserve their own health and well-being (Ewing et al., 2015; Norinder et al., 2021). Still, without knowing the needs of a person, it is difficult to provide personalised and adequate care and support. Nursing interventions related to family caregivers have received growing attention and are shown to have the potential to reduce the negative consequences of caregiving (Ahn et al., 2020; Aoun, Grande, et al., 2015; Becqué et al., 2019; Lund et al., 2020). An intervention that is used in several countries is the Carer Support Needs Assessment Tool Intervention (CSNAT-I) (Cheng et al., 2021; Ewing et al., 2013; Zhou et al., 2021). The intervention is based on a person-centred approach and is uniquely developed to directly assess and address family caregivers’ practical, emotional, existential and social support needs (Ewing et al., 2015).

The CSNAT-I has been shown to be beneficial, providing nurses with guidance and structure for discussions with family caregivers concerning their specific support needs (Aoun, Toye, et al., 2015). The intervention also seems to legitimise nurses’ work in supporting family caregivers as it reinforces nurses’ interest in family caregivers and the importance of them being supported (Ewing et al., 2016). In a recent study (Kisch et al., 2022), family caregivers of patients going through allogenic stem cell transplantation, pointed to the importance of nurses having both competence and experience to
promote valuable conversations. Family caregivers also highlighted that nurses’ professional and personal qualities were of importance to create comfort and confidence. Nurses themselves emphasised the importance of listening and having a humble attitude concerning family caregivers’ life situations (Kisch et al., 2022). However, little attention has been paid to how the intervention affects nurses’ everyday practice and how they relate to family caregivers. Thus, nurses’ experiences of using the CSNAT-I should be further studied.

2.1  |  Aim

The aim was to explore nurses’ experiences of supporting family caregivers in specialised home care while learning to use CSNAT-I.

3  |  METHODS

3.1  |  Study design

This longitudinal study adopted an inductive qualitative approach using interpretive descriptive design: Interviews were conducted at two time points. The design was chosen to enable the acquisition of knowledge regarding nurses’ ways of supporting family caregivers while learning to use a new intervention. The researchers’ theoretical and practical knowledge was used when constructing the study (Thompson Burdine et al., 2021; Thorne, 2016).

3.2  |  The Carer support needs assessment tool intervention (CSNAT-I)

CSNAT-I is designed to assess and address the support needs of family caregivers providing care at home for a person with a life-threatening illness (Ewing et al., 2013; Ewing & Grande, 2013). The intervention comprises two parts, an evidence-based tool (referred to as the CSNAT), which is integrated into a five-stage person-centred process of assessment and support. In the present study, CSNAT version 2 was used (Ewing & Grande, 2013). This version is structured around 14 support domains formulated as questions about the caregiver’s need for more support. Seven questions are about what support the family caregiver needs to be able to care for the patient (enabling support) and seven about what support family caregivers need for their own health and well-being (direct support). In addition, there is an ‘Anything else’ question, which allows the family caregiver to raise any aspect of support required that is not already covered by the existing domains. The domains are broad areas in which family caregivers generally need support as for example, providing personal care, managing symptoms, practical help in the home, dealing with feelings and worries and looking after their own health (Ewing & Grande, 2013). The CSNAT together with the five-stage person-centred process is used in the meetings with family caregivers. In the first stage, the nurse initiates the intervention by introducing the CSNAT (the tool itself) as a conversation starter. In the second stage, the family caregiver considers in their own time what more support they need and self-completes the CSNAT. Once completed, the third stage includes an assessment conversation between the nurse and the family caregiver, focussing on those domains prioritised by the carer for discussion. This stage is vital in unpicking the specific support need(s) the family caregiver has within each prioritised domain being discussed. After this, a fourth stage involves forming a shared action plan based on this needs-led conversation. It is important to ask the family caregiver what type of support they feel would be helpful in addressing their specific needs before offering (or initiating) supportive input. The support can for example be active listening and reassurance, information giving, signposting or referral to other professionals. The agreed supportive input is documented in the shared action plan. The fifth and final stage of the process involves a shared review of the action plan put in place, initiated either by the nurse or the family caregiver (https://csn.org/).

3.3  |  Study context

Data were collected at six specialised home care services in three cities in different parts of Sweden. The services provided care for patients of whom a majority, regardless of diagnosis, had complex care needs and limited survival expectancy. The services provided 24-hours-a-day care, with home visits occurring from once a week to several times a day, depending on each patient’s needs. Services were staffed by intra-professional teams of nurses, physicians, social workers and physical and occupational therapists, with nurses being the largest professional group.

3.4  |  Procedure and participants

The heads of the departments at the care services approved participation after having received written and oral information about the study. They also identified registered nurses at each of the services who were interested in participating. This resulted in a convenience sample of 12 nurses, one to three per service. The interested nurses were all contacted by the researchers who provided them with written information about the study. Next, two of the researchers held a digital video meeting for oral information and opportunity to ask questions with the 12 nurses who all agreed to take part. All were women, aged 28–64 (median = 48) and they had worked in specialised palliative home care between five and 26 years (median = 14). Before the start of the study, none of the researchers had any relation to the participants.

3.4.1  |  CSNAT-I training

The participating nurses completed training, provided by two of the researchers, in order to learn how to use CSNAT-I. The training
was completed before they used the intervention in their meetings with family caregivers. Training consisted of a 30-minute video, which was based on the original CSNAT-I online toolkit (https://csn.org/). Initially, the video presented a short summary of research about family caregivers’ situation. This was followed by a detailed description of CSNAT-I, including the CSNAT, the person-centred process and details of each of the five stages. The video also included reflective questions to facilitate the learning process. When possible, participating nurses working at the same services were encouraged to watch the video together to enable reflective discussions. In addition to the video, nurses were given written information and an accompanying powerpoint presentation with instructions on how to work with the intervention. Open access to all the training materials made it possible for the nurses to repeat the training during the study. Furthermore, digital meetings with one of the researchers (MN) were offered to support the use of CSNAT-I.

3.5 | Data collection

Data were collected through 22 interviews with 12 nurses over a 15-month period between October 2020 and January 2022. To explore potential changes, ten nurses were interviewed twice with the first interview carried out after they had completed CSNAT-I training and the follow-up interview after they had used CSNAT-I at least twice, i.e. with two different family caregivers. Two nurses were, however, interviewed once: One nurse only carried out an initial interview due to sick leave; the other nurse only participated in a follow-up interview, due to the high workload. A study-specific interview guide was used, with open-ended questions, such as ‘How do you usually work to identify and meet family caregivers’ support needs?’ and ‘Describe how you have been working with the CSNAT-I’. The nurses were encouraged to talk about both positive and negative experiences and the interviewer used probing questions to encourage them to elaborate. The structure of the interview guide remained consistent throughout the research process. However, probing questions became more focussed as data collection progressed to help locate the most relevant themes emerging from the data. After each interview, notes were written about areas that needed to be followed up or explored in the subsequent interviews. After 22 conducted interviews, the researchers considered that the data had provided a rich variation of experiences. All the interviews were conducted by the first author (MN), who is a registered nurse with a master’s degree and substantial experience in palliative care. The interviewer therefore strived to manage her preunderstanding during the interviews by carefully listening to what was actually said by the nurses and asking for explanations so that premature interpretation could be avoided. Due to the Covid-19 pandemic, Voice over Internet Protocol (VoIP) technologies (such as Teams) were used for the interviews, lasting between 20 and 80 minutes with a median time of 43 minutes. All interviews were audio recorded.

3.6 | Data analysis

Data collection and analysis occurred concurrently, as interviews were transcribed verbatim after the interview, each interview informing the following in an iterative process (Thompson Burdine et al., 2021; Thorne, 2016). In the first phase of analysis, the first author listened to each of the interviews repeatedly to get a sense of the whole. At the same time, the notes were read and reflected upon to go beyond the immediate impression of what the data contained (Thorne, 2016). Then, questions, close to the study aim, for example, ‘How do the nurses describe their support to the family caregivers?’ were asked of the data, and units of text were extracted and broadly coded. In the third phase, the text was condensed into shorter descriptions of the broad codes. Memos about ideas and preliminary interpretations were documented in the margins of the text. The memos were utilised to support the interpretation of data and themes. During this phase, all the researchers discussed and further condensed the data. In the subsequent interpretive phase, patterns of similarities and variations within the data were identified (Thorne, 2016). The first and last authors grouped together segments of data with similar themes, which were verified by the other authors. Initially, the data were organised into several themes. This phase involved identifying patterns and their inherent variations of nurses’ work in supporting family caregivers. This was carried out for all the interviews and then the analysis moved on to using themes to reflect changes in the nurses’ way of providing support to the family caregivers. As the analysis progressed, the themes merged and a change in support for the family caregivers was identified over time in the final findings. To ensure a developed understanding of the nurses’ experiences, so that no premature closure occurred, the researchers continuously discussed the considered interpretations and alternatives and tested their interpretations, comparing with earlier CSNAT-I findings.

3.7 | Ethical considerations

The study was conducted according to the Declaration of Helsinki (WMA, 2013). Formal approval was granted by the Swedish Ethical Review Authority (No. 2020-00133, 2021-01935). Written and oral study information emphasised the voluntary nature of participation and the right to withdraw from the study at any time. All nurses gave their written informed consent prior to participation. To protect participants’ confidentiality, none of the records, including interview transcripts, noted their names or other identifiers. All findings were presented anonymously, and data access was limited to the core members of the research team.

3.8 | Rigour

Attention to rigour is critical in interpretative description and the influence of bias must be acknowledged (Thompson Burdine
et al., 2021). All the researchers, five females and one male, of whom five are registered nurses and one is a psychologist. The first and last researchers have experiences of clinical specialised home care both of which are considered a strength when using interpretative description but can also be an obstacle to open-mindedness. To prevent bias the co-authors validated the analysis by reading transcripts and participating in discussions about coding and themes. The researchers strived to have a reflexive approach during the process by maintaining an open dialogue and reflecting on the research process.

4 | FINDINGS

The findings revealed that nurses’ experienced changes in their way of supporting family caregivers while learning to use the CSNAT Intervention (CSNAT-I). These changes are presented in three themes: (1) From reactive towards proactive support, (2) From professional responsibility towards a shared responsibility, (3) From ad hoc contacts in the hallway towards scheduled trustful conversations. In the analyses, an overarching theme emerged illustrating professional and personal growth for the participating nurses during the study period (Figure 1). While learning and using CSNAT-I, nurses felt that they developed in their professional role. They felt more secure in relation to family caregivers and by using the CSNAT-I they enabled a partnership between themselves and the family caregivers. Through this new approach, nurses felt safe in taking a step back from being the ‘expert’ in this partnership. It became clearer through the intervention that the family caregivers possessed a significant capacity and contributed a lot of knowledge related to the caregiver situation. The nurses also experienced personal growth as they were invited to take part in various experiences and life stories. They learned about life through active listening and reflecting with the family caregivers.

![FIGURE 1 An illustration of changes in nurses’ way of supporting family caregivers while learning to use the CSNAT Intervention](image)

4.1 | From reactive towards proactive support

While the nurses reflected upon their previous work in supporting family caregivers it was clear that they experienced several challenges. They identified family caregivers’ needs late in the patients’ care process, often at the end of life. Commonly, this was when the family caregivers already found the situation overwhelming and too difficult to handle alone.

‘In the end, when death is approaching, we advise them to take care of themselves and for example, not forget to eat. But earlier in the patient’s illness trajectory, we tend to focus less explicitly on the family caregiver’s needs’.

Nurses expressed that their supportive inputs were provided when the family caregivers in various ways actively signalled that they needed help. They felt a need for a new way of working that could help them to provide adequate support before the family caregivers were completely exhausted.

After having completed CSNAT-I training, nurses believed that the intervention could help them to provide support earlier in the patient’s illness trajectory. Hence, they thought supporting family caregivers could become more naturally incorporated and visible in their work.

‘We do not get to know about family caregivers if we do not sit down and have more comprehensive conversations. Earlier, we did not have a tool for that. It has not been available’.

However, nurses were concerned about the amount of time this kind of support might require.

‘I think it might take more time than you have. Will we be able to prioritise it? That is the biggest challenge—time’.

Despite these concerns, they hoped that CSNAT-I would help them to provide more targeted supportive input according to the needs of each of the family caregivers. Nurses reasoned that adequate and proactive support could actually be timesaving in the end. They considered that by using the intervention they would be able to provide support equitably, more easily and at the right time to all. In their previous experiences, those family caregivers who did not clearly express their needs could be left without support. CSNAT-I also facilitated getting to know family caregivers more closely and already beforehand talk about what might happen and what support might be needed in the future instead of handling needs as they arose. With a proactive approach, nurses could also get to know about for example earlier experiences of illness or losses in life that might be relevant to the family caregivers’ experiences and needs during the present care period.
Nurses reflected on the need for continuity in the contact with family caregivers to enable a trusting relationship. They believed that it was the nurse who had the primary responsibility for the patient’s care who should use CSNAT-I, being the one who most frequently visited the patient at home, thus facilitating a proactive approach. Nurses did, however, identify some organisational challenges in providing proactive support. They experienced it difficult, in terms of time, to complete the intervention with the family caregivers as many patients received their care for only a short period of time before they died. There were also patients who still had a lot of treatments at the oncology ward and commuting between the care services, resulting in the family caregivers not feeling they had time for the intervention.

4.2 From a professional towards a shared responsibility

When the nurses reflected on their prior and current work regarding the support of family caregivers, they talked about their responsibility due to their own professional expert role. They expressed that they felt primarily responsible for acknowledging and identifying support needs.

‘It is in our professional role to assess what needs family caregivers have as we meet them most often and develop close relationships’.

The nurses reflected that as a consequence of this professionally led approach, the family caregiver became more of a bystander to his/her own support needs and was not always given the opportunity to express what was most important for them. A combination of the individual nurse’s professional experience and nursing skills and the family caregivers’ ability to communicate their needs was crucial in identifying and meeting support needs. As the nurses’ experienced great professional responsibility in supporting family caregivers, they also expressed the risk of feeling overstrained when not having the time or ability to acknowledge and meet the needs. Nurses expressed that lack of routines for structured ways of working added to feeling overstrained and they also felt that much was demanded of them.

‘It’s not always possible to identify different needs. You don’t always pick up on them .... That’s why it’s difficult to capture. It’s probably something you can work more with. Even though you have long experience, you may need more tools to identify it, so to speak’.

There were impediments to the proper identification and assessment of the family caregivers’ support needs that could delay access to appropriate supportive input. The nurses tried to compensate for this by using their own individual skills and intuition to identify the family caregivers’ needs.

Nurses felt especially challenged at times when it was obvious that family caregivers were burdened, stressed and in need of both direct and enabling support but still avoided actively reaching out for help.

‘It’s difficult when you can see that they’re having a hard time but they neither tell us nor try to make contact with us’.

However, nurses appreciated that the CSNAT-I seemed to ease their responsibility as it helped the family caregivers identify their support needs. Instead of making assumptions based on their nursing experiences they could discuss support needs and input based on the family caregivers’ own expert knowledge of their current situation.

‘It is usually our assessments that determine and guide the care and support that we provide. With the intervention the support becomes person-centred’.

Nurses emphasised that family caregivers often do not see themselves as being the focus of attention, which further highlights the importance of giving them time and opportunities to show and express their needs.

‘My overall experience with family caregivers, when I come to a home, is that they usually do not take an active part and talk about their own situation. So, you must ask about that. They don’t expect to receive support as it is the patient who has all the needs, and this is where the focus lies’.

With CSNAT-I they found a way to assess the family caregivers’ specific needs and together with them they could also plan what further supportive input would be beneficial. Also, when using the intervention, nurses sometimes met family caregivers who expressed having no support needs at the moment. When this occurred, nurses tried to encourage them to talk freely about their needs; however, they did not always want to talk or could not find ways to talk. Nurses had difficulties accepting this and it was perceived as challenging to handle as they needed to bracket their own thoughts since their professional experience told them that there were existing support needs.

4.3 From ad hoc contacts in the hallway towards scheduled trustful conversations

Before CSNAT-I, nurses used to liaise with family caregivers when visiting the patient at home. Contact usually occurred after they had finished the nursing activities as required for the patient. Consequently, the most important conversations were commonly initiated standing in the hallway when the nurse was on their way to the next visit. Nurses did not, however, feel satisfied meeting briefly with family caregivers and in passing, and therefore strove...
to create opportunities for them to talk about their situation and any needs they had for support. Nurses put extra effort into those who avoided them; however, this was often difficult to manage as they had difficulties in finding the time or privacy for a conversation. They most often ended up with ad hoc meetings.

‘Sometimes they express that they need to talk, look tired or that you know that the patient is deteriorating. Some avoid us when we arrive, so then you may have to go after them and ask how they are. So that there’s not just talk in the hallway’.

In comparison to their earlier work, the nurses experienced that the use of CSNAT-I contributed to scheduled appointments with family caregivers, either at their home or at the care service, depending on what the family caregivers preferred. Nurses then used various strategies to create a trustful environment that enabled the family caregivers to reflect and express their needs. One strategy was to sit with the family caregiver when he or she went through the questions in the CSNAT systematically, one by one.

‘I asked them to look at the questions and tell me what needs they have or what they find difficult. I listened actively, let them do the assessment and prioritise. Then we talked about the questions that were most important and what support they need and where I can contribute’.

Another strategy used was to not focus so much on strictly following the assessment. Most important was to find ways that enabled family caregivers to talk about their situation. To ensure that the questions were understood correctly, nurses used various kinds of clarifications. This was for example done by reformulating the question or helping the family caregivers to shift from the patients’ needs to their own. To build trust and help them reflect on their own needs, nurses used probing questions, active listening and silence.

‘He talked, and I listened a lot and asked questions when I felt it was important. Then I felt that there was something more and tried to work with silence and after a while he began to talk about lost intimacy during his wife’s illness’.

The nurses also used open-ended questions, acted as sounding boards for the family caregivers’ reflections and also tried to summarise at the end of the conversations what had been talked about. Even though nurses welcomed the scheduled conversations they were sometimes experienced as both energy- and time-consuming. Nurses reflected on this as being a possible future barrier as not all nurses may want to make an effort or be interested in learning new interventions. They also spoke about how the new way of having conversations required a great deal of professionalism and nursing skills.

‘It’s very revealing for us too, so it requires that we are professionals when we do it so that we don’t cause any damage’.

The nurses experienced, unlike their previous work, that CSNAT-I helped them to be truly present in their meetings with family caregivers, thanks to the already formulated questions in the CSNAT. In addition, the questions helped them address support needs that they normally did not discuss. To increase feelings of safety, the nurses strove to be flexible concerning the family caregivers’ wishes about how to conduct the conversation. The nurses experienced that the conversations created trusting relationships, but this could also be draining.

‘The information I receive is obviously beneficial to my work. However, the conversations affect me emotionally. I’ve been extremely tired after conversations, but they were also satisfying as you get to know about many human destinies, and it affects you’.

Nurses experienced that the trustful conversations provided a deeper knowledge of the family caregivers’ situation, giving them valuable information, both in supporting the family caregivers’ but also concerning the patients’ care.

5  |  DISCUSSION

This study adds to the limited research on the use of CSNAT-I in nurses’ everyday practice. The findings show that the nurses’ experience of supporting family caregivers changed while learning to use the CSNAT-I. They developed their professional skills and experienced personal growth. Their assessments and supportive input for family caregivers shifted from being reactive, often informal and unstructured, towards being more proactive. Their own approach changed from taking on great professional responsibility to identify both support needs and inputs, towards a more collaborative approach with responsibility shared between them and the family caregivers. The support altered from ad hoc contacts in the hallway, often in passing, towards scheduled trustful conversations.

Nurses in the present study experienced that CSNAT-I facilitated proactive support according to the family caregivers’ own needs, which also enabled them to prepare family caregivers for what might come. This is in line with previous research, which found that nurses experienced that CSNAT-I, when delivered close to admission to palliative care, helped family caregivers avoid stressors that would not have surfaced until later in the care trajectory and they could in this way prevent stressful situations before they occurred (Aoun, Toye, et al., 2015). Already in the validation process of the CSNAT, it was found that the domains included in the tool clearly correlated with preparedness for caregiving (Alvariza et al., 2018; Ewing et al., 2013; Zhou et al., 2021). Preparedness has been described as perceived readiness to manage various aspects of the caregiving role, including
the provision of physical care and emotional support, the planning of care and the stressors of caregiving (Archbold et al., 1990; Mason & Hodkin, 2019). Nurses in the present study specifically felt that the CSNAT (the tool itself) helped them in working proactively as it gave the family caregivers visibility of common support needs, acting as a prompt, which could help them to reflect and prepare for future situations. This may be a contributing factor to why CSNAT-I has also been found to have a positive impact on family caregiver stress and allowed the nurse to reflect and prepare for further situations, which may be a contributing factor to why CSNAT-I has also been found to have a positive impact on family caregiver stress. In a study by Skorpen Tarberg et al. (2020), nurses highlighted the importance of early contact and communication with patients and families as this can facilitate a good relationship later on in the care. Also emphasised, was working proactively and person-centred as that could prevent situations where decisions must be made quickly when patients and family caregivers may not be prepared.

Nurses in the present study experienced that CSNAT-I contributed to a shared responsibility between them and the family caregivers. CSNAT-I requires that nurses take a step back from their expert role to enable a change from a professionally led approach to a family caregiver-led approach facilitating person-centred care. This approach should enable family caregivers themselves to identify and reflect on their support needs and what supportive input they would find helpful (Ewing et al., 2015). In an earlier CSNAT-I trial it was shown that the majority of the forty-four participating nurses felt comfortable using a family caregiver-led approach in everyday practice (Aoun, Toye, et al., 2015). However, in studies by both Austin (2014) and Horseman et al. (2019), the CSNAT-I was used as an add-on to existing practice rather than taking a person-led approach, i.e. there were no changes in nurses’ approach in interacting with family caregivers. Instead of integrating the CSNAT (tool) within CSNAT-I, nurses described how they used the CSNAT at the end of their assessment conversations to identify any issues that had not already been covered.

In the present study, nurses experienced that CSNAT-I provided increased opportunities to pay attention to each of the family caregivers’ narratives and to identify what was important to them. Family caregivers have earlier expressed feeling increased self-confidence and comfort, belonging to the team, when nurses engage them in conversations with an open mind and show that they care. By getting time and personalised information from the nurse, they have also described feeling respected, supported and involved in the care process (Ellington et al., 2018). In person-centred care, the nurse should recognise the other person as unique, form meaningful partnerships, open a space for involving and engaging with the person, and allow them to control their care (Byrne et al., 2020). The person’s narrative is the starting point and lays the ground for the partnership in care and indisputably sets out the person’s views about his/her life situation and always places them in the centre. The healthcare professional takes into account who the person is by considering their context, history and social relationships, as well as their strengths and weaknesses. In order to create a common understanding, narrative communication is important and involves sharing experiences and learning from each other (Ekman et al., 2011). This also becomes important with the family caregivers as they are essential for the care provided at home (Khan et al., 2014).

In the present study, as in earlier studies (Ewing & Grande, 2013; Horseman et al., 2019), CSNAT-I replaced the previous informal conversations with scheduled conversations, which gave the nurses a greater opportunity to provide family caregivers with space and time to reflect on their needs. Both Ewing et al. (2016) and Aoun, Toye, et al. (2015) found that CSNAT-I enabled engagement and space for family caregivers, which helped them to express their needs. More specifically, family caregivers felt they were empowered to ask for help and that their own needs were legitimised as separate from those of the patient (Aoun, Deas, et al., 2015). In the present study, the nurses used various strategies during the assessment conversation, enabling family caregivers to freely talk about their support needs. Strategies are often planned in advance and developed consciously and purposefully (Mintzberg, 1987). The use of strategies has earlier been studied in the context of palliative care nursing. Alvariza et al. (2020) describe how nurses consciously kept an open mind, aware of the significance of showing respect and adjusting to patients and family caregivers. In the present study, nurses adjusted their way of conducting CSNAT-I conversations through strategies such as silence and active listening. By focussing on the CSNAT together with the family caregivers, nurses could more easily manage silence and await family caregivers’ inner reflections. Silence has been described as a complex phenomenon, with implications on how to ‘be with’ another in the final acts of living. It is a powerful and helpful form of communication and a compassionate, supportive partnership. It is person-centred and can contribute to meaning when there are no easy answers. However, healthcare professionals need to be comfortable with silence themselves to be effective with the art of silence (Reid, 2022). Providing time for silence can allow for space and time to connect with thoughts and feelings. Time may be required for fully understanding and moving forward in the best way and finding the courage to continue discussions. In the present study, the CSNAT facilitated the nurses to focus on what family caregivers really talked about. Active listening skills have been described as paramount in palliative care. To give full attention and listen empathetically can provide opportunities for persons to express themselves (Gravier et al., 2019).

Nurses in the present study experienced that the CSNAT-I facilitated for them to be truly present in their meetings with family caregivers and to address each and one’s support needs. This is in line with what Dobrina et al. (2014) found when they identified ten core concepts when reviewing existing palliative care nursing theories. Two of the recurring core concepts were ‘presence’ and ‘uniqueness’. To work in accordance with these concepts, the nurse has to have a genuine desire to be present and focussed in the caring moment. It is important that the nurse finds space to be there for the other person both in time and physically, and to treat each person as unique with different needs, hopes, values and preferences. A third core concept described by Dobrina et al. (2014) is ‘Existential growth’, which may occur when the nurse guides a person in the exploration of understanding of the dying process, which has the potential of also
increasing the nurse’s own understanding of life and death and the meaning of their work, providing personal satisfaction. These core concepts are congruent with palliative care philosophy and emphasize person-centred care.

6 | STRENGTHS AND LIMITATIONS

A strength of the study was the use of repeated interviews that allowed both researchers and nurses to reflect between interviews with the possibility of follow-up on previously mentioned aspects of supporting family caregivers, which contributed to the richness of the dataset. Moreover, both the first and last authors have substantial experience in clinical palliative care, and all authors have significant preunderstanding of the CSNAT-I. This may be considered a strength when using interpretive description as it could improve the interpretation of the data. However, this could also be a risk that might affect the trustworthiness of the findings. To manage the remaining bias, an open dialogue was conducted between co-authors and through reflecting on the research process, data analysis and interpretation (Thompson Burdine et al., 2021).

There are also other limitations that warrant discussion. The majority of interviews were held via VoIP and two were held by telephone. This was necessary as the Covid-19 pandemic made physical meetings impossible. During these interviews, some information, for example, body language, was more difficult to perceive and could have been missed. However, as VoIP provides both voice and video in real time, it gives an opportunity to talk to otherwise inaccessible participants and works well as a complimentary data collection tool for qualitative researchers (Lo Iacono et al., 2016).

Another limitation was that the home care services, due to the Covid-19 pandemic, could participate with fewer nurses than first expected. Thus, only nurses with good knowledge and long experience in palliative care as well as a special interest in family caregivers were included. This may affect the transferability of the findings even though the focus of interpretative description is to gain a deeper understanding of the participant’s perspective (Thompson Burdine et al., 2021). Still, the findings contribute to increased knowledge of the participating nurses’ individual experiences of supporting family caregivers while learning to use CSNAT-I.

During this study process, a third version of the CSNAT was developed, adding a domain about relationships (Ewing et al., 2020). This additional domain may be reflective of support needs arising from prolonged intensive caregiving, which potentially expands its use to other patient populations. The findings of the present study therefore may be somewhat limited as the relationship domain was not included in the CSNAT version 2.

7 | CONCLUSION

The findings show that nurses' everyday clinical practice in relation to supporting family caregivers can further develop through training and the use of the CSNAT-I. Altogether, the findings suggest that nurses felt more secure in working in collaboration with family caregivers after learning the CSNAT-I and their support became more person-centred.

8 | RELEVANCE TO CLINICAL PRACTICE

Nurses play a key role in supporting family caregivers; thus, it is important for them to find ways that have the potential to guide and structure their work. By using the CSNAT-I, nurses may create trusting conversations with family caregivers of patients with life-threatening illnesses cared for in specialised home care. Further practice and research might result in future recommendations for nurses about how to work with the CSNAT-I. It seems that being flexible in both timing and structure for delivering may be of importance to further explore. The CSNAT-I can contribute to professional and personal growth among nurses, increasing their ability to provide person-centred support in everyday clinical practice.

AUTHOR CONTRIBUTIONS

Maria Norinder has made substantial contributions to the conception and design, acquisition of data, analysis and interpretation of data. Anette Alvariza has made substantial contributions to the conception and design, data analysis and interpretation of data. All authors had been involved in drafting the manuscript and revising it critically for important intellectual content and given final approval of the version to be published.

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CONFLICT OF INTEREST

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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**SUPPORTING INFORMATION**

Additional supporting information can be found online in the Supporting Information section at the end of this article.