Review Article

Technology-based support for stroke caregiving: A rapid review of evidence

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The authors declare that they have no conflict of interests

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Ethical Approval
This study focuses on an analysis of literature findings, and thus, no ethical approval is required.

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Technology-based support for stroke caregiving: A rapid review of evidence

**Aim:** This rapid review examines the technology-based interventions for caregivers of stroke proposed in the literature while also identifying the acceptability, effectiveness, and satisfaction of the implemented approaches.

**Background:** The increasing burden of supporting stroke survivors has resulted in caregivers searching for innovative solutions, such as technology-based interventions, to provide better care. Hence, its potential to support caregivers throughout the disease trajectory needs to be assessed.

**Evaluation:** Five electronic databases were systematically searched for articles related to stroke caregiving technologies based on well-defined inclusion and exclusion criteria.

**Key issue(s):** Fifteen articles met the inclusion criteria that focused on supporting caregivers through functionalities such as education, therapy and support, remote consultations, health assessments, and logs and reminders using different devices. The majority of interventions demonstrated positive conclusions for caregiving impact, acceptability, effectiveness, and satisfaction.

**Conclusion:** Findings highlight the influences of technology in improving stroke caregiving and the need to include user-centred design principles to create a meaningful, actionable, and feasible system for caregivers.

**Implications for Nursing Management:** Technology can educate and support stroke caregivers, thereby minimizing uncertainty and ensuring better care for the survivor.

**Keywords:** technology; stroke; caregiver; impact; preparedness; effectiveness, satisfaction; acceptance; usability
1. **Introduction**

Stroke is one of the leading causes of disability worldwide, resulting in physical, cognitive, and behavioural changes depending on the brain’s affected area (Caro et al., 2018). After hospitalization and rehabilitation, most stroke survivors return to home with care primarily provided by an informal caregiver (i.e. family member or friend), who are unprepared to manage the needs of the survivor (Smith et al., 2012). As a result, leading to substantial personal costs to the caregiver (Denham et al., 2019).

Many caregivers often encounter emotional, physical, social, financial and other challenges when caring for the survivor (Hultman et al., 2019). Thus, several research groups have developed technology-based interventions to support stroke caregivers (Aldehaim et al., 2016). These technology-based interventions often provide a convenient and low-cost method for delivering interventions to caregivers, such as information, monitoring and communication tools, and behaviour change support (Marcolino et al., 2018). Besides, previous studies have shown the benefits and capability of these interventions to provide information in different formats, improve decision-making, convenience, and promote health information exchange and social interactions with peers or family members (Godwin et al., 2013). Because of these functionalities and capabilities, technological-based interventions can support caregiving needs and activities, thereby improving caregiving impact and well-being (Lundberg, 2014).

While previous systematic reviews, for example, Aldehaim et al. (2016) had examined the impact of technological-based interventions on informal caregivers, and Mortenson et al. (2012) had reviewed the impact of assistive technology use by individuals with disabilities; to the best of our knowledge, no study has exclusively focused on both caregiving impact and the influence of technology to support caregiving activities. Hence, this rapid review aims to identify and appraise the technology's influence on caregiving impact while also determining the acceptability, effectiveness, and satisfaction of implementing these technologies to their
caregiving activities. Furthermore, this study highlights the interventions' content, such as functionalities, to create awareness of the tools available to support stroke caregiving.

2. Materials and methods

A rapid review methodology (Tricco et al., 2017) was adopted in this review. Rapid reviews are considered an emerging approach in health technology assessment to support informed decision-making in a timely manner (Khangura et al., 2014). This methodology utilizes processes similar to a systematic literature review but limits its scope and various aspects of synthesis (Wu et al., 2020).

2.1 Data sources and strategy

Peer-reviewed articles published up to May 2020 were systematically searched from five electronic databases (i.e. MEDLINE, Embase, CINAHL, PsycINFO, and Web of Science) and other electronic sources (i.e. Google Scholar and University Library). The search strategy included terms related to the PICOS framework, as shown in Table 1 and Supplementary Material A, combined to produce optimal results. Database filters were included to eliminate articles that were not conducted on humans and not published in English.

Titles and abstracts were downloaded from the electronic databases into EndNote X9, and all duplicates were removed. The primary author initially screened titles and abstracts based on well-defined inclusion and exclusion criteria developed by all authors. Potentially relevant articles identified after screening were downloaded and subsequently reviewed by the primary author under the second author's supervision to determine eligibility. All authors discussed any discrepancies until a general consensus was achieved.
2.2 Inclusion and Exclusion criteria

We included articles if they; (i) were published in English, (ii) involved caregivers aged 18 years or older at different stages of study design and evaluation, (iii) included technologies (i.e. telehealth, mHealth, eHealth and Web) designed to support caregiving of stroke, (iv) identified the changes to caregivers' lives and the effectiveness of the technology in supporting their activities, and (v) stated the impact evaluation procedure. Articles were excluded from this review if they were available only as abstracts, opinions, letters to the editor, conceptual papers, protocols, unpublished text, or excluded impact related to the intervention.

2.3 Data extraction

The primary author extracted data from papers that met the inclusion criteria. Specifically, we extracted information related to the study population (size, age, range, and % female), intervention (type of intervention, functionalities, and implementation), design (control condition, follow-up period, and study methodology), setting, and outcomes (impact of technology, acceptability, effectiveness, and satisfaction). Data extracted were subsequently reviewed by the other authors to ensure accuracy. This review also included reference lists of systematic reviews identified through database searches.

2.4 Outcome measures

Outcome measures were evaluated based on (i) the impact of technology to support caregivers and (ii) the overall acceptability, effectiveness, and satisfaction of the technology implemented.

2.5 Risk of bias assessment

The primary and secondary authors assessed the risk of bias based on the Downs and Black (1998) instrument, where each author independently rated each article based on a 24 point
criteria; scored either as 1 (Yes) or 0 (No). Any discrepancies were discussed with other authors until a general consensus was achieved.

3. Results

The combined search strategies identified 3100 potential articles, which were screened for eligibility (Figure 1). After removing duplicates and applying inclusion and exclusion criteria based on their titles and abstract, 53 full-text articles were reviewed, with 15 meeting the selection criteria, published from 2003 to 2020. The primary reasons for exclusion include; (i) articles not related to technology (n=815), (ii) interventions not related to stroke (n=742), (iii) full-text articles unavailable (n=110), (iv) interventions were exclusively designed for survivors, and medical professionals (n=78), (v) studies did not evaluate the impact of technology implemented (n=11), and (vi) not available in English (n=5). Table 2 summarises the characteristics of all of the included studies.

3.1 Characteristics of studies

3.1.1 Study design and setting

The majority of the articles analyzed were Randomized Control Trials (Hartke & King, 2003; Marziali & Donahue, 2006; Pierce et al., 2009; Smith et al., 2012; Van Den Berg et al., 2016; Vloothuis et al., 2019; Zhou et al., 2019). The remaining articles were either pilot (Torpe et al., 2008), feasibility (Blanton et al., 2018; Mahmood et al., 2019; Sureshkumar et al., 2016), iterative user-centred design (Caunca et al., 2020), pre-and post-test design (Stone, 2013), mixed-methods (Lutz et al., 2009) or evaluation (Marziali et al., 2005) based studies. These interventions were evaluated at home (n=9), community (n=4), or the hospital (n=2) settings.
in countries such as the USA (n=7), Canada (n=2), India (n=2), Netherlands (n=2), China (n=1) and Norway (n=1) as demonstrated in Table 2.

3.1.2 Participant characteristics

A total sample of 1490 participants, including 934 caregivers, 552 survivors and 4 rehabilitation researchers were included in the primary studies. Across all articles, female caregivers accounted for more than 30% of participants over 18 years. These caregivers were either spouses (Caunca et al., 2020; Hartke & King, 2003; Lutz et al., 2009; Marziali et al., 2005; Pierce et al., 2009; Smith et al., 2012; Stone, 2013; Torp et al., 2008), children (Lutz et al., 2009; Marziali et al., 2005; Stone, 2013), parents (Stone, 2013) or other known stakeholders (Blanton et al., 2018; Mahmood et al., 2019; Marziali & Donahue, 2006; Marziali et al., 2005; Stone, 2013; Sureshkumar et al., 2016; Van Den Berg et al., 2016; Vloothuis et al., 2019; Zhou et al., 2019); who supported the stroke survivor.

3.2 Interventions and content

This review examined 15 studies comprising functionalities delivered using numerous devices (Table 3). These functionalities include (i) educational materials (Blanton et al., 2018; Caunca et al., 2020; Lutz et al., 2009; Mahmood et al., 2019; Pierce et al., 2009; Smith et al., 2012; Stone, 2013; Sureshkumar et al., 2016; Torp et al., 2008; Zhou et al., 2019), (ii) therapy and support (Hartke & King, 2003; Mahmood et al., 2019; Marziali & Donahue, 2006; Marziali et al., 2005; Van Den Berg et al., 2016; Vloothuis et al., 2019), (iii) remote consultations (Hartke & King, 2003; Lutz et al., 2009; Marziali & Donahue, 2006; Marziali et al., 2005; Pierce et al., 2009; Smith et al., 2012; Stone, 2013; Torp et al., 2008; Van Den Berg et al., 2016; Vloothuis et al., 2019), (iv) health assessments (Van Den Berg et al., 2016), and (v) logs and reminders (Vloothuis et al., 2019; Zhou et al., 2019), as demonstrated in Table 3.
3.3 Impact of Technology on Stroke Caregiving

The technological impact (Table 4) of the included articles were identified using validated instruments, as demonstrated in Table 5. These instruments assessed the influence of the intervention on caregivers through factors such as;

(1) Caregiver Activities of daily living (ADL): The caregivers' ability to support the survivor in their daily living was assessed in two articles (Caunca et al., 2020; Marziali & Donahue, 2006). No statistical difference was identified between the intervention and control group of one article involving the use of communication-based technology (Marziali & Donahue, 2006). In contrast, the other article involving web-based education resources demonstrated caregivers' ability to support instrumental ADL rather than just ADL (Caunca et al., 2020).

(2) Caregiver burden: Nine articles (Caunca et al., 2020; Hartke & King, 2003; Lutz et al., 2009; Marziali & Donahue, 2006; Marziali et al., 2005; Van Den Berg et al., 2016; Vloothuis et al., 2019; Zhou et al., 2019) identified the ability of the intervention to support caregiving burden. Of these articles, only two (Marziali et al., 2005; Van Den Berg et al., 2016) identified statistical differences in the interventions' ability to reduce the caregiving burden. This involved telehealth (Marziali et al., 2005) and eHealth (Van Den Berg et al., 2016) based technologies. Furthermore, 95% of the caregivers involved in the telehealth technology group sessions reported lower stress levels, while those caregivers who used mHealth-based consultation and remote monitoring technology reported psychological benefits (Van Den Berg et al., 2016).

(3) Caregiver health status: Caregiver health status was reported in nine articles (Caunca et al., 2020; Hartke & King, 2003; Marziali & Donahue, 2006; Marziali et al., 2005; Pierce et al., 2009; Smith et al., 2012; Torp et al., 2008; Van Den Berg et al., 2016; Vloothuis et al., 2019), of which five articles (Marziali & Donahue, 2006; Marziali et
demonstrated positive health outcomes in factors such as depression (Smith et al., 2012; Van Den Berg et al., 2016), stress (Marziali & Donahue, 2006; Marziali et al., 2005), fatigue (Van Den Berg et al., 2016) and anxiety (Van Den Berg et al., 2016; Vloothuis et al., 2019). This included the use of communication (Marziali & Donahue, 2006; Marziali et al., 2005), web (Smith et al., 2012), and mHealth (Van Den Berg et al., 2016; Vloothuis et al., 2019) based technologies that delivered remote consultations (Marziali & Donahue, 2006; Marziali et al., 2005; Smith et al., 2012; Van Den Berg et al., 2016; Vloothuis et al., 2019), education (Smith et al., 2012; Vloothuis et al., 2019) and remote patient monitoring (Van Den Berg et al., 2016) based functionalities.

(4) Caregiver preparedness: Four articles (Caunca et al., 2020; Hartke & King, 2003; Stone, 2013; Torp et al., 2008) assessed caregivers preparedness post-intervention use, of which two reported significant caregiver preparedness using web-based consultation technology (Stone, 2013; Torp et al., 2008), while another article reported adequate preparedness, which included the use of web-based education technology (Caunca et al., 2020).

(5) Caregiver quality-of-life: Four articles (Hartke & King, 2003; Pierce et al., 2009; Van Den Berg et al., 2016; Vloothuis et al., 2019) assessed caregivers quality-of-life using interventions such as education (Vloothuis et al., 2019), physical activity monitoring (Van Den Berg et al., 2016) and communication (Hartke & King, 2003; Pierce et al., 2009; Van Den Berg et al., 2016; Vloothuis et al., 2019) based resources. These resources were delivered through telephone (Hartke & King, 2003), web applications (Pierce et al., 2009), and mobile applications (Van Den Berg et al., 2016; Vloothuis et al., 2019). Of the four articles, one article (Van Den Berg et al., 2016) did not present any statistical findings; while the remaining three articles (Hartke & King, 2003; Pierce
et al., 2009; Vloothuis et al., 2019) demonstrated no statistical differences post-intervention use in all participant groups.

(6) Caregiver self-esteem: One article (Smith et al., 2012) demonstrated the influence of survivor depression on caregiver self-esteem. This article focused on delivering a web-based intervention that presents caregivers with education and communication resources. Reduced depression of the survivor was shown to increase caregiver self-esteem significantly.

(7) Caregiver self-efficacy: Four articles (Caunca et al., 2020; Smith et al., 2012; Van Den Berg et al., 2016; Vloothuis et al., 2019) reported the self-efficacy of caregivers post-intervention. Most of these interventions (Caunca et al., 2020; Smith et al., 2012; Van Den Berg et al., 2016) reported had higher self-efficacy. This involved the use of mobile (Van Den Berg et al., 2016) and web (Caunca et al., 2020; Smith et al., 2012) applications for education (Caunca et al., 2020; Smith et al., 2012), physical activity monitoring (Van Den Berg et al., 2016), therapy and consultations (Smith et al., 2012; Van Den Berg et al., 2016). One intervention demonstrated no significant change in self-efficacy when delivering education, communication, therapy, reminders, and log resources (Vloothuis et al., 2019).

(8) Caregiver Healthcare utilization: Only one article (Pierce et al., 2009) assessed caregivers' healthcare utilization, which focused on unspecified follow-ups with the medical professional or primary care after receiving online consultations using web applications. Findings from this study demonstrated no statistical differences between the number of medical professional or provider visits, but significant differences (i.e., 33% fewer visits for web application users) between the web and non-web application users in the emergency department visits. Furthermore, this study also demonstrated
significant differences in hospital readmissions between the two groups (66% fewer hospital readmissions).

(9) Caregiver Social support: Of the 12 articles, four (Caunca et al., 2020; Marziali & Donahue, 2006; Smith et al., 2012; Torp et al., 2008) evaluated social support of caregivers using web applications. One intervention provided caregivers with education-based resources (Caunca et al., 2020), two interventions (Marziali & Donahue, 2006; Torp et al., 2008) provided caregivers with communication-based resources, and one (Smith et al., 2012) included both education and communication resources. The findings from these studies demonstrated no significant difference in the two articles (Marziali & Donahue, 2006; Smith et al., 2012), while the other two articles had adequate differences (Caunca et al., 2020) and a significant positive change (Torp et al., 2008).

3.4 Acceptance, Effectiveness, and Satisfaction

Ten articles focused on evaluating the acceptability, effectiveness, and satisfaction of technological-based interventions (Table 6). The findings from these studies include:

(1) Acceptance: Acceptance of the technological-based intervention was evaluated in seven articles (Blanton et al., 2018; Caunca et al., 2020; Hartke & King, 2003; Mahmood et al., 2019; Marziali & Donahue, 2006; Marziali et al., 2005; Sureshkumar et al., 2016). In these articles, caregivers reported positive benefits when using the intervention. The benefits of the intervention included improvement in knowledge (Blanton et al., 2018), communication (Hartke & King, 2003; Mahmood et al., 2019; Marziali & Donahue, 2006; Marziali et al., 2005), awareness (Mahmood et al., 2019) and information delivery (Mahmood et al., 2019). Moreover, caregivers preferred the
flexibility of accessing resources at any given time beneficial for their acceptance (Caunca et al., 2020). One study also described the technology's ability to reduce recovery time and recovery costs (Mahmood et al., 2019).

(2) Effectiveness: Four articles (Mahmood et al., 2019; Smith et al., 2012; Sureshkumar et al., 2016; Van Den Berg et al., 2016) assessed the system's effectiveness in supporting the individual needs of caregivers. Of the four articles, three (Mahmood et al., 2019; Smith et al., 2012; Sureshkumar et al., 2016) demonstrated effectiveness, which was shown in the caregivers' confidence level during recovery. One study (Smith et al., 2012) reported caregivers' need to share and continue using the app during survivors' recovery. In another study, caregivers' found that information delivery through video resources motivated them to provide better care to survivors (Sureshkumar et al., 2016). Further, one study demonstrated caregivers' willingness to use mobile-based home exercise programmes even if it required them to pay a nominal fee during registration (Mahmood et al., 2019).

(3) Satisfaction: Satisfaction was reported in seven articles (Blanton et al., 2018; Caunca et al., 2020; Hartke & King, 2003; Marziali & Donahue, 2006; Marziali et al., 2005; Stone, 2013; Sureshkumar et al., 2016), with six articles (Blanton et al., 2018; Caunca et al., 2020; Hartke & King, 2003; Marziali & Donahue, 2006; Marziali et al., 2005; Sureshkumar et al., 2016) demonstrating high caregiver satisfaction. Caregivers demonstrated satisfaction in the quality of the content (Blanton et al., 2018; Hartke & King, 2003; Marziali et al., 2005), ease of use (Blanton et al., 2018; Caunca et al., 2020; Marziali & Donahue, 2006; Sureshkumar et al., 2016), number of sessions (Hartke & King, 2003), and overall experience of the technology (Hartke & King, 2003). Some caregivers also reported the benefits of face-to-face communication with people living
with similar experiences to promote better emotional support (Hartke & King, 2003; Marziali & Donahue, 2006; Marziali et al., 2005).

4. Discussion

The limited support available to caregivers in the stroke recovery process presents a potential opportunity for technology-based interventions to support these individuals in their daily activities. This rapid review attends to key factors contributing to the impact, effectiveness, acceptance and satisfaction of the intervention during the disease trajectory. Specifically, it highlights the delivery process and ability to meet the needs of the caregiver, as compared to only understanding its impact on care. For example, the systematic review conducted by Aldehaim et al. (2016) examined the impact of technology on several primary (i.e. depression) and secondary (i.e. burden, problem-solving abilities, health status, social support, preparedness and healthcare utilization) outcomes. Still, it did not consider its effectiveness, acceptance and satisfaction based on the individual needs of the caregiver. Hence, this review uncovers 15 eligible studies, and provides indications of promise towards technology use in stroke caregiving, and future perspectives to consider in its development.

Over the years, technology-based interventions have evolved from telephone to mHealth/eHealth systems (Mermelstein et al., 2017). The purpose of these systems is to promote person-centred care (Dyb et al., 2021) and transform current healthcare practices through the promotion of information delivery, expansion of care and empowerment of individuals to manage their health (Mermelstein et al., 2017). As a consequence, its implementation and evolution are evident in the research literature on stroke caregiving. For example, initially, technology in stroke caregiving focused on telephone or telehealth systems (Hartke & King, 2003; Lutz et al., 2009; Marziali & Donahue, 2006; Marziali et al., 2005;
Smith et al., 2012), which provided remote consultations, therapy and education support. Post-
telephone and telehealth systems adopted web or ICT -based systems (Blanton et al., 2018;
Pierce et al., 2009; Stone, 2013; Torp et al., 2008) to enable education and online discussions.
Currently, mHealth technology (Caunca et al., 2020; Mahmood et al., 2019; Mortenson et al.,
2012; Sureshkumar et al., 2016; Van Den Berg et al., 2016; Vloothuis et al., 2019; Zhou et al.,
2019) has been considered by most researchers to educate, communicate, monitor, deliver and
support care.

The technology implemented in stroke caregiving, irrespective of the type of
technology, presents numerous advantages to support caregiver needs. A caregiver mentioned
learning much about managing feelings and not being stressed as much in a web-based remote
consultations’ study. Moreover, caregivers felt prepared to manage the survivor's future
condition (Marziali et al., 2005). Caregivers also discussed the importance of communication
with nurses (Lutz et al., 2009) and people managing similar conditions (Marziali & Donahue,
2006; Marziali et al., 2005) using remote communication technology as it would allow them to
ask questions or call at any given time (Lutz et al., 2009). Hence, receiving more practical
advice (Marziali et al., 2005; Torp et al., 2008), allows the caregiver to feel less isolated and
frustrated (Marziali et al., 2005). In addition to supporting the needs of the caregiver, these
technologies supported caregivers by improving their health status, preparedness, healthcare
utilization, and self-esteem while influencing caregivers’ activities of daily living and burden.

Despite the potential of technology in supporting caregiver needs, research on these
caregivers is limited and underrepresented compared to the technologies implemented for
caregivers of other chronic diseases. The limitations of this study are predominately
methodological and impact related. Currently, most technologies implemented are based on
credible research or best-practice guidelines (Blanton et al., 2018; Hartke & King, 2003;
Marziali & Donahue, 2006; Marziali et al., 2005; Torp et al., 2008; Zhou et al., 2019). While
theoretical models can form a solid foundation for designing stroke caregiving technology, as highlighted in the review, there is a lack of understanding and ability to support specific issues faced by the caregiver during recovery. As a result, it may affect its adherence throughout recovery.

Lobo et al. (2021) suggest using user-centred design principles in stroke caregiving to limit these methodological issues and enable the researcher to understand a range of characteristics required to support stroke caregivers during recovery. However, only a few studies (Blanton et al., 2018; Caunca et al., 2020; Lutz et al., 2009; Sureshkumar et al., 2016; Vloothuis et al., 2019) have considered user-centred design principles to understand the daily activities of caregivers and develop technologies to provide support. The lack of understanding of user needs may contribute to the limited impact current stroke caregiving technologies have on caregivers. A clear example of the potential of user-centred design in stroke caregiving technology is highlighted by the study conducted by Caunca et al. (2020), which shows improvement in caregiver activities of daily living, self-efficacy, and partial improvement in preparedness and social support. Moreover, caregivers demonstrated positive acceptance and satisfaction for the technology implemented. Hence, providing a case for future technologies in stroke caregiving to enable person-centred care.

4.1 Future Directions

The rapid review findings present two potential opportunities in stroke caregiving technology; the potential of technology interventions to support stroke caregiving and the need to consider usability and user experience in its design. Both opportunities have a common goal; to ensure the design of a system that provides caregivers with a meaningful, actionable, and feasible intervention.

Several human-computer interaction (HCI) studies have explored the possibilities of achieving these aspects through computer-supported cooperative work (Fitzpatrick &
Ellingsen, 2013) and participatory design (Andersen et al., 2019). These include users' involvement as co-designers throughout the design and implementation, considering a mixed-methods approach (i.e., a combination of surveys, interviews, observations, workshops, thinking-aloud sessions, and focus groups) (Kensing & Blomberg, 1998). These techniques allow the researcher to clearly define the project's scope and complexity (Andersen et al., 2019), thereby creating long-term acceptability, adaptability, and accessibility interventions (Liu et al., 2019) that can impact stroke caregiving.

4.2 Strengths and limitations

This rapid review is not without its limitations. Firstly, the review only considered studies available in English; therefore, it would be essential to note that this study does not cover all relevant literature available in technologies to support stroke caregiving, which could be a reason for the small number of articles included in this study. Furthermore, it may limit a comprehensive analysis of the potential of technology to support stroke caregiving. Secondly, there is a possibility of excluding studies based on the limitation of search engines and terms since the definition of stroke caregiving technology is new and still evolving. Therefore, the definitions considered in this review may not have considered all the relevant studies. Thirdly, the review filtration and extraction process were conducted by a single author under the supervision of another author. The filtration and extraction process considered a single author due to the time constraints, which was acceptable under the WHO methodology for rapid reviews. However, it may account for bias in the review. Finally, the review included articles comprising both survivors and caregivers in the evaluation process. This was due to the lack of technology-based interventions that explicitly supported stroke caregiving. Moreover, some studies also included a combination of survivor and caregiver outcomes. This would make it difficult to understand and classify the individual stakeholder's needs in these papers.
Despite the limitations, this review was designed and followed the guidelines based on the WHO methodology for rapid reviews, including a rigorous review, extraction and bias assessment (i.e. to determine article eligibility). The review also revealed the impact of technology's to support caregiving, while showing methodological gaps to consider for future research. Moreover, it also demonstrated the need for user-centred design to ensure improved satisfaction and consideration for user-centred aspects related to intervention usability, content, and delivery to improve user experience and acceptability.

5. Conclusions
The rapid review shows that there is a potential to utilize technology to support caregivers of people with stroke. Technological-based interventions assisted caregivers by providing them tools to educate, support, communicate, assess and manage the stroke survivor while collaborating with other stakeholders. Findings also highlight the impact of technology in stroke caregiving for developed systems through an understanding of caregiver needs. Hence, considerations need to be made to include users throughout the design process using user-centred design techniques, thereby possibly resulting in acceptance, satisfaction, and effectiveness throughout the disease trajectory.

6. Implications for Nursing Management
Stroke caregivers are often faced with uncertainty during recovery when responding to the survivors' needs for support due to the lack of preparation. Technological interventions can educate and support these caregivers, thereby improving the planning and management of a patient with stroke. While there have been technological-based interventions researched in the literature to support these caregivers, their potential has still not been realized as a means to
ensure better caregiving outcomes. Hence, we propose the need to design stroke caregiving technology by including different stakeholders to create more usable and efficient technology to better support the caregiver during the recovery process.

7. References


Table 1 Search terms defined based on the PICOS framework.

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Search terms</th>
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<tbody>
<tr>
<td><strong>Population</strong></td>
<td>Target participant group, i.e. caregiver of stroke, aged 18 years and above</td>
</tr>
<tr>
<td></td>
<td>“cerebrovascular disorders” OR “basal ganglia cerebrovascular disease” OR “brain ischemia” OR “carotid artery diseases” OR “intracranial arterial diseases” OR “intracranial embolism and thrombosis” OR “intracranial haemorrhage” OR “stroke” OR “brain infarction” OR “cerebrovascular accident” OR “vasospasm” OR “vertebral artery dissection” caregiver OR caregivers OR “care givers” OR care-givers OR carer OR carers OR “family caregivers” OR “spouse caregivers” OR “informal caregiver” OR “formal caregiver” OR friends OR “family members” OR children OR spouse OR wife OR son OR daughter OR sibling OR brother OR sister OR mother OR father OR husband OR wife OR nurse</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>Type of technology, i.e. telehealth, mHealth, eHealth, IoT and/or web telehealth OR telemedicine OR telemonitoring OR telepractice OR telenursing OR telecare OR ehealth OR e-health OR mhealth OR “digital health” OR technology OR “mobile health” OR “mobile application” OR apps OR app OR “mobile apps” OR “mobile app” OR smartphone OR mobile OR telemonitor OR telerehabilitation OR “smart home” OR “assistive technology” OR “internet of things” OR internet-of-things OR iot OR “smart devices” OR “connected devices”</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Intervention delivery mechanism</td>
</tr>
<tr>
<td><strong>Comparator</strong></td>
<td>Study design leading to some form of comparison. “qualitative research” OR “cohort studies” OR “observational study” OR “focus groups” OR semi-structured OR semistructured OR unstructured OR informal OR in-depth OR indepth OR face-to-face OR structure OR guide OR interview* OR discussion* OR questionnaire* OR RCT OR “randomised control trial”* OR “randomised clinical trial”* OR pilot OR trial OR evaluation OR control OR feasibility OR acceptability OR usability</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Health outcomes of the caregivers pre- and post-intervention use burden OR stress OR fatigue OR burnout OR strain OR “emotional distress” OR “psychological distress” OR “physical support” OR “information support” OR “professional support” OR “involvement in care” OR support OR supporting OR aid OR assistance OR help OR guidance OR “supporting care”</td>
</tr>
<tr>
<td>Author (Year), Country</td>
<td>Study Design</td>
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<td>Hartke and King (2003), USA</td>
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CG: Control Group, IG: Intervention Group, IGP: Intervention Group per Protocol, PT: Pilot Testing, FT: Field Testing
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- Delivery Formats:  
  o Text and Video | |
| van den Berg (2016), Netherlands | Mobile | Therapy and support | - Caregiver mediated exercises to support survivors | - Remote Consultations  
  • Video Conferencing  
- Health Assessments  
  • Survivor activity monitoring using Fitbit Zip | |
| Blanton (2018), USA | Computer Mobile | Education | - Topics:  
  o Rehabilitation goal setting and Caregiving Techniques  
- Delivery Formats:  
  o Text and Video | |
| Vloothuis (2018), Netherlands | Mobile | Therapy and support | - Caregiver mediated exercises to support survivors | - Remote Consultations  
  • Email Consultations and Video Conferencing  
- Logs and reminders  
  • Survivor Exercise Log | |
| Mahmood (2019), India | Mobile | Education | - Topic:  
  o Physical Support Practices  
- Delivery Formats:  
  o Audio and Video | - Therapy and support  
  • Caregiver mediated exercises to support survivors | |
| Zhou (2019), China | Mobile | Education | - Topics:  
  o Physical Support Practices and Caregiving Techniques  
- Delivery Formats:  
  o Text and Video | - Logs and reminders  
  • Exercise Reminders | |
| Caunca (2020), USA | Mobile | Education | - Topics:  
- Delivery Formats:  
  o Text and Video | |
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### Table 5. Instruments to determine study outcomes.

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>Instruments</th>
</tr>
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</table>
| **Activities of daily living** | Activities of daily living metrics (Finch et al., 1995)  
ADL Index (Katz, 1963) |
| **Caregiver Burden** | 15-item Relative Stress Scale (Greene et al., 1982)  
Burden Index (Liu et al., 2015)  
Strain Index (Al-Janabi et al., 2010; Kruithof et al., 2015; Robinson, 1983; Visser-Meily et al., 2004) |
| **Caregiver Health Status** | Health Status Questionnaire (Kroenke et al., 2001; Pettit et al., 2001)  
Center for Epidemiologic Studies–Depression Scale (CES-D) (Radloff, 1977)  
20-item version of the General Health Questionnaire (GHQ-20) (D. Goldberg, 1985; D. P. Goldberg & Williams, 1988; Malt, 1989)  
Hospital Anxiety and Depression Scale (HADS) (Bjelland et al., 2002; Zigmond & Snaith, 1983)  
Fatigue Severity Scale (Valko et al., 2008) |
| **Caregiver Preparedness** | Caregiver Competence Scale (Pearlin et al., 1990)  
Self-administered carer questionnaire based on Morgan et al. (1998) guidelines  
Preparedness Scale (Archbold et al., 1990; Zwicker, 2010) |
| **Healthcare Utilization** | National Health Interview Survey (National Center for Health Statistics (NCHS), 1987) |
| **Self-Efficacy** | Mastery Scale (Pearlin & Schooler, 1978)  
General Self-Efficacy Scale (Johnston et al., 1995; Laszczynska et al., 2005; Steffen et al., 2002) |
| **Self-Esteem** | 10-item Self-Esteem Scale (Rosenberg, 2015) |
| **Caregiver Quality of Life** | UCLA Loneliness Scale  
Carer Quality of Life Scale (Brouwer et al., 2006; Hoefman et al., 2013)  
Satisfaction with Life Scale (Diener et al., 1985) |
| **Social Support** | MOS Social Support Survey (Sherbourne & Stewart, 1991)  
12-item Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)  
Family and Friendship Contacts Scale (Andersson, 1984)  
Social Support Scale (Barrera Jr et al., 1981; Krause, 1995; Krause & Markides, 1990; Russell et al., 1980) |
Table 6. Acceptance, effectiveness and satisfaction

<table>
<thead>
<tr>
<th>Primary Author (Year)</th>
<th>Study Design, Intervention</th>
<th>Acceptance</th>
<th>Effectiveness</th>
<th>Satisfaction</th>
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2691 Records identified through database searching

409 Records identified through other sources

3100 Records identified from electronic database searches

1776 Records screened for relevance

1324 Duplicates were removed

53 Full-text articles were assessed for eligibility

1723 Records excluded for the following reasons:
Not related to technology (n=807)
Not related to stroke (n=728)
Not for caregivers (n=73)
Not available in English (n=5)
Full-text unavailable (n=110)

15 Studies included in the rapid review

38 Records excluded for the following reasons:
Not related to technology (n=8)
Not related to stroke (n=14)
Not for caregivers (n=5)
No outcomes (n=11)

Figure 1. PRISMA flowchart for the synthesis of articles in this review.