

ORIGINAL ARTICLE

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# PERCEPTION OF FAMILY AS CAREGIVER ABOUT THE IMPLEMENTATION OF ORAL CARE IN CARING FOR STROKE PATIENTS IN MEDAN CITY: A PRELIMINARY ACTION RESEARCH

Bitcar, Setiawan, Cholina Trisa Siregar, Dudut Tanjung, Ikhsanuddin Ahmad Harahap

1 Master student of Faculty of Nursing, Universitas Sumatera Utara, Indonesia

2,3,4 Faculty of Nursing, Universitas Sumatera Utara, Indonesia

\* correspondence: [bbitcar@yahoo.com](mailto:bbitcar@yahoo.com)

## Abstract:

Stroke sufferers continue to increase every year and become polemic in various countries. Stroke is the second most common cause of death after heart disease. Stroke sufferers disrupt physical mobility, so they need help to carry out daily activities, one of which is the implementation of oral care, which is still minimal. The study aimed to describe the perception of family caregivers in implementing oral care among stroke patients in Medan city areas. A qualitative with phenomenology approach was applied in this study. The study conducted in the Health Centre of Medan Deli, in April-August 2018. Twelve participants were recruited using purposive sampling. Data collection used focus group discussion (FGD). We analyzed the data by using the thematic analysis. The results of the study found that four themes, namely: 1) Caregiver knowledge in the implementation of oral care for stroke patients at home is not right, 2) The process of implementing oral care by caregiver for stroke patients at home is less optimal, 3) Family obstacles in carrying out oral care for stroke patients at home, 4) Expectations and suggestions in the implementation of oral care for stroke patients at home. Expected of research to developing or making a guide to the implementation of oral care as health education for families as caregivers in treating stroke patients at home, so that problems of oral care for stroke patients can be minimized.

**Keywords:** oral care, families caregivers, and stroke patients.

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## 1 INTRODUCTION

Stroke is a problem that continues to rise and is a challenge for modern medicine to date. Stroke and mortality rates are a global problem that continues to be observed (1). Stroke is a significant cause of death and disability for life for sufferers (2). Stein says that stroke is a problem for every country (3). According to Abubakar and Isezuo, stroke is the number three cause of death in the world and is the most frequent cause of disability or limited functional activity in adults (4).

Basic Health Research (2013) showed that the number of stroke sufferers in Indonesia continues to increase and increase every year. The number of stroke sufferers was 8.3 per 1,000 in 2007 and became 12.1 per 1,000 in 2013. The prevalence of stroke patients also continued to increase, along with age or aging. Furthermore, data on stroke patients in North Sumatra is high at 10.3 per mile (every 1000 people) (5).

Stroke patients have limited physical activity and need help to other people to achieve their needs. One of the needs often forgotten by caregivers in the treatment of stroke patients at home is oral hygiene or the implementation of oral care for stroke patients (4).

Stroke patients tend to experience disability or limited physical activity (6). Stein states that stroke sufferers cause number one adults to experience limited physical activity (3). Stroke sufferers tend to experience disabilities and limitations that interfere with the quality of life of patients and will depend on support or assistance to family members both emotionally and physically (7).

A study state that a family as a caregiver is a good source of support or motivation for individuals who suffer a stroke, the family is the first person to help patients during their illness (8). Another study said that unfulfilled needs for stroke patients, including eating, bathing, dressing, and in this case, the patient's oral care needs (1).

The phenomenon that occurs, in this case, is the lack of education, information, and implementation by the family regarding the fulfillment of oral care. If this continues to occur, the impact on stroke patients can vary, such as systemic disorders, nutritional problems, dental caries, periodontal problems, respiratory infections, and pneumonia (9).

Oral care is still minimal in systemic diseases, one of which is a stroke. So that it is needed and becomes an essential consideration of the implementation of oral care, for that, we need guidelines, training, and education in terms of oral care (9). A previous study mentioned that only 41.7% of positive caregivers provide oral care for stroke patients treated (10). Another study described the benefits of oral cleansing on improving mouth freshness so that food becomes more delicious, and nutrition for patients can be fulfilled (11).

The perception of oral care for families is an essential part because of the understanding in oral care, so that follow-up steps can be taken to improve it, with various experiences.

Besides the understanding of patients and their families in caring stroke patients, this study also discusses nurses' views in the care process. I

In addition, this study produced baseline data which is useful for the development of guidelines in the application of oral care and strategies that families need to do to support patients.

## **2. OBJECTIVE**

The study aimed to describe the perception of family caregivers in implementing oral care among stroke patients in Medan city areas.

## **3. METHOD**

This study uses qualitative methods with a phenomenological description. The study was conducted in Medan Deli Health Centre Work Area in April - August 2018. The study participants were 12 main participants, namely the family as a caregiver who

treated stroke patients. The participant was taken using purposive/predetermined criteria. Participants in this study were selected based on inclusion criteria. Where the leading participant must have direct experience in caring for stroke patients at home, stroke patients who have no complications in the mouth such as gingivitis, oral cancer, infectious diseases and others that hinder the implementation of oral care, patients who do not experience swallowing disorders, caregivers are communicative people and able to be invited to interview. Data collection was carried out by focus group discussion (FGD) content validity index (CVI) testing with values > 0.80. Data were analyzed using quantitative and qualitative, quantitatively to determine the distribution of participant characteristics. A qualitative was analyzed using a content analysis method.

#### 4. RESULT

The results of the research at the reconnaissance stage by conducting FGDs on participants

##### 4.1 Characteristics of the main participants or caregiver

**Table 1**

**Distribution of characteristics of the participants or caregiver (n = 12)**

Characteristics	f	%
Gender		
Man	1	8,3
Woman	11	91,4
Education		
Elementary school	2	16,7
Middle school	3	25,0
High school	7	58,3
Ethnics		
Bataknese	2	16,7
Minang	3	25,0
Javanese	7	58,3
Age		
<18 years	2	16,7
18-50 years	6	50,0
> 50 years	4	33,3
Religion		
Islam	11	91,4
Christian	1	8,3

The results showed that the majority of participants were female (91.4%), with the education background of high school (58.3%). Most participants were Javanese ethnic (58.3%), age was the most dominant is 18-50 years as many as six people (50%), and Islam is 11 people (91.4%).

## 4.2 Perception of Family as Caregiver about the Implementation of Oral Care in Caring for Stroke Patients in Medan City Areas

The results of the research on the reconnaissance stage found 4 themes, namely: 1) Knowledge of the caregiver in the implementation of oral care for stroke patients at home is not right, 2) The process of implementing oral care by caregiver for stroke patients at home is less optimal, 3) Family obstacles in carrying out oral care for stroke patients at home, 4) Hope and advice in the implementation of oral care for stroke patients at home. Some participant statements are as follows:

Theme 1: Caregiver knowledge in the implementation of oral care for stroke patients at home is not good.

*"If you are like that too, you don't want to be wrong, he is wrong. He doesn't want to budge, sometimes even talking about it is not clear ... It's sometimes me ... (see) ... if mom says this, why is that, no said ... later if he said he was smart-talking too, it would be like ... like he doesn't want a wrong" [Participant 11].*

*"Give me a meal, brush your teeth, whatever it helps. Bathe too. All, everything, assisted, we are patient, like that" [Participant 2].*

Theme 2: The process of implementing oral care by the caregiver for stroke patients at home is not optimal.

*"He can take his bathroom, so we ignore it, and we wait. He can still walk alone, just be carried, we prepare it, if we ask for drinking water it is provided, because the mouth is a bit lame, the first normal water, then the last mouth is using drinking water" [Participant 6].*

*"es, the bath time, brush the teeth to bring it to the bathroom, especially the wheelchair, it's already sitting in a wheelchair ... prepare the toothpaste, prepare the toothbrush in the bathroom, use ordinary water" [Participant 7].*

Theme 3: Family obstacles in carrying out oral care for stroke patients at home.

*"If I am personal, because all at homework, so sometimes we are tired and sometimes forget, sir, we know, we work shifts, going home from work sometimes we don't remember it, we are tired, the mind is saturated with work" [Participant 1].*

*"Personally, sir, because even though we sometimes forget to brush their teeth, they often forget to do it and do it when they remember, and you ask to brush your teeth" [Participant 2].*

Theme 4: Hope and advice on the implementation of oral care for stroke patients at home.

*"Maybe we can be given instructions like pictures, books, or anything that can make us not forget and always strike teeth properly" [Participant 11].*

*"Maybe there are clues that give us more motivation, sir, so that we will be easier to do it again and not forget, right" [Participant 1].*

## 5. DISCUSSION

The results showed that 41.7% of participants' knowledge was still bad about oral care and at the reconnaissance stage with data collection using FGD and analysis using content analysis found 4 themes, namely: 1) Knowledge of the caregiver in the implementation of oral care for stroke patients at home is not right, 2) The process of implementing oral care by caregiver for stroke patients at home is less optimal, 3) Family obstacles in carrying out oral care for stroke patients at home, 4) Expectations and suggestions in the implementation of oral care for stroke patients at home.

The results of this study indicate that families as caregivers need help in fulfilling the daily activities of stroke patients. The family needs a guide, as well as a guide that can guide the family as a caregiver in helping patient activities, in this case, the implementation of oral care.

Family as a caregiver is an essential partner in providing multiple health care services during the treatment of post-stroke patients. The previous study in Indonesia showed that stroke patients with limited functional need help and support from their partners for the daily needs of patients (12).

A previous study showed that families with a high burden of care increased psychological distress (13).

A study stated that family experience in providing care for patients with stroke was still not good (13). A stroke study still needs education, support, and information from the environment regarding traditional medical needs and require professional care to assist patients' needs (14).

Theory of informal caregiving, dynamics shows that families as caregivers have a role in caring for sick families by providing patient care in the form of commitment, management expectations, and role negotiation in a way that is connected between the past, present and future (15). It was consistent with the previous study showed that families as caregivers needed adequate information related to problems experienced by patients during taking care (16). Another study also mentioned that families, as the majority caregiver have fewer skills in treating stroke patients (17).

In addition, stroke patients still need helping other people to meet their basic needs (18). It was consistent with a previous study mentioned that families as caregivers in caring for patients need help and support in caring for patients, as well as in-depth family knowledge as caregivers in caring for patients (19).

Duthie, Roy, and Niven show that stroke is the third cause of limited barriers in New Zealand and this causes tension or limitations in providing family care, especially the treatment experience in the first six months after the stroke (20).

Stroke patients with various weaknesses need help with oral care. Oral care is a treatment given to clean teeth and mouth from food scraps and germs in the mouth (9).

This is in line with the research of Kuo et al. that one treatment that is still lacking for the family is oral care for patients, it shows that the oral care for family training program has an effect on improving behavior in the implementation of oral care for patients measured both in the first month and 2 next month. Kuo et al. state that 50% of stroke sufferers in doing ADL depend on others, and it is estimated that 25% of the

patients rely on the family to fulfill their basic needs, one of which is the implementation of oral care for patients (21).

Park and Choi showed in their study in Korea that the education of home nurses about oral care for families as caregivers was still minimal and oral care education was effective in improving caregiver knowledge and oral hygiene for patients who were being treated at home (22).

According to Chin et al. that oral care is very important for patients who experience limitations or weaknesses, patients with disabilities desperately need the help of others in terms of oral care so that the closest person or family is significant in helping and providing oral care services for these patients (23).

According to Stein and Henry that oral care is still minimal in systemic diseases, one of which is a stroke. So that it is needed and becomes an essential consideration of the implementation of oral care, for that, we need guidelines, training, and education in terms of oral care (24). Clayton states that oral care in stroke patients is critical because it can improve the quality of life of patients (25).

The data in this study were obtained by conducting a focus group discussion, where the data obtained was done by exploring the understanding or perception of participants on the implementation of oral care for stroke patients at home. The participant first made an approach to fostering trust in the participants, making it easier for researchers in the research process.

## **6. CONCLUSION**

In conclusion, the results of the study at the reconnaissance stage with data collection using FGD and analysis using content analysis found 4 themes, namely: 1) Knowledge of the caregiver in the implementation of oral care for stroke patients at home, 2) The process of implementing oral care by caregiver for stroke patients at home is less optimal, 3) Family obstacles in carrying out oral care for stroke patients at home, 4) Expectations and suggestions in the implementation of oral care for stroke patients at home.

Based on current results, we expected that further research for developing oral care guidance for implementing oral care.

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