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ORIGINAL ARTICLE

Patients' and family members' perspectives on the benefits and working mechanisms of family nursing conversations in Dutch home healthcare

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Abstract

The aim of this study is to propose a model of the benefits and working mechanisms of family nursing conversations in home healthcare from the perspective of participating patients and their family members. Family nursing conversations in this study are intended to optimise family functioning, improve collaboration between family and professional caregivers and ultimately prevent or reduce overburden of family caregivers. In a qualitative grounded theory design, data were collected in 2017 using intensive interviewing with participants of family nursing conversations in home healthcare. A total of 26 participants (9 patients and 17 family members) from 11 families participated in a family nursing conversation and the study. Seven nurses who received extensive education in family nursing conversations conducted them as part of their daily practice. Interviews occurred 4–6 weeks after the family nursing conversation. The model that was constructed in close collaboration with the families consists of three parts. The first part outlines working mechanisms of the conversation itself according to participants, i.e. structured and open communication about the care situation and the presence of all of the people who are involved. The second part consists of the benefits that participants experienced during and immediately after the conversation – an increased sense of overview and improved contact among the people involved – and the related working mechanisms. The last part consists of benefits that emerged in the weeks after the conversation – reduced caregiver burden and improved quality of care – and the related working mechanisms. Insight into the benefits and working mechanisms of family nursing conversations may assist healthcare professionals in their application of the intervention and provides directions for outcomes and processes to include in future studies.

KEYWORDS

family caregivers, family nursing, family support, family systems theory, grounded theory, home care

1 | INTRODUCTION

Caregiver burden in families is associated with suboptimal family functioning and lower quality of family relationships (Francis, Worthington, Kypriotakis, & Rose, 2010; Goldsworthy & Knowles, 2008; Heru, Ryan, & Iqbal, 2004). Caregiver burden may have several negative consequences including physical and mental health problems (Bom, Bakx, Schut, & van Doorslaer, 2018) and employment issues (Longacre, Valdmantis, Handorf, & Fang, 2016; Schmitz & Westphal, 2017). Burden is common in situations of long-term, intensive and complex care-giving (Naef, Hediger, Imhof, & Mahrer-Imhof, 2017; Pristavec, 2019; Swinkels, Broese van Groenou, de Boer, & Tilburg, 2019). These types of informal care-giving may become more common due to reforms in north-western European healthcare systems that encourage care recipients to remain home-residing as long as possible and urge the participation of informal caregivers in care-giving (De Klerk, De Boer, Plaisier, & Schyns, 2017; Kok, Berden, & Sadiraj, 2015; Verbeek-Oudijk, Woittiez, Eggink, & Putman, 2014). The risk of caregiver burden also increases when the informal care network is small or when there are disagreements among caregivers (Tolkacheva, Broese Van Groenou, De Boer, & Van Tilburg, 2011).

Nurses are in a key position to optimise family functioning and thus contribute to the prevention of caregiver burden in families. Caring for the family system as well as for individual patients is one of their core roles according to the International Council of Nurses' definition of nursing (ICN, 2019). NANDA-I, a framework for the standardisation and classification of nurses' clinical judgment in terms of nursing diagnoses, contains diagnoses of caregiver role strain and interrupted family processes (Herdman & Kamitsuru, 2014). 'Caregiver role strain' is defined as difficulty in performing the caregiver role, and is similar to caregiver burden. The diagnosis 'Interrupted family processes' is defined as a change in family functioning and/or relationships and may occur as a result of a family member's changed health status. In order to prevent or restore interruption of family processes and prevent informal caregiver burden, nurses need to extend their nursing care to include patients' families. Disagreements could thus be resolved, and the informal care network extended if necessary. Recently, an umbrella review of the effects of family interventions for families with an adult home-residing chronic care recipient was published (Gilliss, Pan, & Davis, 2019). The authors found underlying theoretical models and expected change mechanisms for the interventions to be largely missing. Also, the majority of the interventions appeared to be focused on improving the care that family members provide, which may result in positive outcomes for the patient. In order to also improve family outcomes, however, the results suggest that interventions need to focus on family coping and functioning.

Family Systems Nursing explicitly targets the family system as a focus of care as illness influences not only the patient but also family members and family relationships (Wright & Leahey, 2013). Family Systems Nursing has elaborated theoretical underpinnings including systems theory, communication theories and change theory.

What is known about this topic?

- Informal caregiver burden is increasingly common in north-western Europe and is associated with suboptimal family functioning.
- Family nursing conversations may contribute to family health and family functioning.

What this paper adds?

- Insight into benefits and working mechanisms of family nursing conversations in home healthcare presented in a coherent model.
- Knowledge about patients' and family members' perspectives on the immediate benefits of family nursing conversations – increased overview of the care situation and improved contact among the people involved – and the related working mechanisms.
- Knowledge about patients' and family members' perspectives on the longer-term benefits of family nursing conversations – reduced caregiver burden and improved quality of care – and the related working mechanisms.

Its postmodern worldview maintains that multiple perspectives and beliefs about care, health and illness may coexist and are valid. Family Systems Nursing interventions are typically carried out in conversations between nurses and families in which perspectives are explored, family strengths are identified and illness suffering is acknowledged and assuaged.

The current study is focused on a specific Family Systems Nursing intervention: the family nursing conversation. In the Netherlands, it is designed to strengthen family resilience, improve family–nurse collaboration and ultimately prevent or decrease caregiver burden. A family nursing conversation is indicated when a NANDA-I nursing diagnosis of risk for caregiver role strain, actual caregiver role strain or interrupted family processes applies to the family (Herdman & Kamitsuru, 2014). The intervention consists of 12 core interactional components that outline the structure and content of the conversation and can be found in Table 1. These components are based on the family health conversation model (Benzein, Hagberg, & Saveman, 2008; Östlund, Bäckström, Lindh, Sundin, & Saveman, 2015) and have been adapted to allow incorporation of the intervention into routine home healthcare nursing (Broekema, Paans, Roodbol, & Luttik, 2020).

There is an increasing body of evidence regarding the benefits of Family Systems Nursing interventions. An integrative review based on mainly qualitative studies found that these interventions contribute to affective, cognitive and behavioural family functioning (Östlund & Persson, 2014). Most previous studies have focused on experiences and benefits of Family Systems Nursing interventions (e.g. Benzein, Olin, & Persson, 2015; Dorell & Sundin, 2016, 2019; Marklund, Sjödin Eriksson, Lindh, & Saveman, 2018; Östlund,

TABLE 1 The components of Family Nursing Conversations (adapted from Östlund et al., 2015)

1	Jointly reflecting with the family on expectations of the conversation, and jointly setting the goal for the conversation
2	Getting to know each other; who is present and who is absent
3	Exploring the family structure and finding out who is part of the family by making and discussing the genogram with the family
4	Exploring relationships within the family and relationships between the family and other people and organisations by making and discussing the ecomap with the family
5	Inviting each family member to share their story and narrate expectations, needs and emotions related to the care situation
6	Formulating a shared question or problem regarding the care situation
7	Acknowledging painful experiences and events and related emotions
8	Giving commendations about family strengths, competencies and resources
9	Stimulating open communication between family members, also about difficult topics
10	Signalling and discussing family members' beliefs related to the care situation. Challenge constraining beliefs and support facilitating beliefs
11	Summarising the central issues that have been raised and pursued in the conversation
12	Setting joint goals and agreements for the care situation

Bäckström, Saveman, Lindh, & Sundin, 2016); however, less is known about the working mechanisms of the interventions as they occur in practice. In order to adequately apply a complex intervention that consists of multiple components and evaluate its effects, insight into working mechanisms is crucial (Campbell et al., 2007). Persson and Benzein (2014) have approached this issue by assessing the dialogue or interactional processes in transcribed family health conversations. In the present study, working mechanisms and benefits of the intervention in home healthcare will be explored inductively through patients' and family members' experiences of participating in a family nursing conversation. The aim of this study is to propose a model of the benefits and working mechanisms of family nursing conversations in home healthcare from the perspective of patients and family members.

2 | METHODS

2.1 | Design

A qualitative grounded theory study design was employed with post-intervention interviews with patients and family members who participated in a family nursing conversation. Charmaz' (2014) approach to grounded theory was selected as her emphasis on research as a collective process between researchers and participants is in accordance with the purpose of the study (Singh & Estefan, 2018).

2.2 | Intervention

The family nursing conversations were conducted by nurses who were involved in the regular care for the patient. All of the nurses ($n = 7$) had received a 6-day training in family nursing conversations (Broekema, Luttkik, Steggerda, Paans, & Roodbol, 2018). Nurses invited patients and their family members to participate in a family nursing conversation when one or more of the following NANDA-I nursing diagnoses applied to one or more family members: (a) Risk

for caregiver role strain; (b) Caregiver role strain and (c) Interrupted family processes (Herdman & Kamitsuru, 2014). Patients, sometimes assisted by a family member or the nurse, indicated who should be invited to the family nursing conversation.

Nurses conducted the family nursing conversations according to the components in Table 1. Each family participated in one family nursing conversation. Eight of eleven conversations were audio-recorded. These conversations lasted 46.26 min on average ($SD = 12.14$). Treatment integrity was assessed in a different study with a dataset consisting of these eight and other audio-recorded conversations. Overall, the components were recognisable in the conversations (Broekema et al., 2020).

2.3 | Data collection

At the end of the family nursing conversation, the nurse asked whether the patient and the family members were willing to participate in an interview about their experiences with the conversation. Contact details of the participants who agreed to be interviewed were provided to the interviewer and were approached to be interviewed.

Data were collected between January and June 2017 with intensive interviewing which allowed for an in-depth exploration of each participant's experiences and interpretations (Charmaz, 2014). The interviews were conducted 4–6 weeks after the family nursing conversation. Based on previous studies, benefits of the intervention were expected to be evident after this period (Benzein et al., 2015; Svavarsdottir, Sigurdardottir, & Tryggvadottir, 2014). The exact number of participants was not determined beforehand; data collection was concluded after saturation was reached.

The first author, a researcher who was not involved in delivering the family nursing conversations, conducted all of the interviews. The intention was that they would be individual and face-to-face, however, when participants preferred to be interviewed by telephone or in the presence of other participants, this was agreed upon in order to interview as many conversation participants as possible.

Family role	Family members participating in interviews (n = 26, from 11 families)			Family members not participating in interviews (n = 7, from 4 families)		
	n	Age		n	Age	
		Min–Max	Median		Min–Max	Median
Patient	9 (4 males)	56–83	76	3 (1 male)	81–86	83
Partner	4 (1 male)	62–79	71.5	2 (2 males)	57–87	72
Child (in law)	11 (3 males)	36–62	52	2 (2 males)	22–56	39
Grandchild	2 (0 males)	24–27	25.5	0		

TABLE 2 Family role, gender and age of family nursing conversation participants

Individual rather than group/family interviews were chosen, as the intention was to grasp each participant's unique experiences and perspective after the collective experience of the family nursing conversation (Reczek, 2014). With individual interviews, participants were free to speak openly about their experiences and the family interactions during the family nursing conversation. Participants were asked about their preferences for the interview location; all participants preferred their home.

At the beginning of each interview, the interviewer explained the purpose and procedure of the study. Specifically, the interviewer explained that the intention of the interview was to gain understanding of participants' experiences during the conversation and their ideas about changes, if any, that occurred after the conversation, and that the interviewer was interested in both positive and negative experiences and consequences. Next, the interviewer asked for demographic information. Subsequently, the interviewer asked participants to relate something about the care situation that led to the invitation for the family nursing conversation. The interview was then focused on the family nursing conversation. In order to derive an understanding of families' perspectives on the benefits and working mechanisms of the family nursing conversation, participants were initially asked about their experiences during the conversation and, subsequently, about any changes they experienced after the conversation. When participants did not bring up negative experiences or changes themselves, the interviewer asked about such experiences explicitly, explaining again their value for the study. Next, participants' perspectives on the relationships between the conversation and any changes that they experienced was explored. Ideas and experiences that participants raised were explored in depth. In later interviews, topics and meanings that emerged from previous interviews were explored in more detail.

2.4 | Data analysis

Analyses were performed using Atlas.ti. The audio-recorded interviews were transcribed verbatim by the first researcher after all of the participants from a family had been interviewed. Involving participants in the interpretation of the data and gaining multiple perspectives is important in Charmaz' (2014) approach of grounded

theory. The first rounds of initial line by line and focused coding, therefore, occurred before the next family was interviewed. Thus, issues and gaps in the data and emerging categories and relations were identified. These were explored and analysed in more depth in subsequent interviews with other families and via e-mail and phone contact with previous families that agreed to be involved again. In this iterative process, a model of benefits and working mechanisms gradually emerged. To refine the model, families were asked to comment on the emerging themes and the final model and compare it to their own experiences. The analysis process and outcomes were frequently discussed among the authors. One of the authors who had no previous knowledge of Family Systems Nursing analysed six of the interviews with the first four families; consensus about the categories was reached straightforwardly.

2.5 | Ethical considerations

Approval of the research project of which this study was a part was waived by the regional medical ethical committee (METc2015.463) as the Dutch Medical Research Involving Human Subjects Acts does not apply. Prior to each interview, the interviewer obtained written informed consent from each participant. When this was not possible due to the participant's impaired sight or hand function, the study information was discussed and verbal informed consent was obtained and audio-recorded. All identifiable information such as names and contact details were removed from the transcripts. Audio-recordings and transcripts were stored without reference to personal details.

3 | FINDINGS

3.1 | Participants

Thirteen families were approached to participate in the study of which two families declined due to being overburdened. A total of 26 participants from 11 families participated in a family nursing conversation and were interviewed for the study. From seven families, all of the individuals who participated in the family nursing conversation were interviewed. From the remaining families, one or more

family members who participated in the family nursing conversation were not able or not willing to be interviewed. Demographics of the participating and non-participating family members are outlined in Table 2. In one family, both partners were receiving home health-care and were, therefore, considered, patients. The indications for the family nursing conversation in the form of the NANDA-I nursing diagnoses (Herdman & Kamitsuru, 2014) and the medical diagnoses of the care receiving patients are listed in Table 3. Upon the family's request, one family was interviewed via telephone, and two families were interviewed together. The other interviews were face-to-face and individual.

3.2 | Proposed model of benefits and working mechanisms of family nursing conversations

The model of the benefits and working mechanisms of family nursing conversations that was constructed with the patients and family members is presented in Figure 1. The first theme consists of the working mechanisms that families experienced during the family nursing conversation. The second theme describes both the benefits and their working mechanisms that families experienced during and immediately after the family nursing conversation. The last theme contains benefits and their working mechanisms that gradually manifested in the weeks after the family nursing conversation as a result of the changes that immediately occurred. Each benefit and working mechanism was experienced by most but usually not all families. Participants who did not experience a benefit or working mechanism themselves or in their family still considered these as important in most other care situations with different needs than their own. One family considered the model to describe benefits

and working mechanisms of a family nursing conversation that would have better fulfilled their needs than the conversation that they participated in.

3.2.1 | Working mechanisms during the family nursing conversation

Experiencing structure

Most family members experienced the family nursing conversation as a structured conversation, especially compared to the usual communication within the family. Family members perceived the nurse to be the provider of this structure; the nurse ensured that there was ample time available so that all important topics were discussed in a logical order and that all of the persons who were involved were encouraged to participate. Family members appreciated this structure. Even families who experienced less structure reported that they would have preferred a more structured conversation:

Well, I expected it to be more point-by-point. [...] That would have been calmer than going through criss-cross, although we did cover everything eventually. [...] It has been quite a tough period, lots of things, events that you never experienced before. I think it would have been nice to gain some more of a sense of overview.

(Patient, family 1)

Being open and experiencing others' openness

Family members experienced open communication during the family nursing conversation to a greater extent than in the typical

TABLE 3 Indications for the family nursing conversation and patient medical diagnoses per participating family

Family (nr of pp)	Indication for family nursing conversation (NANDA-I)	Medical diagnosis patient(s)
1 (3)	Interrupted family processes	Cardiovascular accident/ acquired brain injury
2 (4)	Risk of caregiver role strain	Dementia
3 (4)	Risk of caregiver role strain	Neuromuscular disease
4 (4)	Risk of caregiver role strain Caregiver role strain	Dementia
5 (2)	Risk of caregiver role strain	Cardiovascular accident/ acquired brain injury
6 (2)	Caregiver role strain Interrupted family processes	Neuromuscular disease
7 (3)	Risk of caregiver role strain Caregiver role strain	Cancer
8 (3)	Risk of caregiver role strain Interrupted family processes Caregiver role strain	Dementia
9 (3)	Risk of caregiver role strain	Dementia
10 (2)	Risk of caregiver role strain Caregiver role strain	Cardiovascular accident/ acquired brain injury, Chronic obstructive respiratory disease

FIGURE 1 Inductive model of the benefits and working mechanisms of family nursing conversations from patients' and family members' perspectives

contact within the family. They experienced openness about the health condition of the patient, the relationships between participants and each person's care tasks and experiences, emotions, boundaries and burden related to the care situation. As participants were open and experienced the openness of others, they learned new information, felt that they were heard and realised differences among participants. Participants experienced the openness as both valuable and confronting. For most families, the confrontation itself was valuable as well, however, not so much so for families dealing with dementia:

You see, one moment my mother knows that she is forgetful, like her parents, but the next moment she doesn't. [...] And then we have to be open and honest, she wants us to be! So we say that things are getting a bit worse, but she doesn't want to hear it and she goes against it. And we explain, and she understands and feels sad, but a moment later she has forgotten all about it, and we can start over. So you keep hurting her, for no reason it seems.

(Daughter, family 8)

Acknowledging the importance of the participants

Family members acknowledged the importance of participating in the family nursing conversation with all of the people who were of concern in the care situation:

Just that everyone was there, that we talked with all of us together, rather than talking to one person and then the other, and then the first one again, and they don't agree, and I just keep calling and calling and calling. It drains my energy. And now we just sat down together, had some discussion, made agreements, done. Loved it!

(Granddaughter, family 4)

Through the presence of the others, family members were able to experience each participant's involvement in the care situation. In addition to the nurse's sincere involvement, family members also experienced the nurse's expertise as a professional. When important people were absent, family members missed their presence. This also occurred when the relationship was difficult or when a family member was unable to participate due to dementia.

3.2.2 | Benefits and working mechanisms during and immediately after the family nursing conversation

Experiencing an increased sense of overview

Two working mechanisms were identified that contributed to an increased sense of overview. First, during the family nursing conversation, family members discussed the past, the present and the future of the care situation and the people who are involved:

Talking everything through in such a structured manner made us realize where we came from, all that happened, and what everything is like now, what we have done to make things work. And also the network we have around us... You only see one or two at a time, but when you list everyone! That is quite a lot. [...] All of this gives us strength and confidence to continue in our situation.

(Partner, family 11)

Several family members felt that the pieces of the puzzle that were held by different participants were put together so that everyone became aware of the actual health situation of the patient and the burden on the other family members. During the conversation, a clear picture of the events that had led towards the present situation arose combined with an understanding about differences in the way past events were experienced by the participants.

Second, for various families, establishing a shared starting point contributed to the increased sense of overview; differences were acknowledged, and the family could begin with a clean slate and arrive at an overarching goal for the care situation. Each participant's expectations, needs and desires for the future were known. It was clear who was involved in the care situation, how care tasks were divided and who to contact for what.

Experiencing improved contact among the people involved

Family members described that the contact among the participants including the nurse had improved through three working mechanisms. First, family members better understood their own and other's emotions and boundaries in the care situation after they had been discussed:

You understand more of what is painful for the other person, what is difficult, so you can ask about it, or the other way around: be more careful. So when he [patient] says something that I now know makes her sad, I just pinch her shoulder, a small gesture, but just so she knows that I know. [...] Before it seemed like someone became sad or angry out of the blue, now you understand much sooner what is going on.

(Daughter-in-law, family 3)

Second, family members received and provided emotional support and supported each other's boundaries, which is also evident

in the quote above. Finally, participants increasingly trusted each other's good intentions and skills in the care tasks that were agreed upon.

I could really almost feel it shifting; that I can take care of him [father] too, even though I won't do everything exactly the way she [mother] does, but just that she knows that I want him to be safe and happy just as much as she does.... It still touches me, it was very meaningful.

(Son, family 9)

3.2.3 | Longer-term benefits and working mechanisms of the family nursing conversation

Experiencing reduced burden from caregiving tasks

Family members described that maintaining a balanced division of care tasks, setting and keeping clear boundaries, and identifying problems in time helped to reduce or prevent burden from caregiving tasks. A balanced task division was maintained sometimes by sharing care tasks among more people. In most families, discussing the task division and performing those tasks that a person likes to do and is able to do was helpful:

At night I kept thinking: 'Oh if only everything would go right and what if it starts beeping or what if it is empty and oh oh oh...'. So she [nurse] showed us how to do everything, she repeated it as long as needed for us to understand, and to my husband: 'You can do this yourself, right?' She said that! [...] And now he does most of it himself, and I have time for the house and the garden. I did everything before, and I didn't have time for anything.

(Partner, family 6)

The partner added:

It is better like this. For both of us. I turn out to actually be able to do something. And she is more relaxed when she can go outside.

(Patient, family 6)

Family members learned to communicate and protect their own boundaries and also to respect and remind others of their boundaries:

It is funny in a way, we now protect each other's boundaries, so I remind her [partner]: 'Should you be doing that?' And she does the same for me. We know that to stay together we have to be careful with each other. So we ask for help.

(Patient, family 10)

Family members more openly communicated their needs and problems. As they became more familiar and comfortable with the nurse, they felt freer to contact her when needed. Families who had been dealing with illness for years before their participation in the family nursing conversation were convinced that a conversation at an earlier stage would have prevented many problems:

Now they have a network surrounding them, but that took a long time, too long. If you need help, you have to be able to ask for it, and they couldn't. Had this conversation taken place much earlier, it would have been clear right away that this was too much for her, that more help was needed. We could have identified problems, set goals, work towards goals. She may not have become overburdened.

(Son, family 11)

Experiencing improved quality of care for the patient

Several families experienced the quality of care improving for the patient after the family nursing conversation. Two working mechanisms were identified. First, both the professional care and the care by family members were experienced as better fitting the needs and desires of the patient:

I appreciated that she [nurse] really wanted to know how they could help me most. At the time, I was too tired to think about it but, nevertheless, all of us together made a good plan, and it has really helped me to gain back some quality of life.

(Patient, family 7)

Second, after the family nursing conversation family members no longer performed care tasks that they could not perform safely, or they increased their skills. Family members increasingly performed care tasks that they are good at and that they liked:

I used to do everything that they [parents] asked and deep inside I was getting more and more angry with them. It was never enough, and I never did it right. But, they need you, and they are your parents so... But now I only do the things that we agreed upon, and I actually like to go there now. And I feel good about myself, and they appreciate me much more.

(Daughter, family 2)

4 | DISCUSSION

The aim of this study was to propose a model of the benefits and working mechanisms of family nursing conversations from the perspective of patients and family members (Figure 1). The model that evolved from this study consists of three consecutive parts: perceived working mechanisms during the family nursing conversations;

perceived benefits and their working mechanisms during and immediately after the conversation and perceived longer-term benefits and their working mechanisms. Two types of professional strategies seemed to contribute to the benefits of the intervention. First, nurses guided the conversation itself in such a way that families experienced the benefits of increased overview and improved contact and interaction during and immediately after the conversation. Specifically, nurses were perceived as encouraging all of the persons involved in the care situation to participate, providing structure to the conversation and stimulating open communication. As a second strategy, professionals offered families interactional tools, of which the most important is open communication that families can use themselves to prevent or reduce caregiver burden and improve quality of care.

The results of the study indicate that the intended aims of family nursing conversations can be achieved. Improved contact and interaction among family members and between the family and the nurse contribute to family functioning and family–nurse collaboration, respectively. Family members explicitly experience the prevention or reduction in caregiver burden as a benefit of the intervention. This has also been found in recent qualitative (Marklund et al., 2018) and quantitative (Petursdottir & Svavarsdottir, 2019) studies. Interestingly, in the current study, the perceived quality of care for the patient was also found to improve following the family nursing conversation.

The results show how prevention or reduction in caregiver burden in families might be achieved through family nursing conversations. Illness and caregiving can be overwhelming experiences for families (Benzein et al., 2015). The open and structured communication in a family nursing conversation may have contributed to making sense of the situation and regaining autonomy (Epstein & Street, 2011; Lindberg, Fagerström, Sivberg, & Willman, 2014). Gaining an overview of the care situation might also help to make sense of illness and caregiving and thus assist in coping with the situation (Williams, Morrison, & Robinson, 2014). Indeed, participants of the current study described a shared starting point for the future as an immediate outcome of the intervention. This has been described before as creating a whole picture of the situation and processing what has happened (Benzein et al., 2015). Making meaning has also been proposed before as a working mechanism of family systems nursing interventions (Persson & Benzein, 2014).

The current study adds the perspectives of patients and family members on the working mechanisms of Family Systems Nursing interventions to the existing knowledge base. A previous study into the working mechanisms explored with an hermeneutic approach how these interventions may support family health (Persson & Benzein, 2014). In that study, it is suggested that narrating illness experiences, listening to others' narratives and reconsidering and reflecting on the narratives during the intervention may be the mechanisms that support family health. These interactions within the family and with the professional may help to change constraining beliefs, consider other possibilities and make meaning

and increase hope. Differences in terminology when comparing these results to the results of the current study might partially be explained by the deductive approach of the previous study versus the inductive grounded theory approach of the current study. In addition, the difference in the purpose of the intervention – supporting family health versus preventing or reducing family caregiver burden – might also be related to differences in proposed working mechanisms.

4.1 | Strengths and limitations

This study describes benefits and working mechanisms that were experienced by most, but not all, participants. Participants did agree that this model reflects the benefits and working mechanisms of family nursing conversations, but not every aspect of the model is possible or desirable in every care situation or family. This has been noted in the results when necessary. Participants decided whether or not they wanted to participate in the study after the family nursing conversation took place. It is possible that participants who did not want to participate had different or less positive experiences. The study employed a diverse sample in terms of family composition and patients' medical diagnoses as these were naturally occurring in the home healthcare setting and within the nursing diagnoses of caregiver role strain and the risk thereof as well as interrupted family processes (Herdman & Kamitsuru, 2014). The model, therefore, may be applicable to diverse families confronted with various diagnoses such as dementia or non-acquired brain injury. In this study, it was not possible to assess whether the working mechanisms may differ for different subgroups, for example, families confronted with dementia or families diagnosed with caregiver role strain versus interrupted family processes. In addition, nurses' perspectives on the benefits and working mechanisms are not a part of the current study. Their perspective might differ and needs to be explored in future studies. It is possible that the interviewer's prior knowledge of the aims of the family nursing conversation and the benefits that had been found in previous studies unintentionally influenced participants' responses. However, the interviewer had no pre-existing ideas about the working mechanisms of family nursing conversations, and this was the first time this specific intervention was tested in the Dutch population, both of which helped to ensure that we approached participants with an open mind. Finally, the model was developed in the Dutch home healthcare setting with nurses. Transferability of the model to other countries, other disciplines such as social work, or other settings such as in-patient facilities remains to be established.

4.2 | Implications for practice and policy

The model that was developed shows that family nursing conversations can be a valuable tool for supporting and empowering

families in home healthcare that are confronted with illness. The intervention may help to reduce or prevent caregiver burden in families and associated personal and societal costs (Bom et al., 2018; Longacre et al., 2016; Schmitz & Westphal, 2017). Considering the results of the present study, it appears to be important to offer family nursing conversations at an early stage of the care situation in order to optimise family functioning. Thus, caregiver burden within families might be prevented rather than reduced. Additionally, some of the issues that families experienced prior to the family nursing conversation, such as misbalance in task division and performing care tasks that the family member cannot perform safely, should be addressed as soon as possible to ensure safety and well-being.

This study presents a coherent model of benefits and working mechanisms from the perspective of the participants that professionals can utilise in their practice. Nurses have been found to use their clinical judgment to fine-tune their application of the components of family nursing conversations to individual family's needs (Broekema et al., 2020). Insight into families' perspectives on the benefits and working mechanisms can support professionals in their clinical decisions about the application of the components in specific care situations.

5 | CONCLUSION

In this study, a model for the benefits and working mechanisms of family nursing conversations in home healthcare was successfully developed. Families in home healthcare consider family nursing conversations a valuable intervention for functioning optimally in their current and future care situation. In societies in which residential care is discouraged and postponed and family involvement in caregiving is increasingly important, optimising family functioning in care situations and preventing caregiver burden within families is of crucial importance. Insight into the benefits and working mechanisms of family nursing conversations offers directions for outcomes and processes that can be included in future evaluation studies. Nurses and other healthcare professionals can use the benefits and working mechanisms as tools to shape their role as care provider for patients and their families.

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CONFLICTS OF INTEREST

The authors have no conflict of interest to declare.

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