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EVITAMENTO DO ENFERMEIRO AO PROCESSO DE CAPACITAÇÃO DO CUIDADOR INFORMAL: PERSPETIVAS SOBRE OS FATORES CONDICIONANTES

NURSES` AVOIDANCE OF THE CAREGIVER EMPOWERMENT PROCESS: PERSPECTIVES ON CONDITIONING FACTORS

EVITACIÓN ENFERMERA DEL PROCESO DE EMPODERAMIENTO DEL CUIDADOR: PERSPECTIVAS SOBRE LOS FACTORES CONDICIONANTES

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RESUMO

Introdução: Nos contextos clínicos verifica-se que as práticas de enfermagem estão mais centradas na pessoa dependente do que no cuidador, o que pode estar relacionado com a complexidade do processo de capacitação do cuidador informal.
Objetivo: Explorar e conhecer o fenómeno do evitamento dos enfermeiros à capacitação do cuidador informal, com identificação dos fatores subjacentes.
Métodos: Estudo exploratório e descritivo, com abordagem qualitativa. Foram realizadas entrevistas semiestruturadas a 9 enfermeiros de um hospital central de Portugal e após transcrição, efetuada a análise de conteúdo segundo Bardin e apoio do NVivo10®. Cumpridos os pressupostos éticos e obtido parecer favorável da comissão de ética.
Resultados: Emergiram três unidades temáticas com as respetivas categorias e subcategorias: reconhecimento do fenómeno (2 categorias); fatores intrínsecos que condicionam a capacitação do cuidador (4 categorias e 2 subcategorias); e fatores extrínsecos (6 categorias e 6 subcategorias).
Conclusão: É necessária uma abordagem abrangente na preparação do cuidador informal, tendo por base a formação dos enfermeiros, a identificação e avaliação das suas necessidades, a implementação/gestão de cuidados e o planeamento da alta. Deve haver também um compromisso das organizações de saúde e de toda a comunidade na criação de condições para que se consiga uma transição saudável e segura.

Palavras-chave: cuidado centrado na pessoa; cuidados de enfermagem; planeamento da alta; cuidador informal; transições

ABSTRACT

Introduction: In clinical settings, nursing practices are more focused on the dependent person than on the caregiver, which may be related to the complexity of the informal caregiver training process.
Objective: To explore and understand the phenomenon of nurses' avoidance of the informal caregiver training process and identify the underlying factors.
Methods: This is an exploratory and descriptive study with a qualitative approach. Semi-structured interviews were carried out with nine nurses from a central hospital in Portugal. After transcription, content analysis was performed according to Bardin using the NVivo10® software. Ethical requirements were met, and a favorable opinion was obtained from the ethics committee.
Results: Three thematic units emerged that were organized into categories and subcategories: Recognition of the phenomenon (2 categories); Intrinsic factors that condition nurses in training informal caregivers (4 categories and 2 subcategories); and Extrinsic factors that condition nurses in training informal caregivers (6 categories and 6 subcategories).
Conclusion: A comprehensive approach is needed to preparing caregivers, from training nurses to identify and assess caregivers' needs to coordinating and managing the therapeutic regime and planning for discharge. Healthcare organizations and communities should commit to creating the conditions for caregivers to achieve a healthy and safe transition.

Keywords: patient-centered care; nursing care; patient discharge; informal caregivers; transitions

RESUMEN

Introducción: En contextos clínicos, las prácticas de enfermería se centran más en la persona dependiente que en el cuidador, lo que puede estar relacionado con la complejidad del proceso de empoderamiento del cuidador.
Objetivo: Explorar y comprender el fenómeno de la evitación del empoderamiento del cuidador por parte de las enfermeras, identificando los factores subyacentes.
Métodos: Se trata de un estudio exploratorio y descriptivo con enfoque cualitativo. Se realizaron entrevistas semiestructuradas a 9 enfermeras de un hospital central y tras su transcripción, se llevó a cabo el análisis de contenido según Bardin con el apoyo de NVivo10®. Se cumplieron los requisitos éticos y se obtuvo el dictamen favorable del comité de ética.
Resultados: Surgieron tres unidades temáticas con sus respectivas categorías y subcategorías: reconocimiento del fenómeno (2 categorías); factores intrínsecos que condicionan la capacitación del cuidador (4 categorías y 2 subcategorías); y factores (6 categorías y 6 subcategorías).
Conclusión: Es necesario un enfoque integral para preparar al cuidador, que abarque desde la formación del personal de enfermería en la identificación y evaluación de las necesidades del cuidador, hasta la conciliación y gestión del régimen terapéutico y la planificación del alta. También debe existir un compromiso por parte de las organizaciones sanitarias y de toda la comunidad para crear las condiciones necesarias para que el cuidador logre una transición saludable y segura.

Palabras Clave: atención dirigida al paciente; atención de enfermería; alta del paciente; cuidador informal; transiciones

INTRODUCTION

Informal caregivers are people who provide unpaid care to someone with a chronic illness, disability, or other health or long-term care need outside of a professional or formal setting, ensuring 80% of the care provided in Europe (Eurocarers, 2023).

Eurocarers (2023) reports that there were around 58 million informal caregivers in Europe in 2022. However, the European Union's Knowledge Centre on Gender Equality's unofficial figures point to a much higher number and growing needs due to the global increase in life expectancy and demographic ageing, which increases the incidence of chronic illnesses. This situation is exacerbated by the growing demand for care in all age groups, as well as the need for new skills and competencies related to new standards of care and the introduction of new technologies.

Informal caregivers have become increasingly important in healthcare. Quality care provision requires integrating the informal caregiver as a decision-maker, adopting a philosophy that prioritizes the needs of both patients and informal caregivers, who are experiencing transitions that can be facilitated by nurses' interventions (Marques, 2015). These professionals are a significant resource in helping dependent people, whose support can be provided either through the development of patients' skills or the development of family members' ability to assume the role of caregivers (Petronilho, 2013).

The informal caregiver's training process is complex, leading to changes in family dynamics that are often underestimated by health professionals and have harmful consequences. There is evidence that the informal caregivers' training process is avoided. In the study by Nunes et al. (2022), the training process is perceived as complex and avoided by both caregivers and nurses.

1. THEORETICAL FRAMEWORK

Health policies focus on patients, with family caregivers and their needs being overlooked. Education programs for caregivers should be an integral part of health policies, particularly in intervention strategies, but there are still gaps in the responses of the Portuguese health system (Fernandes, 2014).

In this context, Marques (2015) recognizes some weaknesses in the interventions that nurses can put into practice. Studies conducted in hospitals show that informal caregivers are inadequately prepared for the return home (Dixe & Querido, 2020; Petronilho, 2007).

Nunes et al. (2022) highlight the complexity of this training process and the importance of nurses providing caregivers with opportunities to manage knowledge so that they feel more competent, autonomous, and confident in responding to their family member's needs. According to these authors, continuity and systematization are essential elements of the caregiver training process because they help caregivers to provide care of greater or lesser complexity. Nurses should provide caregivers with tools, train them, and negotiate interventions for them to carry out their role.

Informal caregivers of people dependent for self-care who have been more involved and received more information to care for their family members have lower levels of burnout and a better opinion of their performance, which reinforces the importance of preparing informal caregivers throughout hospitalization (Dixe & Querido, 2020).

The research carried out by Marques (2015) examined the perspective of informal caregivers of people with stroke on their training led by nurses. Informal caregivers reported that their needs, abilities, previous experiences, and motivation were not taken into account during this process. They considered nursing teaching to be very important, but insufficient. They reported that teaching involved mainly instrumental care and the methodology used varied from nurse to nurse and did not consider the caregivers' specific abilities. The "understanding and availability" of the nurses described by the caregivers matched the core competencies for the teaching-learning process. However, contrary attitudes, such as "haste and lack of interest", were also found. This study shows that nurses and caregivers have different perspectives of the caregiver training process.

In order to effectively train informal caregivers, nurses must engage in systematic work and demonstrate availability and proximity. However, there is a tendency to avoid this process, prioritizing more practical tasks focused on the dependent individual (Nunes et al., 2022; Petronilho, 2007).

Given the lack of clarity surrounding the phenomenon of nurses avoiding informal caregivers' training, it is essential to investigate this issue further. Therefore, this study aimed to explore and understand the phenomenon of nurses' avoidance of training informal caregivers and identify the underlying factors.

To this end, the following research questions will be addressed:

- What are nurses' perceptions of avoidance of the informal caregiver training process?
- What factors condition nurses' avoidance of the informal caregiver training process?

2. METHODS

A qualitative exploratory study was conducted at a central hospital in central Portugal. Participants were selected based on their expertise in nursing information and documentation systems and clinical practice. The aim was to identify individuals with a critical and comprehensive understanding of the phenomenon under study.

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Participants were contacted beforehand to explain the project and research objectives and to obtain written informed consent. On the agreed day, in-person semi-structured interviews were conducted by two researchers, using a script. Each interview lasted on average 45 minutes. They were audio recorded and then transcribed verbatim.
Theoretical data saturation was achieved after nine interviews. Data were analyzed according to Bardin's (2028) content analysis method using NVivo 10® software.
All ethical assumptions were met, and a favorable opinion was obtained from the Ethics Committee of the Hospital Center where the study was carried out.

3. RESULTS

Three thematic units emerged from the analysis of the empirical material: a) Recognition of the phenomenon; b) Intrinsic factors that condition nurses in training informal caregivers; c) Extrinsic factors that condition nurses in training informal caregivers. Table 1 summarizes the interviews in these three thematic units with their categories and subcategories.

Table 1- Synthesis of the interviews organized into thematic units, categories, and subcategories

THEMATIC UNITS	CATEGORIES	SUBCATEGORIES
Recognition of the phenomenon	Validation of the phenomenon Non-validation of the phenomenon	
Intrinsic factors	Lack of conceptual knowledge clarifying nurses' social mandate	More focus on the patient than on the family Lack of information during patient handovers
	Lack of relational skills	
	Avoidance of the informal caregiver's physical presence	
	Assumptions about the informal caregiver without prior assessment	
Extrinsic factors	Limitations of the information system	
	Concern with the outcome rather than the process	
	Devaluation of this area by the organization and managers	
	Methodology for organizing nursing care	Lack of knowledge of the patient and family Lack of responsibility in identifying the informal caregiver Difficulty in identifying the informal caregiver
	Organization of the healthcare team for the provision of care	Lack of process initiation Doctor-nurse coordination at discharge Medical pressure to discharge patients
	Lack of suitable accommodation	

Recognition of the phenomenon

The first thematic unit is 'Recognition of the phenomenon'. Nurses' statements reveal that they validate the phenomenon: "Nurses avoid training a lot" (I1)" "We often neglect this aspect until the end of hospitalization, thinking that people will respond, but it's an outcome, it's not a process" (I1); "I also try to avoid it" (I3) and "Only when it's almost time for the patient to go home, I get the feeling that it's done almost at the last minute, if no one has done it yet, someone else will have to do it and it will probably be me" (I3).
Nurses who work in units that organize care based on the 'Reference Nurse' (*Enfermeiro de Referência*) method do not validate the phenomenon of avoidance, even revealing difficulty in understanding it and requiring a detailed explanation: "Implementing the 'reference nurse' care methodology, which allows identifying the care provider immediately and having a different perspective" (I6); "As for whether or not there is avoidance, I don't think there is avoidance. I think there are (...) limitations and barriers that need to be worked on" (I8).
The before and after the implementation of the 'Reference Nurse' methodology:
Ok, ok, but in the past, (...) no one was actually responsible for identifying the caregiver, and now this concern exists. Now there is a more targeted and intentional concern to identify who is going to provide continuity of care for that person (I6).
The nurses' narratives made it possible to identify reasons behind their avoidance of training informal caregivers, which were divided into two thematic units: intrinsic factors and extrinsic factors.

Intrinsic factors that condition nurses in training informal caregivers

The intrinsic factors are divided into four categories and their subcategories: Lack of conceptual knowledge clarifying nurses' social mandate (More focus on the patient than on the family and Lack of information during patient handovers); Lack of relational skills; Avoidance of the informal caregiver's physical presence; Assumptions about the informal caregiver without prior assessment.

The participants reported that there is a lack of preparation and conceptual knowledge clarifying nurses' social mandate: "The assessment of the family process using the Calgary Model (...) is not actually used, analyzed, or translated into objective interventions" (I1). The lack of knowledge about theoretical models results in a lack of clarity regarding the expectations placed on nurses, which in turn leads to a devaluation of autonomy and difficulties in making decisions and managing complex diagnoses and documentation: "...nurses hardly (...) see themselves as decision-makers (...), whether in an initial diagnostic approach to the family's main problems or in identifying the real capacities of the person who will take on the caregiver's role" (I1). The participants also believe that the inability to manage time dedicated to care management is a consequence of the devaluation of the nurse's social mandate, which then impacts therapeutic intentionality: "We weren't able to (...) develop the necessary conditions so that (...) we could plan the introduction of a moment to direct attention to this potential caregiver" (I1).

Additional subcategories include 'More focus on the patient than on the family', illustrated by the statement "...I'm always very focused (...) on medication, hygiene, patient lifting, routines" (I3), which are to be developed with the patient, while "preparing a provider is secondary". (I3). Another subcategory is 'Lack of information during patient handovers', and the failure to guarantee continuity of care further weakens the process. The following transcripts illustrate this subcategory: "The difficulties I feel are the continuity itself, the patient handovers, the importance of some aspects that are then devalued" (I1); and "the person who arrives today sometimes no longer knows how well that family is prepared, the aspects that have already been addressed" (I4).

The interviewees believed that the "lack of relational skills" hinders involvement and favors distancing between the nurse and the informal caregiver: "Relational skills are necessary, they are very important when working with the caregiver" (I9).

The interviewees also reported that nurses find it difficult to deal with the caregiver's physical presence and avoid it because they feel uncomfortable. They are afraid of being observed and evaluated: "We often ignore them, we don't cope well with their presence, we avoid them" (I1);

...nurses are afraid or ashamed, that's why I say it's more comfortable, or fear being judged, and I even think that maybe many negative ideas family members have of nurses are because we don't show what we're doing (I3).

Nurses make several assumptions that make them avoid training informal caregivers. They often assume that the caregiver already has the knowledge without prior assessment, "we often think 'oh, but he was already at home', we don't explore it, he was at home, but under what conditions?" (I4). Other times, they assume that the caregiver will not accept the role, "This happens sometimes, it probably has to do with the family's acceptance, I believe it varies a lot." (I2) or will not be able to assume it:

...they are older people looking after older people, which is another difficulty. What am I going to teach? What can I do in this situation? I can help the person make good decisions, that's all, and mobilize the community's resources well because we cannot expect that a person who already needs help... they mustn't lose that role if it's a role that the person wants to play and that the patient also expects from them, but it's not easy... (I7).

Extrinsic factors that condition nurses in training the informal caregiver

The extrinsic factors that condition nurses in training the informal caregiver are divided into six categories: Limitations of the information system; Concern with the outcome rather than the process; Devaluation of this area by the organization and managers; Methodology for organizing nursing care; Organization of the healthcare team for the provision of care; and Lack of accommodation conditions.

As for the 'Limitations of the information system' category, the participants consider that the nursing information and documentation system in use at the institution does not meet the requirements for adequate documentation of the informal caregiver training process, specifically in interventions related to teaching and training, where they do not seem to be properly considered: "...it may not facilitate teaching and training or help nurses clarify and list aspects that made sense and make sense to put on the table..." (I9); and "Decision-making is complex, and I don't think it's actually translated into the information systems" (I1).

The category related to nurses' concern with the outcome rather than the process was also found to hinder the caregiver training process: "We base our practice a lot on outcomes, and we're not concerned with understanding the processes that will lead to those outcomes" (I1).

Another category that emerged from this analysis was the lack of value placed on this area of care by the organization and nursing managers. For the participants, the work carried out in this area is not valued, resulting in a methodological and organizational plan that does not include the time needed for this process: "From a methodological and care organization point of view, institutions don't plan and provide conditions for nurses to effectively identify and develop this role" (I1); "Lack of strategy ... from managers" (I9); and "decision in terms of patient distribution, distribution of care hours" (I9).

This lack of importance is reflected in the 'inadequate staffing', both in terms of quantity and quality, as the following excerpts show: "regarding staffing, clinical settings clearly don't always have adequate staffing, either in terms of quantity or quality" (I1); and "we obviously need to have more nurses in some settings where patient autonomy really has a huge impact, in other words, it's very low" (I3).

The 'Methodology for organizing nursing care' category is related to the operational management of resources, as exemplified by the following excerpts: "The methodology for organizing care almost leads to a lack of responsibility in identifying this role" (I1); "We end up being responsible for a patient for 8 hours, but we are not responsible for the patient during the hospital stay, in other words, we are not the reference nurse..." (I3); and "The work is organized according to the professionals' needs" (I7).

The following subcategories emerged from the previous category: 'Lack of knowledge of the patient and family'; 'Lack of responsibility in identifying the informal caregiver'; and 'Difficulty in identifying the informal caregiver'.

Regarding the 'Lack of knowledge of the patient and family' subcategory as a limiting factor in the adequate training of informal caregivers, the participants stated that:

You have to know a lot about a person's needs (...), I can be with a patient in the afternoon and not know what they need in terms of self-care, hygiene, or going to the toilet, so how can I prepare and talk to the caregiver about what's going to happen when I don't even know this person (...), now that I'm here, I'm going to prepare them? That's also difficult (I9).

As for the 'Lack of responsibility in identifying the caregiver' subcategory, the participants reported that this lack of responsibility allows nurses to shirk this role, as the following statements illustrate: "Everyone runs away from this and in the patient handover we highlight that we need to know better, and when we come back two or three days later, things are exactly the same, because no one is held responsible." (I3); and "...responsibilities should be assigned to nurses who had more contact with potential caregivers, and (...) actually identify potential caregivers." (I3).

As for the 'Difficulty in identifying the informal caregiver' subcategory, participants reported that informal caregivers are not always correctly identified or are identified at a late stage. The following interview excerpts support this subcategory: "Nurses often define a caregiver as someone who is close but not capable to play that role" (I1); "We don't even check whether or not they have the capacity to replace the person in therapeutic self-care" (I1); "Knowing if they are can do it, if they can't, if they have the right conditions, if there are other family members who can do it, we know that they should be prepared from the start but they often aren't..." (I2); "...they don't identify the provider in the documentation..." (I3); and "It's hard because it's not always possible to identify just one provider, because families are different now and people's activities and schedules are complicated..." (I4).

The 'Organization of the healthcare team for the provision of care' category was reported by most of the participants. This category was divided into three subcategories: 'Lack of process initiation'; 'Doctor-nurse coordination at discharge'; and 'Medical pressure to discharge patients'.

The 'Lack of process initiation' subcategory is reflected in the postponement of the informal caregiver's training by the nurse until they are expected to go home or until the doctor discharges the patient, as illustrated by the following excerpts: "they are waiting for a starting signal..." (I9); and "we are always waiting for the doctor to say that the patient can go home" (I3).

The difficulties in 'Doctor-nurse coordination at discharge', which are reflected in the "lack of communication" between these two professionals, are portrayed in the following excerpt: "There is a lack of communication between the two teams, that's the key point, because some aspects are not properly addressed" (I7).

Deficits in interdisciplinary communication become even more relevant when there is a lack of information about discharge and treatment plans, as illustrated by the following excerpt: "The doctor doesn't always tell us about their future plans for treatment" (I7).

According to the participants, 'Medical pressure to discharge patients' is another extrinsic factor that hinders the training process, as illustrated by the following statement: "Sometimes it's also the doctors' pressure to discharge the patient at short notice" (I6).

Another factor was the 'Lack of suitable accommodation', as the surrounding physical space can affect the relationship with the caregiver in the teaching and training process:

We have a closer relationship with the family member, which also means we have a different structure, I don't have to share with neighbors what I'm talking about with the person, with the caregiver, and with the patient (I7).

4. DISCUSSION

The analysis of the findings indicates that the participants recognize the phenomenon. The avoidance of training informal caregivers as a process of preparation for returning home is more evident in contexts where the work methodology is the individual method and is not recognized in contexts where there is a reference nurse. Rego and Coelho (2016) state that the organization of care by a reference nurse ensures individuality, comprehensiveness, responsibility, and continuity of nursing care, while promoting greater coordination with the family. The lack of conceptual knowledge in nursing was one of the intrinsic contributing to difficulty in identifying the social mandate of the profession and in considering the family as a unit of care. Although slow, there has been an evolution in the institution's adoption of theoretical nursing models. However, as a result of historical contextualization, the biomedical model of care, which is centered on the illness and the patient and regards the family a resource rather than the focus of nursing interventions, is still present. Regarding the Calgary Family Assessment Model, Fernandes (2014, p. 67) posited that "nurses require a solid knowledge of family assessment, intervention models, interview techniques, questions, etc." to integrate these elements into their practice in hospital settings.

Thus, the lack of integration of theoretical frameworks focused on the family impedes the collection of relevant data, the systematization of diagnoses and interventions, and the relevance of the information conveyed during patient handovers. From the participants' view, preparing for the return home should be a mandatory component of patient handovers. Based on the guidelines issued by the Directorate-General for Health (2022) and research carried out by Matos (2021), the institution where this study was carried out has been developing strategies to minimize the loss and lack of information at patient handovers to

guarantee safety and continuity of care. These strategies focus on training the caregiver, including information about the family, and clarifying the current or future interaction with the caregiver.

The data analysis reveals a deficiency in relational skills that could compromise the informal caregiver's training process. As Meleis and Dean (2012) point out, the nursing process is developed through communication and interaction, which are essential tools and processes for nursing practice.

One factor hindering the training process was the avoidance of the caregiver's physical presence and the nurse's fear of being observed and evaluated. This finding aligns with the results of Shibily et al. (2021). These authors studied the perception of nurses and nursing students about family involvement in care and found that 61.1% of participants reported that the presence of the family member was a source of stress, but also encouraged them to provide better quality care.

The assumptions about the caregiver mentioned by the participants point to a poor prior assessment, which does not help the transition to the role of informal caregiver. According to Meleis (2010), preparation and knowledge are fundamental for a healthy transition, which naturally requires a prior assessment by the nurses of the caregiver's abilities, skills, knowledge, and availability.

Considered by the participants as an extrinsic factor conditioning the training of informal caregivers, the information systems used to document nursing care should be facilitators throughout the process (assessment, planning, and provision of care). For this and other areas of nursing care, there has been an increasing concern to make these systems more efficient and easily updated to support nurses in their decision-making. The development of knowledge, the evolution of social and economic contexts, and the need to generate useful information for the development of organizations should encourage the continuous evolution of health information systems (Grupo Sistemas de Informação e Documentação em Enfermagem / CHUC - SIDE, 2017).

With regard to inadequate nurse staffing, the evidence leads us to the area of omitted care, showing that the lack of professionals in adequate numbers and with adequate preparation has negative effects on patient-related outcomes and nurses' job satisfaction (Cho et al., 2020). However, this should not be considered the only factor, and the studies reviewed do not explicitly address family caregiver training as an omitted care dependent on or related to inadequate staffing.

As regards the nursing care organization methodology, Albsoul et al. (2021) believe that the provision of nursing care is dehumanized in highly technological and complex healthcare environments, where procedures are reduced to a biomedical model. This dehumanization represents a form of omitted care. In this context, nursing practice cannot be seen from a conventional linear and reductionist perspective, but rather within a model that includes dynamic processes and personal and professional interactions.

The 'Difficulty in identifying the family caregiver' is often related to the fact that this role can be assumed by several people simultaneously (family members, neighbors, friends), who work together to ensure an adequate response to the dependent person's needs. This dynamic can be difficult for nurses because the primary caregiver is not always the one to talk to. Therefore, in addition to assessing the ability and willingness to learn, identifying the caregiver is a dynamic process influenced by social, professional, emotional, and economic factors, among others (Guimarães et al., 2020).

Concerning the 'Organization of the healthcare team in the provision of care', Albsoul et al. (2021) state that, historically, nurses tend to focus on activities that are quantifiable and prioritize the medical aspects of care, neglecting the relational and psychological aspects, which can be seen as marginal contributors to patient health outcomes. This perspective on the importance of quantifiable activities can explain why managers and organizations fail to consider the time required to train caregivers and the limitations of conceptual frameworks that affect nurses regardless of their professional category.

The lack of systematization of the informal caregiver training process emerged from the participants' interviews, as evidenced by the lack of process initiation and the lack of coordination among the multidisciplinary team. These results are aligned with those found by Petronilho (2007, p. 181), who states that preparing for the return home is not recognized "as a professional nursing practice" and is based on "individual initiatives (...), both in hospital and home settings, and is therefore still a poorly systematized process".

Regarding healthcare team organization, the 'doctor-nurse coordination at discharge' subcategory shows that a safe return home should not be the responsibility of one professional group, because the involvement of the entire multidisciplinary team and the informal caregiver in the dependent person's discharge has been shown to improve patient's physical fitness, adherence to the therapeutic regime, quality of life, and satisfaction with care (Mizuma et al., 2020).

Although the literature reviewed does not explicitly address the physical and structural conditions that affect the training of informal caregivers, when referring to difficulties related to accommodation conditions, the participants in this study emphasize that providing privacy and comfort optimizes caregiver training. Thus, improvement measures to train informal caregivers must consider the structure of services, which may require changes to existing dynamics and adjustments to resources.

CONCLUSION

Demographic aging and the increased prevalence of chronic diseases remain challenging aspects for caregivers of dependent family members. For this reason, integrating the informal caregiver into healthcare is becoming increasingly important. As promoters of safe transitions, nurses play a key role in facilitating the assumption of the caregiver's role. However, both clinical and scientific evidence show that there is a lack of training for the caregiver when preparing to return home.

The development of this study with nurses has revealed that the phenomenon is validated and that the training of informal caregivers is avoided. The analysis of the data revealed nurses' perceptions of the intrinsic and extrinsic factors that condition the process of training caregivers.

In terms of implications for clinical practice, although these results are limited to the context in which the study was conducted, they support the evidence of inadequate training of caregivers in hospital settings and reveal the importance of nursing practice based on conceptual models that integrate the family in care and the need to develop intervention programs focused on informal caregivers.

In addition, the identification of intrinsic and extrinsic factors by nurses contributed to the development of tools that can measure the phenomenon in institutions, thereby allowing for the evaluation of the phenomenon and the extension of the research to other contexts.

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AUTHOR CONTRIBUTIONS

Conceptualization, T.V., M.G., L.F., and A.M.; data curation, T.V., M.G., L.F., and A.M.; formal analysis, T.V., M.G., L.F., A.F., and A.M.; investigation, T.V., M.G., L.F., A.F., and A.M.; methodology, T.V., M.G., L.F., A.F., and A.M.; project administration, T.V., M.G., L.F., A.F., and A.M.; resources, T.V., M.G., L.F., A.F., and A.M.; software, T.V., M.G., L.F., A.F., and A.M.; supervision, A.M.; validation, T.V., M.G., L.F., A.F., and A.M.; visualization, T.V., M.G., L.F., A.F., and A.M.; writing-original draft, T.V., M.G., L.F., A.F., and A.M.; writing-review and editing, T.V., M.G., L.F., A.F., and A.M.

CONFLICTS OF INTEREST

The authors declare no conflict of interest.

REFERENCES

Albsoul, R. A., FitzGerald, G., Hughes, J. A., & Ahmed Alshyyab, M. (2021). Missed nursing care and complexity theory: a conceptual paper. *Journal of Research in Nursing*, 26(8), 809–823. https://doi.org/10.1177/17449871211013073

Bardin, L. (2018). *Análise de conteúdo* (5ª ed.). Edições 70.

Cho, S. H., Lee, J. Y., You, S. J., Song, K. J., & Hong, K. J. (2020). Nurse staffing, nurses prioritization, missed care, quality of nursing care, and nurse outcomes. *International Journal of Nursing Practice*, *26*(1), 1–9. https://doi.org/10.1111/ijn.12803

Direção Geral da Saúde. (2022). Documento Técnico para a Implementação do Plano Nacional para a Segurança dos Doentes 2021 |2026. *Ministério Da Saúde. Direção-Geral Da Saúde*, 1–66. https://www.dgs.pt/qualidade-e-seguranca/seguranca-dos-doentes/plano-nacional-para-a-seguranca-dos-doentes-2021-2026.aspx

Dixe, M. D. A. C. R., & Querido, A. I. F. (2020). Informal caregiver of dependent person in self-care: Burden-related factors. *Revista de Enfermagem Referência*, *2020*(3), 1–8. https://doi.org/10.12707/RV20013

Euro Carers. (2023). Euro Carers. https://eurocarers.org/about-carers/

Fernandes, C. (2014). *A família como foco dos cuidados de enfermagem - aprendendo com o family nursing game*. [Tese de Doutoramento, Instituto de Ciências Biomédicas Abel Salazar]. https://sigarra.up.pt/icbas/pt/pub_geral.pub_view?pi_pub_base_id=33839.

Grupo Sistemas de Informação e Documentação em Enfermagem - CHUC-SIDE. (2017). Tomada de decisão em Enfermagem no CHUC - O percurso da mudança, 2012-2016 (1ªed. ed.). Centro Hospitalar e Universitário de Coimbra.

Guimarães, A. C., Freitas, L., Costa, S. O., & Brandão, V. (2020). Caring for Carers: Caregiver Assessment Tools. *Gazeta Médica*, *7*(1). https://doi.org/10.29315/gm.v7i1.281

Marques, C. (2015). Capacitar para o cuidado: percepção do cuidador informal da pessoa com acidente vascular cerebral. [Dissertação de Mestrado, Escola Superior de Enfermagem de Coimbra]. https://repositorio.esenfc.pt/rc/

Matos, A. C. (2021). *Passagem de turno: contributo para a qualidade na gestão da informação* [Dissertação de Mestrado, Escola Superior de Enfermagem de Coimbra]. https://www.oasisbr.ibict.br/vufind/Record/RCAP_9f3189d0fb23403314c1ddd44ed0349f

Meleis, A. I. (2010). *Transitions theory - middle range and situation specific theories in nursing research and practice*. Springer Publishing Company.

Meleis, A., & Dean, M. (2012). *Theoretical Nursing - Development and Progress* (Fifth Edit ed.). Wolters Kluwer - Lippincott Williams & Wilkins.

Mizuma, K., Amitani, M., Mizuma, M., Kawazu, S., Sloan, R. A., Ibusuki, R., Takezaki, T., & Owaki, T. (2020). Clarifying differences in viewpoints between multiple healthcare professionals during discharge planning assessments when discharging patients from a long-term care hospital to home. *Evaluation and Program Planning*, *82*(June), 101848. https://doi.org/10.1016/j.evalprogplan.2020.101848

Nunes, M. do C. D., Gonçalves, M. A. R., Vidinha, T. S. dos S., Santos, E. J. F. dos, & CHUC, N. de I. em E. (NIE) –. (2022). El juicio clínico de las enfermeras sobre el empoderamiento del cuidador. *Index de Enfermería*, *31*(3 SE-Originales), 1–5. https://doi.org/10.58807/indexenferm20225152

Petronilho, F. (2007). *Preparação do regresso a casa*. Formasau - Formação e saúde. https://repositorium.sdum.uminho.pt/handle/1822/32305

Petronilho, F. (2013). *A alta hospitalar do doente dependente no autocuidado: decisões, destinos, padrões de assistência e de utilização dos recursos. Estudo exploratório sobre o impacte nas transições do doente e do familiar cuidador*. [Tese de Doutoramento, Universidade de Lisboa]. https://repositorio.ul.pt/bitstream/10451/10572/1/ulsd067227_td_Fernando_Petronilho.pdf

Rego, A., & Coelho, P. (2016). Organizar a Prestação de Cuidados Por "Enfermeiro de Referência" Promove a Qualidade. Servir, 59(5–6), 68–75. https://doi.org/https://doi.org/10.48492/servir025-6.23469.

Shibily, F. M., Aljohani, N. S., Aljefri, Y. M., Almutairi, A. S., Almutairi, W. Z., Alhallafi, M. A., Alsharif, F., Almutairi, W., & Badr, H. (2021). The perceptions of nurses and nursing students regarding family involvement in the care of hospitalized adult patients. *Nursing Reports*, *11*(1), 133–142. https://doi.org/10.3390/nursrep11010013