Do nurses and other health professionals’ in elderly care have education in family nursing?

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Background: Family caregivers are an important resource for providing care to elderly living at home. How nurses and other health professionals interact with family caregivers can have both a positive and a negative impact on the family caregiver’s situation. We lack knowledge of Norwegian nurses’ and other health professionals’ participation in educational programmes about family caregivers’ needs and situations.

Aim: The purpose of this study was to investigate whether nurses and other health professionals working in home-care nursing had participated in educational programmes about family caregivers. Additionally, the study aimed to determine whether participation in educational programmes was associated with awareness of family caregivers’ contributions to elder care.

Methods: This is a quantitative study, and it was conducted as a cross-sectional study. The participants were required to be educated as nurses, nursing assistants or other health professionals with relevant health education and to be working with the elderly in home-care nursing settings. Descriptive statistics and trivariate table analysis using the Pearson Chi-square t-test were conducted using Statistical Package for the Social Sciences (SPSS).

Result: A total of 152 nurses and health professionals in home-care nursing in 23 municipalities have participated (in one county in Norway). The results showed that only half of the respondents had participated in educational programmes about family caregivers’ needs and situations. The study did not provide a clear answer regarding the association between participation in educational programmes and awareness of family caregivers’ contributions.

Conclusions: The results indicate that nurses and other health professionals, to a small extent, have participated in educational programmes about family caregivers and that family caregivers’ contributions must be made visible and must be appreciated. In addition, healthcare authorities are focusing on ensuring that caregivers with demanding responsibilities have sufficient support.

There are many reasons why nurses and other health professionals should have knowledge of, and pay attention to, the family caregiver's situation. The Norwegian welfare state is normally characterised as the Scandinavian welfare model. Central to this welfare model is the principle that the basis of health care should be public health care (4). One of the central goals of the welfare state is to make all individuals free of involuntary dependence on their families. As a result, the elderly need not depend on their families, other informal caregivers or their own wealth when they need health care. Instead, the state is officially responsible for elder care. In

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Norway, research has shown that the general population, as well as the elderly themselves, believe that the primary responsibility for health care should rest on the welfare state (5, 6). The elderly do not want to be dependent, or be a burden, on their families. However, despite strong support for the welfare state in Norway, families do provide extensive help and support for their members in need of care (7). Family caregivers provide comprehensive care and practical assistance to the elderly. This extensive contribution from the family presupposes that nurses and other healthcare providers must collaborate with family caregivers when caring for the elderly. However, caring for family members can be a great burden on family caregivers (8–10). Representatives of the public healthcare system, both nurses and other health professionals, therefore have a responsibility to ensure that providing care for a family member does not have a negative impact. In addition, the public healthcare system has a legal responsibility to facilitate the involvement in family caregivers if this aligns with both the patient’s and the family caregiver’s wishes (11). Last but not least, it is argued that holistic care for the patient should involve family caregivers (12).

Several studies, both Norwegian and international, indicate that family caregivers who care for the elderly at home find themselves in demanding care situations, which can be both physically and mentally challenging (8–10, 13, 14). However, there are also positive experiences associated with being a family caregiver (15, 16). In this context, nurses and other health professionals can play an important role, as their interactions with family caregivers can have both positive and negative impacts on the family caregivers’ experiences (17–19). In elderly care in Norway, as in other Western countries, there has long been a focus on home-based service, as opposed to institutional care (20). It is reasonable to assume that this increased focus on home-based service makes collaboration with family caregivers even more important.

Many different factors can influence nurses and other health professionals’ attitudes towards and interest in collaboration with family caregivers. In this context, education and participation in instructional courses are important. Few Norwegian studies have investigated what kind of professional knowledge nurses and other health professionals need to collaborate successfully with family caregivers, and whether they possess this knowledge. A review of the Norwegian nursing curriculum raised the question of whether the family as a unit and the family caregiver’s perspective are sufficiently emphasised (21). Research from other countries provides examples of the many different approaches to integrating the family perspective into nursing education (22). If the family is to play a central role in nursing practice, it is argued that theories and practical approaches to working with the family must be included in nursing education (12, 23, 24). As a result of this type of education, attention to the family will become a more integrated part of nursing practice (12, 23). It is not only nurses who should have professional knowledge about collaborating with family caregivers; such knowledge is essential for all health professionals working with patients and caregivers, as well as for nurses in leadership positions. Nurses in leadership positions will not necessarily be in direct contact with family caregivers, but they do have professional liabilities, and they are responsible for allocating nursing resources.

The purpose of this study was to investigate whether nurses and other health professionals had participated in educational programmes about the needs and situation of family caregivers. An additional purpose was to investigate whether nurses’ and other health professionals’ awareness of family caregivers’ contributions to elderly home care was associated with participation in educational programmes and particular educational backgrounds.

The Research Questions of this Study:

- Have nurses and other health professionals employed in home-care nursing settings participated in educational programmes about the needs and situations of family caregivers?
- Does participation in educational programmes vary based on educational background or job function?
- How do nurses and other health professionals in home-care nursing settings assess family caregivers’ contributions towards caring for the elderly?
- Do nurses and other health professionals’ assessments of family caregivers’ contributions vary based on participation in educational programmes, educational background or job function?

**Method**

This is a quantitative study; it was conducted as a cross-sectional study. An electronic questionnaire was prepared in QuestBack and distributed via email with a link to QuestBack.

**Development of questionnaire**

The questionnaire was developed based on the results of a qualitative study (25). A reference group, comprising relevant professionals, contributed to the design and content of the questionnaire. To clarify interpretation, important concepts in the questionnaire were explained. The questionnaire was pilot-tested by five nurses who work with elderly in home-care nursing settings in a different county than where the survey was conducted. Also, three nurses working at Sogn og Fjordane University College tested the questionnaire. The main focus of the pilot testing was to obtain feedback on the formulation and to clarify the interpretation of the questions.
Inclusion criteria

Participants were required to be working with the elderly in home-care nursing settings in Sogn og Fjordane. The participants were required to be educated as nurses, nursing assistants or other health professionals with relevant health education. Further, this article will distinguish between nurses and other health professionals. The group ‘other health professionals’ refers to those who have had vocational training. This study included health professionals both with and without leadership positions.

Data collection

The initial request was sent to a municipal leader, and 23 of 26 municipalities chose to participate in the study. The leaders of home-care nursing settings contributed the email addresses of all current employees who met the inclusion criteria. An email was sent to participants with information about the survey and a direct link to the questionnaire. A total of 555 forms were electronically sent via QuestBack to participants in the 23 municipalities. The survey was conducted during the period from 11 January 2014 to 1 May 2014. To increase the response rate, four reminders were sent by email, the collection period was extended, and leaders in home-care nursing services were contacted and asked to remind staff members of the survey.

Demographic data

Demographic data from participants included their position in home-care nursing, age, gender, educational background (vocational training or college/university) and years of experience working in home-care nursing. The variable ‘position in home-care nursing’ was originally given three values in the questionnaire. For the analysis, ‘position in home-care nursing’ was recoded into two values: ‘regular position’ or ‘leadership position’ (i.e. leadership position and a combination of leadership and regular positions). The variable ‘educational background’ was given two values: ‘vocational training’ and ‘college/university’.

Respondents were able to skip questions they did not wish to answer, and therefore, the number of respondents (n) varies in the tables. A consequence of this was that few respondents answered the demographic questions about age and years of experience working in home-care nursing. Therefore, these variables were excluded from the analysis.

Independent variables

In addition to the demographic variables, the variable ‘participation in educational programmes about family caregivers needs’ was used as an independent variable. Originally, this variable had four values, which were recoded into two values. All respondents who answered, ‘have participated in education programmes, were given the value 1. This category included all respondents who had participated in educational programmes during basic education, further education, or other courses, in one or more of the stated topics. The participants who answered, ‘have not participated in educational programmes, were given the value 2.

Dependent variables

In the questionnaire, the variable regarding nurses’ and other health professionals’ assessments of family caregivers’ roles and contributions included the answer options ‘yes’, ‘no’ or ‘yes and no’. This variable was recoded into two values: ‘yes’ and ‘no/yes and no’. The purpose of recoding this value was to focus on unambiguously positive answers.

Analysis

An analysis of the data was conducted using Statistical Package for the Social Sciences (SPSS) version 20. Descriptive statistics were used to provide an overview of nurses’ and other health professionals’ participation in educational programmes about family caregivers’ needs, and of how they assess the contributions of family caregivers. Trivariate table analysis using the Pearson Chi-square test was used to examine whether the educational backgrounds of nurses and other health professionals, and their participation in educational programmes about family caregivers’ needs, had an impact on how they assessed the contributions of caregivers. Additionally, we tested whether the positions of nurses and other health professionals in home-care nursing settings, and their participation in educational programmes about family caregivers’ needs, had an impact on how they assessed family caregivers’ contributions. The significance level was set to \( p < 0.05 \).

Ethics

This study was approved by the Norwegian Social Science Data Service and did not contain personally identifiable or sensitive data. All participants were provided with written information outlining the purpose and the topics of the study and how the data would be stored. They were informed that they had provided consent through their decision to participate in the study. Additionally, the written information explained that the participants could withdraw from the study at any time, without having to provide a reason.
Sample description

Nurses and other health professionals from 23 municipalities in one county in Norway, Sogn og Fjordane, participated in the survey. A total of 152 participants replied to the questionnaire, and the response rate was 25% (Table 1). Dropout analysis showed that according to size, municipalities were equally represented in the gross and net samples. In absolute numbers, there are more respondents from the smallest municipalities (those with fewer than 3000 residents). This distribution reflects the municipal structure of Sogn og Fjordane. Sogn og Fjordane is one of Norway’s smallest counties, with a total of 109 170 inhabitants. Thirteen of the 26 municipalities have fewer than 3000 inhabitants, and the average number of inhabitants per municipality is 4198.

The average age of the respondents was 44 (Table 1). The majority of the respondents (57%) had nursing or another postgraduate forms of health education. Only two of the participants stated that they had postgraduate education other than nursing, and therefore, this article refers to the group as nurses. Of the participants, 34% had worked in home-care nursing for more than 5 years and 12% had fewer than 5 years of work experience. Only one percentage of the respondents had worked in home-care nursing for less than a year. The majority of the participants (63%) held positions without leadership responsibilities, while one of four was leaders or had both a leadership and a regular position.

Table 1 Description of the Survey Sample: Response Rate by Size of Municipality, Average Age in Years, Educational Background and Position in Home-care Nursing (n = 152)

<table>
<thead>
<tr>
<th>Response rate by size of municipality (%)</th>
<th>Gross samples in parenthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3000</td>
<td>27 (228)</td>
</tr>
<tr>
<td>3000-6000</td>
<td>24 (152)</td>
</tr>
<tr>
<td>&gt;6000</td>
<td>24 (175)</td>
</tr>
<tr>
<td>Total</td>
<td>25 (555)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age in years, mean</th>
<th>44 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational background (%)</td>
<td></td>
</tr>
<tr>
<td>Nurse assistants</td>
<td>35</td>
</tr>
<tr>
<td>Nursing education and other forms of postgraduate health education*</td>
<td>57</td>
</tr>
<tr>
<td>Not specified</td>
<td>8</td>
</tr>
<tr>
<td>Job function (%)</td>
<td></td>
</tr>
<tr>
<td>Regular position</td>
<td>63</td>
</tr>
<tr>
<td>Leadership positions and a combination of leadership positions and regular positions</td>
<td>20</td>
</tr>
<tr>
<td>Not specified</td>
<td>17</td>
</tr>
</tbody>
</table>

*Only two respondents had forms of postgraduate health education other than a nursing education.

Results

The main result is that nurses and other health professionals have, to a small extent, participated in educational programmes about family caregivers’ needs and situations (Table 2). Fewer than one of four answered that they had participated in training as part of their basic education. The topic about which most of the respondents had participated in educational programmes as part of their basic education (24%) was ‘measure to meet family caregiver’s needs’. A majority of the respondents (76%) stated that they had not participated in educational programmes about the legal regulations related to working with family caregivers. Consistently, more respondents had participated in educational programmes through their basic educations rather than through continuing education or courses. One exception was the topic ‘practical arrangements and aids in the home to relieve family caregivers’, about which 18% of the respondents had attended training courses.

When we examine participation in all educational programmes concerning the family caregiver’s needs, the results show that 52% of respondents have participated in educational programmes on at least one of the given topics (Table 3). A statistically significant (p < 0.05) higher proportion of the respondents with a college/university degree (62%) had participated in educational programmes compared with health professionals with vocational training (40%). For nurses and other health professionals with leadership positions, 65% had participated in educational programmes.

Table 4 shows how nurses and other health professionals assess family caregivers’ contributions. The results show that more than 50% of the respondents agreed with the statement that the home-care service is completely dependent on family caregivers’ contributions; 44% of the respondents stated that family caregivers have too large a care burden. In addition, 29% of the respondents replied that measures to meet family caregivers’ needs were taken too late, and 24% agreed with the statement that the home-care service does not pay enough attention to the important role of family caregivers.

Table 5 shows how nurses and other health professionals assess family caregivers’ contributions, distributed by educational background and participation in educational programmes about family caregivers needs. The main trend is that nurses and other health professionals, despite their educational backgrounds, have relatively similar assessments of family caregivers’ contributions. However, there were statistically significant (p > 0.05) differences between the groups on the question, stating that the home-care service is completely dependent on family caregivers’ contributions. Sixty-five percentage of respondents with a college/university degree agreed with
the statement, compared to 44% of respondents with vocational training. The results show that there is some association, but not a strong one, between participation in educational programmes about family caregivers’ needs and assessments by nurses and other health professionals of the given topics. Among the respondents who have participated in educational programmes, more agree with the given statements compared with respondents who have not participated in educational programmes; the difference is between two and five percentage points.

Table 6 shows how nurses and other health professionals assess family caregivers’ contributions, distributed by position in home-care nursing. There are more nurses and other health professionals with leadership positions (71%) than with regular positions (52%) who replied that the home-care service is completely dependent on family caregivers’ contributions. However, the results show that there are more nurses and other health professionals in regular positions (52%) compared with leadership (26%) positions who assess family caregivers as having too great a care burden; the differences is statistically significant (p < 0.05). In response to the question, ‘measures to meet family caregivers’ needs are taken too late’, there were considerable differences in how nurses and other health professionals in regular positions (compared with leadership positions) replied. More than one of three respondents in a regular position replied that measures were taken too late, but this was only the case for one of five respondents with leadership positions. For the respondents with leadership positions, there were differences based on whether they had participated in educational programmes. The results show that, compared to respondents who had not participated in educational programmes, more of the respondents with leadership positions who had participated in educational programmes replied that family caregivers have too great a care burden. The difference for this question was 12 percentage points. More respondents with leadership positions who had participated in educational programmes, compared to
Discussion

The purpose of this study was to obtain information about whether nurses and other health professionals had participated in educational programmes about the needs and situations of family caregivers. In addition, the purpose was to investigate whether nurses’ and other health professionals’ awareness of family caregivers’ contributions to home-care nursing was associated with their participation in educational program or their educational backgrounds. The survey also obtained information about nurses’ and other health professionals’ assessments of family caregivers’ contributions to elder care.
Participation in educational programmes

The main result from this study showed that nurses and other health professionals, to a small extent, had participated in educational programmes about family caregivers’ needs regarding the topics surveyed in this study. Only one-fourth of the respondents had participated in educational programmes about family caregivers needs as part of their basic education. This can be seen as a small fraction, considering the important role that family caregivers play in caring for elderly. However, previous Norwegian research supports our findings. Based on a review of the Norwegian nursing education curriculum, Sørfond and Findstad (21) questioned whether the family perspective was sufficiently emphasised in nursing education.

We found that a significant higher proportion of the nurses compared with other health professionals with vocational training had participated in training about family caregivers’ needs. This result is not surprising. However, we expected a larger difference because these educational programmes are at different levels and of different lengths.

There may be many reasons why educational programmes about family caregivers’ needs are not sufficiently emphasised in Norwegian basic education. One explanation may be that informal care, which is often provided by families, has been more or less invisible to the formal healthcare system and healthcare professionals. Therefore, it may also have been invisible to those responsible for educational programmes. Additionally, caring for the elderly is, as we have seen, a public responsibility in Norway (4). We cannot ignore the fact that this may have contributed to the fact that family care has received relatively little attention from educational programmes. Educational programmes may have focused on how to care for the patient instead of focusing on how to help both the patient and the family.

Here we must note that this study only asked questions about participation in educational programmes, a measure of formal competence. Therefore, this study does not include other forms of learning about collaboration with family caregivers. Thus, this study does not provide answers regarding skills the respondents may have obtained through work experience, which may provide time for questions, reflection and discussion.

Nurses’ and other health professionals’ assessments of family caregivers’ contributions

Our findings indicate that nurses and other health professionals, to a large extent, consider family caregivers’ contributions to be an important part of caring for the elderly. This finding is consistent with both national and international research emphasising the important roles and contributions of family caregivers (7, 8, 26–28). It is worth noting that a large proportion of respondents answered that family caregivers have too great a care burden. Previous research has concluded that family caregivers’ responsibilities can be both physically and mentally challenging, which can lead to negative consequences for them (8–10). Our study therefore illustrates the need to focus on collaboration with family caregivers.

The results indicate that participation in educational programmes about family caregivers’ needs had a slightly positive influence on how nurses and other health professionals assess family caregivers’ workloads. However, we found no statistically significant difference between nurses and other health professionals who had (or had not) participated in educational programmes, in terms of their assessments of the roles and contributions of family caregivers. This finding is not in accordance with international research, which has noted that participation in educational programmes about family care contributes to the development of students’ perspectives (12, 23). There may be several reasons why participation in educational programmes does not affect the assessments of nurses and other health professionals on this topic. The questions asked in the survey may be one reasonable explanation because they may not capture the full reality of education. Nurses and other health professionals’ need for guidance and support when using their knowledge in the current context (29) may also explain this. Furthermore, another explanation may be that the survey asked questions regarding nurses’ and other health professionals’ opinions and therefore also their attitudes. Nurses and other health professionals may have different views and expectations regarding family caregivers’ contributions and how they experience their situations. Nevertheless, we can assume that being aware of family caregivers’ contributions, and their experience of their situations, are essential to providing family caregivers with good help and support.

The results of this study showed statistically significant differences between nurses and other health professionals’ assessments of family caregivers’ burdens, based on their positions in home-care nursing. More of the nurses and other health professionals in regular positions assessed the family caregivers as having too great a burden. This may be because they work closely with family caregivers and therefore have the opportunity to observe how they experience their situations. Another reason may be the differences in responsibilities among nurses and other health professionals in leadership positions. Nurses and other health professionals in leadership positions have to ensure that all patients and family caregivers in need receive justifiable help; at the same time, they have a responsibility to ensure cost-effective service (30). Therefore, it is reasonable to assume that their responsibilities in allocation of resources will affect their attitudes and assessments.
towards family caregivers’ contributions. It is worth noting the results that indicated that nurses and health professionals in leadership positions who had participated in educational programmes, to a larger extent than those who had not, assessed family caregivers’ burdens to be too great and stated that measures to meet family caregivers’ needs were taken too late. These findings led us to assume that participation in educational programmes about family caregivers’ needs (in addition to their responsibilities for the allocation of resources) may be especially important for those who do not have daily contact with family caregivers.

Limitations of the study

One limitation of this study is the low response rate, which gives reason to question the representativeness of the results for all employees in home-care nursing in the county. There may be several reasons for this low response rate. The implementation of the survey through email may have been a disadvantage, as it is uncertain how often staff members read their email. There were no options in the questionnaire to save information and return later; therefore, it may have been challenging for staff members to find enough time during the workday to answer the survey. The response rate was approximately equal for the various municipal groups, and this indicates equal representation of the various municipal groups. We have no knowledge of the gender distribution of the total sample, but in the net sample, there were very few men, indicating an underrepresentation of men. Therefore, we have no knowledge of differences between gender, and the survey gives no information on male staff members’ views and assessments of family caregivers’ contributions.

We must interpret the results of this survey with caution because relatively few respondents answered the questionnaire. In addition, we have very few other Norwegian studies with which to compare our results because there is very little research in this field. Nevertheless, we must be aware of the relatively large differences required between the groups to obtain a statistically significant result in a small sample. In a larger sample, there could have been several analyses that generated statistically significant differences between groups, a type 2 error (31). Therefore, this article report results that are not statistically significant. In the light of the low response rate, and the fact that the survey was only conducted in one county with relatively small municipalities, the possibility of generalisation is limited to other counties in Norway. In spite of these limitations, this study still shows statistically significant differences between groups that are worth noting, and the results highlight important areas in which we need more research.

Implications for practice and recommendations for further research

Based on the results of this study, we question whether nurses and other health professionals have the necessary knowledge to support positive collaboration with family caregivers. The results suggest that we need to know more about what types of professional knowledge are required by nurses and other health professionals if they are to collaborate successfully with family caregivers. In addition, we must know whether they possess this knowledge. This is particularly important at present, when new reforms in the Norwegian health service are challenging nurses’ and other health professionals’ knowledge in many fields of expertise (25, 32).

This development therefore raises the question of whether increased attention to caring for family caregivers will be required in future, perhaps primarily by the management of municipalities. The results of this study indicate that it will be important to ensure that nurses in leadership positions also participate in educational programmes about family caregivers’ needs. Required knowledge may include how nurses and other health professionals can contribute to positive collaboration with family caregivers, insight into the comprehensive contributions of family caregivers, and knowledge of how their responsibilities can affect the health of family caregivers.

Conclusion

The results of this study indicate that nurses and other health professionals, to a small extent, have participated in educational programmes about family caregivers’ needs and situations. Our study does not provide any clear answers as to how participation in educational programmes influences nurses’ and other health professionals’ assessments of family caregivers’ contributions. Nevertheless, trends observed in our results suggest that nurses’ and other health professionals’ participation in educational programmes may be particularly important for nurses and other health professionals in leadership positions and for health professionals with vocational training.

Author contribution

Olivia Sissil Sunde contributes to the study design, data analysis and drafting of the manuscript. Karianne Rossummoen Øyen contributes to the study conception/design, data collection and critical revisions for important intellectual content and Siri Ytrehus contributes to the.
study conception/design, critical revisions for important intellectual content and supervision.

**Ethical approval**

The study was approved by the NSD—Norwegian Centre for Research Data, No. 36289.

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