



Anticipatory Caring

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Abstract

Today, more and more people die in own homes and nursing homes, which fundamentally affects community nursing. The aim of this study was to develop a grounded theory of palliative home nursing care and we analyzed interviews and data related to the behavior of community nurses caring for palliative cancer patients. *Doing Good Care* emerged as the pattern of behavior through which nurses deal with their main concern, their desire to do good care. The theory *Doing Good Care* involves three caring behaviors; *anticipatory caring*, *momentary caring* and *stagnated caring*. In anticipatory caring, which is the optimal caring behavior, nurses are doing their best or even better than necessary, in momentary caring nurses are doing best momentarily and in stagnated caring nurses are doing good but from the perspective of what is expected of them. When nurses fail in doing good, they experience a feeling of letting the patient down, which can lead to frustration and feelings of powerlessness. Depending on the circumstances, nurses can hover between the three different caring behaviors. We suggest that healthcare providers increase the status of palliative care and facilitate for nurses to give anticipatory care by providing adequate resources and recognition.

Introduction

The demographics of dying have changed with more people dying at home or in nursing homes. The number of hospital beds has declined and homecare has increased, and more own home deaths are expected in the future (Burge, Lawson & Johnston, 2003; Higginson, Astin & Dolan, 1998; Socialstyrelsen, 2006). The extension of palliative care varies in different parts of Sweden (Socialstyrelsen, 2006) and fewer hospital beds increases the strain for both acute hospital care and homecare (Fürst, 2000). The acute hospital care has a high pace and a “culture of quickness” (Andershed & Ternstedt, 1997) and this high pace was found to be one explanation to why nurses suffered emotional overload while caring for palliative cancer patients in acute hospitals (Sandgren, Thulesius, Fridlund & Petersson, 2006). In the contrast to the high pace in the acute

hospitals, the hospice philosophy has a “culture of slowness” (Andershed & Ternestedt, 1997) and it has thus been suggested that the hospice philosophy should be spread to all care settings with dying people (Clark, 1993). At the same time, it has been proposed that palliative care should be available wherever the patient is. In addition, the patients and their families should receive the same standard of care irrespective of domicile and source of service delivery (Dunne, Sullivan & Kernohan, 2005; SOU, 2001). In homecare, the community nurses have a central position (Wright, 2002), but their work is in a way an invisible work, predominantly conducted in the patients’ homes (Goodman, Knight, Machen & Hunt, 1998; Luker, Austin, Caress & Hallett, 2000). Community nursing has shown to offer stimulation and appreciation, especially from patients and relatives, but also a possibility for nurses to use all their professional skills (Dunne et al., 2005; Goodman et al., 1998). However caring for palliative cancer patients in their homes has also been shown to be stressful (Berterö, 2002; Dunne et al., 2005), emotionally burdensome (Griffiths et al., 2007), and causing feelings of powerlessness (de Schepper, Francke & Abu-Saad, 1997). The knowledge of community nurses’ role has increased during the last years, but there is a paucity of knowledge on community nurses in palliative home nursing care.

Our aim in the present study was to develop a grounded theory of palliative home nursing care. The research question guiding the study was; what is the main concern for community nurses caring for palliative cancer patients and how do they resolve it?

Method

Classic Grounded theory is a general method, which means that both qualitative and quantitative data can be used, since “all is data” (Glaser, 1998, p.8). We chose classic grounded theory for both data collection and analysis since it suited our basic research question. Grounded theory aims at conceptualizing patterns of human behavior (Glaser, 1978, 1998). In Grounded theory categories and their properties emerge from data and eventually become parts of hypotheses in a theory. The theory is a probability statement explaining the behavior that accounts for the resolving of a main concern for the participants (Glaser, 2003). In this study, the theory aims at explaining the patterns of behavior that community nurses engage in while caring for palliative cancer patients.

This study was carried out from 2004 to 2006 in seven different rural communities with a population of 178,000 in the south of Sweden. These communities lacked any organized form of advanced palliative home care or palliative unit or hospice at the time of the study. End of life care was provided mainly at acute hospitals, in nursing homes and in the patients’ own homes. A palliative care counseling team consisting of four nurses and one physician was a link between the communities and the two hospitals and supported the community nurses during office hours.

We interviewed 32 female nurses and one male nurse, and 30 of them had more than 10 years of working experience at hospitals or/and in homecare. The interviews began with: “Tell me what it’s like to care for palliative cancer patients”. Ideas emerged of what to ask next while interviewing, and more specific questions for later interviews while analyzing such as “Tell me about a difficult caring situation”, “How do you handle difficult situations?” and “Tell me about a caring situation that went well”. This procedure is a property of theoretical sampling. “Theoretical sampling is the process of data collection for generating theory whereby the analyst

jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges” (Glaser, 1978, p.36). The first ten interviews were tape-recorded and transcribed, but for the later interviews, only field notes were taken according to classic grounded theory (Glaser, 1998, 2001). Interviews lasted between 45 and 90 minutes. By the end of the study, interviews were shorter owing to the delimiting properties of grounded theory.

We analyzed the transcribed interviews and the field notes line by line after each interview. Incidents articulated in the data were analyzed and coded. During the open coding, the basis for concept generation, we asked a set of questions to our data: What is this data a study of? What category does this incident indicate? What is actually happening in the data? What is the nurses’ main concern? How do they continually resolve this concern? The purpose of these questions is to keep the analyst theoretically sensitive and to avoid description, when analyzing, collecting, and coding data (Glaser, 1998). We compared open codes with each other followed by comparing newly generated concepts to new open codes and then concepts to other concepts and eventually the core concept *Doing Good Care* emerged. Hereafter, selective coding was done to delimit the coding to variables related only to the core concept. The core concept was thus a template for further data collection and theoretical sampling (Glaser, 1978, 1998; Glaser & Strauss, 1967). During the selective coding, secondary analysis was also done on data that had been collected in our earlier studies. We chose the interviews that were most comprehensive; 11 formal interviews with community nurses and 3 focus group interviews with 5 community nurses, 3 surgeons, and 10 general practitioners (Thulesius, Håkansson & Petersson, 2003) and 16 nurses in acute hospital care caring for palliative cancer patients (Sandgren et al., 2006). The purpose of the secondary analysis was to refine the categories and delimit the coding only to variables related to the emerged core concept. We also analyzed documents from an education for community nurses and the palliative counseling team. At the same time we analyzed field notes and memos from informal interviews, participant observation at cancer care conferences, and grounded theory seminars. We compared these data with the formal interview data, consistent with the grounded theory concept “all is data”. Our selection of data was guided as much as possible by theoretical sampling and we stopped collecting data when a saturation point was reached (Glaser, 1978). Saturation was reached when the most recent interviews and field notes did not contribute with any further categories or properties in relation to the core concept. The theory *Doing Good Care* focuses on the properties that repeated themselves across the majority of the data.

During the whole analytic process, we wrote theoretical memos in the shapes of text and figures. Memos are the “theorizing write-up of ideas about substantive codes and their theoretically coded relationships as they emerge during coding, collecting and analyzing data and during memoing” (Glaser, 1998, p. 177). We also wrote memos on memos, and developed a rich memo bank. Through the sorting of memos, we sought relationships between categories and the core concept, and put aside time, place, and individuals in the theoretical coding as this stage indicates. During the analysis, typology emerged as the most suitable theoretical code and the theory is therefore built up as a typology, which is one theoretical code out of many theoretical coding families (Glaser, 2005). We finally wrote up the memos to a theory as a last stage of the grounded theory methodology. According to classic grounded theory principles, a literature

review was done after the substantive theory was formulated, using the literature as another source of data integrated into the constant comparative process (Glaser, 1998).

A grounded theory should be judged by fit, relevance, workability and modifiability. Fit is an aspect of validity and depicts how the concepts match the incidents they represent. Relevance means that the concepts relate to what is really going on and how it is continually resolved. A theory that works explains how a main concern is resolved with variation. The theory should be modifiable by comparing new relevant data to existing data. A grounded theory, therefore, should be judged according to these principles, but a grounded theory is never right or wrong, the theory only has more or less fit, relevance, workability and modifiability (Glaser, 1998). The theory *Doing Good Care* is modifiable since there are many properties of the core concept yet to be discovered. The literature review that we did gave indications of our theory's relevance, workability and modifiability. When lecturing on the *Doing Good Care* theory to caregivers and researchers, we received approval pertaining to fit, relevance and workability.

This study was approved by The Regional Ethics Committee of Lund University, Sweden (LU 680-3) and by those responsible for home care in the municipalities involved. We obtained written informed consent from the 33 participants before the interviews. At the end of each interview, we assessed possible needs for emotional support and provided each participant with information about where they could find this if they wished or felt upset about issues that taking part had raised for them.

A Theory of Doing Good Care

A genuine desire of doing good is the motivation for caring and the main concern for the nurses. Caring takes time and the nurses just cannot leave the patient, walk away, and hope that someone else will take over. The nurses thus feel a responsibility towards the patients and their relatives. When nurses sense that they fail in doing good, they also feel that they are letting the patient down, which may lead to frustration and powerlessness. A failure in doing good can come from not having the right resources, either internal or external. Therefore, a lack of time or knowledge, limited access to physicians, lack of feedback, no advance planning, and lack of emotional competence are some reasons for this perceived failure in caring. When nurses cannot do what is best for the patient, this may also lead to ethical stress, for example knowing what to do, but not being able to do it is distressing and leads to feelings of guilt. Nurses are dealing with this in different ways depending on their type of caring behavior.

The theory *Doing Good Care* involves three different caring behaviors based on the nurses' desire of doing good (Table 1). *Anticipatory caring* emerged as the optimal way of giving palliative care and means positioning future and doing ones best or even better than necessary. In *momentary caring* nurses are doing best momentarily and in *stagnated caring* nurses are doing good but from the perspective of what is expected of them. Which caring behavior they choose depend on external or internal factors such as the organization, resources, personality, emotional competence, knowledge, but also the nurses' personal life situation. This means that the nurses can hover between the three different care types depending on the circumstances. Elsewhere emotional energy drains, for example from the nurses' family lives, may also affect the caring behavior. This energy loss decreases the nurses' emotional competence and is most common in

momentary caring and stagnated caring. Momentary caring can also result in good palliative care, but this is contingent on the individual nurse who gives the care. Stagnated caring on the other hand may cause a distance or a cold shield towards the patients and relatives and with this shield; it can be difficult to create trust.

Table 1. The theory Doing Good Care as emerged from data in palliative home nursing care (cannot be shown, see pdf version)

Anticipatory Caring

The optimal home care orientation for patients, their relatives, and for the nurse herself, is anticipatory caring. It is done by advance care planning through foreseeing trajectories, creating trust and safety, collaborating and prioritizing. Driven by their intention of doing their best or even doing better than necessary, the nurses have a strong interest in palliative care caused by their personality and their attitude to life.

Foreseeing Trajectories

Foreseeing trajectories is done through predicting and being one step ahead. **Predicting** means fore-sighting using knowledge and experience to predict what might happen; “It is an ability to foresee what might happen, even if it’s not possible every time”. With experience, the nurses develop a “clinical gaze” that promotes safety when facing strange and unexpected situations. During the whole caring process nurses continually are assessing, predicting, planning and solving different issues. This is often considered as a challenge done to the best of their abilities. To facilitate this process and to be able to plan ahead, nurses encourage “cutting point talks” with patients and relatives to inform and elucidate what is happening and what might happen. In addition, nurses may run an errand without any medical cause, just to see a patient to form their own opinion about the patients’ future.

Being one step ahead involves planning and organizing on the basis of what can be predicted; “You have to think one step further and plan for what might happen”. By being one step ahead, nurses are “creating future” and striving forward. Patient issues are often discussed with colleagues in order to find out what care the patients should receive. Sometimes nurses are trying to do more than possible under the circumstances. This is caused by their strong objective of doing best all the time. They are trying to overcome obstacles that arise since they can see the existing possibilities and potentials to render good palliative care. It is emotionally demanding when foresight does not work and nurses cannot do enough to help the patients. This can be experienced as a defeat, for example, when a patient unwillingly is transferred to hospital just because the foresight was lacking. When caring for patients in their own homes, therefore, nurses anticipate what might happen. It could be an extra prescription for pain relief, or a preplanned direct transfer to a nursing home if home care does not work. With a flexible planning, the patient can stay at home during daytime and spend the night at a nursing home.

Creating Trust

Creating trust is done by cultivating relationships with patients and relatives and it promotes safety; “You have to get to know the patient to be able to create trust”. This becomes easier with experience and knowledge, but the nurses’ personalities are also important in the process. Actually, the “personal chemistry” between the nurse and the patient or relative can sometimes be more important than experience to create trust. Nurses with high emotional competence can show empathy and be honest with the patient and relatives and this increases trust. The first meeting is important since the first impression of the nurse and her attitude affects how much the patient and relatives will trust her in the future. It is easier to create mutual trust with patients and relatives if nurses are engaged early in the palliative phase. Therefore, the nurses, if possible, visit the patients in the hospital before they return home. Insecurity is the biggest obstacle to home care perceived by patients. If the patients do not feel safe, anxiety will take over. The insecurity of relatives can also make it impossible for patients to stay at home. This insecurity can be prevented by the access to competent staff whenever the patient or the relatives need them.

Collaborating

Collaboration with colleagues to discuss and assess the needs of patients and relatives is essential when giving anticipatory care; “You can’t do everything by yourself, you have to collaborate when giving palliative care”. Sometimes nurses collaborate with experts such as the oncology counseling team. They support nurses in difficult situation of either a practical or of a more psychosocial nature. The availability of the counseling team increases nurses’ self-confidence and trust, which improves the care. The continuity and availability of physicians increase trust for both nurses and patients. Reciprocal respect between nurses and physicians, therefore, is a prerequisite for Anticipatory caring. When physicians and nurses do not share the same caring perspective, this causes conflicts and difficulties in giving high quality palliative care. Different opinions about the patients’ care in the team can cause Momentary caring or even cause Stagnated caring outcomes.

Prioritizing

Prioritizing is a prerequisite for Anticipatory care. Limited caring resources leads to down prioritizing tasks that can wait and patients not dying, and up prioritizing dying patients that now become priority one. **Time prioritizing** is often done while Anticipatory caring. Taking the time that does not exist may increase the workload for other team colleagues although it is considered legitimate to take more time with palliative patients; “It causes a burden for my colleagues, but they know that it will save them time in the future, because the patient will be satisfied”. Investing in tasks that take more time momentarily will eventually save time in the future.

Flexibility in the nurses’ daily work is important, but also team flexibility, for example when a nurse does not have the energy or the competence to care for the dying patient this can be done by another nurse in the team; “When a nurse is in a personal life situation that makes it difficult for her to care for dying persons, we are flexible and change patients”. However, there is thus a risk that flexibility decreases continuity of care for the patients.

Emotional Survival Strategies while Giving Anticipatory Care

The nurses' desire of doing best or even better is emotionally demanding, and creating trust requires dedication. Also, the closeness to the patient and relatives can negatively affect the nurses' emotional health. Professional Shielding is used as a protective attitude towards emotionally difficult situations. There is a risk of losing this professional shield and getting too close in the patient-nurse relationship. The closeness limit can be subtle and sometimes the relationship is taken over by the nurses when their own private issues come in focus and not the patients'.

When nurses give Anticipatory care and experience feelings of letting the patient down, this is mostly caused by unpredictable situations out of the nurses' own control. If the nurses did everything in their power to do good, but it did not help the patient this causes frustration, guilt and a sense of powerlessness. These emotions are managed through Emotional Processing, for example by using the strategies Self-reflecting and Confirmation-seeking. When nurses reflect over what happened in the trajectory of a dying patient in relation to doing best they are Self-reflecting. They feel satisfied when they have done all they could and this makes it easier to move on. Finishing a trajectory is important to be able to move on. Finishing means for example being present when the patient dies or talk about what happened later with colleagues. When Confirmation-seeking, nurses look for recognition from professional counseling, colleagues, patients, relatives, and from their own family. Recognition is necessary for building up self-confidence in order to do best all the time. Without recognition, it is impossible to keep on doing best and Anticipatory caring is turned into Momentary caring.

Momentary Caring

Momentary caring involves temporary solutioning, which means solving problems when they arise. The nurses are doing best momentarily, which means doing as good as possible in every situation. Momentary caring with a future view is used when nurses have an anticipatory thinking but lack the resources to render anticipatory care.

Temporary Solutioning

Temporary solutioning entails momentary prioritizing and sporadic collaborating. ***Momentary prioritizing*** is often done because of inadequate resources, which makes it difficult to be one step ahead and plan for what might happen. In some workplaces, it is not allowed to take the extra time that palliative care requires. Therefore, nurses are momentarily prioritizing without any future planning. Solving a problem when it arises and if necessary, using their professional contacts to get momentary help; "When a problem arises, we try to solve it and do as good as we can". They are doing as good as they can under the circumstances and use temporary solutions, which can lead to patients not receiving optimal care.

Sporadic collaborating is done if necessary, but nurses often handle problems themselves. The uncertainty is a thrill and it is a challenge that motivates them because "you never know what will happen". Nurses may have tried collaboration before, but not succeeded. This in turn can be explained by incoherent care goals. By sporadic collaborating with the palliative counseling team, some temporary solutioning facilitates for the nurses. Sporadic collaborating with physicians is often caused by a lack of continuity of physicians and unclear patient

responsibilities. Sometimes the nurses feel trapped between the hospital physician and the general practitioner. A limited sporadic collaboration may lead to a decreased understanding and communication between the communities and the hospitals. Sporadic contacts might not be enough, for example, to prevent an unnecessary hospital admission. Nurses giving Momentary care also create trust and promote safety. However, it can be difficult to create trust when collaboration is sporadic and patients do not know what to expect. It is often difficult to create trust when patients return home from hospital in a late palliative care phase, and without anticipatory care planning.

Emotional Survival Strategies while Giving Momentary Care

The nurses' desire to do good care drives them to try to change the circumstances. Their intentions are good but they cannot do all they want due to limited resources, a lack of guidelines and so on. Instead, they increase their palliative care knowledge by education or reading literature. Feelings of letting the patient down often depends on knowing what should have been done, but because of lack of knowledge or lack of resources the patients did not receive a good enough care. This can lead to giving up the struggle to improve the care and risking burnout symptoms. They feel that it does not matter what they are doing any more. Nurses giving momentary care sometimes have the tendency to take over the relationship to become the patients' favorite nurse. Therefore, at the same time as they feel that they have to give a lot and sometimes sacrifice themselves, they think it is worth it.

In momentary care, nurses also use the strategy of professional shielding as an emotional protection, but they risk losing the shield if recognition is lacking. Receiving recognition and confirmation is necessary for continuing momentary care. Emotional processing while momentary caring is mostly done through confirmation-seeking and chatting. Chatting means taking a break just to chat with colleagues or someone else shortly after a difficult situation to get some confirmation. To hear that they are doing good and that their care giving is fine is vital in momentary care. Lack of confirmation and recognition leads to "future fear" and "future neglect". This means that nurses neither have the energy nor the motivation to think of what might happen in the future, and they are afraid of what the future might bring. This reduces the possibility of advance planning and results in feelings of resignation. If the nurses at the same time consider that they could not give the care that they wanted they get more and more frustrated. To deal with this frustration they may start to ruminate, which means pondering the situation without any positive results or they postpone the emotions with or without the intention of dealing with them later. Using these two strategies eventually leads to a stagnated caring behavior.

Stagnated Caring

Stagnated caring entails avoiding changes and resigning. Stagnated caring can be a consequence of decreased recognition when giving momentary care making the nurses resign and give up. It can also be caused by the nurses' low emotional competence and their own fear of death. Nurses giving stagnated care are doing what is expected of them. They are also driven by a desire of doing good, but they are satisfied with the care they give and cannot see any reasons for changing it.

Avoiding Changes

By avoiding challenges, nurses avoid changes in order to protect themselves. Challenges often cause changes both for the nurse herself, for example her attitudes, and for the organization, for example work changes. Nurses giving stagnated care protect themselves against changes or challenges since this requires more effort than the nurses can handle. In addition, nurses lack the capacity to deal with the consequences of the changes. This lack of capacity can be caused by own fear and lack of selfconfidence, but also by lack of emotional competence, experience and palliative care knowledge. A pending attitude of suspicion or distrust towards new technical equipment and new techniques is common. Nurses in stagnated care do problem solving on their own because they do not see any reason for involving other people; “We have always managed this by ourselves before. Why do we need experts now?” This is often related to decreased communication with the hospitals, which may lead to reduced trust and quality of care for the patients.

Resigning

Resigning is part of stagnated caring. Resigning can be caused by either giving up, or a lack of emotional capacity to care for dying persons. Giving up is a more common cause of stagnated care than lack of emotional capacity. Giving up means that nurses have gone from anticipatory or momentary caring to stagnated caring. This is often caused by a lack of recognition or adequate resources leading to frustration, powerlessness and decreased energy; “It’s no use to try anymore. I have tried before but without any success”. Without energy, it is easy to give up and resign, which may lead to cold shielding, an unconscious emotional protection with a cold distance to the patients and relatives. A lack of emotional competence to care for dying is a more rare cause of resigning. Without the emotional sensitivity necessary to care for dying persons it is hard to create trust and predict what might happen. Lack of emotional competence leads to difficulties to receive critique and causes emotional fear, which then leads to postponing emotions.

Emotional Survival Strategies while Giving Stagnated Care

When nurses think they are doing as good as they can and are not trying to do more or to change their way of caring, they are doing what is expected of them and nothing more. They do not believe that they can do anything different and that it does not matter what they are doing. The attitude of not having the responsibility of life and death becomes a false safety protection. This can also be an excuse for not involving oneself more than necessary, which can lead to a routine manner care.

Nurses in stagnated caring are normally less emotionally involved in their patients than nurses who give anticipatory or momentary care. When stagnated care nurses are emotionally processing what happened, they believe they did what was expected and that they could not influence the situation. They lack the energy or emotional competence to deal with difficult emotions that arise. Postponing emotions without processing them leads to cold shielding. This in turn leads to a false sense of satisfaction where nurses sincerely believe that there is nothing more to improve. They are not aware of this cold distance that may decrease the quality of the

given care. Therefore, they do not take advantage of resources that may exist to improve the care quality. Either they do not have the emotional competence or the knowledge to improve the care, or they have resigned from Momentary caring and have no energy left.

Discussion

In this grounded theory, we found that the main concern for nurses caring for palliative cancer patients in basic homecare is their desire of doing good care. The nurses use different caring behaviors to handle this “do-good-desire” with anticipatory caring as the optimal behavior. However, the most common caring behavior is momentary caring. Stagnated care is less common but can cause serious consequences for the nurses, patients and relatives. When nurses fail in doing good care, depending on their caring behavior, they use different strategies such as emotional shielding, emotional processing and emotional postponing as seen in a previous study (Sandgren et al., 2006). Yet, this triad typology of caring behavior does not represent the nurses’ entire being or doing. The nurses are surely engaged in other patterns of behavior that need to be further explored. It should also be emphasized that the context in this study was nursing in basic homecare, not advanced palliative homecare, which has a different caring philosophy (Andershed & Ternstedt, 1997). The prerequisites for palliative homecare differ from place to place, but there are commonalities. Community nurses usually care for only a few cancer patients at a time and therefore have more time for dying patients. Goodman et al. (1998) found that it is legitimate to take extra time and ask for more resources when caring for dying patients. With more and more people wanting to be cared for and also die in their own homes (O’Neill & Rodway, 1998; Socialstyrelsen, 2006), homecare eventually will involve more palliative care in the future (Fürst, 2000). To meet this demand basic homecare need input from the hospice philosophy and other resources to give high quality palliative care.

Doing good is indeed a common nursing concept (Avis, Jackson, Cox & Miskella, 1999; Freeman, Ekins & Oliver, 2005; Tishelman et al., 2004). The need to “do good” or act for what was deemed the best, could actually be in conflict with the patients’ wishes (Tishelman et al., 2004). This could be compared with anticipatory caring when nurses want to do their best or even better but feel that it does not work out. The risk of feeling that one has “let the patient down” is greater when giving anticipatory care or momentary care than when giving stagnated care, depending on the use of cold shielding during stagnated care. Giving momentary care requires lots of commitment and without recognition there is a great risk of stagnation or burnout symptoms. Other studies also found frustration and powerlessness while nursing (BerterÖ, 2002; de Schepper et al., 1997) and among relatives caring for patients at home (Milberg, 2003).

Anticipatory care has earlier been addressed in studies in nursing, cancer care, and primary care but with various definitions (Crebolder & van der Horst, 1996; Howarth & Willison, 1995; Kearney, 1999; Pridham, Hansen & Conrad, 1979; Wros, Doutrich & Izumi, 2004). To be able to give Anticipatory care, both internal and external resources are needed, but Tishelman et al. (2004) found that there is a tension between care giving ideals and the problematic realities of daily work, for example limitations in time and space for the staff. In our study, we found that early contact with the patient is essential and that homecare nurses sometimes contact the patient already in the hospital. Griffiths et al. (2007) also showed the importance of an early contact. Yet, Pateman, Wilson, McHugh and Luker (2003) found that patients could experience this early

contact as negative. Our concept of creating trust and safety therefore, plays an important role in the early contact to avoid the negative aspects of an early contact. Appelin and Berterö (2004) found that patients felt secure when they sensed that nurses created safety by being sensitive, competent, and professional. O'Neill and Rodway (1998) showed that patients were more likely to seek admission to hospital if they were insecure or lacked confidence in their support network at home. Patients were also admitted to hospital as a result of inadequate management of symptoms (Addington-Hall, Altmann & McCarthy, 1998) or inadequate practical help at home (O'Neill & Rodway, 1998). Dunne et al. (2005) argue that if nurses were more aware of how to control symptoms, the patients could remain in their own environment to die. Yet, we found that in momentary caring many nurses could not manage this without collaboration with physicians. Adequate resources therefore seem essential so that nurses stay in anticipatory caring and decrease the risk of switching to momentary or stagnated caring.

Avis et al. (1999) found that caregivers were often anxious about not 'doing enough' for the dying patients. To minimize feelings of guilt, Irurita and Williams (2001) saw that some nurses ignored cues given by patients and only approached patients when necessary. This behavior resembles the cold shielding strategy (Sandgren et al., 2006) used in stagnated care. Momentary caring is an emotionally demanding behavior with risk of losing the professional shield if recognition and resources are lacking. Luker et al. (2000) claim that it is more emotionally demanding to get to know patients and relatives in their own homes than in hospitals. However, we found in an earlier study, that hospital nurses were constantly at risk of emotional overload, not because they got to know patients too well, but rather too little (Sandgren et al., 2006). Öhman and Söderberg (2004) found that homecare nurses were invited to share patients' intimacy and their experiences of being ill which led to close relationships. De Schepper et al. (1997) suggested that nurses should stand back when getting too close and let someone else take over. In anticipatory caring there is an awareness of the risk of getting too close while Momentary caring often lacks this awareness. Therefore, there is a higher risk of burnout or a transfer to stagnated caring from momentary caring than from anticipatory caring.

Lack of emotional competence is one cause of stagnated caring. Nurses can see the symptoms and practical things that have to be done, but are avoiding the emotional needs. This can be compared with seeing the diagnosis but not the whole person behind the diagnosis, which can depend on a lack of energy or competence to handle the emotions (Georges, Grypdonck & Dierckx de Casterle, 2002). Dunne et al. (2005) also found that some community nurses had difficulties in communicating with dying and relatives. We found that lack of emotional competence can cause cold shielding, a cold distance towards patients and relatives. Through professional counseling and continual feedback, the emotional competence can increase, which may lead to a transfer from stagnated caring over to momentary caring.

Conclusion and Implications

Our study contributes to existing knowledge with a theory presenting a typology of caring behaviors, which provides a comprehensive framework for understanding how community nurses give palliative care in basic homecare. Although the theory emerged from data concerned with community nursing, the theory might well be expanded to other areas, contributing to a general understanding of how people deal with their desire to do good. The theory "Doing Good

Care” is a complex theory and further research is needed to understand how nurses’ caring behaviors affect patients and relatives.

All nurses should have the opportunity to give anticipatory care, which is the optimal way of caring. Health care providers thus need to increase palliative homecare resources as well as the status of caregivers through adequate recognition. The first step could be helping nurses to avoid stagnated caring by giving them recognition. Then with the right resources, both internal and external, anticipatory caring is possible.

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