

Family Caregiver Preparedness for Symptom Management in Home-Based Palliative Care: Educational Needs and Nursing Support

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Abstract

Family caregivers increasingly undertake symptom observation, medication administration, personal care, nutrition and hydration support, and communication with professionals while caring for people with advanced illness at home. Their ability to perform these responsibilities cannot be understood from information provision alone. This conceptual article examines family caregiver preparedness as a multidimensional and changing condition shaped by what caregivers know, what they can do, how emotionally and relationally ready they are to sustain care, how capable they believe themselves to be, the demands imposed by the illness trajectory, and the professional support available when those demands exceed family capacity. Drawing on contemporary palliative-care, caregiver-support, symptom-management, educational, and nursing evidence, the article develops a caregiver preparedness and nursing-support framework. Preparedness is conceptualized as domain-specific and relational: a caregiver may be well informed yet practically uncertain, technically capable yet emotionally overwhelmed, or confident while lacking the knowledge required for safe action. Medication management, nutrition and hydration decisions, deterioration recognition, and professional communication illustrate how these dimensions interact. The central implication is that home-palliative nursing should assess preparedness repeatedly and match education, coaching, reinforcement, and escalation to the particular mismatch between care demands and available caregiver capability. Preparedness is therefore best treated as a dynamic clinical and relational condition whose meaning depends on task, trajectory, context, and access to professional support.

Keywords: Family caregivers, Home palliative care, Caregiver preparedness, Symptom management, Nursing support, Caregiver education

Introduction

Home-based palliative care transfers substantial day-to-day responsibility to family members while illness severity, symptoms, treatment burden, and care priorities continue to change. Caregivers may prefer different kinds of professional support at different stages of late palliative illness, particularly when the aim is to remain at home through deterioration and dying [1]. At the same time, caregiver burden and patient quality of life are related concerns that cannot safely be treated as interchangeable outcomes or as evidence of a single causal pathway [2]. Practical workload, employment pressures, limited respite, caregiver health, and available support can all contribute to burden [3]. These observations point to a more specific question than whether caregiving is difficult: whether a caregiver is sufficiently prepared for the particular work that the present phase of illness requires. Preparedness is commonly invoked as if it were a unitary state. In practice, a caregiver may recognize that a symptom is worsening but be uncertain what action is appropriate; understand medication instructions but lack

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confidence administering medicines; perform technical tasks competently while becoming emotionally depleted; or feel capable until symptom intensity exceeds what can safely be managed without professional intervention. Such combinations matter because home palliative care is not delivered by caregivers in isolation. Preparedness develops within family relationships, professional support arrangements, service availability, and changing illness demands.

This article develops a caregiver preparedness and nursing-support account of symptom management in home-based palliative care. Information may be sufficient where the principal deficit concerns understanding; demonstration and coached practice may be required where capability is uncertain; emotional support may be more salient where technical competence coexists with distress; and clinical escalation is required where responsibility exceeds what family care can safely absorb.

Conceptual foundations

Family caregiving in palliative care is shaped by both the meaning assigned to family responsibility and the way services operationalize family-centred practice. Recent concept analysis distinguishes culturally grounded understandings of family obligation from the clinical and organizational practices through which professionals engage families in care [4].

Caregiving also involves active attempts to preserve stability in circumstances characterized by deterioration, uncertainty, and shifting roles. Grounded-theory work with next-of-kin in palliative cancer care describes this as an effort to construct stability while confronting helplessness and changing responsibilities [5]. A caregiver may have adequate factual knowledge while remaining uncertain about whether a new symptom signals expected decline, whether requesting help represents failure, or how to reconcile a patient's wishes with increasing practical strain.

Symptom management adds a second conceptual layer. Effective palliative symptom management has been described as dependent on engagement, partnership, decision-making, and coordinated care delivery, with family understanding and professional relationships influencing what can be achieved [6]. This means caregiver preparedness cannot be reduced to possession of correct information. Safe home management often depends on whether family members can interpret symptoms, undertake permitted actions, obtain advice, and transfer responsibility when a problem exceeds their role. Preparedness is consequently relational: it concerns both what the caregiver can mobilize and how the surrounding care system responds.

Family caregiving in home-based palliative care

Family caregivers support far more than isolated clinical tasks. Analysis of caregiver-support needs in home palliative care shows that families require assistance both to enable them to care for the patient and to protect their own functioning and well-being [7]. Needs may involve information, practical guidance, training, counselling, coordination, referral, or reassurance that professional assistance remains available. These categories can coexist, and their relative importance can change even when the diagnosis remains the same.

Longitudinal evidence likewise indicates that caregiver needs do not disappear once specialist palliative care has begun. Informational, psychosocial, and service needs can persist across phases of care and into bereavement, although their pattern changes over time [8]. Preparedness should therefore not be treated as a one-time educational endpoint. A caregiver who was adequately prepared for a stable phase may become unprepared after a sudden increase in symptom intensity, a medication change, new feeding difficulties, cognitive deterioration, or loss of informal support.

Home caregiving is also embedded in wider social and service conditions. Qualitative research based on a social-ecological perspective describes burden and need at individual, family, community, and societal levels [9]. This matters because apparent lack of preparedness may sometimes reflect inaccessible services, fragmented professional contact, limited respite, financial pressure, or weak support networks. An assessment that focuses only on the caregiver risks misclassifying environmental constraints as personal deficiency.

The resulting distinctions among caregiving context, support need, capability, and preparedness are summarized in **Table 1**.

Table 1. Differentiating caregiver-context and preparedness constructs in home-based palliative symptom management

Analytical construct	Primary question	What it captures	What it should not be assumed to represent	Nursing relevance
Care demand	What is the present illness and care situation asking the family to manage?	Symptom intensity, task complexity, frequency, uncertainty, vigilance, relational work	Caregiver competence or willingness	Establishes the workload against which preparedness must be interpreted
Support need	What assistance does the caregiver identify or require?	Information, practical help, emotional support,	Proof of inability or failure	Identifies areas requiring professional response

		coordination, respite, referral		
Knowledge and understanding	Does the caregiver understand the illness, symptoms, instructions, and expected changes?	Interpretive and informational readiness	Practical execution, confidence, emotional capacity	Directs explanation, clarification, anticipatory guidance
Practical capability	Can the caregiver safely perform the relevant task?	Task execution, use of equipment or medicines, monitoring, problem solving	Emotional readiness or global preparedness	Directs demonstration, coached practice, observation and review
Emotional and relational preparedness	Can the caregiver sustain the role psychologically and relationally under current conditions?	Distress tolerance, role acceptance, relational strain, uncertainty	Technical incompetence	Directs emotional support and reconsideration of role demands
Self-efficacy	How capable does the caregiver believe they are?	Perceived confidence to perform or manage	Verified knowledge or safe performance	Helps identify underconfidence, overconfidence, and coaching needs
Access to professional support	Can the caregiver obtain timely advice, review, escalation, and practical assistance?	Availability and usability of formal support	A personal caregiver attribute	Determines whether home management remains supportable and safe
Preparedness	How well do the relevant caregiver resources fit the current care demands?	Task-specific configuration of understanding, capability, emotional readiness, confidence, and support access	A fixed personality trait or simple information score	Organizes repeated assessment and tailored intervention

Note: Constructs are analytically separated even though they may interact in practice. No numerical hierarchy or threshold is implied.

Preparedness as a multidimensional construct

Preparedness has been operationalized as perceived readiness to undertake caregiving activities and cope with associated stresses. A randomized trial of a web-based psychoeducational intervention in specialized palliative home care found no significant between-group improvement in preparedness, even though preparedness increased over time in both groups [10]. The null intervention effect is theoretically important. It suggests that access to education does not automatically produce greater preparedness and that changes over time may reflect adaptation, clinical support, evolving experience, or other processes.

Support-needs assessment provides a complementary but distinct perspective. The Carer Support Needs Assessment Tool has demonstrated validity and reliability in palliative settings and is associated with constructs including burden and preparedness [11]. Yet a support-need instrument does not measure the whole of preparedness. It identifies areas where assistance may be required; it does not by itself establish whether the caregiver possesses the knowledge, skill, emotional readiness, or confidence necessary for a specific symptom-management task.

Cross-cultural validation further cautions against assuming that one assessment form functions identically in every setting. The traditional Chinese version of the Carer Support Needs Assessment Tool showed good overall validity and acceptability in Hong Kong palliative-care settings, while selected items demonstrated weaker retest reliability [12]. Assessment should therefore be sensitive not only to what is measured but to language, context, role expectations, and the way caregivers interpret requests for help.

A recently developed care-competency scale for family caregivers in home palliative care similarly identified several dimensions, including knowledge, daily and special care skills, caregiving qualities, self-care, and acquisition of support resources [13]. These dimensions overlap with preparedness but do not define it completely. The present framework treats preparedness as the fit between multiple caregiver capacities and the demands of a particular phase of care. A caregiver may therefore be prepared in one domain and unprepared in another.

Knowing: understanding illness and symptoms

Knowing refers to the caregiver's ability to understand the illness situation, recognize relevant symptom information, interpret instructions, and distinguish expected changes from events requiring assistance. The multidimensional structure of home-palliative caregiver competency supports treating knowledge as one component among several [13]. Health literacy research among family caregivers of people with cancer likewise demonstrates that the ability to obtain, understand, and use health information constitutes a distinct caregiving resource [14].

Knowing becomes clinically meaningful when it guides interpretation. Caregivers need to understand what a symptom may signify, what actions have been recommended, what variation is expected, and which changes warrant contact with professionals. Yet knowledge has limits. Correctly identifying a medication indication does

not establish competence in dose administration [15]. Recognizing declining intake does not resolve value-laden decisions about hydration. Knowing that breathlessness may worsen does not ensure confidence in deciding when home management is no longer sufficient. The informational domain should therefore be assessed specifically and never used as a proxy for the entire preparedness configuration.

Doing: practical symptom-management tasks

Doing concerns enacted capability: the ability to perform the practical work associated with symptom management under home conditions. A systematic review and meta-analysis of home-based physical symptom-management interventions found that caregiver-targeted approaches can improve selected patient and caregiver outcomes, although interventions, diagnoses, tasks, and study designs were heterogeneous [16]. Practical support may therefore be beneficial, but evidence does not justify a single universal training package.

Digital education illustrates the same distinction. In a randomized trial involving family caregivers of homebound patients with incurable cancer, a palliative-care educational application that included symptom and adverse-effect management improved patient health-related quality of life over the trial period [17]. Such findings support the usefulness of accessible educational resources, while leaving open the mechanism through which benefit occurs. Information may improve recognition, support practical decision-making, facilitate earlier help-seeking, or reinforce existing professional teaching [18].

The practical domain is best assessed at the level of the actual task. A caregiver who can verbally repeat instructions may still be unable to administer medication accurately, reposition a weak patient safely, monitor an evolving symptom, or use equipment under stressful conditions. Conversely, repeated experience may produce considerable practical skill even where formal health literacy is limited. Nursing assessment should therefore examine what caregivers can demonstrate and manage in context, not simply what information they have received.

Being: emotional and relational preparedness

Being refers to the capacity to remain emotionally and relationally engaged in caregiving under conditions of uncertainty, progressive loss, disrupted roles, and responsibility for another person's comfort. This dimension includes distress tolerance, willingness to occupy the caregiving role, capacity to make difficult decisions, and the ability to remain connected to the patient without interpreting every difficulty as personal failure.

Caregiver self-care practices vary with well-being and preparedness, suggesting that caregiving readiness is intertwined with the caregiver's own functioning [19]. Contemporary evidence from specialist palliative home care also documents psychological distress together with unmet emotional and informational needs among informal caregivers [20]. Emotional burden should not be interpreted as technical incompetence. A caregiver can perform tasks correctly while becoming exhausted, frightened, or unable to sustain the role without additional support.

Relational preparedness also concerns the changing meaning of responsibility. As illness progresses, the family member may move from companionship and ordinary assistance into intimate personal care, medication work, vigilance, and decision-making. The question is therefore not whether distress is absent. It is whether the caregiver can continue to participate in care without the emotional and relational demands exceeding what can reasonably be supported at home.

Pain and medication management

Medication work makes the distinction among knowing, doing, being, and support access particularly visible. Reviews of family caregivers' experiences of managing medicines for people dying at home describe substantial organizational, practical, and relational responsibility [21]. Caregivers may have to interpret symptoms, remember schedules, prepare and administer medicines, monitor effects, obtain refills, and decide when professional advice is required.

Qualitative evidence from family caregivers administering end-of-life medications in China further identifies challenges involving symptom recognition, dose decisions, medication access, fear of errors, emotional concerns, and contextual barriers [22]. These findings should not be transferred uncritically across regulatory systems, but they illustrate why medication preparedness cannot be reduced to written instruction. The caregiver's role is constrained by what clinicians have prescribed, what support is available, and what actions are legally and clinically appropriate.

Knowledge and confidence must also remain separate. Among family caregivers of adults with cancer in a resource-limited setting, pain-management knowledge and self-efficacy were empirically distinguishable [23]. Confidence does not prove correct practice, while lower confidence does not necessarily indicate poor knowledge. This distinction has immediate nursing relevance because an overconfident caregiver may require verification and observation, whereas a knowledgeable but hesitant caregiver may benefit from supervised practice and reassurance.

Interventions designed to support family caregivers in pain management span education, coaching, communication, and other strategies, but systematic review evidence remains heterogeneous [24]. The appropriate

question is therefore which aspect of preparedness is limiting safe medication management in a particular situation. A knowledge deficit requires clarification; a skill deficit may require demonstration and return demonstration; low confidence may respond to coached practice; distress may require emotional support; and complexity beyond the caregiver's role requires professional reassessment.

Nutrition and hydration tasks

Nutrition and hydration create a different preparedness problem because technically possible actions may conflict with patient preferences, clinical goals, or expectations about dying. Qualitative work on artificial nutrition and hydration decisions in hospice care demonstrates that such decisions can involve perceived risks, goals of care, family values, social influences, and moral distress [25]. The reported trajectory is context-specific and should not be treated as a universal sequence, but it highlights the limits of a purely instructional approach.

Caregivers may interpret declining intake as a task to be corrected even when reduced appetite and fluid intake are part of progressive dying. Preparedness in this domain therefore includes understanding the clinical meaning of change, tolerating uncertainty, communicating about goals, and knowing when professional interpretation is required. Emotional readiness may be especially important where offering food or fluids is closely linked to caregiving identity, affection, cultural duty, or fear of neglect.

Recognizing deterioration and crisis

A caregiver's ability to recognize deterioration forms the bridge between home symptom management and escalation. Crisis in outpatient palliative care does not appear to result from a single trigger. Family-caregiver accounts describe interacting structural, illness-related, care-intensity, and psychological factors that accumulate until the situation can no longer be managed as before [26].

This evidence argues against a universal threshold defining when a caregiver is "prepared." The same symptom may be manageable for one family and destabilizing for another because the available skills, emotional resources, nighttime support, professional accessibility, and competing responsibilities differ. Recognition therefore involves two judgments: that the patient's condition has changed and that the current caregiver-support configuration may no longer be sufficient.

Nursing preparation for deterioration should include anticipatory guidance without shifting diagnostic responsibility onto the family. Caregivers can be taught what changes deserve attention, whom to contact, what information to report, and which actions are already authorized. They should not be expected to independently resolve uncertainty that requires clinical assessment.

Communication with professionals

Communication with professionals is a cross-cutting capability because it converts recognition into access to advice, reassessment, and escalation. It includes being able to describe symptoms, report what has already been tried, express uncertainty, ask for clarification, communicate patient preferences, and identify when home care is becoming unsustainable.

A caregiver-targeted web-based psychoeducational intervention in specialized home care has been examined for its effects on communication between spouses and people with incurable illness [27]. Although the pre-post design limits strong causal inference, the study reinforces the principle that communication processes are modifiable and clinically relevant. Communication is therefore more than a consequence of knowledge. A caregiver may understand the clinical situation but struggle to raise concerns, challenge an unclear instruction, or request additional support.

Professional communication also has an organizational side. The caregiver can only escalate effectively when services are reachable, messages are taken seriously, and responsibility is clear. Preparedness should consequently include knowledge of how to access help and confidence in using those pathways, while avoiding the assumption that communication failure lies solely with the family. A responsive service can compensate for limited caregiver experience; fragmented or inaccessible services can undermine even a knowledgeable and highly committed caregiver.

The interaction among medication work, symptom recognition, communication, and professional responsibility is summarized in **Table 2**.

Table 2. Interaction of caregiver capability, symptom-management demands, and professional responsibility

Clinical situation	Caregiver preparedness question	Potential limiting mechanism	Appropriate nursing response	Point at which responsibility must shift
New or worsening pain	Can the caregiver recognize change and follow the agreed medication plan?	Uncertain symptom interpretation, dosing concern, fear of adverse effects	Clarify plan, check understanding, observe technique where relevant, reinforce contact criteria	Pain remains uncontrolled, presentation is atypical, or treatment requires reassessment

Scheduled medication administration	Can the caregiver prepare and administer medicines safely?	Practical complexity, memory burden, low confidence, competing tasks	Simplify instructions where clinically possible, demonstrate, use teach-back/return demonstration	Safe administration cannot be maintained or medication plan changes beyond caregiver competence
Breakthrough symptoms	Does the caregiver know which authorized actions are available?	Confusion between routine and rescue treatment, uncertainty about timing	Provide individualized action guidance and escalation instructions	Rescue plan is ineffective, unclear, contraindicated, or symptoms deteriorate rapidly
Declining food or fluid intake	Does the caregiver understand the clinical context and patient's goals?	Belief that all reduced intake must be corrected, relational distress	Explain expected changes, explore goals and values, support discussion	Clinical uncertainty, distress, conflict, or decisions exceed the agreed home-care plan
Possible deterioration	Can the caregiver identify relevant change and report it?	Ambiguous symptoms, vigilance burden, uncertainty about urgency	Anticipatory guidance, concise reporting cues, explicit contact pathway	Change requires professional assessment, diagnosis, or treatment modification
Emerging caregiver crisis	Can the caregiver safely continue the current level of responsibility?	Exhaustion, fear, competing duties, emotional overload, weak support	Reassess preparedness and care demand, mobilize respite/support, reduce caregiver load	Care demands exceed sustainable family capacity
Contact with professionals	Can the caregiver obtain and use timely advice?	Unclear service route, communication difficulty, fragmented responsibility	Establish named contacts, escalation routes, feedback and confirmation	Service must assume coordination or direct clinical management
High confidence with uncertain competence	Is confidence supported by correct knowledge and safe performance?	Overestimation of ability	Verify knowledge and observe relevant task; correct unsafe assumptions	Unsafe practice persists or requires clinical judgement
Adequate knowledge with low confidence	Is practical performance intact despite hesitation?	Underconfidence, anxiety, lack of experience	Coached practice, reassurance, reinforcement, staged independence	Distress or uncertainty prevents safe execution

Note: The matrix separates caregiver capability from clinical responsibility. It does not authorize caregivers to diagnose, prescribe, independently alter treatment, or undertake tasks outside the agreed care plan.

Caregiver self-efficacy

Self-efficacy concerns perceived capability, not verified knowledge or performance. Preparedness research shows that educational exposure alone does not guarantee greater preparedness [10], while home-palliative competency research separates knowledge, skills, self-care, and support-resource acquisition [13]. Pain-management evidence likewise distinguishes knowledge from self-efficacy [23]. Nursing assessment should therefore compare confidence with understanding and task performance. Low confidence may require coaching; high confidence with inaccurate knowledge or unsafe technique requires correction [28].

Educational needs

Educational need follows from the specific gap between care demand and preparedness. Explanation suits misunderstanding; demonstration and coached practice suit practical uncertainty; emotional support suits distress that coexists with technical competence. Repeated telephone coaching has shown benefit in a small rural heart-failure palliative-care trial, but its setting and sample do not justify a universal package [29]. Education should therefore be targeted, revisable, and linked to the task rather than treated as completed information transfer.

Nursing assessment of preparedness

Assessment should be multidimensional and repeated as illness changes. Support-needs tools [11], culturally adapted assessment instruments [12], and competency measures separating knowledge, practical care, self-care, and resource acquisition [13] each capture part of the problem. None validates the present framework as a whole. Nurses should assess understanding, relevant performance, confidence, emotional strain, and usable professional support, then interpret these against current care demands.

Nurse-led teaching and coaching

Nurse-led support extends beyond instructions. Nurses providing palliative care at home describe understandable information, relationship building, need identification, and creation of security, while also reporting that support can lack structure [30]. Teaching should match the assessed deficit: clarification for interpretive uncertainty, demonstration for practical difficulty, coaching for limited experience, and referral or redistribution when care demands exceed the family role [15, 31].

Ongoing support and reinforcement

Preparedness changes with experience, fatigue, symptom progression, and service availability. Mixed-method hospice evidence indicates that intervention timing matters and that usefulness varies across the caregiving trajectory [32]. Longitudinal support preferences [1] and persistent needs across palliative phases [8] reinforce this temporal view. Reassessment should identify what has changed, what has been learned, and whether responsibility remains appropriately allocated [33-35].

Proposed caregiver preparedness framework

Preparedness is conceptualized as the fit among care demands, caregiver resources, and accessible professional support. Four caregiver-level elements remain distinct: knowing, doing, being, and self-efficacy. Knowing concerns interpretation; doing concerns practical performance; being concerns emotional and relational readiness; self-efficacy concerns perceived capability. Professional support determines whether advice, reassessment, coaching, respite, and escalation can be obtained [36-44].

Preparedness is therefore task- and time-specific. A caregiver may manage routine medication yet be unprepared for rapid deterioration, or perform care competently while no longer being able to sustain it emotionally. Nursing support begins with identifying the limiting domain, then uses targeted teaching, coaching, reinforcement, or escalation. **Figure 1** depicts this configuration.

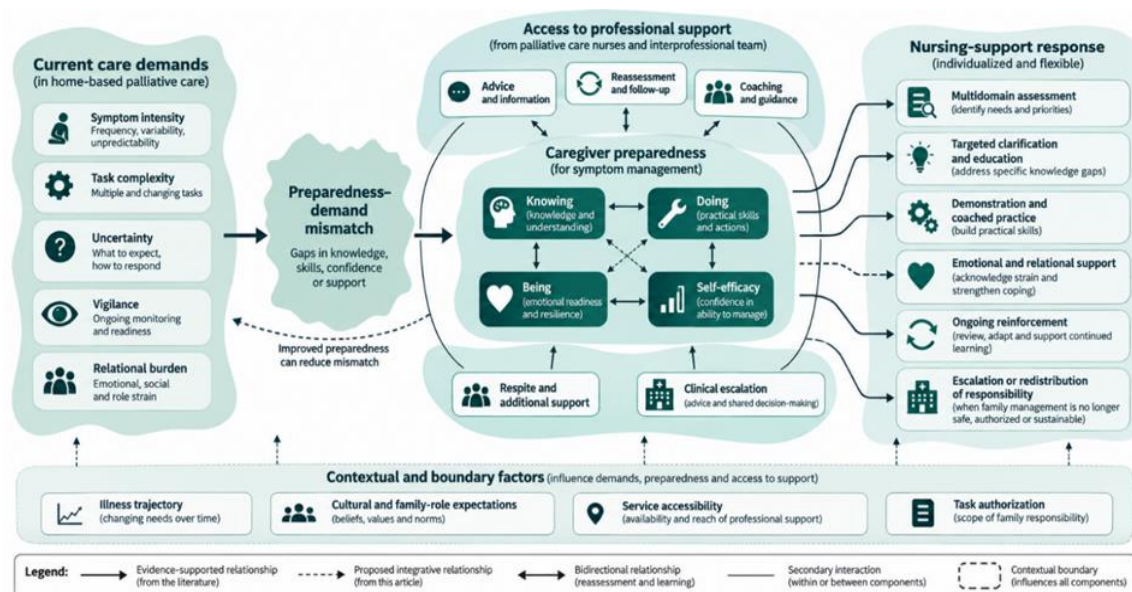


Figure 1. Preparedness–Demand Configuration and Nursing-Support Response in Home Palliative Symptom Management

Mismatch between care demands and preparedness

Mismatch occurs when current task demands exceed the caregiver resources relevant to that task or when professional support cannot compensate. It may be informational, practical, emotional, confidence-related, or organizational. No numerical threshold is proposed. The concept is situational: a caregiver can remain well prepared overall while one new symptom creates a clinically important deficit [45-49].

Escalation and support pathways

Escalation is appropriate when a problem requires professional assessment, treatment modification, respite, coordination, or direct care. Crisis evidence shows that deterioration may arise from interacting illness, care-intensity, structural, and psychological factors [26]. Communication [27] and nursing support [30] create pathways out of unsupported family responsibility. Remediable deficits may receive education or coaching; demands outside the legitimate or sustainable family role require redistribution toward professional services.

Boundary conditions

The framework is not universally invariant. Family-role expectations vary culturally [4]; assessment tools may perform differently across settings [12]; competency measures require external validation [13]; nutrition and hydration decisions are value-sensitive [25]; and diagnosis-specific intervention findings have limited generalizability [29]. The framework may also operate differently where professional home-care access is poor, the patient declines family involvement, or illness changes faster than support can be mobilized.

Implications for home-palliative nursing

Home-palliative nursing should treat preparedness as a repeated assessment rather than a completed education checklist. Support can then be matched to the identified gap while explicitly preserving the boundary between family participation and clinical responsibility.

Research propositions

Proposition 1. Knowledge, practical capability, emotional-relational preparedness, and self-efficacy will show discriminant value when measured separately.

Proposition 2. Task-specific preparedness–demand mismatch will explain escalation need more precisely than information exposure or caregiver burden alone.

Proposition 3. Support matched to the limiting preparedness domain will outperform untailored information provision for task-relevant outcomes.

Proposition 4. Responsive professional support will moderate the relationship between caregiver preparedness and sustainable home symptom management.

Proposition 5. Changes in illness demand will predict longitudinal changes in preparedness even when baseline caregiver characteristics are stable.

Results and Discussion

This synthesis treats preparedness as a changing fit among what caregivers understand, can do, can emotionally sustain, believe they can manage, and can obtain from professional services. It accommodates apparently inconsistent evidence: educational interventions can improve selected outcomes [17], while web psychoeducation may fail to improve preparedness beyond control [10]. These findings can coexist if education affects only some components or if experience and support also shape readiness.

The framework also prevents burden, distress, low confidence, limited knowledge, and practical difficulty from being treated as one deficit. Its contribution is therefore the linkage between differentiated assessment and differentiated support, including recognition that further teaching is sometimes inappropriate.

Limitations

The literature is heterogeneous in diagnosis, country, setting, measurement, intervention design, and illness stage. Several relationships derive from qualitative or cross-sectional evidence, and the integrated configuration has not been prospectively validated. Cancer and specialist palliative services are overrepresented. The domains and mismatch mechanism should therefore be treated as an empirically testable synthesis, not an established causal model or validated clinical instrument.

Conclusion

Family caregiver preparedness for home-based palliative symptom management depends on the fit among understanding, practical capability, emotional and relational readiness, self-efficacy, current care demands, and access to professional support. Nursing support is most defensible when it identifies the limiting part of that configuration and responds with clarification, coaching, reinforcement, emotional support, or escalation. Family caregiving is most sustainable when preparedness is assessed against the demands actually being faced and responsibility can return to professional care when those demands exceed what families can safely or reasonably provide.

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