Family Caregiver Capacity Building Program for Older People with Dependency in Thailand: A Randomized Controlled Trial

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Abstract: This randomized control trial investigated the effectiveness of the Family Caregiver Capacity Building Program on caregivers' care ability and quality of care. A sample of 55 family caregivers, currently caring for older people with dependency in two rural communities in a central Thailand, were randomly assigned to a control group (n=29) and an experimental group (n=26). The experimental group received the Program based on Hulme's work in family empowerment. The control group received usual home visits. Data were collected at baseline, week 12 for caregiver ability, and at week 24 for quality of care at week 24. Data were analysed using descriptive statistics, independent t-test, and paired t-test.

Results revealed that after attending the Program the experimental group had significantly higher overall care ability than at the baseline, except for social aspect. There were significant differences in overall quality of care, physical, psychological, and financial aspects but not for environmental, medical management, and human rights dimensions. When comparing between groups, the experimental group had significantly higher overall care ability than those in the control group, except for social aspect. However, there were no significant differences of overall quality of care and their dimensions, except for physical aspect. Findings revealed that the Program was effective in improving the ability of care givers to provide quality care for older people with dependency. Nurses in Thai district hospitals or sub-district health promoting hospitals could apply this Program to improve care ability of family caregivers for older people with dependency in similar communities in Thailand. However, it is recommended that the Program be further evaluated with larger or different groups.

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Introduction

Older people with dependency needs experience limitations in and loss of their physical, psychological, social, and economic abilities, including a decrease in intellectual talent. They need assistance from others and cannot live their lives as they have previously been accustomed to doing.[1,2] Mostly, this population

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experiences physical disabilities in carrying out daily activities of living such as bathing, dressing, standing up, moving, and using the toilet (both urination and defecation).[1-4]

In 2014, there were approximately 180,000 older people with dependency in Thailand. This number is estimated to increase to 741,766 by 2020 and 1,103,754 by 2030.[1-3] Families have to provide a primary family caregiver without wages or compensation. Ongoing care for the older people with dependency needs requires a daily routine in terms of socialization, emotional stability, mental acuity, health care, and problem solving when faced with an emergency.[3-5] The problems with which family caregivers are confronted become a complicated process of either solving problems or supporting decisions regarding caregiving.[5,6] The complications are associated with family caregiving result in escalating family expenses with a significant impact on family members' lives as family capacity for caregiving diminishes.[1,3-6] Caregiving capability may further decline, especially in terms of essential knowledge and skills for caregiving assistance.[3-6] Thus, family caregiving ability needs to be strengthened through family empowerment in providing care for older people with dependency. [3-8]

The concept of family empowerment, proposed by Hulme[9], was developed from Gibson's empowerment concept.[10] This encourages families to be able to face the challenge of caregiving for older people with chronic illnesses[7-11] and empowers caregivers through capacity building to improve family members' relationships and increase their awareness of their own ability; develop self-worth and improve knowledge and skills. These translate to better patient care, by affecting the care ability and quality of care (QoC) that family caregivers are able to provide to older people.[9-11] This enhanced ability reflects the caregiver's acceptance of the role of caregiving through a process of learning, understanding, and giving appropriate care such as hygiene, feeding, dressing, mobility, and toileting. Family caregiving also involves social aspects such as shopping, preparation of meals, telephoning, financial management, participate in religious ceremonies, healthcare, and coordination with a healthcare professional.[12-15] Moreover, such capacity which can be viewed as a structure, process, or result, and ultimately, QoC represents the potential to give the best care to older people by the family caregiver. Activities of care involve environmental, physical, psychological, and economic aspects, as well as respect towards older people.[16-20] Previous studies have concluded that problems of caregiving often result from knowledge deficit, lack of care ability, and resources of family caregivers which leaded to a diminished QoC.[13-18] There are a paucity of studies of capacity strengthening of family caregivers for older people with dependency in Thailand, so the researcher was interested in developing and testing the Family Caregiver Capacity Building Program (FCCBP) using empowerment strategies and following the empowerment phases of Hulme[7.] The FCCBP emphasizes the interaction between the family caregivers and the researcher via education, skill training and support to empower them to take responsibility for managing and providing care to older people with dependency.

Review of Literature

Capacity-building empowerment increases a person's ability to complete a task and improves processes to achieve better results or efficiency and standardization.[12-16, 23-26] Empowerment influences caregivers to provide efficient care.[12-13, 23-25] Gibson explained that the process of empowerment requires discovering reality, that is, recognition, understanding, and acceptance of true incidents expresses recognition and sensation. Critical reflection requires people to carefully review an incident to make decisions and properly fix the problem. Taking charge of a reasonable belief leads to effective executions that are sustainable. Learning processes cause changes at the individual, family, and community level and include social interaction among people who make decisions and solve problems through their participation and appropriate utilization of resources in order to increase their capability to achieve the goal.[10, 11] Hulme's[7] family empowerment encourages the family to be able to face the challenge of caregiving through capacity building. This requires healthcare personnel, whom the family trust, to participate in initial care giving while helping family members to be able to participate in making care decisions. After that, the capacity building process transitions the balance of power until family members have full knowledge, capability, and confidence to take care of their family member themselves.

Capacity building via empowerment of the family creates abilities and improves the quality of care for the older person with dependency needs.[27-29] Caregivers meet the needs of their older relatives in caring for various physical and daily life needs because they are limited in their own ability to perform self-care,[3-6] such as transfers, opening doors, going outdoors, managing stairs, and physical activities of daily living, such as combing their hair, washing their bodies, going to the toilet, dressing, cutting fingernails or toenails, and more.[3-6] Caregivers reflect acceptance of the caregiving role through a process of learning, understanding, and giving appropriate care in hygiene, feeding, dressing, mobility, and toileting. Family caregivers also are involved in social aspects such as shopping, preparation of meals, telephoning, use of money, aid in participation in religious ceremonies, health care, and coordination with healthcare professionals.[3-8, 12-18] Moreover, capacity building affects the QoC that is available to an older person.[13-15, 29-31.] Proper environmental management and establishing guidelines or standards are the responsibilities of health personnel. They need to aim for the highest consumer benefits in terms of efficiency, effectiveness, acceptance, assistance, access to health services and equality in terms of rules and professional standards that utilize empirical evidence to judge the value of care in order to meet consumers' needs.[19-21] From these studies, we concluded that empowerment programs will help family caregivers improve their ability to provide care for older people with dependency by enhancing their knowledge and training skills[8,12-18] Moreover, capacity building affects the QoC that is available to older people.[13-15, 29-31] Furthermore, these studies emphasized empowerment through individual, family, and community in interventions that had significant outcomes.[18,29] Empowerment can help make caregivers confident, experienced, and skillful in caring for the older people with dependency and improve their QoC.[16-18,19- 31]

The FCCBP was based on critical reviews of Hulme's family empowerment model[7] and consists of changing behavior through empowerment strategies in four phases: professional-dominated phase, participatory phase, challenging phase, and collaborative phase. The first phase builds trust by creating rapport with the families and establishing a direct relationship with the family caregivers, prioritizing the family's perceived needs, providing accurate and complete information, and supporting family caregivers in setting goals, including knowledge related to problems and needs of older people with dependency, such as common chronic illnesses, geriatric syndrome, and rehabilitation. The second phase, participatory, helps the family determine setting goals and family care plan, guides them in assessing their resources, and skills training such as activities of daily living, vital sign monitoring, feeding, oxygen, and catheter care.

The challenging phase supports family caregivers in a peer support group reinforcing their ability to identify choices in health care, discuss advocacy techniques, and build the caregivers' skills in negotiating with health professionals. This phase enhances their ability in caring for their older relative. The last phase, the collaborative phase, involves monitoring and supporting caregiving skills at home and acknowledging caregivers as their care improves. The interactions between family caregivers and the researcher in the process of empowerment[12-13, 24-25] can help to strengthen care ability by increasing caregiver knowledge and confidence by creating a sense of self-worth, and leading to higher QoC for older people with dependency.[13-16, 29-31]

Study Aim and Hypothesis

This study determined the effects of the FCCBP on the care ability score and QoC score of family caregivers providing care for older people with dependency needs. The following hypotheses were proposed:

1) In the experimental group, the family caregivers receiving the Program would have a significantly higher care ability at week 12 and QoC at week 24 than at baseline.

2) When comparing between groups, the family caregivers receiving the Program would have a significantly higher in care ability at week 12 and QoC at week 24 than the control group.

Methods

Design: A randomized controlled trial.

Ethical Considerations: Study approval was obtained from the Institutional Review Board, Faculty of Nursing, Chiang Mai University, and the local Public Health District and Provincial Health Office. All participants received written and verbal explanations of the study. Before giving written informed consent they learnt of the objectives, methods, risks, benefits, and their right to withdraw from the study at any time.

Setting: This study was conducted in two sub-districts in central Thailand. These had comparable characteristics in terms of socioeconomic conditions, location, transportation, culture, and health services from the sub-districts' health-promoting hospitals.

Sample: The sample was family caregivers of older people with partial or total dependency needs, aged 60 years and living in two sub-districts in central Thailand. Inclusion criteria were: family caregivers aged 20-59 years living with their older relative; willing to participate in the Program; had not participated in another family capacity program for at least 6 months prior to the beginning of this study; and able to communicate in Thai. Multi-stage random sampling was used during the first phase to randomize ten villages from two rural communities. Sample size was estimated based on the findings of another study regarding skills training.[14] We enrolled 58 family caregivers intending to obtain sufficient statistical power (80%) and a significant of $p<0.05$. There were 1,018 family caregivers who lived with older people with dependency. One hundred and thirty five family caregivers who met the study criteria were recruited using a computer-generated randomization list and assigning the 58 participants to either the experimental group (n = 29) and control group (n = 29). At week 12, one older relative being cared for by a participant in the experimental group had died, another was admitted in the hospital, and one moved to another area, so we excluded three participants. At week 24, two participants of the experimental group and four from the control group lost with the same reasons. Therefore, data were analyzed using 49 participants as shown in **Figure 1**.

Intervention Program: The Program was developed by the researcher based on the family empowerment concept proposed by Hulme.[7] It has 11 sessions spread over s weeks and the length of intervention given at each session is 90 minutes. There are four phases: professional-dominated phase, participatory phase, challenging phase, and collaborative phase. The Program contains individual and group education, caregiving skill training, and home and telephone visits (see **Table 1**). The Program content was validated by five experts in the fields of gerontology, education, and family nursing. This was revised according to the recommendations of those experts, and piloted with three older people with dependency and their family caregivers before full implementation.

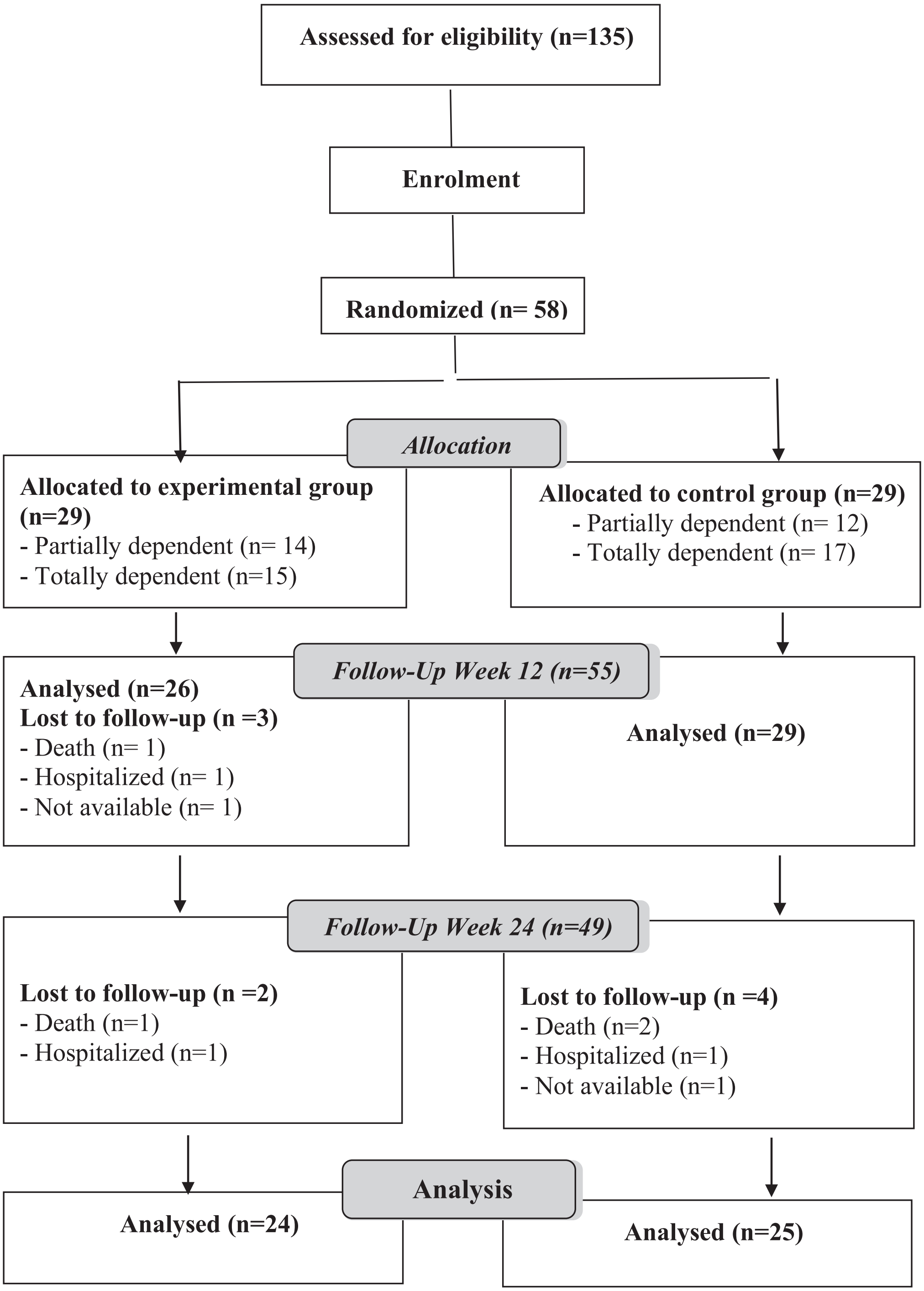

Figure 1: Flow Diagram of Recruitment and Analysis

Table 1 Schedule and Content of FCCBP Intervention Program

Week/Session	Content	Empowerment Strategies
Week 1	**Professional-dominated phase**	
Session1 (90 mins)	Information about problems and needs of older people with dependency and needed skills to fulfill those needs.	- Building trust by creating rapport with the families and establish a direct relationship with the family caregivers.
Session2 (90 mins)	Information about most common chronic diseases, common geriatric syndrome, approaches to self-care.	- Prioritizing families' perceived needs. - Providing accurate and complete information.
Week 2		
Session 3 (90 mins)	Information about roles of caregivers, caregiving activities, and home and environment modification.	- Supporting caregivers to set goals.
Session 4 (30 mins)	Refreshing knowledge session 1-3.	
Week 2		
Session 3 (90 mins)	Information about roles of caregivers, caregiving activities, and home and environment modification.	- Providing accurate and complete information.
Session 4 (30 mins)	Refresh knowledge session 1-3.	- Supporting the caregivers in setting goals
Week 3	**Participatory phase**	
Session 5 (90 mins)	Group and individual demonstration and return demonstration on the basic activities of daily living, including bathing, dressing, eating, mobility, moving from chair to bed and vital signs monitoring.	- Helping family determine the family care. - Providing accurate and complete information. - Supporting caregivers in setting goals.
Session 6 (90 mins)	Information about prevention of complications of immobilization, care activities for persons with drainage, feeding, urinary catheter care and constipation prevention and management.	- Guiding caregivers in assessing support system, resources and strengths. - Strengthening capacity of caregivers in caring and problem solving.
Week 4		
Session 7 (90 mins)	Information on rehabilitation.	
Session 8 (30 mins)	Refresh knowledge session 5-8.	
Week 5	**Challenging phase**	
Session 9 (90 mins)	Communication strategies, and partnership relationship development.	- Supporting caregivers in peer support group.
Session 10 (90mins)	Problem solving and negotiation skills.	- Reinforcing family's ability to identify healthcare choices.

Table 1 Schedule and Content of FCCBP Intervention Program (continued)

Week/Session	Content	Empowerment Strategies
		- Discussions with caregivers regarding advocacy techniques. - Building skills in negotiating with health professionals.
Week 6	**Collaborative phase**	
Session 11 (90 mins)	Repeating implementation by reviewing skills and troubleshooting; questioning knowledge until score indicates improvement of preparedness for caregiving.	- Monitoring and supporting about caregiving skills at home. - Acknowledging family caregivers for their better care.

Data collection: Three instruments were used:

The Caregiver's Care Ability Scale (CCAS) was developed by Pukdeeporm[34] to measure the ability of family caregivers to care for older people with dependency. It consists of 14 positive and negative questions that measure the ability to provide care in four dimensions, physical care, psychological care, social care, and environmental care. Each item is assessed on a Likert-type scale from 1-5, where 1 = "I do not agree at all" and 5 = "I completely agree." A higher score means higher ability of care, while a lower score means lower ability of care. Five experts in the fields of gerontology, education, and family nursing validated the content. The content validity index was .83. The explanations and suggestions from experts were taken into attention to revise the CCAS. The pre-test reliability for the CCAS was tested with 15 family caregivers who were similar to the sample. Cronbach's alpha demonstrated an acceptable reliability of 0.93, and 0.81 for the main study.

The *Quality of Care Assessment Scale* (QUALCARE) was developed in English by Philips *et al.*[19-21] to measure QoC. It contains 53 items that measure six components: environmental, physical, psychosocial, medical management, human rights, and financial aspects. The scoring for this 5-level measurement ranges from 1 (best possible care) to 5 (worst possible care) points. A lower scores indicates higher QoC.

The QUALCARE was translated from English into Thai by the researcher and a translator, who was an expert in foreign language, and then back-translated from Thai into English by two bilingual experts. Comparison of the back-translated version of the QUALCARE to the original English version was made by the research team. Finally, the original English version and the back-translated English version were compared for semantic equivalence in translation. The QUALCARE was tested for its internal consistency reliability using inter-rater reliability. This technique was used to assess the degree to which different observers gave consistent estimates of the same phenomena. A research assistant and researcher were assigned to observe the QoC of one participant by following the items on the QUALCARE and providing a score with three family caregivers. Then the calculation of the correlation between the ratings of the observers was conducted and the results indicated an acceptable inter-rater agreement index which was 1.0.

The *Preparedness for Caregiving Scale* (PCS)[35-38] was developed by Wirojratana[38] to measure preparedness of Thai family caregivers caring for older people. The PCS includes 8 items with a 5-point scale ranging from 0 (not at all prepared) to 4 (very well prepared). The higher the score the better prepared are the family members for caregiving.

Data collection procedures: At baseline assessment in the first week, all participants were asked to provide demographic information and data on preparedness of care, caregiver's care ability, and QoC at their own home. The intervention began one week after the baseline measures were administered. The experimental groups received the FCCBP program of 11 sessions, 90 minutes per session for 6 weeks, including individual and group education, caregiving skill training, and home and telephone visits, while the control group received only usual home visit. Data were obtained at weeks 12 for caregiver care ability and at week 24 for QoC.

***Data Analysis*:** Descriptive statistics were used to explain the demographic data. Chi-square, Fisher's tests, and t-tests were used to examine the differences between the experimental and control groups. Paired t-tests and independent t-tests were conducted to test the differences in the mean scores of caregiver care ability and QoC.

Results

The participants were 59 family caregiver of older people with dependency needs randomly divided into the experimental and control groups, 29 in each group. There were three dropped cases (15.51%) after the 12 weeks and six dropped out cases after 24 weeks. The mean ages in the experimental and control groups were 46.7 years (SD = 8.0) and 45.3 years (SD = 11.5) respectively. There were more female participants than male in both groups (92.3% vs. 7.7% in the experimental group, 86.2% vs.13.8% in the control group). More than half the participants in both groups were married (73.1% vs. 82.8%), and most had at least primary school education (76.9% vs. 72.1%). The majority of caregivers were daughters of the older relative (61.6% vs. 62.1%). All demographic characteristics were not significantly different between experimental and control groups **(Table 2)**.

Table 2: Comparison of Demographic Characteristics of Family Caregivers between Experimental and Control Groups

Variable	Experimental Group (n=26)	Control Group (n=29)	t-test	X^2-test	Fisher's Exact	*p*-value
	n (%)	n (%)				
Age						
20-29	2 (7.7)	3 (10.3)	1.224			.227
30-39	1 (3.8)	3 (10.3)				
40-49	13 (50.0)	14 (48.3)				
50-59	10 (38.5)	9 (31.0)				
($\overline{X}$, SD)	(46.7, 8.0)	(43.5,11.5)				
Gender						
Male	2 (7.7)	4 (13.8)		.525		.672
Female	24 (92.3)	25 (86.2)				
Marital status						
Single	6 (23.1)	5 (17.2)		1.513		.469
Married	19 (73.1)	24 (82.8)				
Separated	1 (3.8)					
Educational level						
No formal education	4 (15.4)	9 (31.0)				
Primary school	20 (76.9)	18 (62.1)		1.870		.393
Secondary school and higher	2 (7.7)	2 (6.4)				
Occupation						.827
Working at home	9 (34.6)	7 (24.1)		.895		
Civil servant	1 (3.8)	1 (3.4)				
Employee	13 (50.1)	18 (62.2)				
Farmer	3 (11.5)	3 (10.3)				

Table 2: Comparison of Demographic Characteristics of Family Caregivers between Experimental and Control Groups (continued)

Variable	Experimental Group (n=26)	Control Group (n=29)	t-test	X^2-test	Fisher's Exact	*p*-value
	n (%)	n (%)				
Relationship						.558
Daughter	16 (61.6)	18 (62.1)			.440	
Son	4 (15.4)	1 (3.4)				
Daughter-in-law/son-in-law	-	3 (10.3)				
Grandchild	4 (15.4)	6 (20.7)				
Sister/brother	1 (3.8)	1 (3.4)				
Spouse	1 (3.8)	-				
Sufficiency of income						.155
Sufficient income	6 (23.1)	13 (44.8)		2.868		
Not sufficient income	20 (76.9)	16 (55.2)				

After attending the Program the experimental group had significantly higher overall care ability than at the baseline ($p<.05$), except social aspect. There were significant differences in overall QoC, physical, psychological, and financial aspects ($p<.01$), but environmental, medical management, and human rights dimensions (**Table 3**). When comparing between groups, the experimental group had significantly higher overall care ability and their dimensions than those in the control group ($p < .01$), except social aspect. There were no significant differences in overall QoC and its dimensions, except for the physical aspect ($p < .05$) (**Table 4**). Furthermore, the effect size was analyzed and interpreted using Cohen's classification (0.2 = small, 0.5 = medium, and 0.8 = large). Effect size for caregiver care ability (0.75) and QoC (0.27) were medium and small, respectively.

Table 3 Comparison of Caregiver Care Ability and Quality of Care (QoC) of Family Caregivers in the Experimental Group

Variables	Mean(SD) Baseline	Mean(SD) Post-test	t	*p*-value
Care Ability*	47.44(3.65)	50.35(3.69)	-4.72	.00
Physical	24.25(2.28)	26.85(3.15)	-5.49	.00
Psychological	6.13(0.96)	5.80(0.83)	2.23	.03
Social	9.82(1.11)	9.69(0.98)	0.63	.53
Environmental	7.24(0.88)	7.73(0.97)	-3.03	.00
QoC**	127.00(20.10)	120.10(20.33)	3.76	.00
Environmental	33.02(7.66)	33.45(7.66)	-0.63	.53
Physical	26.06(4.28)	21.98(4.91)	6.18	.00
Medical Management	12.61(2.91)	12.43(2.29)	0.51	.61
Psychological	27.29(4.80)	25.08(4.33)	3.36	.00
Human Rights	14.49(2.69)	14.76(2.47)	-0.56	.58
Financial Aspect	13.53(2.81)	12.41(3.10)	3.09	.00

* Post-test = Data were collected 12 weeks after completion of the interventions.

** Post-test = Data were collected 24 weeks after completion of the interventions.

Table 4 Comparison of Caregiver's Care Ability and QoC of Family Caregivers between the Experimental and Control Groups Pre- and Post-Intervention

Variables	Experimental Group	Control Group	t	*p*-value
	M (SD)	M (SD)		
Baseline Care Ability	47.69 (3.73)	47.41(3.70)	0.28	.78
Physical	24.21(2.13)	24.41(2.39)	0.73	.59
Psychological	6.34(0.89)	6.00(1.94)	1.36	.18
Social	9.83(1.36)	9.79(0.92)	0.11	.91
Environmental	7.31(0.89)	7.21(0.86)	0.45	.65
Baseline QoC	123.96(13.92)	129.92(24.56)	-1.05	.30
Environmental	32.17(5.23)	33.84(9.47)	-0.77	.45
Physical	25.13(3.42)	26.96(4.88)	-1.53	.13
Medical management	12.21(2.50)	13.00(3.25)	-0.96	.34
Psychological	26.58(4.09)	27.96(5.38)	-1.01	.32
Human Rights	14.58(1.84)	14.40(3.35)	.24	.81
Financial Aspect	13.29(2.71)	13.76(2.93)	-.58	.56
Post-test Caregiver Care Ability	51.73 (3.57)	49.10 (3.40)	2.79	.00
Physical	28.58(2.25)	25.31(3.07)	4.53	.00
Psychological	5.50(0.81)	6.07(0.75)	-2.69	.00
Social	9.46(0.86)	9.90(1.05)	53	.97
Environmental	8.04(0.87)	7.45(0.99)	2.36	.02
Post-test QoC	117.29 (13.36)	122.80 (25.29)	-0.96	.34
Environmental	33.83(6.72)	33.08(8.59)	.34	.73
Physical	20.54(2.04)	23.37(6.34)	-2.11	.04
Medical management	12.04(2.07)	12.80(2.47)	-1.17	.25
Psychological	24.54(2.45)	25.60(5.58)	-1.01	.32
Human rights	14.38(1.47)	15.12(3.14)	-1.07	.29
Financial aspects	11.96(2.64)	12.84(3.45)	-1.00	.32

Discussion

The findings of this study partially support the hypotheses in that after receiving the Program, the experimental group had a significantly higher overall mean scores on caregiver care ability and on physical, psychological and environmental dimension than at baseline and compared to the control group. However, there was no significant difference in the social aspect. These results are congruent with the assumptions of Hume's family empowerment to focus on assisting the change of behavior conditions through the Program following strategies in four stages: professional-dominated, participatory, challenging, and collaborative phase. The Program achieved its aim of building the care ability of caregivers by giving health education and skills, establishing a relationship between an older people and family caregivers, discussing in small group to share their experiences, supporting and empowering family caregivers to do good performance for older adults.[12-13, 24-25] Thus, we believed the Program strengthened the confidence of family caregivers, improving care by creating a sense of self-worth, and lowering expenditures for patient care and all of which lead to a higher QoC for older people with dependency.[13-16, 29-31] The results of this study were consistent with the findings of previous studies of caregiver-empowerment programs, based on Gibson's concept of empowerment[9-11,25] involving recognizing the caregiving burden, realizing the potential value of care, and committing to care for six months, showing that the mean difference in the burden of care at the posttest compared to before the Program had a statistically significant difference.[10-11] Unfortunately, there were no significant differences in the mean social aspect in this study in the experimental group and between groups. The findings are not surprising since these two groups had similar limitations in earning incomes in their family. That is, they did not have sufficient income and they had to take responsibility to care for their older relative in congruence with Thai traditions of family responsibility. This might limit caregivers in both groups to find chances to participate in social activities with the community, resulting in a lack of practice of skills in empowering themselves in taking care of older people.[1-3, 38]

For the QoC the overall mean scores at posttest and on physical, psychological and financial dimensions were improved significantly from those at baseline, but there was a significant difference in the environmental, medical management, and human rights dimensions. When compared with the control group, there was no significant difference between groups on overall mean score at posttest and other aspects except physical dimension. These results partially achieved following Hulme's family empowerment concept reporting that care ability will lead to better QoC for older people.[16-20,30-31] However, this study did not show significant differences in every aspect either in the experimental group or between groups that might result from many factors including inappropriate home environment, family income, health education, community resources, and health insurance.[1-3,18,21] Thus, nurses can help work family problems out through considering and educating them about factors that assist with better QoC for older adults with dependency. Moreover, the activities of the Program were concerned individual and group education, caregiving skill training, and home and telephone visits to enhance their care ability.

These findings were congruent with a controlled trial study of hospitalized older people in the CARE program (Creating Avenues for Relative Empowerment) which reported that there had no difference in emotional coping measures for QoC at 2 weeks and 2 months, except for the care role of family caregivers.[18] However, some studies found that follow-up activities for one year including home visits and telephone, and positive reinforcement for caregiver skills significantly increased QoC.[16-18]

Limitations and Issues in Study

The researcher met with the experimental group on 11 occasions for 90 minutes per session, assisting them and collecting data. However, the participants found it was inconvenient to join the group for every meeting because they were involved with caregiving at home. Thereafter, the researcher met the participants individually in home visits. In future studies, the program could be adjusted to have more appropriate follow up using health care volunteers in community.

Conclusion and Implication for Nursing Practice

Findings revealed that the Program could be an effective intervention for the strengthening care ability of family caregivers who provide care for older people with dependency. Nurses in the district hospitals or sub-district health promoting hospitals could apply the Program to improve care ability of family caregivers resulting in achieving QoC for their relatives. In future studies researchers should consider meeting with the experimental group less frequency and use a double-blinded technique. As well we recommend that there should be follow up for at least a year after the initial Program, using home visits and telephone calls, and data collection should be undertaken in the home as well.

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โปรแกรมการเสริมสร้างศักยภาพญาติผู้ดูแลในครอบครัวสำหรับผู้สูงอายุที่มีภาวะพึ่งพิงในประเทศไทย: การวิจัยแบบทดลองเชิงสุ่ม

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การวิจัยทดลองแบบสุ่มครั้งนี้มีวัตถุประสงค์เพื่อศึกษาผลของโปรแกรมการเสริมสร้างศักยภาพญาติผู้ดูแลในครอบครัวต่อความสามารถในการดูแลและคุณภาพการดูแลของผู้ดูแลในครอบครัว กลุ่มตัวอย่างเป็นผู้ดูแลผู้สูงอายุที่มีภาวะพึ่งพิงที่อาศัยอยู่ใน 2 ชุมชนชนบทในเขตภาคกลางของประเทศไทย จำนวน 55 รายได้รับการสุ่มเข้ากลุ่มควบคุมจำนวน 29 รายและกลุ่มทดลองจำนวน 26 ราย กลุ่มทดลองได้รับโปรแกรมเสริมสร้างศักยภาพ ที่สร้างขึ้นตามแนวคิดการเสริมสร้างศักยภาพครอบครัวของฮูม กลุ่มควบคุมได้รับการเยี่ยมบ้านจากอาสาสมัครตามปกติ รวบรวมข้อมูลความสามารถในการดูแลก่อนและหลังการได้รับโปรแกรม 12 สัปดาห์และประเมินคุณภาพการดูแลก่อนและหลังการได้รับโปรแกรม 24 สัปดาห์ วิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณนาและสถิติที

ผลการศึกษาพบว่า ภายหลังได้รับโปรแกรมในกลุ่มทดลอง มีคะแนนเฉลี่ยความสามารถในการดูแลโดยรวมสูงกว่าก่อนทดลองอย่างมีนัยสำคัญทางสถิติ ยกเว้นมิติด้านสังคม ส่วนคะแนนเฉลี่ยคุณภาพการดูแลโดยรวม ด้านร่างกาย ด้านจิตใจ และประเด็นทางการเงิน ดีกว่าก่อนทดลองอย่างมีนัยสำคัญทางสถิติ ยกเว้นด้านสิ่งแวดล้อม ด้านการจัดการความเจ็บป่วย และด้านสิทธิผู้ป่วย เมื่อเปรียบเทียบระหว่างกลุ่มพบว่ากลุ่มทดลองมีคะแนนเฉลี่ยความสามารถในการดูแลโดยรวมและรายด้านดีกว่ากลุ่มควบคุมอย่างมีนัยสำคัญทางสถิติ ยกเว้นด้านสังคม ส่วนคะแนนเฉลี่ยคุณภาพการดูแลโดยรวมไม่แตกต่างกันอย่างมีนัยสำคัญทางสถิติ ยกเว้นด้านร่างกาย ค้นพบครั้งนี้แสดงให้เห็นว่าโปรแกรมการเสริมสร้างศักยภาพญาติผู้ดูแลในครอบครัวมีประสิทธิภาพในการเพิ่มความสามารถของญาติในการดูแลและคุณภาพการดูแลผู้สูงอายุที่มีภาวะพึ่งพิงพยาบาลที่ปฏิบัติงานในโรงพยาบาลชุมชนหรือโรงพยาบาลส่งเสริมสุขภาพตำบลควรนำโปรแกรมไปส่งเสริมศักยภาพของญาติผู้ดูแลในครอบครัว ทำให้เกิดคุณภาพการดูแล การศึกษาครั้งต่อไปควรทดสอบประสิทธิผลของโปรแกรมในชุมชนที่มีความความคล้ายกันในประเทศไทย

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