CHAPTER 4

Results and Discussion

Results of the Study

This research project was conducted to examine the effects of the family caregiver capacity building program on care ability and quality of care of family caregivers of dependent elders. The results were presented in 3 parts: 1) The demographic characteristic of the samples both dependent elders and family caregivers, 2) effect of the family caregiver capacity building program on care ability, and 3) effect of the family caregiver capacity building program on quality of care.

Part I: Demographic characteristic of the samples.

1. Characteristics of the samples, experimental group and control group of dependent elders in Table 4-1.

2. Characteristics of the samples, experimental group and control group of family caregivers in Table 4-2.

Part II: The comparison of care ability of family caregivers between baseline and week-12 of the experimental and control groups.

Part III: The comparison of quality of care of family caregivers between baseline and week-24 of the experimental and control groups.

Part I: Demographic Characteristic of the Samples

The samples in this research were randomized into experimental and control groups, consisted of fifty-eight subjects with twenty-nine subjects in each group. There were nine dropped out cases (15.51%) after 12 weeks (3 cases) and six dropped out cases after 24 weeks (6 cases) respectively as shown in Figure 5.

The mean ages in the experimental and control groups were 79.5 years (SD = 7.9) and 81.0 years (SD = 8.7). The percentage of female participants was higher than male in both groups (84.6% vs. 15.4% in the experimental group, 75.9% vs. 24.1% in the control group). Most of the participants in both groups were windowed (65.4% vs. 58.6%), and had at least primary school education (80.8% vs. 86.2%). The previous occupation in both groups was farming and gardening (46.2% vs. 55.2%). Almost half of subjects in the experiment group (42.3%) had monthly income more than 10,000 baht, while there was found only one fourth of the subjects of the control group. About one third in the experimental group had three diseases, while only 1 disease was found in the control group. More than half of subjects in both groups were totally dependent (57.7%, 58.6%).

The findings revealed that there were no differences in demographic characteristics of age, gender, marital status, education level, previous occupation, family income, health problem, and level of dependency of dependent elders of both groups (Table 4.1).

Table 4-1

Characteristics of the Sample, Experimental Group and Control Group of the Dependent Elders

Demographic characteristics	Experimental group (n=26)	Control group (n=29)	Statistic test	*p*-value/ Fisher's Exact
	n (%)	n (%)		
Age				
60-69	2 (7.7)	3 (10.3)		
70-79	11 (42.3)	8 (27.6)		
80-89	12 (46.2)	13 (44.8)		
90-99	1 (3.8)	4 (13.8)		
≥100	-	1 (3.4)		
($\overline{X}$, SD)	(79.5, 7.9)	(81.0, 8.7)	.507 [t]	.647
Gender				
Male	4 (15.4)	7 (24.1)	.510 [a]	.656
Female	22 (84.6)	22 (75.9)		
Marital status				
Single	1 (3.8)	2 (6.9)		
Married	8 (30.8)	9 (31.0)	.282[a]	.856
Widowed	17 (65.4)	17 (58.6)		
Divorced	-	1 (3.4)		
Educational level				
No formal education	5 (19.2)	4 (13.8)	.721[a]	.296
Primary school	21 (80.8)	25 (86.2)		
Previous occupation				
Housewife	3 (11.5)	2 (6.9)		
Civil servant	2 (7.7)	-	1.835[a]	.302
Employee	9 (34.6)	11 (37.8)		
Farming and gardening	12 (46.2)	16 (55.2)		

Table 4-1 (continued)

Demographic characteristics	Experimental group (n=26) n (%)	Control group (n=29) n (%)	Statistic test	*p*-value/ Fisher's Exact
Own income (Baht/month)				
< 3,000	-	4 (13.8)		
3,001-5,000	1 (3.8)	1 (3.4)		
5,001-8,000	5 (19.2)	8 (27.6)	.635[t]	.429
8,001-10,000	9 (34.6)	8 (27.6)		
> 10,000	11(42.3)	8 (27.6)		
Sufficiency of income				
Sufficient income	6 (23.1)	13 (44.8)		
Not sufficient income	20 (76.9)	16 (55.2)	2.868[a]	.155
Number of diseases				
No	2 (7.7)	4 (13.8)		
1	6 (23.1)	11 (37.9)		
2	6 (23.1)	6 (20.7)	.3.126[a]	.537
3	9 (34.6)	5 (17.2)		
≥ 4	3 (11.5)	3 (10.4)		
Diseases*				
Hypertension	21 (36.2)	17 (34.7)		
Diabetes mellitus	10 (17.2)	5 (10.2)		
Heart disease	7 (12.1)	9 (18.4)		
Hyperlipidemia	8 (13.8)	8 (16.3)		
Stroke	6 (10.3)	-	.897[t]	.385
Dementia	-	3 (6.1)		
Osteoarthritis	3 (5.2)	2 (4.1)		
Peptic ulcer	2 (3.4)	2 (4.1)		
Urinary tract infection	1 (1.7)	2 (4.1)		
COPD	-	1 (2.0)		
Level of dependency				
Partially dependent	11(42.3)	12 (41.4)	.005[a]	1.000
Totally dependent	15(57.7)	17 (58.6)		

Note. [t] = t-test. [a] = Chi-square test. [b] = Fisher's Exact test. * = Choose more than 1 answer.

Characteristics of the samples, experimental group and control group of family caregivers. The mean ages of family members in the experimental and control groups were 46.7 years (SD = 8.0) and 43.5 years (SD = 11.5). The percentage of female participants was higher than male in both groups (92.3% vs.7.7% in the experimental group, 86.2% vs. 13.8% in the control group). Most of family members in both groups were married (73.1% vs. 82.8%), and had at least primary school educational level (76.9% vs. 62.1%). The occupation in both groups was employee (50.1% vs. 62.2%). Most of them had no health problems (80.8% vs. 69.0%). Almost two third of family caregivers were daughters (61.6% vs. 62.1%) and spent less than five years to care for dependent elders (61.5% vs. 51.7%).

The findings were shown that there were no differences in demographic characteristics of gender, age, marital status, education level, occupation, health problem, relationships with the dependent elders, and duration of caregiving of family caregivers of both groups (Table 4.2).

Table 4-2

Characteristics of the Samples, Experimental Group and Control Group of the Family Caregivers

Demographic characteristics	Experimental group (n=26)	Control group (n=29)	Statistic test	*p*-value/ Fisher's Exact
	n (%)	n (%)		
Age				
20-29	2 (7.7)	3 (10.3)		
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)	1.224[t]	.227
Gender				
Male	2 (7.7)	4 (13.8)	.525[a]	.672
Female	24 (92.3)	25 (86.2)		
Marital status				
Single	6 (23.1)	5 (17.2)		
Married	19 (73.1)	24 (82.8)	1.513[a]	.469
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[a]	.393
Secondary school & higher	2 (7.7)	2 (6.4)		
Occupation				
Housewife	9 (34.6)	7 (24.1)		
Civil servant	1 (3.8)	1 (3.4)	.895[a]	.827
Employee	13 (50.1)	18 (62.2)		
Farming	3 (11.5)	3 (10.3)		
Number of diseases				
No	21 (80.8)	20 (69.0)		
1	5 (19.2)	5 (17.2)	3.872[a]	.144
2	-	4 (13.8)		

Table 4-2 (continued)

Demographic characteristics	Experimental group (n=26)	Control group (n=29)	Statistic test	*p*-value/ Fisher's Exact
	n (%)	n (%)		
Duration of caregiving (years)				
< 5	16 (61.5)	15 (51.7)		
5-10	5 (19.2)	6 (20.7)	.654[a]	.721
> 10	5 (19.2)	8 (27.6)		
Relationship with elders				
Daughter	16 (61.6)	18 (62.1)		
Son	4 (15.4)	1 (3.4)		
Daughter in law & son in law	-	3 (10.3)	.440[b]	.558
Grandchild	4 (15.4)	6 (20.7)		
Sister & brother	1 (3.8)	1 (3.4)		
Spouse	1 (3.8)	-		

Note. [t] = t-test. [a] = Chi-square test. [b] = Fisher's Exact test.

Part II: The Comparison of Care Ability of Family Caregivers Between Baseline and Week-12 in the Experimental and Control Groups

This part presented an effect of the family caregiver capacity building program on care ability, comparative analysis between family caregivers receiving the family caregiver capacity building program and those who did not receive the program, and comparative analysis of care ability of family caregivers between before and after receiving the family caregiver capacity building program.

The underlying assumption of statistical t-test which was normal distribution of all variables was evaluated. Care ability scores of family caregivers both the control (29 cases) and experimental groups (26 cases) distributed normally at baseline and 12th week. Independent t-test was used to test the difference of mean scores at baseline and at week-12 of both groups. The results of comparison of baseline scores between groups showed that the mean scores of care ability were not statistically significant different (t = .782; *p* = .438) (Table 4-3).

Table 4-3

Comparison of Care Ability of Family Caregivers Between the Experimental Group (n=26) and Control Group (n=29) at Baseline

Participant group	Range	Mean	SD	t	Sig
Experimental group	40-55	48.00	3.59	.782	.438
Control group	40-56	48.79	3.93		

p > .05

The results of comparison of care ability at week-12 between groups after receiving the family caregiver capacity building program showed that the mean scores of care ability were statistically significantly different at $p < .05$ as presented in Table 4-4.

Table 4-4

Comparison of Care Ability of Family Caregivers Within the Experimental Group (n=26) and Control Group (n=29) at Week-12

Participant group	Range	Mean	SD	t	Sig
Experimental group	50-66	57.65	2.91	8.308	.021
Control group	37-57	49.14	4.44		

$p < .05$

Paired t-test was used to test the difference of mean scores at baseline and week-12 of both groups. The results of the experimental group after receiving the family caregiver capacity building program demonstrated that a mean scores of care ability increased from baseline to week-12 ($p<.000$) as presented in Table 4-5.

Table 4-5

Comparison of Care Ability of Family Caregivers in the Experimental Group Between Pre-test and Post-test

Participant group	Range	Mean	SD	t	Sig
Pre-test	40-55	48.00	3.59	16.163	.000
Post-test	50-66	57.65	2.91		

$p < .001$

In the control group, the results showed that the mean scores of care ability at baseline and week-12 were not statistically significantly different (t = 1.095; $p = .283$) (Table 4-6).

Table 4-6

Comparison of Care Ability of Family Caregivers in the Control Group Between Pre-test and Post-test

Participant group	Range	Mean	SD	t	Sig
Pre-test	40-56	48.79	3.93	1.095	.283
Post-test	37-57	49.14	4.44		

$p > .05$

In conclusion, the family caregivers who received the family caregiver capacity building program had better care ability than those who did not receive the program. Thus, providing the family caregiver capacity building program in family caregivers can increase the care ability of family caregiver who care for the dependent elders.

Part III: The Comparison of Quality of Care of Family Caregivers Between Baseline and Week-24 After Experiment in the Experimental and Control Groups

This part presented an effect of the family caregiver capacity building program on quality of care of family caregivers. The quality of care scores of family caregivers of both the experimental group (24 cases) and control group (25 cases) distributed normally at baseline and at week-24. Independent t-test was used to test the difference of mean scores at baseline and at week-24 of both groups. The results revealed that quality of care scores at baseline of the experimental group were not statistically significantly different from those of the control group (t = .021; p = .082) (Table 4-7).

Table 4-7

Comparison of Quality of Care of Family Caregivers Within the Experimental Group (n=24) and Control Group (n=25) at Baseline

Participant group	Range	Mean	SD	t	Sig
Experimental group	106-157	123.96	13.92	.021	.082
Control group	73-191	123.84	24.22		

$p > .05$

The results of comparison of quality of care scores between the experimental and control groups at week-24 demonstrated that the quality of care scores of the experimental group were higher than those of the control group (p<0.5) (Table 4-8).

Table 4-8

Comparison of Quality of Care of Family Caregivers Within the Experimental Group (n=24) and Control Group (n=25) at Week-24

Participant group	Range	Mean	SD	t	Sig
Experimental group	106-159	117.29	2.73	.959	.038
Control group	66-189	122.80	5.06		

$p < .05$

Paired t-test was conducted to test the difference of mean scores between baseline and week-24 of both experimental and control groups. The results showed that the experimental group after receiving the family caregiver capacity building program demonstrated lower score than baseline (lower score indicated higher quality of care) (Table 4-9).

Table 4-9

Comparison of Quality of Care of Family Caregivers in the Experimental Group Between Pre-test and Post-test

Participant group	Range	Mean	SD	t	Sig
Pre-test	106-157	123.96	13.92	3.157	.004
Post-test	106-159	117.29	13.36		

$p < .01$

The results of comparison of quality of care scores between baseline and week-24 of the control group showed that there was no statistically significantly difference (Table 4-10).

Table 4-10

Comparison of Quality of Care of Family Caregivers in the Control Group Between Pre-test and Post-test

Participant group	Range	Mean	SD	t	Sig
Pre-test	73-191	123.84	24.22	.859	.399
Post-test	66-189	122.80	25.29		

$p > .05$

Discussion

This study aimed to investigate the effects of the family caregiver capacity building program on care ability and quality of care of family caregivers who care for dependent elders. The study indicated that all hypotheses were confirmed.

1. The results showed that the family caregiver capacity building program of dependent elders by promoting families with the empowerment renders the caregivers to have ability for better care. This can be explained as follows:

The family empowerment of family caregiver of dependent elders with the empowerment strategy provides the family caregivers to have a caring confidence. These strategies include trustworthiness, creating direct relationship, assisting family in making decisions on caring treatment, providing correct information, control and protection for change and danger that may occur, setting goal, assisting family in assess supporting resource, capacity building of family and strategy in solving the problem or face the problem, assisting family in creation of support group or peer support group, capacity building of family encouragement or opening multiple options or perspectives, discussion on health system and system access, development of negotiation skill with health personnel as a partnership and share information, supporting, admiring and accepting the good of care of family caregiver following the capacity building development phases of Hume (1999) concept. The development phases start from the professional-dominated phase which the family caregivers have not the confidence in caring the dependent elders due to the lack of caring knowledge and skill until the collaborative phase which family caregivers have more confidence in caring and can take care well the dependent elders. The demand is less and less for depending on health personnel, until finally the family caregivers can perform their roles and duties.

The first phase of family caregiver capacity building development by empowering is the phase of depending on health personnel. This stage will encourage the family caregivers to have knowledge and skill in taking care of dependent elders. Before learning, the empowerment strategy of building trust by establishing rapport was introduced for the opportunity discussion by family caregivers. They will talk about the caring activities, caring problems and difficulties. The researcher is a good listener and

accepts what the caregivers shared and expressed which will help then discovered reality on situation of dependent elders care and reflection. Because the family caregiver who provide care for the dependent elders on this phase do not know the process to take care the dependent elders owing to the lack of information about problem and requirement as well as the treatment instruction to meet the demand for both health and daily life, the empowerment strategies which were building trust and establishing a direct relationship employed to motivate the family members to exchange the caring experience that will help family to reflect the belief of strengths and capabilities, apart from the exchange of caring activities, caring problems and difficulties. When families exchange problems and difficulties followed by the reflection of their capabilities including their strengths which previously never seen before, the nurse will listen the issue of the family concern and accept the family capabilities. This will make family confident through the nurse and lead to the further steps which are information gathering, participation in care and decision making.

The second phase of empowerment is participatory phase. This is the stage which family members realize their importance as a caregiver of dependent elders and involve with health personnel in making decision about caring. It is the stage after family members rely on health personnel, and they will find and gather the information. The family caregiver capacity building program focuses on activities for providing information about dependent elder problems, requirements and guidelines of health care that will help family caregivers to have more knowledge and understanding on the health status of dependent elders. The increased knowledge will help family caregivers to decide on a plan of care that properly meets the requirement of dependent elders. When family caregivers get information and have opportunity to express an idea with the acceptance of health personnel, this will make caregivers confident and feel to be involved in caring procedures. The information received on the dependent elderly guidelines will assist the family to analyze altogether with own capability analysis. This will help families to be able to specify what more of learning needs for dependent elderly care and learn to know how to manage with uncertainty that may occur from the lack of sufficient data (Hulme, 1999). In addition to providing information, family caregivers have also the opportunity to share information from other family members that are caregivers who have to face the

same issues. The family caregivers can get different information which had been effectively preceded apart from the main theory information only given by the nurse. The information received by caregivers is in accordance with the requirements since the first phase is the creation of trust that the family members have the opportunity to express the idea and exchange the experience, including identify the issues and needs for their own care.

Besides, the skill development of family caregivers on caregiving the dependent elder that focuses on participation in care is the capacity building development of important empowers since the family has developed all fields of expertise for dependent elderly care. Promoting the family's ability is the major activity based on belief that families are those with capabilities and who know the best about the problems and needs of dependent elders after they have developed trust through the nurse and extensively received information about care which all fields of family capability encouragements include enhancing the family's ability to meet their needs, solving problems and mobilizing appropriate resources to satisfy the health care needs of the dependent elders and finally preserving family life. The activity of empowerment is to help family to achieve the care which family has involved in responsibility of doing activity, recommend family to evaluate the supporting resource including access the beneficial resource and supporting resources for effective care of dependent elders. In addition, the opportunity families have to evaluate their own strengths and capabilities before skill practicing makes them confident to engage with the health personnel for caregiving dependent elders. The phase of care skill consists of the activity of care practiced by own family members with the analysis of those practices. The analysis will be compared with the information received from the nurse in order to reflect the accuracy and decency caregiving dependent elders. The skill of care will enhance family members to have abilities to control different situations by their own with less depending on the health personnel.

However, apart from the mentioned skill practice, families have also obtained the coaching skill to negotiate with the health personnel if needed to communicate with them or when making decision on plan of elderly care. The importance of family capacity building encouragement through empowerment with the adult learning approach is the nurses have belief that family caregivers are the expert in taking care as the same health

personnel. They have potential to discover their own solution and are the mirror of family strengths. The nurses are not too judgmental when interacting with the families. Although they are not family members, they have compassionate stranger. This allows families to more participate in the family care in which the nurses are those who create the atmosphere according to family member's requirement, so that the family members have involved in caregiving the dependent elders (Meetoo & Gopaul, 2005). For this stage, the family members have more confidence in their capabilities and begin to realize that they are people who know and understand the dependent elders the best. There is prioritization of activities, which ones should be carried before and after base on variety of factors involved. Also, having a chance to review the self-defined goals with the nurses at the first period whether it can be achieved and whether it needs to revise the plan or activity, it is found that family members begin to change not only how to ensure caregiving the dependent elders but also change the attitudes, beliefs and goals in their life and family altogether (Gipson, 1991, 1995).

The third phase of empowerment is challenging phase which the family members are aware of their own ability for caregiving the dependent elders. So it may have a question to health personnel about the caring activities or it may have a conflict with health personnel about the existing health status of elderly. In this stage, family members may have frustration, less confidence to health personnel and uncertainty. These may be from inability to achieve the short defined goal due to various limitations of the increased caring capability which cannot meet the requirement or achieve the goal. The empowerment activities of program for this stage are the development in reinforcing the family's ability to identify choices, the negotiation skill and open negotiation with value or admiration of acknowledge family for good care. Such activities allow family members to be aware of their own power in controlling the different situations that may arise from caregiving the dependent elders continually.

When family members can effectively take care and solve problem of the care, they will be more confident and may cause self-confident and assertiveness that allows them to less depend on health personnel. *This stage is collaborative phase* which family members can confidently negotiate with the health personnel and change the family role and responsibility for keeping the well-being of family life. The importance is family

members in this stage recognize their own power to control things that may occur when the environment or circumstances have changed. Furthermore, family members can also manage with the impact arising from caregiving the dependent elders and can efficiently care taking the elderly with more patience and steady practice. Sometimes it may have to change the view of time that is the achievement of result may take longer than to achieve the defined goal of care both short term and long term goals. For activities of the family caregiver capacity building program, it will use the result the same as involvement stage that are value and admiration, access and usage of resource for community, peer support group, advocacy and healthy system analysis and defined healthy system of community leading to achieve the goal. This research is to coordinate with the Sub-district Health Promotion Hospital to precede the activities for caregiving the dependent elders continually by a regular home visit and assess capacity building of family members, problem, and difficulty as well as assist family to have potential for continuing care.

The proceeding activities of family caregiver capacity building for developing empowerment program can make ability for caregiving the dependent elders of family caregiver better when comparing to the control group. The results of this research are consistent with the studies that introduce the concept of empowerment to use with the family caregiver capacity building development for several studies of chronic patients.

The results of this study were congruence with the findings of previous studies of caregiver empowerment program based on empowerment concept for increasing ability of care. Chetratanon (2013) studied the effect of empowerment program to care given burden patient of cerebrovascular disease at Tharuea hospital by using the concept of empowerment of Gipson. The program empowerment consists of development recognized caregiving burden, to realize the value potential development of care, and to develop a commitment to care for six months. The sample consisted of caregiver of cerebro-vascular disease patient are admitted to hospital 30 person. To develop a commitment to care for six months, tools used to collect data is measure form the burden of care for stroke patients. The study found that after the program administrator has the burden of care on average than before the program statistically significant (Chetratanon, 2013). The study found that after the program administrator has the burden of care on average than before the program statistically significant (Chetratanon, 2013). An

empowering was given confidence care ability and enhancing the quality of care congruence the study by Chaoniyom et al (2005) confirmed the effect of strengthen the family health leader capability program in Thai family caregiver to encourage self-care and health promotion. This research is quasi-experimental and qualitative research, which compares before and after comparison of knowledge, capability, leadership, and motivation of family health leader in community health promotion before and after potential development. The program was separated into 3 phases, including community preparation phase, capacity building phase and building network phase, training about health promotion, communication and problem solving skills and evaluation skill. It was conducted at the first, third, and sixth month. The results demonstrated that knowledge, capability, leadership, and motivation in taking care of oneself and family and community health promotion of family health leaders after potential improvement was significantly better than before or than that of the control group at $p < .05$.

However, the study of Li et al (2012) is the effects of the program CARE (Creating Avenues for Relative Empowerment: CARE), no significant difference between the experiment and control groups. The program focuses on the involvement of relatives caregiving the elderly in hospitals with the ability to communicate information to care the elderly in hospitals, 407 couples long program was divided into two experimental groups received information empowerment for 1-2 days after treated in hospital for 1-3 days and before discharge from the hospital, and follow-up in 2 weeks and 2 months after returning home. However, in the study of sub-group showed a significant difference in caregiving of the caregivers therefore, to study and develop a program to ensure effectiveness.

2. The results showed that the family caregiver capacity building program of dependent elders by promoting families with the empowerment renders the caregivers to have quality of care. The effects of the capacity building program on quality of care of the family caregiver could be explained the quality concept of Donabedian (2003) as follows:

Efficiency

The efficiency of the holistic approach, in part comes from appropriate and timely physical care which results in positive patient outcomes. By fulfilling these basic needs, positive outcomes are met and a better quality of care is achieved. The physical aspect of

the holistic approach includes, but not exclusive to, the offering food that meets nutrition demands, adequate hydration for the health of all body functions, fresh air, thorough hygiene to avoid infections, movement to maintain flexibility and muscle tone, repositioning to maintain skin integrity, and bowel and bladder management to reduce complications of incontinence.

Psychological care and support is an important component of holistic care that leads to decreased depression, stress reduction and can provide increased self-esteem and self worth. This type of care comes in the form of activities, such as allowing family members to participate in food preparation, the folding of laundry and other inclusive activities which can bolster self-worth and improve self-esteem. Psychological health can also be fostered by allowing the family members have more choice in what kind, how and when cares are completed.

Social care and support is another essential component of holistic care that leads to an increase of well being. In the receiving of support, the family member has an increased perception that they are still a part of the society which gives purpose and meaning. By offering inclusion in social gatherings, such as the playing of card or board games with family or peers, this can decrease loneliness and the potential for despair.

Environmental care is another important part of holistic care that can lead to a decrease of risk to harm and injury. This would entail the removing of obstacles that could cause tripping and falls, such as rugs, cords and other loose objects. This would also include removing or addressing items that could cause burns, fires or electrical injuries, such as candles, gas burners or frayed electrical cords. By reducing the potential for injury from the living environment, the family member will remain injury free, thus more independent which allows the family member to live at home longer, resulting in a decrease burden to family, as well as financial and social resources.

Health care is yet another integral component of holistic care that is achieved by ongoing attentiveness and assessment to the physiological health needs, can result in the reduction in the severity of disease, decrease complications from immobilization, thus decreasing bedsores and decreasing chances of infection. Frequent body examinations

during bathing, toileting and clothes changing are essential. By providing proper nutrition, hydration as well as medical care, the physiological integrity of the individual can improve.

Equity

Equity refers to the receiving of care services based on the patient's right to receive that care with fairness and equality. Quality caregiving sees through the extent health services from professional and health care provider focused to taking on the role of services at home.

Effectiveness outcomes of care to caregivers

Quality of care can also positively impact family caregivers giving them a feeling of happiness, a sense of altruism and pride through giving to another, as well as satisfying a feeling of duty and respect to a parent. As a caregiver, stress and individual role effect the outcomes to the caregivers, for example, if the caregiver cannot meet the components of their own holistic needs, then there is potential for burnout. The quality of the relationship between the caregiver and the family member can take a precipitous drop if the caregiver is not taking care of their own needs, such as proper nutrition, lack of sleep, or the use of drugs or alcohol to cope with stressors. As a consequence of the needs of the caregiver not being met, abuse can happen in the form of neglect, which can include the family member not receiving proper hygiene, poor nutrition, insufficient hydration, social isolation and psychological abuse.

Saves cost of care

Saves cost of care refers to the idea that the family caregivers can provide most of the services of care and as a result decreases demand on health care from health care providers.

The results of this study were congruence with the findings of previous studies of caregiver empowerment program based on empowerment concept for increasing quality of care for the elderly. The study demonstrated effects of capacity building of the family found that empowerment program to enhancing quality of caregiving by Shyu et al.

(2010) was to examine the effect of caregiver-orientation intervention program of older stroker victims in Taiwan to increase caregiver preparedness enhancing caregiver perception. The randomized clinical trial (RCT) was conducted in 158 family caregivers into experimented test group of 72 persons and a control group of 86 persons. The program was health education and occasional discharge referrals consultation in caregivers needs after discharge by teaching 2 sessions to empower and education, consisted of materials describing hospitals services and information services. The results demonstrated that the program increased quality of care during 12 months following discharge. The research about capacity building program for relatives in taking care elderly person by Li et al. (2003) or CARE program (Creating Avenues for Relative Empowerment: CARE), it is a program emphasizing on relatives' participation in taking care of elderly persons in the hospital to be able to communicate, receive the information about sickness, confront the problem, and be confident that they can take care of elderly persons. It was a randomized clinical trial (RCT) conducted in 49 elder caretakers in the hospital comparing to normal care in the hospital. The program was divided into 2 phases. The first phase was information provision and tape for care support. The second phase is listening to the tape to acknowledge care information and participation in exchanging learning as well as elderly care in the hospital. It took 2 weeks for the experiment in the hospital and 2 months at home. The result showed that the program was able to encourage the caretakers to learn and participate in taking care of elders. It decreased the incident of acute confusion and depression. The results demonstrated after follows at 2 weeks and 2 months are no difference in emotional coping measures for amount the quality of care but this result could improve the role of care of family caregivers in hospitalized elders.

It can be seen that the family caregiver capacity building program are both a process and outcome from a health professional relationships or interactions between family caregivers, social, community, and healthcare services. By empowering through their experiences, confidence in order to the many choices and make a decisions appropriately. This concept can be applied to healthcare personnel by creative resources of more capacity efficiency to help family caregivers and the dependent elders.