KNOWLEDGE ASSESSMENT OF CAREGIVERS OF STROKE PATIENTS ABOUT THEIR CARING ROLE

PROJECT REPORT

Submitted in partial fulfillment of the requirements for the

DIPLOMA IN NEUROSURGICAL NURSING

Submitted by

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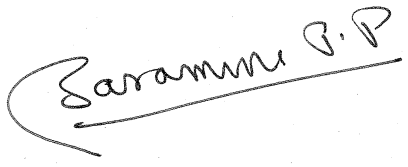
NOVEMBER 2009

CERTIFICATE FROM SUPERVISORY GUIDE

This is to certify that **Mrs. AMRITHA C.K** has completed the project work on **"A STUDY TO ASSESS THE KNOWLEDGE OF CAREGIVERS OF STROKE PATIENTS ABOUT THEIR CARING ROLE"** under my direct supervision and guidance for the partial fulfillment for the Diploma in Neuro Nursing, in the University of Sree Chitra Tirunal Institute for Medical Science and Technology, Trivandrum.

It is also certified that no part of this report has been included in any other thesis for processing any other degree by the candidate.



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CERTIFICATE FROM THE CANDIDATE

This is to certify that the project report on **"KNOWLEDGE ASSESSMENT OF CAREGIVERS OF STROKE PATIENTS ABOUT THEIR CARING ROLE"** is a genuine work done by me at the Sree Chitra Tirunal Institute for Medical Sciences and Technology Trivandrum, under the guidance of Mrs. Saramma P.P, Senior Lecturer In Nursing. It is also certified that this work has not presented previously to any university award of degree, diploma or other recognition.

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APPROVAL SHEET

This is to certify that Mrs. Amritha C.K bearing Roll No – 5895 has been admitted to the Diploma in Neuro Nursing in January 2009 and she undertaken the project entitled, "**KNOWLEDGE ASSESSMENT OF CAREGIVERS OF STROKE PATIENTS ABOUT THEIR CARING ROLE**", which is approved for the Diploma in Neuro Nursing awarded by the Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, as it is found satisfactory.

Examiners

1. _____

2. _____

Guide(s)

1. _____

2. _____

Place :

Date :

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First of all let me thank God of almighty for the unending love, care and blessing especially during the tenure if this study.

I take this opportunity to express my sincere gratitude to Dr Saramma P.P, Senior Lecturer in Nursing, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum. For the guidance, she provided for executing this study. Her advices regarding the concept, basic guidelines, and analysis of data were very much encouraging. Her contributions and suggestion have been of great help for which I am extremely grateful, with profound sentiments and gratitude the investigator acknowledge for encouragement and help received from the following person for the successful completion of this study.

Special thanks to library staff of Sree Chitra Tirunal Institute of Medical Sciences and Technology for granting permission to utilize library facility.

The investigator wishes to express heartful thanks to parents and near ones for their prayer, encouragement and help throughout this project.

The investigator also takes this opportunity to express the sincere gratitude to all caregivers who co-operated during the time of data collection.

Amritha C.K

ABSTRACT

A study to assess the knowledge of caregivers of stroke patients about their caring role.

Caregiver refers to any relative, partner, who has a significant personal relationship with, and provides a broad range of assistance for stroke patients. These individuals may be primary or secondary caregivers and live with from the person receiving care. And caregiver assessment refers to a systematic process of gathering information that describes a care-giving situation and identifies that particular problems, needs, resources and strengths of the family. Caregiver assessment is vital because they are the core part of the health care system. Due to the acute nature of the disease many caregivers of stroke patients enter the caring role abruptly and have little time to adapt. Many caregivers feel inadequately prepared to face the emotional and physical challenges of caring for someone with a disability, suggesting that the early weeks and months after discharge are an uncertain and vulnerable time for caregivers. The objective of the study was to assess the knowledge of caregivers of stroke patients and to assess the functional abilities of the patients. The study was done in SCTIMST Trivandrum with 20 samples. In person administration of questionnaire was done and using BARTHEL INDEX did the functional assessment. The findings presented in this study indicate that improvements have been made with regard to general stroke care information, because there is no significant score in the knowledge assessment test.

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CHAPTER - 1

INTRODUCTION

1.1 INTRODUCTION

The yearly global incidence of stroke is approximately 15 million (WHO, 2008). Stroke is a major health problem; especially among the elderly. It is the primary cerebrovascular disorder in the world. Although preventive efforts have brought about a steady decline in incidence over last several years, it has a major impact in the developing world especially in Asian countries. It has been established that stroke is presently among the top four leading causes of death. It occurs predominantly in the middle and later years of age. It is the leading cause of serious, long term disability. The incidence of stroke increases with age, thus the disability affects many people in their "golden age".

The most significant cost of stroke is the human cost. Up to 50 percentage strokes results in death, those who do not survive often are disabled. (AHA, 2007). According to the National Heart, Lung and Blood Institute, six months after ischemic stroke, 30 percentage of individuals 65 years of age or older are unable to walk without assistance, 26%are dependent in activities of daily living, and 26 percentage are in nursing homes. (Kelly-hayes et al. 2003). Although stroke is devastating and its impact is wide spread, many people have a limited knowledge about stroke symptoms and available treatments.

Due to the acute nature of the disease, many caregivers of stroke survivors enter the caring role abruptly and have a little time to adapt. (kerr,et al in 2001). Many care givers are inadequately prepared to face the physical and emotional challenges of caring for someone with a disability (Baker, et al 2002,) suggesting that early weeks and months after discharge are an uncertain and vulnerable time for caregivers.

Consequently, family members known as 'informal caregivers' inevitably have to provide additional support. Not only must they carry out all the duties or tasks that stroke patients have done before their illness, they also have to perform important activities of daily living (ADLs) and instrumental activities of daily living (IADLs), including informal rehabilitation. Unlike other caregivers of chronically ill patients, stroke caregivers are suddenly and unexpectedly thrust into the new care provider role after a stroke event. Therefore, uninitiated in special health care skills, the new caregiver has many needs in dealing with this new challenging role. It is important for professional health care staffs to know who the informal stroke caregivers are and what they need in order to provide appropriate care for both caregivers and patients.

1.2 BACKGROUND OF THE STUDY

Stroke is a heterogeneous, neurological syndrome characterized by gradual or rapid, no convulsive onset of neurological deficits that fit a known vascular territory and that last for 24 hours or more. Stroke occurs when oxygen supply to a localized area in the brain is interrupted, resulting in a series of intricate

processes that lead to the destruction of neural tissue and consequent brain damage. Stroke is divided into the two major categories of ischemic stroke and hemorrhagic stroke. Ischemic stroke accounts for about 85 percent of all cases. Ischemic strokes occur as a result of an obstruction within a blood vessel supplying blood to the brain. A hemorrhagic stroke is caused by a ruptured blood vessel (aneurysm) or a leaky arteriovenous malformation (AVM). This type of stroke is particularly dangerous because it can easily cause an increase in pressure inside the brain, ultimately leading to brain damage.

Care of the stroke can be divided into three phases. Phase1 or initial care, phase 2, which is concerned with rehabilitation efforts, and phase 3, during which plans are made for continuity of care once the patient returns home. These are phases in the sense that one begins only after another is finished. There is overlapping of activities in each phase.

The majority of survivors return home to reside in community with various physical, psychological, emotional, social and spiritual health disabilities after the initial period of hospitalization and rehabilitation. These disabilities are preventing the patient from functioning independently and effectively in the community. Approximately three fourths of them continue to receive assistance of daily living activities from family caregivers. So family caregivers play an important role, as a substantial portion of the cost of home care is born by them.

The demands of providing care depend on factors such as the patient's personality; the type or stage of illness; and the caregivers' physical, cognitive, social, organizational, and psychological knowledge and skills. Caregivers need to perform complex medical tasks, supervise patients, make decisions, solve problems, provide emotional support and comfort, and coordinate care. Using these skills, caregivers administer medications, plan and provide meals, handle medical equipment, and provide direct care such as wound care and lifting and turning. Caregivers also provide custodial care, transportation, and advocacy. Some tasks are merely time-consuming; others are difficult. Family caregivers also typically manage the household activities. To improve function and safety for the patient, caregivers may need to modify the environment and acquire equipment and assistive devices.

Caregivers also need to learn to monitor patients for new signs and symptoms, adverse events, and positive responses to treatment. Care giving is more complex and the family's distress more acute if the patient has impaired cognition or neuropsychological symptoms changes in the severity of symptoms or the appearance of new symptoms, as the disease progresses can heighten the caregiver's perception of loss of control. A self dedicated person can improve the condition of the patient.

So an ideal caregiver is

- Emotionally and physically capable of handling the work.
- Able to share duties and responsibilities with other willing family member.
- Able to plan solutions and solve problems instead of withdrawing under stress.

- Able to speak in a simple and clear way.
- Comfortable in giving and receiving help. able to handle unpleasant tasks such as changing diapers, bathing or cleaning bedsores.
- Able to speak to and understand the care receiver.
- Ability to cope with frustration and anger.
- Able to make this person feel useful and needed
- Valued by other family members.

1.3 NEED AND SIGNIFICANCE OF THE STUDY.

Providing careers and stroke survivors with comprehensive and adequate information is vital. Because better treatments have improved the life span of most patients with chronic illnesses, caregiver involvement is often required for several years. Poorly developed support resources for careers that offer minimal information and advice can not only add to careers distress but also impede the stroke survivors recovery process. (Henley,et al 1999;). However, careers still voice concerns that they are poorly prepared for this role. (Murrain et al,2003) as they don't have the necessary skills and knowledge to provide sustained care for a person with a chronic illness. So they lack confidence.

The caregiver's assessment is very important in the well being of stroke patients. The public and private programs should recognize key dimensions of family care giving due to

- The unit of care is the care recipient and the caregiver.
- The caregiver is the part of the care team and service plan.
- Services should be consumer directed and family focused.
- Caregiver assessment and support improves out comes and continuity of care for the care recipient.

Caregiver assessment is systematic process of gathering information that describes a care-giving situation and identifies particular problems, needs and resources and strengths of the family caregiver. Because most community dwelling older peoples and adults with disabilities rely solely on their own families and friends for assistance with daily living and are dependent upon their health and well-being. Establishing career assessment as a core part of care of persons with chronic or disabling conditions is essential to effective out comes and quality of care.

Caregiver assessment is a tool to help identify strengths and limitations and to develop a realistic plan for the next stage of care. The goal is twofold: (1) to ensure that the patient's health and well-being are maintained and enhanced; and (2) to ensure that the caregiver's capacities and needs are considered and addressed in a care plan.

Caregivers can assess the condition of the patients by using Barthel Index. Barthel Index serves a measure of daily living activities in relation to personal care and mobility of the person. It has been used for such tasks as predicting time needed for the caregivers for giving care.

It consists of 10 variables describing daily living and mobility. A higher number is associated with a greater likely hood of being able to live at home with a degree of independence following discharge from hospital. It can also be used to assess the improvement of the patients condition.

1.4 STATEMENT OF THE PROBLEM.

A study to assess the knowledge of caregivers of stroke patients about their caring role.

1.5 OBJECTIVES.

- To assess the knowledge of caregivers.
- To assess the functional abilities of patients as reported by caregivers.

1.6 OPERATIONAL DEFINITIONS.

CAREGIVER: refers to any relative, partner, who has a significant personal relationship with, and provides a broad range of assistance for stroke patient. These individuals may be primary or secondary caregivers and live with from the person receiving care.

CAREGIVER ASSESSMENT: refers to a systematic process of gathering information that describes a care giving situation and identifies that particular problems, needs, resources and strengths of the family.

CARING ROLE: refers to the role of the caregiver in the caring of the patient.

KNOWLEDGE: refers to knowledge test regarding the home care of the stroke patients.

FUNCTIONAL ABILITIES: refers to the ability of the patient to do the daily living activities with out the help of others.

1.7 RESEARCH METHODOLGY

SETTINGS: stroke clinic in SCTIMST, Trivandrum

STUDY DESIGN: data collected through in person administration of questionnaires and the functional assessment of the patients are done by the Barthel index as reported by the caregiver.

SAMPLE TECHNIQUE: consecutive sampling.

EXCLUSION CRITERIA: those who are not able to read and write Malayalam.

1.8 TOOL

The investigator assessed the knowledge of caregivers by using self-prepared questionnaire and using Barthel index does the functional assessment of the patients. The questionnaire contains three sections. Section A: demographic data, section B: knowledge assessment questionnaire containing 15 questions and section C: functional assessment of the patient using BARTHEL INDEX containing scores 100.

1.9 DELIMITATIONS

- Only Malayalam speaking caregivers were included in the study.
- Only those who are interested and willing to participate are included in the study.
- Sample size was limited to 20.
- Sample was selected from only one institution.

1.10 ORGANISATION OF THE REPORT.

Chapter 1 deals with the introduction, background of the study, and statement of the problem, need and significance of the study, statement of problem, objectives, operational definition and delimitations. Chapter 2 deals with review of literature, Chapter 3 deals with the methodology, chapter 4 presents analysis and interpretation of the data, and chapter 5 include summary, discussion, conclusion and recommendation, reference and appendices are given towards the end.

CHAPTER - 2

REVIEW OF LITERATURE

Review of literature is an important aspect of any research project from the beginning to end. It gives character insight into the problem and helps in selecting methodology, developing and also analyzing the data.

According to Cooper (1988) 'a literature review uses as its database reports of primary or original scholarship, and does not report new primary scholarship itself. The primary reports used in the literature may be verbal, but in the vast majority of cases reports are written documents. The types of scholarship may be empirical, theoretical, critical/analytic, or methodological in nature. Second a literature review seeks to describe, summarise, evaluate, clarify and/or integrate the content of primary reports'.

The review of literature relevant to this study is presented in the following section.

2.1 Studies related to the knowledge assessment of caregivers of stroke patients.

2.2 Stroke related knowledge and health care behaviours among post stroke patients.

2.1 STUDIES RELATED TO THE KNOWLEDGE ASSESSMENT OF CAREGIVERS OF STROKE PATIENTS.

Teel, et al., (2001) conducted a study on care giving experiences after stroke by giving mailed questionnaires among 83 caregivers. The result of this study was the caregivers reported stable perceptions of fatigue, vigor, recurrent sorrow, perceived stress, finances, family support, physical health and depressive state symptoms 1,3and 6 months after the loved ones stroke.

May, et al., (2005) conducted a study on supporting family caregivers in stroke by a structured review of literature identified from nursing, medicine and psychology databases from 1970-2004. The results of this review show that the strength of evidence for problem solving interventions for caregivers of stroke patients is limited.

Yu-ying tang, et al., (2004) done a study about health promotion behaviours in Chinese family caregivers of patients with stroke. A structured home interview survey methodology was used to collect data from 134 primary caregivers responsible for care of stroke patients in Taiwan. Result was that care recipients with a higher functional status engaged in more health promotion activities.

Elain, et al., (2001) evaluated a study on fast stoke prevention educational program for middle school students. A 2 months stroke prevention educational

program focused on improving knowledge of stroke signs and symptoms, risk factors, treatment seeking behaviors, over all attitude towards stroke, including perceived self efficacy in identifying stroke warning signs and dealing with a stroke victim. The study was done by a pre test, an educational intervention, immediate posttest and a long-term posttest at 2 months. A convenience sample of 72 students with a mean age of 13.25 years was used. Results indicated significant increase in knowledge of stroke risk factors and warning signs in stroke.

Kalra, et al., (2004) conducted a structured caregiver training which comprised information on management of stroke, involvement goal settings planning ,informal instructions of facilitating transfers, mobility and ADL and information on community services and benefits. At 12 months, patients in the caregiver training group had improved mood and quality of life.

Yu-ying, et al., (2009) conducted a family caregiver oriented discharge planning program for older stroke patients and their family caregivers. A randomized experimental design was used to explore the effects of a discharge planning program of 158 older stroke patients and their caregivers. The control group (86) received only routine hospital planning services and the experimental group (72) routine hospital discharge planning services plus the caregiver oriented discharge-planning program. Caregivers in experimental group received better knowledge of care giving and had better satisfaction.

Bet han, et al., (1999) conducted a study on family care giving for patients with stroke. It reviewed with the goal of evaluating the effects of stroke care giving on caregivers well being. A total of 20 care giving research articles were included in this review. Across studies, the effects of care giving on caregiver's well being and the significant predictors.

2.2 STROKE RLATED KNOWLEDGE AND HEALTH BEHAVIORS AMONG POST STROKE PATIENTS AND CAREGIVERS.

Koenig, et al., (2007) conducted a study on health behaviors on stroke patients undergoing inpatient rehabilitation and their caregivers. Total of 130 stroke patients and 85 caregivers were interviewed after ischemic stroke. In that stroke patients participating in inpatient rehabilitation and their caregivers have large gaps in stroke knowledge and have sub optimal personal health behaviors, there by putting patients at risk for recurrent stroke. These findings highlights the need to develop stroke – education programs for rehabilitating patients that are effective in closing these gaps in knowledge and personnel health behaviors.

Goldstein LB, et al., (2009) Conducted a study on stroke related knowledge among uninsured Latino immigrants in Durham country, North Carolina. According to this study knowledge of stroke risk factors and symptoms is a necessary prerequisite for improving prevention and reducing treatment delays. They selected a convenient sample of 76 Latino Spanish speaking

clients of a community based health care management program a uninsured residents of Durham community, North Carolina, between January and march 2007. Then they concluded stroke related knowledge may be particularly poor in the uninsured Latino immigrant population. Novel approaches will be needed to improve awareness and prevention in this high-risk group.

Haley, et al., (2009) Studied about the problems and benefits reported by stroke family caregiver. The prevalence and stressfulness of stroke related problems, and perceived benefits of care giving, as reported by an epidemiological derived sample of caregivers of stroke survivors. They find that caregivers rated patient problems with mood, memory and physical care, as the most stressful, but reported prevalence of these problems. Epidemiologically based studies of care giving provide a unique picture of caregiver strains and benefits compared with clinical studies, which tent to over present more impaired patients .Support for caregivers should include interventions to aid their coping with highly stressful mood, physical care, and cognitive problems of stroke patients, but should also attend to perceived benefits of care giving.

McNamara, et al., (2008) Wants to evaluate the need for additional pre - hospital stoke training opportunities in Montana. They conducted a telephone survey of a representative sample of EMS providers in Montana. Responders were stratified into two. Those working in the urban and frontier countries. They concluded that stroke knowledge did not differ between urban and frontier groups, stroke screens and stroke protocols were less likely to be

used in the frontier areas. Training opportunities and the implementation of stroke protocols and screening tools are needed for EMS providers, particularly in frontier countries.

Table 2.1

Key terms used for literature search

Key Terms	No.of articles
Knowledge assessment of caregivers of stroke patience	1050
Functional assessment of stroke patience	123
Caregivers	123

CHAPTER - 3

METHODOLOGY

This chapter deals with research approach, research designs, setting the sample and sample technique, development of tool, description of tool, pilot study, data collection and plan of analysis. The aim of the study is

- To assess the knowledge of caregivers of stroke patients about their caring role.
- To assess the functional abilities of stroke patients as reported by the caregivers using the BARTHEL INDEX.

3.1 RESEARCH APPROACH

In person administration of questionnaire.

3.2 RESEARCH DESIGN.

Data collected through in person administration of questionnaires and the functional assessment of the patients are done by the Bethel index as reported by the caregiver.

3.3 SETTINGS.

The study was conducted in stroke clinic in SCTIMST, TRIVANDRUM. The rationale for selecting this hospital was that this is one of the famous hospital in India and many stroke patients visit the stroke clinic daily. More over the investigator was familiar with this hospital.

3.4 SAMPLE AND SAMPLING TECHNIQUE.

In person administration of the questionnaire was used .All caregivers who met the inclusion criteria were selected. Twenty caregivers consisted of the sample. It includes both males and female's .the total period of the study was from September 2009- November 2009.

3.5 INCLUTION CRITERIA.

- Both male and female caregivers.
- Those caregivers who are co-operative.
- Those caregivers who know Malayalam

3.6 EXCLUSION CRITERIA:

- Those who do not know Malayalam.
- Those who are not co-operative.

3.7 DEVELOPMENT OF TOOL

After relevant study of the subject the investigator prepared the questionnaire to assess the knowledge of the caregivers. With help of BARTHEL INDEX made the functional assessment of the patients. It was scrutinized and approved by the experts in Sree Chitra Tirunal institute of medical sciences and technology.

3.8 DESCRIPTION OF THE TOOL

The tool used in the present study consists of the following parts.

Part 1 : This part includes the demographic profile of the caregivers including age, sex, education, occupation and income.

Part 2 : It consists of the questionnaire prepared by the investigator to assess the knowledge of caregivers about their caring role which consists of 14 questions including different areas such as skin care, bladder and bowel care, eye care, respiratory care, swallowing assessment etc of the patient.

Part 3 : It contains the functional assessment of the patient. Using BARTHEL INDEX, which was translated into Malayalam, does it by the caregiver itself.

3.9 PILOT STUDY

Pilot study was done in October 15 2009 in stroke clinic. The aim of study was to assess the knowledge of caregivers of stroke patients about their caring role. The study was conducted among ten caregivers. Total time required is 30 minutes for a caregiver. Pilot study revealed that they need more information and education about the care of the stroke patients depending on their functional abilities. Because there is no significant score in the knowledge assessments test.

3.10 DATA COLLECTION

Data collection was done after the formal permission of the authorities Period of data collection is from September 2009- November 2009. Data was collected from the caregiver who visits the stroke clinic of SCTIMST Trivandrum.

The investigator first introduced her and explained the need and purpose of the study to the caregivers. After getting consent from the caregivers the questions were distributed. Using the BARTHEL INDEX did the functional assessment of the patients.

3.11 PLAN OF ANALYSYS

The investigator developed plan of data analysis after the pilot study. By the score obtained in the knowledge assessment test prepared a master sheet.

3.12 SUMMARY

This chapter deals with research approach, the study design, setting of the study, sample and sampling technique, and development of tool, data collection and plan of analysis.

CHAPTER - 4

ANALYSIS AND INTERPRETATION OF DATA

This chapter presence analysis and interpretation of Data collected from 20 caregivers who visit the stroke clinic, in SCTIMST, Trivandrum. Analysis is a process of organizing and synthesizing in such a way that project elicit meaning form collected data. The aim of the research was to assess the knowledge of caregivers about their caring role and to assess the functional abilities of stroke patients.

Interpretation referrers to the process of making sense of the results and of examining the implication of the findings with a broader content the date were corded, entered in Micro soft excel and analyzed using epi info version 3.2.

The finding of the study were arranged and analysed under the following section.

4.1 DISTRIBUTION OF SAMPLE ACCORDING TO THE DEMOGRAPHIC VARIABLES.

4.2 MEAN STANDARD DEVIATION AND P. VALUE OF KNOWLEDGE ASSESSMENT SCORE

4.3 MEAN STANDARD DEVIATION AND P. VALUE OF FUNCTIONAL ASSESSMENT SCORE.

4.1 THE DISTRIBUTION OF SAMPLE ACCORDING TO DEMOGRAPHIC VARIABLES.

DISTRIBUTION OF SAMPLE ACCORDING TO SEX.

Table 4.1

Sex	Frequency	Percentage
Female	10	50
Male	10	50

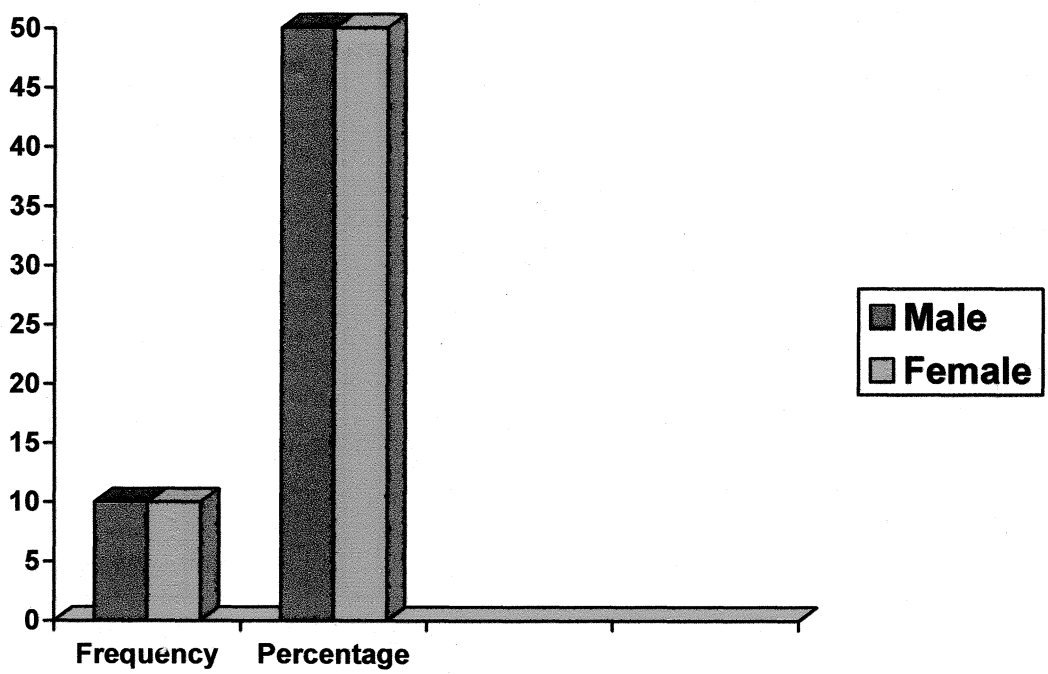

Fig. 4.1 Bar diagram showing distribution of sample according to sex

DISTRIBUTION SAMPLE ACCORDING TO AGE.

Table 4.2

Age Group	Frequency	Percentage
21-30	3	15
31-40	3	15
41-50	11	55
51-60	3	15
Total	**20**	**100**

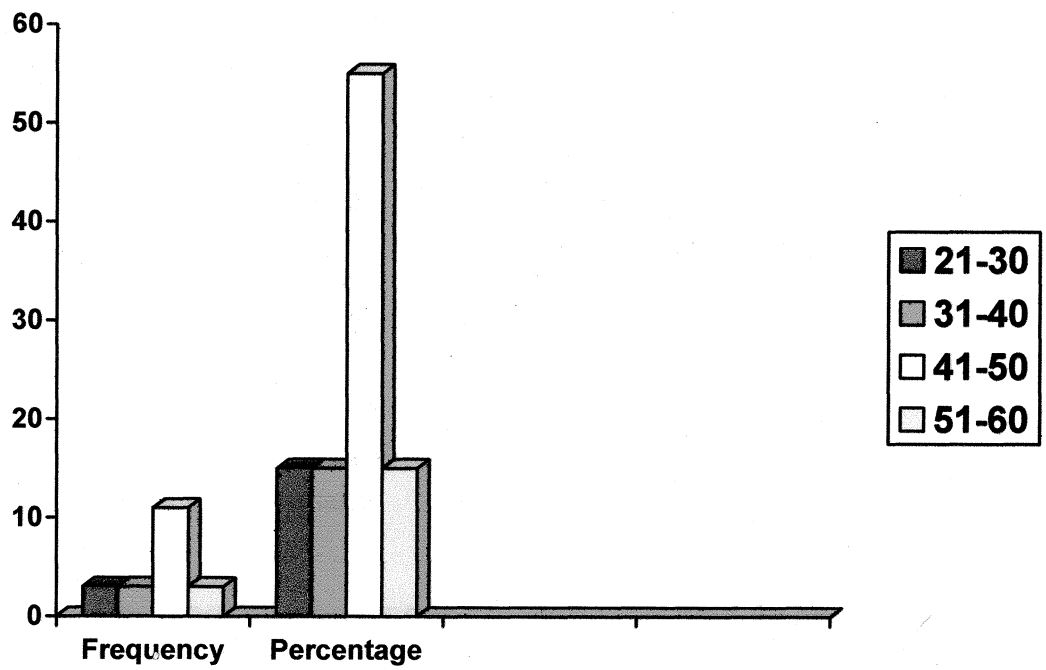

Fig. 4.2 Bar diagram showing the distribution sample according to age.

The mean age of the sample ranged from 22-52 with a mean of 52.75 (9.13) and mode 50.

DISTRIBUTION SAMPLE ACCORDING TO EMPLOYMENT STATUS.

Table 4.3

Employment Status	Frequency	Percentage
Employed	4	20
Unemployed	16	80
Total	**20**	**100**

The data given in Table 4.3 shows 80 % of the caregivers are unemployed.

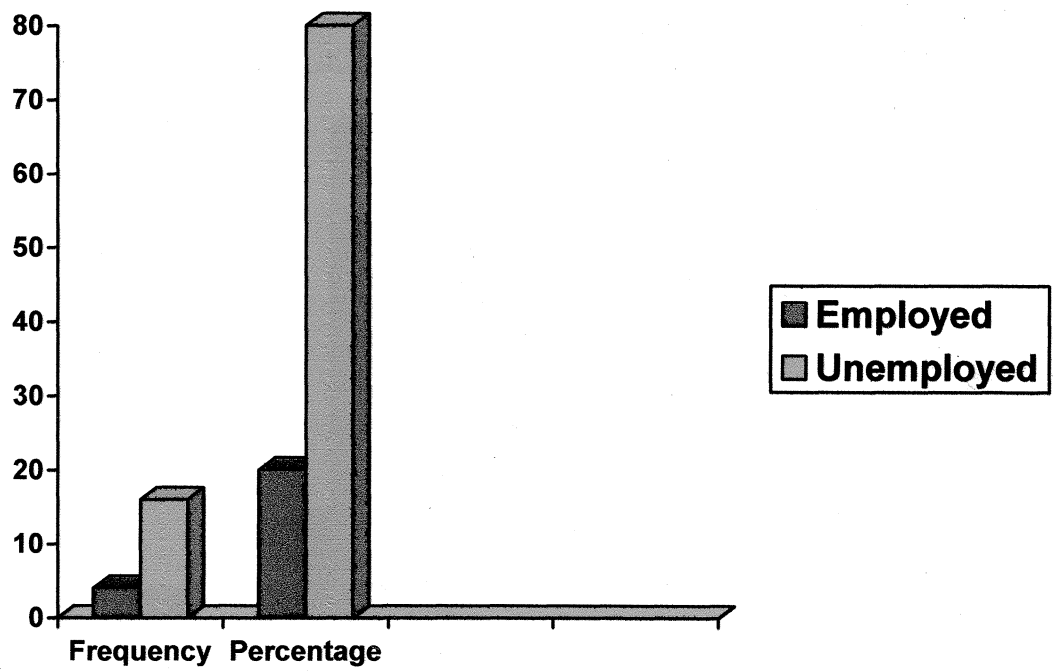

Fig. 4.3 Bar diagram showing the distribution sample according to the employment status.

4.4 MEAN STANDARD DEVIATION AND p. VALUE OF KNOWLEDGE ASSESSMENT SCORE

Table 4.4

Score	Frequency	Percentage
2-4	4	20
5-7	12	60
8-10	2	10
11	2	10

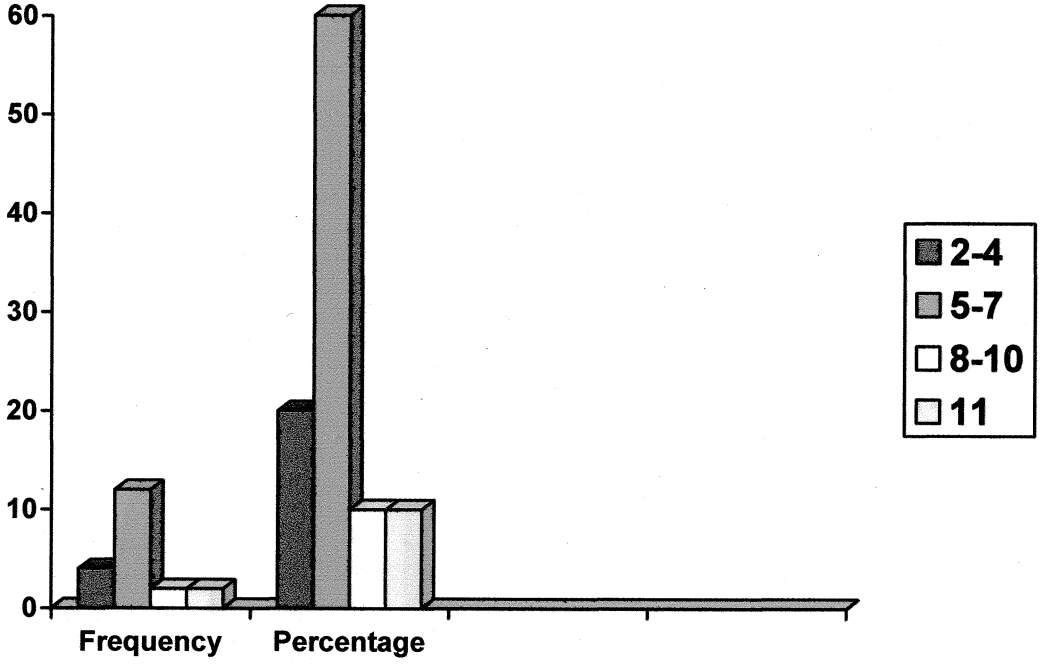

Fig. 4.4 Bar diagram showing the distribution of score obtained in knowledge assessment test.

Knowledge ranged to 22-11 with a mean of 6.25 (S.D 2.4) with a median of 6 and mode 5. Maximum obtainable score was 14. Only 4 persons have score above 8.

4.3 The Mean, Standard Deviation and p.Value of functional assessments for according to Barthel Index.

Table 4.5

Barthel Score	Frequency	Percentage
25-50	7	35
55-75	10	50
>75	**3**	**15**

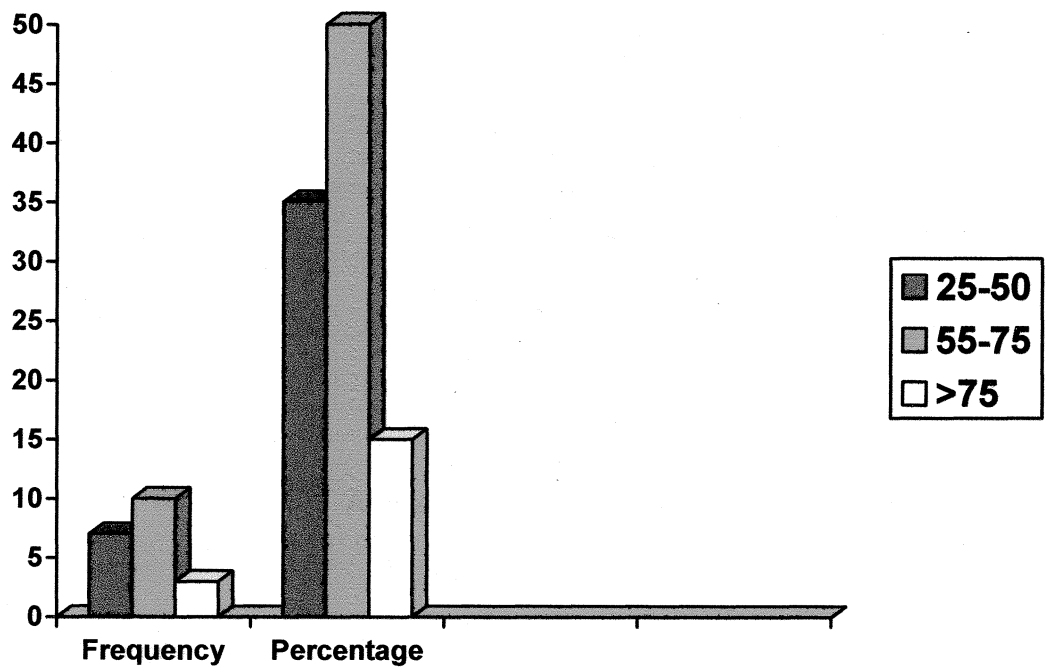

Fig. 4.5 Bar diagram showing the distribution of score obtained in functional assessment using Barthel Index.

Total Barthel Index score ranged from 25-90 with a mean of 56.25 (S.D 17.98) with a median of 25 and mode of 55.

4.4 Distribution of score according to activities obtained in Barthel Index

According to Feeding

Table 4.6

Score	Frequency	Percentage
0	1	5
5	12	35
10	7	60

According to Bathing

Table 4.7

Score	Frequency	Percentage
0	16	80
5	4	20

According to Grooming

Table 4.8

Score	Frequency	Percentage
0	16	80
5	4	20

According to Dressing

Table 4.9

Score	Frequency	Percentage
0	5	25
5	12	60
10	3	15

According to Bowel

Table 4.10

Score	Frequency	Percentage
0	5	25
5	6	30
10	13	65

According to Bladder

Table 4.11

Score	Frequency	Percentage
0	1	5
5	8	40
10	11	55

According to Toilet Use

Table 4.12

Score	Frequency	Percentage
0	4	20
5	11	55
10	5	25

According to Transfer

Table 4.13

Score	Frequency	Percentage
0	6	30
10	13	65
15	1	5

According to Mobility

Table 4.14

Score	Frequency	Percentage
5	2	10
10	17	85
15	1	5

According to climbing Stairs

Table 4.15

Score	Frequency	Percentage
0	4	20
5	16	80

SUMMARY

The chapter deals with analysis and interpretation of date collected from 20 caregivers. Descriptive statistics and inferential statistic were used for the date analysis. Bar Diagram were used to illustrate the findings of the study.

4.1 THE DISTRIBUTION OF SAMPLE ACCORDING TO DEMOGRAPHIC VARIABLES.

DISTRIBUTION OF SAMPLE ACCORDING TO SEX.

Table 4.1

Sex	Frequency	Percentage
Female	10	50
Male	10	50

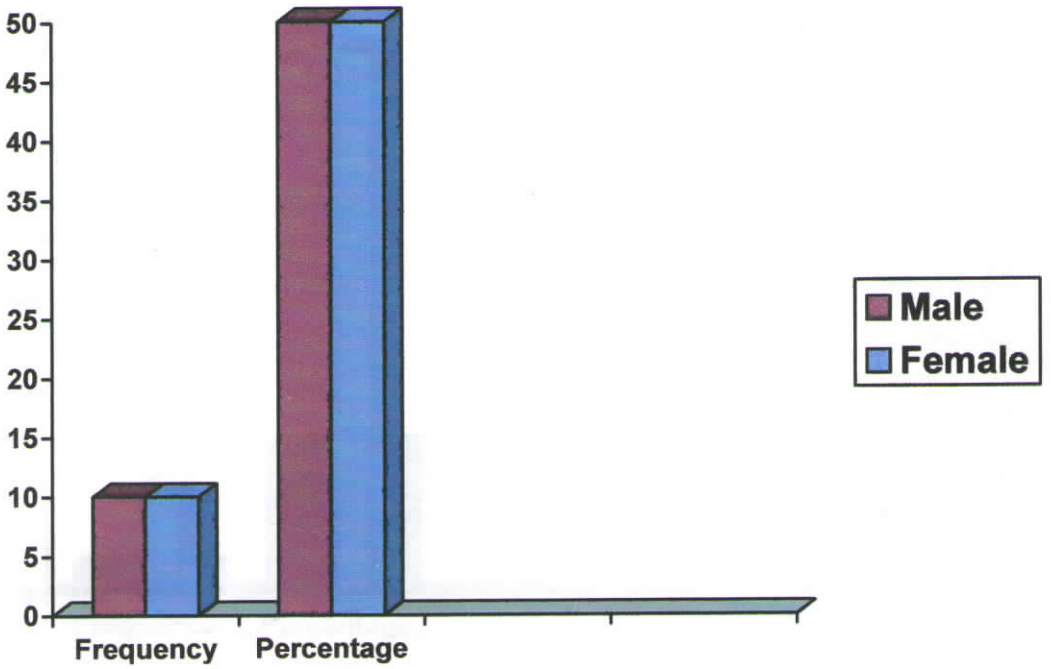

Fig. 4.1 Bar diagram showing distribution of sample according to sex

DISTRIBUTION SAMPLE ACCORDING TO AGE.

Table 4.2

Age Group	Frequency	Percentage
21-30	3	15
31-40	3	15
41-50	11	55
51-60	3	15
Total	**20**	**100**

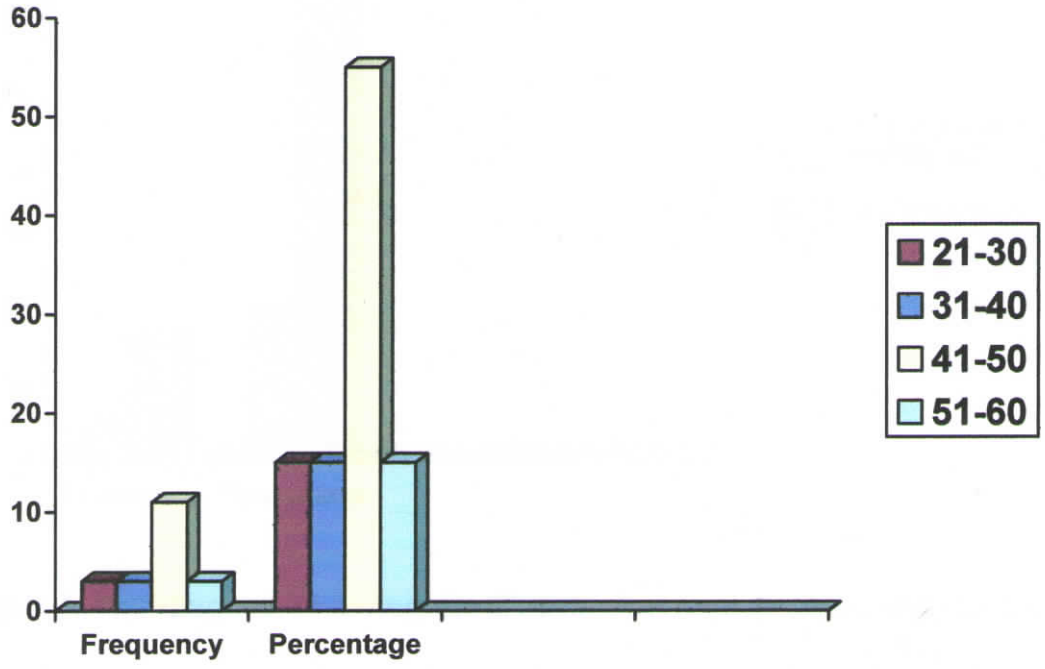

Fig. 4.2 Bar diagram showing the distribution sample according to age.

The mean age of the sample ranged from 22-52 with a mean of 52.75 (9.13) and mode 50.

DISTRIBUTION SAMPLE ACCORDING TO EMPLOYMENT STATUS.

Table 4.3

Employment Status	Frequency	Percentage
Employed	4	20
Unemployed	16	80
Total	**20**	**100**

The data given in Table 4.3 shows 80 % of the caregivers are unemployed.

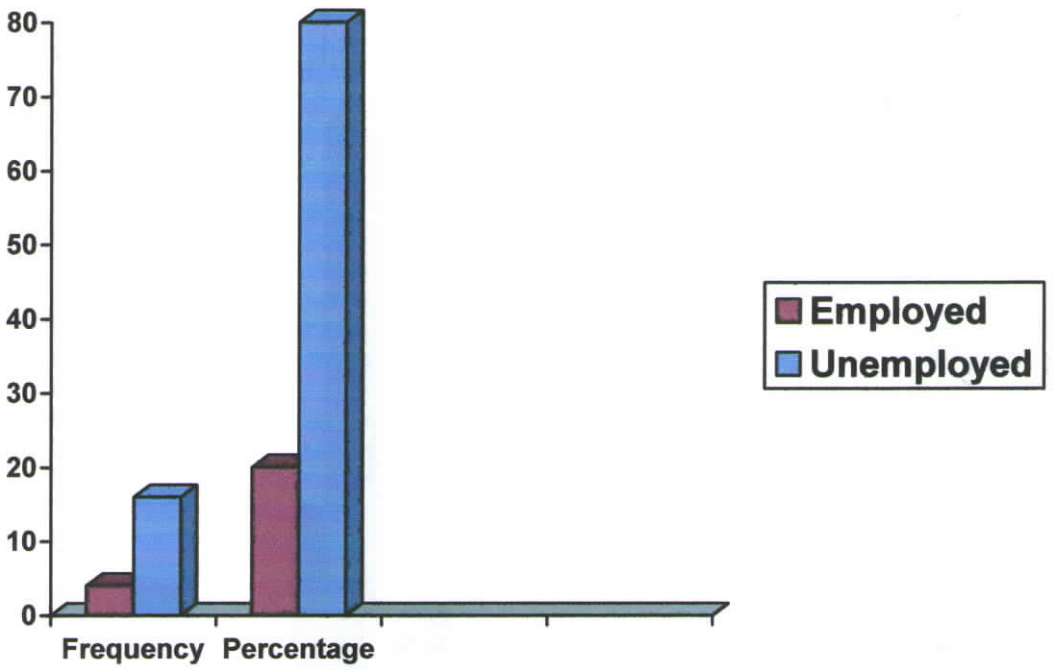

Fig. 4.3 Bar diagram showing the distribution sample according to the employment status.

4.4 MEAN STANDARD DEVIATION AND p. VALUE OF KNOWLEDGE ASSESSMENT SCORE

Table 4.4

Score	Frequency	Percentage
2-4	4	20
5-7	12	60
8-10	2	10
11	2	10

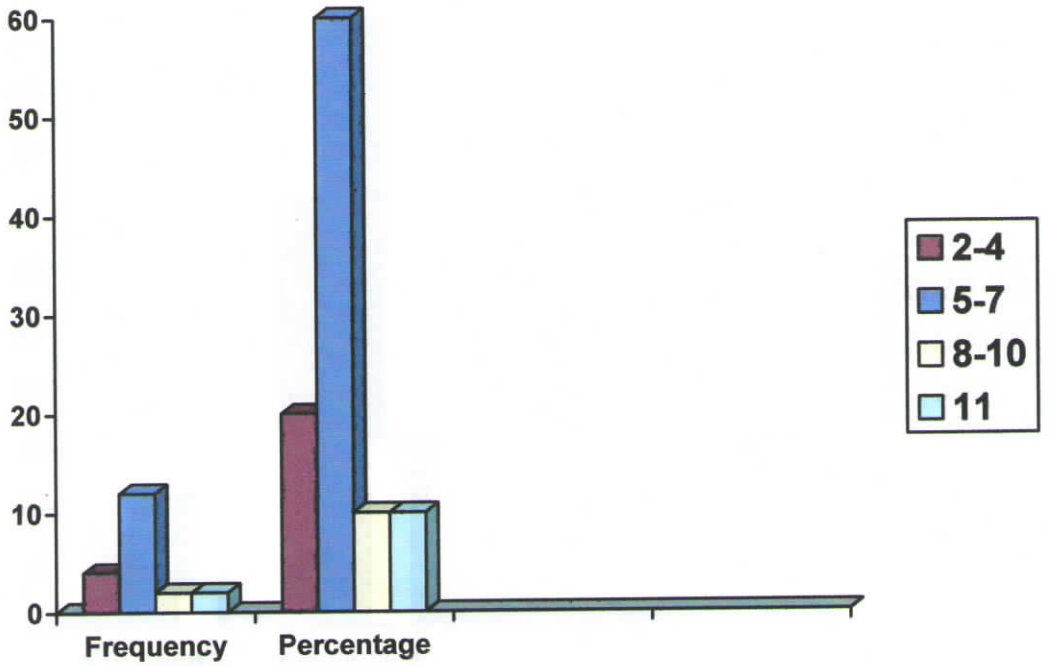

Fig. 4.4 Bar diagram showing the distribution of score obtained in knowledge assessment test.

Knowledge ranged to 22-11 with a mean of 6.25 (S.D 2.4) with a median of 6 and mode 5. Maximum obtainable score was 14. Only 4 persons have score above 8.

4.3 The Mean, Standard Deviation and p.Value of functional assessments for according to Barthel Index.

Table 4.5

Barthel Score	Frequency	Percentage
25-50	7	35
55-75	10	50
>75	**3**	**15**

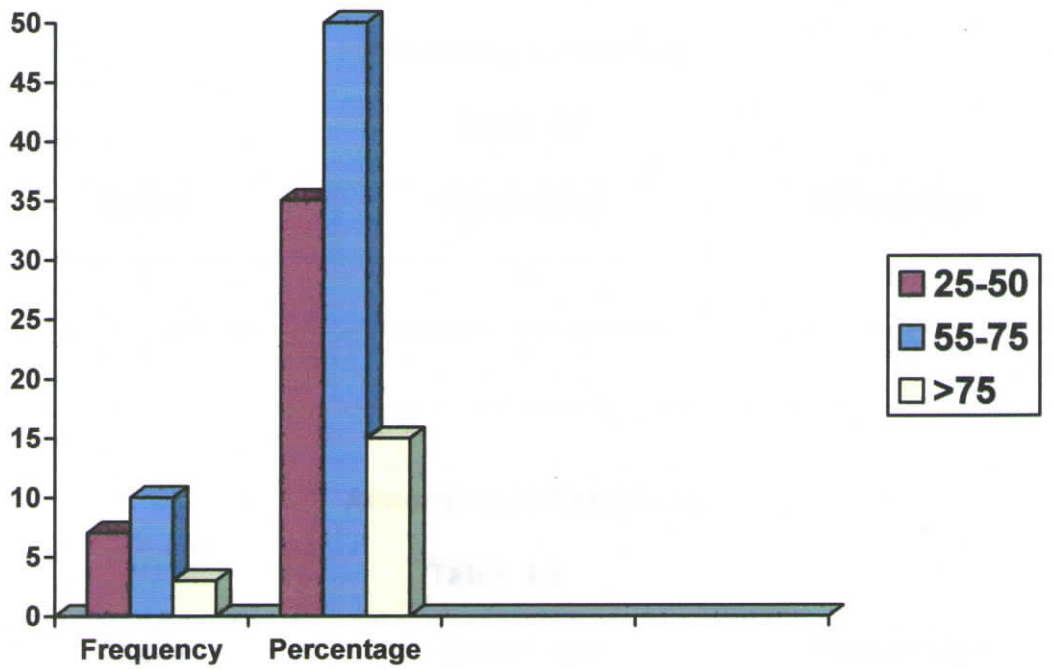

Fig. 4.5 Bar diagram showing the distribution of score obtained in functional assessment using Barthel Index.

Total Barthel Index score ranged from 25-90 with a mean of 56.25 (S.D 17.98) with a median of 25 and mode of 55.

CHAPTER - 5

SUMMARY, CONCLUTION, DISCUSSION, AND RECOMMENDATIONS

A brief account of the study is given in this chapter, which cover objectives, findings of the study and possible application of the result. Recommendations for future research and suggestions for improving the present study are also presented.

5.1 SUMMARY

This study was undertaken to assess the knowledge of caregivers of stroke patients about their caring role and to assess the functional abilities of these patients who visit the stroke clinic of SCTIMST.

A questionnaire was prepared by the investigator to assess the knowledge of caregivers and using the BETHEL INDEX does functional assessment of the patients. The study shows that the caregivers need more information about the caring of the patients based on their functional abilities.

The study was conducted in SCTIMST Trivandrum during the period of September, 2009- November 2009 with sample size of 20 caregivers.

5.2 THE MAJOR FINDINGS OF THE STUDY

The findings presented in this study indicate that improvements have been made with regard to general stroke care information, because there is no significant score in the knowledge assessment test.

5.3 LIMITATIONS

- Study was limited to SCT IMST Trivandrum.
- Study was conducted in a single group of community.
- Study was conducted only among patients who could read Malayalam.

5.4 DISCUSSION

Knowledge assessment of caregivers of stroke patients is vital because careers not only play an indispensable role in patient care and management, but their ability manage this role is also crucial to sustaining to health care system.

Family members have a greater responsibility for care of stroke patients because stroke may lead to serious disabilities to the patient. Depending on the severity of the stroke, these caregivers may assist survivors with variety of activities of daily living.

Evidence is emerging about the key role of family during recovery. A supportive family environment can improve the functional status of a stroke survivor and the psychosocial outcomes for the survivor

5.5 RECOMMENDATIONS

Recommendations for the future study includes examining a more ethnically and diverse group of caregivers to increase the generalizability of the findings. In addition, a comparison with other type of caregivers would provide information on whether these findings are unique to caregivers of stroke patients.

5.6 CONCLUSION

The results of the study highlight the importance of providing adequate information to caregivers of stroke patients depending upon the functional status of the patients as the caregivers are the core part of the health care system.

However once back in the community, careers feel abandoned and lack the skills necessary to fulfill their care-giving role.

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APPENDIX

A QUESTIONNAIRE TO ASSESS THE KNOWLEDGE OF CAREGIVERS OF STROKE PATIENTS ABOUT THEIR CARING ROLE

Name of the caregiver :

Age :

Sex :

Educational qualification :

Occupation :

Relationship with the patient :

Age of the patient :

Sex of the patient :

Diagnosis :

Encircle the best choice

1. When feeding a patient with hemiplegia put the feed in the

   a. Affected side of the mouth
   b. Unaffected side of the mouth
   c. Middle of the mouth
   d. Don't know

2. Swallowing reflex is tested by giving

   a. Milk
   b. Plantain
   c. Ice chips or fluids
   d. Don't know

3. Aspiration may lead to

   a. Fatigue
   b. Pneumonia
   c. Asthma
   d. Don't know

4. How often should you take care of the skin of the patient

   a. Once daily
   b. Twice daily
   c. Once in two days
   d. Don't know

5. When dressing the client always start putting the dress from the

   a. Affected side
   b. Unaffected side
   c. Both side simultaneously
   d. Don't know

6. To prevent constipation give

   a. Liquid feeds only
   b. Give high fibrous diet
   c. Give milk products
   d. Don't know

7. How should you prevent urinary tract infection in your client?

   a. Give more fluids
   b. Use diapers
   c. Catheterize the bladder
   d. Don't know

8. when helping a patient with moving difficulty always lift him from

   a. Affected side
   b. Unaffected side
   c. Both sides together
   d. Don't know

9. To prevent contractures do active and passive exercises

   a. Once daily
   b. Twice daily
   c. Thrice daily
   d. Don't know

10. To prevent pressure sores you should keep the client in

    a. Hard surface
    b. Cotton mattress
    c. Water or air mattress
    d. Don't know

11. How often should you change the position of your client if bed ridden?

    a. Two hours
    b. Four hours
    c. Six hours
    d. Don't know

12. To prevent aspiration of saliva and tongue fall you should keep the client in

    a. Supine position
    b. Prone position
    c. Side lying position
    d. Don't know

13. The eyes of the unconscious client is kept closed to prevent

    a. Dryness
    b. Tearing
    c. Vision
    d. Don't know

14. When approaching a client with diplopia always approach the patient from

    a. Affected side
    b. Unaffected side
    c. Front
    d. Don't know

15. Any other care which you provide?

Assess the functional abilities of your patient

Activity	Score
Feeding 0 = unable 5 = needs help cutting, spreading butter, etc., or requires modified diet 10 = independent	0 5 10
Bathing 0 = dependent 5 = independent (or in shower)	0 5
Grooming 0 = needs to help with personal care 5 = independent face/hair/teeth/shaving (implements provided)	0 5
Dressing 0 = dependent 5 = needs help but can do about half unaided 10 = independent (including buttons, zips, laces, etc.)	0 5 10
Bowels 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent	0 5 10
Bladder 0 = incontinent, or catheterized and unable to manage alone 5 = occasional accident 10 = continent	0 5 10
Toilet Use 0 = dependent 5 = needs some help, but can do something alone 10 = independent (on and off, dressing, wiping)	0 5 10
Transfers (bed to chair and back) 0 = unable, no sitting balance 5 = major help (one or two people, physical), can sit 10 = minor help (verbal or physical) 15 = independent	0 5 10 15
Mobility (on level surfaces) 0 = immobile or < 50 yards 5 = wheelchair independent, including corners, > 50 yards	0 5 10 15

10 = walks with help of one person (verbal or physical) > 50 yards 15 = independent (but may use any aid; for example, stick) > 50 yards	
Stairs 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent	0 5 10
TOTAL (0 - 100)	

പക്ഷാഘാത രോഗികളെ ശുശ്രൂഷിക്കുന്നതു സംബന്ധിച്ച് അതിലേർപ്പെട്ടിരിക്കുന്നവരുടെ അറിവ് പരിശോധനയ്ക്കുള്ള ചോദ്യാവലി

ശുശ്രൂഷകന്റെ പേര് :

വയസ് :

സ്ത്രീ/പുരുഷൻ :

വിദ്യാഭ്യാസ യോഗ്യത :

ജോലി :

രോഗിയുമായുള്ള ബന്ധം :

രോഗിയുടെ വയസ് :

സ്ത്രീ/പുരുഷൻ (രോഗിയുടേത്) :

രോഗ നിർണ്ണയം :

ഏറ്റവും ശരിയെന്നു കാണുന്നതിനെ അടയാളപ്പെടുത്തുക

1. ഹെമിപ്ളീജിയ രോഗിക്ക് ആഹാരം നൽകുമ്പോൾ അത്

   (1) വായയിലെ രോഗബാധിത വശം വഴി
   (2) രോഗബാധിതമല്ലാത്ത വശം വഴി
   (3) വായുടെ മധ്യഭാഗം വഴി
   (4) അറിയില്ല

2. ഭക്ഷണം ഇറക്കാനുള്ള കഴിവ് പരിശോധിക്കാൻ കൊടുക്കേണ്ടത്.

   (1) പാൽ
   (2)വാഴപ്പഴം
   (3) ഐസ് കഷണങ്ങൾ/വെള്ളം
   (4) അറിയില്ല

3. ശ്വാസകോശത്തിൽ ആഹാരം കുടുങ്ങുന്നത് താഴെ പറയുന്നതിലേക്ക് നയിക്കും

(1) വേദന
(2) ന്യൂമോണിയ
(3) ആസ്തമ
(4) അറിയില്ല

4. രോഗിയുടെ ചർമം എത്ര തവണയാണ് വ്യത്തിയാക്കേണ്ടത്.

(1) ദിവസം ഒരു തവണ
(2) ദിവസം 2 നേരം
(3) രണ്ടു ഭാഗത്തു നിന്നും ഒരേ സമയം
(4) അറിയില്ല

(5) രോഗിയെ വസ്ത്രം ധരിപ്പിക്കുമ്പോൾ അത്

(1) രോഗ ബാധിതവശം വഴി
(2) രോഗം ബാധിക്കാത്തവശം വഴി
(3) രണ്ടു ഭാഗത്തു നിന്നും ഒരേ സമയം
(4) അറിയില്ല

(6) മലബന്ധം ഒഴിവാക്കാൻ

(1) ദ്രവാഹാരം നൽകുക
(2) ആഹാരക്രമത്തിൽ നാരുകളടങ്ങിയ ഭക്ഷണം കൂടുതലായി ഉൾപ്പെടുത്തുക
(3) പാൽ ഉപയോഗിച്ചുണ്ടാക്കിയ ഭക്ഷണം നൽകുക
(4) അറിയില്ല

(7) രോഗിയുടെ മൂത്രനാളിയിൽ അണുബാധ ഉണ്ടാകാതിരിക്കാൻ

(1) ദ്രവഹാരം കൂടുതൽ നൽകുക
(2) ഡയപ്പർ ഉപയോഗിക്കുക
(3) കത്തീറ്റർ ഇടുക
(4) അറിയില്ല

(8) അനങ്ങാൻ പ്രയാസമുള്ള രോഗിയെ ഏത് ഭാഗത്തുനിന്നാണ് എപ്പോഴും ഉയർത്തേണ്ടത്.

(1) രോഗബാധിത ഭാഗത്തു നിന്ന്

(2) രോഗം ബാധിക്കാത്തവശത്തുനിന്ന്

(3) ഇരുവശത്തു നിന്ന്

(4) അറിയില്ല

(9) വ്യായാമ മുറകൾ ചെയ്യേണ്ടത്

(1) ദിവസം ഒരു നേരം

(2) ദിവസം രണ്ടു നേരം

(3) ദിവസം മൂന്ന് നേരം

(4) അറിയില്ല

(10) വ്രണങ്ങൾ ഉണ്ടാകാതിരിക്കാൻ രോഗിയെ

(1) മാർദവമില്ലാത്ത പ്രതലത്തിൽ കിടത്തണം

(2) പഞ്ഞികൊണ്ടുള്ള മെത്തതിൽ

(3) ജലമോ വായുവോ നിറച്ച ബെഡിൽ

(4) അറിയില്ല

(11) ശയ്യാവലംബിയായ രോഗിയാണെങ്കിൽ എപ്പോഴെല്ലാം രോഗിയെ മാറ്റിക്കിടത്തണം

(1) രണ്ടു മണിക്കൂറിലൊരിക്കൽ

(2) നാലുമണിക്കൂർ

(3) ആറുമണിക്കൂർ

(4) അറിയില്ല

(12) ഉമിനീരൊഴുക്കും നാക്കുതാഴ്ചയും ബാധിച്ച രോഗിയെ

(1) മലർത്തികിടത്തുക

(2) കമഴ്ത്തികിടത്തുക

(3) വശം ചരിച്ചു കിടത്തുക

(4) അറിയില്ല

(13) അബോധാവസ്ഥയിലുള്ള രോഗിയുടെ കണ്ണുകൾ അടച്ചുവയ്ക്കുന്നത്

(1) ഉണക്കുതടയാൻ

(2) കണ്ണിൽ നനവുണ്ടായിരിക്കാൻ

(3) കാഴ്ചയ്ക്ക്

(4) അറിയില്ല

(14) ഒരു വസ്തുവിനെ രണ്ടായി കാണുന്ന തരത്തിൽ രോഗം ബാധിച്ച ആളെ സമീപിക്കേണ്ടത്.

(1) രോഗബാധ വന്ന വശത്തുകൂടെ

(2) രോഗം ബാധിക്കാത്ത വശത്തുകൂടെ

(3) മുൻവശത്തുകൂടെ

(4) അറിയില്ല

(15) നിങ്ങൾ നൽകുന്ന മറ്റേതെങ്കിലും ശുശ്രൂഷ

നിങ്ങളുടെ രോഗിയുടെ ശാരീരികക്ഷമത തിട്ടപ്പെടുത്താമോ

ആഹാരം കഴിക്കാൻ 0= കഴിയില്ല 5= പരസഹായം ആവശ്യമാണ്. സ്വയം ആഹാരം എടുക്കാൻ കഴിയുന്നില്ല 10= പ്രത്യേക ഭക്ഷണ രീതി വേണ്ടി വരുന്നു	0 5 10
കുളിക്കാൻ 0= പരസഹായം 5= സ്വയം കുളിക്കാനാകും	0 5
തല ചീകൽ, ഷേവിംങ്, പല്ലുതേയ്ക്കൽ തുടങ്ങിയവ ചെയ്യാൻ 0= സഹായം ആവശ്യമാണ് 5= സ്വന്തമായി ചെയ്യാനാകും	0 5
വസ്ത്രധാരണത്തിന് 0= പരസഹായം 5= സഹായം വേണം, അതുകൂടാതെ പകുതിയോളം ചെയ്യാൻ കഴിയും 10= ബട്ടൻസ്, സിബ് എന്നിവ ഇടാനും ബുട്ട്ലേസ് കെട്ടാനും ഉൾപ്പെടെ സ്വന്തമായി ചെയ്യാനാകും	0 5 10
മലശോധന 0= എനിമ വേണ്ടിവരുന്നു 5= ചിലപ്പോൾ അസ്വാഭികമായി 10= സാധാരണ നിലയിൽ	0 5 10
മൂത്രശോധന 0= അസ്വഭാവികം, കത്തീറ്റർ വേണ്ടി വരുന്നു. സ്വയം നിയന്ത്രിക്കാനാകുന്നില്ല 5= കൂടെകൂടെ അസ്വാഭാവികം 10= സാധാരണ നിലയിൽ	0 5 10
ടോയിലറ്റ് ഉപയോഗിക്കുന്നതിന് 0= പരാശ്രയം 5= സഹായം വേണം, കുറെ സ്വന്തമായി ചെയ്യാനാകും 10= സാധാരണ നിലയിൽ	0 5 10
സ്ഥാന ചലനം 0= കഴിയില്ല, ഇരിക്കുവാനുള്ള ബാലൻസ് ഇല്ല	

5= ഒന്നു രണ്ടു പേരുടെ സഹായം ആവശ്യമാണ് 10= ചെറിയ സഹായം മതി 15= സ്വന്തമായി ചെയ്യാനാകും	0 5 10 15
നിരപ്പുള്ള നിലത്ത് നടക്കാൻ 0= നടക്കാനാകില്ല അല്ലെങ്കിൽ അൻപതടിയിൽ താഴെ 5= സ്വയം വീൽചെയർ ഉപയോഗിച്ച് സഞ്ചരിക്കാനാകും, അമ്പതടിയിൽ കൂടുതൽ 10= ഒരാളുടെ സഹായത്തോടെ നടക്കാനാകും, അൻപതടിയിൽ കൂടുതൽ 15= സ്വന്തമായി നടക്കാനാകും (ഊന്നുവടിയുടെ സഹായത്തോടെ) അമ്പതടിയിൽ കൂടുതൽ	0 5 10 15
കോണിപടികൾ കയറാൻ 0= കഴിയില്ല 5= സഹായം ആവശ്യമാണ് 10= സഹായം ആവശ്യമില്ല	0 5 10
ആകെ (0-100)	