The Development of an Islam-Based Caring Model for Muslim Family Caregivers of Patients with Peritoneal Dialysis in Southernmost Thailand

Sunisa Seephom

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in Nursing (International Program)

Prince of Songkla University

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Author	Miss Sunisa Seephom
Major Program	Nursing (International Program)

Major Advisor

……
(Assoc. Prof. Dr. Piyanuch Jittanoon)

Co-advisor

……
(Assoc. Prof. Dr. Karnsunaphat Balthip)

Examining Committee:

……Chairperson
(Assoc. Prof. Dr. Chiraporn Tachaudomdach)

……Committee
(Assoc. Prof. Dr. Piyanuch Jittanoon)

……Committee
(Assoc. Prof. Dr. Karnsunaphat Balthip)

……Committee
(Asst. Prof. Dr. Umaporn Boonyasopun)

……Committee
(Assoc. Prof. Dr. Kittikorn Nilmanat)

The Graduate School, Prince of Songkla University, has approved this thesis as partial fulfillment of the requirements for the Doctor of Philosophy Degree in Nursing (International Program).

……..
(Prof. Dr. Damrongsak Faroongsarng)
Dean of Graduate School

This is to certify that the work here submitted is the result of the candidate's own investigations. Due acknowledgement has been made of any assistance received.

……..Signature
(Assoc. Prof. Dr. Piyanuch Jittanoon)
Major Advisor

……...Signature
(Miss Sunisa Seephom)
Candidate

I hereby certify this work has not been accepted in substance for any degree, and is not being currently submitted in candidature for any degree.

…… Signature
(Miss Sunisa Seephom)
Candidate

ชื่อวิทยานิพนธ์ การพัฒนารูปแบบการดูแลโดยใช้แนวคิดศาสนาอิสลามเป็นฐานสำหรับผู้ดูแลมุสลิมของผู้ป่วยที่ได้รับการล้างไตทางช่องท้องในจังหวัดชายแดนภาคใต้ของประเทศไทย
ผู้เขียน นางสาวสุนิสา สีผม
สาขาวิชา การพยาบาล (หลักสูตรนานาชาติ)
ปีการศึกษา 2564

บทคัดย่อ

การวิจัยเชิงปฏิบัติการแบบเทคนิคเพื่อพัฒนารูปแบบการดูแลโดยใช้แนวคิดศาสนาอิสลามเป็นฐานสำหรับผู้ดูแลมุสลิมของผู้ป่วยที่ได้รับการล้างไตทางช่องท้อง โดยประยุกต์ใช้กระบวนการดูแล (5Rs) ตามหลักศาสนาอิสลามของบาโรเลียและคาร์มาเลียนี ซึ่งประกอบด้วย การตอบสนอง (response) การสะท้อนคิด(reflection) สัมพันธภาพ (relationship) ความเกี่ยวข้อง (relatedness) และการเป็นแบบอย่าง (role modeling) ร่วมกับแนวคิดความกตัญญูกตเวทีตามหลักศาสนาอิสลามของลาทีฟ ผู้ให้ข้อมูลหลักคือพยาบาลวิชาชีพมุสลิมที่ดูแลผู้ป่วยล้างไตทางช่องท้อง จำนวน 5 คน และผู้ดูแลมุสลิม จำนวน 13 คน และผู้ป่วยมุสลิมที่ล้างไตทางช่องท้อง จำนวน 10 คน เป็นผู้ให้ข้อมูลร่วม เก็บข้อมูลโดยการสัมภาษณ์เชิงลึก การสนทนากลุ่ม การสังเกต และการจดบันทึกภาคสนาม การวิเคราะห์ข้อมูลเชิงคุณภาพใช้วิธีวิเคราะห์เชิงเนื้อหาเริ่มต้นด้วยการให้รหัส จัดข้อมูลเป็นหมวดหมู่ย่อย หมวดหมู่ทั่วไป และหมวดหมู่หลัก ตามลำดับ

ผลการศึกษาครั้งนี้ พบว่ารูปแบบการดูแลโดยใช้แนวคิดศาสนาอิสลามเป็นฐานสำหรับผู้ดูแลมุสลิมของผู้ป่วยที่ได้รับการล้างไตทางช่องท้องเบื้องต้น ประกอบด้วย 3 องค์ประกอบหลัก คือ ปัจจัยนำเข้า กระบวนการดูแลแบบองค์รวมตามหลักศาสนาอิสลาม และผลลัพธ์ สำหรับองค์ประกอบที่ 1 ปัจจัยนำเข้า ประกอบด้วย พยาบาลวิชาชีพที่ดูแลผู้ป่วยล้างไตทางช่องท้อง ซึ่งต้องมีสมรรถนะที่จำเป็นในการดูแลผู้ดูแลมุสลิม คือ สมรรถนะเชิงวัฒนธรรม สมรรถนะการคิดอย่างมีวิจารณญาณ และสมรรถนะด้านการพยาบาลแบบองค์รวม และต้องมีความสามารถในการดำเนินกระบวนการกลุ่มเพื่อนช่วยเพื่อนและการใช้กระบวนการดูแลแบบองค์รวมตามหลักศาสนาอิสลามและผู้ดูแลมุสลิม สามารถแบ่งออกได้เป็น 2 กลุ่มตามระยะเวลาการทำหน้าที่เป็นผู้ดูแล ได้แก่ กลุ่มผู้ดูแลมุสลิมที่ทำหน้าที่เป็นผู้ดูแลน้อยกว่าหรือเท่ากับ 3 เดือน และกลุ่มผู้ดูแลมุสลิมที่ทำหน้าที่เป็นผู้ดูแลมากกว่า 3 เดือน องค์ประกอบที่ 2 กระบวนการดูแลแบบองค์รวมตามหลักศาสนาอิสลามพัฒนามาจากการประยุกต์ใช้กระบวนการดูแลและแนวคิดความกตัญญูกตเวทีตามหลักศาสนาอิสลามร่วมกับกระบวนการพยาบาล กลยุทธ์สำคัญที่ใช้ในการดูแลแบบองค์รวมตามหลักศาสนาอิสลามนี้

ได้แก่ ความร่วมมือระหว่างบุคลากรทีมสุขภาพ การประชุมระหว่างทีมที่ดูแลกับครอบครัว การจัดกลุ่มเพื่อนช่วยเพื่อน และการเยี่ยมบ้าน โดยประยุกต์ใช้หลักศาสนาอิสลามที่เกี่ยวข้องได้ เช่น หลักคำสอนและความเชื่อ และหลักการปฏิบัติทางศาสนา และองค์ประกอบที่ 2 ผลลัพธ์ของรูปแบบการดูแล ได้แก่ ภาระการดูแล และสมดุลชีวิตของผู้ดูแลมุสลิม

ผลการศึกษาแสดงให้เห็นว่ารูปแบบการดูแลโดยใช้แนวคิดศาสนาอิสลามเป็นฐานส่งผลให้เกิดการเปลี่ยนแปลงของพฤติกรรมการดูแลของพยาบาล ลดภาระการดูแลของผู้ดูแลด้านจิตใจและสังคม และเพิ่มสมดุลชีวิตสำหรับผู้ดูแลมุสลิมจากการมีความสามารถในการบริหารจัดการการดูแลและความพึงพอใจในการให้การดูแลที่เพิ่มขึ้น รูปแบบการดูแลโดยใช้แนวคิดศาสนาอิสลามเป็นฐานสำหรับผู้ดูแลมุสลิมของผู้ป่วยที่ได้รับการล้างไตทางช่องท้องเบื้องต้นนี้สามารถใช้เป็นรูปแบบการดูแลแบบองค์รวม และสามารถใช้เป็นความรู้พื้นฐานในการพัฒนาองค์ความรู้ทางการพยาบาลต่อไปในอนาคต พยาบาลทั้งมุสลิมและไม่ใช่มุสลิมสามารถใช้รูปแบบการดูแลโดยใช้แนวคิดศาสนาอิสลามเป็นฐานนี้เป็นแนวทางในการพัฒนาการปฏิบัติการพยาบาลได้ การนำรูปแบบการดูแลไปประยุกต์ใช้ในบริบทที่แตกต่างจากการศึกษาในครั้งนี้อาจจำเป็นต้องมีการปรับให้สอดคล้องกับบริบทจริงก่อนนำไปใช้

คำสำคัญ: รูปแบบการดูแลโดยใช้แนวคิดศาสนาอิสลามเป็นฐาน, ผู้ดูแลมุสลิม, การล้างไตทางช่องท้อง

Thesis Title The Development of an Islam-Based Caring Model for Muslim Family Caregivers of Patients with Peritoneal Dialysis in Southernmost Thailand

Author Miss Sunisa Seephom

Major Program Nursing (International Program)

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ABSTRACT

This technical action research (TAR) aimed to develop an Islam-based caring model for Muslim family caregivers of patients with peritoneal dialysis. The process of the 5Rs consisting of response, reflection, relationship, relatedness, and role modeling in Islamic caring theory, according to Barolia and Karmaliani, integrated with gratitude approach within an Islamic thought of Latheef were used to guide the model. Five Muslim peritoneal dialysis (PD) nurses were the key participants, as well as thirteen Muslim family caregivers, and ten Muslim patients with peritoneal dialysis who were recruited for the study as associate participants. Data were gathered using face to face in-depth interviews, focus group discussion, observation, and field notes. Content analysis was used to analyse the data with initial codes grouped into sub-categories, generic categories, and main categories.

Results revealed that the initial Islam-based caring model was composed of three components: inputs, the holistic Islamic caring process, and outcomes. Two main inputs included those from PD nurses and Muslim family caregivers. The essential PD nurses' competencies in relation to caring for Muslim

family caregivers included cultural, holistic nursing, critical thinking competencies, ability regarding peer group support, and holistic Islamic caring process. Muslim family caregivers can be grouped based on the duration of caregiving including less than or equal to and more than three months, which cover slightly different caring activities. The holistic Islamic caring process consisted of the process of caring from an Islamic perspective (5Rs) and the gratitude approach integrated with the nursing process. The relevant strategies for providing a holistic Islamic caring process included health professional collaboration, family meetings, peer group support, and home visits. Two main Islamic perspectives in relation to caring for Muslim family caregivers were required such as the religious doctrines and beliefs, and religious practices. The outcomes of the model included caregiver burden and harmony in life of Muslim family caregivers. The findings revealed that the initial Islam-based caring model had a significant impact on the changes of nurse caring behavior and the reduction of caregiver burden in social and psychological aspects. Meanwhile, harmony in life was improved in terms of encouraging the Muslim family caregivers' ability to manage caregiving and pleasantness in caregiving.

The initial Islam-based caring model can be valued as a holistic caring model. Its benefit therefore can be seen as a basic knowledge that can be used further in developing the body of knowledge in nursing science and of the knowledge of PD nurses, both Muslim and non-Muslim, who can use the model as a guide for nursing care in their practice. The model's application in a different context may need to be modified before being implemented.

Key words: Islam-based caring model, Muslim family caregivers, Peritoneal dialysis

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Chapter 1

Introduction

Background and Significance of the Problem

A patient with kidney failure (CKD stage 5) is defined as the patient who has a level of glomerular filtration rate (GFR) of < 15 mL/min/1.73 m^2 or the occurrence of signs and symptoms of kidney failure necessitating the initiation of treatment by replacement therapy, respective of the level of GFR (National Kidney Foundation, 2002). Recently, the incidence of kidney failure has been increasing and has had a major impact on health care costs and health outcomes. Chronic kidney disease is the cause of deaths that was ranked 17^{th} in 2015 rising from 21^{st} in 2005 worldwide. Overall, the mortality rate of chronic kidney disease has increased by 31.7% within 10 years (Wang et al., 2016). Likewise, internationally the number of patients with kidney failure who received dialysis is projected to increase to 5.4 million by 2030 (Liyanage et al., 2015). In Thailand, the mortality rate of chronic kidney disease has been increasing in every part of country including the southern region. Overall, the mortality rate was 34.9 per 100,000 population in 2018 increasing from 33.9 in 2017. Focusing on the Southern Thailand, the mortality rate was 22.6 in 2018 increasing from 21.9 in 2017 (Bureau of Policy and Strategy, 2018). Likewise, the number of patients with kidney failure was 859,333 in 2020 increasing from 855,419 in 2019 (Ministry of Public Health, 2020). Moreover, it was estimated that the number of patients with kidney failure will also increase in developing countries

depending the rising population of elderly people (National Kidney Foundation, 2015).

Once chronic kidney disease progresses to an advanced stage or stage 5, renal replacement therapy (RRT) including hemodialysis (HD), peritoneal dialysis (PD), and kidney transplantation (Tx) must be considered. Although, generally kidney failure can be treated by these three modalities, PD is promoted as the first choice of therapy in several countries including Thailand because PD is more advantageous than HD in terms of survival outcomes (Foote et al., 2016; Yang et al., 2015), quality of life (Atapour, Nasr, Boroujeni, Taheri, & Dolatkhah, 2016; Rad, Mostafavi, Delavari, & Mostafavi, 2015; Wyld, Morton, Hayen, Howard, & Webster, 2012), and cost (Karopadi, Mason, Rettore, & Ronco, 2013). Therefore, PD is selected as the first choice of therapy in kidney failure patients due to being more cost effective than HD (Chang et al., 2016).

Peritoneal dialysis is a one type of treatment for people who have kidney failure, in which case their kidney functions are not working well resulting in wastes and extra fluid congesting the blood and making the people sick (National Kidney foundation, 2006). In October 2007, the Thai government decided to include RRT under the universal coverage health care scheme (UC) and the “PD first policy” has been established as a health benefit for patients under UC in 2008 (Sirivongs, 2015). Subsequently, the incidence of RRT has increased from 227.2 to 338.4 patients per million populations in 2018 and 2019 respectively. Likewise, the incidence of new patients receiving peritoneal dialysis (PD) increased from 2,069 in 2018 to 3,598 in 2020 (Chuasuwan & Lumpaopong, 2020). Beside this, many patients and their caregivers decide to select PD because of the convenience to perform PD at home

(Morton, Tong, Webster, Snelling, & Howard, 2011). Focusing on Southern Thailand, the prevalence of peritoneal dialysis has increased from 301.5 to 346.8 patients per million populations in 2014 and 2015 respectively (Chuasuwan & Lumpaopong, 2015) as well as the prevalence of peritoneal dialysis in Satun province increasing from 20 cases to 114 cases in 2013 and 2015 respectively (Chuasuwan & Lumpaopong, 2015).

Peritoneal dialysis is a home-based therapy; patients and their caregivers are required to perform dialysis-related tasks at home. After starting PD, the patients may face negative experiences in physiological health (Jacquet & Trinh, 2019), psychological and emotional health (Griva et al., 2014), and social changes in terms of limited travel and social contact, strict schedule, diet, and fluid intake, lack of activities, and being dependent on others (Jacquet & Trinh, 2019; Hoang, Green, & Bonner, 2018). In performing dialysis at home, the patients need necessary knowledge, skills training, and continuity of support from healthcare professionals. They also required holistic care delivery and person-centeredness to promote social and emotional wellbeing (Hughes et al., 2019; Petersson & Lennerling, 2017; Tong, Lesmana, Johnson, Wong, Campbell, & Craig, 2013).

In addition, support from family caregivers was reguired especially in patients who have barriers to self-care (Hurst & Figueiredo, 2015; Petersson & Lennerling, 2017; Varitsakul, 2012). Their support included: managing the medical equipment (Tong et al., 2013), providing assistance with getting appointments, emotional and social support, and assisting with domestic duties such as cooking, washing, and earning (Hughes et al., 2019). They perceived that support from family caregivers is crucial as it influences the success and ability to maintain them at home

on PD (Hurst & Figueiredo, 2015). Therefore, the caregivers are the key factor to the successful health management of patients receiving PD at home.

Family caregiver is defined as a relative or friend who provides unpaid assistance to a person with a chronic or disabling condition (Collins & Swartz, 2011). They play a key role in the successful health management of patients with PD, particularly those who lack the ability to self-care (Ng et al., 2020). Their important roles include providing caregiving with comfort and support regarding dialysis-related activities, diet management, symptoms relief, personal hygiene, teaching self-care, and transportation (Kang, Yu, Foo, Chan, & Griva, 2019; Tao et al., 2020). The evidences showed that health outcomes in patients with dialysis assisted by family caregivers were better than those who did not have family caregivers (Cicolini, Palma, Simonetta & Nicola, 2012; Xu, Zhuo, Yang & Dong, 2012). The evidences supported the importance and effectiveness of a caregiver's roles to improve positive outcomes in patients with PD.

In order to perform the caregiver's role, usually, the main caregivers' needs consist of four categories including information, skills training, social support, and financial support. Information needs include performing peritoneal dialysis, diet and fluid management, medication management, and complications prevention especially in the first few months after starting dialysis (Isenberg & Trisolini, 2008). Skills training focuses on the general aspects such as activities of daily living, and specific aspects such as technical health procedures (Sauvé, Vandyk, & Bourbonnais, 2016) expanding to resources and guidance (Pereira & Botelho, 2011). In regard to social support, caregivers focus on support from peers, family members including their care receiver, and health care providers (Hurst & Figueiredo, 2015; Silva,

Teixeira, Teixeira, & Freitas, 2013) for accessing assistance in terms of information, skills training, and emotional support. Lastly, financial support is required for management and care for relatives either in short or long-term periods. For Thai caregivers, the types of support that caregivers need included giving information and mental support, sharing information and experiences, and assisting with financial issues (Limpanichkul, 2004). Apart from information needs, social and emotional support have been identified as the primary needs. Family caregivers expressed that support was a facilitator in performing their roles of caregiving (Sauvé et al., 2016). Consistent with the patients' perspectives, they expressed that family caregivers also needed support and additional assistance from health care providers especially from nurses and doctors who work at the PD unit because they live with multiple caring responsibilities and having health concerns while performing their duties as a caregiver (Hughes et al., 2019; Petersson & Lennerling, 2017).

Fulfilling the role of a family caregiver has an effect on the family caregiver's life. The caregiver may experience both psychological and physical burden, with previous studies showing that psychological burden represents more of a toll than physical burden. Most caregivers perceived that the continued use of home dialysis was a burden of care (Sauvé et al., 2016). Moreover, most caregivers reported that they were more involved in tasks related to providing comfort or coaching for the patient that constitute a burden (Griva et al., 2016). Hence, family caregivers are more likely to be at risk for reducing psychological health (Cantekin, Kavurmaci, & Tan, 2016) in term of depression, anxiety, worry, stress/tension (Avsar et al., 2015; Kang, Yu, Foo & Griva, 2015), resentment, guilt, loss (Tao et al., 2020), and loneliness (Hoang, Green, & Bonner, 2018).

Psychological burdens were influenced by various factors that can be categorized into patient-dependence factors such as changes in a patient's health (Jacquet & Trinh, 2019; Williams, 2015; Williams et al., 2016) and dependence of the patient (Kim, 2012), and caregiver-dependence factors such as lack of social support (Tao et al., 2020), lack of psychological support, low socioeconomic levels (Shah et al., 2017), duration of care in terms of both the period of being a caregiver and hours of care per day/week that positively correlated with caregiver burden (Shah et al., 2017; Williams, 2015; Zhang et al., 2016), especially for the sole caregivers who cannot share their roles with anybody else (Zhang et al., 2016). They perceived that caregiving is as never-ending burden (Oyegbile & Brysiewicz, 2017) particularly caregivers who provided prolonged caregiving may have raised levels of distress (Oshio, 2015). Likewise, a study conducted among Thai caregivers found that being a caregiver of a patient with CAPD for a long term (Limpanichkul, 2004), and the duration of care (Limpawattana et al., 2013; Netchang, 2012) were associated with an increased caregiver burden. It was suggested that once family caregivers are involved in the dialysis, the impacts and burden on those caregivers should undergo routine assessment (Hurst & Figueiredo, 2015).

Focusing on Southern Thailand, a large population is Muslim. Culturally, they live their lifetime by using the Islamic beliefs and practices based on the Qur'an, the Hadith, Sunnah, and Sunnah (Alsharif, Galt, & Kasha, 2011). Muslims are required to respect their elders and to take care of their parents. Caring for the parents was mentioned as the offspring's responsibility in Islam (Nashif, Hammad, Kane, & Al-Wattary, 2020). The importance of family is specified within the Islamic values and attitudes. Islamic belief in family and kinships are the keystone

of Muslim life. Caring for family members is a primary responsibility of both the individual and the community (Koenig & Shohaib, 2014). And every human is tasked with taking care of other humans (Sadat-Hoseini & Khosropanah, 2017). Relatives take care of the elderly, and regularly a member of the family will take care of the family's seniors and elderly parents as instructed by the Qur'an and the Prophet of Islam (Begum & Seppänen, 2017). As the study of Hemman and colleagues (2017) proposes, Muslim caregivers for patients with ESRD took care of their receivers by the feeling of repaying gratitude as instructed by the Qur'an and the Hadith. However, they can face negative feelings such as stress, anxiety, and becoming tired of cargiving caused by being engaged in long-term caregiver being (Hemman, Nilmanat, & Matchim, 2017).

Seen from an Islamic perspective, a human being consists of five dimensions including physical, ethical, ideological, spiritual, and intellectual dimensions (Barolia & Karmaliani, 2008). Health is achieved by achieving an equilibrium in the existential dimensions of being human (Alimohammadi & Taleghani, 2015). Once some dimensions are disturbed and the human faces obstacles to care for himself/herself, it can cause the person to suffer from health impairment. A nurse performing a helping role is viewed as a supporting person in all aspects (Sadat-Hoseini, Alhani, Khosro-panah, & Behjatpour, 2013). Consistent with the concept of caring in nursing from an Islamic perspective, its aim is to keep the balance in the five dimensions of being human through the processes of response, reflection, relationship, relatedness, and role modeling (5Rs), which empower the nurses in maintaining harmony among all the five human dimensions. If a nurse succeeds in

keeping harmony, caring behaviors and caring actions are perceived as the results (Barolia & Karmaliani, 2008).

Harmony is defined as peace, balance, and rhythm (Easley, 2007). It is defined as a part of attributes of holistic practice. The promotion of harmony in nursing interaction will result to benefits for family caregivers (Easley, 2007). For Muslims, harmony is the fundamental aspect (Wani, Abdullah, & Chang, 2015). The Islamic faith and its holistic direction focus on a way of life that promotes health and harmony of the mind, body and soul (Easley, 2007). That is, holistic caring from an Islamic perspective focuses not only on the physical aspects, but it is concerned with the interrelationship between the multiple dimensions of a human (Barolia & Karmaliani, 2008; Ismail, Hatthakit, & Chinawong, 2015; Taleghani et al., 2013), and is based on well-being improvement, healing (Ismail et al., 2015), and burden reduction (Suro & Weisman De Mamani, 2013).

Practically, the holistic care among Muslims is infrequently provided by nurses particularly in Muslim family caregivers. Focusing on Thai family caregivers, they experienced stress, anxiety, and becoming tired of caregiving (Hemman et al., 2017). The existing nursing care for family caregivers of patients with PD only focusing on information and/or skills training does not respond to all aspects of being human in Islam context. In spite of holistic nursing for caregivers of patient with CAPD recently is suggested to be a challenge role of PD nurse (Kaenkarn, 2015), there are insufficient of holistic caring models for Muslim caregivers. Nursing care in family caregivers of patients with PD still has a gap of service comparing with the present guideline.

Previously, the holistic care was provided through the Islam-based interventions or models in the participants both healthy persons such as student (Al-Seheel & Noor, 2016) and illness Muslims patients such as multiple sclerosis (Saeedi, Nasab, Zadeh, & Aliebrahimi, 2015), acute myocardial infarction (Mardiyono, 2012), schizophrenia (Jannah, Suttharangsee, & Nukeaw, 2016), addicts (Khaledian, Pishvaei, Baghteyfouni, & Smaeili, 2017), pregnant women who have high anxiety and depression (Aslami, Alipour, Najib, & Aghayosefi, 2017), and critically ill patients (Ismail, 2016). All of these interventions mainly focused on Muslim patients in specific area.

As of the moment, there is no specific evidence of an Islam-based holistic caring model conducted by or for the family caregivers. That is, previous interventions or models cannot be absolutely applied in Muslim family caregivers. There are also limitations of those interventions in terms of the feasibility of utilization. Some interventions mainly focus on Islamic teaching (Khaledian et al., 2017), non-Muslim nurses may encounter obstacles in providing their nursing practice. Therefore, a new caring model was developed in this study aimed to fulfill the limitations of previous interventions/models in terms of expanding it to be conducted in Muslim family caregiver, with simplicity and being applicable by non-Muslim PD nurses, showing feasibility in practice, and being consistent with the Islamic thought.

The concepts of caring and gratitude within Islamic perspectives were used to develop a new caring model. Also, in order to promote the PD nurses to provide more holistic care to Muslim family caregivers and overcome the barriers in providing holistic care, the Muslim PD nurses should participate in the process of an

Islam-based caring model modification. The technical action research approach was used characterized by promoting the involvement of all related person in relation to caring model implementation.

The researcher anticipates that the development of an Islam-based caring model proposed in this study using technical action research approach will help the PD nurses to achieve the caring model that fits with the setting context and culture. Consequently, the provision of holistic care of the PD nurses will be improved and eventually lead to reducing caregiver burden and enhancing harmony in life in Muslim family caregivers of patients with PD.

Objective of the Study

To develop an Islam-based caring model for Muslim family caregivers of patients with peritoneal dialysis.

Research Questions

1. What are the components of an Islam-based caring model for Muslim caregivers of patients with peritoneal dialysis?

2. How does an Islam-based caring model affect caregiver burden and harmony in life among Muslim family caregivers of patients with peritoneal dialysis?

Theoretical Framework

An Islam-based caring model is developed based on the concepts of caring in nursing from an Islamic perspective of Barolia and Karmaliani (2008) integrated with the concept of gratitude within an Islamic thought of Latheef (2013) and underpinned by a thorough literature review.

The concepts of caring in nursing from an Islamic perspective

The concepts of caring in nursing within Islamic perspective were carried out on the basis of existing theories of caring including Jean Watson's theory of human caring, which has widely been used to develop caring models. According to Watson's theory of human caring, a person is a combination of three parts consisting of body, mind, and spirituality correlated with each other (Madani, Cheraghi, Salsali, & Rashvand, 2018). Therefore, the aim of this theory is to assure a balance and harmony between health and illness experiences of a person (Watson, 2010).

Harmony is also embeded in Islam. Living in peace and harmony with each other is Allah's Will and His test (Wani et al., 2015). Achieving harmony and balance between all components of a person implies achieving well-being and health (Madani et al., 2018). Any human being is allowed to determine and find the meaning in one's own existence and experience. An imbalance or disharmony can be caused by a deficit of a human element due to needs not being met. Disharmony between person and world are determined as nursing problems (Sadat-Hoseini et al., 2013). Transpersonal caring through the processes of caring and healing and being in authentic relationships is emphasized with the aims of increasing harmony,

wholeness, and unity of being by releasing some of the disharmony (Watson, 2010), which is presented through a pleasant environment, feelings of satisfaction, and positive self-concepts (Easley, 2007). Harmony is also determined as a holistic concept feature of comprehensive nursing care (Madani et al., 2018).

The concepts of caring and harmony are also embedded in the theological framework of Islam. According to Barolia and Karmaliani (2008), caring is defined as a natural outcome of love that one has for humanity. Caring in Islam focuses not only on the physical aspect of a being human, but it is concerned with the interrelationship between the multiple dimensions of being human. Barolia and Karmaliani (2008) reported the five dimensions of being human consisting of the physical, ethical, ideological, spiritual, and intellectual dimensions, which constitute the core category in the theory of caring in nursing from an Islamic perspective. Each dimension is described as following.

1.1 Physical dimension

Physical care from an Islamic perspective consists of pain relieving—either physical or psychological (mental) pain—, piety or maintaining cleanliness in the physical sense and purity of mind, and prevention required for physical caring in Islamic context.

1.2 Ethical dimension

This focus of the Islamic ethics involves the decision-making process based on the principle of doing good to humanity. The ethical caring is about respecting the others' rights provided in Islam.

1.3 Ideological dimension

The ideological dimension frameworks are 1) the duties toward Allah, 2) the duties toward mankind, and 3) the duties toward self. Ideological caring is maintaining a balance in performing all duties.

1.4 Spiritual dimension

Spiritual dimensions were expressed as the concepts of inner satisfaction achieved from service, human bonding, compassion, empathy, and hope.

1.5 Intellectual dimension

Viewed from an Islamic perspective, Muslims believe that intellectual nurturing together with searching is taught through the verses in the Holy Qu'ran. Muslims search and use intellect at all levels of caring.

Islam emphasizes keeping a balance among the five dimensions of the human personality, which is based on the philosophy of Islam and the Holy Quran. Therefore, balancing the five dimensions of the human personality is central for providing nursing care resulting in harmony in life in an Islamic perspective. The nurses can promote the balancing of all five dimensions of being human by using the processes of response, reflection, relationship, relatedness, and role modeling, which is a circular process. This process is named the caring action in this theory.

Response

Response refers to the actions that the nurses engage in when responding to a unique human need to be accepted as a caring person and to be supported in caring (McCance, McKenna, & Boore, 1999). This means that caring is person-to-person recognition of intrinsic value and response to the value of him/her (Boykin & Schoenhofer, 1990).

Reflection

A combination of reflection and action is named as a caring praxis (Watson, 2010). Reflection in nursing is often used for the analysis of nursing practice in order to achieve an understanding of nurses' practices and the development of the critically thoughtful approaches for providing nursing care in complex situations (Pierson, 1998). The nurses use reflection as a tool in learning in each of their experiences, accessing often-overlooked issues, and then adapting their learning to the new situation (Edwards, 2017).

Relationship

Caring is as a phenomenon in an interpersonal relationship process (Blasdell, 2017). The intimate relationships are defined as an attribute of caring process featured as protective and trusting. It is the type of closeness leading to strong emotional feelings. The caring activities for promoting the intimate relationships involve active listening, sincerity, helping patients or relatives to make an appropriate decision, using respectful communication, paying more attention to other experiences, and assurance of the human presence (Azizi-Fini, Mousavi, Mazroui-Sabdani, & Adib-Hajbaghery 2012).

Relatedness

Relatedness in nursing refers to the interpersonal interaction between nurse and patient. The characteristics of relatedness include genuineness, acceptance, listening, presence, and empathy. In the process of a nurse-patient relatedness, the nurse must open herself to the emotional or physical pain of the patient. In a clinical setting, the relatedness is related to a patient's feeling that the nurse genuinely likes, respects, and values them. The nurses can support the relatedness in their practice by

allowing the patients to talk and nurses are actively listening, providing simply touch in recognition of the patients' presence, considering the patient's cultural preference related to health beliefs, food preferences or spiritual practices, and allowing the patients in planning care (Crary, 2016).

Role modeling

Role modeling influences learning environment and increasing the competence of persons (Badruddin, 2018). It can be used for learning particular skills and behaviors, representing the possible goals, and inspiring desirable goal (Morgenroth, Ryan, & Peters, 2015). The persons who are role models should recognize the state of interdependence, willingly entwining themselves with others, learning and sharing with others. In this process of interaction, both the person and the other may be changed in a positive way by the shared experience and the relationship. The outcome of sharing experiences is to allow the role model influencing the other person while also being changed by interactions with others. The role models value continuous learning from observing and learning from others. A positive role model can strengthen a positive effect on creating new behaviors for success in desired goals (Lee, Kwon, & Ahn, 2021).

Concepts of gratitude in caring from an Islamic thought.

Caring within Islamic thought is not only a task of nurses, but every human is tasked with taking care of other humans (Sadat-Hoseini & Khosropanah, 2017). Caring for family members is a primary responsibility of both the individual and the community (Koenig & Shohaib, 2014). Gratitude has been a fundamental focus of Islam in caring for family members or kinships in Islamic context. As in

Qur'an stated the word of God that "Show gratitude to me and to your parents: to Me is Goal" (Khalil, 2016).

The concept of gratitude within Islamic perspectives was described by Latheef (2013). He explained that gratitude is the fundamental aspects of Islam. Islam viewed the gratitude as a human virtue. It is categorized into two principles.

2.1 Gratitude to Allah

Gratitude to God is a central thought of Islam. Gratitude to Allah is the essence of faith and responsibility of each human. The individual who accepts the reality of Allah is a grateful person. The worship is a sign of thankfulness expressed by them. Gratitude is what the most merciful creator requires from human beings. The soul of Islam, all Muslims are taught to praise and be grateful to God. Praise and thanks to God is expressed through the word "Alhamdulillah".

2.2 Gratitude to human beings

Gratitude in Islamic thought does not only put much emphasis on gratitude towards God, but Islam also gives much focus on gratitude towards human beings. It is viewed as a virtue of a human. A Muslim can express his/her gratitude through the word "Jazakumullahu Khair" meaning that giving thanks to Allah and whoever does good at the same time. Expressed gratitude is as the key belief in performing caring for family members. Muslims are required to respect their elders and to take care of their aging parents. As stated in the words of the Qur'an: "Show gratitude to me and to your parents: to Me is the Goal" (Khalil, 2016).

In the Islamic perspective, Islam reinforces people to express gratitude or thanks giving. There are beliefs that gratitude is part of obedience, for blessings, from the mind, and for the purpose of creation. Showing gratitude is an integral part

of Muslim daily life. Praising five times through prayers constitutes a sign of showing gratitude to God in a day. Muslims believe that everything comes from blessings of Allah, therefore, Muslims are always thankful to Allah whether they face good or bad experiences. Muslims always show their grateful to God through worship and they believe that Allah will offer rewards to people who show gratitude to him (Latheef, 2013).

Methodological Framework

The methodological framework of this study is technical action research (TAR). It is based on the positivism paradigm which is guided by interest in improving control over outcomes (Jacobs, 2018). Positivism is addressed in technical action research because positivist research techniques such as quasi-experimental design may be used in action research. Meanwhile, action research including technical action is empirical, experimental, observational, and intervention (Petersen, Gencel, Asghari, Baca, & Betz, 2014). There is an assumption that behavior is objective and testable, and generalizable and predictable. Its goal is problem-solving through generalizations and empirical facts. Within positivism, epistemology is explained that knowledge consists of facts and is measured and quantifiable. Epistemology of technical action research is explained in the sense that knowledge is gained through a disinterested stance on the issue being investigated and generated through causal explanations and instrumentations. Ontology is also explained in the sense that reality is independent of social construction and is objectively given without the bias of the

researchers and their instruments. That is, its values are empirical testing of inductive and deductive hypotheses (Jacobs, 2018).

This study is claimed as a technical action research. The power of technical action research is the idea that often resides with the facilitator who controls power in the research (Eilks & Markic, 2011). Within TAR, truth is discovered by conducting the study designed by the researchers based on their knowledge related to interested phenomena. Knowledge and truth are gained from data which is experienced and verified between independent observers (Jacobs, 2018). The goal of TAR is to test a particular intervention based on a pre-specified theoretical framework. The nature of the collaboration between the researcher and other participants is technical and based on facilitation. Researcher neutrality is required (Jacobs, 2018). The researcher who is considered an expert and authority takes action in the identification of the problem and designing a specific intervention, and then the participants who involved in the investigation of the problem agree to facilitate the implementation of the intervention.

Technical action research is a research design which the participants depend on researcher as a facilitator while the participants are often co-opted. The main objective aims at effectiveness and efficiency in performance, changes in social practices (Gunbayi, 2020; Holloway, 2005). In order to achieve the outcomes of their practice, it may involve changing the way others are participated in the practice. Both participants and researchers together decide what is to be done, what is to be changed, and what is to be evaluated and observed. Technical action research presents a one-way relationship between the participant-researcher and the others who are involved in or are affected by the research (Holloway, 2005). This research is designed using

the action research process consisting of four aspects which are dynamic and link into a cycle, and then continues to move into a spiral of planning, action, observation, and reflection. The activities in each aspect are explained by Kemmis and McTaggart (1988) as following:

1. Planning

In the planning process, the process in TAR starts with acquiring access to the problem identified by the researcher. The researcher takes actions into practice by telling what to do based on feedback (Gunbayi, 2020). Participants have to collaborate in discussions—both theoretical and practical discourse—to build a key idea. Then, an intervention for improvement, a goal, and data collection methods must be agreed upon (Wieringa & Morali, 2012). Therefore, all participants have to analyze and demonstrate their understanding and involvement in action in the situation. The general plan must be flexible for adaptation to unexpected effects and unrecognized factors in the action phase.

2. Action

Action is a careful and thoughtful variation of practice. It is guided by planning. The implementation of the action plan in this phase will assume the nature of social and political endeavor towards improvement.

3. Observation

After the action process, the effects of the action need to be observed. Observation must be planned, flexible, and open to record the unexpected. It can encourage improvement of practice through better understanding and more critically informed strategies.

4. Reflection

Reflection is an evaluative process. The effects of intervention and the suggestions for continued proceeding are required through discussion among all participants. This process leads to the reconstruction of the meaning of the situation and will provide the revised plan.

In summary, the development of an Islam-based caring model in this study aims to maintain the balance of the five dimensions of being human through the process of 5Rs mentioned in the concepts of caring in nursing from an Islamic perspective as formulated by Barolia and Karmaliani (2008) and integrating the gratitude approach within an Islamic thought of Latheef (2013), while encompassing the technical action research approach of Kemmis and McTaggart (1988).

The process of 5Rs consisting of response, reflection, relationship, relatedness, and role modeling and showing gratitude through the process of praising and worship are the major concepts, which are used to guide the scope of the nursing activities in an Islam-based caring model aimed to encourage the balancing of the five dimensions of being human in Muslim family caregivers. Meanwhile, the action research approach is used as a method in the development of an Islam-based caring model. The steps of model's development follow the five steps of action research including reconnaissance, planning, action and observation, and reflection. The theoretical and methodological frameworks of the study are shown in Figure 1.1 and the details are described in chapter 3.

Definition of Terms

1. **The Islam-based caring model** is a newly developed caring model of holistic care for Muslim family caregivers of patients with PD. It is developed based on the concepts within Islamic perspectives including the concept of caring in nursing of Barolia and Karmaliani (2008) and gratitude of Latheef (2013) and underpinned by a thorough literature review. Action research described by Kemmis and McTaggart (1988) is used as a methodological framework. This model development is mainly designed by the researcher and is implemented by the PD nurses to Muslim family caregivers and their patients with PD.

2. **Nurse caring behavior** refers to the actions of Muslim PD nurses while providing Islamic-based caring model to Muslim family caregivers of patients with PD in practice. This caring behavior includes verbal and nonverbal actions. It was evaluated by qualitative data collection methods.

3. **Caregiver burden** refers to the perception of caregivers regarding their emotional and physical health, social life, and financial status as a result of caring for their relative (Zarit, Reever, & Bach-Peterson, 1980). It was evaluated by qualitative data collection methods.

4. **Harmony** is defined as peace, balance, and rhythm perceived by the family caregivers (Easley, 2007). The family caregivers are encouraged to express their perceptions regarding a global and overall assessment of whether their life involves balance, mindful non-judgmental acceptance, fitting in and being attuned with their life by using a qualitative data collection method.

Significance of the Study

1. The development of the caring model based on an Islamic thought through the use of a technical action research (TAR) approach in this study is as the initial holistic caring model for PD nurses in fulfilling the gap of present nursing care for Muslim family caregivers of patients with PD. The PD nurses can apply this holistic caring model, which is feasible and practical. Finally, they can apply this model into their work in order to improve quality of care in Muslim family caregivers.

2. The development of an Islam-based caring model encourages the PD nurses to be aware and sensitive to the cultural distinction of each Muslim family caregiver. The PD nurses can achieve and then provide the caring model that truly fits with Muslim culture. Consequently, Muslim family caregivers are engaged in delivering care holistically covering the meaning of being human within Islamic perspectives leading to caregiver burden reduction and harmony in life improvement.

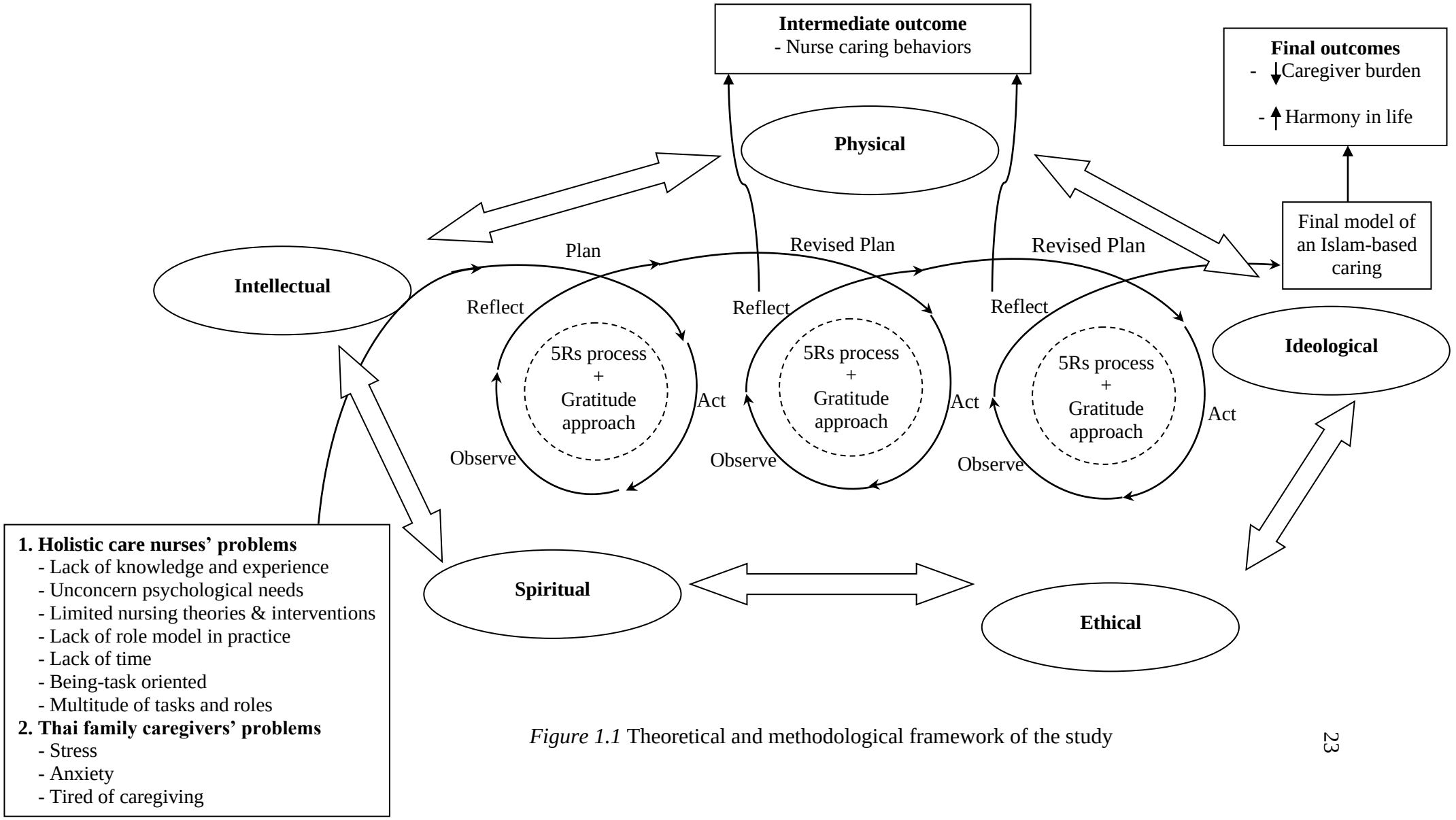

Figure 1.1 Theoretical and methodological framework of the study

Chapter 2

Literature Review

This study was designed to develop an Islam-based caring model for Muslim family caregivers of patients with peritoneal dialysis. The literature review was conducted in order to guide this study as follows:

1. Patients with peritoneal dialysis (PD)
    1.1 Situation of patients with peritoneal dialysis (PD)
    1.2 The impact of peritoneal dialysis
        1.2.1 The impact of peritoneal dialysis on the health care system
        1.2.2 The impact of peritoneal dialysis on family caregivers and their patients
    1.3 Caring for family caregivers of patients with peritoneal dialysis
2. Family caregivers of patients with peritoneal dialysis within an Islamic context.
    2.1 Family caregiver's role
    2.2 Family caregiver's needs
    2.3 Factors related to caregiver care
3. Concepts of caring
    3.1 Theory of caring in nursing
    3.2 Concepts of caring in nursing from an Islamic thought
    3.3 Concepts of gratitude in nursing from an Islamic thought
    3.4 Nursing process
    3.5 Evidences related to Islam-based caring programs/models
        3.5.1 Activities/strategies of Islam-based caring programs/models
        3.5.2 Duration of interventions and follow-up periods

1. Patients with Peritoneal Dialysis (PD)

1.1 Situation of patients with peritoneal dialysis (PD)

The incidence of patients with peritoneal dialysis has increased depending on the rising number of patients with kidney failure. In 2015, chronic kidney disease was ranked 17th of the causes of deaths rising from 21st in 2005 worldwide. In Thailand, the number of patients with kidney failure was 859,333 in 2020 increasing from 855,419 in 2019 (Ministry of Public Health, 2020). The mortality rate of chronic kidney disease also has been increasing. Overall, the mortality rate was 34.9 per 100,000 population in 2018 increasing from 33.9 in 2017. Focusing on Southern Thailand, the mortality rate was 22.6 in 2018 increasing from 21.9 in 2017 (Bureau of Policy and Strategy, 2018).

Likewise, internationally the number of patients with kidney failure receiving dialysis is projected to increase to 5.4 million by 2030 (Liyanage et al., 2015). Consistent with the number of patients with PD in Thailand, the incidence of new patients receiving peritoneal dialysis (PD) increased from 2,069 in 2018 to 3,598

in 2020 (Chuasuwan & Lumpaopong, 2020). Specifically in Southern Thailand, Muslims represent around 24.3% of the population, which is large in comparison with other regions in Thailand (National Statistical Office, 2016). The growth rate of PD was ranked 4th out of 7 regions in Thailand. The prevalence of peritoneal dialysis has increased from 301.5 to 346.8 patients per million populations in 2014 and 2015 respectively (Chuasuwan & Lumpaopong, 2015). Specifically, the prevalence of peritoneal dialysis in Satun province that is a province in the southern part of Thailand, the number of patients with PD has increased from 20 cases to 114 cases in 2013 and 2015 respectively (Chuasuwan & Lumpaopong, 2015).

When CKD progresses to kidney failure, renal replacement therapy (RRT) either by dialysis or transplantation will be required in order to extend life expectancy. Prior to the initiation of RRT, the patients should receive timely education about kidney failure and dialysis options including kidney transplantation, peritoneal dialysis, hemodialysis, and conservative treatment (KDIGO, 2013). The K/DIGO 2012 clinical practice guideline suggests that dialysis be initiated when one or more of the symptoms are present including symptoms or signs of kidney failure such as serotitis, acid-base or electrolyte imbalance, inability to control volume status or blood pressure, progressive deterioration in nutrition status, and cognitive impairment (KDIGO, 2013).

Normally, the treatments of kidney failure or ESRD are dialysis and kidney transplantation. Two different types of dialysis are peritoneal dialysis and hemodialysis. Peritoneal dialysis is a treatment for people who have kidney failure, in which their kidney functions are not working well resulting in wastes and extra fluid congesting in the blood and making the people sick (National Kidney Foundation,

2013). It works through the body's peritoneal membrane functioned as a natural filter. Naturally, the peritoneal membrane is semi-permeable allowing some substances to pass through. In the peritoneal dialysis process, dialysate or dialysis solution is filled into the peritoneal cavity that acts as a reservoir holding through the peritoneal catheter. Once the dialysate is inside the peritoneal cavity, the body's waste products pass from the bloodstream across the peritoneal membrane into dialysate. The duration of dialysate staying in the peritoneal cavity is set depending on the body size and amount of waste. It can last two hours or more. When a pre-set number of hours is completed, the used dialysis solution is drained and replaced with a fresh solution again (National Kidney foundation, 2013). Conversely, hemodialysis works through using a machine as a filter called a dialyzer or artificial kidney to clean the blood (National Kidney foundation, 2013).

At present, there is no consensus on the existing evidence of patient's quality of life. Many studies found that quality of life was similar between hemodialysis and peritoneal dialysis patients (Rad et al., 2015). Some studies found that quality of life in the PD patients was higher than for the HD patients (Atapour et al., 2016). However, PD treatment has been selected based on medical conditions, life style, and personal preference (Tamura, Tan, & O'Hare, 2012) decided by patients, families and caregivers, and multidisciplinary teams. Previous studies indicated that patients and family caregivers will mostly select the treatment that enhances survival that is convenient to be performed at home, and does not affect their daily life (Morton et al., 2011; Morton et al., 2012).

1.2 The impact of peritoneal dialysis

1.2.1 The impact of peritoneal dialysis on the health care system

As renal replacement therapy has been included in health benefits for patients under UC since 2008, peritoneal dialysis has been promoted as the first treatment option for ESRD, called the "PD-first policy" (Sirivongs, 2015). The demand for peritoneal dialysis has been rising. Mandatory strategies have been developed to increase PD utilization and to improve quality of PD care. In the early stage of the development process, the medical personnel and stakeholders involved in policy making were supported by organizing visits to Hong Kong to learn about the process and problems of PD first policy implementation. PD nurses were also given support to learn and update PD practice and patient care problem in Singapore. Later, a PD technology and training center was established for providing training for medical personnel including PD nurses, nephrologists, internists, and surgeons. PD problem solving meetings have been set up for discussing patient problems, insufficient manpower, and psychological support. Since 2014, regional RRT technology and training centers have been developed to improve the quality of PD care in each region of Thailand. Their role are site visits, data collection and analysis, quality assessment, key performance index monitoring, and running training program for medical personnel (Sirivongs, 2015). Focusing on PD nurses, the shortage of skillful PD nurses is a serious concern. To remedy the situation, the nationwide PD nurse training course was established in 2007 with the collaboration of many organizations and institutes and with full financial support from the National Health Security Office (NHSO) (Thaiyuenwong et al., 2011). In 2015, more than 400 nurses attended the PD training courses (Sirivongs, 2015) and the number of peritoneal

dialysis centers was 224 covering seven regions of Thailand (Chuasuwan & Lumpaopong, 2015).

Moreover, the national CAPD guidelines were established for caring for CAPD patients and providing treatment of complications including malnutrition, peritonitis, and inadequate dialysis (Dhanakijcharoen, Sirivongs, Aruyapitipan, Chuengsaman, & Lumpaopong, 2011). After establishment of the PD first policy, relevant personnel have tried to study the impact of dialysis either in patients or their caregivers and explore strategies in order to improve quality of PD care in practice.

In summary, many of the previous studies supported PD as being more appropriate to the patients' and family caregivers' perspectives than HD in terms of survival outcomes, quality of life, and cost. Therefore, PD has been selected as the first choice of therapy in ESRD patients. As PD is a home-based therapy, the family caregivers or support persons are likely to play roles as the key factor to successfully manage the health in those who receive PD. There are many studies that have described an association between family caregivers and the improvement of health outcomes in the patients. The study showed an advantage of family-assisted patients in terms of decreasing the duration and the rate of peritonitis. However, once the family caregivers get involved in performing a caregivers' role, they may face burdens in all aspects. The psychological burden is the most revealed burden compared with the two other burdens. Therefore, the nurse should not ignore those problems that are likely to occur in family caregivers.

1.2.2 The impact of peritoneal dialysis on family caregivers and their patients

When patients receive the peritoneal dialysis treatment, they may face negative experiences including in physiological health such as fatigue, bloating or pain, and interference with sleep (Jacquet & Trinh, 2019), as well as psychological and emotional health issues such as depression and anxiety (Griva et al., 2014), and social changes such as restricted and limitation life in terms of limited travel, strict schedule, diet, and fluid, limited income, high medical expenses, limited social contact, lack of activities, time consumed by the treatment, and being dependent on others (Jacquet & Trinh, 2019; Hoang, Green, & Bonner, 2018). A previous study reported that the psychosocial impact of dialysis on patients especially anxiety, depression, and stress constituted a risk factor for low physical and mental quality of life (García-Llana, Remor, Peso, & Selgas, 2014). This is consistent with a study of Griva and colleagues (2014); they reported that the patients with PD are at risk for emotional distress which leads to poor physical health.

Peritoneal dialysis affects both patients and family caregivers. A family caregiver is viewed as the key persons to successfully manage the patients' health. Many previous studies supported that health outcomes in patients with dialysis assisted by family caregivers were better than those who did not have family caregivers (Cicolini et al., 2012; Xu et al., 2012). The impact of dialysis caregiving on family caregiver has been explored. When family caregivers are involved in dialysis care, certainly, it impacts on their life. When they knew that they were to become a caregiver for a loved one, the caregivers expressed their experiences saying that they felt like they were losing the ability to have control over time because they spent more

time in caring for their recipients; they felt alone, and they perceived taking care of someone else's life as being the result of performing their new role of caregiver (Pereira & Botelho, 2011). Most caregivers perceived that patients' understanding and continued use of home dialysis were a burden of care (Sauvé et al., 2016). Beside dialysis-related activities, most caregivers reported that they were more involved in tasks of providing comfort or coaching the patient which become a burden (Griva et al., 2016). Caregivers reported multiple negative changes in their health related to the caregiving experiences related to their psychological and physical health.

Psychological problems

Caregivers are more at risk when it comes to experiencing a deterioration in their psychological health status as previous studies showed that the psychological aspect was the most affected dimension in caregivers (Cantekin et al., 2016). Burden regarding psychological health aspects such as the caregiver burden (Avsar et al., 2015; Bayoumi, 2014; Limpawattana et al., 2013; Mashayekhi, Pilevarzadeh, & Rafati, 2015) was defined as role strain and personal strain (Bayoumi, 2014), depression, anxiety, worry, stress/tension (Avsar et al., 2015; Kang et al., 2015), resentment, guilt, loss (Tao et al., 2020), loneliness (Hoang, Green, & Bonner, 2018), and burnout (Sinnakirouchenan & Holley, 2011). These burdens were found that it could be waned over time (Kang et al., 2019). Especially, during the first three months after being a caregiver, family caregivers experience greater levels of burden. It may be caused by lack of family support, or financial strain (Milbury, Badr, Fossella, Pisters, & Carmack, 2013). It also depends upon self-efficacy (Lee et al., 2018), patients' conditions (Manskow et al., 2015), and activity of daily living of the patients (Goto et al., 2019).

Specifically, in the case of Muslim caregivers, the study of Rabiei and colleagues (2015) reported that Muslim caregivers of patients undergoing dialysis faced negative feelings such as anxiety, worry, and uncertainty caused by caregiving. Similarly, the study of Pourghaznein and colleagues (2018) found that the caregivers of patients with HD perceived dialysis as prison for them and their loved ones. It made them face exhausting, emotional and psychological tension such as hopelessness, endless concerns, suffering and sorrow, and a sense of neglect. Consistent with Thai-Muslim caregivers, they experienced feelings of anxiety and stress resulting from being a caregiver of a patient with ESRD over a long period of time (Hemman et al., 2017).

Physical problems

The negative changes in physical health include health problems, little time for self-care (Alnazly & Samara, 2014), feeling tired, decreased exercise, energy, and the amount and quality of sleep, and increases in body weight (Avsar et al., 2013). They revealed that caregiving can result in negative physical health effects (Williams et al., 2016), especially during the first three months after being a caregiver (Milbury et al., 2013). This may be caused by the feelings of being unprepared and by physical disturbances (Stamataki, Elliss, Costello, Fielding, Burns, & Molassiotis, 2014).

Specifically, in the case of Muslim caregivers, they can face frustration (Rabiei, Eslami, Abedi, Masoudi, & Sharifirad, 2015) and fatigue as expressed by Thai Muslim family caregivers (Hemman et al., 2017). In summary, family caregivers experience not only psychological burden, but they also faced physical burden.

Social problems

Other burdens that were identified by family caregivers were social problems such as social isolation from family and friends (Alnazly & Samara, 2014; Pourghaznein, Heydari, & Manzari, 2018). They described that caregiving resulted in disconnection with others. They could not engage in social activities and social relationships (Oyegbile & Brysiewicz, 2017). These may increase the risk of social isolation (Sun et al., 2019).

Spiritual problems

When family caregivers experience burden, spiritual health is affected. The results from previous studies showed that the caregiver burden was negatively correlated with the domains of spirituality (Anum & Dasti, 2016; Chafjiri, Navabi, Shamsalinia, & Ghaffari, 2017). Even though the caregivers prefer the healthcare providers to address spiritual issues, spiritual support for caregivers is lacking in practice (Selman et al., 2018). In a Muslim context, the meaning of spirituality is defined as the relationship with Allah and trust in Allah. Praying, saying prayers, reciting the Holy Qu'ran are perceived as a spiritual practice. Muslims believe that these spiritual practices can help them to relieve and cope with their stress. Once caregivers get involved in the caregiving process, some caregivers stated that they spend less time to practice spiritual activities (Kiyancicek & Caydam, 2017).

These impacts are important. Caregiver burden had a negative effect on both the caregiver and the patient. This is especially true for the caregiver as the study supported that caregiver burden had a greater negative effect more than on the patient (Griva et al., 2016). In addition, the burdens of each aspect have an intercorrelation as a previous study showed that depression and anxiety are associated with role conflict,

poor caregiver health, and fear about the future outcomes of the patient (Williams et al., 2016). Likewise, the role of spirituality can influence the psychological health of caregivers (Anum & Dasti, 2016). In the long-term, many factors as outlined above finally influence caregivers' quality of life. The previous studies found that the experience of burden, caregiver workload, and stress had adverse effects on the quality of life in caregivers (Starks, 2016).

1.3 Caring for family caregivers of patients with peritoneal dialysis

Based on the impact of peritoneal dialysis on family caregivers as described above, there are holistic effects on family caregivers' life. The PD nurses have challenged roles in protecting and reducing caregiver burden. Identification and support of family caregivers should be assessed as soon as family caregivers are identified. Initial family caregiver assessment should be composed of an observation of the family caregiver's situation aimed to identify needs and resources. Reassessment is suggested to be considered whenever the health and functional status of family caregivers and their care recipients change triggered by the diagnosis of treatment (Swartz & Collins, 2019).

According to Watson's theory of human caring, family caregivers should be allowed to find the caring process meaningful, and encourage psychological well-being, and personal development. Its process can be started with the identification of caregivers' problems followed by making care plan and evaluating outcomes of these plans (Şentürk et al., 2017). Appropriate interventions and resources should be directly provided as support to family caregivers. Psychoeducation, skills training, and therapeutic counseling interventions are recommended to be provided to family caregivers because it shows success in

decreasing caregiver burden and improving caregiver quality of life (Swartz & Collins, 2019). Support, assistance, and training of the family caregivers should be provided by nurses in such a way that family caregivers can periodically reduce their difficulties of caregiving. According to Couto et al. (2018), nursing care for family caregivers based on their culture needs to be executed with awareness, respect, and valued by the nurses when providing nursing activities. Preservation or maintenance of cultural care is beneficial to maintain and strengthen positive feelings, experiences, adaptation, and self-esteem of family caregivers. Accommodation or negotiation and repatterning of cultural care methods need to be established. Nursing actions aimed to assist the family caregivers in the modification process of negative patterns should be sought.

Nurses' role in relation to caring for family caregivers includes advocacy, monitoring, and administrative duties. Information and education must be provided (Morrison & Korol, 2014). Skill training is also important. It affects a caregiver's confidence, mental health, and burden (Mollica, Litzelman, Rowland, & Kent, 2017). However, physical care is only one component of nurses' tasks. Psychological, social, and spiritual needs are also important dimensions of care, which are difficult to attend to (Morrison & Korol, 2014). Caregiver care requires a multidisciplinary approach. Therefore, the nurses sometimes need to take action as coordinator with multidisciplinary teams in order to manage the care needed for family caregivers (Grant & Ferrell, 2012).

2. Family Caregivers of Patients with Peritoneal Dialysis within an Islamic Context

2.1 Family caregiver's roles

A family caregiver is defined as a friend or relative who provides unpaid assistance to a person with a chronic or disabling condition (Collins & Swartz, 2011). Caregiving is defined as "the process of helping another person who is unable to do so for themselves in a holistic manner" (Hermanns & Mastel-Smith, 2012). Generally, the caregiver can be categorized into two main groups which are a primary caregiver (referring to a person who has the greatest responsibility for care), and secondary caregivers (referring to a person who provides a supportive role to the primary caregiver or care recipient with discontinuous activities) (Marino, Badana, & Haley, 2020). A family caregiver's activities cover the complexity and multitude of activities and tasks. It can be summarized as including activities of daily living and caregiving activities such as performing dialysis, personal hygiene, diet management, symptom management, comfort, teaching self-care, transportation (Kang et al., 2019), medical appointment arrangement, and organization of supplies (Hoang, Green, & Bonner, 2018).

Caregivers' roles can be described into five dimensions of caregiving activities such as appraising, advocating, juggling, routinizing, and coaching. Appraising was defined as monitoring and evaluating the patients' conditions and their response. Those caregivers were continually appraising and reappraising depending on the receivers' conditions and their situations. Advocating was defined as communicating in favor of or entreating on behalf of the loved one while in the

process of interaction with other related persons especially health care providers. Juggling was defined as maintaining more than one valued activity in movement or going forward at one time usually used in appraisal. Routinizing was defined as the establishment of a streamlined pathway of behavior that was changed over time and normally followed usual activities. The last dimension, coaching, was defined as activities assured to facilitate the patient to perform self-care (Hoang, Green, & Bonner, 2018).

Caregivers of patients with peritoneal dialysis are involved in the management of technical health procedures for their loved one. The initiation of being a caregiver includes the caregiver having to learn and appraise their life. McDonald and colleagues (2016) described the learning pathway of family caregivers to manage technical health procedures at home as consisting of three phases as follows.

First is an initial phase which is a concentrated duration of training. This phase aims to ensure a family caregiver's ability to perform the procedure by his/her self at home. Thus, the most concentrated teaching and training are provided by health professionals in order to ensure patient safety. Many aspects to teaching and learning to manage a technical health procedure include education regarding the larger health condition which necessitated the procedure, the practical techniques regarding the procedure, clinical reasoning and decision-making skills, recognizing and monitoring potential problems, managing and seeking resources for helping and supporting. In this phase some caregivers face negative emotional experiences such as feeling nervous and fearful.

In the second phase of novice carers, it begins when the caregivers are adequately competent to perform the technical health procedures at home.

Professional health care providers tend to disengage except for when caregivers request their assistance. Caregivers try to seek additional resources for learning such as the internet and other caregivers. In this phase most caregivers stick to the procedures that have been given by health professionals, then they began to apply individualized standard procedures. Sometimes they experience difficulties from unexpected situations. The caregiver proposed that they need professional support to help and advise them. Problem-solving and an adaptation process was involved in adapting to a life that led to new routines. They also face negative emotional experiences such as distress. They try to cope by using several strategies both positive and negative ways such as focusing on the benefit at the end, seeking other options, refusing to manage that procedure, and avoidance.

In the last phase, becoming and being an expert caregiver, the caregivers developed into experts who were highly competent to manage specific procedures. The time for development into this phase varied depending on the frequency of practice, the complexity of procedures, experience dealing with variations and problems, and individual factors. Therefore, the needs of caregivers likewise vary depending on several factors.

2.2 Family caregiver's needs

In order to perform the caregiver's role, caregivers' needs should be responded to. There are four categories of caregivers' needs mentioned in previous studies. Three categories of caregivers' needs were reported in the study of Silva and colleagues (2013) consisting of information and training, professional support, and legal and financial support as well as spiritual care needs (Kiyancicek & Caydam, 2017).

2.2.1 Information and training

Generally, caregivers require information regarding the clinical diagnosis and condition, progression of the disease covering signs and symptoms, prognosis, and management of abnormal behaviors, diet management, supporting resources and accessing ways as well as guidance for performing their tasks. Training was focused on the general aspects such as activities of daily living, and specific aspects such as technical health procedures. Some cases extend to information about the end of life.

In regard to specific caregivers of patients with peritoneal dialysis, the literature review found that the information needs will change over time. It can be separated into three phases depending on the three stages of dialysis care. First, the initial stage of dialysis care was referred to as the time of the initiation of diagnosis. Usually, most caregivers focus on the following two main issues, understanding the diagnosis and the necessity for the patient to be treated with dialysis and habituating themselves with dialysis by learning about the aspects of dialysis and the expected outcomes (Oyegbile & Brysiewicz, 2017). In the second phase, the stage during the first few months after beginning dialysis, caregivers' needs are changed to focus on the common role of family members. They began to establish standard procedures for their specific situation. They also sought the additional sources for learning such as internet for information and communication with peers. Professional healthcare support was required when unexpected situations occurred. In the third phase, they became an expert caregiver. The experience and confidence in their skills and judgment resulted in modification of techniques or procedures. They still had limitations in terms of skills and knowledge so that additional teaching from

professional healthcare was still needed (McDonald, McKinlay, Keeling, & Levack, 2016).

2.2.2 Professional support

Professional support was mentioned by most caregivers in several studies. The main reasons are to recruit efficient resources that can be available for accessing assistance. This category also covers emotional support due to caregivers possibly having difficulties for coping and managing their stress. Besides, these caregivers need professional support for helping in the identification of emotional problems as well as helping in building support groups, reframing their situations, and dealing with their family. They also expressed that they need social support for adjustment (Jiang et al., 2015). Specifically, caregivers of patient with peritoneal dialysis, in regard to social support, focus on support from peers, family members including their care receiver, and health care providers (Hurst & Figueiredo, 2015; Barutcu & Mert, 2016). Support was a facilitator for family caregivers to perform their roles (Sauvé et al., 2016). In addition, mental support and sharing information and experiences were addressed as the needs of Thai family caregivers (Limpanichkul, 2004).

Moreover, in order to achieve effective support from healthcare providers and/or others such as peers, family members, and care receivers, family caregivers emphasized that the need of effective communication is important in improving communication with other related persons especially the professional health care providers. They perceived that effective communication is as an instrument for better interaction particularly between the nurse and caregiver or the caregiver and care receiver.

2.2.3 Legal and financial support

Caregivers emphasized the needs of legal and financial support for assistance in the clarification of eligibility regulations as well as Thai family caregivers (Limpanichkul, 2004). It was also helpful for the management of their finances either in short or long-term planning.

2.2.4 Spiritual care

Spiritual care needs are often neglected by healthcare provider as perceived by caregivers, in spite of spirituality being deeply rooted in the caregivers' culture and religious values and that caregiving process can be reorganized from a negative experience into a positive experience regarding their role and situation (Akoob, 2013). The family caregivers may face the negative feelings such as anger and disbelief in earlier stage. When caregiving process is continued, the family caregivers will turn to spirituality and finally accept their situations (Pourghaznein et al., 2018).

Spiritual needs of Muslim family caregivers were reported that were for companionship, to experience or appreciate beauty, to be accepted as a person, to give or receive love, and for compassion and kindness (Kiyancicek & Caydam, 2017). Caregivers reported that spiritual care or support was inadequate because of insufficient staff time, lack of motivation and prioritization and/or interest. The need to develop educational interventions for staff such as considering ways to make spiritual care suitable for different populations, improving the assessment of spiritual care needs, studying the impact of spiritual care and considering caregivers' spiritual care needs were emphasized by caregivers (Selman et al., 2018). Healthcare providers can support their spiritual practices by showing respect for their practice, cheering up

and showing sympathy to their practice, providing psychological support, and being gracious (Kiyancicek & Caydam, 2017).

The meetings about caregivers' needs led to effective adaptation in performing caregivers' roles. Once family caregivers faced difficulties, the strategies that they tried to use for coping were for maintaining quality of life, sustaining psychosocial well-being and ensuring suitable care (Barnieh et al., 2014). These strategies were for seeking support from healthcare providers, family or/and friends, and turning to spirituality in acceptance and trust in God (Nashif et al., 2020; Nemati, Rassouli, Ilkhani, & Baghestani, 2017). Adjustment in the psychosocial and spiritual domains can enhance quality of life, according to previous studies (Davison & Jhangri, 2013; García-Llana et al., 2014; Kaltsouda et al., 2011; Kristofferzon et al., 2011). Therefore, family caregiver's needs should have been fulfilled in order to enhance positive coping.

2.3 Factors related to caregiver care

In caring for family caregivers, in practical terms, nurses may experience the barriers to provide holistic care to family caregivers such as lack of knowledge and experience (Carvajal, Haraldsdottir, Kroll, McCormack, Errasti-Ibarrondo, & Larkin, 2019; Green & Kim-Godwin, 2020; Neathery, Taylor, & He, 2020), lack of time, being task-oriented, lack of family involvement, multitude of tasks and roles (Chen et al., 2017; Kenny & Allenby, 2013), lack of conformity with professional norm (Zamanzadeh, Jasemi, Valizadeh, Keogh, & Talleghani, 2015), lack of communication skills (Carvajal et al., 2019), and unclear organization policy (Burkhart et al., 2019). Also, the lack of guideline and support from healthcare providers were perceived as a contributing factor to the negative experiences or

burden of family caregiver (Couto, Caldas, & Castro, 2018). There was evidence reported that nurses should recognize family caregivers' experiences of caring for care recipients and respond to the actual expectations and needs. The understanding regarding family caregivers' experiences of caregiving is required and aimed to improve family caregiver support (Martín, Olano-Lizarraga, & Saracíbar-Raxquin, 2016).

Negative experiences or all aspects of burden as mentioned earlier can be referred to as "caregiver burden". Zarit and colleagues (1980) defined caregiver burden as "the extent to which caregivers perceived their emotional, physical health, social life, and financial status as a result of caring for their relative". Burden can be grouped into subjective and objective burden. Firstly, subjective burden was the personal perception of the caregivers while performing caregiving tasks (Pristavec, 2019). Secondly, objective burden implies events or activities regarding negative caring experiences (Liu, Heffernan, & Tan, 2020). There was an evidence reported that caregiver burden can be increased within 6 months after the initiation of dialysis (Goto et al., 2019). Adelman and colleagues (2014) reviewed risks factors for caregiver burden that included gender, low educational attainment, staying with care receiver, depression, social isolation, financial stress, prolonged hours of caregiving, and lack of choice in being a caregiver. With a focus only on caregivers of patients with end-stage renal disease, the caregiver care and support related with various factors can be categorized into patient-dependence and caregiver-dependence factors.

2.3.1 Patient-dependence factors

There are three patient-dependence factors mentioned in previous studies including age, changes in a patient's health, and dependence of the patient.

Age, especially older patients, the study showed that older patients positively correlated with caregiver burden (Williams, 2015).

Patient's health, there was study supported the view that patients' health and changes in a patient's health had negative correlation with caregiver burden. Dependence of the patient is reported as affecting and increasing caregiver burden (Tao et al., 2020). Whenever caregiving demand increased, especially among care-recipients who depended totally on their family caregivers for caregiving, the burden subsequently was developed (Oyegbile & Brysiewicz, 2017). Similarly, the study of Kim (2012) demonstrated that dependence of peritoneal dialysis patients had positive correlation with burden of their family caregivers.

Moreover, asking for more help than needed was perceived as the cause of being stressed in caregiving (Shah et al., 2017).

2.3.2 Caregiver-dependence factors

Caregiver-dependence factors can be grouped into personal characteristics factors, social support factors, and duration of care.

Personal characteristics factors

Personal characteristics factors of caregivers include gender in which it cannot now be exactly concluded whether male is more vulnerable than female. Some evidence showed that males have higher levels of perceived caregiver burden than females (Adelman et al., 2014; Limpawattana et al., 2013). Some studies reported that burden is not different between males and females especially in the short-term (Oshio, 2015). In contrast, in the long-term, females who provided prolonged caregiving are more disposed to present psychological problems than males (Oshio, 2015). Other factors, such as older age, race such as white (Williams, 2015), economic status

especially low socioeconomic levels or inadequate income (Limpawattana et al., 2013), and health status were positively correlated with caregiver burden (Limpanichkul, 2004; Limpawattana et al., 2013; Williams et al., 2016).

Social support factors

Social support factors relate to caregiver burden especially lack of social support (Tao et al., 2020) in terms of psychological, emotional, financial support from both health care providers and the family (Washio et al., 2012).

Duration of care

Duration of care in terms of both the period of being a caregiver and the hours of care per day/week positively correlated with caregiver burden (Shah et al., 2017; Williams, 2015). Caregivers perceived regarding caregiving that it is a never-ending burden (Oyegbile & Brysiewicz, 2017). They spent more time on caring for their loved one than on caring for own health (Jowsey, McRae, Gillespie, Banfield, & Yen, 2013).

During the first 6 months of caregiving, family caregivers expressed that they had higher levels of burden, especially the time-dependence and physical burden. The result showed that after becoming a caregiver, caregiver burden decreased from the start of caregiving to 3 months, and then increased up to 9 months caused by reducing work hour or leaving the jobs (Pucciarelli et al., 2018). Consistent with the study of Milbury et al. (2013), their study reported that health problems related to caregiving had greater levels of burden at 3-month follow-up as well as lack of family support and financial strain. These may associate with the caregiver's needs and preparedness. There is evidence supporting the claim that the caregiving demands were higher during the first three months.

Once they felt unprepared for and had the feelings of physical disturbance, they are faced with a greater caregiver burden (Stamataki et al., 2014). The perception regarding caregiver burden over the 6-month were different based on the family caregiver's self-efficacy (Lee et al., 2018) and patients' conditions (Manskow et al., 2015). This is consistent with the information in family caregivers of patients with dialysis. Activity of daily living of patients with dialysis were decreased during the first three months of dialysis initiation, which caused a high caregiver burden (Goto et al., 2019). In addition, there was a previous study which supported that caregiver who provided prolonged caregiving may have raised levels of distress (Oshio, 2015), and caregiver burden over time (Kang et al., 2019). Based on this information, it can be concluded that the first 3-9 months of caregiving are particularly problematic for family caregivers.

With regard to the Thai caregivers, a study of Limpanichkul (2004) reported that caregiver burden was at a mild to moderate level. The factors that influenced caregiver burden included the patient's physical functioning. Likewise, the study of Varitsakul (2012) reported that most of the patients with PD were more dependent and had less self-management capability. Other factors that influenced Thai caregivers were economic status (Limpanichkul, 2004; Limpawattana et al., 2013), the age of the caregiver, caregiver's health status, and the duration of care in terms of both the period of being a caregiver and the hours of care. The studies found that being a caregiver of a patient with CAPD over a long period of time, the duration of care was associated with an increased caregiver burden (Limpanichkul, 2004; Limpawattana et al., 2013; Netchang, 2012), especially for a sole caregiver who cannot take a vacation.

In summary, caregiver burden can be influenced by several factors of patient-related and caregiver-related factors. Complexity of patients' health and dependence of patients' function are the main causes of increased caregiver burden. There are many caregiver-related factors that induce caregiver burden including personal characteristics, social support, and duration of care factors. Specifically, economic status, the age of the caregiver, caregiver's health status, and the duration of care in terms of both the period of being a caregiver and the hours of care are the leading cause of increased caregiver burden in Thai caregivers. A direct intervention aimed at dealing with those factors may face difficulties. Therefore, helping family caregivers adjust their thought to living with caregiver's roles is as an alternative way to promote positive feelings in the long term. This requires development of best practices and the development of a caring model for family caregivers that meets their needs as they find themselves challenged by new responsibilities.

3. Concepts of Caring

3.1 Theory of caring in nursing

A nursing theory that has been widely used as a framework to guide the development of caring models is Watson's theory of human caring. This theory aims to assure a balance and harmony between health and illness experiences of a person. Nursing in this theory is characterized as a profession that performs personal, scientific, ethical, and aesthetical practice (Ozan, Okumus, & Lash, 2015). A caring model defined by Watson is both art and science; it embraces and intersects with art, science, humanities, spirituality, and new dimensions of mind-body-spirit. The

original major concepts of the theory of human caring are composed of four concepts including carative factors/clinical caritas process, transpersonal caring relationship, caring moment/caring occasion, and caring-healing consciousness (Watson, 2010).

First, ten carative factors, Watson stated that ten carative factors constitute a framework for providing a format and focus for nursing or core of nursing. This is the guidance for nursing. Later, carative factors were transposed to clinical caritas process in which spiritual dimension and evocation of love and caring are merged.

Second, transpersonal caring relationship, this focuses on a concern for the inner life world and subjective meaning of a person who has an experience. In the process of caring and healing, transpersonal caring is used to connect with and embrace the spirit or soul that is an authentic relation in the moment. The nurse will enter into the life space or experience of another person and be able to identify the other person's condition of being influenced by the caring consciousness and intentionality and the energy generated by them. Namely, the nurse will focus on caring, healing, and wholeness rather than on disease and pathology. It refers to the nurse focusing on the uniqueness of self and other and the uniqueness of the moment (Watson, 2010).

Third, caring moment/caring occasion, it refers to the moment whenever the nurse and another person interact for caring. A caring moment involves an action and an option by both the nurse and the other. The opportunity to decide how to be and what to do with it and in the moment is created (Watson, 2010). Thus, communications and interactions will occur between a nurse providing care and another receiving care (Şentürk, Küçükgüçlü, & Watson, 2017).

Lastly, caring-healing consciousness, Watson believed that transpersonal caring proceeds through the nurse's consciousness. She emphasized that caring-healing consciousness can be obtained through love and that this happens whenever the nurses approach their patient with love. Also caring and healing can be gained when caring is based on healing consciousness (Şentürk et al., 2017; Watson, 2010).

3.2 Concepts of caring in nursing from an Islamic thought

Islamic thoughts are the concepts that have tangible meaning in the mainstream of life. The concepts of Islam are controls to the conduct of individual in this worldly life and toward the Hereafter. It is a particular way of life, which Muslims are expected to be in accordance with (Tahrir, 2013). Islamic beliefs and practices are based on the Qur'an, the Hadith, Sunnah, and the opinions of early jurists based on their interpretation of the Qur'an, the Hadith, and Sunnah (Alsharif et al., 2011).

Regularly, Muslims live their lifetime by using the five core beliefs or pillars to guide their practices. The five core pillars of Islam are; 1) the creed of beliefs (shahada) or Islamic beliefs consisting of belief in God, belief in the Prophet, belief in the Quran, belief in the day of judgment, belief in Angels, and belief in Destiny or fate. Other related beliefs include beliefs about life after death, intercession, and the individual; 2) daily prayer (salah) means that the prescribed ritual rinsing and prayers are performed five times a day; 3) giving to the poor (zakat) means the donation of 2.5% per year of a person's chattels to the poor; 4) fasting during Ramadan (sawm) means the fasting by abstaining from all food and drink from dawn to sunset during the month of Ramadan; and 5) pilgrimage to Mecca (haji), if

possible (Atkinson, 2015; Koenig & Shohaib, 2014). The last four core pillars of Islam are grouped into Islamic practices. These shape the way of individuals to interpret and seek help for their situations.

Nursing in Islamic thought is defined as the act of guiding a person toward a solution with feminine criteria (Sadat-Hoseini et al., 2013). It is a scientific process that the men can be involved in. Nursing covers all aspects of human life such as physical, spiritual, social and economic aspects that interact with the ethical and legal aspects. In the Qu'ran, the relationship among family member is perceived as a model for nursing. Affection, love, compassion, and kindness are radiated to family members (Sadat-Hoseini et al., 2013). Therefore, nursing should offer remedies according to love, compassion, and kindness. Within Islamic beliefs, an individual has the responsibility of caring for himself/herself. Whenever an individual is not able to care for himself/herself or faces the problems, the nurse has to enter and help him/her in all aspects or following a holistic approach (Sadat-Hoseini et al., 2013).

Taleghani and colleagues (2013) listed the four attributes of nursing in Islamic thought, consisting of: 1) holiness and to be corresponding to worship; nursing is a sacred job and in parallel with the supreme kinds of worship, 2) generosity and altruism; nursing is a kind of generosity and altruism, 3) responsibility and social commitment, and 4) the virtue of benevolence; nursing is under a divine love, which has sympathy, compassion, and inherently about assisting others. This is consistent with the study of Atkinson (2015) who proposed the Islamic values in nursing care as consisting of the following tenets: 1) altruistic relationships are a core value, 2) all care is spiritual care, 3) participants require understanding and respect, 4) nurses have a professional kinship transcending culture, religion, and nationality, 5)

nursing ethics is derived from divine ethics, 6) religious teachings promote health, and 7) the desire for life implies an acceptance of God's will, balanced with hope of reward.

Moreover, Sadat-Hoseini and colleagues (2013) analyzed the characteristics of nursing based on Islamic sources. The results showed that nursing in Islamic context is 1) a nurturer seeking remedies for others, covering all human aspects, and superior to caring, 2) nursing is patient-centered and conducted based on the apparent or hidden request of the patient, 3) nursing has characteristics similar to motherhood, and 4) the process of nursing develops the values and capacities of the nurse contributing to self-growth.

As known, caring is the essence of nursing. The concepts of caring in nursing within Islamic perspective were carried out on the basis of existing theories of caring including Jean Watson's theory of human caring. However, there are some differences between these two theories. For example, caring in Islam is defined based on the divine commands, religious duties, and human nature. Whereas, the definition of caring in Watson's theory is defined based on the person's experiences resulting from human interaction with their environment. And in terms of the dimensions of caring, Watson defined that caring is an external process, which is responsible for improving self-caring capability. Conversely, caring is an internal process, which is responsible for taking care of themselves based on a feeling of love and their human nature, and is the duty of individual (Sadat-Hoseini & Khosropanah, 2017).

Caring in Islamic thought is defined as a natural outcome of love that one has for Allah, the Prophet (Rassool, 2000), humanity (Barolia & Karmaliani, 2008), and also for other creatures of the world (Taleghani et al., 2013). The concept

of caring is embedded in the theological framework of Islam. Caring has a religious consequence, which is to love God and the Prophet, and it is what the human is supposed to do. Its principles are based on the Divine revelation and on following the Prophet's habits (Taleghani et al., 2013).

Caring in Islam focuses not only on the physical aspect of a human being, but it is also concerned with the interrelationship between the multiple dimensions of being human. Barolia and Karmaliani (2008) reported the five dimensions of a human being consisting of the physical, ethical, ideological, spiritual, and intellectual dimensions, which constitute the core category in the theory of caring in nursing from an Islamic perspective. Each dimension was described as following.

1) Physical dimension

Physical care from an Islamic perspective consists of pain relieving—either physical or psychological pain—piety or maintaining cleanliness in physical matters and the purity of mind, and prevention required for physical caring in Islamic context.

2) Ethical dimension

This focuses on the Islamic ethics, which is the decision-making process based on the principle of doing good to humanity. The ethical caring implies respecting the rights provided in Islam.

3) Ideological dimension

The ideological dimension frameworks are 1) the duties toward Allah, 2) the duties toward mankind, and 3) the duties toward self. Ideological caring is maintaining a balance in performing all duties.

4) Spiritual dimension

Spiritual dimensions were expressed as the concepts of inner satisfaction achieved from service, human bonding, compassion, empathy, and hope.

5) Intellectual dimension

In Islamic perspectives, Muslims believe that intellectual nurturing with searching is taught through the verses in the Holy Qu'ran. Muslims search and use intellect at all levels of caring.

Human beings are viewed as having an individual responsibility for self-care and development capacities in accord with human nature. However, whenever the individual faces obstacles or he/she is not able to care for himself/herself, the nurse has to enter for helping as this is viewed as a supporting the person in all aspects (Sadat-Hoseini et al., 2013; Ismail et al., 2015; Taleghani et al., 2013). The balancing of all dimensions of the human being is necessary for providing nursing care in Islamic context. This indicates that caring in Islamic thought focuses on holistic care.

Generally, the definition of holistic care in nursing refers to the nurses' activities that recognize a person as a whole and acknowledge the interdependence among biological, social, psychological, and spiritual aspects. The nurse engaging in holistic care has to consider the patient or other as a whole within his/her specific experience and believe that he/she is made up of body, mind, and spirit (Jasemi, Valizadeh, Zamanzadeh, & Keogh, 2017).

The definition of holistic care in nursing within the Islamic perspective is quite similar. Islamic holistic nursing was explained by Taleghani and colleagues (2013). Seen from the Islamic viewpoint, they explained that, firstly, a human being is

a unique construct with body or material (substance, body and person) and soul or immaterial (spirit, psyche and soul). Therefore, caring in nursing should include consideration of both material and immaterial constructs. Secondly, the body and soul are united and integrated into the world system to form a whole. Therefore, material and immaterial elements are not the only ones considered in nursing and caring, but also the integrated manner should be considered. In Islamic thought, one also believes that there is a relationship between soul and body. Whenever there is a deficiency in one, it will result in a deficiency in the other. Thirdly, a human being has talents and abilities inherent in its immaterial construct and developed in the cognitive/perceptual, emotional, social, and spiritual sub-dimensions. Hence, nursing and caring is not only based on the unity of both material and immaterial constructs, but all sub-dimension in material and immaterial should be considered.

Sadat-Hoseini and Khosropanah (2017) viewed caring in Islam as holistic and based on human nature. Nursing from Islamic thought believes that caring has a holistic paradigm and includes all of the dimensions and aspects of being human (Talaghani et al., 2013). Its concept is derived from the divine commands and religious duties. This results in the definition of caring as praying to God, virtuous caregiver, and the sense of emanating attribute of God (Rooddehghan, Nayeri, & Okhovat, 2015). The four types of caring in Islam summarized by Sadat-Hoseini and Khosropanah (2017) are as follows:

1. *God taking care of humans*

Within Islamic context, there is belief that the whole world is under God's authority and God is the director, protector and caregiver of the world.

2. Humans taking care of themselves (self-care)

According to Islamic thought, humans are tasked with taking care of their own body and soul with love in order to maintain or improve their physical and health of soul.

3. Humans taking care of each other

There are two modes of this type: first, the usual type of caring between humans, and second, humans taking specialist care of each other. This point means that every human is tasked with taking care of other humans.

4. The universe taking care of humans and vice versa

Consistent with God's commands, the universe is obligated to serve humans and take care of them. Humans then may benefit from the assistance of the universe. This aspect guides the nurse to provide nursing care that makes the universe available to humans.

Caring means the intention to be responsible, sensitive, concerned with the motivation and commitment to act in the right manner in order to achieve perfection. It is expressed on three levels composed of intention, thought, and action. The intention and thought levels are the understanding of what, when, who to care for, and why. And the action level is how and this is related to knowledge, skills, and resources (Rassool, 2000). Taleghani and colleagues (2013) suggested the human principles that the nurse who is a holistic nurse should consider the following features in his/her contact with patients:

1. A human is respected with the highest values and reverence, and is developed to get the position of vicegerent of God. A human has control over nature, Earth, and heavens. This idea will establish the nurse as a good role model.

2. A human is a creature being related to God in a way that God guides him/her toward the ultimate destination that he/she has been created and evolved for. Therefore, a nurse should encourage the clients to attend to this fact in order to create the feelings of peacefulness.

3. A human has a talent and capability for ascending to the highest level of perfection or closeness to God. Therefore, a holistic nurse should be aware of the purposefulness of nursing in fulfilling the needs that allow the clients to overcome the obstacles. In Islamic thought, the turning of clients' attention from other to God can promote the position of perfection.

4. A human is a selector creature and is able to make decisions in dilemmas. This belief leads the nurse to value the clients' views, selections, and decisions in his/her health care practice and to encourages them to participate in the health care plan or treatment.

5. A human is an accountable creature. This belief encourages the nurse to be aware that the clients can be responsible for their health based on their ability and they should participate in decision making process related to their health independently.

The caring process from Islamic perspectives

According to Barolia and Karmaliani (2008), in order to maintain harmony among the five dimensions of being human in a holistic manner, the caring process in the practice setting should consist of response, reflection, relationship, relatedness, and role modeling (5Rs). The state of maintaining a balance among these five dimensions is claimed as the central theme of the caring process, which means that caring in Islamic perspective should be viewed as a circulation process.

Response

Response refers to the actions that the nurses apply to respond to a unique human need to be accepted as a caring person and to be supported in caring (McCance, McKenna, & Boore, 1999). This means that caring is person-to-person recognition of intrinsic values and a response to the value of him/her (Boykin & Schoenhofer, 1990). The caring or response of nurses within the Islamic context means the will to be responsible, sensitive, concerned with the motivation, and showing commitment to act in the right order to gain perfection. The nurses need to provide caring with love that is focused and spiritually based. Love is how nurses respond to patients/families/groups emotions, will, and volition. Muslims mostly have the hope, the faith, and the trust in Allah. Therefore, spiritual based care is the finding and respecting of spiritual beliefs and practices of care-receivers, which can be a source of comfort in alleviating their spiritual distress. Seeking help from Allah and praying should be encouraged by nurses (Ismail et al., 2015).

Reflection

A combination of reflection and action is named as a caring praxis (Watson, 2010). Reflection in nursing is often used for the analysis of nursing practice in order to achieve an understanding of nurses' practices and the development of the critically thoughtful approaches for providing nursing care in complex situations (Pierson, 1998). The nurses use reflection as a tool in learning from each of their experiences, accessing often-overlooked issues, and then adapting their learning to the new situation (Edwards, 2017).

Relationship

Caring is as a phenomenon in an interpersonal relationship process (Blasdell, 2017). A caring relationship is recognized as being essential to the healing process of care-receivers (Ismail et al., 2015). The intimate relationships are defined as an attribute of a caring process that are featured as protective and trusting. It is the type of closeness leading to strong emotional feelings. The caring activities for promoting the intimate relationships involve active listening, sincerity, helping patients or relatives to make an appropriate decision, using respectful communication, paying more attention to other experiences, and assurance of the human presence (Azizi-Fini et al., 2012).

Relatedness

Relatedness in nursing refers to the interpersonal interaction between nurse and patient. The characteristics of relatedness include genuineness, acceptance, listening, presence, and empathy. In the process of a nurse-patient relatedness, the nurse must open herself to the emotional or physical pain of the patient. In a clinical setting, the relatedness is related to a patient's feeling that the nurse genuinely likes, respects, and values them. The nurses can support the relatedness in practice by allowing the patients to talk and nurses are actively listening, providing simple touch in recognition of patients' presence, considering the patient's cultural preference related to health beliefs, food preferences or spiritual practices, and allowing the patients to participate in planning care (Crary, 2016).

Role modeling

Role modeling influences the learning environment and increases the competence of persons (Badruddin, 2018). It can be used for learning particular skills

and behaviors, offering a representation of the possible goals, and inspiring to achieve a desirable goal (Morgenroth, Ryan, & Peters, 2015). The persons who are role models should recognize the state of interdependence, willingly entwining themselves with others, learning and sharing with others. In this process of interaction, both the person and the other may be changed in a positive way by the shared experience and the relationship. The outcome of sharing experience is to allow the role model influencing the other person while also being changed by interactions with others. The role models value continuous learning from observing and learning from others. A positive role model can strengthen a positive effect on creating new behaviors for success in desired goals (Lee, Kwon, & Ahn, 2021).

In addition, as suggested by Athar (as cited in Rassool, 2000), an Islamic code of ethics has been suggested for the development of a model of care. Athar stated the major role of the nurses in the care for patient is 1) understanding the concerns of the patient and family and transmitting them to health care professionals involved in the decision making process, 2) interpreting the Holy Qur'an as it applies to specific concerns of the patient, 3) consoling and comforting the patient and family or important others so that they can accept the present situation as reflecting the will of Allah and pray for a better life in the hereafter, and 4) taking care of the needs of the family in all aspects after the death of the loved one.

3.3 Concepts of gratitude in nursing from an Islamic thought

There are Islamic values and attitudes including ethical values, positive attitudes, importance of family, importance of work, and admonitions against adultery and polygamy (Koenig & Shohaib, 2014). Under importance of family mentioned in Islamic values and attitudes, Islam believes that family and kinships are the keystone

of Muslim life. Islam emphasizes that caring for family members is a primary responsibility of both the individual and the community (Koenig & Shohaib, 2014). And every human is tasked with taking care of other humans (Sadat-Hoseini & Khosropanah, 2017). That is, Muslim thought prioritizes caring for family member and something that an individual in Islam should do as caregiver.

The importance of caring for family members or kinships in Islamic context is influenced by other beliefs. A Muslim is nurtured to show respect for all older people. This is considered a communal obligation and virtue to care for the elderly, even for extended family members (Queensland Health and Islamic Council of Queensland, 2010). Muslims are required to respect their elders and to take care of their aging parents. This cultural trait is clearly represented particularly in strict Islamic society. Relatives take care of the elderly, and regularly a member of the family will take care of the family's seniors and elderly parents as instructed by the Qur'an and the Prophet of Islam (Begum & Seppänen, 2017). As in the Qur'an stating the word of God: "Show gratitude to me and to your parents: to Me is the Goal" (Khalil, 2016). This verse indicates that adult children must care for their parents and other elderly family members at home. This is consistent with Thai culture. There are four gratitudes reflected by Thai adolescents including gratitude to oneself, gratitude to parents and significant others, gratitude to friends and others, and gratitude to the wider world (Balthip, Pasri, Suwanphahu, McSherry, & Kritpracha, 2021).

Expressed gratitude constitutes the key belief in performing caring for Muslim family members. Likewise, in the study of Hemman and colleagues (2017), they proposed that Muslim caregivers for patients with ESRD should take care of their receivers by the feeling of repaying gratitude as instructed by the Qur'an and the

Hadith. This is grounded in their belief that Muslims who exhibit gratitude and kindness towards their parents or family also express gratitude towards Allah and will be rewarded (Nemati et al., 2017).

From the perspective of Islam, gratitude is one of the fundamental aspects of Islam. Islam viewed gratitude as a virtue of human beings. It is categorized into two principles, including gratitude to Allah and gratitude to the creation of Allah (Latheef, 2013).

1. Gratitude to Allah

Gratitude to God is a central thought of Islam. Gratitude to Allah is the essence of faith and the responsibility to each human being. The individual who accepts the reality of Allah is a grateful person. The worship is a sign of thankfulness expressed by them. Gratitude is what most merciful Creator requires from human beings. Reflecting the soul of Islam, Muslims are taught to praise and be grateful to God. Praise and thanks to God is expressed through the word “Alhamdulillah”.

2. Gratitude to human beings.

Gratitude in Islamic thought did not only greatly emphasize on gratitude towards God, but Islam also gives much focus on gratitude towards human beings. It is viewed as a human virtue. A Muslim can express his/her gratitude through the word “Jazakumullahu Khair” meaning that giving thanks to Allah and to whoever who does good at the same time.

In the Islamic perspective, Islam reinforces people to express gratitude or thanks giving. There are beliefs that gratitude forms a part of obedience, for obtaining blessings, coming from the mind, and reflecting the purpose of creation. Showing gratitude is an integral part of Muslim daily life. Muslims can express their

gratitude to God by praising. They believe that Allah will offer rewards to people who show gratitude.

In addition, Khodayarifard and colleagues (2016) declared that gratitude is another aspect of positive thinking in the Islamic context. They summarized that gratitude means thankfulness and appreciation for a person's kindness and beneficence. Sensing the favor may originate from positive thinking towards God. That is, a positive person is able to understand what has been given to him/her as a blessing. They also reported other benefits of gratitude involving psychological aspects. Firstly, if an individual knows that a blessing has been given to him/her, he/she considers himself/herself under the supervision of a trustful caregiver who has provided him/her innumerable blessing. It is like a feeling that leads to a sense of trust and calmness. And secondly, the purity of the soul and thought is another psychological outcome of gratitude. Likewise, in the study of Hemman and colleagues (2017), they proposed that Muslim caregivers for patients with ESRD believed in Divine benevolence that leads to stress releasing. Consistent with the previous studies, the findings showed that gratitude has moderate to strong negative correlation with mental illness and positive correlation with subjective well-being (Aghababaei & Tabik, 2013) as well as spirituality and life satisfaction (Gōcen, 2016) in a Muslim context.

The expression of gratitude through writing and thinking about the things that a person appreciates in his/her life was the key strategy of gratitude-based interventions in previous studies (Lambert & Fincham, 2011; Wong, Owen, Gabana, Brown, Mcinnis, Toth, & Gilman, 2016). Cultivating and nurturing the sense of gratitude by encouraging the participants to do all good things for themselves and

others improved the wellness, as well as stimulating a sense of pride that could improve behaviors and moral virtue (Balthip et al., 2021). According to the study of Al-Seheel (2012), a gratitude approach was used in Islamic-based exercise through encouraging the participants to notice how fortunate Allah gives them in all aspects of their lives, and recognizing all good things that Allah blesses them with, which they are grateful for at the present and in the past. The results of this study showed that the level of happiness of participants was improved.

3.4 Nursing process

Nursing process is a scientific method aimed to guide procedures and quality nursing care. It has been defined as a systematic and dynamic process for providing nursing care (Hagos, Alemseged, Balcha, Berhe, & Aregay, 2014). Positivism and empiricism were critiqued as putting emphasis on the philosophical nature of the nursing process (Zamanzadeh, Valizadeh, Tabrizi, Behshid, & Lotfi, 2015). Effective implementation of the nursing process offers benefits in making and planning an effective nursing care that leads to improved quality of care (Hagos et al., 2014). Therefore, the nursing process has been used as an organizing framework for professional nursing practice through a critical thinking process, which aims to provide the best caring for clients. Key components of the nursing process include: assessment, nursing diagnosis, planning, implementation, and evaluation (Ackley, Ladwig, Makic, & Martinez-Kratz, 2017) as follows:

Assessment

The nursing process is started with the assessment phase. Data on all dimensions of being human are embedded in the assessment. A holistic nursing assessment is performed through completing a thorough health and medical history,

active listening, and observing. Open-ended questions, physical assessment, and noting diagnostic test results are strategies for obtaining more information. Recording all of this information on the forms needs to be done carefully.

Nursing diagnosis

Nursing diagnosis is the outcome of analysis in the information of an individual person. This step starts with clustering the information followed by determining and evaluating judgment about the problems and unmet needs. The process of thinking or clinical reasoning is used to gather and analyze all information, evaluate the significant data, and determine the value of alternative actions. The holistic assessment in the first step is essential in determining the type of nursing diagnosis, related factors, and priority of each diagnosis.

Planning

The planning phase includes the identification of priorities, determination of appropriate specific outcomes, objectives, and interventions. These processes require client and health care team participation in the plan of care.

Implementation

The implementation phase includes the provision of the specific and individualized interventions to the client. The individualized nursing intervention should be supported by evidence. During performing nursing interventions, the appropriateness and effectiveness of the nursing intervention needs to be considered by the client and health care team who participate in an implementation of the nursing care plan.

Evaluation

Evaluation is the final phase in the nursing process. This phase includes evaluating the client's response and outcomes. The individual plan of care needs to be examined to determine whether it must be revised. Reassessment should be done for re-planning. The evaluation of the client's response should also be documented with the aim to assure collaboration within the health care team. Therefore, the facility's tool for documentation and recording the nursing activities should be used as well as the results of the nursing interventions.

3.5 Evidences related to Islam-based caring programs/models

3.5.1 Activities/strategies of Islam-based caring programs/models

There are a few studies that developed Islam-based programs/models to reduce negative feelings and enhance positive outcomes particularly in family caregivers. Most previous Islam-based interventions or models were developed and tested in participants who were either healthy persons such as student (Al-Seheel & Noor, 2016) or Muslims patients suffering from an illness such as multiple sclerosis (Saeedi et al., 2015), acute myocardial infarction (Mardiyono, 2012), schizophrenia (Jannah et al., 2016), addicts (Khaledian et al., 2017), pregnant women who have high anxiety and depression (Aslami et al., 2017), and critically ill patients (Ismail, 2016) as well as patients with hemodialysis (Aghajani, Afazel, & Morasai, 2014; Babamohamadi, Sotodehasl, Koenig, Jahani, & Ghorbani, 2015; Babamohamadi, Sotodehasl, Koenig, Zaben, Jahani, & Ghorbani, 2017; Frih et al., 2017; Sharifian, Rambod, & SHarifian, 2017). The objectives of previous programs/models development based on Islamic thought were to reduce negative feeling such as anxiety and depression, and to enhance positive outcomes such as quality of life, perceived

control, self-esteem, mental health, levels of happiness, harmony, acceptation and adaptation toward disease, and medication adherence.

Islam-based activities that were applied in previous interventions can be summarized including Islamic comment, Islamic relaxation such as remembrance of Allah (Zikr), tapping at the point of head, deep breathing and saying thanks to Allah, praying, reciting the selected Quranic verses, reciting the divine names, explaining the divine fate, listening to the sound of the Quran, reading the Quran, explaining the biography of the Prophet, mindfulness, and Islamic-based gratitude such as recalling all good things that Allah has blessed them with and composing a letter of gratitude by expressing their gratefulness to the Merciful Allah. Focusing on Islam-based activities conducted among patients with hemodialysis include listening to the Quran, Quran recitation, spiritual counseling, praying, and reading the Quran (Aghajani et al., 2014; Babamohamadi et al., 2015; Babamohamadi et al., 2017; Frih et al., 2017; Sharifian et al., 2017). All studies showed that all Islam-based activities are effective in reducing negative feeling and enhancing positive outcomes in patients (Aghajani et al., 2014; Al-Seheel & Noor, 2016; Aslami et al., 2017; Babamohamadi et al., 2015; Babamohamadi et al., 2017; Frih et al., 2017; Ismail, 2016; Jannah et al., 2016; Khaledian et al., 2017; Mardiyono, 2012; Saeedi et al., 2015; Sharifian et al., 2017).

3.5.2 Duration of interventions and follow-up periods

Based on previous studies, the duration of Islam-based caring interventions/models can range from 4 days to 24 weeks as well as the follow-up period. When only focusing on reducing negative feelings such as anxiety and depression, the duration of Islamic thought based caring interventions can last 4 days

to 8 weeks in a quasi and experimental study (Aslami et al., 2017; Babamohamadi et al., 2015; Babamohamadi et al., 2017; Mardiyono, 2012). While the duration of Islam-based caring interventions for enhancing positive feelings such as quality of life, level of happiness and harmony, self-esteem and mental health can last 3 weeks to 24 weeks in quasi and experimental study (Al-Seheel & Noor, 2016; Frih et al., 2017; Khaledian et al., 2017; Saeedi et al., 2015). Specifically, in action research, each iteration of planning, action, observation, and reflection can last four months, and overall, the process of research can range over one year (Ismail, 2016).

3.5.3 Outcomes of an Islam-based caring model

Most of previous studies regarding Islam-based caring interventions/models were conducted among patients suffering from either physical or psychological illness as well as among healthy persons. The outcomes are mostly measured in the patients, even though Islam-based caring interventions/models also are beneficial to others such as their families and the nursing team (Marzband, Hosseini, & Hamzehgardeshi, 2016). The effectiveness of Islam-based caring interventions/models can be grouped into two main outcomes consisting of reducing the psychological burden and strengthening the positive outcomes.

Islamic-based interventions/models were effective in reducing the psychological burdens in the patients such as anxiety (Aghajani et al., 2014; Aslami et al., 2017; Babamohamadi et al., 2015; Frih et al., 2017; Hosseini et al., 2013; Mardiyono, 2012) and depression (Aghajani et al., 2014; Aslami et al., 2017; Babamohamadi et al., 2017; Frih et al., 2017; Sharifian et al., 2017). It was also effective in strengthening the positive psychological outcomes such as spirituality, life satisfaction (Göcen, 2016), well-being in terms of personal well-being indicated by

job satisfaction, family satisfaction, and life satisfaction (Achour, Grine, Nor, & MohdYusoff, 2015), emotional-spiritual well-being measured through dignity, self-control, and personhood (Ismail et al., 2015), and psychological well-being measured through levels of self-actualisation, meaning in life, and personal growth initiative (Ivtzan, Chan, Gardner, & Prashar, 2013), harmony (Ismail, 2016), happiness (Al-Seheel & Noor, 2016; Göcen, 2016; Mardiyono, Songwathana, & Petpichetchian, 2011), perceived control (Mardiyono, 2012), self-esteem (Khaledian et al., 2017), mental and psychological health (Khaledian et al., 2017; Marzband et al., 2016), lives saved, safety (Ismail, 2015), quality of life (Frih et al., 2017; Saeedi et al., 2015; Saffari, Pakpour, Naderi, Koenig, Baldacchino, & Piper, 2013), medication adherence (Jannah et al., 2016), health status (Frih et al., 2017; Ismail et al., 2015; Mardiyono et al. 2011; Saffari et al., 2013), trust relationship, and feeling closer family relations (Ismail et al., 2015). Furthermore, the benefits of Islamic-based caring model to family, and nurse were reported including family's satisfaction, nurse-patient relationship, and nurse caring behavior respectively (Ismail, 2016).

In summary, as known, caring constitutes the core of nursing and Islamic belief including gratitude constitutes the core of the practice in Muslim caregivers. Literature reviews show that the integration of Islamic beliefs in caring has effectiveness in enhancing health. The Islamic-based activities that can be integrated into nursing practices include Islamic comment, Islamic relaxation praying, reciting the Quran, listening to the Quran, reading the Quran, explaining the biography of the Prophet, and mindfulness. Duration for providing Islamic based activities can last from 4 days to 24 weeks. And the outcomes can be in terms of physical and psychological aspects.

4. Action Research (AR)

The concept of action research is originated by Kurt Lewin in 1946. The definition of action research is “a form of collective self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices” (Kemmis & McTaggart, 1988). The understanding of their practices and situations are carried out as well. Since the action research is gained through the critically examined action of individual group members, that means the action research is a group activity. Reason and Bradbury (2008) described that action research is a participatory process concerned with developing practical knowing in the pursuit of human purposes. They also defined that action research is as a practice for the systematic development of knowing and knowledge.

4.1 Philosophical and theoretical underpinnings of action research

There are five dimensions of action research described by Reason and Bradbury (2008). They described that “action research is an approach to human inquiry concerned with developing practical knowing through a participatory, democratic process in the pursuit of worthwhile human purposes, drawing on many ways of knowing in an emergent, developmental fashion”. Each dimension is described by Reason (2003).

1. Practical knowing

The primary purpose of action research is to produce practical knowledge that is useful to people in their lives. And the general purpose is to

contribute through the practical knowledge to the increased well-being of humans and communities, and to a more equitable and sustainable relationship with the universal of which they are an intrinsic part.

2. Democracy and participation

Reason and Bradbury (2008) explained that the central element of action research is building democratic, participative, pluralist communities of inquiry. Action research relies on participation with, for and by persons, groups, and communities.

3. Ways of knowing

In action research, the research is claimed to go beyond the orthodox empirical and rational western epistemology, which begin with a relationship between the researcher and others through participation and intelligence.

4. Human and ecological flourishing

Action research aims to contribute to the flourishing of human persons, groups, communities, and the ecosystems of which the persons are part.

5. Emergent form

Action research is concerned with the emergent deepening of the understanding of the issues that the persons wish to mention, and the development over time of communities of inquiry.

Action research falls under the post-positivist research methods. It is empirical, interpretive, experimental, multivariate, observational, and interventionist (Baskerville & Wood-Harper, 1996). It is also like a method of scientific inquiry with respect to three research paradigms including positivism and interpretivism. Positivism is addressed in action research because positivist research techniques such

as quasi-experimental design may be used in action research. Meanwhile, when we consider the conditional nature of action research, it can be classified as a post-positivism overlapping interpretivism. Post-positivism refers to a scientific methodology that aims to understand social phenomena, the possibilities, multiple points of view and perspectives, and different variables that may influence the proceeding of the whole. Moreover, interpretivism concentrates the meaning of social interactions. This paradigm claims that social facts are different because the subjects of social facts are human beings and their relations with each other. And the interpretivist research aims to achieve an understanding of the meaning of social facts for those experiencing them (Tekin & Kotaman, 2013).

The characteristics of action research that reflect a post-positivism mode of inquiry were clarified by Tekin and Kotaman (2013) as the following principles:

1. There is a social reality or social facts. The persons are influenced by the social facts on which there is congruence.

2. In action research, the purpose of inquiry is mainly to access or generate practical information that is useful for improving the effectiveness of the application.

3. The subject of research is a problem that the persons face in their situations. Science can contribute to the betterment of society.

4. All participants can act as the researchers.

5. All participants possess equal rights in action research. Collaboration of all participants related to the issues/application is required. Therefore, the data

gained through action research can provide a more holistic grasp of the issue. Meanwhile, the researcher can design intervention that covers a range of solutions.

6. There is no end point of action research because social issues are dynamic involving problems that occur all the time.

Furthermore, they proponents described that the action research claims that social reality is not completely knowable because social processes are dynamic and changing which is consistent with the interpretivism paradigm. Tekin and Kotaman (2013) also explained that action research methods such as interview and observation used for data collection are utilizing both a post-positivist and an interpretivist approach as well as triangulation techniques.

4.2 Types of action research

Action research is categorized into three types, as follows:

4.2.1 Technical action research/technical collaborative approach/the scientific-technical view of problem-solving

It occurs when an outside facilitator or researcher takes action like a leader, and participants are persuaded to test the finding from external research in their own practice (Gaffney, 2008). The power of technical action research is the idea that often resides with the facilitator who controls power in the research (Eilks & Markic, 2011). The goal of this approach is to test a particular intervention based on a pre-specified theoretical framework. The nature of the collaboration between the researcher and other participants is technical and based on facilitation. The researcher takes action in the identification of the problem and designing a specific intervention, and then the participants who are related the problem are involved and agree to facilitate the implementation of the intervention. The collaboration is mainly between

the facilitator and the group. The advantages of the use of technical action research include the following (Cilliers, 1999):

1. Technical action research promotes more efficient and effective practice;
2. Technical action research encourages personal participation by the persons in the process of improvement;
3. Technical action research results in the accumulation of predictive knowledge;
4. The key thrust of technical action research is based on the validation and refinement of existing theories and is importantly deductive.

4.2.2 Practical action research/mutual collaborative approach/practical-deliberative action research

It happens when an outside researcher builds cooperative relationships with participants and takes action as a facilitator in helping them to state their own concerns, plan strategies for change, monitor the problems and effects of change, and reflect on the actions and outcomes of the changes (Gaffney, 2008). The power of this approach is shared between a group of equal participants (Eilks & Markic, 2011). The researcher and other participants are as a team for identification of the problem and finding possible solutions together (Cilliers, 1999).

4.2.3 Emancipatory action research/critical-emancipatory action research/critical science perspective

It happens when the group of participants coordinates responsibility to change and improve their practice aiming to explore the problems and effects of group conditions and individual practices (Gaffney, 2008). The power is wholly the

group, not with the facilitator and not with individual within the group (Eilks & Markic, 2011).

4.3 Process of action research

Technical action research, the participants and researcher aim to control and improve the outcomes in their practice. The aim is to change the ways of those who are involved in the practice. The participants and researcher are the key persons who identifies problems, change practices, and methods of evaluation (Kemmis, McTaggart, & Nixon, 2014).

The participants are engaged in four fundamental aspects of the action research including planning, action, observation, and reflection in order to identify the thematic concern. These four aspects of action research are dynamic and link into a cycle, and continually moves into a spiral of such cycles.

The activities in a spiral of planning, action, observation, and reflection are explained by Kemmis and McTaggart (1988) as follows:

1. Planning

In the planning process, participants have to collaborate in discussion involving both theoretical and practical discourse to build a key idea. All participants have to analyze and make their understanding and action in the situation. The general plan must be flexible to allow for adaptation to unexpected effects and unrecognized factors in the action phase.

2. Action

Action is a careful and thoughtful variation of practice. It is guided by planning. The implementation of action plan in this phase will assume the nature of social and political endeavor towards improvement.

3. Observation

After completion of the action process, the effects of action need to be observed. Observation must be planned, flexible, and open to record the unexpected. It can encourage the improvement of practice through better understanding and more critically informed strategies.

4. Reflection

Reflection is an evaluative process. The effects of the intervention and the suggestions for continued proceeding are established through discussion among all participants. This process leads to the reconstruction of the meaning of the situation and will provide the revised plan.

Kemmis and McTaggart (1988) described that the action research process can begin by taking a first action step in some groups that already have some plan for action formulated. Others will have some data and will prefer to begin by reflecting on it and then formulating an action plan. And some groups need to begin with an initial phase of reflection on their situation that constitutes a basis for planning and action. They also described the steps of action research.

Step 1: Initial reflection on your situation or reconnaissance

This step begins with formulation the thematic concerns. And then, an initial analysis of the key ideas and discourse, relevant activities and practices, social relationships and organization of your situation in relation to your thematic concern will be conducted in order to gain clear understanding of your recent situation. This phase may be called “Diagnosing a problem”.

Step 2: Planning

A rationale for change and an action plan is produced. Each of the participants needs to decide and think about their thematic concern. The possibilities and limitations of their situation will be considered. In this step, the participants must consider what is planned, what it is most practically important, significant and useful to do. The first draft of the plan should be negotiated with the action group and then revised based on the group's feedback. In the planning phase, the methods of evaluation and monitoring the implementation and effects of the action will be included.

Step 3: Acting the plan and observing its effects

This step is for implementing the plan. Each of the participants goes ahead and tries to do what they plan to do. Then, data collection will be conducted in order to determine the effects of action on the situation.

Step 4: Reflection

The activities of participants in this step are carried out to decide what happened, to review about thematic concerns, to reconsider the opportunities and limitation of their situation, to review the achievements and limitations of the first action step, to determine its consequences, and to re-think or re-plan about implementations for the next action step. Finally, a revised action plan will be designed.

5. The Tentative Islam-Based Caring Model Development

The integration of religious beliefs into a caring model refers to providing care to person based on specific beliefs influencing his/her mind-body-spirit dimensions, especially in the case of Muslims who live their life strictly following Islamic beliefs. Whenever a Muslim experiences difficult situation, there is a tendency toward relying on religious or spiritual beliefs and this mostly seems to be used as a coping strategy as well by Muslim caregivers (Pourghaznein et al., 2018; Saffari et al., 2013). Muslim caregivers may have negative feelings at an earlier stage. The turning to spirituality, appeal to God, and acceptance of the difficult caregiving as a divine test and part of God's will are utilized in order to cope with negative situations (Pourghaznein et al., 2018). A study reported that religious involvement such as praying, reading and reciting the Quran or watching/listening to religious programs, giving alms to the poor, fasting during Ramadan, and pilgrimage to Mecca are correlated with better mental and physical health outcomes (Zaben et al., 2015). Thus, providing Islam-based interventions may be effective in improving mental health in Muslim caregivers.

In addition, for the nursing model for Muslim family caregivers to be acceptable, it is suggested that it should be following a holistic approach as derived from spiritual, cultural and professional nursing values. The concept of shared meaning and spirituality between the nurse, the family caregivers and their patients are perceived as the heart of the caring model for Muslims (Lovering, 2012). Also, in order to overcome the barriers of providing holistic care perceived by nurses and promote them to provide more holistic care in family caregivers, the nurses affected

by this issue should participate in the process of the modification of an Islam-based caring model. Therefore, the use of the action research (AR) approach is appropriate as it can increase the probability of implementation in practice. This study is classified as a technical action research due to the outside researcher taking action as an identifier of the problem and developer of the model. Meanwhile, PD nurses will participate in the implementation the model into their practice.

In this study, a new Islam-based caring model was developed in order to fulfill the gap and limitations of previous interventions/models, which mostly were conducted among Muslim patients. There is no specific evidence of an Islam-based holistic caring model being implemented for family caregivers. That is, existing models cannot be absolutely applied in Thai family caregivers. Also, there are the other limitations of those interventions in terms of the feasibility of utilization. Some interventions mainly focus on Islamic teaching that general nurses may have obstacles to overcome in their nursing practice. Therefore, this study was expanded to include in Muslim family caregivers. The model was developed with easiness and feasibility in practice in mind. Moreover, it should be consistent with Islamic thought and can be applied by non-Muslim PD nurses aiming to achieve effective implementation in specific settings.

The concepts of caring in nursing from an Islamic perspective formulated by Barolia and Karmaliani (2008) and the concepts of gratitude within an Islamic thought of Latheef (2013) are applied to guide the study. The process of five Rs including response, reflection, relationship, relatedness, and role modeling stated by Barolia and Karmaliani (2008) is integrated into the nursing process in order to encourage the balancing of all five dimensions of being human or Muslim family

caregivers in this study. These concepts are merged into steps of nursing process including assessment, nursing diagnosis, planning, implementation, and evaluation, as follows:

(1) Assessment

Holistic assessment is more emphasized in this study. For Muslim family caregivers, the religious beliefs, health, cultural, and personal characteristics of Muslim family caregivers must be assessed as well as the present or possible problems, factors or causes, needs and performances regarding caregiving management of Muslim family caregivers following the five dimensions of being human. Interviews, observations, and questionnaires can be used in obtaining complete information. The process of caring (5Rs) from Islamic perspectives must be started with *relationships*, followed by *relatedness* and *reflection*. The PD nurses have to encourage Muslim family caregivers to reflect on their difficulties and needs in relation to caregiving in all aspects of being a Muslim.

(2) Nursing Diagnosis

All information obtained from the assessment step have to be analyzed and determined. The needs, holistic effects, and possible problems of each Muslim family caregiver must be identified covering all of the five dimensions of being human from the Islamic perspective by PD nurses and health care team collaborators. Nurses' behaviors showing *relatedness* could be practiced continuously in this step, followed by the *response* process. The PD nurses need to respond to Muslim family caregivers' difficulties and their needs as individuals.

(3) Planning

The identification of priorities, expected outcomes, nursing activities, and evaluation methods for monitoring must be done in this step. *Relatedness* and *response* can be performed continuously. The *gratitude* approach can be provided to Muslim family caregivers in order to encourage their peace of mind, including 1) cultivating and nurturing the sense of gratitude by encouraging Muslim family caregivers to do all good things for themselves and their patients, 2) encouraging Muslim family caregivers to express their gratitude through talking, thinking, and recalling about all things that they appreciate in relation to caregiving, and 3) stimulating Muslim family caregivers to notice what gift Allah gives them in all aspects of their lives, and recognizing all good things that Allah blesses them with.

The participation of the health care team and Muslim family caregivers is also necessary. The information of each Muslim family caregiver must be discussed and subsequently caring activities must be developed together with the health care team, Muslim family caregivers, and their patients.

(4) Implementation

The PD nurses are required to implement a nursing care plan in their practice based on Muslim family caregivers' needs covering all of the five dimensions of being human from an Islamic perspective. Nurses' behaviors showing *response* can be provided continuously during this step. The process of *role modeling* can be conducted.

(5) Evaluation

The outcomes of Muslim family caregivers in all aspects of holistic health must be evaluated using interviews, observation, and questionnaires. *Reflection*

can be used again at this step aimed to encourage Muslim family caregivers to reflect on their caregiving and reconsider the present difficulties and needs in relation to caregiving in all aspects of being an Islamic person.

All activities based on both of these concepts are provided through the process of action research including:

1) Providing an opportunity to nurses and family caregiver to get involved in the decision-making process based on the principle of doing good to humanity.

2) Interpreting of the Qur'an and Hadiths regarding health, illness, healing, family importance, and caring family member.

3) Assisting the family caregivers believe in Allah.

4) Supporting the family caregivers to praise and be grateful to God through the word "Alhamdulillah".

5) Supporting the family caregivers to pray, read, and recite the Qur'an regarding the importance of the family, being a caring family member, and gratitude.

6) Providing the verses regarding the importance of the family, being a caring family member, and gratitude taken from the Qur'an and Hadiths to the family caregivers.

The duration of the implementation of the Islamic thought based caring model in this study will range about 3 weeks so as to effectively increase positive outcomes from previous study (Al-Seheel & Noor, 2016).

In terms of the outcomes of this study, nurse caring behavior is evaluated as the intermediate outcome, whereas caregiver burden and harmony in life of family caregivers are evaluated as the final outcomes respectively.

Firstly, nurse caring behavior will be tackled, as the previous studies showed that nurses experienced barriers to provide holistic care because of lack of knowledge and experience (Carvajal et al., 2019; Green & Kim-Godwin, 2020; Neathery, Taylor, & He, 2020), lack of time, being-task oriented, lack of family involvement, multitude of tasks and roles (Chen, Chan, Chan, Yap, Wang, & Kowitlawakul, 2017; Kenny & Allenby, 2013), lack of conformity with professional norms (Zamanzadeh et al., 2015), lack of communication skills (Carvajal et al., 2019), and unclear organization policy (Burkhart, Bretschneider, Gerc, & Desmond, 2019). One objective of the development of an Islamic-based caring model through technical action research in this study is to overcome these barriers.

Nurse caring behavior suggested in the process of caring (5Rs) and the concepts of gratitude from an Islamic perspective are proposed in the Islamic-based caring model in order to guide the actions of PD nurses in practice. Nurse caring behavior based on the process of 5Rs was described as shown in Appendix F. Furthermore, nurse caring behavior following nursing process was proposed in a holistic Islamic nursing care plan for Muslim family caregiver as shown in Appendix G. If PD nurses provide caring for Muslim family caregivers based on this model, the changes of their caring behaviors will be perceived by the receivers as the results. Therefore, nurse caring behavior changing to prioritize holistic care constitutes the intermediate outcome resulting from the implementation of an Islamic thought-based caring model in this study.

Secondly, caregiver burden is defined as “the extent to which caregivers perceived their emotional, physical health, social life, and financial status as a result of caring for their relative” (Zarit, Reever, & Bach-Peterson, 1980). Burden

was the subjective perception of the caregivers while they were performing caregiving tasks (Pristavec, 2019). In accordance with Islamic perspective, health is achieved by an equilibrium in the dimensions of being human (Alimohammadi & Taleghani, 2015). Whenever some dimensions are disturbed and a person has limitations to care for himself/herself, health impairment will happen. In the case of Muslim family caregivers, there was evident support for holistic effects on their life caused by being a caregiver such as psychological, physical, social, and financial burden. This information indicates that PD nurses need to be relied upon for helping and supporting those family caregivers in all aspects that lead to the development of Islam-based caring model for Muslim family caregivers in this study. There is study supporting the notion that spirituality helped family caregivers find the meaning and purpose in stressful situations, sustaining their psychological well-being, reducing caregiver burden, and other negative feelings (Kim, Reed, Hayward, Kang, & Koenig, 2011). The researcher anticipates that the development of an Islam-based caring model in this study will result in caregiver burden reduction; it is therefore identified as the final outcome for Muslim family caregivers in this study.

Thirdly, harmony in life is evaluated in Muslim family caregivers. It is defined as peace, balance, and rhythm (Easley, 2007), which relates to cooperation, agreement and meditation (Kjell, et al., 2013 as cited in Garcia, Nima, & Kjell, 2014). It also is defined as a part of attributes of holistic practice that leads to harmony, healing, empowering, increased personal development and self-satisfaction, and increased job satisfaction in care-receivers, respectively (McEvoy & Duffy, 2008). The promotion of harmony in nursing interaction will result to benefitting family caregivers (Easley, 2007). For Muslims, harmony is the fundamental aspect (Wani et

al., 2015). The Islamic faith and its holistic direction focus on a way of life that promotes health and harmony of the mind, body and soul (Easley, 2007). That is, holistic caring from an Islamic perspective focuses not only on the physical aspects, but it is concerned with the interrelationship between the multiple dimensions of a being human (Barolia & Karmaliani, 2008; Ismail et al., 2015; Taleghani et al., 2013). This framework leads to the development of Islam-based caring model in this study. Based on previous information, an imbalance caused by being a caregiver and disharmony among all of five dimensions of being human may be experienced by Muslim family caregivers of patients with PD. These are the key nursing problems that the Muslim PD nurses need to address and handle by using the Islam-based caring model proposed in this study. The researcher anticipates that the development of the Islam-based caring model in this study not only results in caregiver burden reduction, but it may improve the balance of all dimensions of being human as well. Therefore, it is identified as the final outcome for Muslim family caregivers. The harmony in life that is expected to be attained in this study will be assessed through qualitative data collection methods including in-depth interview and focus group discussion.

6. Summary

The number of patients with peritoneal dialysis is increasing in developing countries related to the increase of the elderly population. Peritoneal dialysis (PD) is one type of dialysis treatment that is more cost effective than hemodialysis (HD). PD has been promoted as the first choice of therapy in end stage

renal disease patients. Caregivers play roles as the key factor to successfully manage the health in patients who receive PD. Their roles are appraising, advocating, juggling, routinizing, and coaching. While they perform their roles, they may experience burden—both a physical and a psychological burden. The caregiver burdens were influenced by patient-dependence factors such as changes in a patient's health and the dependence of the patient, and caregiver-dependence factors such as lack of social support, duration of care in terms of both the period of being a caregiver and the hours of care per day/week that positively correlated with caregiver burden. While being a caregiver puts one in a position in which one cannot leave, applying strategies for improving positive feelings is more likely necessary.

Focusing on the Southern Thailand, a large population is Muslim. The Qur'an, the Hadith, Sunnah, and Sunnah are used to shape their beliefs and practices in their lifetime. Likewise, taking care of their parents and their elders, caring for family members is a primary responsibility of both the individual and the community in Islamic belief that is instructed by the Qur'an and the Prophet of Islam. Even though Muslim caregivers took care of their receivers guided by the feeling of repaying gratitude as instructed by the Qur'an and the Hadith, they can face negative feelings such as stress, anxiety, and getting tired of caregiving caused by being a long-term caregiver.

In the Islamic perspective, caring focuses not only on the physical aspects, but it is concerned with the interrelationship between the multiple dimensions of a human being or reflecting a holistic care in nursing. Practically, the holistic care for Muslims is infrequently provided by nurses particularly by Muslim family caregivers. Even if there are many previous Islamic thought-based caring

interventions or models, these interventions cannot be absolutely applied in Muslim family caregivers due to all of these interventions being mainly focused on Muslim patients in a specific area, which are different from the context of Muslim family caregivers. Moreover, there are the weaknesses of those interventions in terms of the feasibility of utilization. In this study, a new holistic caring model was developed in order to remedy the weakness observed in previous intervention/models in terms of expanding them to be conducted among Muslim family caregivers, with ease. The model should also be of such a nature that it can be applied by non-Muslim PD nurses, possessing feasibility in practice, and being consistent with Islamic thought aimed to achieve effective implementation in a specific setting.

The activities based on both of these concepts are provided through the process of action research including 1) providing an opportunity to nurses and family caregiver to get involved in the decision-making process based on the principle of doing good to humanity, 2) interpreting teaching of the Qur'an and Hadiths regarding health, illness, healing, importance of family, and caring for family members together involving the nurses as well as the family caregivers, 3) assisting the family caregivers to believe in Allah, 4) supporting the family caregivers and their patients to praise and be grateful to God through the word "Alhamdulillah", 5) supporting the family caregivers and their patients to pray, read, and recite the Qur'an regarding importance of the family, caring for family members, and showing gratitude, and 6) providing the verses regarding the importance of the family, caring for family member, and showing gratitude from the Qur'an and Hadiths to the family caregivers and their patients.

The outcomes of this study were nurses caring behaviors that were evaluated by in-depth interviews and field notes, caregiver burden and harmony in life that was evaluated by in-depth interviews.

Chapter 3

Research Methodology

This chapter describes the methodology used for this technical action research (TAR). The purpose of this study was to develop an Islam-based caring model for Muslim family caregivers of patients with peritoneal dialysis. This chapter covers the following topics: research design, researcher roles, research setting, participants of the study, research instruments, research process, data collection methods, data analysis, trustworthiness of the data, and ethical issues.

Research Design

This study was a technical action research (TAR) performed to create a new caring model based on Islamic perspectives for Muslim family caregivers of patients with PD, which aimed to improve the holistic care of the PD nurses in caring for Muslim family caregivers of patients with PD. A new Islam-based caring model was first developed based on the concepts of caring in nursing from an Islamic perspective formulated by Barolia and Karmaliani (2008) integrated with gratitude within an Islamic thought of Latheef (2013), underpinned by a literature review, and a pilot study. Then, the participants who were engaged in holistic caring for Muslim family caregivers of patients with PD were involved and decided to implement the Islam-based caring model into practice. The technical action research approach described by Kemmis and McTaggart (1988) was used to guide the processes of the study.

The outcomes of the study revealed nurse caring behaviors that were evaluated as intermediate outcome, whereas caregiver burden and harmony in life of family caregivers were evaluated as the final outcomes. The findings from the final evaluation of the model guided the components of the Islam-based caring model.

Researcher Roles

Technical action research is a mode of action research involving the researcher as an identifier of the research problem and initiating the development of a specific intervention (Akram, Mohamad, Meerah, ZamZam, & Abdullah, 2012). The researcher acts as the intervention developer, intervention investigator or facilitator, and participant helper in the processes of the technical action research (Wieringa & Morali, 2012). The researcher roles were described following the process of technical action research covering preparation and action phase starting with reconnaissance and then followed by iterations of planning, action, observation, and reflection as follows:

1. Preparation phase

The researcher took actions as the identifier of the research problem and intervention developer in this phase. A gap in the provision of holistic care of the PD nurses in caring for Muslim family caregivers of patients with PD in practice was identified as a research problem by the researcher in this study. The researcher then initially developed the tentative Islam-based caring model based on theories, literature review, and a pilot study (Figure 3.1).

2. Action phase

2.1 Reconnaissance

The researcher assessed and analyzed the recent holistic caring situations for Muslim family caregivers in terms of relevant activities and practices, social relationships, and organization in order to gain insights and understanding of the situations in the PD unit. The researcher then identified the problem of holistic care of the PD nurses in caring for Muslim family caregivers of patients with PD in the research setting.

2.2 Planning

The researcher used the information obtained from the reconnaissance phase to guide the modification of a tentative Islam-based caring model. Beginning the process of planning, the researcher provided the information regarding holistic caring situations for Muslim family caregivers obtained from Muslim PD nurses, Muslim family caregivers' and their patients' problems and the needs to Muslim PD nurses. The researcher encouraged Muslim PD nurses to reflect on and think about the problems. The possibilities and limitations of their practices were then analyzed and discussed. The researcher then informed Muslim PD nurses including the head of PD nurse about the tentative Islam-based caring model. The tentative Islam-based caring model was given the feedbacks and revised again based on the information from Muslim PD nurses. Before implementation of the model, the researcher encouraged the head of PD nurse to consider what was planned, whether it was practical, important, significant and useful. The researcher assisted the head of PD nurse to revise the action plans and strategies for implementing the Islam-based caring model initially designed by the researcher. The methods of evaluation and monitoring the

implementation of the developed caring model were also collaboratively formulated by the researcher and Muslim PD nurses including the head of PD nurse.

2.3 Action

The researcher acted as facilitator in the implementation the Islam-based caring model in this step. Before the implementation, the researcher facilitated the head of PD nurse to inform the other staff in PD unit regarding the action plans and the Islam-based caring model. The researcher also facilitated all healthcare providers in the PD unit to get involved in the planning of the actions. Two manuals of holistic care for Muslim family caregivers developed by the researcher and related instruments were provided to Muslim PD nurses to be used as a guideline for implementing the tentative Islam-based caring model. Consequently, the researcher continuously took action as the facilitator in encouraging Muslim PD nurses to implement the tentative Islam-based caring model into their practice, and maintaining the collaboration of all participants in the study.

2.4 Observation

In the initial research process, the researcher planned to conduct data collection from Muslim PD nurses and Muslim family caregivers using observation and field notes in an evaluation of nurse caring behavior. However, during the second wave of the COVID-19 pandemic, the visitors faced restrictions in gaining access to the hospital, a move aimed at controlling the transmission of the virus. Therefore, the implementation and the outcomes of tentative Islam-based caring model in cycle 1 were mainly reported by the Muslim PD nurses and Muslim family caregivers.

2.5 Reflection

The researcher evaluated and encouraged the Muslim PD nurses and Muslim family caregivers to reflect and give feedbacks on the outcomes of an Islam-based caring model through face-to-face interviews. Because of the second wave of COVID-19 pandemic, the outside visitors including the researcher were not allowed to visit the hospital. The researcher therefore facilitated the Muslim PD nurses and Muslim family caregivers to reflect and give feedbacks on the outcomes of an Islam-based caring model through telephone in-depth interview only. The researcher also encouraged Muslim PD nurses and Muslim family caregivers to identify additional resources and refine action plans to ensure feasibility and sustainability of implementation of the Islam-based caring model in practice, and then re-evaluate the results.

Research Setting

The setting in recruitment of the Muslim PD nurses who were the key participants of this study were four dialysis units in southernmost part of Thailand. One of four dialysis units was selected to be the setting in an implementation of the Islam-based caring model. This setting is a general hospital which has a dialysis unit providing care for patients with PD based on the guideline of CAPD caring. There were approximately sixty PD patients treated at PD unit during October 2019 to January 2020. They and their family caregivers are mostly Muslim, approximately 75-78%. Most of them have universal health insurance coverage.

There are three PD nurses working at PD unit—where was the setting in an implementation of the Islam-based caring model—including two Muslim and one Buddhist PD nurses. The nursing activities in the dialysis unit include providing information and skills training, home visits at least one time or more in some cases, and follow-ups every 1-3 months in the initial period. The patients and their family caregivers come for follow-up at the dialysis unit on Wednesday every 1-3 months depending on the patients' condition. Other healthcare professionals in this dialysis unit include a nephrologist, a practical nurse, and a nutritionist. The knowledge and the ability to perform peritoneal dialysis are always assessed especially in family caregivers. Each of family caregivers are asked to demonstrate peritoneal dialysis and dressing procedures. They are then given the feedback from PD nurse individually. Additional information is also given to the patients and their family caregivers. Health problems especially in the patients can be assessed such as blood result, blood pressure level, exit wound, complications, and other behaviors related to dietary control and medication management.

Participants of the Study

The participants of the study were PD nurses, family caregivers, and the patients with PD. The key participants were Muslim PD nurses. The associated participants were Muslim family caregivers and their PD patients, and the head nurse of the PD unit.

1. The inclusion criteria of PD nurses who were the key participants were as follows:

1.1 Muslim PD nurses who has provided nursing care for patients with PD in a peritoneal dialysis center in southernmost part of Thailand for at least 1 year, and who can provide intensive experiences in terms of nurse caring behaviors, barriers, and Islamic perspective in relation to holistic caring for Muslims.

1.2 Having nursing license.

1.3 Willing to share the experiences.

2. The inclusion criteria of the associated participants were as follows:

2.1 Inclusion criteria of family caregiver were as follows:

2.1.1 Primary Muslim family caregivers aged at least 18 years old who care for patients who have been undergoing PD for at least 1 month, and who can provide intensive experiences in caregiving in terms of difficulties, solving/coping, and the needs for a holistic care provided by Muslim PD nurses.

2.1.2 Able to communicate, read, and write in Thai language.

2.1.3 Have no cognitive impairments as assessed by Mini-Mental State Examination Thai version (MMSE-Thai 2002).

2.2 Inclusion criteria of patients with PD were as follows:

2.2.1 Muslim patients aged at least 18 years old who have received peritoneal dialysis for at least 1 month, and who can report about intensive experiences in care-receiving from their family caregivers and their needs in relation to caregiving.

2.2.2 Able to communicate, read, and write in Thai language.

2.2.3 Have no cognitive impairments as assessed by Mini-Mental State Examination Thai version (MMSE-Thai 2002).

Data Collection Methods

The data collection methods as identified in the initial research process in this study included individual face-to-face in-depth interviews, focus group discussions, observation, field notes, and the demographic and caregiver burden questionnaires. An audio recorder was used to gather the data during the process of the study.

1. In-depth interview

In-depth interviews were used to collect data from Muslim PD nurses, Muslim family caregivers and their patients receiving PD. In Muslim PD nurses, face-to-face in-depth interviews were used to assess nurses caring behaviors and barriers to providing holistic care in Muslim family caregivers of patients with PD in the reconnaissance step. It was adjusted to telephone in-depth interviews during COVID-19 pandemic to evaluate the outcomes of the tentative Islam-based caring model including nurse caring behavior as well as the strengths and the weakness of the tentative Islam-based caring model implementation in the reflection step.

For Muslim family caregivers of patients with PD, face-to-face in-depth interviews were used to assess their experiences in caregiving, difficulties/problems and solving/coping, and the needs for a holistic care provided by Muslim PD nurses in the reconnaissance step. It was adjusted to telephone in-depth interviews during the COVID-19 pandemic to evaluate the outcomes of the tentative Islam-based caring model including nurse caring behavior, caregiver burden, and harmony in life after implementation of the model in the reflection step.

For patients receiving peritoneal dialysis, face-to-face in-depth interviews were used to assess their experiences in care-receiving from their family caregivers and the other needs requiring assistance from the PD nurses for their family caregivers in the reconnaissance step.

2. Focus group discussion

The data from Muslim family caregivers of patients with PD were also collected through focus group discussions. This method was used to assess Muslim family caregivers' experiences in obtaining holistic care and Islam-based caring provided by the Muslim PD nurses in the ward and their needs in the reconnaissance step.

3. Observation

The observation was initially planned to be conducted for assessment of nurses caring behaviors in providing the Islam-based caring model to Muslim family caregivers of patients with PD in the reconnaissance and observation step. After the COVID-19 pandemic, hospital established restrictive policies with the aim of controlling viral transmission. The visitors including the researcher were restricted to visit the hospital. Therefore, the observation either verbal or nonverbal of caring behaviors was completely conducted before an implementation of the tentative Islam-based caring model in the reconnaissance step. The observation could not be used to assess the nurse caring behaviors in providing Islam-based caring model to Muslim family caregivers of patients with PD during implementation the model in observation step as planned.

4. Field notes

The data obtained from observation were confirmed by the unstructured observation such as through field notes in order to gather the real data. Field notes contained unstructured observation about the daily nursing activities based on the nursing process used in the reconnaissance phase. This reflected the data of providing Islam-based caring model by PD nurses to Muslim family caregivers of patients with peritoneal dialysis.

5. Questionnaires

Questionnaires using in data collection in this study included demographic and caregiver burden questionnaires. The demographic questionnaire was used to collect characteristics of Muslim PD nurses, Muslim family caregivers, and Muslim PD patients in the reconnaissance step. Regarding the caregiver burden questionnaire,-it was planned to be used to evaluate caregiver burden among Muslim family caregivers of patients with PD after implementation of the Islam-based caring model in the reflection step of cycle 3.

However, at the onset of the second wave of the COVID-19 pandemic, Muslim family caregivers and their patients have been restricted to engage in follow-ups at the PD unit as well. The epidemic curve of COVID-19 could not be clearly predicted at that time, which meant it could take a long time. This resulted in causing limitations of the implementation of the Islam-based caring model in Cycle 2 and 3. The next cycle could not be started. The research process therefore was revised to be conducted only through the first cycle. In the end, the caregiver burden questionnaire was not used to come up with a final evaluation of caregiver burden among Muslim family caregiver of patients with PD as planned.

Research Instruments

The fieldwork instruments used in this study were an audio recorder and field notes. The data collection instruments consisted of a demographic questionnaire, interview guide, observation guide, and the caregiver burden questionnaire (Thai version).

Data collection instruments

Demographic questionnaires

The demographic questionnaires consisted of three parts; 1) the demographic characteristics of Muslim PD nurses such as age, educational background, years of working at PD unit, the experiences in relation to holistic care providing, Islamic nursing training, and Islam-based caring providing, 2) the demographic characteristics of Muslim family caregivers such as age, gender, marital status, educational background, occupation, relationship with care recipient, income, duration of caring (hours per day), and duration of being a caregiver , and 3) the demographic characteristics of the patients such as age, gender, educational background, marital status, and co-morbidity.

Interview guides

There were two types of interview guides used in this study including interview guides for in-depth interviews and interview guides for focus group discussions. All interview guides were developed by the researcher and conducted in Thai language.

Interview guide for in-depth interview

There were two interview guides for in-depth interviews. The first in-depth interview guide was used to assess the caring situations and problems and consisted of three parts. The first part was used to assess nurse caring behaviors, holistic caring experiences, and the barriers perceived by Muslim PD nurses consisting of ten questions. The example questions are “What are your difficulties in providing holistic care for Muslim family caregivers?” and “How do you want to develop the Islam-based caring model for Muslim family caregivers?”. The follow-up probes then addressed the “Response, Relationship, Relatedness, Reflection, and Role modeling”. The second part was used to assess Muslim family caregivers’ experiences in caregiving in terms of difficulties/problems, problem solving/coping, and the needs of a holistic care provided by PD nurses consisting of eleven questions. The example questions are “What have you experienced as a caregiver?” and “What caregiving affected your normal life?”. The third part was used to assess the experiences of Muslim patients with PD in care-receiving from their family caregivers and their needs in relation to caregiving consisting of five questions. The example question is “What are your needs for your caregiver?”. The probes then addressed the “physical, psychological, social, and spiritual or belief dimensions” of providing caregiving.

The second in-depth interview guide consisted of two parts. The first part was used for Muslim PD nurses, to assess the strengths, the weakness, and the outcomes of providing the tentative Islam-based caring model into their practice consisting of seven questions. The example questions are “How did your caring behavior change during implementation of the Islam-based caring model?” and “What are your barriers to providing the Islam-based caring model in your practice?”.

The second part was used for Muslim family caregiver after receiving the tentative Islam-based caring model aimed to evaluate the outcomes of the tentative Islam-based caring model on caregiver burden and harmony in life consisting of nine questions. The example question is “How does the change of nurse caring behavior affect your feelings?”. The probes then addressed the “burden and harmony in life”. Both interview guides for in-depth interviews contained face-toface, semi-structured questions followed by probing questions (Appendix B). However, because of the COVID-19 pandemic, the second in-depth interview could not be conducted through face-to-face. It was therefore adjusted to telephone in-depth interview.

Interview guide for focus group discussion

The interview guide for focus group discussions was developed by the researcher. It was used among Muslim family caregivers before implementation of the Islam-based caring model in the reconnaissance step and consisted of twelve questions. The example questions are “How does being a caregiver affect your normal life?” and “What are your needs for reducing your burden?”. The probes then addressed the “physical, psychological, social, and spiritual or belief dimensions” of caregiving. This interview guide was used to assess Muslim family caregivers’ experience in obtaining holistic care and Islam-based caring provided by the Muslim PD nurses and their needs (Appendix C).

Observation guide

The observation was planned to be used for assessment of the nurse caring behaviors in providing an Islam-based caring model to Muslim family caregivers of patients with PD before and during implementation of the model. The observation guide was developed by the researcher. It was composed of two parts

including verbal and nonverbal caring behaviors. The first part consisting of eleven items covers verbal caring behaviors. The second part consisting of eleven items covers nonverbal caring behaviors in combination with unstructured observation such as field notes in order to gather the real data. The unstructured observation covers the daily nursing activities based on nursing process (Appendix D).

The Zarit Burden Interview (ZBI) (Thai version)

The Zarit Burden Interview (ZBI) was planned to be used to evaluate caregiver burden among Muslim family caregiver of patients with PD after implementation of the Islam-based caring model in cycle 3. It was translated into the Thai version by Toonsiri and colleagues (2011) from Zarit and Zarit (1986). They initially translated it into Thai language and then it was examined by three experts: one professional health care worker who has language proficiency in English and Thai and two experts who had experiences of nursing research in order to confirm the content and criterion-related validity. Subsequently, back translation was conducted which was then passed on to the expert who has language proficiency in English and Thai to translate it into Thai again. After that, the instrument was provided to three experts in order to reconfirm content validity. Lastly, it was finally revised based on the experts' suggestions. It consists of 22 items covering 4 aspects of caregiver burden which are personal strain (9 items), privacy conflict (4 items), guilt (5 items), and uncertain attitude (4 items). It uses a 5-points Likert scale ranging from 0 (never) to 4 (nearly always). The higher score indicates severe burden. Reliability from the previous study was .92 (Toonsiri et al., 2011).

Validity and Reliability of the Instruments

There were two groups of research instruments, namely qualitative and quantitative research instruments. Qualitative research instruments included both types of interview guide and observation guide. The quantitative research instrument included the Zarit Burden Interview (ZBI) (Thai version).

Validity

Qualitative research instruments including an interview guide for in-depth interviews and an interview guide for focus group discussions, and an observation guide were examined by three experts consisting of 1) a nurse instructor who is an expert in caring for patients with peritoneal dialysis, 2) a nurse instructor who is an expert in action research (AR), and 3) a Muslim PD nurse who is an expert in caring for Muslim patients with peritoneal dialysis. This was done in order to confirm content validity.

Reliability

The quantitative research instrument—the Zarit Burden Interview (ZBI) (Thai version)—was tried out with ten Muslim family caregivers of patients with PD whose characteristics are the same as those of the participants of this study. The reliability tested by Cronbach's Alpha coefficient was .80.

Research Process

There were two phases in the research process. First, the preparation phase composed of the literature review and pilot study. The literature review aimed to guide the development of a tentative Islam-based caring model designed in accordance with Thai culture and Thai healthcare context. The pilot study aimed to know the setting and conduct a context analysis in order to gain a clear and comprehensive understanding of the organizational and people's culture within Thai healthcare context and culture. Once this was completed, the second phase—the action research phase—was initiated consisting of the process of action research entailing reconnaissance, planning, acting, observing, and reflecting.

1. Preparation phase

The objectives of the preparation phase were to develop a tentative Islam-based caring model and to gain a clear and comprehensive understanding of the real context of organization within Thai culture. There were two steps in the preparation phase including literature review and pilot study.

1.1 Literature review

The literature review was performed focusing on a review on Islam, Islamic thought, caring within Islamic perspectives, and Islam-based caring models or interventions or programs. This involved the books and journals sourced from libraries and databases. A tentative Islam-based caring model was initially developed based on the theory and literature review by the researcher following the concepts of

caring in nursing from an Islamic perspective of Barolia and Karmaliani (2008) integrated with the concept of gratitude within an Islamic thought of Latheef (2013).

1.2 Pilot study

The pilot study was conducted in order to gain a clear and comprehensive understanding of the real context of the research setting, to develop and to test the possibility and feasibility in an implementation of the tentative Islam-based caring model and data collection processes. It also allowed the researcher who was inexperienced in action research to practice in a real situation.

1.2.1 Building rapport

The study began with developing a relationship with the PD nurses in the PD unit by establishing trust and respect, balancing cultural humility with technical humility, and overcoming communication difficulties. The researcher tried to embed herself into a team as member in the setting. In this phase, the researcher acted as an identifier of the problems and developer of the tentative Islam-based caring model. The researcher also gained insights and deeper understanding about the real context of the research setting in terms of working situations, daily nursing practices, and environment.

1.2.2 Development of the tentative Islam-based caring model

The initial tentative Islam-based caring model was modified by the researcher based on the pilot study as shown in Figure 3.1.

1.2.3 Testing the data collection

The researcher tested the interview guides for in-depth interview and observation guides to collect data from the PD nurses. The interview guides for in-

depth interview and focus group discussion were also tested among the Muslim family caregivers and the patients.

The nursing activities under the use of 5Rs integration with gratitude approach in the tentative Islam-based caring model

Response

Physical dimension: The activities of PD nurses are;

- To encourage the family caregivers to express their experiences, to respond to and manage their physical and psychological problems.
- To reinforce Muslim family caregivers to express gratitude or thanks giving to Allah and their care-receivers when they involve in caregiving tasks.

Ethical dimension: The activities of PD nurses are;

- To establish trust, allow and respect the rights/decisions of Muslim family caregivers in planning care, cooperate with the multidisciplinary healthcare team to adjust appropriate caring.

Ideological dimension: The activities of PD nurses are;

- To encourage Muslim family caregivers to provide caring for self, caring for patients, and caring for God.

Spiritual dimension: The activities of PD nurses are;

- To assist the family caregivers to consider that performing caregivers' roles of them is based on the Qur'an and Hadiths regarding family importance, caring family members, and gratitude.
- To encourage Muslim family caregivers to praise and be grateful to God when they do good actions to care-receivers.
- To arrange a time and room to Muslim family caregivers and their patients for praying when they come to follow-up at the dialysis unit.
- To provide and support the family caregivers to pray, read, and recite the Qur'an and Hadiths regarding family importance, caring family members, and gratitude.
- To assist Muslim family caregivers to show remembrance of Allah through the simple words such as Basmillah and Alhamdulillah.

Intellectual dimension: The activities of PD nurses are;

- To provide information about the patients' conditions to the Muslim family caregivers.
- To assist Muslim family caregivers to understand the difficult situations and current their needs, and advise them to manage both physical and psychological problems of them based on Islamic beliefs.

Relationship

The PD nurses establish the relationship with Muslim family caregivers by active listening and communicating with informal technique, friendly interaction, providing information, encouraging family caregivers to express their concerns, establishing trust and respect, and assisting them to cope with difficult situations.

Relatedness

The PD nurses allow the Muslim family caregivers to talk and they are active listening and providing simply touch in recognition of Muslim family caregivers' presence.

Reflection

The PD nurses encourage the Muslim family caregivers to reflect on their experiences and needs in relation to caregiving covering both physical &psychological aspects.

The PD nurses encourage the Muslim family caregivers to reflect on their beliefs and cultural preference related to health beliefs, spiritual practices, and gratitude.

Role modeling

The PD nurses take action as the role modeling for learning and sharing experience in order to change others in a positive way.

The PD nurses help the Muslim family caregivers to seek the role model in relation to caregiving.

Figure 3.1 The tentative Islam-based caring model developed from theory, literature review, and pilot study

2. Action phase

In this phase, all of the 5Rs consisting of response, reflection, relationship, relatedness, and role modeling stated by Barolia and Karmaliani (2008) and the concept of gratitude described by Latheef (2013) were merged into the steps of technical action research described by Kemmis and McTaggart (1988). The steps of technical action research worked through the activities of relationships and relatedness between the researcher and all participants.

2.1 Reconnaissance

1) The researcher began with the development of an intimate relationship with all participants by building rapport, establishing trust and respect, active listening, communicating with informal techniques, and showing friendly interaction. Providing information, encouraging all participants to express their concerns, assisting them to solve the problems, and spending time with them were done.

2) The environment scan was then conducted while spending time with all participants at the dialysis unit. Assessing the context of study setting was analyzed, and insights and understanding were acquired regarding the current situation of the dialysis unit through in-depth interviews, focus group discussions, and observations.

3) The researcher first facilitated the Muslim PD nurses to discuss both theoretical and practical discourse in order to build a key idea. The researcher also encouraged the Muslim PD nurses to reflect on their experiences in relation to providing holistic care among Muslim Family caregivers through face-to-face in-depth interviews, field notes, and observations.

4) The researcher encouraged Muslim family caregivers and the patients with PD to reflect on their experiences in relation to caregiving and care-receiving including the difficulties, the feelings, and the needs through face-to-face in-depth interview. After data saturation was reached, the Muslim family caregivers were encouraged to confirm the information again through focus group discussion. Field notes were also utilized during face-to-face in-depth interview and focus group discussion. The relatedness in this step was promoted by allowing the Muslim family caregivers and the patients with PD to talk while the researcher was actively listening, considering Muslim family caregivers' cultural preference related to health beliefs and spiritual practices, and allowing the Muslim family caregivers and the patients with PD to get involved in planning care.

5) The researcher identified the problems, then modified the tentative Islam-based caring model based on the qualitative data obtained from Muslim PD nurses, Muslim family caregivers, and Muslim PD patients.

2.2 Plan

1) Information regarding the concepts of the Islam-based caring model and technical action research process were passed on to the Muslim PD nurses.

2) All Muslim PD nurses were informed about the problems, relevant activities, and practices in relation to providing holistic care in Muslim family caregivers reflected by Muslim PD nurses in the reconnaissance step.

3) All Muslim PD nurses were informed about the experiences of Muslim family caregivers and Muslim patients with PD in relation to caregiving and care-receiving including the difficulties, the feelings, and the needs.

4) The researcher assisted the Muslim PD nurses assigned to the dialysis unit in the southernmost part of Thailand to establish holistic nursing activities based on the concepts of caring and gratitude and the information obtained from the reconnaissance step, to identify the possibilities and limitations of the situation, and to reflect on the tentative Islam-based caring model.

5) The tentative Islam-based caring model was then remodified again based on the information and suggestions made by the Muslim PD nurses.

4) The remodified tentative Islam-based caring model and action plans were passed on to the head nurse of PD unit of the implementation setting.

6) The action plans of the tentative Islam-based caring model were then modified by the head nurse of PD unit.

7) The methods of evaluation and monitoring the implementation and the outcomes of the tentative Islam-based caring model were then identified by the researcher together with the head nurse of PD unit.

2.3 Action and observation

The researcher still acted as the facilitator in the implementation of the tentative Islam-based caring model into practice by conducting the data collection, and assuring and monitoring participation of all participants in the study. The Muslim PD nurses who work in the dialysis unit at the implementation setting acted as the providers of the tentative Islam-based caring model to Muslim family caregivers. The activities of Muslim PD nurses in this step were as follows:

1) Establishing the relationship with Muslim family caregivers by active listening, communicating with informal techniques, showing friendly interaction, providing information, encouraging Muslim family caregivers to express

their concerns, establishing trust and respect, and assisting them in coping with difficult situations.

2) Having been provided with the action plans obtained from the reconnaissance step, the Muslim PD nurses put these into practice to respond to the concerns/values/beliefs of Muslim family caregivers. The relatedness in this step was promoted by allowing the Muslim family caregivers to talk while Muslim PD nurses were actively listening and by providing simply touch in recognition of the Muslim family caregivers' presence. The duration of providing the tentative Islam-based caring model lasted for three months (12 weeks) based on the information obtained from the literature review and the patient's appointment, which is normally scheduled every three months.

3) During the action and observation step, there was the second wave of the COVID-19 pandemic. Hospital established restrictive policies with the aim of controlling viral transmission. The visitors, including the researcher, were restricted from visiting the hospital. Therefore, the outcomes of tentative Islam-based caring model in terms of changes in nurse caring behaviors were mainly reported by the Muslim PD nurses and Muslim family caregivers.

2.4 Reflection

In the reflection step, the researcher encouraged all participants including Muslim PD nurses and Muslim family caregivers to evaluate, reflect, and give feedbacks on the results of the Islam-based caring model. The strengths and weaknesses of practice were discussed. Role modeling was sought for learning and sharing experiences in order to change others in a positive way. Identification of additional resources and re-planning of new or different actions in the next cycle of

planning, action, observation, and reflection between all participants were also performed in order to ensure probability and sustainability of the implementation of the caring model in practice.

During this step, there was a second wave of the COVID-19 pandemic. Face-to-face in-depth interviews could not be conducted because of visitor restriction policies of the hospital. The researcher therefore facilitated the Muslim PD nurses and Muslim family caregivers to reflect and give feedback on the results of the tentative Islam-based caring model in terms of changes in nurse caring behavior, caregiver burden, and harmony in life through telephone in-depth interviews.

Moreover, the epidemic curve of COVID-19 could not be clearly predicted at that time. This was the cause why the implementation of the Islam-based caring model in Cycle 2 could not be started. Therefore, the researcher decided to revise the research process to be conducted only through the first cycle. The evaluation of caregiver burden among Muslim family caregivers of patients with PD using the caregiver burden questionnaire was not conducted as identified in an initial research process. The initial and revised research processes are presented in Figure 3.2 and 3.3, respectively. The activities of all participants in each step of technical action research are also presented in Table 3.1

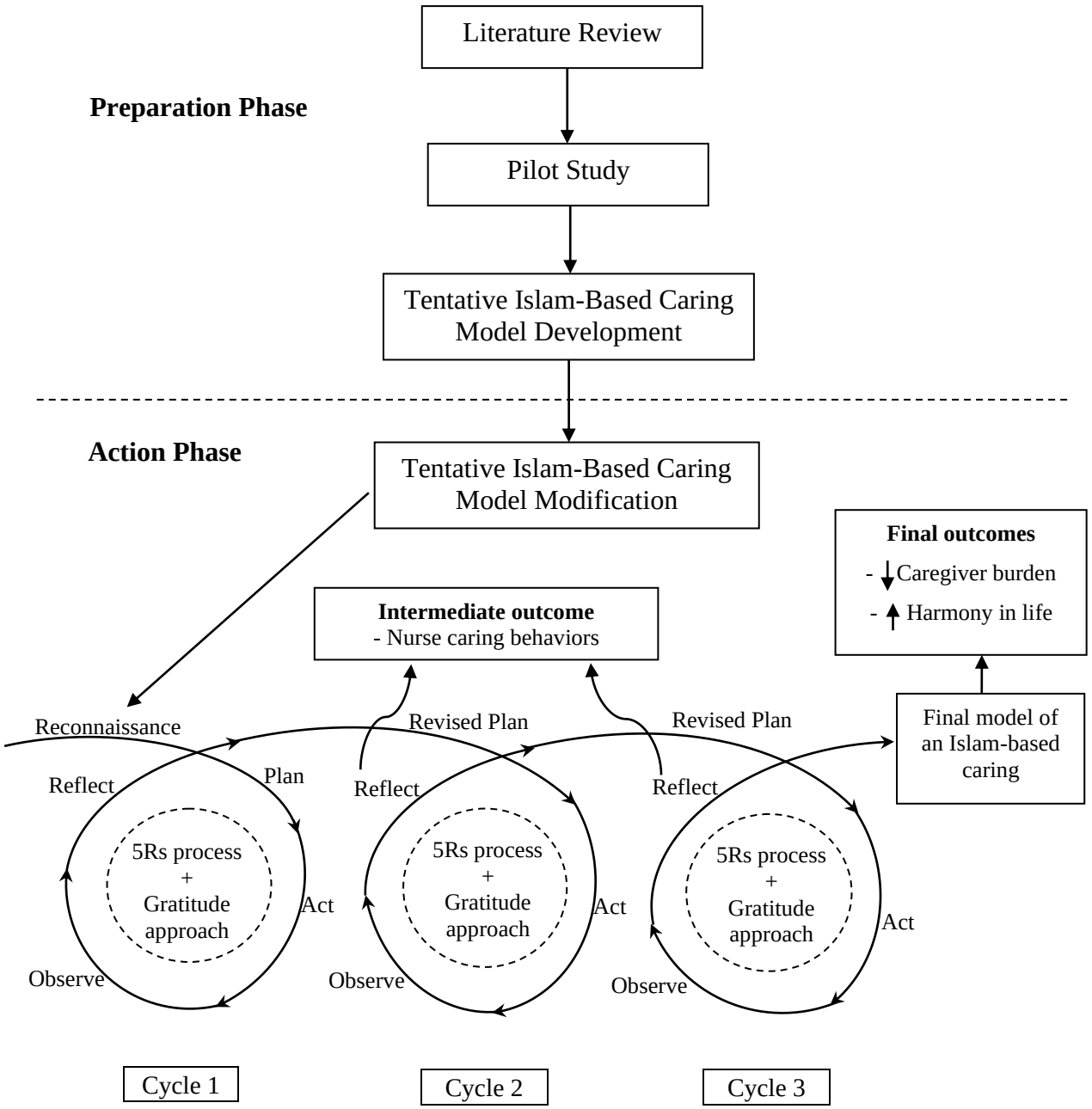

Figure 3.2 The initial research process

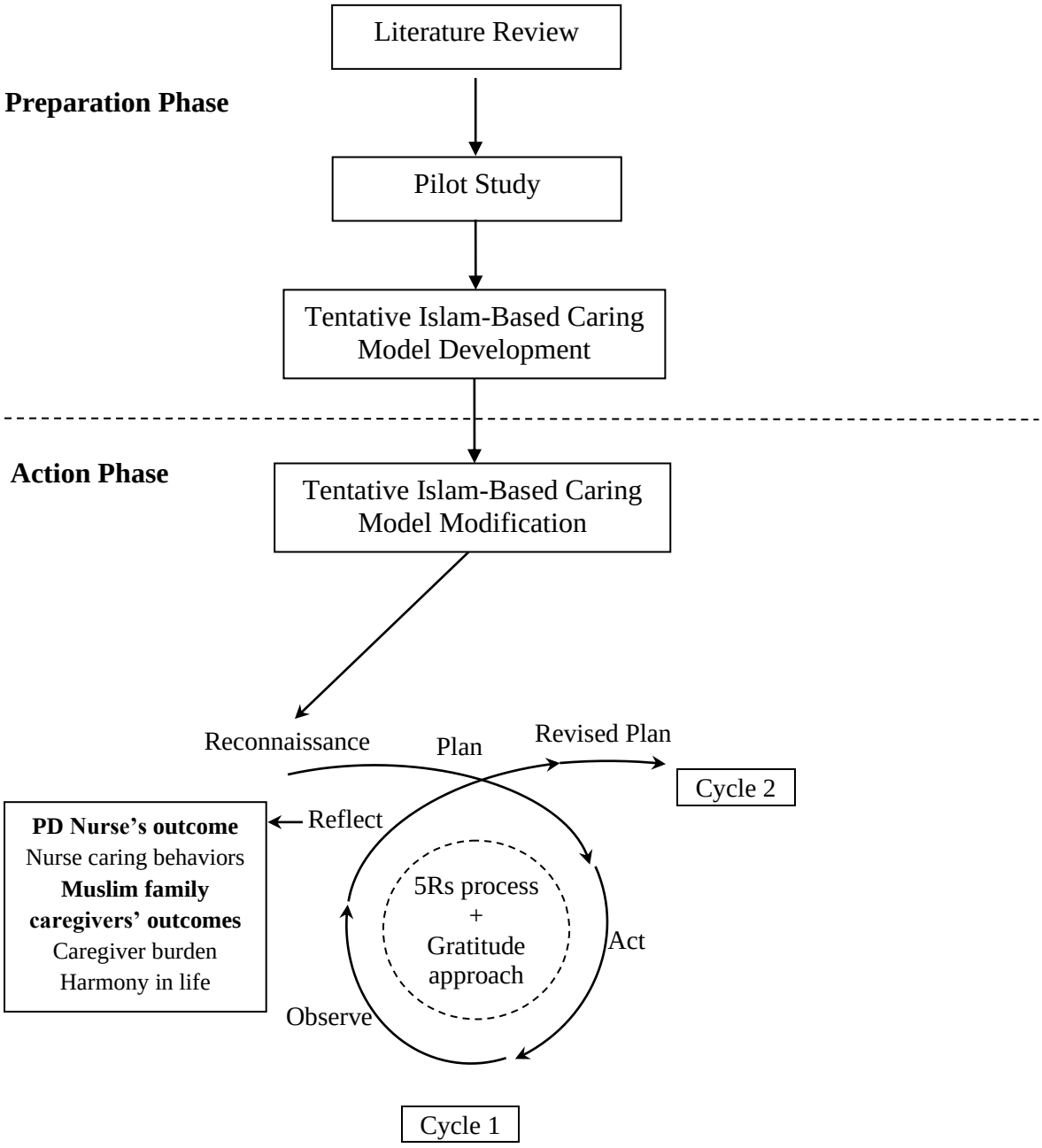

Figure 3.3 The revised research process

Table 3.1 *Key participants' activities in this study separated by action research steps*

AR steps	Researcher	Muslim PD nurses	Muslim family caregivers
Reconnaissance	1. Get to know the setting, culture, and people 2. Establish the intimate relationship with all participants 3. Establishing trust and respect to all participants 4. Conduct the environment scan 5. Encourage all participants to reflect on their experience in relation to caring, caregiving, and care-receiving. 6. Promote relatedness. 7. Identify the problem and analyze recent situation in terms of relevant activities and practices, social relationships, and organization 8. Design tentative Islam-based caring model based on theories and literature review	1. Incorporate with the researcher in discussion about theoretical and practical discourse in order to build a key idea. 2. Reflect on their experience in relation to providing holistic care in Muslim family caregivers.	1. Reflect on their experiences in relation to caregiving and care-receiving. 2. Express their feelings and needs.
Plan	1. Encourage all participants who related to the concerned problem to: 1.1 Reflect and think about the problem 1.2 Consider the possibilities and limitations of the situation	1. Incorporate with the researcher in reflection and thinking about the concerned problem/issue 2. Consider the possibilities and limitations in relation to the situation	1. Share the experiences in caregiving regarding the difficulties/problems and solving/coping, and the patients share the experience in care-receiving. 2. Share the beliefs about health, illness,

AR steps	Researcher	Muslim PD nurses	Muslim family caregivers
	2. Inform the concepts of the Islam-based caring model and action research process to the PD nurses, head nurse, physician, and nutritionist. 3. Encourage the PD nurses to: 3.1 Reflect and revise the tentative Islam-based caring model based on the information from them, Muslim family caregivers and their patients. 3.2 Establish the action plan based on the concept of caring and gratitude 3.3 Create the methods of evaluation and monitoring the implementation and effects of the model.	3. Consider the information about: 3.1 Muslim family caregivers' and patients' health beliefs in the holistic context. 3.2 Interpretation of Qur'an and Hadiths regarding health, illness, healing, family importance, and caring family member. 4. Reflect and give feedbacks on the tentative Islam-based caring model based on the previous information. 5. Revise the tentative Islam-based caring model. 6. Establish the action plan based on the concept of caring and gratitude. 7. Create the methods of evaluation and monitoring the implementation and effects of the model.	healing, family importance, and caring family member as well as norms, cultures, and values based on Islamic context. 3. Interpret of Qur'an and Hadiths regarding health, illness, healing, family importance, and caring family member together between Muslim nurses, family caregivers, and patients. 4. Share about the family caregivers' and their patients' needs in holistic care.
Action & Observation	1. Facilitate the nurses to implement the Islam-based caring model into practice. 2. Conduct data collection. 3. Maintain the participation of all participants in the study. 4. Observe and collect the data. 5. Facilitate the PD nurses to evaluate,	1. Establish the relationship through active listening and communicating with informal technique, friendly interaction, providing information, encouraging family caregivers to express their concerns, establishing trust and respect, and assisting them	1. Use the verses regarding family importance, caring family member, and gratitude from the Qur'an and Hadiths guide their behaviors or actions. 2. Pray, read, and recite the Qur'an regarding family importance, caring family member, and gratitude in order

AR steps	Researcher	Muslim PD nurses	Muslim family caregivers
	reflect and give feedback about the result in term of feasibility in practice and nurse caring behaviors changes.	cope with difficult situation. 2. Promote the relatedness. 3. Respond to the family caregiver based on their values/beliefs/concerns. 4. Provide the activities of an Islam-based caring model to Muslim family caregivers developed based on the concept of caring and gratitude (Figure 3.1) 5. Support the family caregivers to pray, read, and recite the Qur'an regarding family importance, caring family member, and gratitude. 6. Evaluate the outcomes. 7. Reflect and give feedback about the result in term of feasibility in practice and nurse caring behaviors changes.	to reduce caregiver burden and enhance harmony in life. 3. Evaluate the strengths and weakness in obtaining an Islam-based caring model
Reflection	1. Encourage all participants to: 1.1 Evaluate, reflect, and give feedbacks the results of the model. 1.2 Discuss about the strengths and weaknesses of practice 1.3 Identify additional resources.	1. Evaluate, reflect, and give feedbacks the results of the Islam-based caring model. 2. Discuss about the strengths and weaknesses of practice 3. Identify additional resources.	1. Reflect, give feedbacks, and discuss about the strengths and weaknesses of the Islam-based caring model. 2. Evaluate and reflect the effects of the Islam-based caring model on caregiver burden and harmony in life.

AR steps	Researcher	Muslim PD nurses	Muslim family caregivers
	1.4 Re-planning of new or different action in the next cycle 2. Re-evaluate the results and evaluate the final outcomes	4. Re-planning of new or different action in the next cycle 5. Perform as a Role modeling 6. Re-evaluate the results	

Data Analysis

The data obtained from several sources were organized before performing the data analysis. All data sets were transcribed to verbatim transcriptions in Thai from the audio recorder. The data were then transcribed into English for analysis. The researcher read and reread the verbatim transcriptions of each interview several times.

The content analysis approach described by Elo and Kyngäs (2008) was used to analyze the data. First phase was the preparation phase. The researcher analyzed the meaning of words or sentences from manifest content based on research questions and objectives. In then organizing phase, inductive content analysis was selected. In this phase, open coding, categories, and abstraction were created. First, open coding was conducted by using a computer to highlight codes in each line of the data for identification and description of the existing phenomena in the text; usually the name of the codes came directly from the text. Next, codes were grouped into sub-categories by considering relationships between codes based on inductive reasoning. Next, each sub-category was grouped into generic categories by considering similarity or difference. Lastly, categories were grouped as main categories. The name of sub-categories, generic categories, and main categories were created from the content.

The quantitative data were analyzed using frequency in order to describe the demographic information of the Muslim PD nurses, Muslim family caregivers and their patients.

Trustworthiness of the Data

Trustworthiness or rigor refers to the degree of confidence in data, interpretation, and methods of a study indicating the quality of a study (Polit & Beck, 2014). The five criteria of trustworthiness include credibility, dependability, confirmability, transferability, and authenticity.

Credibility

Credibility refers to the truth of the data or the participant views and the interpretation by the researcher. It indicates the confidence in the truth of the study and the findings (Polit & Beck, 2014). Credibility is established through prolonged engagement and persistent observation, member checking, peer debriefing, negative case analysis, and triangulation (Connelly, 2016; Tappen, 2011).

In this study, credibility involved prolonged engagement and persistent observation, member checking, peer debriefing, and triangulation. Prolonged engagement and persistent observation allow sufficient time and opportunity to test interpretation and develop emerging interpretations (Tappen, 2011). In this study, initially the researcher planned to engage and observe the participants' experiences in all processes of the study from the preparation phase until the end of the action phase. Unfortunately, due to the COVID-19 pandemic, the researcher could finally engage and observe the participants' experiences in the preparation phase until the end of the plan step of the action phase covering about six months. During these phases, the researcher tried to embed herself into the team as a member in the setting aimed to

gain insights and deep understanding about the real context of research setting in terms of work situation, daily nursing practice, and environment.

For member checking, credibility was obtained by using focus group discussions of Muslim family caregivers to confirm and validate the findings from their experiences. In this study, focus group discussions were conducted in order to discuss, confirm, and validate the experiences of Muslim family caregivers in caring for patients receiving PD from in-dept interviews.

Peer debriefing is seeking feedbacks from individuals with expertise on the subject and methodology of the study. In this study, the feedbacks from the advisor and co-advisor served as peer debriefing.

Finally, triangulation was used to achieve credibility. *Methodological triangulation* means the use of multiple methods to collect data. In this study, the collection data methods consisted of in-depth interview, focus group discussion, and observations. *Source triangulation* means obtaining different viewpoints. In this study, the information or viewpoints were obtained from Muslim PD nurses, Muslim family caregivers and their patients. *Theory triangulation* means the results can be related to multiple theories. For this study, the findings were draw from the experiences and the literature review.

Dependability

Dependability refers to the stability of the data over time and over the conditions of the study (Polit & Beck, 2014). It can be achieved when another researcher agrees with the trails of each stage of the research process (Cope, 2014). Procedures for dependability are maintenance of an audit trail of process logs and peer debriefings with a colleague. Process logs are the researcher notes of all activities

happening during the study and decisions regarding aspects of the study (Connelly, 2016). Stepwise replication, triangulation, peer examination, and code-recode procedure are suggested as the strategies to establish dependability (Krefting, 1991).

In this study, dependability was obtained through the dependability audit from experts including the advisor and co-advisor. Dense description of research methods and any summaries or ideas that occurred to the researcher during the study were also reported. Additionally, a code-recode procedure was performed.

Confirmability

Confirmability refers to the ability of the researcher to demonstrate that the data reflect real responses from the participants without the researcher's biases or viewpoints (Polit & Beck, 2012). Creditability can be demonstrated by describing how conclusions and interpretations are established and explaining that the results are derived directly from the data (Cope, 2014). Peer debriefing and member checking can also be used to establish confirmability (Connelly, 2016).

In this study, confirmability was demonstrated through providing dense description of research methods and providing several summaries or ideas that occurred to the researcher during the study. The rich quotes from the participants that described each emerging theme were presented in the report. Peer debriefing and member checking were conducted.

Transferability

Transferability refers to the findings that can be applied into other settings or groups (Polit & Beck, 2012). This focused on the characteristics of informants and their story. In this study, transferability was demonstrated by

providing detailed description of the context, location, characteristics and sampling methods of participants of the study.

Authenticity

Authenticity refers to the ability and extend to which the researcher faithfully shows the feelings and emotions of the participants' experiences (Polit & Beck, 2012). Selection of suitable participants for the study and providing a rich and detailed description are strategies to establish authenticity (Connelly, 2016).

In this study, authenticity was achieved through the purposive sampling. The participants who have experiences in accordance with the objectives and the questions of the study were selected. In reporting, the details of selection of participants of the study were provided.

Ethical Considerations

The research proposal was approved by the Institutional Review Board on Research Involving Human Subjects of Prince of Songkhla University (PSU IRB 2019-NSt 009) and by the hospital in which that data were collected (ETA004/62). The researcher selected the participants who met the inclusion criteria and were willing to participate in the study. Before participants provided signed consent, the participants were informed by the researcher about the objectives, processes, disadvantages and benefits of this study. The researcher answered every question the participants asked without hiding anything. The participants were allowed to refuse and withdraw from this study at any time without causing any negative impact on their work or their treatment. Their information was kept secret and was exposed in

the format of findings of the study. It was presented to healthcare provides who were involved in this study. If the study posed a threat to the participants, the researcher solved the issue based on the standards of the hospital.

Chapter 4

Findings and Discussions

This chapter reports the findings and discussion of the study. Technical action research was used as the methodology and the results are based on qualitative data analyzed using content analysis as follows.

1. Demographic characteristics of the participants
2. Process of developing the Islam-based caring model
    - 2.1 Reconnaissance phase
        - 2.1.1 Muslim PD nurses
            - 2.1.1.1 Nurses' perceptions in providing care for Muslim caregivers
            - 2.1.1.2 Barriers to providing holistic care on the part of Muslim family caregivers
        - 2.1.2 Muslim family caregivers
            - 2.1.2.1 Overwhelmed with suffering
            - 2.1.2.2 Coping with negative feelings
            - 2.1.2.3 The needs of Muslim family caregivers
        - 2.1.3 Muslim PD patients with peritoneal dialysis
    - 2.2 The development of a tentative Islam-based caring model
    - 2.3 The implementation of a tentative Islam-based caring model
3. Evaluation of the tentative Islam-based caring model
    - 3.1 PD nurses
    - 3.2 Muslim family caregivers
    - 3.3 Lessons learned

3.4 Suggestions received

4. The initial Islam-based caring model for Muslim family caregivers of patients with peritoneal dialysis

5. Discussion

1. Demographic characteristics of the participants

The key participants were five Muslim PD nurses and the associated participants were thirteen Muslim family caregivers and their ten PD patients. The demographic characteristics of the participants are described as follows:

1.1 Muslim PD nurses

A total of five Muslim PD nurses participated in this study. The ages of the nurses ranged from 33 to 52 years with the average age of 41.80 years (SD =8.01). All of the Muslim PD nurses were female. Four of five had a peritoneal dialysis diploma. Their average work experience in the PD unit was 13.90 years. Three of five had experience in informal Islam-based caring training and often applied Islam-based caring in their practice (table 4.1).

Table 4.1 *Demographic characteristics of Muslim PD nurses (N=5)*

Characteristics	**N**
Age mean = 41.80 years (SD =8.01, Min=33, Max=52)	
Gender	
Female	5
Education	
Bachelor degree	1
Bachelor degree with a peritoneal dialysis certificate	4
Self-report in providing holistic care	
Often	2
All the time	3

Table 4.1 *Demographic characteristics of Muslim PD nurses (N=5) (continued)*

Characteristics	**N**
Experienced in training in Islamic doctrines	
Yes	3
No	2
Experience in providing Islam-based caring	
Often	3
All the time	2

1.2 Muslim family caregivers

A total of thirteen Muslim family caregivers participated in this study (in-depth interviews, n = 10; focus group discussions, n = 4.). One participant participated in both the in-depth interview and the focus group discussion. The average age of the Muslim family caregivers was 38.58 years (SD=13.36). Twelve of the Muslim family caregivers were female. The relationship with the care receivers was child (n=8), spouse (n=4), and relative (n=1). Nearly half of the Muslim family caregivers had a high school education (n=5), followed by primary school (n=4), junior high school (n=2), a peritoneal dialysis diploma (n=1), and a bachelor degree (n=1). Ten were married. Their occupations mostly were farmers (n=5), followed by merchants (n=3), unemployed (n=2), businessperson (n=1), employee (n=1), and housewife (n=1). Their incomes ranged from less than 10,000 Baht (n=7) to 10,000-15,000 Baht (n=3), 15,001-20,000 Baht (n=2), and no income (n=1). Most of the Muslim family caregivers stated that their income was not sufficient (n=7). They

reported spending an average of 12 hours a day on caregiving. The average duration of caregiving was 23.2 months (table 4.2).

Table 4.2 *Demographic characteristics of the Muslim family caregivers (N=13)*

Characteristics	**N**
Age mean = 38.58 years (SD=13.36, Min=20, Max=63)	
Gender	
Female	12
Male	1
Relationship with PD patients	
Child	8
Spouse	4
Relative	1
Education	
Primary school	4
Junior high school	2
High school	5
Diploma	1
Bachelor degree	1
Marital status	
Single	3
Married	10

Table 4.2 *Demographic characteristics of the Muslim family caregivers (N=13) (continued)*

Characteristics	**N**
Occupation	
Farmer	5
Merchant	3
Unemployed	2
Businessperson	1
Employee	1
Housewife	1
Income status	
Sufficient	5
Not sufficient	7
Not specified	1
Duration of being a caregiver average of 23.2 months (SD=27.7, Min=1, Max=84)	
The hours of care average of 12 hours per day (SD=8.08, Min=4, Max=24)	

1.3 PD Patients

A total of ten Muslim PD patients participated in this study. The average age of the PD Muslim patients was 54.7 years (SD =8.90). The number of female and male PD patients was equal. Most of them had a primary school level of education (n =6). All of them were married and had an underlying disease, including hypertension (n=10), dyslipidemia (n=4), heart disease (n=3), diabetes insipidus type II (n=2), gout (n=2), and hyperthyroidism (n=1). The average duration of PD was 36.2 months.

Table 4.3 *Demographic characteristics of Muslim PD patients (N=10)*

Characteristics	**N**
Age mean = 54.7 years (SD =8.90, Min=43, Max=69)	
Gender	
Female	5
Male	5
Education	
Primary school	6
High school	1
Diploma	1
Bachelor degree	1
None	1
Marital status	
Married	10
Underlying disease	
Hypertension	10
Dyslipidemia	4
Heart disease	3
Diabetes insipidus type II	2
Gout	2
Hyperthyroidism	1
The duration of dialysis average of 36.2 months (SD =36.2, Min=3, Max=96)	

2. Process of Developing the Islam-Based Caring Model

The Islam-based caring model was developed through the process of action research beginning with reconnaissance and then followed by a spiral of planning, action, observation, and reflection. The Islam-based caring model was developed during two phases of the research process.

2.1 Reconnaissance

Reconnaissance was conducted in order to identify the problem and to analyze the recent holistic caring situations of the Muslim family caregivers in terms of relevant activities and practices, social relationships, and organizational system aimed to gain insights into the situations in the PD unit through face-to-face in-depth interviews with five Muslim PD nurses, ten Muslim family caregivers, and ten Muslim PD patients, and focus group discussion with four Muslim family caregivers (table 4.4).

Table 4.4 *Main categories derived from Muslim PD nurses, Muslim family caregivers, and Muslim PD patients*

Muslim PD nurses	Muslim family caregivers	Muslim PD patients
1. Nurses' perceptions in providing care for Muslim family caregivers 2. Barriers to providing holistic care for Muslim family caregivers	1. Overwhelmed with suffering 2. Coping with negative feelings 3. The needs of the Muslim family caregiver in caring for his/her loved one	1. Information support 2. Monitoring the family caregivers in providing care 3. Emotional support

2.1.1 Muslim PD nurses

Two main categories were emphasized in this group: 1) nurses' perceptions in providing care for Muslim caregivers, and 2) barriers to providing holistic care.

2.1.1.1 Nurses' perceptions in providing care for Muslim family caregivers

The findings showed that there were three generic categories related to the provision of care for the Muslim family caregivers perceived by the PD nurses.

1) Required nursing competencies

There were three sub-categories of nursing competencies in providing care for the Muslim family caregivers: holistic nursing, cultural and critical thinking competencies. The holistic nursing competencies were reflected in the interaction involving respect, trust, empathy, sincerity, and spirituality on the part of the Muslim family caregivers. Effective communication in terms of friendly interaction, active listening, observing, and paying attention were seen as the necessary skills required of PD nurses. Secondly, in terms of cultural competency, PD nurses should provide care for Muslim family caregivers based on their personal and cultural background, and language and religious and health beliefs. Lastly, critical thinking competencies are required for the assessment and evaluation of the information derived from communication and observation. As two Muslim PD nurse stated:

"While they consulted me…they seemed to perceive that…I had sincerity…I allowed them to express their feelings first while I observed their facial expression…I perceived…nobody was happy…they were stressed…I therefore allowed them to express their feelings first…I was actively listening…after that…I

could initially assess…how their context is…what their problems are …it was different depending on their context." (Nurse, P03)

"For caregivers…I must also pay attention…not only to caregiving tasks…it has to be holistic care…their economic status…family… I have to know everything about them…when they become a caregiver…it helps me to plan easily…where are they working...I have to know…I have to help them to manage their schedules together with their patients and other family members." (Nurse, P03)

2) Islamic perspective in relation to caring

There were two sub-categories of Islamic perspectives in relation to caring: religious beliefs and religious practices. Religious beliefs mentioned by Muslim PD nurses included beliefs in God, belief in the Prophet and the Qur'an, and other Islamic beliefs. Belief in God was explained as referring to faith in Allah and remembrance of Allah. Belief in the Prophet and the Qur'an put emphasis on gratitude and holistic human being. Both of these religious beliefs were identified as those that Muslim PD nurses can encourage while providing care for Muslim family caregivers. In addition, Muslim PD nurses addressed other Islamic beliefs including pilgrimages, fasting during Ramadan, and keeping the body undisclosed. These should be of concern in providing care according to Islam.

Regarding religious practices, prayer for blessing from Allah called "Dua" and reading the Qur'an were mentioned by Muslim PD nurses. Both religious beliefs and religious practices can be used to encourage and manage the negative feelings of the Muslim family caregivers, which can be integrated into the clinical practice of Muslim PD nurses. As two Muslim PD nurse stated:

"In Muslim society, they mostly live with their parents, they easily accept caregiving roles. Muslim strongly trust in Allah, they accepted the patients' illness and turning to Allah. They accepted, so it was easy to deal with them." (Nurse, P03)

"Family caregivers faced more stress related to caregiving. Muslim, prayer is more beneficial, when they pray…they perceived the difficulties as a testing from Allah, testing their patient. Muslim family caregivers who recognized about religious beliefs, they said…they felt better." (Nurse, P01)

3) Expected outcomes in providing care for Muslim family caregivers

Family caregivers' and patients' outcomes were expected in providing care for the Muslim family caregivers. Focusing on the Muslim family caregivers, the Muslim PD nurses anticipated that they should have quality of life. This means that Muslim family caregivers are able to provide long-term effective caregiving with happiness and without "burnout" resulting in the patients' health improvement. Muslim PD nurses need to integrate religious beliefs in relation to health from credible sources into their caring. They mentioned that developing a care model based on religious beliefs was a benefit for them.

"I would like to have a guideline because Muslims are the largest population, approximately 77%, in my setting. But a nurse cannot do without collaboration. Patients, family caregivers, and religious leader should reflect because some beliefs are not completely correct. My knowledge is inadequate. Therefore, we should establish the guideline by analyzing the problem and solving it together with the health care team." *(Nurse, P05)*

2.1.1.2 Barriers to providing holistic care for Muslim family caregivers

In order to gain a clear and comprehensive understanding of the real situation in the peritoneal dialysis unit, the researcher conducted an environment scan and in-depth interviews with five PD nurses. There were three generic categories related to the barriers in providing holistic care as perceived by the PD nurses, including the following: 1) barriers related to Muslim family caregivers; 2) barriers related to PD nurses; and 3) barriers related to the organizational system.

1) Barriers related to Muslim family caregivers

Caregivers are one of the factors that influenced the holistic care provided in practice, especially Muslim family caregivers who engaged in non-self-disclosure. It led to a gap in the communication between Muslim PD nurses and Muslim family caregivers in practice. Muslim PD nurses could not gain insight into personal information resulting in facing difficulties in providing holistic care as perceived by the PD nurses. As two Muslim PD nurse stated:

"During training, we can build the relationship, but we cannot get insight into them because someone is a close-minded person." (Nurse, P02)

"The main problem of Muslims is their beliefs…everything is designation of God…this is the creation of Allah. Thus, we cannot argue." (Nurse, P01)

2) Barriers related to the Muslim PD nurses

Holistic competency was mentioned as the major barrier to providing holistic care. Lack of knowledge and awareness, ineffective communication, poor relationship, and a shortage of PD nurses were illustrated as the barriers to providing effective holistic care for the Muslim family caregivers.

2.1) Lack of knowledge

Lack of knowledge was described in terms of insufficient religious knowledge in relation to health as seen in the statements below:

"As a Muslim, my knowledge… I have not sought the information from the reliable resource yet. I would like to have the guideline because there are Muslims about 77% that is the largest population." *(Nurse, P05)*

2.2) Lack of awareness

Even if the PD nurses were Muslim, they perceived that caregivers' difficulties are a family matter, and the PD nurses cannot manage them. That is, the PD nurses often neglected the psychological problems of the family caregivers, and they sometimes ignored the details of the religious beliefs:

"Caregivers' difficulties are hard to manage because these are a family matter. Something we can suggest, but we cannot support…most caregivers are neglected by PD nurse. In fact, they feel stressed because they experienced caregiving in long term. Someone changed their social roles in order to take care of their loved one. We sometimes ignore them; we only focus on the patients. In fact, the patients' outcomes will be improved depending on caregivers. Therefore, we have to focus on caregiver also, how do they do it? Are they burned out? Psychological support should be continued." *(Nurse, P01)*

2.3) Ineffective communication

Ineffective communication on the part of the healthcare providers was reported as a barrier to providing holistic care. Caring for the caregivers required the involvement of a multi-disciplinary team. Some information may be lost through

ineffective communication, resulting in incomplete holistic care, as a Muslim PD nurse explained below:

"Sharing information within the team is necessary. Because our team includes a few PD nurses. I sometimes knew the information, but my junior does not know. She may lose monitoring." (Nurse, P01)

2.4) Poor relationships between the caregivers and PD nurses

Poor relationships between the caregivers and the PD nurses also were seen to affect the provision of holistic care. This factor is related to the characteristics of the PD nurses. A junior PD nurse described that she was not a talkative person and sometimes it was difficult for her to build a rapport with the caregivers, as can be seen in the following:

"Caregivers who came with patients during the follow-up period were not the person who came to train before. Our relationship is poor because PD nurses can establish relationship with the caregiver during training period." *(Nurse, P02)*

2.5) Shortage of PD nurses

The shortage of PD nurses was a common barrier for holistic care provision. Meanwhile, they have a lot of responsibilities, and the patients normally were more emphasized than the family caregivers.

3) Barriers related to the organizational system

The PD nurses explained that the organizational system was unfavorable to holistic care provision in terms of shift-working conditions. They have no time to fully provide holistic care. One PD nurse stated that "*holistic…it is not complete. In fact, we have to visit them at home. But we have to work at the clinic full-time. We cannot visit at home…we just provide caring in the hospital*." *(Nurse, P01)*

2.1.2 Muslim family caregivers

The experiences of Muslim family caregivers regarding caring for patients with PD were categorized into three main categories: overwhelmed with suffering, coping with negative feelings, and the needs of Muslim family caregivers in caring for their loved ones.

2.1.2.1 Overwhelmed with suffering

Overwhelmed with suffering means that being a family caregiver negatively affects multiple dimensions of the lives of Muslim family caregivers. Being overwhelmed with suffering was described. The participants indicated that when they became caregivers, their lives changed; they felt that their lives were completely full of suffering. This was described through five generic categories: (i) feeling discouraged; (ii) loss of freedom in living; (iii) facing an economic crisis; (iv) experiencing family conflicts; and (v) physical disturbance.

Feeling discouraged

Feeling discouraged refers to the negative feelings resulting from being a caregiver. This was explained through feelings of uncertainty, fear, hopelessness, and helplessness caused by the increase in workload and the lack of improvement in patients' health, as can be seen in the following:

"I'm stressed out, and I'm tired…I have worked all my life… I have worked like everyone else…but it's still not improved. I'm discouraged… sometimes I cried." (Daughter, P05)

"I'm stressed, I take care of him (husband) until I'm exhausted…so much…I'm exhausted…I'm discouraged." (Wife, P09)

During the focus group discussion, the experience of discouragement was expressed by two participants who had to take care of their parents, as illustrated in the following statements:

"*I'm willing to take care of her (mother)…I have to do everything…I'm a fisher…I changed to go fishing at night…and I had to come to take care of my mother in the morning…sometime, I'm discouraged…and I cried…" (Daughter, FG1)*

"For me…I had to take care of both my father and mother…nobody helps me…sometimes, my parents were admitted in different hospitals…I have to hire a caregiver…I also have two children…It's really difficult to manage…sometimes I'm discouraged…I have to do everything." (Daughter, FG4)

Loss of freedom in living

Loss of freedom in living refers to the experience of no longer having the ability to go anywhere as needed. They were more concerned about patients' caregiving. Their lifestyle had to be changed after becoming caregivers. They spent more time with caregiving leading to feeling of losing time for social interaction with others and travel. Living with limitations was perceived, as indicated in the following:

"Before the dialysis started, I used to see my friends. Now, there's no one… I want to see my friends…I want to live like my friends. But I can't." (Daughter, P03)

"I am not social anymore…I don't go anywhere… anywhere. Before becoming a caregiver, I used to hang out with others. But this illness (dialysis) made me…for example, I have to go to my wife's home and return on the same day. I can't travel…When I leave, I have to hurry home." (Son, P01)

Facing an economic crisis

Facing an economic crisis refers to the financial problems caused by taking the caregiver role. This may cause a lower income and the higher cost of care explained by most of the participants. Nearly all of Muslim family caregivers were farmers who generally had a low income. Some quit their jobs since becoming a caregiver which resulted in losing their income entirely, especially those who had no savings, as stated below:

"I quit my job because I had to be a caregiver. That affected my income…I hope to have more income. Now I'm a farmer…It's enough to survive but I don't have any savings." (Granddaughter, P10)

"It's difficult to manage…I'm living hand to mouth… medication money…When we go to the hospital…we spend about 400-500 baht each time…And then transportation expenses…daily life expenses…And if he's admitted… at least 300 baht a day…I am the only one who earns…It's not enough." (Wife, P02)

Experiencing family conflict

Experiencing family conflict means conflict between a family caregiver and his or her family members, and between a family caregiver and his or her loved one. This was expressed especially by Muslim family caregivers who performed caregiving tasks without family support, as a sole family caregiver who was responsible for taking care for her mother alone mentioned:

"Sometimes, I felt irritability…why…they [her brother] push all responsibility to me…I thought…She's our mother… Sometimes, I am angry… why…our mother, why don't they help me to take care of her… I sometimes argue with my brothers." (Daughter, P03)

Physical disturbance

Physical disturbance refers to changes in physical health of Muslim family caregivers during performing caregiving tasks. They mentioned that caregiving affected their physical health in terms of body weight loss resulting from decreased appetite and delayed eating, loss of leisure, and sleep deprivation. Their workload and the patient's illness were the causes of this physical disturbance, as indicated in the following:

"I lost weight. I couldn't swallow anything, like my throat was obstructed, I couldn't sleep, I had no appetite for about 2-3 months. When he was ill, it seemed like I was ill too." (Wife, P09)

2.1.2.2 Coping with negative feelings

Caregivers' coping with negative feelings refers to the strategies that Muslim family caregivers used in dealing with the negative feelings in order to achieve greater harmony in life during performing caregivers' roles. This was described through four generic categories: (i) adherence to religious doctrine and religious practices; (ii) valuing being a caregiver as a child's responsibility; (iii) seeking support and searching for information; and (iv) balancing roles.

Adherence to religious doctrine and religious practices

The participants stated that they are required to take care of their family members. According to the Qur'an, caregiving is an act of kindness or a good deed performed by children for their family members and parents. Caregiving is also a chance to show faith in Allah, gratitude, and love for family. Moreover, the value of religious practices was seen in values during performing caregivers' roles, especially prayers and reading the Qu'ran. During prayers, feeling closer to God, receiving a

blessing from Allah (Dua), and asking God to forgive their sins and bad deeds (Taubah) were performed. Whenever they had aligned their behavior with their religious doctrine and beliefs, and religious practices, they were more willing to accept their roles and achieve harmony in life, as articulated in the following passages:

"Taking care of my parents is one of the highest merits in Islam. Our life is so hard today, but our life after death will be in heaven. Although our life is now so hard, it will be happy in the future…My difficulties are God's test of my faith… I sometimes feel stressed, but after prayer I feel better. It means that I can get closer to God." (Daughter, P05)

Two other Muslim family caregivers stated:

"Love…love (cry)…a new job can be found anytime, but…the parents I can't find anywhere. I lost my job. I lost my money. I have now become a merchant, I get more income than before, this is the reward that he (God) gives to me…I have taken care of my parents, and he (God) returns the reward to me." (Daughter, P06)

"About the bad thing, I think… Allah gives it to me…it comes from Allah. Belief…I really believe even though I cannot see it. I appreciate that…faith…I have faith that if I ask anything, I will get it…I pray for my father. I pray for him to be better and do his duty at Masjid…could pray five times like others. I pray…pray from Allah…Taubah (repentance)…like a forgiveness." (Wife, P09)

Valuing being a caregiver as a child's responsibility

The value of being a caregiver refers to the value of caregiving perceived by Muslim caregivers. Caregiving is valued as the responsibility of a person living with a care-recipient. The youngest children are automatically required to be a

caregiver. When they meaningfully recognised their culture and value, they became more aware of their roles, as stated by the following woman:

"I'm the youngest daughter. My brother and sister are married. I am the only one who lives with him (father). It's my responsibility. Taking care of our parents is our duty." (Daughter, P08)

During the focus group discussion, two participants expressed that being a caregiver was the most valuable role of a Muslim, as illustrated in the following statements:

"In Islam…the religion requires the son to take care of his parents…It has been described in the Qur'an…The son has responsibility in taking care of the parents." (Son, FG3)

"I don't think so…my mother has two sons and two daughters…my two brothers refused to take care of her (mother)…but I didn't blame them…I can do it…taking care of the parents is the duty of children…it's my responsibility." (Daughter, FG1)

Seeking support and searching for information

Seeking support and searching for information refer to the strategies used to ensure stability in the management of caregiving. Other family members, relatives, healthcare providers, and peers were sought during performing caregiving tasks. Family members and relatives were mainly mentioned when Muslim family caregivers needed help in managing caregiving and financial support. Peers' and healthcare providers' support were mainly required when they needed more information regarding caregiving, as seen in the following:

"I have more things to do…spend less time to care for him (husband). Someone has other people to help them…I have no one…if I had someone, they would help me…reduce my workload…I would spend more time with the patient." (Wife, P02)

"They came for a follow-up on the same day. The patients can meet each other. There are caregivers who are the role models. They gave me courage. It's not bad at all." (Son, P01)

During the focus group discussion, two participants described that they consulted healthcare providers when they needed more information about caregiving, as demonstrated in the following statements:

"When my mother got sick…sometimes I had to manage her medicines… I didn't know…I consulted them (PD nurses) by calling…they told me everything." (Son, FG3)

"I had ever called to consult them…I didn't know…how to manage abnormal signs at home…they told me how to solve them." (Daughter, FG4)

Balancing roles

Balancing roles refers to the way that a new Muslim family caregiver used to balance his or her multiple roles while becoming a caregiver. Most of the participants were adults who had multiple roles of responsibility. They tried to keep the balancing of multiple roles associated with caregiving. Revising schedules and managing new lifestyle had to be done. Rearrangement of priorities was identified in order to adjust to their caregiving. The changes of work schedules were done in order to continuously perform caregiving, especially working-family caregivers.

Meanwhile, the changes in educational plans or school schedules were explained by one school-age caregiver, as stated below:

"After my mom became bedridden, I changed my work shifts to night shifts. I can take care of her during the day. Before I go to work, I do dialysis activities at about 7.30 p.m. because my sister can't do it. The dialysate is drained out the next morning when I come back. It's a little too late, but I have to do it like this because my sister can't do it." (Daughter, P05)

"My school schedule was formal at first, then, after my mother got sick, it was changed to non-formal. I would like to take care of my mom." (Daughter, P03)

"I tried to participate in Muslim merit-making, I came back for peritoneal dialysis, then I went back there again." (Daughter, P06)

2.1.2.3 The needs of the Muslim family caregiver in caring for his/her loved one

Healthcare providers' support

The support from the healthcare providers was mainly focused on when they were asked about supporting resources. Focusing on their unmet needs, the Muslim family caregivers reported that they need healthcare provider support by assisting them in performing dialysis tasks in some situations that are difficult for them, in reducing the frequency of follow-ups because of the difficulty in travelling, continuing home visits at least two times a year, and the provision of more information regarding dietary management at home. Moreover, the healthcare providers are required by the Muslim family caregivers to provide emotional support that helps them to be comfortable in performing their caregiving.

"It seems…I don't know…how much she can eat…what can she eat…or…after dialysis…I got less dialysate…I need more information…It may be provided through brochure…I need more information about vegetables and fruits that she can eat." (Granddaughter, P10)

A participant who is a sole Muslim family caregiver stated:

"I need a nurse or other health care providers…sometimes I have to go out of town for a few day…I don't have a second caregiver or relatives…I need a nurse or health care staff to help in dialysis…only when I'm not available." (Wife, P04)

A participant expressed the needs after starting peritoneal dialysis during the first two or three months, as illustrated in the following statements:

"At the beginning of performing dialysis…I need encouragement…I need some suggestions…but…when I do it for a long time…I can do it…I'm confident." (Daughter, P08)

Family/relative support

Family members, including the care receivers, other family members, and relatives, are required to support family caregivers in the matter of the reduction of workloads and financial support. Some Muslim family caregivers need to keep a balance between their life and caregiving tasks; they tried to find new work in accordance with their caregiving responsibilities; and they need to have time for socialization with friends, and they cannot manage that without family member support.

"I have to do everything…these make me take less care of him…someone has another family member to support…but I don't…if someone can

help me…my work load will be reduced…I can spend more time with caregiving." (Wife, P02)

"The first three to four months after being a caregiver…I did everything…after that…my mother has helped me…I have to work…when my mother has helped me in caregiving…I can work for earning." (Daughter, P06)

Peer support

Peer support is important for Muslim family caregivers. Especially in the peer group meetings, they expressed that peers can take action as the supporter in aspects of social and emotional support. They can benefit from others' life experiences in terms of obtaining more information and encouragement from others in the peer group meeting.

"I need…meeting…at least one time a year…both the patients and family caregivers…caregivers can share their experiences…talking and asking…when we meet…we can share the ideas." (Daughter, P07)

"When we met…we already had the role model who is successful in caregiving…He/she gave me the encouragement…it's (being a caregiver) not bad." (Son, P01)

2.1.3 Muslim PD patients

The PD patients' experiences in care receiving from their caregivers were assessed in terms of their satisfaction and the needs of the family caregivers. Most of the PD patients were satisfied with the care that they received and appreciated their family caregivers as well as the PD nurses. Regarding other needs for their family caregivers, the results are summarized as follows:

2.1.3.1 Information support

In the earlier phase of caregiving, especially within the first two months, most of the patients perceived the caregivers' doubt about their caregiving. The patients therefore paid more attention to the information provided by the PD nurses after being discharged and sent home. The required information included dialysis tasks and management, caregiving tasks, the patients' health and emotional changes, complication monitoring, and supporting resources. The strategy for providing information frequently suggested by the patients was home visits, either face to face or *via* telephone calls. An easily accessible communication system was also recommended to be developed.

"We sometimes have the problems…they (PD nurses) allow us to call first…sometimes they (PD nurses) can help…we need to consult something…they previously provided it…but…it's not enough." (Patient, 03)

"I need…they (PD nurses) suggest them something…what is to be done…monitor…food…what can the patient eat…what cannot…I want them (PD nurses) to advise on the changes of lifestyle…what are to be changed…before and after starting dialysis." (Patient, 04)

2.1.3.2 Monitoring the family caregivers in providing care

Due to being a new caregiver, the patients perceived that their caregivers may not be confident in providing caregiving and management. Providing care, having difficulties, and the problem solving of the caregivers needed to be monitored by the PD nurses. These covered dialysis procedures, dialysate, diet, the environment, and instrument management in a real context. The strategy for

monitoring family caregivers in providing care frequently suggested was home visits, either face to face or with telephone calls.

"I need PD nurse to go to monitor… caregiving activities of caregiver…what does he (son) do…right or wrong…dialysis performing." (Patient, 01)

"I need them (PD nurses) to monitor…caregiving performing…how does she (wife) do…she should be strict as before…they always should remind her." (Patient, 02)

2.1.3.3 Emotional support

Some of the PD patients perceived that their family caregivers were not willing to be a caregiver. Reminding them about religious beliefs and gratitude in relation to caregiving by the PD nurses may encourage them to become an effective caregiver. In addition, some of the patients perceived that family caregivers may experience negative feelings such as fear, stress, and lack of confidence. Religious practice, including prayer, was suggested to the PD nurses for encouraging the family caregivers, aimed at decreasing negative feelings. Friendly language was also required in emotional support.

"At PD unit…they (PD nurses) can provide religious beliefs related to being a caregiver…for example…religious doctrine…gratitude…they can integrate these into psychological caring…encourage them (caregivers) to continuously take caregivers' roles." (Patient, 03)

2.2 The development of the tentative Islam-based caring model

The tentative Islam-based caring model was initially developed based on a literature review and information obtained from the pilot study. The process of

the 5Rs in the concept of caring from an Islamic perspective of Barolia and Karmaliani (2008), which incorporated the gratitude approach within an Islamic thought of Latheef (2013) were integrated into the model in order to guide the actions of Muslim PD nurses in practice (Appendix F).

In the reconnaissance step, the data showed that being a caregiver has holistic effects on the Muslim family caregivers' life. This result confirmed that Muslim family caregivers also need caring from PD nurses. After data analysis, the result showed that the main participants involved in applying the Islam-based caring model in this study included Muslim PD nurses and Muslim family caregivers. Muslim PD nurses are required to possess the essential nursing competencies such as holistic nursing, cultural and critical thinking competencies.

Regarding Muslim family caregivers, the information obtained from Muslim family caregivers and Muslim PD patients supported that there were several determinants of suffering especially during the first three months after becoming a caregiver including the increase in workload, lack of improvement in patients' health, facing negative feelings such as discouragement, uncertainty and fear in relation to caregiving and the patients' illness, physical disturbance, and lack of support. After three months, most Muslim family caregivers expressed that they were more confident in performing dialysis tasks, as it had become familiar to them. However, some negative feelings still persisted continuously such as hopelessness and helplessness. Moreover, other problems may dominantly show up in family caregivers' lives such as loss of freedom in living, reduced social interaction and travelling, facing an economic crisis, and family conflicts. This information indicated that there were differences in terms of the difficulties and the needs between Muslim

family caregivers who provided caregiving less than or equal to three months and those who provided caregiving for more than three months. Therefore, the Muslim family caregivers were divided into two groups in this model consisting of being a family caregiver for less than or equal to three months and being a family caregiver for more than three months. This aimed to determine the holistic nursing activities that are consistent with their difficulties and needs as much as possible.

Focusing on the holistic care of Muslim PD nurses in this study, a gap in providing holistic care to Muslim family caregivers was revealed that was mainly caused by the barriers related to the PD nurse. Insufficient religious knowledge, lack of awareness, ineffective communication between healthcare team, poor relationship between the caregivers and PD nurses, and shortage of PD nurses were described by Muslim PD nurses. The first four of five barriers can be remedied through the development of a new Islam-based caring model proposed in this study. Encouragement of Muslim PD nurses to focus on the Muslim family caregivers' caring by increasing knowledge and awareness and improving the practices concerned with holistic caring in Islam was the first objective specified into cycle 1.

The information about Muslim family caregivers' difficulties and the needs obtained from the reconnaissance step were considered in re-determining the holistic nursing activities of each step of nursing process covering five dimensions of being human. The barrier of ineffective communication between healthcare team was dealt with through conducting health professional meeting and providing family caregiver information record forms. The actions of Muslim PD nurses based on the 5Rs process, especially *relationship* and *relatedness* were emphasized within the holistic Islamic caring process in this model aimed to reduce the barrier of poor

relationship between the caregivers and PD nurses. Other three Rs in the process; *response*, *role modeling*, and *reflection* were also applied into the holistic Islamic caring process aimed at keeping a balance of the five dimensions of being human according to Islam as described by Barolia and Karmaliani (2008).

In addition, the information on the Islamic perspective in relation to caring and caregiving obtained from Muslim PD nurses and Muslim family caregivers was applied into the holistic Islamic caring process for guiding the actions of Muslim PD nurses. When providing holistic Islamic caring to Muslim family caregivers, it is suggested that the latter should be made aware of religious doctrine and beliefs and religious practice in relation to caregiving.

Lastly, regarding the expected outcomes obtained from Muslim PD nurses, caregivers' health is referred to as having a quality of life and providing long-term effective caregiving with happiness and without burnout. These results are consistent with health described from Islamic perspectives, which is defined as an equilibrium in the dimensions of being human. Therefore, caregiver burden reduction and harmony in life are determined as the final outcomes resulting from providing the holistic Islamic caring process.

In summary, the tentative Islam-based caring model consists of three components. First component is inputs, which are essential PD nurses' competencies such as holistic nursing, cultural and critical thinking competencies, and the Muslim family caregivers that are the primary family caregiver (≤ 3 months and > 3 months). Second component is the holistic Islamic caring process, the nursing process (assessment, diagnosis, planning, implementation, and evaluation) integrated with the 5Rs (response, reflection, relationship, relatedness, and role modeling), and the

gratitude approach, underpinned by religious doctrine and beliefs and religious practices (prayer, fasting, and pilgrimages) covering the five dimensions of being human according to Islam (the physical, ethical, ideological, spiritual, and intellectual dimensions) (Appendix G). Essential strategies have been used in this process that include health professional collaboration, family meetings, peer group support, and home visits. Third component is the outcomes, including nurse caring behaviors, the caregiver burden, and harmony in life of Muslim family caregivers (Figure 4.1).

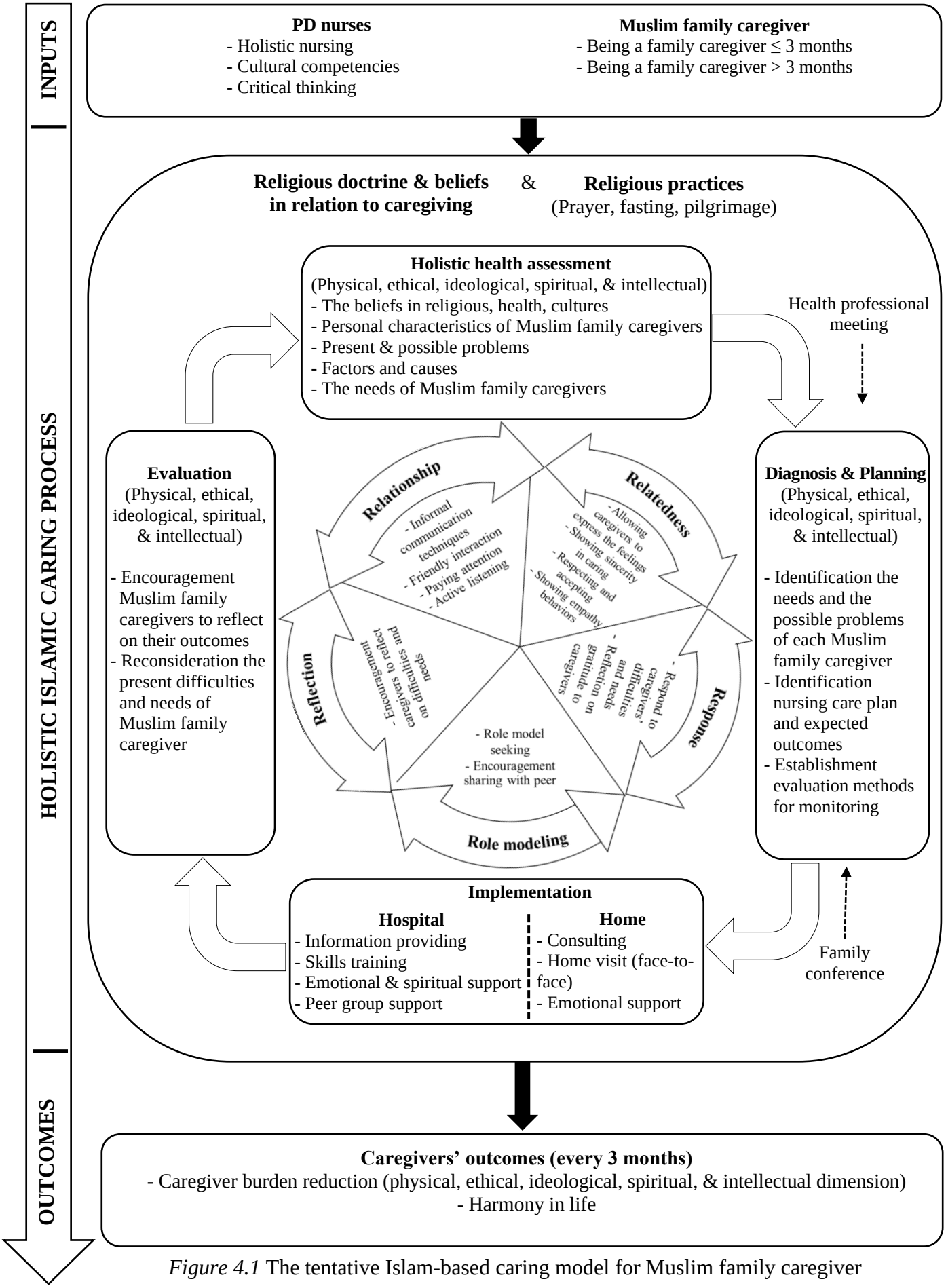

Figure 4.1 The tentative Islam-based caring model for Muslim family caregiver

The tentative Islam-based caring model was implemented, evaluated, and revised through the TAR cycle as seen in Figure 4.2.

Cycle 1: Implementing and evaluating the tentative Islam-based caring model to encourage PD nurses to focus on the Muslim family caregivers' caring: increasing knowledge and awareness and improving the practices concerned with holistic caring in Islam.

Implementation and evaluation of the tentative Islam-based caring model in cycle 1.

The background problems in this cycle were grouped into two main parts: the caregiving situation and barriers to providing holistic care. The caregiving situations described by the Muslim family caregivers and their PD patients were: facing holistic effects and not having their needs met. The barriers to providing holistic care consisted of three main groups: Muslim PD nurses, Muslim family caregivers, and the organizational system. The Muslim PD nurses had insufficient knowledge, lacked awareness, exhibited ineffective communication within the team, had poor relationships with the Muslim family caregivers, and there was a shortage of PD nurses. Regarding the Muslim family caregivers, there was poor communication between the PD nurses and them. Additionally, in terms of the organizational system, the limitations of the shift-working conditions were mentioned.

(1) Plan

Based on the problems in providing holistic caring for the Muslim family caregivers, the Muslim PD nurses and the researcher collaboratively formulated action plans and strategies for the Islam-based caring model to be implemented (table 4.5). It was agreed that the aims of this cycle were to increase

knowledge and awareness and to improve the practices concerned with holistic caring in the Islamic context. The action plans began with discussing the information about the Muslim family caregivers' problems and the needs of the Muslim PD nurses that work in the dialysis unit, as well as the concepts of holistic caring in Islam. Then, the tentative Islam-based caring model that was first modified by the researcher was explained to the Muslim PD nurses as well as the action plans and related instruments that were first designed by the researcher for modifying and considering possibilities and limitations of the setting for the implementation of the model. The methods for evaluating and monitoring the implementation of the model were identified by the researcher together with the head of PD nurse.

All of the Muslim PD nurses approved the tentative Islam-based caring model as modified by the researcher. The action plan and related instruments were modified based on the information and suggestions from the head of the PD nurses. Before implementation of the tentative Islam-based caring model, a manual of holistic care for Muslim family caregivers (Appendix H) and a manual for holistic care for Muslim family caregivers: individual guiding (Appendix I), were established, aimed to guide the holistic care for Muslim family caregivers who provided caregiving for less than or equal to three months and those who provided caregiving for more than three months respectively. The head of the PD nurses then presented the model, the action plan, and related instruments to all of the healthcare providers in the PD unit, such as general PD nurses, practical nurses, and nutritionists for promoting collaboration in applying the model in practice. A healthcare provider meeting was considered for communicating within the healthcare team.

Table 4.5 *Action plan of Islam-based caring model*

PD UNIT	
Holistic Needs Assessment	1. Assess the religious beliefs, health, culture, and personal characteristics of Muslim family caregivers during the first visit by face-to-face interview. 2. Assess recent and possible problems, factors and causes in relation to caregiving management covering holistic aspects of Islam by interview, observation, the caregiver burden questionnaire, and harmony in life questionnaire in all the time. 3. Assess the Muslim family caregivers' performances in caregiving management by interview and observation all the time.
Holistic Care Plan	Holistic care plan for Muslim family caregivers (individual) **A new Muslim family caregiver (≤ 3 months)** 1. Pre-conference the information of the Muslim family caregivers with other staff members before the meeting. 2. Identify the possible problems and needs of each person. 3. Set goals of caring and the nursing care plan for the Muslim family caregivers together with the team, and record this in *the assessment form* for communicating with others in the team. 4. Establish expected outcomes and evaluation methods for monitoring all the time. 5. Collaborate with the Muslim family caregivers, the patients, and/or other family members in developing and managing a care plan as well as seeking solutions for preventing and solving possible problems of the family caregivers based on the family center in decision-making and planning. 6. Care and help the Muslim family caregivers in holistic aspects corresponding to the problems and needs of the Muslim family caregivers based on their beliefs, culture, and individual characteristics (see *the manual of holistic caring for Muslim family caregivers*). 7. Support the Muslim family caregivers in terms of sharing their experiences with others. 8. Develop consulting systems while caregiving in the home. 9. Provide information such as the manual, brochure, knowledge sheets, and a video about Islamic beliefs in relation to caregiving.

PD UNIT	
	Being a Muslim family caregiver more than three months 1. Pre-conference regarding the information of Muslim family caregivers with other staff members before the meeting (selected cases). 2. Identify the possible problems and needs of each person. 3. Reconsider the goals of caring and the nursing care plan for Muslim family caregivers together with team, and record this in the assessment form for communicating with others in the team. 4. Establish expected outcomes and evaluation methods for monitoring during each follow-up. 5. Care for and help Muslim family caregivers in holistic aspects corresponding to their problems and needs based on their beliefs, culture, and individual characteristics (seeing *the manual of holistic caring in Muslim family caregivers: individual guiding*) 6. Collaborate with the multi-disciplinary team for continuing care (if necessary).
Implementation	1. PD nurses and team implement the action plan for the Islam-based caring model by using the instruments as follows: 1.1 The manual of holistic caring for Muslim family caregivers 1.2 The manual of holistic caring in Muslim family caregivers: individual guiding 2. PD nurses and team implement the action plan of Islam-based caring model by using the strategies as follows: 2.1 Pre-conference with other staff members on Tuesday every week aimed to: 2.1.1 Discuss and identify possible problems and the needs of each person. 2.1.2 Set goals of caring and nursing a care plan for Muslim family caregivers together with the team. 2.1.3 Establish expected outcomes and evaluation methods for monitoring at every follow-up. 2.2 The family conference aims to encourage family members to participate in the caregivers' caring and to seek solutions for preventing and solving possible problems.

PD UNIT	
	Being a new Muslim family caregiver (≤ 3 months) 2.2.1 1st time: Before beginning peritoneal dialysis (done) 2.2.2 2nd time: After beginning peritoneal dialysis for one to two weeks (done) 2.2.3 3rd time: After beginning peritoneal dialysis for six months **Being a Muslim family caregiver more than three months:** Every six months (the date of transfer set changing) 2.3 The self-help group conducted by multi-disciplinary teams every month aims to encourage Muslim family caregivers to share their experiences in caregiving with others. 3. Establishing consulting distancing (Line application) 4. Providing information such as the manual book, brochure, knowledge sheets, and video about Islamic beliefs in relation to caregiving
Evaluation	1. Evaluate the outcomes of the Muslim family caregivers in all aspects of the holistic human being continuously while they visit the hospital. 2. Evaluate the caregiver burden every three months or every time at follow-up by interviewing and *via* questionnaire assessment. 3. Evaluate harmony of life every three months by interviewing and *via* questionnaire assessment.

Home period	
Holistic Needs Assessment	Assess the information of the Muslim family caregivers covering physical, psychological, social, and spiritual aspects as follows: 1. Family status, the acceptance of Muslim family caregivers and their family in caregiving management, and supporting resources 2. Life style and the coping of the Muslim family caregivers 3. Dialysis procedures and wound dressing skills 4. Environment

Home period	
Holistic Care Plan	**Holistic care plan for Muslim family caregivers** 1. Coordinate with the Muslim family caregivers and primary healthcare teams for home visit planning. 2. Conduct home visits for a new Muslim family caregiver one month after discharge by the PD nurses or primary healthcare teams for assessing the Muslim family caregivers' problems and practices the home visit will be conducted again if needed. 3. Develop home visits at a distance using a telephone or the Line application together with the home healthcare team. 4. Develop continuing home care systems. 5. Organize a workshop to provide knowledge about peritoneal dialysis to the primary healthcare team such as general nurses and healthcare volunteers at least one time a year for reviewing and encouraging home visits continuously.
Implementation	1. Face-to-face home visits 2. Home visits at a distance through the telephone or Line application every month
Evaluation	1. Evaluate the outcomes for the Muslim family caregivers in all aspects of the holistic human being continuously during home visits. 2. Evaluate the caregiver burden and harmony in life every three months by interviewing.

(2) Action and observation

The PD nurses were encouraged to implement the model continuously. The researcher was the facilitator of the implementation of the tentative Islam-based caring model in practice, of conducting the data collection, and for assuring and monitoring the participation of all participants in the study. The tentative Islam-based caring model was provided to six Muslim family caregivers by the Muslim PD nurse and related healthcare providers who work in the dialysis unit at the setting where the

study was implemented. During this step, there was a second wave of the COVID-19 pandemic. Visitor restriction policies of the hospital were established for controlling disease transmission. The researcher could not visit the implemented setting. The observation of nurse caring behavior therefore could not be conducted by the researcher. This outcome was instead reported by the Muslim PD nurses and Muslim family caregivers.

(3) Reflection and evaluation

Reflection was a part of the action phase in cycle one. Evaluation of the outcomes of the tentative Islam-based caring model implementation was gathered from the Muslim PD nurses, including the changes in nurses' caring behaviors and Muslim family caregivers, including caregiver burden and harmony in life. The strengths and weaknesses of the model and practices were also discussed. Additional resources and re-planning of new actions for the second cycle were redesigned in order to ensure the probability and sustainability of the implementation of the model in practice. All of the information and outcomes were planned to collect using face-to-face in-depth interviews. However, because of the second wave of the COVID-19 pandemic, the outside visitors were restricted from visiting the hospital. The researcher therefore adjusted the plan to collect all of the information and outcomes through telephone interviews. The phase of cycle one took three months.

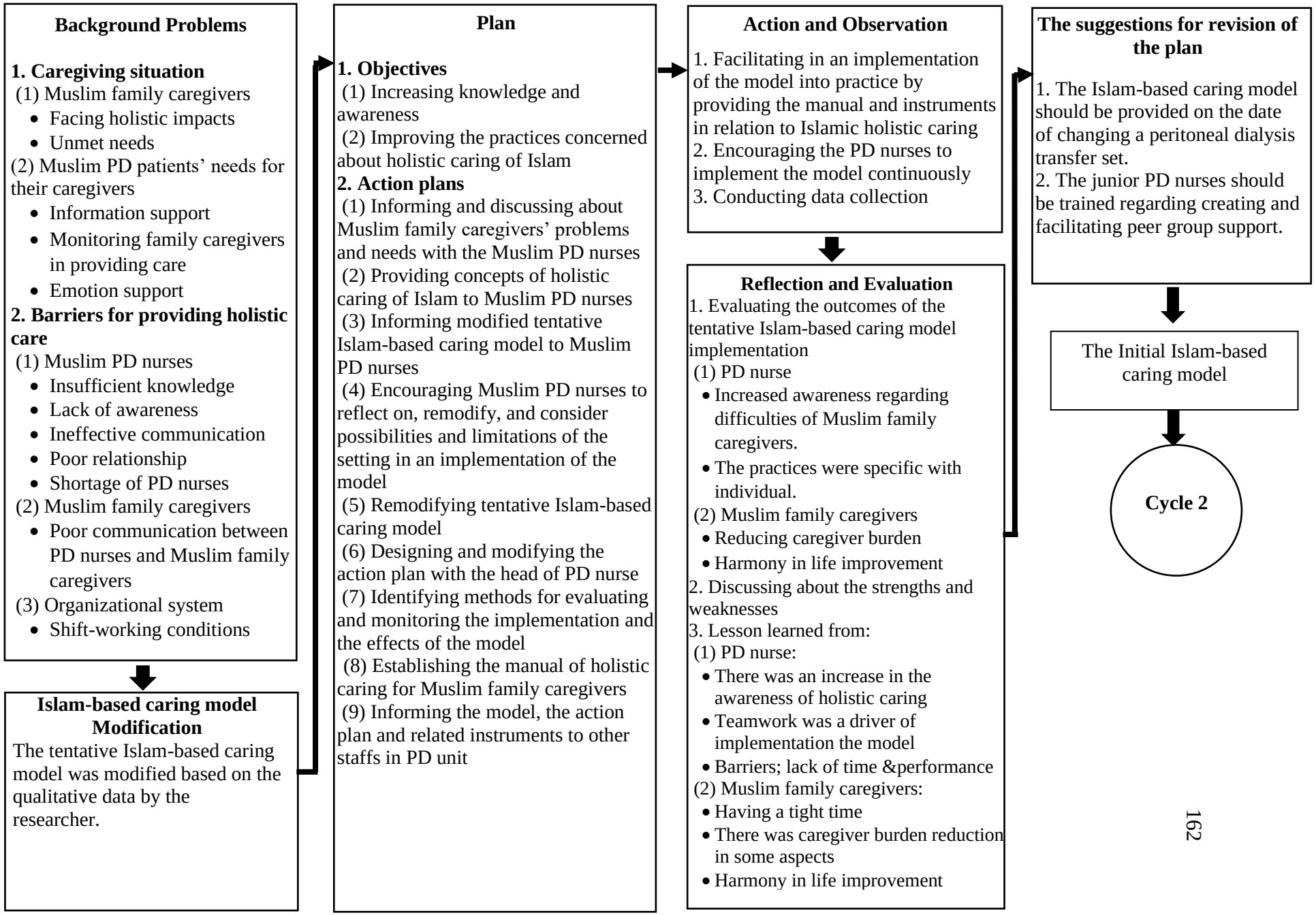

Figure 4.2 Cycle 1 Implementing and evaluating the tentative Islam-based caring model (three months)

3. Evaluation of the Tentative Islam-Based Caring Model

The results in the first cycle of the implementation phase were from the Muslim PD nurses and the Muslim family caregivers.

3.1 Muslim PD nurses: The Muslim PD nurses' experiences in the implementation of the Islam-based caring model are summarized as follows:

3.1.1 Increased awareness regarding the difficulties of Muslim family caregivers

According to the Muslim PD nurses, there were slight changes in their normal practice during implementation of the tentative Islam-based caring model. They were more aware and focused on the difficulties of the Muslim family caregivers. Holistic care was a concern in the care planning, as indicated below:

"I sometimes gave the information…I told them…focused only on your health…during performing caregiving roles…how do you feel…focused on your feelings…then I gave him/her time for considering without pressure…I think…we did not only focus on the patients…we paid attention to family caregivers as well. All of us at the clinic provided caring for the family caregivers as the holistic…we were concerned with their problems…how they do…how they come to the hospital…we did not take care of only one aspect. We tried to take care of them as a holistic human being." (Nurse, P01)

The changes in the nurses caring behaviors were described by the Muslim family caregivers—that the Muslim PD nurses provided care with friendly interaction. Informal communication using local language with a polite tone was

perceived. They felt that the relationship between the Muslim PD nurses and them was improved, as suggested in the following:

"They paid attention to me…asking…attention…politeness…and they used easy-to-understand language…they used local language…easy to understand…they spoke the same language as me… if they used formal language…sometimes…I had the difficulty to answer. (Husband, P03)

Another Muslim family caregiver stated:

"They paid attention to both patient and caregiver…they asked about caregiving…the nurses were good…everyone…caring…talking…friendly…being sociable…they greeted…they greeted us first…they used local language…it was friendly." (Wife, P01)

The Muslim PD nurses were more focused on the Muslim family caregivers' problems. They paid attention by asking questions and allowing the Muslim family caregivers to describe their problems and negative feelings that made them satisfied in receiving care in terms of a relaxed situation, feeling comfortable in expressing their feelings about their difficulties, and encouragement of social interaction, as seen in the following:

"We were talking…they asked me about the feelings related to caregiving…they always asked me but now they asked me more than before…there were more details than general discussion as before." (Wife, P02)

3.1.2 The practices were specific to the individual.

The tentative Islam-based caring model showed the instruments for holistically assessing the difficulties of the Muslim family caregivers. The Muslim PD nurses were able to access the factual information of an individual, leading to specific

nursing care planning. The model also guided the strategies for strengthening the care for the Muslim family caregivers, as noted in the following passage:

"It has the score…I think, it helps us to know the phenomena of our family caregivers…this is useful to establish the nursing care plan being specific to each Muslim family caregiver." (Nurse, P01)

3.2 Muslim family caregivers: the tentative Islam-based caring model was provided to six Muslim family caregivers by Muslim PD nurses that work in the dialysis unit. Four of the six Muslim family caregivers were interviewed *via* telephone regarding the strengths and weaknesses of current practices. The other two could not be contacted. Based on the viewpoints of the four Muslim family caregivers, there were many benefits without disadvantages. The outcomes of the tentative Islamic based caring model for the Muslim family caregivers are summarized as follows.

3.2.1 Reducing caregiver burden

Depending on the perceived burden, the tentative Islam-based caring model reduced the caregiver burden in some aspects, especially their social and psychological burdens, as stated in the following:

"I felt…someone attached great importance to me by asking…sometimes my relatives did not pay attention to my difficulties…they (relatives) encouraged me once in a while when we met…I felt encouraged." (Wife, P02)

"Someone felt suppressed…this helped them to express their feelings…some cases felt difficulties caused by the patients' illness." (Wife, P01)

3.2.2 Harmony in life improvement

In this study, the tentative Islam-based caring model was seen to enhance the harmony in the life of the Muslim family caregivers in terms of encouraging their ability to manage the caregiving and the pleasantness in caregiving, as stated below:

"It helped me a lot...they provided the consultation through line application…when I had the problems…I can call or send the message…then they help me in solving…they have cooperated well." (Wife, P02)

"It helped…if the patient is healthy, I will be healthy…my wife is comfortable, I'm also pleasant…I can work without feeling uncomfortable." (Husband, P04)

Whether the tentative Islam-based caring model promoted harmony in life depended on the meaning of harmony in life. In this study, the meaning of harmony in life is summarized as follows:

Harmony in life is the satisfaction in being able to live a normal life

Caregiving became the additional role of family caregivers. Their life style was managed to be a new one. Once they can manage and maintain the balance between the caregiving roles and other roles leading to life satisfaction, harmony in life will be achieved. On the other hand, if they cannot maintain a caregiving-life balance, they will experience dissatisfaction in their life and their harmony in life will be low, as noted below:

"I have the harmony in life right now…I mean that…I don't have the caregiving's problems…My harmony in life means that I can…I can live as normal life without difficulties." (Wife, P02)

"My harmony now is…I cannot work outside…I spent too much time with caregiving…My harmony in life means I can do everything as normal…but now there is a lack of the life balance because…I have several tasks." (Husband, P03)

Harmony in life is having peace of mind

As the results show, when Muslim family caregivers are involved in caregiving, they can face several psychological problems during all phases of caregiving. Once their psychological problems are solved, however, psychological well-being can be achieved. Then, harmony in life is perceived, as suggested in the following:

"Right now, I…I have the balance…My life has the balance…It's not the same as before…I don't have the anxiety...because my wife gets better…I'm glad…I don't have the burden right now…I think…my life has the balance...now my wife gets better…I'm happy…happy…without anxiety". (Husband, P04)

3.3 Lessons learned

Based on the information from the Muslim PD nurses and the Muslim family caregivers, there were important lessons learned in the implementation of the tentative Islam-based caring model in cycle one; and the participants were satisfied with the implementation of the tentative model.

3.3.1 Muslim PD nurses

3.3.1.1 Increasing the awareness of holistic caring for Muslim family caregivers and being willing to continually apply the tentative model in caring practices

In the implementation of the tentative Islam-based caring model, the Muslim PD nurses were provided information and encouraged to be aware of the

Muslim family caregivers' problems by the head of the PD nurses so that they could perceive the difficulties of the Muslim family caregivers in providing caregiving. The Muslim PD nurses were satisfied with the tentative Islam-based caring model because it presents the process of holistic caring as a guide to holistic caring for Muslim family caregivers. They can gain substantial information about Muslim family caregivers to be utilized for improving their caring practices holistically, and from which Muslim family caregivers can receive benefits as well. Therefore, the Muslim PD nurses were willing to put the sustainability of the model into their practice.

3.3.1.2 Encouraging teamwork for driving the implementation of the tentative model

Teamwork was perceived as important for implementing the tentative model in terms of collaboration. The head of the PD nurses allowed the other staff in the PD unit to participate in the action plan. The process for implementing the model was then discussed together within the team. Meanwhile, the head of the PD nurses continuously encouraged and monitored her team members to implement the tentative model in their practice so that all of the healthcare providers in the PD unit would value the tentative model implementation.

3.3.1.3 Improving relationships between the Muslim PD nurses and the Muslim family caregivers

The relationships between the Muslim PD nurses and the Muslim family caregivers were basically good. After implementation of the model, relationship improvement could be seen between the Muslim PD nurses and the Muslim family caregivers as perceived by the Muslim family caregivers. Friendly

interaction and informal communication were used to implement the tentative model, resulting in good cooperation from the Muslim family caregivers.

3.3.1.4 Facing some barriers to provide the tentative Islam-based caring model

The barriers to providing the tentative Islam-based caring model were identified according two aspects as follows.

Muslim PD nurses' barriers

Lack of time

Initially the Muslim PD nurses had limitations in practice. They identified that their major limitation was the lack of time because there were many patients for each appointment. The patients' health and knowledge and skills in performing the peritoneal dialysis tasks of the family caregivers were more focused. The Muslim PD nurses had limited time in providing holistic care, while the implementation of the tentative Islam-based caring model was time consuming, as discussed in the following:

"In the follow-up period, I think, sometimes we have the limited time either the nurses or the family caregivers. We (PD nurses) provided the information quickly…practices were squeezed in time…I cannot spend more time in each case, so I assigned to other staff to practice, but we cannot do it well…therefore, we discussed in our team…if we implement the model in the date of changing a peritoneal dialysis transfer set, we will have more time." (Nurse, P01)

Lack of performance of some specific skills

The tentative Islam-based caring model requires specific skills on the part of the PD nurse. Especially in the process of peer group support, the junior

Muslim PD nurses could not handle the group. Therefore, peer group support can be conducted only by a senior PD nurse. Meanwhile, the senior PD nurse had to provide nursing care in the clinic at the same time, as discussed in the following:

"I think, the self-help group (peer group support) is beneficial. But there was a time limit. I did it in the past. I did it a few times only in the patients. Role model was encouraged to share the experience in the group. I felt good. This produced the concrete information. But our junior PD nurses cannot handle it effectively. They were not confident. If they can do it, I think, they can reduce my workload." (Nurse, P01)

3.3.2 Muslim family caregivers

3.3.2.1 Time constraints regarding full participation of the tentative model

The implementation of the tentative model may be inappropriate during the follow-up period. Based on the information from the Muslim PD nurses, they reported that some of the Muslim family caregivers had time constraints on the date of the follow-up. There were many activities with their loved ones, such as taking blood tests, redemonstrating how to dress wounds, and seeing the doctor. Some had to immediately go back to work. There was limited time. Therefore, the implementation of the tentative model on the date of the follow-up may be ineffective practically either for the Muslim PD nurses or the Muslim family caregivers.

3.3.2.2 Caregiver burden reduction in some aspects

Caregiver burden was initially evaluated after implementing the tentative Islam-based caring model within three months. The finding showed that caregiver burden was reduced in two aspects: social and psychological. This may be

due to the changes of nurse caring behaviors when providing the tentative Islam-based caring model. The actions of Muslim PD nurses based on the process of 5Rs and the gratitude approach that guided the tentative Islam-based caring model were applied into practices including paying more attention to Muslim family caregivers' difficulties, asking, and allowing them to express their feelings. These nurse caring behaviors influenced the perceived burden as described by Muslim family caregivers after receiving tentative Islam-based caring model for a short time. This finding indicated that the tentative Islam-based caring model may reduce the caregiver burden in all aspects of the human being in the long-term.

3.3.2.3 Harmony in life improvement

Based on the meaning of harmony in life expressed by Muslim family caregivers in this study, regarding their satisfaction in being able to live a normal life and having peace of mind, the tentative Islam-based caring model seemed to enhance the harmony in life in this study. This may be due to the holistic Islamic caring process. Nursing activities based on the process of 5Rs and gratitude approach in this model equally emphasized all five dimensions of being human according to Islam. Caregiving problems in all aspects were assessed and solved, which resulted in establishing a balance between the caregiving roles and other roles leading to being able to live a normal life and having peace of mind, as described by Muslim family caregivers after receiving tentative Islam-based caring model in this study.

3.4 Suggestions

3.4.1 The Islam-based caring model should be provided on the date of changing a peritoneal dialysis transfer set.

The Muslim PD nurses and healthcare teams suggested that the implementation of the Islam-based caring model should be provided on the date of changing the peritoneal dialysis transfer set, which is held every six months, and when there is more time for providing holistic care.

3.4.2 The junior Muslim PD nurses should be trained regarding peer group support.

For sustainability, the head of the PD nurses suggested that the junior Muslim PD nurses in the PD unit should be trained regarding conducting peer group support as well as the holistic Islamic caring process. If they are trained, the tentative Islam-based caring model can be widely implemented in a setting.

3.5 Cycle 2: Fostering the possibility and the sustainability of the Islam-based caring model in PD unit.

Based on the suggestions for implementation of the model from cycle 1, there were some barriers to applying the Islam-based caring model. For sustainability, the action plan for providing Islam-based caring model needs to be revised. After discussion, the head of PD nurse planned to provide the Islam-based caring model on the date of changing a peritoneal dialysis transfer set that is performed every six months. On that occasion, there is more time for providing holistic care to Muslim family caregivers. In addition, the junior Muslim PD nurses in the PD unit will be trained regarding peer group support and the holistic Islamic caring process before implementation of the model in cycle 2.

4. The Initial Islam-Based Caring Model for Muslim Family Caregivers of Patients with Peritoneal Dialysis

After implementing the tentative Islam-based caring model in cycle one, the tentative model was modified by the researcher together with the head of the PD nurses. It is slightly different from the previous tentative Islam-based caring model, as shown in Figure 4.3. The initial Islam-based caring model included three main components: inputs, the holistic Islamic caring process, and outcomes. Each component of the initial model is described as follows.

Inputs

Inputs refer to two main persons who are involved in the Islamic based caring model: the PD nurses and the Muslim family caregivers. Their characteristics are described as follows.

(1) PD nurses' competencies

Nurses' competencies refer to the nursing skills required for providing the Islam-based caring model to Muslim family caregivers in practice. The essential PD nurses' competencies initially required by Muslim PD nurses included cultural, holistic nursing, and critical thinking competencies.

First, cultural competencies were explained by the Muslim PD nurses in this study, in the sense that PD nurses should provide caring for Muslim family caregivers based on their personal and cultural background, language, and religious and health beliefs. Secondly, holistic nursing competencies refer to interaction involvement with respect, trust, empathy, sincerity, and spirituality with Muslim family caregivers. Effective communication such as friendly interaction, active

listening, observing, and paying attention was the essential skills set described by the Muslim PD nurses. Lastly, critical thinking competencies are essential for assessment and evaluation of the information derived from communication and observation.

After implementation of the model, the additional abilities required by the Muslim PD nurses were the ability to conduct peer group support and provide the Islamic caring process.

(2) Muslim family caregivers

The Muslim family caregivers who should participate in the Islam-based caring model can be grouped into two groups as identified in the tentative model: being a family caregiver for less than or equal to and for more than three months. There are slightly different nursing activities for each group in the holistic Islamic caring process.

Holistic Islamic caring process

The holistic Islamic caring process was designed by integrating the processes of caring from an Islamic perspective or the 5Rs and gratitude into the nursing process (assessment, diagnosis, planning, implementation, and evaluation) (Appendix G). Whenever the PD nurses, including Muslims and non-Muslims, perform nursing activities following the holistic Islamic caring process in this model, the family caregivers' positive outcomes will be achieved.

Within the holistic Islamic caring process, the Muslim family caregivers who participate in this model should receive care covering five dimensions of being human according to Islam. All of the nursing activities in this process should be based on religious doctrine and beliefs, and religious practices (prayer, fasting, pilgrimages). In providing care for Muslim family caregivers, the religious doctrine

and beliefs include faith in and remembrance of Allah. The beliefs in the Prophet and the Qur'an regarding gratitude and holistic care should be applied. Meanwhile, religious practices such as fasting during Ramadan, and pilgrimages also should be of concern. Prayer for blessing from Allah and reading the Qur'an can be used to encourage and manage the negative feelings in Muslim family caregivers described by the Muslim PD nurses in this study.

Nursing activities of each step of the nursing process can be explained as follows:

(1) Assessment

The main issues that should be assessed for each Muslim family caregiver include the beliefs in the religious, health, cultural, and personal characteristics of Muslim family caregivers. The present or possible problems, factors or causes, and needs of Muslim family caregivers should be assessed following the five dimensions of being human through interviews, observations, and questionnaires during each follow-up as well as the Muslim family caregivers' performances regarding caregiving management.

Before assessment, establishing a relationship between the PD nurses and the Muslim family caregivers is important in gaining deep information from the Muslim family caregivers. The process of caring (5Rs) from Islamic perspectives that can be integrated into this step should be begun with *relationships*. The behaviors of the PD nurses in the relationship process include the following: 1) the use of interpersonal communication skills; 2) introducing the experience of caring; 3) using informal communication techniques; 4) showing friendly interaction through facial expressions and local language; 5) paying attention to the Muslim family caregivers'

difficulties in holistic aspects; and 6) active listening. These behaviors are beneficial in encouraging trust with Muslim family caregivers.

The behaviors of the PD nurses showing *relatedness* should be subsequently provided in practice. The nurses' behaviors representing relatedness in this step include: 1) allowing Muslim family caregivers to express their feelings about the caregiving difficulties; 2) showing sincerity in caring through talking, active listening, paying attention, and continuing to monitor through home visits or telephone calls; 3) respecting and accepting decision-making, religious beliefs, health beliefs, personal and cultural background, language, and spirituality; and 4) showing empathetic behaviors by using friendly interactions such as facial expressions, emotional reactions, language, and providing simple touch in recognition of the family caregivers' presence.

Reflection should also be used in this step. The PD nurses should encourage Muslim family caregivers to reflect on their difficulties and needs in relation to caregiving in all aspects of being a Muslim.

(2) Diagnosis and Planning

The PD nurses are required to interact with the Muslim family caregivers in planning nursing activities based on their needs and problems. Before seeking appropriate solutions and strategies, the information of holistic effects should be discussed between the PD nurses and Muslim family caregivers, and the PD nurses and the healthcare team. Then, the needs and possible problems of each person should be identified, followed by identification of expected outcomes, the nursing care plan, and evaluation methods for monitoring.

Nurses' behaviors representing *relatedness* could be practiced continuously in this step, followed by the *response* process. The behaviors of the PD nurses showing a response indicated that the PD nurses need to respond to Muslim family caregivers' difficulties and their needs as individuals. Muslim family caregivers should be reminded about gratitude related to caregiving in order to encourage their peace of mind.

The communication system within the healthcare team is required in the steps of assessment, and diagnosis and planning. Health professional collaboration should be encouraged in practice. Providing information about the difficulties of Muslim family caregivers in providing caregiving should be done to the healthcare team as well as encouraging them to be aware of Muslim family caregivers' problems. Conferences or meetings among healthcare teams in the hospital and with health professional networks in rural areas are the strategies that the PD nurses can use in order to encourage interprofessional collaboration. The information of each Muslim family caregiver must be discussed and subsequently caring activities must be developed together with other healthcare staff. This strategy will help healthcare providers develop a care plan to meet the holistic needs of the Muslim family caregivers and it will allow Muslim family caregivers to receive continuing care after discharge.

Family meetings can also be used as a strategy to encourage family members to participate in caregivers' caring and to discuss solutions for preventing and solving the possible problems of Muslim family caregivers. This strategy has been offered under the needs of each Muslim family caregiver. Based on the perception of both the Muslim PD nurses and Muslim family caregivers, less

participation from other family members had an adverse effect on the family in terms of managing their difficulties and caregiving. Therefore, family meetings are required as an important strategy within this tentative Islam-based caring model. Caregiving management, the factors related to the caregiver burden, and information about difficulties and possible burdens should be discussed in order to reduce caregivers' burdens and improve harmony in life. The activities in family meetings are summarized in Appendix H.

(3) Implementation

The PD nurses are required to implement a nursing care plan in their practice. The PD nurses' activities in this step can be separated into two periods: in the PD unit and after discharge. At the PD unit, essential nursing activities include providing information, skills training, emotional and spiritual support, and establishing peer group support. After discharge of the patient, essential nursing activities include consulting, face-to-face home visits, telephone or Line visits, and emotional support. The holistic Islamic nursing care plans for Muslim family caregivers in each dimension are described in Appendix G.

In the PD unit, information provision and skills training are always provided by the PD nurses. Emotional and spiritual support is also needed. Peer group support was mainly required by the Muslim family caregivers in this study. They perceived that peers can help with social and emotional support, and they can get information and encouragement from others in peer group meetings. Conventional peer group support was initially designed by the head of PD nurses in the tentative model, but it was not practical because the nurses' ability to conduct peer group

support was insufficient as only the senior Muslim PD nurses could handle the group, and meanwhile, they had to provide nursing care in the clinic at the same time.

The use of mobile applications in peer support was instead developed by the Muslim PD nurses together with the Muslim family caregivers in order to promote the possible implementation of the initial Islam-based caring model. A peer support group through the Line application was later established. The Muslim PD nurses took action as a facilitator of the peer group support activity. This strategy was helpful for the Muslim family caregivers, as they reported that they could get information and solutions from others that had similar experiences in caregiving.

After being discharged and sent home, healthcare provider support was required for consultation. Home visits are a strategy that Muslim family caregivers required from the healthcare providers in terms of supporting them with information and monitoring their caregiving behaviors. Face-to-face home visits are required every six months for a new family caregiver during the first year. After the first year, face-to-face home visits are required yearly. Telephone or Line visits can instead be applied in the setting. Emotional support from family members was required at home.

Nurses' behaviors showing *response* should be provided continuously during this step. The process of *role modeling* could be conducted through the peer support group. Role model seeking is required by Muslim family caregivers for sharing their experiences in relation to caregiving. The PD nurses facilitate the peer group support. The guide for conducting peer group support is explained in Appendix H.

(4) Evaluation

Evaluation through interviews and observation of the outcomes of the Muslim family caregivers in all aspects of holistic health needs to be continuously carried out when they visit the hospital. *Reflection* should be used again at this step. The PD nurses can encourage Muslim family caregivers to reflect on their caregiving and reconsider the present difficulties and needs in relation to caregiving in all aspects of being an Islamic person.

Outcomes

Caregiver burden reduction and improved harmony in life are expected to be found. PD nurses can evaluate these outcomes by using the assessment form for Muslim family caregivers, the caregiver burden questionnaire, the harmony in life questionnaire, and the interview guide for assessing the holistic effects in Muslim family caregivers. After implementation of the tentative model, these outcomes were suggested to be evaluated every six months because the Muslim PD nurses need more time for evaluation. All of the instruments are presented in Appendix H.

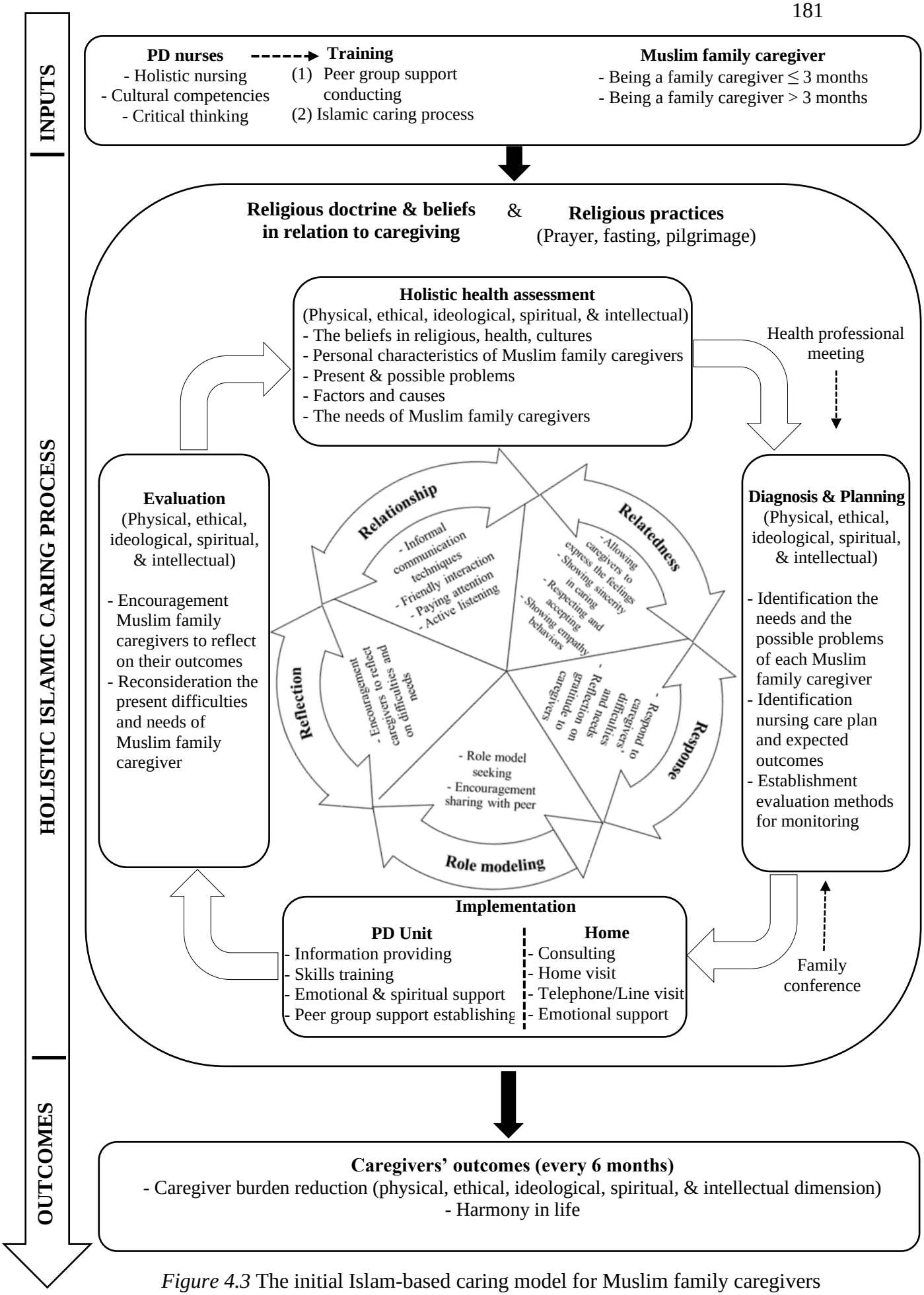

Figure 4.3 The initial Islam-based caring model for Muslim family caregivers

5. Discussion

The findings of this study were discussed through three main topics: the holistic caring situations for Muslim family caregivers in a PD unit, the development of the Islam-based caring model, and the components of the initial Islam-based caring model.

The holistic caring situations for Muslim family caregivers in PD unit

This information was obtained from three main groups, namely: Muslim PD nurses, Muslim family caregivers, and Muslim PD patients.

First, the holistic caring of Muslim PD nurses in caring for Muslim family caregivers, even though Muslim PD nurses tried to provide holistic care to Muslim family caregivers, in practice, they faced difiiculties in providing holistic care for them. The findings in this study showed that the barriers in providing holistic care included barriers related to Muslim family caregivers, barriers related to PD nurses, and barriers related to the organizational system.

Barriers related to Muslim family caregivers, Muslim family caregivers who engage in non-self-disclosure led Muslim PD nurses to experience difficulties in information accessibility and dealing with problems. Self-disclosure is valued in quality communication. It helps a person to express what he/she want to say better, which leads to revealing insights into his/her thoughts, feelings, and wishes (İbrahimoğlu et al., 2021). It is necessary in building relationships from the initial stage to the termination process. The degree of disclosure influences social interaction (Sprecher, Treger, Wondra, Hilaire, & Wallpe, 2013).

The results in this study also showed the barriers related to PD nurses including lack of knowledge and awareness, ineffective communication, poor relationship, and a shortage of PD nurses. These findings are consistent with several previous studies. There was sufficient evidence supporting that, nurses experienced barriers in providing holistic care to family caregivers due to lack of knowledge and experience (Carvajal et al., 2019; Neathery, Taylor, & He, 2020), lack of time due to multitude of tasks and roles (Kenny & Allenby, 2013), and lack of communication skills (Carvajal et al., 2019). In addition, organizational system, shift-working conditions were also perceived as barriers to provide holistic care to family caregivers. This related to the perceived lack of time. Shift-working conditions restricted them to fully provide holistic care in their practice, as described by Muslim PD nurses in this study.

Moreover, Islamic perspectives in relation to caring obtained from Muslim PD nurses were summarized. The findings showed that religious beliefs and religious practices were suggested to be applied into holistic care for Muslim family caregivers as well.

Second, the experiences of Muslim family caregivers in caring for Muslim PD patients were analyzed and summarized into three main categories, including overwhelmed with suffering, coping with negative feelings, and the needs of Muslim family caregivers in caring.

These findings indicated that Muslim family caregivers' lives have been holistically affected from being a caregiver. Overwhelmed with suffering was described as the main difficulty. This was defined by feeling discouraged, loss of

freedom in living, facing an economic crisis, experiencing family conflicts, and physical disturbance.

Feeling discouraged was explained through the feelings of uncertainty, fear, hopelessness, and helplessness. The main determinants of this suffering were the increase in workload and a lack of improvement in patients' health. During the first three months, feelings of uncertainty and fear were mainly expressed. These may be caused by transitioning to a new caregiver. Even though they were regularly prepared by the PD nurses before discharge to home, this preparation may not have been adequate for learning and performing caregiving tasks without help. This finding is consistent with previous studies. Its result showed that family caregivers can face negative feelings such as uncertainty, fear, and an increased burden, especially in the initial phase of caregiving (McDonald et al., 2016; Rabiei et al., 2015). Subsequently, the negative feelings may change depending on the trajectory of caregiving. Hopelessness and helplessness were more evident. These findings are confirmed by a previous study, which reported that Thai Muslim family caregivers of patients with kidney failure had the feeling of being tired (Hemman et al., 2017). These issues remind one that PD nurses should focus on the negative feelings resulting from caregiving regardless of the duration of being a caregiver, although it can wane over time.

Social problems were also described through the feeling of loss of freedom in living. This may be caused by reduced social interaction and travelling while being a caregiver. Muslim family caregivers in this study described that they spent an average of twelve hours a day on caregiving resulting in reduced interacting with others and travelling. This problem subsequently can cause social isolation (Sun,

Finkelstein, & Ouchida, 2019). Therefore, the PD nurses should not overlook this problem by try detecting it early and solving it immediately.

Facing an economic crisis was one of the problems that affected Muslim family caregivers' lives. This referred to the financial problem caused by taking a caregiving role. This problem may be due to increased expenses and reduced income. Even though peritoneal dialysis modalities have been supported by all coverage healthcare schemes, out-of-pocket costs in each follow-up are still the responsibility of the patients or family caregivers such as transportation and daily living expenses. This finding is supported by a previous study. Most out-of-pocket spending was for transportation, fees paid to the hospital, food, and accommodation (Chuengsaman & Kasemsup, 2017). While the expenses have increased, their income has been reduced. This may relate to their occupation and income levels. Most of them were farmers and workers. Whenever they became a caregiver, they were always more focused on caregiving roles than on earning, which may result in reduced income.

Family conflicts between a family caregiver and other family members including his/her patient were also experienced while being a caregiver. This may be influenced by Islamic culture and beliefs. Muslims regularly believe that children have to show their responsibility in taking care of their parents. Every child should be involved in caregiving. Once someone cannot take action as expected, conflicts may follow within the family. These findings were supported with a previous study which reported that caregiving has an impact on families and friends (Manera et al., 2019).

Physical disturbance also was mentioned by Muslim family caregivers in this study including body weight loss, loss of leisure, and sleep deprivation. As

mentioned above, during performing caregiving roles, Muslim family caregivers often spent more time with caregiving duties and consequently self-neglect (Amankwaa, 2017; Liu et al., 2017).

Dealing with these sufferings, this experience should be deeply understood, as it is useful for other Muslim family caregivers who have similarities in caregiving situations. The findings in this study showed that coping strategies that Muslim family caregivers used to deal with the negative feelings included adherence to religious doctrine and religious practices, valuing being a caregiver as a child's responsibility, seeking support and searching for information, and balancing roles.

Islamic beliefs and practices are embedded into the daily living of Muslims (Alsharif et al., 2011). This information was confirmed by the findings in this study. Muslim family caregivers expressed that adhering to religious doctrine and religious practices were mainly used in dealing with negative feelings while being a caregiver. Caregiving was believed to be the highest merit, representing the love, and expressing gratitude to their loved one. Whenever they expressed gratitude and kindness towards their parents or family, they also expressed gratitude towards Allah, and subsequently they will receive the rewards (Nemati et al., 2017), which indicated a strong faith in Allah as well (Nashif et al., 2020; Nemati et al., 2017). These beliefs are embeded in Muslims' faith, which can encourage them to continue being a caregiver with well-being (Balthip et al., 2021). Meanwhile, prayers and reading the Qu'ran were the religious practices commonly used to cope with negative feelings. These are useful in managing stress (Shaw, Peacock, Ali, Pillai, & Husain, 2019) and improving a positive caregiving experience (Pearce, Medoff, Lawrence, & Dixon, 2016).

Valuing being a caregiver as a child's responsibility was also expressed by sole Muslim family caregivers in this study. Within Islamic context, children are cultivated to take care of their parents or families (Begum & Seppänen, 2017). Being a caregiver is valued as part of the duties of a Muslim, family responsibilities, and living with a care-recipient determined by culture and religious values of Thai Muslims.

Seeking support and searching for more information was mentioned as it aimed at keeping the balance of multiple roles. Healthcare providers, family members, relatives, and peer support were required. Beside these, balancing multiples roles was managed through revising schedules and managing a new lifestyle. Rearrangement of priorities, changing a work or educational plan, and modifying the schedule were strategies commonly used by Muslim family caregivers in this study. Evidence supported the claim that these strategies were beneficial in reducing the caregiver burden (Gaugler et al., 2018).

The needs of Muslim family caregivers must also be deeply understood when aiming to develop a tentative Islam-based caring model that fits with their needs. Based on the information obtained from Muslim family caregivers in this study, the needs of Muslim family caregivers included healthcare providers' support, family/relative support, and peer support. In addition, information support, monitoring the family caregivers in providing care, and emotional support were required from Muslim PD nurses.

Regarding healthcare providers' support, this was required by both Muslim family caregivers and their patients in terms of providing information regarding caregiving. Family members' and relatives' support was required and aimed

to reduce the workload and financial burden. The presence of peers was required in providing social and emotional support. According to Noohi et al. (2016), they reported that peers are facilitators and offer emotional support.

After gaining a clear understanding of the caring situation in a PD unit, all information was applied into the modification of a tentative Islam-based caring model initially designed from the literature review and pilot study in the preparation phase, and the development of the action plans before implementation of the model into practice. The objective was to develop the tentative Islam-based caring model and action plans that would fit the real context.

Third, the PD patients' experiences in receiving care from their caregivers were summarized in terms of their satisfaction and the needs of the family caregivers. Most of the PD patients expressed that they were satisfied and appreciated their family caregivers regarding the caregiving. Other needs for Muslim family caregivers identified by Muslim PD patients included information support, monitoring the family caregivers in providing care, and emotional support. This is consistent with the previous studies. The patients expressed that their family caregivers also needed support and additional assistance from health care providers (Hughes et al., 2019; Petersson & Lennerling, 2017).

The development of the Islam-based caring model

The Islam-based caring model was initially developed based on the literature review and pilot study. The tentative model was guided by the concepts of caring from an Islamic perspective of Barolia and Karmaliani (2008). The process of the 5Rs in Islamic caring theory integrating a gratitude approach within the Islamic thought of Latheef (2013) was applied to this model. After the reconnaissance phase,

the tentative Islam-based caring model was first modified based on the qualitative data obtained from the Muslim PD nurses, Muslim family caregivers, and Muslim PD patients by the researcher. Then, the tentative model was remodified again by the Muslim PD nurses in order to promote the possibilities of its usage and to reduce the limitations of the setting in the implementation the model. Lastly, the tentative model was revised to be an initial Islam-based caring model after implementing the model in cycle one.

This model is considered to be valuable for the holistic Islamic care of Muslim family caregivers of patients with peritoneal dialysis. The definition of being human and the caring process within Islamic caring theory were considered and integrated into the Islam-based caring model development in this study. In addition, the qualitative data from the Muslim PD nurses, the Muslim family caregivers, and the patients were analyzed in terms of the difficulties and needs of Muslim family caregivers within the five dimensions of the holistic human being in Islam; the physical, psychological, ethical, ideological, spiritual, and intellectual dimensions. A previous study stated that the meaning and spirituality sharing among nurses, families, and patients represent the concept that is at the heart of the caring model in Islam (Lovering, 2012).

Regarding the Muslim PD nurses, this model promotes the awareness of caring for Muslim family caregivers, and for improving and providing practices concerning Islamic beliefs and practices. This is consistent with previous evidence, which mentioned that the Islamic caring model reflects nursing behavior that is focused on Islamic values and a nurse’s competence in enhancing the patient’s

psychospiritual comfort (Bakar, Nursalam, Adriani, Kusnanto, Qomariah, & Efendi, 2018).

In addition, regarding Muslim family caregivers, this model promotes care receiving in terms of assessing the difficulties and caring under the holistic health of Islam. This model is valued because it is consistent and specific to the Muslim family caregivers in the Thai context. Consisting with the study of Lovering (2012), the results showed that a nursing model for meeting the holistic needs of Muslims consists of spiritual care, cultural care, psychosocial care, interpersonal care, and clinical care.

The components of the initial Islam-based caring model

According to the process of the development of the Islam-based caring model, all of the components of the initial Islamic-based caring model were derived from a literature review and the information obtained from relevant stakeholders, including Muslim PD nurses, Muslim family caregivers, and Muslim PD patients. All of the components of the initial Islam-based caring model were designed to meet the needs of all stakeholders, especially PD nurses and Muslim family caregivers. Therefore, this initial model can be claimed to encourage PD nurses to provide holistic Islamic care for Muslim family caregivers, resulting in caregiver burden reduction and harmony in life improvement.

Before providing a holistic Islamic caring process for Muslim family caregivers, two main inputs should be considered: the PD nurses and the Muslim family caregivers.

As is known, caring is the essence of nursing practice. The concept of caring is characterized by the nurses' personal qualities, including professional

knowledge, attitudes, and skills, personal maturity, and interpersonal sensitivity, resulting in protection, emotional support, and the meeting of the holistic needs of the person (Drahošová & Jarošová, 2016). Therefore, as this model can be valued as a form of holistic Islamic caring for Muslim family caregivers of patients with peritoneal dialysis, essential nursing competencies should be considered for providing an Islam-based caring model for Muslim family caregivers. The findings in this study illustrate that cultural, holistic nursing, and critical thinking competencies are required in providing such a caring model.

Based on theory, cultural competencies consist of five attributes: 1) cultural awareness; the development of the consciousness of nurses with different values, beliefs, norms, and lifeways of the person; 2) cultural sensitivity; nurses' appreciation, respect and comfort to the cultural diversity of the person; 3) cultural knowledge; nurses' understanding of the different beliefs, values, and behaviors of the person; 4) cultural skills; the ability to perform cultural assessment, planning, and provision in a particular setting; and 5) dynamic process; nurses' ability to provide culturally caring that is consistent with every person (Cai, 2016). These cultural competencies were prioritized by the Muslim PD nurses in providing the Islam-based caring model in this study. This finding is consistent with previous study. Domocmat (2016) for example highlighted that cultural awareness and the sensitivity of nurses in caring for Muslims are very important. Reflection on clinical practice and understanding the impact of religious and cultural differences should be considered by nurses. Having an awareness of the Islamic faith and the Islamic beliefs of the nurses ensures that Muslims will receive high-quality care (Rassool, 2015).

Holistic nursing competencies were characterized by the Muslim PD nurses for providing the Islam-based caring model in this study. Several competencies were mentioned as the essentials for holistic nursing, including competencies related to communication, assessment, management, collaboration, and critical thinking, which were consistent with the desired competencies in the standards of holistic nursing practice established by the American Holistic Nurses Credentialing Corporation (2012). These competencies have been described through the standards of holistic nursing practice.

Beginning with standard 1: assessment; the nurse collects comprehensive data related to the person's health or situation. Standard 2: diagnosis or health issues; the nurse analyzes the data to consider the diagnosis or issues related to health, wellness, disease, or illness. Standard 3: outcome identification; the nurse identifies outcomes for a plan individualized to the person or the situation. Standard 4: planning; the nurse develops a plan that identifies strategies and alternatives to obtain outcomes. Standard 5: implementation; the nurse implements caring in partnership with the person. Standard 6: evaluation; the nurse evaluates progress toward expected outcomes and reorganizes a plan (American Holistic Nurses Credentialing Corporation, 2012). Moreover, the competencies related to the holistic nurse are as a collaborator and leader in the provision of holistic care. These standards mean that the nurse collaborates with the person, family, and others in the conduct of holistic nursing practice, and provides leadership in the professional practice setting (Mariano, 2013).

Generally, holistic nursing is defined as all nursing practices that heal the whole person and improve the harmony among mind, body, emotions, and spirit in

the changes of the environment (Jasemi, Valizadeh, Zamanzadeh, & Keogh, 2017). From the Islamic perspective, Islamic holistic nursing emphasizes the integration of the care of the spirit with the care of the body (Atkinson, 2015). According to Taleghani et al. (2013), Islamic holistic nursing can include consideration of either body or spirit (divine soul) that are united and integrated into the world. Whenever there is a deficiency in one, it will result in a deficiency in the other. Islamic holistic nursing should therefore consider the unity of all body and soul sub-dimensions.

Critical thinking competency was required by the Muslim PD nurses in providing holistic Islamic care for Muslim family caregivers. Whenever the PD nurses have critical thinking competency, the problems of be Muslim family caregivers can be better identified. Critical thinking ability is therefore required as a general aptitude of nurses (Takase, 2011). Moreover, there are additional abilities in which PD nurses need to be trained, including conducting sessions for peer group support and the provision of holistic Islamic care.

Besides PD nurses' competencies, Muslim family caregivers' traits should be focused on as well, especially the duration of caregiving. As the findings revealed, caregiving has effects on Muslim family caregivers holistically depending on its trajectory. It has a greater effect on Muslim family caregivers' lives during the first one to three months. Then, even if family caregivers are better in performing their caregiving tasks, their emotional resilience can wane over time and finally they may end up with burnout (Kang, Yu, Foo, Chan, & Griva, 2019). For this reason, all Muslim family caregivers should be considered.

The holistic Islamic caring process is the core component in this model. It consists of the process of caring from an Islamic perspective, integrated

(5Rs) with the nursing process aimed at keeping a balance of the five dimensions of being human according to Islam. The PD nurse is required to perform nursing activities following the holistic Islamic caring process. He or she has to be aware that being human in Islam consists of five dimensions. Health in Islamic thought consists of an equilibrium in the existential dimensions of being human, as it is holistic (Alimohammadi & Taleghani, 2015). Once some dimensions are disturbed, it can cause the person to suffer from health impairment requiring care.

In providing the holistic Islamic caring process**,** PD nurses have to begin with holistic health assessment. The assessment of existing caregivers' caring situations under the perception of the individual Muslim family caregiver aims to ensure that the basic needs of the Muslim family caregivers are embedded in nursing interventions. Kitson et al. (2014) proposed that in meeting the fundamental care needs of clients, their basic needs have to be embedded into the thinking, reflection, and assessment processes of the nurses. Considering the needs of family caregivers before planning interventions benefits the decrease in the caregiver's burden and encourages health and well-being (Mthembu, Brown, Cupido, Razack, & Wassung, 2016). Moreover, difficulties and other factors should be assessed. Discovering the caregiving difficulties and factors among the family caregivers is beneficial in providing care (Saimaldaher & Wazqar, 2020).

After having obtained information about Muslim family caregivers, the needs and the possible problems or difficulties of each individual should be identified in the diagnosis and planning step, including expected outcomes and the methods for evaluating and monitoring. There is evident support for the idea that if nurses spend more time evaluating the caregiver burden, devising appropriate interventions will be

more successful (Hassankhani, Eghtedar, Rahmani, Ebrahimi, & Whitehead, 2019), and for this reason nurses need to consider the caregivers' difficulties and create strategies for reducing them (Hassankhani et al., 2019).

Many strategies were used to reduce the caregiver burden and to enhance their harmony in life as well in this study. Encouraging collaboration among health professionals can be considered a key strategy for the successful provision of the holistic Islamic caring for Muslim family caregivers, especially in the assessment and diagnosis and planning steps. Healthcare team conferences (meetings) are a strategy that the head of the PD unit used to encourage interprofessional collaboration in the setting of this study. All of the healthcare providers in the PD unit were allowed to participate in developing a care plan. Its benefit was ensured by previous evidence, as healthcare provider meetings provided a valuable opportunity to develop a care plan to meet the holistic needs of families (Washington, Guo, Albright, Lewis, Oliver, & Demiris, 2017) because healthcare providers can have an overview of the problems of the patients and families during the team meeting (Dongen, Bokhoven, Danniëls, Lenzen, Weijden, & Beurskens, 2017). Moreover, meetings can create uniformity in the family caregivers' care, and it can also increase the healthcare providers' awareness and ability to solve problems based on the clients' needs (Winfield, Sparkman-Key, & Vajda, 2017). Meanwhile, encouraging health professional collaboration may help the healthcare team to feel a sense of ownership of the care plan so that they will try to practice as planned, which can improve the Muslim family caregivers' outcomes.

Family meetings were also a strategy used in the diagnosis and planning step in this model. The aim was to encourage family members to become

involved in caregiving management. Information regarding the difficulties and possible burdens of the family caregivers can be provided to other family members during family meetings. The factors related to the caregiver burden and the solutions should be discussed subsequently. As previous evidence suggested, conferences between the healthcare team and the family should be held, because they help to alleviate the caregiver burden (Tabootwong & Kiwannuka, 2020; Yoon, Kim, Jung, Kim, & Kim, 2014). Similarly, in a study of Yildiz et al. (2017), they recommended that nurses encourage family caregivers to share the caregiving responsibilities with other family members, which is beneficial in reducing the caregiver burden and improving self-efficacy.

Within the implementation step, the nursing care plan was provided to the individual Muslim family caregiver. Peer group support and home visits were additionally required by the Muslim family caregivers in this study.

The Muslim family caregivers expressed that they could receive benefits from others in the peer group meetings, especially on the social and emotional aspects. This finding is ensured by previous studies, where the results showed that peer support groups are effective in reducing the caregiver burden in terms of practical, motivational, and emotional support (Barutcu & Mert, 2016; Eagleton, Walker, Freene, Gibson, & Gibson, 2021). Moreover, having a peer support group encourages family caregivers to feel a sense of social connectedness, resulting in the feeling of the reduction of isolation and the reception of practical advice (Donald et al., 2019; Oveyssi et al., 2021). The peer support program and support intervention were recommended to be offered in the clinical practice of peritoneal

dialysis for psychological and emotional support (Avsar, et al., 2013; Oveyssi et al., 2021).

The PD nurses can offer peer group support with practical possibilities. Traditional and telephone peer group support can be used with the facilitation of the PD nurses. The previous studies supported the notion that mobile applications can effectively provide solutions for family caregivers. Their functions include supporting educational information, resources and services, and solutions to problems during caregiving and assessing the caregivers' well-being (González, Jover, Guilabert, & Mira, 2021; Frieman, Trail, Vaughan, & Tanielian, 2018). This strategy was suggested to the nurses in providing holistic care of family caregivers. The nurses could facilitate the development of peer support groups by encouraging caregivers to participate, and by suggesting meeting spaces and providing meeting times (Abendroth, Greenblum, & Gray, 2014).

Home visits are a strategy that Muslim family caregivers requested from the healthcare providers in this study. This finding is also consistent with a previous study. Most family caregivers need follow-ups by home visits in order to be supported in their caregiving (Alshammari, et al., 2017). This can significantly reduce the caregiver burden, engage families in the caregiving process (Tamizi, Khoshknab, Dalvandi, Shahboulaghi, Mohammadi, & Bakhshi, 2020), improve the feeling of security, and alleviate psychological distress (Kitamura, Tanimoto, OE, Kitamura, & Hino, 2019). In addition, one previous study supported that home visits provided by nurses is an effective and holistic action for the family; nurses can provide holistic care for the family caregivers in this way (Marinho, Ramos, Oliverira, Caramoni, &

Fontes, 2020), so that the Islam-based caring model in this study is valued as a holistic caring model.

During the implementation of holistic nursing care, nurse caring behavior is important. Providing caring with friendly interaction was perceived through behaviors and language. Using local language with politeness, friendly greetings, and being sociable were valued in providing caring. These behaviors represent the concept of compassion in Islamic caring (Bakar, Nursalam, Adriani, Kusnanto, Qomariah, & Efendi, 2018). Meanwhile, paying attention by asking and allowing Muslim family caregivers to express their problems and negative feelings regarding caregiving was valued in feeling comfortable during care-receiving. The study of Bakar et al. (2018) suggested that in Islamic caring, a nurses' behavior should include compassion and competence to enhance the psychological comfort. Once, the higher the nurse's Islamic caring practice, the higher the person satisfaction will be (Wardaningsih & Junita, 2021).

Lastly, regarding the evaluation step, the expected outcomes identified in the panning step have to be evaluated and monitored in this step. If the PD nurses provide effective holistic Islamic nursing care, the Muslim family caregivers should finally experience outcome improvement. Therefore, Muslim family caregivers should be encouraged to reflect on their outcomes and reconsider their present difficulties and needs in relation to caregiving in all aspects of being an Islamic believer.

In addition, throughout the provision of the holistic Islamic caring process, the Islamic perspectives in relation to caring for Muslim family caregivers should be understood as mentioned by all of the participants in this study. There were

two main Islamic perspectives in relation to caring for Muslim family caregivers: the religious doctrine and beliefs, and religious practices.

Religious beliefs are important for nurses in order to gain an understanding aimed to offer culturally appropriate nursing care. Similarly, a previous study has demonstrated that caring in Islam that is related to religious beliefs could create a sense of peace in body, mind, and spirit (Ismail, Hatthakit, & Songwathana, 2018). Several Islamic beliefs will affect Muslim's attitudes and behaviors (Rassool, 2015), which are related to healing and hope (Almukhaini & Watson, 2020). Therefore, there was a suggestion that nurses should learn and understand the religious beliefs of Muslims (Almukhaini & Watson, 2020).

Similarly, in terms of religious practices, previous evidence has supported the idea that Muslims need support from religious healing practices such as reading the Qur'an, prayer, and religious supplications. Supporting prayer is a key nursing action. Nurses can use religious words during their nursing care and procedures. This will establish trust and connections between the nurses and the patients or families (Lovering, 2012).

After implementation of the holistic Islamic caring process, the final outcomes can be evaluated intermittently. In this study, caregiver burden was decreased, including social and psychological burdens. Previous evidence has supported the notion that attention to family caregiver support significantly affects the reduction of caregiver burden in Islam (Etemadifar, Bahrami, Shahriari, & Farsani, 2014). Therefore, in order to explicitly evaluate the effects of this model, caregiver burden levels should be followed-up continuously as recommended in a previous study (Swartz & Collins, 2019).

Obtaining harmony in the life of the Muslim family caregiver was also a final outcome in this study. The satisfaction of being a caregiver with a normal life and having psychological well-being without negative feelings in caregiving were perceived as harmony in life. These findings are in line with previous studies, where it was seen that Muslims try to keep a balance between oneself and others or circumstances in order to maintain harmony in life, which is associated with obtaining psychological well-being (Garcia, Nima, & Kjell, 2014; Permana, Ormandy, & Ahmed, 2019).

Considering harmony in life improvement in this study; this may result from the Islam-based caring model, which was developed based on the concept of caring from the Islamic perspective. The presence and beliefs of Muslim family caregivers were deeply understood holistically before designing the model. There is evidence that supports the notion that religious and spiritual beliefs play a vital role in family caregivers' adaptation to their situation (Gholamzadeh, Hamid, Basri, Sharif, & Ibrahim, 2014). In addition, the ability of caregiving management was encouraged while implementing the model, resulting in a balance of multiple roles. Whenever Muslim family caregivers trust in their abilities and act toward caregiving by learning to overcome overwhelming obstacles, their harmony will be achieved. Meanwhile, if the ability of Muslim family caregivers in caregiving management is improved, the patients' conditions will improve subsequently. Satisfaction in caregiving and peace of mind are finally achieved. These findings ensure that the Islam-based caring model in this study has the value of being comprehensive or representing holistic nursing care. As the study of Madani et al. (2018) indicates, the features of comprehensive

nursing care should encourage harmony and balance between the components of a human being that influence his or her well-being and health.

Overall, after evaluation of the Islam-based caring model in this study, it is possible that this model will be continuously applied. The findings revealed that the Muslim PD nurses were willing to put the sustainability of the model into their practice. This indicates that they were satisfied and received benefits from this initial Islam-based caring model. Obtaining benefits from Islamic caring will support nurses in continuously implementing the model (Wardaningsih & Junita, 2021).

In conclusion, the development of the Islam-based caring model in this study was designed based on the concepts of caring within the Islamic perspective, including the notion of gratitude. The principles of holistic nursing care have been emphasized, and it can therefore be claimed that the Islam-based caring model in this study is valuable for holistic Islamic caring for the Muslim family caregivers of patients with peritoneal dialysis.

The initial Islam-based caring model for Muslim family caregivers of patients with peritoneal dialysis consists of three main components: inputs, holistic Islamic caring processes, and outcomes. First, two main inputs should be considered, namely both PD nurses and Muslim family caregivers. PD nurses should be encouraged to have the essential nursing competencies in relation to caring for Muslim family caregivers. The ability to create and facilitate peer group support and provide Islamic caring processes should be prepared. Meanwhile, Muslim family caregivers should be considered based on the duration of caregiving. The caregivers that have a duration of caregiving of less than or equal to three months can experience

holistic impacts more than those that have a duration for caregiving greater than three months.

Secondly, regarding the holistic Islamic caring processes, which is the core process in this model, it mainly consists of the process of caring (5Rs) from an Islamic perspective and nursing processes. This process should be provided from Islamic perspectives in relation to caring for Muslim family caregivers: doctrines of Allah and religious beliefs, and religious practices, and five dimensions of being human in Islam. Nursing activities, besides knowledge provision and skills training perceived as fundamental nursing care for Muslim family caregivers, professional health meetings, family meetings, peer group support, and home visits need to be practiced continuously. Nursing care behaviors should be of concern because the behaviors of PD nurses showing relationships, relatedness, and responses are valued in terms of promoting positive outcomes on the part of Muslim family caregivers. Lastly, regarding outcomes, caregiver burden and harmony in life should be considered continuously after providing this Islam-based caring model.

Chapter 5

Conclusions and Recommendations

This chapter reports the conclusion, implications for nursing education and practice, future research recommendations, and the limitations of the study.

Conclusions

This study is technical action research that aimed to develop an Islam-based caring model for Muslim family caregivers of patients with PD. The expected outcomes of this study were to reduce caregiver burden and to improve the harmony the life of Muslim family caregivers. Two objectives were achieved: 1) to ascertain the components of an Islam-based caring model for Muslim caregivers of patients with PD, and 2) the results of an Islam-based caring model implementation on Muslim PD nurse and Muslim family caregivers of patients with PD.

The process of the development of an Islam-based caring model was initially planned to be conducted within two cycles of action research. In cycle one, the objectives were 1) promoting the focus on Muslim family caregivers by increasing the knowledge and awareness of caring for Muslim family caregivers by Muslim PD nurses; 2) creating Islam-based caring practices; and 3) improving the practices concerned with holistic caring within the context of Islam. The reconnaissance phase was conducted in order to gain a clear understanding of the caring situation in a PD unit based on the viewpoint of five Muslim PD nurses, thirteen Muslim family

caregivers, and ten patients with PD through face-to-face in-depth interviews and focus group discussions, together with observation and field notes.

After obtaining a deep understanding of the caring situation in the PD unit, the spiral of action research for developing the Islam-based caring model was consequently conducted. A tentative Islam-based caring model was initially designed by the researcher based on literature reviews and a pilot study, and was then modified based on the qualitative data from the reconnaissance phase. The model was then remodified again by the head of the PD nurses in order to encourage the possibility of implementation of the model in the PD unit. The action plan, strategies, and methods of evaluation and monitoring were also designed by the researcher and the head of the PD nurses. Before implementation, the head of the PD nurses first informed other staff in the PD unit of the action plan and the tentative Islam-based caring model for applying the model into their practice.

The main setting of the implementation of the tentative Islam-based caring model was the PD unit in a public hospital in Satun province, Thailand. The Muslim PD nurses were encouraged to implement the tentative Islam-based caring model continuously. The researcher was the facilitator of the implementation of the caring model. During the reflection and evaluation phase, all of the participants, including the Muslim PD nurses and Muslim family caregivers, reflected on the results of the Islam-based caring model, and all of the data were gathered from the semi-structured interviews, which were conducted by the researcher through telephone interviewing because of the COVID-19 pandemic. The strengths and weaknesses of the implementation of the tentative Islam-based caring model into clinical practice were discussed.

Subsequently, additional resources and re-planning of new actions were redesigned in order to ensure the probability and sustainability of the implementation of the caring model in the second cycle. However, because of the COVID-19 pandemic, the second cycle could not be implemented in the PD unit. Therefore, the present study was implemented only through the first cycle. A tentative Islam-based caring model was established preliminarily. The components of an initial Islam-based caring model for Muslim caregivers of patients with peritoneal dialysis were then drafted. This model consisted of three main components: inputs, the holistic Islamic caring process, and outcomes.

First, inputs refer to the two main persons involved in the Islamic-based caring model: the PD nurses and the Muslim family caregivers. For the PD nurses, the essential competencies required for providing caring for Muslim family caregivers include cultural, holistic nursing, and critical thinking competencies, and the ability to conduct peer group support and to provide the holistic Islamic caring process. Muslim family caregivers can be grouped into two groups. There were slightly different nursing activities in the holistic Islamic caring process assigned to those family caregivers who had less than or equal to three months and those who had more than three months of carrying out their caregiving duties.

Secondly, the holistic Islamic caring process should be applied in providing caring for Muslim family caregivers. This includes the process of caring from an Islamic perspective, including response, reflection, relationship, relatedness, and role modeling (5Rs) integrated with a gratitude approach and nursing processes, such as assessment, diagnosis, planning, implementation, and evaluation. For conducting the processes of holistic Islamic caring, the relevant strategies are used in

this model, which aim to reduce caregiver burden and enhance harmony in life. These strategies include encouraging health professional collaboration, family conferences or meetings, peer group support, and home visits.

Thirdly, the outcomes of the Islam-based caring model include caregiver burden and harmony in life. After implementation of the tentative Islam-based caring model in the first cycle, the results of the tentative Islam-based caring model were seen to have significant impacts on the nurse caring behaviors and the family caregivers' outcomes. These findings revealed that the nurses' caring behaviors were positively changed in practice, as perceived by the Muslim family caregivers. Providing caring with friendly interaction and using informal communication or the local language with a polite tone were satisfying in terms of the relationship between the Muslim PD nurses and the Muslim family caregivers, leading to improved relationships. Greater focus on the family caregivers' problems by paying attention and asking and allowing the Muslim family caregivers to describe their problems and negative feelings was perceived by the Muslim family caregivers. These nurse caring behaviors improved the family caregivers' satisfaction in receiving care from Muslim PD nurses in terms of feeling relaxed and comfortable in expressing their difficulties and encouraged social interaction.

Meanwhile, the Muslim PD nurses were also satisfied in providing the Islam-based caring model. They now are more aware and focus more on the difficulties of Muslim family caregivers than before. Holistic health has been their concern while providing nursing care with the Islam-based caring model. Holistic assessment and caring for Muslim family caregivers are guided for practice within the Islam-based caring model. The PD nurse perceived the benefits of this model so that

they were willing to put the sustainability of the model into their practice as they plan to implement the initial Islam-based caring model on the date of changing the peritoneal dialysis transfer set because there is more time for providing holistic care.

Regarding the Muslim family caregivers' outcomes, which were claimed as the outcomes of this model, the implementation of the tentative Islam-based caring model had significant impacts on the reduction of the caregiver burden in social and psychological aspects as described by the Muslim family caregivers. Meanwhile, harmony in life was improved in terms of encouraging the ability to manage care and in terms of the satisfaction in caregiving.

Nursing Implications

Nursing education

Holistic nursing under the cultural diversity of the individual is one of the challenges of quality care improvement. This study discovered information about Muslim family caregivers, especially the negative multiple effects that are sometimes overlooked in caring. Education must be more focused on the holistic care of family caregivers along with PD patients. This study also provided information about the religious awareness of Muslim family caregivers, which affects their health and well-being. Moreover, this study reported new knowledge on Islam-based caring for Muslim family caregivers of patients with peritoneal dialysis. The model highlighted the integration of the Islamic caring process into the nursing process, which is essential for nursing. It presents comprehensive nursing care, which is aimed to reduce caregiver burden and encourage harmony and balance among the components

of Muslim family caregivers. This model therefore is of benefit as basic knowledge that can be used further in developing the body of knowledge in nursing science.

Nursing practice

Providing holistic nursing is a challenging role for nurses in practice. Obtaining comprehensive understanding regarding the "real" situation, health beliefs, and religious beliefs is important in providing holistic care. This study reflects the real experiences of being a caregiver, which are sometimes overlooked in nursing practice. Aspects of the caregiver burden and harmony in life as perceived by Muslim family caregivers were revealed, and these findings can be beneficial for goal setting in nursing care.

Furthermore, this study preliminarily revealed the components of an Islam-based caring model that PD nurses, especially Muslim PD nurses, can use as a guide for providing nursing care in their PD units. Meanwhile, general nurses can use this Islam-based caring model that was developed as an initial model to guide the frameworks of development of holistic care for Muslim family caregivers of patients living with other chronic illnesses who may be different in terms of their difficulties and the needs. For encouraging practical possibilities, other healthcare providers should be informed about the model for mutual establishment of the action plan. In addition, before implementation of the model, some strategies involving training such as for peer group support should be imparted to PD nurses, so that results may be widely used in their practice.

Research recommendations

The information obtained from reconnaissance step showed that the experiences of Muslim family caregivers in caring for patients with PD were different

depending on caregiving phases. The caregiving difficulties and support needs across the caregiving trajectory should be sought out in further research. Furthermore, this study was conducted under the first cycle of technical action research. The methods of fostering the possibility and sustainability of the Islam-based caring model in practice could not be tried out. If this study re-conduct, the Islam-based caring model should be tested until ensuring the possibility and sustainability. Alternatively, mixed methods research is recommended in further study.

Beside these, the Islam-based caring model in this study was implemented only by Muslim PD nurses. Further study implementing the Islam-based caring model by non-Muslim PD nurses is also recommended in order to ensure simplicity and applicability in their practice. Stronger evidence is required regarding the effectiveness of the model in relation to Muslim family caregivers in other settings.

Strengths of the Study

The initial Islam-based caring model was developed based on theories, a literature review, a pilot study, and the information obtained from Muslim PD nurses, Muslim family caregivers, and Muslim patients with PD who had the required experiences in holistic caring that would fit the Islamic context. This information is beneficial to frame and guide the development of an Islam-based caring model, which is suitable within the research setting. Moreover, the developed Islam-based caring model in this study was an initial model. This model provides the frameworks that

guide PD nurses in the provision of holistic care for the Muslim family caregivers in their practice.

The Limitations of the Study

The implementation of the Islam-based caring model in this study was conducted in a general hospital in Satun province, Thailand, so its application may be limited only to the study setting. Even though this model was developed by the researcher and Muslim PD nurses from four PD units in the southernmost part of Thailand, each setting usually has a different context in terms of working conditions, shortage of PD nurses, number and characteristics of Muslim family caregivers, workplace culture and environment, and organizational systems.

The shortage of PD nurses also may be a barrier to providing the Islam-based caring model in the setting in an effective manner. The Muslim PD nurses had limited time in providing holistic care following the Islam-based caring model because they had many other responsibilities. Therefore, the action plan for the implementation of Islam-based caring model was adjusted in order to foster the possibilities and sustainability of the model in study setting. Unfortunately, the second action plan could not be implemented because of the COVID-19 pandemic. The possibility and sustainability of the Islam-based caring model in this study could not be tested. That is, these should be tested before applying it in practice.

Moreover, the implementation about religion suggests that the outcomes of implementation of the Islam-based caring model may differ according to how strictly Muslim family caregivers adhere to the religion. Therefore, the findings

in this study may not completely explain the outcomes of Muslim family caregivers in an Islamic context. Additionally, the Islam-based caring model in this study was implemented by Muslim PD nurses. Therefore, the findings only reflected the information about the effectiveness and applicability of the Islam-based caring model provided by Muslim PD nurses. This is the reason why the implementation of this Islam-based caring model by non-Muslim PD nurses is required in further studies as suggested in research recommendations.

Meanwhile, the methods of evaluating the outcomes were limited to using in-depth telephone interviews instead of face-to-face in-depts interviews and observation because of the COVID-19 pandemic. Hence, the information regarding outcomes was gathered only from the telephone in-depth interviews, which may not fully reflect the information about the effectiveness of providing the Islam-based caring model.

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Appendices

Appendix A-1

Demographic Data Form for Muslim PD Nurse

Please complete the following questions using check sign (✓) in ❑ and fill in blank to help us know a little about you

1. Gender ❑ Male ❑ Female

2. Age……years

3. Educational level ❑ Bachelor ❑ Bachelor with PD Diploma
❑ Master or higher

4. Duration of work experience in PD unit.....years.....months

5. The experience in holistic care training ❑ Yes duration……
❑ No

6. The experience in Islam-based caring training ❑ Yes duration……
❑ No

7. The experience in providing holistic care ❑ Never ❑ Rarely
❑ Often ❑ Always

8. The experience in providing Islam-based caring ❑ Never ❑ Rarely
❑ Often ❑ Always

Nursing activities…….
…….
…….

Appendix A-2

Demographic Data Form for Muslim Family Caregiver

Please complete the following questions using check sign (✓) in ❑ and fill in blank to help us know a little about you

1. Gender ❑ Male ❑ Female

2. Age……years

3. Relationship with patient ❑ Daughter/Son ❑ Wife/Husband
❑ Mother/Father ❑ Other.....

4. Educational level ❑ No ❑ Primary school
❑ Junior high school ❑ Senior high school
❑ Diploma ❑ Bachelor
❑ Master or higher

5. Marital status ❑ Single ❑ Married
❑ Divorced/Widowed ❑ Separated

6. Occupation ❑ Government employee ❑ State enterprise employee
❑ Employee ❑ Self-employed
❑ Farmer/Gardener/Fisherman ❑ Merchant
❑ Retired ❑ Unemployed
❑ Student ❑ Other .....

7. Income (Baht/month) ❑ No income ❑ Less than 10,000
❑ 10,000 – 15,000 ❑ 15,001 – 20,000
❑ 20,001 – 25,000 ❑ 25,001 – 30,000
❑ 30,001 – 35,000 ❑ More than 35,000

8. Income status ❑ Enough ❑ Not enough

9. Duration of caregiving.....hr/day

10. Duration of being a caregiver.....years.....months

Appendix A-3

Demographic Data Form for Muslim PD Patient

Please complete the following questions using check sign (✓) in ❑ and fill in blank to help us know a little about you

1. Gender ❑ Male ❑ Female

2. Age……years

3. Educational level
❑ No ❑ Primary school
❑ Junior high school ❑ Senior high school
❑ Diploma ❑ Bachelor
❑ Master or higher

4. Marital status
❑ Single ❑ Married
❑ Divorced/Widowed ❑ Separated

5. Underlying Disease
❑ DM ❑ HT
❑ DLP ❑ Heart .....
❑ Cerebrovascular disease ❑ Gout
❑ Renal stone ❑ BPH
❑ Auto immune disease ❑ Other .....

Appendix B

Interview Guide for In-dept Interview

1. แนวคำถามในการสัมภาษณ์เชิงลึกรายบุคคลเพื่อวิเคราะห์สถานการณ์ปัจจุบัน (Reconnaissance step)

ส่วนที่ 1: สำหรับพยาบาล

1) ประสบการณ์การดูแลผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้อง ที่ท่านปฏิบัติอยู่ในปัจจุบันเป็นอย่างไร
2) ท่านได้นำแนวทางศาสนาอิสลามมาใช้ในการดูแลผู้ดูแลเหล่านี้อย่างไรบ้าง กรุณายกตัวอย่างประกอบการอธิบาย
3) ท่านคิดว่าผู้ดูแลได้รับการดูแลแบบองค์รวมหรือไม่ และปัญหาในการให้การดูแลผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้องคืออะไร กรุณายกตัวอย่างประกอบการอธิบาย
4) ท่านอยากให้รูปแบบการดูแลผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้อง เป็นอย่างไร และอยากให้มีการปรับหรือพัฒนา เพิ่มเติมอย่างไรบ้าง
   คำชี้นำ: Response, Relationship, Relatedness, Reflection, Role modeling
5) การนำแนวทางศาสนาอิสลามมาประยุกต์ใช้ในการดูแลผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้องตามความเข้าใจของท่านเป็นอย่างไร และท่านคิดเห็นอย่างไรถ้ามีนำแนวทางศาสนาอิสลามมาประยุกต์ใช้ในการดูแลผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้อง
6) ท่านคิดว่าสามารถนำแนวทางศาสนาอิสลามมาประยุกต์ใช้ในการดูแลผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้องแบบองค์รวมได้อย่างไรบ้าง/ท่านจะใช้รูปแบบการดูแลที่มีการประยุกต์แนวคิดศาสนาอิสลามมาใช้ในการดูแลผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้องอย่างไรบ้าง
7) ท่านคิดว่า ปัจจัยสนับสนุนอะไรบ้างที่จะช่วยส่งเสริมให้ผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้อง ได้รับผลลัพธ์ตามที่ท่านคาดหวังไว้
8) ผลลัพธ์หรือสิ่งที่ท่านคาดหวังจากการนำแนวทางศาสนาอิสลามมาประยุกต์ใช้ในการดูแลผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้องคืออะไร กรุณาอธิบาย
9) ท่านคิดว่าสมดุลชีวิตของผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้องคืออะไร กรุณายกตัวอย่างตามประสบการณ์ของท่านประกอบการอธิบาย

10) ท่านคิดว่าการนำรูปแบบการดูแลที่มีการประยุกต์แนวคิดศาสนาอิสลามมาใช้ในการดูแลผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้องจะช่วยส่งเสริมให้เกิดสมดุลชีวิตในผู้ดูแลได้อย่างไร

ส่วนที่ 2: สำหรับผู้ดูแล

1) บทบาทหรือหน้าที่ที่ท่านปฏิบัติอยู่ในการดูแลญาติของท่านมีอะไรบ้าง กรุณายกตัวอย่างประกอบการอธิบาย
2) กรุณาเล่าประสบการณ์ว่าท่านปฏิบัติตามหลักศาสนาอิสลามอย่างไร และท่านได้นำหลักการหรือแนวทางศาสนาอิสลามมาใช้ในการดูแลผู้ป่วยหรือไม่ อย่างไรบ้าง กรุณายกตัวอย่างประกอบการอธิบาย เหตุใดจึงทำเช่นนั้น
3) สิ่งที่ท่านคาดหวังหรืออยากให้เกิดในการให้การดูแลผู้ป่วยคืออะไร กรุณายกตัวอย่าง และสิ่งที่ท่านปฏิบัติอยู่ในปัจจุบัน เป็นไปตามความคาดหวังของท่านหรือไม่ อย่างไร
4) ท่านได้รับการช่วยเหลือในการดูแลผู้ป่วยที่ได้รับการล้างไตทางช่องท้องจากใคร และอย่างไร กรุณายกตัวอย่างประกอบการอธิบาย
5) ท่านได้รับการดูแลจากพยาบาลในฐานะผู้ดูแลหลักอย่างไรบ้าง และท่านรู้สึกอย่างไรเกี่ยวกับการดูแลที่ท่านได้รับจากพยาบาล กรุณายกตัวอย่างประกอบการอธิบาย
6) ปัญหา/อุปสรรค/ความยากลำบากที่เคยเกิดขึ้นกับท่านในขณะให้การดูแลผู้ป่วยมีอะไรบ้าง และส่งผลต่อสมดุลชีวิตของท่านอย่างไรบ้าง
   คำชี้นำ: ด้านร่างกาย, ด้านจิตใจ, ด้านสังคม, ด้านจิตวิญญาณ
7) ท่านอยากให้มีการจัดการกับปัญหาและอุปสรรคเหล่านั้นอย่างไร
8) ท่านต้องการได้รับความดูแล/ช่วยเหลือเพิ่มเติมจากพยาบาลเพื่อลดภาระในการตัวท่านอย่างไรบ้าง
   คำชี้นำ: ด้านร่างกาย, ด้านจิตใจ, ด้านสังคม, ด้านจิตวิญญาณ
9) การดูแลที่มีการนำแนวทางศาสนาอิสลามมาประยุกต์ใช้ตามความเข้าใจของท่านเป็นอย่างไร ประกอบด้วยอะไรบ้าง
10) ท่านคาดหวังว่าการดูแลที่มีการประยุกต์แนวคิดศาสนาอิสลามมาใช้ช่วยลดภาระในการดูแลและช่วยส่งเสริมให้ท่านมีสมดุลชีวิตได้อย่างไร

ส่วนที่ 3: สำหรับผู้ป่วย

1) ท่านได้รับการดูแลจากผู้ดูแลหลักอย่างไรบ้าง เพียงพอหรือไม่ และเป็นไปตามความคาดหวังของท่านหรือไม่ อย่างไร
2) สิ่งที่ผู้ดูแลหลักของท่านได้รับการดูแลในปัจจุบันเป็นอย่างไร มีการนำแนวทางศาสนาของฮัลเลาะห์มาใช้หรือไม่ อย่างไร เหตุใดจึงเป็นเช่นนั้น
3) สิ่งที่ท่านคาดหวังหรืออยากให้เกิดในการให้การดูแลผู้ดูแลหลักของท่านคืออะไร กรุณายกตัวอย่าง และสิ่งที่โรงพยาบาล/พยาบาลปฏิบัติอยู่ในปัจจุบัน เป็นไปตามความคาดหวังของท่านหรือไม่ อย่างไร
4) ท่านอยากให้โรงพยาบาล/พยาบาลช่วยเหลือผู้ดูแลหลักของท่านอย่างไรบ้าง
5) ถ้าจะให้พยาบาลสร้างรูปแบบการดูแลผู้ดูแลหลักของท่าน ท่านอยากให้ผู้ดูแลหลักของท่านได้รับการดูแลอะไรบ้าง อย่างไร
   คำชี้นำ: ด้านร่างกาย, ด้านจิตใจ, ด้านสังคม, ด้านจิตวิญญาณ

2. แนวคำถามในการสัมภาษณ์เชิงลึกรายบุคคลเพื่อประเมินผลภายหลังการนำรูปแบบการดูแลที่ประยุกต์หลักการทางศาสนาอิสลามไปใช้ในการดูแลผู้ดูแลชาวมุสลิม (Reflection step)

ส่วนที่ 1: สำหรับพยาบาล

1) ท่านคิดว่าภายหลังได้ทดลองใช้รูปแบบการดูแลที่ประยุกต์แนวทางศาสนาอิสลาม พฤติกรรมการให้การดูแลของท่านที่มีต่อผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้อง มีการเปลี่ยนแปลงจากเดิมหรือไม่ อย่างไร กรุณายกตัวอย่างประกอบการอธิบาย
2) ผลลัพธ์ที่เกิดขึ้นจากการทดลองใช้รูปแบบการดูแลที่ประยุกต์แนวทางศาสนาอิสลามในผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้อง เป็นไปตามความคาดหวังของท่านหรือไม่ อย่างไร
3) ท่านมีความพึงพอใจอย่างไรต่อผลลัพธ์ของการใช้รูปแบบการดูแลที่มีการประยุกต์แนวทางศาสนาอิสลามในครั้งนี้อย่างไร/การใช้รูปแบบการดูแลที่มีการประยุกต์แนวทางศาสนาอิสลามช่วยลดภาระในการดูแล และช่วยส่งเสริมสมดุลชีวิตของผู้ดูแลได้อย่างไร กรุณายกตัวอย่างประกอบการอธิบาย
4) ปัญหาและอุปสรรคในการใช้รูปแบบการดูแลที่ประยุกต์แนวทางศาสนาอิสลามในการดูแลผู้ดูแลในครอบครัวของผู้ป่วยมุสลิมที่ได้รับการล้างไตทางช่องท้องมีอะไรบ้าง อย่างไร

5) ท่านคิดว่าจุดดี/จุดแข็งของรูปแบบการดูแลที่ได้ประยุกต์แนวทางศาสนาอิสลามมาใช้ มีอะไรบ้าง
6) ท่านคิดว่าจุดอ่อน/จุดที่ควรปรับปรุงของรูปแบบการดูแลที่ได้ประยุกต์แนวทางศาสนาอิสลามมาใช้ มีอะไรบ้าง
7) ท่านจะพัฒนา/ปรับเปลี่ยนรูปแบบการดูแลที่ประยุกต์แนวทางศาสนาอิสลามเพื่อนำไปทดลองใช้ในครั้งต่อไปอย่างไร

ส่วนที่ 2: สำหรับผู้ดูแล

1) สิ่งที่ท่านได้รับการดูแลจากพยาบาลในปัจจุบันแตกต่างจากก่อนหน้านี้หรือไม่ อย่างไรบ้าง กรุณายกตัวอย่างประกอบการอธิบาย
2) สิ่งที่ท่านได้รับการดูแลจากพยาบาลสอดคล้องกับหลักศาสนาอิสลามหรือไม่ อย่างไร ยกตัวอย่างประกอบการอธิบาย
3) จุดเด่น/จุดอ่อนของกิจกรรมการดูแลที่ท่านได้รับจากพยาบาลมีอะไรบ้าง
4) ท่านพึงพอใจกับรูปแบบการดูแลที่มีการประยุกต์แนวทางศาสนาอิสลามมาใช้ของพยาบาลหรือไม่ เหตุใดจึงคิดเช่นนั้น
5) ผลลัพธ์ที่เกิดขึ้นในตัวท่าน ภายหลังได้รับการดูแลที่มีการประยุกต์แนวทางศาสนาอิสลามมาใช้จากพยาบาลมีการเปลี่ยนแปลงอย่างไร สอดคล้องกับความคาดหวังของท่านหรือไม่ เหตุใดจึงคิดเช่นนั้น กรุณายกตัวอย่างประกอบการอธิบาย
   คำชี้นำ: ด้านร่างกาย, ด้านจิตใจ, ด้านสังคม, ด้านจิตวิญญาณ (ความเชื่อ)
6) ท่านมีความพึงพอใจต่อผลลัพธ์ที่เกิดขึ้นกับตัวท่านจากการใช้รูปแบบการดูแลที่มีการประยุกต์แนวทางศาสนาอิสลามมาใช้ของพยาบาลอย่างไร
7) ภาระในการดูแล และสมดุลชีวิตตามการรับรู้ของท่านหมายความว่าอย่างไร
8) การดูแลที่มีการประยุกต์แนวคิดศาสนาอิสลามมาใช้ช่วยลดภาระในการดูแล และช่วยส่งเสริมให้ท่านมีสมดุลชีวิตได้อย่างไร สอดคล้องกับความคาดหวังของท่านหรือไม่
9) ท่านอยากให้มีการปรับเปลี่ยน/เพิ่มเติมรูปแบบการดูแลของพยาบาลให้สอดคล้องกับแนวทางศาสนาอิสลามของท่านอย่างไรบ้าง กรุณาอธิบาย

Appendix C

Interview Guide for Focus Group Discussion

2. แนวคำถามในการสัมภาษณ์รายกลุ่ม (Interview Guide for Focus Group Discussion) สำหรับผู้ดูแล (Reconnaissance step)

1) ท่านได้ใช้หลักหรือแนวทางศาสนาอิสลามมาใช้ในการดูแลผู้ป่วยหรือไม่ อย่างไรบ้าง กรุณายกตัวอย่างประกอบการอธิบาย เหตุใดจึงทำเช่นนั้น
2) สิ่งที่ท่านคาดหวังหรืออยากให้เกิดในการให้การดูแลผู้ป่วยคืออะไร กรุณายกตัวอย่าง และสิ่งที่ท่านปฏิบัติอยู่ในปัจจุบัน เป็นไปตามความคาดหวังของท่านหรือไม่ อย่างไร
3) ท่านได้รับการช่วยเหลือในการดูแลผู้ป่วยที่ได้รับการล้างไตทางช่องท้องจากใคร และอย่างไรบ้าง กรุณายกตัวอย่างประกอบการอธิบาย
4) ท่านเคยได้รับการดูแลจากพยาบาลในฐานะผู้ดูแลหลักอย่างไรบ้าง และท่านรู้สึกอย่างไรเกี่ยวกับการดูแลที่ท่านได้รับจากพยาบาล กรุณายกตัวอย่างประกอบการอธิบาย
5) การดูแลดังกล่าวส่งเสริมสุขภาพองค์รวมของท่านอย่างไรบ้าง
6) ปัญหา/อุปสรรค/ความยากลำบากที่เคยเกิดขึ้นกับท่านในขณะให้การดูแลผู้ป่วยมีอะไรบ้าง และส่งผลต่อสมดุลชีวิตของท่านอย่างไรบ้าง
   คำชี้นำ: ด้านร่างกาย, ด้านจิตใจ, ด้านสังคม, ด้านจิตวิญญาณ
7) ท่านอยากให้มีการจัดการกับปัญหาและอุปสรรคเหล่านั้นอย่างไร
8) ท่านต้องการได้รับความดูแล/ช่วยเหลือเพิ่มเติมจากพยาบาลเพื่อลดภาระในการดูแลอย่างไรบ้าง
   คำชี้นำ: ด้านร่างกาย, ด้านจิตใจ, ด้านสังคม, ด้านจิตวิญญาณ
9) ท่านเคยได้รับการดูแลที่สอดคล้องกับหลักหรือความเชื่อทางด้านศาสนาอิสลามของท่านหรือไม่ อย่างไร และท่านคิดเห็นอย่างไรถ้าพยาบาลนำแนวทางศาสนาอิสลามมาประยุกต์ใช้ในการดูแลท่านได้อย่างไรบ้าง
10) ท่านคิดว่าประเด็นหรือแนวทางศาสนาอิสลามที่พยาบาลควรคำนึงถึงในการให้การดูแลมีอะไรบ้าง กรุณายกตัวอย่างประกอบการอธิบาย
11) ท่านคาดหวังว่าการดูแลที่มีการประยุกต์แนวคิดศาสนาอิสลามมาใช้จะช่วยลดภาระในการดูแล และช่วยส่งเสริมให้ท่านมีสมดุลชีวิตได้อย่างไร

Appendix D

Observation Guide Nurse Caring Behavior

This observation guide is used to assess the nurse caring behavior in providing Islamic thought based caring model to Muslim family caregivers of patients with peritoneal dialysis. Please give ✓ on the box of lists.

Observation	Yes	No
Verbal caring behaviors		
1. Encourage the family caregivers to express their experiences		
2. Assess physical problems		
3. Assess psychological problems or feelings		
4. Discuss about physical and psychological problems or issues of family caregiver regarding caregiving.		
5. Assist Muslim family caregivers to understand the difficult situations and current their needs		
6. Advise Muslim family caregivers to manage both physical and psychological problems of them based on Islamic beliefs		
7. Encourage Muslim family caregivers to provide caring for self, caring for patients, and caring for God.		
8. Reinforce Muslim family caregivers to express gratitude or thanks giving to Allah and their care-receivers when they involve in caregiving tasks through the word “Alhamdulillah”.		
9. Provide and support the family caregivers to pray, read, and recite the Qur’an and Hadiths regarding family importance, caring family members, and gratitude.		
10. Assist the family caregivers to consider that performing caregivers’ roles of them is based on the Qur’an and Hadiths regarding family importance, caring family members, and gratitude.		
11. Provide information about the patients’ conditions to the Muslim family caregivers		
Nonverbal caring behaviors		
1. Listen carefully to the Muslim family caregivers.		
2. Communicating using informal technique (friendly conversation, using informal massage)		
3. Friendly interaction		
4. Use appropriate Islamic caring touch when interacting with the Muslim family caregivers (Using right hand for handing objects to them, gently touch, stroking hair, holding hands)		

Observation	Yes	No
5. Keep eye contact when interacting with the family caregivers.		
6. Arrange a time and room to Muslim family caregivers and their patients for praying when they come to follow-up at the dialysis unit.		
7. Allow and respect the rights/decisions of Muslim family caregivers in planning care, cooperate with the multidisciplinary healthcare team to adjust appropriate caring.		
8. Show an act that reflect as a Muslim to the Muslim family caregivers (provide shaking hand with the same sex)		
9. Provide the nursing activities to relieve physical and psychological problems.		
10. Take action as the role modeling for learning and sharing experience.		
11. Help the Muslim family caregivers to seek the role model in relation to caregiving.		

Appendix E

Informed Consent Form

แบบยินยอมอาสาสมัคร

ข้าพเจ้า (นาง / นางสาว / นาย) ..... นามสกุล ..... อายุ ..... ปี บ้านเลขที่ .....หมู่ที่ ..... ตำบล .....อำเภอ .....จังหวัด ..... ได้อ่านแบบคำชี้แจงอาสาสมัครเกี่ยวกับการเข้าร่วมการเป็นผู้ตอบแบบสอบถามในโครงการวิจัยเรื่อง “การพัฒนารูปแบบการดูแลโดยใช้แนวคิดศาสนาอิสลามเป็นฐานสำหรับผู้ดูแลมุสลิมของผู้ป่วยที่ได้รับการล้างไตทางช่องท้องในจังหวัดชายแดนภาคใต้ของประเทศไทย” ซึ่งประกอบด้วย วัตถุประสงค์ของการวิจัย ประโยชน์โดยตรงที่อาสาสมัครจะได้รับจากการเข้าร่วมโครงการวิจัยในครั้งนี้ ขั้นตอนการปฏิบัติตัว ตลอดจนการรับรองจากผู้วิจัยที่จะเก็บรักษาข้อมูลในการตอบแบบสอบถามของข้าพเจ้าไว้เป็นความลับ และไม่ระบุชื่อหรือข้อมูลส่วนตัวเป็นรายบุคคลต่อสาธารณชน โดยผลการวิจัยจะนำเสนอในลักษณะภาพรวมที่เป็นการสรุปผลการวิจัยเพื่อประโยชน์ทางวิชาการเท่านั้น

ข้าพเจ้าได้อ่านและเข้าใจตามคำอธิบายข้างต้นแล้ว จึงได้ลงนามยินยอมเข้าร่วมโครงการวิจัยนี้ด้วยความสมัครใจ

ลงชื่อ ..... อาสาสมัคร

(.....)

วันที่ ..... เดือน .....พ.ศ. .....

Appendix F

The actions of Muslim PD nurses based on the processes of 5Rs

Process of caring	Nurse's behaviors
Relationship	Build the relationship using interpersonal communication skills including: 1. Establish trust with Muslim family caregivers by introducing the name, surname, and experiences in caring and using informal communication techniques. 2. Show friendly interaction through facial expression and the use of local language. 3. Pay attention to Muslim family caregivers' difficulties, active listening, observing, and assessing the caregiving's difficulties in holistic aspects.
Relatedness	1. Allow Muslim family caregivers to express their feelings about the caregiving's difficulties. 2. Show sincerity in caring through talking, active listening, paying attention, and continued monitoring Muslim family caregivers and their patients by (home) visit or telephone calls. 3. Respect and accept the decision making of the Muslim family caregivers and their families. 4. Show the empathy behaviors to Muslim family caregivers through friendly interaction through facial expression, emotional reactions, language, and providing simply touch in recognition of family caregivers' presence. 5. Aware and accept in religious beliefs affecting caregiving. 6. Aware and accept in personal and cultural background, language, health beliefs, and spirituality in an information providing. For example, offering encouragement or emotional by using local language.
Response	Respond to Muslim family caregivers' difficulties and needs in an individual
Role modeling	1. Establish peers support group for Muslim family caregivers and seek the role model for sharing the experiences in relation to caregiving 2. Encourage Muslim family caregivers to share their experience to others as a role model 3. Facilitate Muslim family caregivers to participate and share their experiences through peer group support activity. 4. Establish the informal peer group support without hospital visit such as using line application
Reflection	Encourage Muslim family caregivers to reflect on their difficulties and needs in relation to caregiving in all aspects of Islamic human being.
Gratitude	Encourage Muslim family caregivers to reflect on their religious beliefs and cultural preference in term of gratitude related to caregiving

Appendix G

Holistic Islamic nursing care plan for Muslim family caregiver

Nursing care plan / Human dimension	Assessment	Objectives	Nursing care	Evaluation
1. Physical care	1. Assess the beliefs in religious, health, cultures, and personal characteristics of Muslim family caregivers in an individual 2. Assess health's problems such as underlying disease and possible problems such as sleep disturbance, frustration, nutrition problems (poor appetite, body weight loss), self-care ability, and physical problems management 3. Assess the factors related to the physical aspect, self-care ability, and physical problems. 4. Assess the Muslim family caregivers' ability in self-care and physical problems management. 5. Assess the Muslim family caregivers' needs related to self-care and physical problems management.	To encourage the Muslim family caregivers to have the ability in self-care and physical problems management	1. Provide the information about self-care and health promotion to Muslim family caregiver in an individual such as relaxation, nutrition, and exercise. 2. Give the information about the strategies for managing the physical problems. 3. Support and encourage the Muslim family caregivers to manage their time for self-care.	1. Muslim family caregivers have the appropriate self-care behaviors. 2. Muslim family caregivers have the knowledge in relation to physical problems management. 3. The perceived physical problems are reduced.

Nursing care plan / Human dimension	Assessment	Objectives	Nursing care	Evaluation
2. Psychological care	1. Assess the beliefs in religious, health, cultures, and personal characteristics of Muslim family caregivers in relation to psychological dimension. 2. Assess the possible psychological problems such as stress, anxiety, fear, burnout, fatigue, loneliness, guilty, irritation, and burden. 3. Assess the causes and factors affected the psychological problems. 4. Assess the Muslim family caregivers' ability and strategies in managing psychological problems. 5. Assess the Muslim family caregivers' needs related to caregiving and managing psychological problems.	1. To relieve the psychological difficulties in Muslim family caregivers. 2. To encourage the Muslim family caregivers to manage their psychological difficulties appropriately and effectively.	1. Encourage the Muslim family caregivers in performing caregiver' roles. 2. Provide the strategies in managing psychological difficulties effectively. 3. Provide skill training in managing psychological difficulties 4. Support the family member to express their gratitude and encouragement to Muslim family caregivers as the family support 5. Encourage the family member to involve in caring and supporting Muslim family caregivers invariably. 6. Encourage peer group to express emotional support through encouragement.	1. Muslim family caregivers have the knowledge and ability in managing psychological difficulties. 2. The stress and burden in Muslim family caregivers are reduced. 3. The psychological difficulties are reduced perceived by Muslim family caregivers.

Nursing care plan / Human dimension	Assessment	Objectives	Nursing care	Evaluation
3. Ethical care	1. Assess the ethical problems (feeling guilty in an ineffective caregiving) 2. Assess the causes and factors affected the feeling guilty. 3. Assess the Muslim family caregivers' ability and strategies in managing the feeling guilty. 4. Assess the Muslim family caregivers' needs related to the managing the feeling guilty.	To encourage the Muslim family caregivers to cope and manage the feeling guilty in an ineffective caregiving	1. Allow the Muslim family caregivers, the patients, and others family members to involve in caregiving planning as well as seeking the solving. 2. Support the Muslim family caregivers, the patients, and others family members to be decision maker 3. Reinforce other family caregivers to express their responsibilities in caregiving.	The feeling guilty in an ineffective caregiving is reduced.
4. Ideological care (role/finance/social)	1. Assess the difficulties in maintaining multiple roles, financial status, and social involvement. 2. Assess the causes and factors affected their other roles, financial status, and social involvement. 3. Assess the Muslim family caregivers' ability and strategies in managing their other roles, financial status, and social involvement. 4. Assess the Muslim family caregivers' needs related to the managing their other roles, financial status, and social involvement.	1. To reduce or prevent family conflict 2. To encourage or maintain the balancing of multiple roles 3. To reduce the financial strain 4. To maintain the social interaction with others as normal	1. Encourage others family members to involve in caregiving planning and managing in order to reduce work load and financial problems, and to maintain the balancing between multiple roles and caregiving in Muslim family caregivers 2. Assist Muslim family caregivers to adjust the PD schedules in accordance with their work, school, religious practices, and social activities. 3. Assist Muslim family caregivers to seek the social support from others and strategies for asking the help.	1. Muslim family caregivers can manage their roles. 2. Muslim family caregivers perceive the balancing between caregiving and other roles. 3. Muslim family caregivers can manage the financial difficulties. 4. Muslim family caregivers do not perceive the feeling of social isolation.

Nursing care plan / Human dimension	Assessment	Objectives	Nursing care	Evaluation
			4. Collaborate and encourage Muslim family caregivers, patients, and other family members to discuss the solutions or manage the difficulties in order to keep the balancing of multiple roles in Muslim family caregivers. 5. Develop the program for supporting and facilitating Muslim family caregiver in caregiving such as follow-up appointment management and dialysate's distribution management in order to reduce financial burden. 6. Provide the information about the financial management. 7. Assist the Muslim family caregivers to seek the solution in reducing the financial burden. 8. Seek and provide the information about the supporting resources in hospital and community. 9. Collaborate with the related network for asking the support. 10. Establish the activities for promoting family caregiver to socialize with others	

Nursing care plan / Human dimension	Assessment	Objectives	Nursing care	Evaluation
5. Spiritual care	1. Assess the beliefs in religious, the goals and the meaning in life. 2. Assess the impact of caregiving on spiritual and the perception of meaning in life. 3. Assess the factors influenced the spirituality and the perception of meaning in life.	To encourage the Muslim family caregivers to gain spiritual well-being and perception of meaning in life.	1. Provide caring to Muslim family caregivers by concerning the religious and health beliefs such as cleanliness, Halal food, pilgrimage, body undisclosed, and fasting in Ramadan. 2. Support and encourage Muslim family caregivers to show remembrance of and faith in Allah. 3. Support and encourage Muslim family caregivers to do the religious practices such as pray, blessing from Allah (Dua), read/recite the Qur'an and Hadiths. 3. Encourage the Muslim family caregivers to recognize about the Islamic beliefs (Qur'an and Hadiths) and doctrine of Allah in relation to caregiving 4. Encourage the Muslim family caregivers to seek the meaning in life based on the religious belief and the doctrine of Allah. 4. Offer encouragement and encourage other family members to always show emotional support to Muslim family caregivers in performing caregiving.	1. Muslim family caregivers can do religious practices as normal 2. The spiritual well-being is at a high level. 3. The harmony in life of the Muslim family caregivers is at a high level.

Nursing care plan / Human dimension	Assessment	Objectives	Nursing care	Evaluation
			5. Establish peer group support and encourage peers to show spiritual support. 6. Provide the information about the religious beliefs in caregiving.	
6. Intellectual care	1. Assess the difficulties and needs in relation to self-care and caregiving. 2. Assess the causes and factors related to seeking the knowledge of self-care and caregiving. 3. Assess the Muslim family caregivers' ability in seeking the knowledge of self-care and caregiving. 4. Assess the supporting resources in seeking the knowledge of self-care and caregiving.	1. Encourage the Muslim family caregivers to seek the knowledge of self-care and caregiving from reliable resources. 2. Support the Muslim family caregivers to access to the knowledge of self-care and caregiving from reliable resources 3. Improve the ability of Muslim family caregivers in providing self-care and caregiving effectively.	1. Provide information related to the providing self-care and caregiving from reliable sources to Muslim family caregivers and review the knowledge in each follow-up. 2. Provide skills training regarding caregiving and redemonstrate in every follow-up. 3. Provide the information instruments such as brochure, VDO, and handbook/sheet of PD patient caring 4. Provide a telephone helpline for supporting Muslim family caregivers	1. Muslim family caregivers have the knowledge of self-care and caregiving 2. Muslim family caregivers have the readiness in performing self-care and caregiving activities.

Appendix H

คู่มือการดูแลผู้ดูแลมุสลิมแบบองค์รวม

สำหรับพยาบาล

จัดทำโดย

หน่วยล้างไตทางช่องท้อง โรงพยาบาลสตูล

คำนำ

ปัจจุบันจำนวนผู้ป่วยโรคไตเรื้อรังที่ได้รับการล้างไตทางช่องท้องก็มีจำนวนเพิ่มขึ้นทุก ๆ ปี จากรายงานความชุกของผู้ป่วยโรคไตเรื้อรังที่ได้รับการล้างไตทางช่องท้องในประเทศไทยเพิ่มขึ้นจาก 328.8 เป็น 369.0 คนต่อประชากรล้านคนในปีพ.ศ. 2557 และปีพ.ศ. 2558 ตามลำดับ (Chuasuwan & Lumpaopong, 2015) เมื่อพิจารณาความชุกของผู้ป่วยโรคไตเรื้อรังที่ได้รับการล้างไตทางช่องท้องเฉพาะในภาคใต้ จากรายงานพบว่ามีความชุกเพิ่มขึ้นจาก 301.5 คนต่อประชากรล้านคนในปีพ.ศ. 2557 เป็น 346.8 คนต่อประชากรล้านคนในปีพ.ศ. 2558 (Chuasuwan & Praditpornsilpa, 2014) และเมื่อพิจารณาความชุกของผู้ป่วยโรคไตเรื้อรังที่ได้รับการล้างไตทางช่องท้องเฉพาะในจังหวัดสตูลพบว่าเพิ่มขึ้นจาก 20 ราย เป็น 114 รายในปีพ.ศ.2556 และปีพ.ศ. 2558 ตามลำดับ (Chuasuwan & Lumpaopong, 2015)

การล้างไตทางช่องท้องเป็นการบำบัดรักษาที่ผู้ดูแลมีบทบาทสำคัญในการดูแลผู้ป่วยที่บ้าน ซึ่งการปฏิบัติบทบาทของผู้ดูแลอาจส่งผลต่อการดำเนินชีวิตและส่งผลให้บุคคลเหล่านั้นต้องเผชิญกับปัญหาที่เกิดจากการดูแลหรือที่เรียกว่า ภาระในการดูแล (Caregiver burdens) ทั้งด้านร่างกาย จิตใจ สังคม จิตวิญญาณ ตลอดจนเศรษฐกิจ แบบแผนการดำเนินชีวิต และการทำหน้าที่ตามบทบาทของผู้ดูแล

การดูแลแบบองค์รวม (Holistic care) ในผู้ดูแลถือเป็นบทบาทที่ท้าทายสำหรับพยาบาลที่จะต้องพัฒนาให้เกิดขึ้นเพื่อเพิ่มประสิทธิภาพในการดูแลและเพื่อให้สอดคล้องกับนโยบาย PD First Policy ของสำนักงานหลักประกันสุขภาพแห่งชาติ สำหรับพื้นที่ในจังหวัดชายแดนภาคใต้ที่มีประชากรส่วนใหญ่เป็นมุสลิม การให้การดูแลผู้ดูแลมุสลิมแบบองค์รวม จึงควรมีการนำหลักศาสนาอิสลามเข้ามาประยุกต์ร่วมด้วย ดังนั้นคณะผู้จัดทำจึงได้จัดทำคู่มือการดูแลผู้ดูแลมุสลิมแบบองค์รวมสำหรับพยาบาลนี้ขึ้น โดยหวังว่าจะช่วยให้พยาบาลหน่วยล้างไตทางช่องท้องใช้เป็นแนวทางในการดูแลผู้ดูแลมุสลิมได้ครอบคลุมองค์รวม สอดคล้องกับบริบทและวัฒนธรรมของมุสลิม ซึ่งจะนำไปสู่การพัฒนาคุณภาพระบบบริการด้านการพยาบาลในหน่วยล้างไตทางช่องท้องให้มีประสิทธิภาพ ช่วยลดภาระในการดูแลและเพิ่มความสมดุลของชีวิตในผู้ดูแลมุสลิมต่อไปได้

วัตถุประสงค์

1. เพื่อใช้เป็นแนวทางในการดูแลผู้ดูแลมุสลิมของผู้ป่วยที่ได้รับการล้างไตทางช่องท้อง สำหรับพยาบาลวิชาชีพที่ปฏิบัติงานในหน่วยล้างไตทางช่องท้องหรือหน่วยงานอื่นที่เกี่ยวข้อง

2. เพื่อให้พยาบาลวิชาชีพที่ปฏิบัติงานในหน่วยล้างไตทางช่องท้อง สามารถให้การบริการทางคลินิกแก่ผู้ดูแลมุสลิมครอบคลุมองค์รวม สอดคล้องกับบริบทและวัฒนธรรมของมุสลิมได้อย่างมีประสิทธิภาพ

3. เพื่อให้ผู้ดูแลมุสลิมของผู้ป่วยที่ได้รับการล้างไตทางช่องท้องได้รับการดูแลครอบคลุมแบบองค์รวม ซึ่งจะนำไปสู่การมีคุณภาพชีวิตที่ดีในระยะยาว

สารบัญ

กรอบแนวคิดการดูแลผู้ดูแลมุสลิมแบบองค์รวมโดยประยุกต์ใช้แนวคิดศาสนาอิสลาม

การพยาบาลแบบองค์รวม (Holistic care) หมายถึง การปฏิบัติกิจกรรมการพยาบาลโดยคำนึงถึงความเป็นองค์รวมของบุคคล อันประกอบด้วย มิติด้านร่างกาย จิตใจ สังคม และจิตวิญญาณ ซึ่งมีความเกี่ยวข้องสัมพันธ์กันไม่สามารถแยกจากกันได้ พยาบาลจะต้องพิจารณาผู้รับบริการให้ครอบคลุมองค์รวมภายใต้บริบทหรือประสบการณ์ที่เฉพาะเจาะจงของบุคคลนั้น ๆ

ตามทัศนะของศาสนาอิสลาม อธิบายว่า มนุษย์ (human being) มีลักษณะเฉพาะที่ประกอบขึ้นด้วยร่างกาย (body) รวมกันเป็นหนึ่งเดียวกับจิตวิญญาณ (soul) และเชื่อมโยงเข้ากับระบบโลก (world system) กลายเป็นองค์รวม ดังนั้นการพยาบาลแบบองค์รวมตามทัศนะของอิสลสาม จึงหมายถึง กิจกรรมการดูแลที่ครอบคลุมทุกมิติของมนุษย์

Barolia และ Karmaliani (2008) อธิบายว่า การดูแลทางการพยาบาลตามทัศนะของอิสลามมีวัตถุประสงค์เพื่อคงไว้ซึ่งความสมดุลของมนุษย์ (human being) ครอบคลุมทั้ง 5 ด้าน ได้แก่ ด้านร่างกายและจิตใจ (physical dimension) ด้านจริยธรรม (ethical dimension) 3) ด้านอุดมการณ์หรือคตินิยม (ideological dimension) ด้านจิตวิญญาณ (spiritual dimension) และด้านปัญญา (intellectual dimension)

กระบวนการพยาบาลผู้ดูแลมุสลิมแบบองค์รวม

กระบวนการพยาบาลผู้ดูแลมุสลิมแบบองค์รวมนี้ ประยุกต์มาจากแนวคิดการดูแลแบบองค์รวมตามทัศนะของอิสลามของ Barolia และ Karmaliani (2008) ซึ่งเสนอแนะให้กระบวนการดูแล ประกอบด้วย การสร้างสัมพันธภาพ (**R**elationship) การมีปฏิสัมพันธ์กันในสังคม (**R**elatedness) การตอบสนอง (**R**esponse) การมีบุคคลต้นแบบ (**R**ole modeling) และการสะท้อนคิด (**R**eflection) หรือเรียกว่า 5Rs ร่วมกับการประยุกต์ใช้แนวคิดเรื่องความกตัญญู (Gratitude) ซึ่งถือเป็นหน้าที่ทางศีลธรรมของมุสลิมทุกคน

กระบวนการดูแล	พฤติกรรมของพยาบาล
การสร้างสัมพันธภาพ (**R**elationship)	สร้างสัมพันธภาพกับผู้ดูแลโดยใช้ทักษะการสื่อสารระหว่างบุคคล ได้แก่ 1. แนะนำตัวเอง ประสบการณ์การทำงาน โดยใช้ภาษาและคำพูดที่เป็นมิตร ไม่เป็นทางการ เพื่อสร้างความไว้วางใจ 2. แสดงสีหน้า ใช้ภาษาและน้ำเสียงที่เป็นมิตร 3. แสดงออกถึงความสนใจในการช่วยเหลือแก้ไขปัญหาของผู้ดูแล สอบถาม ตั้งใจรับฟัง และประเมิน และประเมินปัญหาที่เกี่ยวข้องกับการทำหน้าที่ผู้ดูแลครอบคลุมทุกด้าน
การมีปฏิสัมพันธ์กันในสังคม (**R**elatedness)	1. เปิดโอกาสให้ผู้ดูแลได้ระบายความรู้สึกเกี่ยวกับปัญหา 2. แสดงความจริงใจในการให้การดูแล เช่น สอบถามและติดตามปัญหาของผู้ดูแลและผู้ป่วยอย่างต่อเนื่อง ให้ความสนใจ ตั้งใจรับฟัง และแสดงออกถึงความกระตือรือร้นในการค้นหาแนวทางแก้ไขปัญหาของผู้ดูแล

กระบวนการดูแล	พฤติกรรมของพยาบาล
	3. แสดงพฤติกรรมที่แสดงออกถึงความเคารพและยอมรับในการตัดสินใจของผู้ดูแล ผู้ป่วยและครอบครัว 4. แสดงสีหน้า อารมณ์ ท่าทาง ใช้ภาษา/คำพูดที่เป็นมิตรและแสดงออกถึงความเข้าใจและเห็นอกเห็นใจผู้แล เช่น การสัมผัส เป็นต้น 5. แสดงออกถึงความตระหนักและการยอมรับในความแตกต่างของความเชื่อด้านศาสนา 6. แสดงออกถึงความตระหนักและการยอมรับในความแตกต่างของความเชื่อด้านสุขภาพ วัฒนธรรม ภาษา และพื้นฐานของแต่ละบุคคล เช่น ให้เวลาและให้กำลังใจผู้ดูแลในการทำหน้าที่เป็นผู้ดูแล การใช้ภาษาท้องถิ่นในการสื่อสาร เป็นต้น
การตอบสนอง (Response)	ให้การดูแลโดยตอบสนองต่อปัญหาและความต้องการของผู้ดูแลแต่ละราย
การมีบุคคลต้นแบบ (**R**ole modeling)	1. ค้นหาผู้ดูแลต้นแบบ (role model) ในการจัดการปัญหาและการปรับตัว 2. กระตุ้น/สนับสนุนให้ผู้ดูแลที่สามารถจัดการปัญหาและสามารถปรับตัวได้เกิดความรู้สึกอยากถ่ายทอดประสบการณ์ไปสู่ผู้ดูแลอื่น 3. อำนวยให้ผู้ดูแลต้นแบบได้แลกเปลี่ยนประสบการณ์การจัดการปัญหาและการปรับตัวกับผู้ดูแลอื่นผ่านการทำกิจกรรม Peer group support 4. พัฒนาช่องทางการสื่อสารระหว่างผู้ดูแลด้วยกัน
การสะท้อนคิด (**R**eflection)	เปิดโอกาสให้ผู้ดูแลสะท้อนคิดเกี่ยวกับการดูแลของพยาบาลครอบคลุมปัญหาทุกด้านของผู้ดูแล
ความกตัญญู (Gratitude)	กระตุ้นให้ผู้ดูแลทบทวนเกี่ยวกับแนวคิด/ความเชื่อทางศาสนาที่เกี่ยวข้องกับการทำหน้าที่เป็นผู้ดูแล เช่น หน้าที่ของมุสลิมต่อเพื่อนมนุษย์ หลักความกตัญญูของมุสลิม

แผนการพยาบาลผู้ดูแลมุสลิมแบบองค์รวม

ขั้นตอน / มิติของมนุษย์	การเก็บรวบรวมข้อมูล	วัตถุประสงค์	กิจกรรมการพยาบาล	การประเมินผลลัพธ์
1. การดูแลตนเองและการจัดการปัญหาด้านร่างกาย	1. ประเมินความเชื่อด้านศาสนา สุขภาพ วัฒนธรรม และพื้นฐานของผู้ดูแลเป็นรายบุคคล 2. ประเมินปัญหาด้านสุขภาพ เช่น โรคประจำตัว และปัญหาที่พบบ่อย เช่น ปัญหาการนอนหลับ ความอ่อนล้า ปัญหาด้านโภชนาการ (ความอยากอาหารลดลง น้ำหนักลดลง) การดูแลตนเอง และการจัดการปัญหาด้านร่างกายที่เกิดแล้ว/อาจจะเกิดอย่างเป็นระบบ 3. ประเมินปัจจัยเสี่ยงที่ส่งผลกระทบต่อร่างกาย การดูแลตนเอง และก่อให้เกิดปัญหาด้านร่างกาย 4. ประเมินความสามารถของผู้ดูแลในการจัดการปัญหาที่เกี่ยวข้องกับการดูแลตนเองและการจัดการปัญหาด้านร่างกาย 5. ประเมินความต้องการที่เกี่ยวข้องกับการดูแลตนเองและการจัดการปัญหาด้านร่างกาย	ส่งเสริมให้ผู้ดูแลมีการดูแลตนเองและมีการจัดการปัญหาด้านร่างกายที่เหมาะสม	1. ให้คำแนะนำ/ข้อมูลเกี่ยวกับการดูแลตนเองและการมีพฤติกรรมสร้างเสริมสุขภาพที่เหมาะสมกับผู้ดูแลแต่ละราย ได้แก่ การพักผ่อน โภชนาการ และการออกกำลังกาย 2. แนะนำแนวทาง/กลยุทธ์เกี่ยวกับการจัดการปัญหาด้านร่างกาย ได้แก่ ปัญหาการนอนหลับ ความอ่อนล้า ความอยากอาหารลดลง น้ำหนักลด 3. แนะนำเกี่ยวกับการบริหารจัดการเวลาในการดูแลตนเอง	1. ผู้ดูแลมีพฤติกรรมการดูแลตนเองที่เหมาะสม 2. ผู้ดูแลมีความรู้เกี่ยวกับแนวทางการจัดการปัญหาด้านร่างกายของตนเอง 3. ผู้ดูแลรับรู้ว่าปัญหาด้านร่างกายของตนเองเกิดขึ้นลดลง

ขั้นตอน / มิติของมนุษย์	การเก็บรวบรวมข้อมูล	วัตถุประสงค์	กิจกรรมการพยาบาล	การประเมินผลลัพธ์
2. การดูแลและสนับสนุนด้านจิตใจ	1. ประเมินความเชื่อด้านศาสนา สุขภาพ วัฒนธรรม และพื้นฐานของผู้ดูแลที่เกี่ยวข้องกับอารมณ์และจิตใจ 2. ประเมินปัญหาด้านอารมณ์และจิตใจ ได้แก่ เครียด วิตกกังวล กลัว หมดไฟ อ่อนล้า โดดเดี่ยว รู้สึกผิด โกรธ ความรู้สึกภาระในการดูแล ฯลฯ 3. ประเมินสาเหตุและปัจจัยเสี่ยงที่ส่งผลต่ออารมณ์และจิตใจ 4. ประเมินความสามารถและกลวิธีของผู้ดูแลในการจัดการปัญหาด้านอารมณ์และจิตใจ 5. ประเมินความต้องการที่เกี่ยวข้องกับการดูแลและการจัดการปัญหาด้านอารมณ์และจิตใจ	1. บรรเทาปัญหาทางด้านอารมณ์และจิตใจของผู้ดูแล 2. ส่งเสริมให้ผู้ดูแลมีการจัดการปัญหาด้านจิตใจอย่างเหมาะสมและมีประสิทธิภาพ	1. ให้การสนับสนุนทางอารมณ์ เช่น ให้กำลังใจผู้ดูแลในการกระทำบทบาทผู้ดูแลต่อพ่อแม่/ญาติ 2. แนะนำแนวทาง/กลยุทธ์ที่ในการจัดการปัญหาด้านอารมณ์และจิตใจอย่างมีประสิทธิภาพ 3. ฝึกผู้ดูแลให้มีทักษะในการจัดการปัญหาด้านอารมณ์และจิตใจ 4. สนับสนุนให้สมาชิกในครอบครัวได้มีโอกาสในการแสดงออกถึงความกตัญญูและการสนับสนุนทางอารมณ์แก่ผู้ดูแล เพื่อให้ผู้ดูแลรับรู้ว่าทุกคนเห็นคุณค่าของญาติผู้ดูแลและพร้อมที่จะให้ความช่วยเหลือเมื่อมีปัญหา 5. แนะนำสมาชิกในครอบครัวให้มีส่วนร่วมในการให้กำลังใจ และรับฟังปัญหาของญาติผู้ดูแลอย่างสม่ำเสมอ 6. สนับสนุนให้กลุ่มเพื่อนได้แสดงออกถึงการสนับสนุนทางอารมณ์ เช่น พูดคุยให้กำลังใจผู้ดูแล	1. ผู้ดูแลมีความรู้และสามารถเลือกแนวทาง/กลยุทธ์ที่เหมาะสมไปใช้ในการจัดการปัญหาด้านอารมณ์และจิตใจได้ 2. ความเครียดและภาระในการดูแลมีคะแนนลดลง 3. ประสบการณ์ปัญหาด้านอารมณ์และจิตใจตามการรับรู้ของผู้ดูแลลดลง

ขั้นตอน / มิติของมนุษย์	การเก็บรวบรวมข้อมูล	วัตถุประสงค์	กิจกรรมการพยาบาล	การประเมินผลลัพธ์
3. การจัดการด้านจริยธรรม (ความรู้สึกผิดที่ดูแลไม่ดี)	1. ประเมินปัญหาด้านจริยธรรมในการดูแล ได้แก่ ความรู้สึกผิดที่ดูแลญาติไม่ดี 2. ประเมินสาเหตุและปัจจัยที่ก่อให้ เกิดความรู้สึกผิดที่ดูแลญาติได้ไม่ดี 3. ประเมินความสามารถและการปรับตัวต่อความรู้สึกผิดที่ดูแลญาติได้ไม่ดี 4. ประเมินความต้องการที่เกี่ยวข้องกับการจัดการปัญหาความรู้สึกผิดที่ดูแลญาติได้ไม่ดี	ส่งเสริมให้ผู้ดูแลมีการปรับตัวและมีการจัดการปัญหาความรู้สึกผิดที่ดูแลญาติได้ไม่ดีอย่างมีประสิทธิภาพ	1. ประสานงานกับผู้ดูแล ผู้ป่วย และสมาชิกในครอบครัวในการวางแผนการดูแลผู้ป่วยร่วมกันตลอดจนค้นหาแนวทางแก้ไขปัญหา 2. สนับสนุนให้ผู้ดูแล ผู้ป่วย และสมาชิกทุกคนในครอบครัวเป็นผู้รับผิดชอบตัดสินใจวางแผนและเลือกแนวทางแก้ไขปัญหาร่วมกัน 3. แนะนำและสนับสนุนให้สมาชิกในครอบครัวได้แสดงออกให้ผู้ดูแลรับรู้ว่าการดูแลผู้ป่วยเป็นความรับผิดชอบร่วมกันของทุกคน	ผู้ดูแลไม่เกิดความรู้สึกผิดที่เกี่ยวข้องกับการดูแลผู้ป่วย
4. การช่วยเหลือด้านอุดมการณ์/คตินิยม (การปรับบทบาท/เศรษฐกิจ/สังคม)	1. ประเมินปัญหาด้านการปรับบทบาท/เศรษฐกิจ/สังคม 2. ประเมินสาเหตุและปัจจัยที่ส่งผลกระทบต่อบทบาท/เศรษฐกิจ/สังคม 3. ประเมินความสามารถและการจัดการปัญหาด้านการปรับบทบาท/เศรษฐกิจ/สังคม 4. ประเมินความต้องการที่เกี่ยวข้องกับการจัดการปัญหาด้านการปรับบทบาท/เศรษฐกิจ/สังคม	1. ลดความขัดแย้งหรือคงไว้ซึ่งความสมดุลในการกระทำตามบทบาทของผู้ดูแล 2. ส่งเสริมให้ผู้ดูแลมีการปรับบทบาทได้อย่างเหมาะสม 3. ลดภาระด้านเศรษฐกิจของผู้ดูแลและครอบครัว 4. คงไว้ซึ่งการปฏิสัมพันธ์กับบุคคลอื่นในสังคมตามปกติ	1. แนะนำสมาชิกในครอบครัวให้มีส่วนร่วมในการรับผิดชอบ ช่วยเหลือ จัดการ และบริหารงานด้านกาปรับบทบาทและเศรษฐกิจภายในครอบครัว เพื่อช่วยแบ่งเบาภาระของผู้ดูแล 2. ช่วยเหลือผู้ดูแลในการบริหารจัดการเวลาในการปฏิบัติกิจกรรมต่าง ๆ ตามบทบาท เช่น ช่วยเหลือปรับตารางการล้างไตของผู้ป่วยให้สอดคล้องกับเวลาละหมาด และตารางปฏิบัติงานของผู้ดูแล เป็นต้น 3. ช่วยเหลือผู้ดูแลในการระบุบุคคล/หน่วยงานที่ได้รับผลกระทบจากการปรับแผนการดำเนิน	1. ผู้ดูแลสามารถบริหารจัดการเวลาและสามารถปฏิบัติหน้าที่ตามบทบาทของตนเองได้ครบถ้วน 2. ผู้ดูแลมีแนวทางในการปรับบทบาทของตนเองให้สอดคล้องกับการทำหน้าที่ผู้ดูแล 3. ผู้ดูแลมีแนวทางในการแก้ไขปัญหาด้านเศรษฐกิจ 4. ผู้ดูแลไม่เกิดความรู้สึกแยกตัวจากสังคม

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			ชีวิต/การทำงาน/การเรียน และแนวทางการประสานงานกับบุคลและหน่วยงานนั้น ๆ 4. สนับสนุนให้ผู้ดูแลและสมาชิกในครอบครัวร่วมกันค้นหาแนวทางและวางแผนการปรับแผนการดำเนินชีวิต รูปแบบการทำงาน และการเรียนของผู้ดูแลให้สอดคล้องกับการทำหน้าที่ผู้ดูแล 5. ค้นหาแนวทางที่ช่วยลดภาระด้านเศรษฐกิจของผู้ดูแล เช่น การบริหารจัดการเรื่องการมาพบแพทย์ การบริหารจัดการเรื่องการเบิกน้ำยาล้างไตทางช่องท้องในพื้นที่ห่างไกล (ต่างอำเภอ) เป็นต้น 6. แนะนำและให้ข้อมูลเกี่ยวกับการบริหารจัดการด้านเศรษฐกิจของผู้ดูแลและครอบครัว ได้แก่ แนวทางการลดรายจ่าย เพิ่มรายได้ 7. ช่วยเหลือผู้ดูแลในการค้นหาแนวทางการเพิ่มรายได้และฝึกทักษะที่จำเป็น 8. ค้นหาและให้ข้อมูลเกี่ยวกับแหล่งสนับสนุนและแหล่งประโยชน์ในโรงพยาบาล และชุมชน 9. ประสานงานกับหน่วยงานที่เกี่ยวข้อง เช่น นักสังคมสงเคราะห์ มูลนิธิฯ อาสาสมัคร เพื่อ	

ขั้นตอน / มิติของมนุษย์	การเก็บรวบรวมข้อมูล	วัตถุประสงค์	กิจกรรมการพยาบาล	การประเมินผลลัพธ์
			ขอความช่วยเหลือ 10. จัดกิจกรรมสังสรรในโอกาสพิเศษ เช่น กิจกรรมวันปีใหม่ วันสงกรานต์ เพื่อส่งเสริมให้ผู้ดูแลมีปฏิสัมพันธ์กับบุคคลอื่นในสังคม	
5. การส่งเสริมการมีสิ่งยึดเหนี่ยวจิตใจ และการรับรู้ถึงความหมายของการมีชีวิต	1. ประเมินความเชื่อด้านศาสนา สิ่งยึดเหนี่ยวจิตใจ และการรับรู้ถึงความหมายของการมีชีวิต 2. ประเมินผลกระทบของการทำหน้าที่ผู้ดูแลต่อการมีสิ่งยึดเหนี่ยวจิตใจและการรับรู้ถึงความหมายของการมีชีวิต 3. ประเมินปัจจัยหรือสิ่งที่ช่วยส่งเสริมให้ผู้ป่วยมีสิ่งยึดเหนี่ยวจิตใจ และรับรู้ถึงความหมายของการมีชีวิต	ส่งเสริมให้ผู้ดูแลมีสิ่งยึดเหนี่ยวจิตใจ และรับรู้ถึงความหมายของการมีชีวิต	1. ให้การดูแลโดยคำนึงความเชื่อด้านศาสนา เช่น ความสะอาด อาหารฮาลาล การเดินทางไปแสวงบุญ การปกปิดร่างกาย และการถือศีลอดในเดือนรอมฎอน เป็นต้น 2. ให้การสนับสนุนด้านจิตวิญญาณ โดยการสนับสนุนให้ผู้ดูแลระลึกถึงหรือนำหลักความเชื่อทางศาสนาของมุสลิมที่เกี่ยวข้องเป็นหลักยึดเหนี่ยวจิตใจในการทำหน้าที่ผู้ดูแล เช่น การศรัทธาและการระลึกถึงพระอัลเลาะห์ การขอพรจากพระอัลเลาะห์ การละหมาดดุอาอฺ การระลึกถึงความเชื่อ/คำสอน หลักความกตัญญู/การสำนึกขอบคุณต่อพระอัลเลาะห์ ความเชื่อเรื่องผลของการกระทำและการทำดี เป็นต้น 3. กระตุ้นให้ผู้ดูแลได้ทบทวนและตระหนักถึงความหมายและเป้าหมายของการมีชีวิต	1. ผู้ดูแลสามารถปฏิบัติกิจกรรมทางศาสนาได้ตามปกติ 2. ความผาสุกด้านจิตวิญญาณอยู่ในระดับดี 3. การรับรู้สมดุลชีวิตของผู้ดูแลอยู่ในระดับดี

ขั้นตอน / มิติของมนุษย์	การเก็บรวบรวมข้อมูล	วัตถุประสงค์	กิจกรรมการพยาบาล	การประเมินผลลัพธ์
			4. ให้การสนับสนุนทางอารมณ์ เช่น ให้กำลังใจผู้ดูแลในการกระทำบทบาทผู้ดูแลต่อพ่อแม่/ญาติ 5. สนับสนุนให้กลุ่มเพื่อนได้แสดงออกถึงการสนับสนุนทางจิตวิญญาณ เช่น ให้กลุ่มเพื่อนช่วยกันทบทวนถึงความสอดคล้องของการทำหน้าที่ผู้ดูแลกับหลักคำสอนอิสลาม 6. จัดทำสื่อหลักความเชื่อทางศาสนาของมุสลิมที่เกี่ยวข้องกับการทำหน้าที่ผู้ดูแล	
6. การแสวงหาความรู้ในการดูแลตนเอง/ผู้ป่วย	1. ประเมินปัญหาและความต้องการของผู้ดูแลที่เกี่ยวข้องกับการแสวงหาความรู้ในการดูแลตนเอง/ผู้ป่วย 2. ประเมินปัจจัยที่เกี่ยวข้องกับกระบวนการแสวงหาความรู้ในการดูแลตนเอง/ผู้ป่วย 3. ประเมินความสามารถในการแสวงหาความรู้ในการดูแลตนเอง/ผู้ป่วย 4. ประเมินแหล่งสนับสนุนและแหล่งประโยชน์ที่เกี่ยวข้องกับกระบวนการแสวงหาความรู้ในการดูแลตนเอง/ผู้ป่วย	1. ส่งเสริมให้ผู้ดูแลมีกระบวนการแสวงหาความรู้ในการดูแลตนเอง/ผู้ป่วยจากแหล่งข้อมูลที่น่าเชื่อถือ 2. ส่งเสริมให้ผู้ดูแลสามารถเข้าถึงแหล่งข้อมูลเพื่อแสวงหาความรู้ในการดูแลตนเอง/ผู้ป่วยได้ง่าย 3. เพิ่มความสามารถของผู้ดูแลในการดูแลตนเอง/ผู้ป่วยได้อย่างมีประสิทธิภาพ	1. ให้ความรู้เกี่ยวกับแนวทางการดูแลตนเองและการดูแลผู้ป่วยล้างไตทางช่องท้อง และทบทวนทุกครั้งเมื่อผู้ดูแลพาผู้ป่วยมาพบแพทย์ตามนัด 2. ฝึก/ทบทวนทักษะการล้างไตทางช่องท้องและการทำแผลแก่ผู้ดูแลทุกครั้งที่ผู้ดูแลพาผู้ป่วยมาพบแพทย์ 3. สนับสนุนสื่อ (คู่มือ แผ่นพับ เอกสารความรู้ วิดีทัศน์) เกี่ยวกับการดูแลตนเองและการดูแลผู้ป่วยล้างไตทางช่องท้อง ตลอดจนแหล่งประโยชน์ต่างๆ ได้แก่ หมายเลขโทรศัพท์ในกรณีฉุกเฉิน หมายเลขโทรศัพท์ในการขอ	1. ผู้ดูแลมีความรู้ในการดูแลตนเองและการดูแลผู้ป่วยล้างไตทางช่องท้อง 2. ผู้ดูแลมีความพร้อมในการดูแลตนเอง/ผู้ป่วย

ขั้นตอน / มิติของมนุษย์	การเก็บรวบรวมข้อมูล	วัตถุประสงค์	กิจกรรมการพยาบาล	การประเมินผลลัพธ์
			คำปรึกษา ให้แก่ผู้ดูแล 4. ให้คำปรึกษาทางโทรศัพท์ โปรแกรมไลน์ หรือทางอื่น ๆ ตามความสะดวกของผู้ดูแลแต่ละรายทั้งในเวลาและนอกเวลา	

แบบบันทึกและแบบประเมินต่าง ๆ

แบบประเมินสำหรับผู้ดูแล

แบบประเมินนี้เป็นแบบประเมินภาวะสุขภาพแบบองค์รวมสำหรับผู้ดูแล จงทำเครื่องหมาย ✓ ลงในช่องที่ตรงกับข้อมูลและความรู้สึกของตัวท่าน

ส่วนที่ 1 ข้อมูลทั่วไป

ชื่อ-สกุล..... อายุ.....ปี

เพศ ❑ ชาย ❑ หญิง

ศาสนา ❑ พุทธ ❑ อิสลาม ❑ คริสต์

สถานภาพสมรส ❑ โสด ❑ คู่ ❑ หม้าย ❑ หย่า/แยก

ความสัมพันธ์กับผู้ป่วย

❑ สามี/ภรรยา ❑ บุตร

❑ พ่อ/แม่ ❑ ญาติ (หลาน/ลูกสะใภ้/.....)

❑ พี่/น้อง ❑ อื่นๆ ระบุ.....

สถานะครอบครัว ❑ อยู่บ้านเดียวกันผู้ป่วย ❑ อยู่คนละบ้านกับผู้ป่วย

อาชีพ ❑ เกษตรกร (ทำสวน) ❑ ประมง ❑ ค้าขาย ❑ รับจ้าง

❑ นักเรียน/นักศึกษา ❑ ธุรกิจส่วนตัว ❑ พ่อบ้าน/แม่บ้าน ❑ ไม่ประกอบอาชีพ

❑ อื่นๆ ระบุ.....

ระดับการศึกษา ❑ ไม่ได้ศึกษา ❑ ประถมศึกษา ❑ มัธยมศึกษาตอนต้น

❑ มัธยมศึกษาตอนปลาย ❑ ปวช./ปวส. ❑ ปริญญาตรี

รายได้...../เดือน ❑ เพียงพอ ❑ ไม่เพียงพอ

ระยะเวลาการทำหน้าที่เป็นผู้ดูแล.....ปี

กิจกรรมการให้การดูแล (ตอบได้มากกว่า 1 ข้อ)

❑ ล้างไตทางหน้าท้อง ❑ ทำแผล ❑ ดูแลให้รับประทานยา

❑ จัดเตรียมอาหาร ❑ ดูแลความสะอาดด้านร่างกายและสิ่งแวดล้อม

❑ การสังเกตอาการผิดปกติและภาวะแทรกซ้อน

หน้าที่รับผิดชอบอื่น ๆ ในครอบครัว ระบุ.....

บุคคลที่มีส่วนร่วมในการดูแลญาติขณะอยู่ที่บ้าน (ตอบได้มากกว่า 1 ข้อ)

❑ พี่/น้อง ❑ สามี/ภรรยา ❑ พ่อ/แม่ ❑ บุตร

❑ ญาติ ❑ เพื่อนบ้าน ❑ ชุมชน (ระบุ.....)

ส่วนที่ 2 แบบประเมินผู้ดูแลแบบองค์รวม

หัวข้อประเมิน	ครั้งที่.....วัน/เดือน/ปี.....	ครั้งที่.....วัน/เดือน/ปี.....	ครั้งที่.....วัน/เดือน/ปี.....
1. สภาพปัญหาด้านร่างกาย			
❑ การพักผ่อน	❑ ไม่มี ❑ มี ระบุ.....	❑ ไม่มี ❑ มี ระบุ.....	❑ ไม่มี ❑ มี ระบุ.....
❑ โภชนาการ/การรับประทานอาหาร	❑ ไม่มี ❑ มี ระบุ.....	❑ ไม่มี ❑ มี ระบุ.....	❑ ไม่มี ❑ มี ระบุ.....
❑ อ่อนเพลีย	❑ ไม่มี ❑ มี ระบุ.....	❑ ไม่มี ❑ มี ระบุ.....	❑ ไม่มี ❑ มี ระบุ.....
❑ เหนื่อยล้า	❑ ไม่มี ❑ มี ระบุ.....	❑ ไม่มี ❑ มี ระบุ.....	❑ ไม่มี ❑ มี ระบุ.....
❑ โรคประจำตัว	❑ ไม่มี ❑ มี ระบุ.....	❑ ไม่มี ❑ มี ระบุ.....	❑ ไม่มี ❑ มี ระบุ.....
❑ อื่นๆ	ระบุ.....	ระบุ.....	ระบุ.....
2. สภาพปัญหาด้านอารมณ์/จิตใจ			
❑ เครียด	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ วิตกกังวล	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ กลัว	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ ภาระการดูแล (burden)*	❑ ไม่มี ❑ มี (ระบุระดับ).....	❑ ไม่มี ❑ มี (ระบุระดับ).....	❑ ไม่มี ❑ มี (ระบุระดับ).....
❑ เหนื่อยล้า/หมดไฟ (burn out)	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ อื่นๆ	ระบุ.....	ระบุ.....	ระบุ.....
3. สภาพปัญหาด้านการจัดการจริยธรรม			
❑ รู้สึกดูแลผู้ป่วยได้ไม่ดี	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....

หัวข้อประเมิน	ครั้งที่.....วัน/เดือน/ปี.....	ครั้งที่.....วัน/เดือน/ปี.....	ครั้งที่.....วัน/เดือน/ปี.....
4. สภาพปัญหาทางสังคม			
❑ ปฏิสัมพันธ์กับเพื่อน/สังคมลดลง	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ แยกตัวออกจากสังคม	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ ขัดแย้งกับบุคคลอื่นในครอบครัว	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ ท่องเที่ยวลดลง	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
5. สภาพปัญหาทางเศรษฐกิจ			
❑ รายได้ลดลง/ไม่มีรายได้	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ รายจ่ายเพิ่มขึ้น	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ แหล่งสนับสนุนด้านเศรษฐกิจ	❑ ไม่มี ❑ มี (ระบุแหล่ง).....	❑ ไม่มี ❑ มี (ระบุแหล่ง).....	❑ ไม่มี ❑ มี (ระบุแหล่ง).....
6. สภาพปัญหาการปรับบทบาท/หน้าที่			
❑ การปรับแบบแผนการดำเนินชีวิต	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ การปรับการทำงาน	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ การปรับรูปแบบการเรียน	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ การบริหารจัดการเวลาในการปฏิบัติศาสนกิจ	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
7. สภาพปัญหาด้านจิตวิญญาณ			
❑ การปฏิบัติกิจกรรมทางศาสนาลดลง	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....
❑ ความผาสุกด้านจิตวิญญาณลดลง	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....	❑ ไม่มี ❑ มี (ระบุสาเหตุ).....

หัวข้อประเมิน	ครั้งที่.....วัน/เดือน/ปี.....	ครั้งที่.....วัน/เดือน/ปี.....	ครั้งที่.....วัน/เดือน/ปี.....
8. สภาพปัญหาด้านการแสวงหาความรู้ใน <u>การดูแลตนเอง</u>			
❑ ขาดความรู้	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....
❑ ขาดทักษะในการปฏิบัติ	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....
❑ ขาดแหล่งข้อมูล/แหล่งสนับสนุน	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....
9. สภาพปัญหาด้านการแสวงหาความรู้ใน <u>การดูแลผู้ป่วย</u>			
❑ ขาดความรู้	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....
❑ ขาดทักษะในการปฏิบัติ	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....
❑ ขาดแหล่งข้อมูล/แหล่งสนับสนุน	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....	❑ ไม่มี ❑ มี (ระบุ).....
10. การรับรู้สมดุลชีวิต**			
11. ข้อเสนอแนะ/สิ่งที่ต้องติดตามต่อเนื่อง			
ผู้ประเมิน/ตำแหน่ง			

หมายเหตุ: * ประเมินจากแบบวัดภาระในการดูแลของผู้ดูแลผู้ป่วยเรื้อรัง

** ประเมินจากแบบวัดสมดุลชีวิตโดยรวม

แบบวัดภาระในการดูแลของผู้ดูแลผู้ป่วยเรื้อรัง ฉบับภาษาไทย

****

คำชี้แจง: แบบสัมภาษณ์นี้เป็นการสัมภาษณ์ที่สะท้อนความรู้สึกในการให้การดูแลผู้อื่น จงทำเครื่องหมาย ✓ ลงในช่องที่บอกถึงความรู้สึกของท่านในปริมาณมากน้อยตามคะแนนดังนี้

ประจำ หมายถึง ในขณะดูแลผู้ป่วย ท่านมีความรู้สึกตามข้อความนั้นเกิดขึ้นเป็นประจำสม่ำเสมอ (ร้อยละ 76-100)

บ่อยครั้ง หมายถึง ในขณะดูแลผู้ป่วย ท่านมีความรู้สึกตามข้อความนั้นเกิดขึ้นเป็นส่วนมาก (ร้อยละ 51-75)

บางครั้ง หมายถึง ในขณะดูแลผู้ป่วย ท่านมีความรู้สึกตามข้อความนั้นเกิดขึ้นและไม่เกิดขึ้นใกล้เคียงกัน (ร้อยละ 26-50)

นาน ๆ ครั้ง หมายถึง ในขณะดูแลผู้ป่วย ท่านมีความรู้สึกตามข้อความนั้นเกิดขึ้นน้อยครั้ง (ร้อยละ 1-25)

ไม่เคยเลย หมายถึง ในขณะดูแลผู้ป่วย ท่านไม่มีความรู้สึกตามข้อความนั้นเลย

เกณฑ์การให้คะแนน

4 = ประจำ

3 = บ่อยครั้ง

2 = บางครั้ง

1 = นาน ๆ ครั้ง

0 = ไม่เคยเลย

เกณฑ์การแปลผล

61-88 รู้สึกเป็นภาระการดูแลระดับมาก (severe burden)

41-60 รู้สึกเป็นภาระการดูแลระดับปานกลาง (moderate burden)

21-40 รู้สึกเป็นภาระการดูแลระดับน้อย (mild burden)

<21 ไม่รู้สึกเป็นภาระการดูแล (no burden)

ภาระการดูแลของผู้ดูแล	ความถี่ของการเกิดความรู้สึกจากการดูแลของผู้ดูแล				
	ประจำ	บ่อยครั้ง	บางครั้ง	นานๆครั้ง	ไม่เคยเลย
1. ท่านรู้สึกว่าผู้ป่วยร้องขอความช่วยเหลือมากกว่าความต้องการจริง					
2. ท่านรู้สึกว่าท่านไม่มีเวลาเพียงพอสำหรับตัวเอง เนื่องจากว่าใช้เวลาในการดูแลผู้ป่วยมาก ไม่มีเวลาเป็นของตนเอง					
3. ท่านรู้สึกมีความเครียดทั้งงานที่ต้องดูแลผู้ป่วยและงานอื่นที่ต้องรับผิดชอบ					
4. ท่านรู้สึกอึดอัดใจต่อพฤติกรรมผู้ป่วย					
5. ท่านรู้สึกหงุดหงิดใจ หรือโกรธ ขณะอยู่ใกล้ผู้ป่วย					
6. ท่านรู้สึกว่าผู้ป่วยทำให้ความสัมพันธ์ของท่านกับสมาชิกในครอบครัวหรือเพื่อนแย่ลง					
7. ท่านรู้สึกกลัวเกี่ยวกับสิ่งที่จะเกิดขึ้นในอนาคตกับผู้ป่วยซึ่งเป็นญาติของท่าน					
8. ท่านรู้สึกว่าผู้ป่วยต้องพึ่งพาท่าน					
9. ท่านรู้สึกตึงเครียดขณะที่อยู่ใกล้ผู้ป่วย					
10. ท่านรู้สึกว่าสุขภาพของท่านไม่ค่อยดีเนื่องมาจากการดูแลผู้ป่วย					
11. ท่านรู้สึกว่าท่านไม่มีความเป็นส่วนตัวเท่าที่ต้องการ เนื่องจากการดูแลผู้ป่วย					
12. ท่านรู้สึกว่าท่านไม่สามารถมีสังคมได้ตามปกติเนื่องจากการดูแลผู้ป่วย					
13. ท่านรู้สึกไม่สะดวกในการติดต่อ/คบหากับเพื่อน เนื่องมาจากการดูแลผู้ป่วย					
14. ท่านรู้สึกว่าผู้ป่วยคาดหวังในตัวท่านมาก เสมือนมีท่านคนเดียวเท่านั้นที่พึ่งพาได้					
15. ท่านรู้สึกว่าท่านไม่มีเงินเพียงพอที่จะดูแลผู้ป่วย					
16. ท่านรู้สึกว่าท่านจะไม่สามารถอดทนดูแลผู้ป่วยได้อีกต่อไป					
17. ท่านรู้สึกว่าท่านไม่สามารถควบคุมจัดการชีวิตตนเองได้ ตั้งแต่ดูแลผู้ป่วย					

ภาระการดูแลของผู้ดูแล	ความถี่ของการเกิดความรู้สึกจากการดูแลของผู้ดูแล				
	ประจำ	บ่อยครั้ง	บางครั้ง	นานๆครั้ง	ไม่เคยเลย
18. ท่านอยากที่จะเลิกดูแลผู้ป่วยซึ่งเป็นญาติของท่านและให้คนอื่นมาดูแลแทน					
19. ท่านรู้สึกว่าไม่มีอะไรที่มั่นคงแน่นอนเกี่ยวกับสิ่งที่ทำให้ผู้ป่วย					
20. ท่านรู้สึกว่าท่านควรจะดูแลญาติของท่านให้มากกว่านี้					
21. ท่านรู้สึกว่าท่านอาจจะดูแลญาติของท่านได้ดีกว่านี้					
22. โดยภาพรวมท่านรู้สึกว่า การดูแลผู้ป่วยเป็นภาระสำหรับท่าน					

(ที่มา: ชนัญชิดาดุษฎี ทูลศิริ และคณะ, 2554)

แบบวัดสมดุลชีวิตโดยรวม

แบบสอบถามนี้เป็นแบบประเมินความรู้สึกต่อภาวะสมดุลชีวิตของผู้ดูแลในภาพรวม ประกอบด้วยข้อความ 5 ข้อความ ให้ผู้ดูแลระบุระดับความคิดเห็นและความรู้สึกว่า เห็นด้วย หรือไม่เห็นด้วย กับข้อความในแต่ละข้อความ โดยทำเครื่องหมาย ✓ ลงในระดับที่ตรงกับความคิดเห็นของตัวท่านมากที่สุด

1 = ไม่เห็นด้วยอย่างยิ่ง 2 = ไม่เห็นด้วยค่อนข้างมาก 3 = ค่อนข้างไม่เห็นด้วย

4 = ไม่แน่ใจ 5 = ค่อนข้างเห็นด้วย 6 = เห็นด้วยค่อนข้างมาก

7 = เห็นด้วยอย่างยิ่ง

ข้อความ	1	2	3	4	5	6	7
1. วิถีการดำเนินชีวิตของฉันทำให้ฉันอยู่ใน/มีภาวะสมดุล							
2. ชีวิตฉันอยู่ในภาวะสมดุล เกือบทุกด้าน							
3. ฉันรู้สึกพึงพอใจในชีวิตตนเอง ณ ปัจจุบัน							
4. ฉันยอมรับเงื่อนไขต่างๆของชีวิตฉัน							
5. ฉันปรับตัวเข้ากับสิ่งแวดล้อมรอบตัวได้ดี							

(ที่มา: Kjell et al., 2016 และ ปิยะนุช จิตตนูนท์ และสุมาลี วังธนากร, 2561)

แนวคำถามในการสัมภาษณ์ผู้ดูแลเพื่อประเมินปัญหาแบบองค์รวม

1. ด้านการดูแลตนเองและสภาพปัญหาด้านร่างกาย

1.1 กิจกรรมที่ท่านดูแลญาติของท่านในปัจจุบัน เป็นอย่างไร สอดคล้องกับภาวะสุขภาพ/ความสามารถในการดูแลตนเองของญาติที่ท่านดูแลอยู่หรือไม่

1.2 ภาวะสุขภาพของท่านภายหลังทำหน้าที่เป็นผู้ดูแลเปลี่ยนแปลงไปหรือไม่ ถ้ามีท่านมีการจัดการปัญหานั้นอย่างไร

1.2.1 โรคประจำตัว

1.2.2 การนอนหลับพักผ่อน

1.2.3 พฤติกรรมการรับประทานอาหารเปลี่ยนแปลง/ความอยากอาหารลดลง/น้ำหนักลด

1.2.4 เหนื่อยล้า/อ่อนเพลีย

1.2.5 ปวดเมื่อยกล้ามเนื้อ/ปวดหลัง/ปวดเข่า

1.3 ปัจจุบันท่านได้รับการรักษา/รับประทานยาเพื่อรักษาอาการใดบ้าง

1.4 เวลาในการดูแลตนเองของท่านเปลี่ยนแปลงไปหรือไม่ อย่างไร

1.5 สิ่งที่ท่านต้องการเพิ่มเติมในการดูแลตนเองและจัดการปัญหาด้านร่างกายของท่านมีอะไรบ้าง

2. สภาพปัญหาด้านอารมณ์/จิตใจ

2.1 การทำหน้าที่ผู้ดูแลส่งผลกระทบทางด้านอารมณ์หรือจิตใจของท่านหรือไม่ อย่างไรบ้าง (เครียด วิตกกังวล กลัว โกรธ รู้สึกผิด กดดัน หมดไฟ ฯลฯ)

2.2 ท่านมีกลยุทธ์ในการจัดการกับปัญหาทางด้านอารมณ์และจิตใจของท่านอย่างไร

2.3 ความต้องการที่เกี่ยวข้องกับการดูแลและการจัดการปัญหาด้านอารมณ์และจิตใจของท่านมีอะไรบ้าง

2.4 ภาระในการดูแลตามการรับรู้ของท่านหมายความว่าอย่างไร และภาระในการดูแลที่ท่านรู้สึกขณะนี้เป็นอย่างไร

3. ด้านจริยธรรม (รู้สึกผิดที่ดูแลไม่ดี)

3.1 ความรู้สึกต่อการทำหน้าที่ผู้ดูแลที่ท่านปฏิบัติอยู่เป็นอย่างไร เป็นไปตามความคาดหวังของท่านหรือไม่ (กรณีผู้ดูแลมีความรู้สึกว่าดูแลญาติได้ไม่เต็มที่ ให้ถามคำถามต่อไป)

3.2 ปัจจัยหรือสาเหตุอะไรที่ทำให้ท่านรู้สึกเช่นนั้น

3.3 ท่านมีการจัดการกับปัญหาหรือความรู้สึกนี้อย่างไร

3.4 สิ่งที่ท่านต้องการเพื่อแก้ไขปัญหาหรือความรู้สึกนี้มีอะไรบ้าง

4. ด้านการปรับบทบาท/เศรษฐกิจ/สังคม

4.1 บทบาท/หน้าที่รับผิดชอบอื่น ๆ ในครอบครัวที่ท่านปฏิบัติอยู่ในปัจจุบันมีอะไรบ้าง อย่างไร

4.2 การทำหน้าที่เป็นผู้ดูแลส่งผลให้ท่านต้องปรับแบบแผนการดำเนินชีวิตในเรื่องใดบ้าง อย่างไร

4.3 ท่านรู้สึกถึงความยากลำบาก/มีความขัดแย้งในการปฏิบัติบทบาทต่าง ๆ เนื่องจากต้องรับผิดชอบดูแลญาติของท่านหรือไม่ อย่างไร

4.4 การทำหน้าที่เป็นผู้ดูแลส่งผลกระทบต่อภาวะเศรษฐกิจ/การเงินของท่านหรือไม่ อย่างไร

4.5 การทำหน้าที่เป็นผู้ดูแลทำให้ท่านมีปฏิสัมพันธ์กับเพื่อนหรือผู้อื่นลดลงหรือไม่ อย่างไร

4.6 ภายหลังการทำหน้าที่เป็นผู้ดูแล ท่านคิดว่าการเข้าสังคมหรือการมีส่วนร่วมในกิจกรรมทางสังคมของท่านลดลงหรือไม่ อย่างไร

4.7 สมาชิกในครอบครัวของท่านมีส่วนร่วมในการให้การดูแลญาติของท่านหรือไม่ อย่างไร

4.8 การดูแลญาติ/การทำหน้าที่เป็นผู้ดูแลของท่านทำให้ท่านมีความขัดแย้งกันกับสมาชิกคนอื่นในครอบครัวหรือไม่ อย่างไร

4.9 ท่านรู้สึกพึงพอใจต่อการช่วยเหลือของสมาชิกในครอบครัวของท่านในตอนนี้หรือไม่ อย่างไร

4.10 ท่านมีการจัดการกับปัญหาเหล่านั้นอย่างไร

4.11 ความต้องการในการจัดการปัญหาเหล่านี้ของท่านมีอะไรบ้าง

5. ด้านจิตวิญญาณ

5.1 การปฏิบัติบทบาทผู้ดูแลของท่านส่งผลกระทบต่อการปฏิบัติศาสนกิจของท่านหรือไม่ อย่างไร

5.2 ท่านรู้สึกพึงพอใจต่อชีวิตการเป็นอยู่ของท่านในปัจจุบันแล้วหรือไม่ อย่างไร

5.3 ท่านมีการปรับตัวและยอมรับการเปลี่ยนแปลงที่เกิดขึ้นกับชีวิตของท่านได้อย่างไร

5.4 ความรู้สึกทางบวก/ผลดีที่เกิดขึ้นกับท่านจากการที่ท่านให้การดูแลญาติมีอะไรบ้าง

5.5 สิ่งยึดเหนี่ยวสูงสุดในการทำหน้าที่ผู้ดูแลของท่านคืออะไรและอย่างไร

5.6 สมดุลชีวิตของผู้ดูแลตามการรับรู้ของท่านมีความหมายว่าอย่างไร และชีวิตของท่านปัจจุบันมีความสมดุลสอดคล้องตามความคาดหวังของท่านแล้วหรือไม่ อย่างไร

5.7 สิ่งที่ท่านต้องการ/ความช่วยเหลือที่ช่วยส่งเสริมการมีสมดุลชีวิตของท่านมีอะไรบ้าง อย่างไร

6. ด้านการแสวงหาความรู้ในการดูแลตนเอง/ผู้ป่วย

6.1 ความรู้และทักษะในการดูแลตนเอง/ดูแลญาติของท่านตอนนี้เป็นอย่างไร รู้สึกมั่นใจหรือไม่

6.2 สิ่งที่ท่านต้องการ/ความช่วยเหลือในการเพิ่มความรู้และความสามารถในการดูแลตนเอง/ญาติคืออะไร

6.3 แหล่งประโยชน์ของท่านในการจัดการกับปัญหาเหล่านี้มีอะไรบ้าง

6.4 แหล่งสนับสนุนในชุมชนที่มีส่วนช่วยเหลือท่านในการจัดการกับปัญหาที่เกี่ยวข้องกับการดูแลมีใครหรือหน่วยงานไหนบ้าง อย่างไร

กิจกรรมต่าง ๆ ที่เกี่ยวข้องกับการดูแลผู้ดูแลแบบองค์รวม

กิจกรรม Family Meeting ภายหลังเริ่มล้างไตทางช่องท้อง

วัตถุประสงค์ เพื่อ

1. สร้างความเข้าใจเกี่ยวกับบทบาทของผู้ดูแล หน้าที่ความรับผิดชอบในการบริหาร จัดการการดูแลญาติระหว่างทีมสุขภาพ ผู้ดูแลและสมาชิกในครอบครัว
2. ส่งเสริมให้สมาชิกในครอบครัวร่วมกันประเมินผลกระทบจากการทำหน้าที่เป็นผู้ดูแลปัญหาและอุปสรรคในการจัดการปัญหาที่เกิด/อาจจะเกิดขึ้นในผู้ดูแลแบบองค์รวม ตลอดจนสาเหตุและปัจจัยของปัญหา
3. กระตุ้นให้สมาชิกในครอบครัวมีส่วนร่วมในการรับผิดชอบ ช่วยเหลือ จัดการ และบริหารงานในการดูแลญาติ เพื่อช่วยแบ่งเบาภาระของผู้ดูแล
4. กระตุ้นให้สมาชิกในครอบครัวมีส่วนร่วมในการค้นหาแนวทางแก้ไขหรือจัดการปัญหาที่เกิด/อาจจะเกิดขึ้นในผู้ดูแล และร่วมกันวางแผนในการช่วยเหลือหรือจัดการปัญหาของผู้ดูแล โดยให้สมาชิกในครอบครัวเป็นศูนย์กลางในการตัดสินใจ
5. ส่งเสริมให้สมาชิกในครอบครัวได้มีโอกาสในการสนับสนุนทางอารมณ์และจิตวิญญาณ และรับฟังปัญหาของญาติผู้ดูแลอย่างสม่ำเสมอ
6. สนับสนุนให้สมาชิกในครอบครัวได้มีโอกาสในการแสดงออกถึงความกตัญญูแก่ผู้ดูแล เพื่อให้ผู้ดูแลรับรู้ว่าทุกคนเห็นคุณค่าของผู้ดูแลและพร้อมที่จะให้ความช่วยเหลือเมื่อมีปัญหา
7. ค้นหาแหล่งสนับสนุนภายในครอบครัว โรงพยาบาล และชุมชน ที่เกี่ยวข้องเพื่อนำมาวางแผนในการจัดการและบริหารงานในการดูแลญาติ
8. ให้ข้อมูลเกี่ยวกับแหล่งสนับสนุนและแหล่งประโยชน์ในโรงพยาบาล และชุมชน

ขั้นตอนการทำ Family Conference

1. การเตรียมความพร้อมก่อนทำ Family Conference

1.1 ทีมทบทวนวัตถุประสงค์ของการทำ Family Conference

1.2 พิจารณาบุคคลที่ควรเข้าร่วมประชุม

1.3 ทบทวนข้อมูลของผู้ป่วย ผู้ดูแล และสมาชิกในครอบครัว ตลอดจนความสัมพันธ์ระหว่างสมาชิกในครอบครัว

1.4 ชี้แจงถึงความจำเป็นและเป้าหมายของการประชุมแก่ผู้ป่วย ผู้ดูแล และสมาชิกในครอบครัว พร้อมทั้งนัดเวลาและสถานที่ที่สะดวก

2. ขั้นดำเนินการ

2.1 พยาบาลกล่าวแนะนำตัวและบอกบทบาทที่เกี่ยวข้องกับการดูแลผู้ป่วยและผู้ดูแล พร้อมทั้งให้ผู้ป่วย ผู้ดูแล และสมาชิกในครอบครัวแนะนำตัวเอง

2.2 พยาบาลผู้นำทีมชี้แจงวัตถุประสงค์ของการทำ Family Conference และแจ้งประเด็นที่ต้องการให้ผู้ป่วย ผู้ดูแล และสมาชิกในครอบครัวได้ร่วมกันตัดสินใจหรือรับทราบ

2.3 พยาบาลผู้นำทีมชี้แจงข้อตกลงของการประชุม เช่น การเรียงลำดับการแสดงความคิดเห็น (ผู้ดูแล ผู้ป่วย จากนั้นเรียงลำดับตามสมาชิกในครอบครัวที่มีอำนาจในครอบครัวน้อยที่สุดไปมากที่สุด) และแจ้งระยะเวลาของการประชุมโดยประมาณให้ทุกคนทราบ

2.4 ทบทวนเป้าหมายของการดูแล และแผนการดูแลที่ได้วางแผนไว้ก่อนเข้าสู่กระบวนการล้างไตทางช่องท้อง

2.5 เปิดโอกาสให้สมาชิกแต่ละคนแสดงความคิดเห็น/สะท้อนคิดเกี่ยวกับประสบการณ์ที่ผ่านมา

2.5.1 ผู้ป่วย: สอบถามเกี่ยวกับประสบการณ์การดูแลตนเอง และการได้รับการดูแลจากผู้ดูแลและบุคคลอื่นในครอบครัว

2.5.2 ผู้ดูแล: สอบถามเกี่ยวกับประสบการณ์การให้การดูแลผู้ป่วย ผลกระทบต่อผู้ดูแลแบบองค์รวม ความยากลำบาก ปัญหาและอุปสรรคในการให้การดูแล และความต้องการที่เกี่ยวข้องกับการดูแลผู้ป่วยในอนาคตที่ผู้ดูแลต้องการจากทีมและสมาชิกในครอบครัว

2.5.3 สมาชิกในครอบครัว: สอบถามเกี่ยวกับเป้าหมายของการมีส่วนร่วมในการดูแล แนวทางการจัดการและการช่วยเหลือผู้ดูแลในการดูแลผู้ป่วยในอดีตและอนาคต ความต้องการของครอบครัวด้านต่าง ๆ ที่อยากให้ทีมช่วยเหลือ

3. ขั้นสรุปและปิดการประชุม

3.1 พยาบาลผู้นำกล่าวสรุปและปิดการประชุม เปิดโอกาสให้สมาชิกในครอบครัวได้ซักถามข้อสงสัย

3.2 สรุปประเด็นที่ได้พูดคุย แผนการจัดการหรือช่วยเหลือผู้ดูแลในการดูแลผู้ป่วยในอนาคต ตลอดจนหน้าที่ความรับผิดชอบของสมาชิกในครอบครัวแต่ละคนในการมีส่วนร่วมในการให้การดูแลผู้ป่วย

3.3 กล่าวขอบคุณทุกคนที่เข้าร่วมประชุม

หมายเหตุ: ควรมีการจดบันทึกสิ่งที่ได้พูดคุยระหว่างการประชุมในประเด็นที่สำคัญลงในแบบบันทึกข้อมูลของผู้ดูแล

กิจกรรม Peer Group Support

วัตถุประสงค์ เพื่อ

1. เปิดโอกาสให้ผู้ดูแลได้แลกเปลี่ยนประสบการณ์การจัดการการดูแลผู้ป่วย การจัดการปัญหา และการปรับตัวกับ role model
2. สนับสนุนให้ผู้ดูแลได้มีโอกาสในการสนับสนุนทางอารมณ์หรือให้กำลังใจ ตลอดจนสนับสนุนทางจิตวิญญาณซึ่งกันและกันระหว่างสมาชิกภายในกลุ่ม
3. เพื่อส่งเสริมให้ผู้ดูแลได้มีโอกาสในการมีปฏิสัมพันธ์ทางสังคมกับบุคคลอื่น

จำนวนสมาชิกภายในกลุ่ม: 7-10 คน

ระยะเวลาในการดำเนินการกลุ่ม: 1-1½ ชั่วโมง

ขั้นตอนการจัดกิจกรรมกลุ่ม

1. ระยะเริ่มต้นหรือระยะสร้างสัมพันธภาพ (10-20 นาที)

1.1 พยาบาลผู้ทำหน้าที่เป็นผู้นำกลุ่มกล่าวต้อนรับ แนะนำตัวเอง และเปิดโอกาสให้สมาชิกกลุ่มแนะนำตัวเอง เพื่อสร้างสัมพันธภาพระหว่างกันภายในกลุ่ม

1.2 ผู้นำกลุ่มชี้แจงวัตถุประสงค์ของการดำเนินการกลุ่ม ระยะเวลา สถานที่และแนวทางในการปฏิบัติตัวในการเข้าร่วมกลุ่ม

2. ระยะดำเนินการ (40-50 นาที)

2.1 ผู้นำกลุ่มชี้แจงให้สมาชิกกลุ่มทราบว่าข้อมูลภายในกลุ่มจะถูกเก็บไว้เป็นความลับรับทราบกันเฉพาะภายในกลุ่มเท่านั้น

2.2 ผู้นำกลุ่มกระตุ้นให้สมาชิกได้แสดงความรู้สึกหรือความคิดเห็น ตลอดจนส่งเสริมให้สมาชิกได้พูดระบายปัญหาของตนเองให้สมาชิกในกลุ่มรับฟัง

2.3 ผู้นำกลุ่มกระตุ้นให้สมาชิกได้แลกเปลี่ยนประสบการณ์เกี่ยวกับการจัดการการดูแลผู้ป่วย แนวทางการจัดการปัญหา และกลยุทธ์ที่ใช้ในการปรับตัวของตนเอง

2.4 ส่งเสริมให้สมาชิกในครอบครัวได้แสดงออกถึงการสนับสนุนทางอารมณ์และจิตวิญญาณ เช่น การให้กำลังใจ เป็นต้น

3. ระยะสิ้นสุดการทำกลุ่ม (10-20 นาที)

3.1 ผู้นำกลุ่มสรุปประสบการณ์ทั้งหมดในการทำกลุ่ม

3.2 ผู้นำกลุ่มกระตุ้นให้สมาชิกประเมินความก้าวหน้า ความเปลี่ยนแปลงในการพัฒนาตนเองและความสำเร็จของกลุ่ม

3.3 ผู้นำกลุ่มกล่าวสนับสนุนให้สมาชิกลุ่มรู้สึกว่าตนเองสามารถเผชิญกับปัญหาได้ด้วยตนเอง

3.4 ผู้นำกลุ่มแจ้งกำหนดการจัดกิจกรรมครั้งต่อไป

3.5 เปิดโอกาสให้สมาชิกกลุ่มซักถามข้อสงสัย

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Appendix I

คู่มือการดูแลผู้ดูแลมุสลิมแบบองค์รวมเฉพาะกรณี

จัดทำโดย

หน่วยล้างไตทางช่องท้อง โรงพยาบาลสตูล

คำนำ

การล้างไตทางช่องท้องเป็นการบำบัดรักษาที่ผู้ดูแลมีบทบาทสำคัญในการดูแลผู้ป่วยที่บ้าน ซึ่งการปฏิบัติบทบาทของผู้ดูแลอาจส่งผลต่อการดำเนินชีวิตและส่งผลให้บุคคลเหล่านั้นต้องเผชิญกับปัญหาที่เกิดจากการดูแลหรือที่เรียกว่า ภาระในการดูแล (Caregiver burdens) ทั้งด้านร่างกาย จิตใจ สังคม จิตวิญญาณ ตลอดจนเศรษฐกิจ แบบแผนการดำเนินชีวิต และการทำหน้าที่ตามบทบาทของผู้ดูแล

การดูแลแบบองค์รวม (Holistic care) ในผู้ดูแลถือเป็นบทบาทที่ท้าทายสำหรับพยาบาลที่จะต้องพัฒนาให้เกิดขึ้นเพื่อเพิ่มประสิทธิภาพในการดูแลและเพื่อให้สอดคล้องกับนโยบาย PD First Policy ของสำนักงานหลักประกันสุขภาพแห่งชาติ สำหรับพื้นที่ในจังหวัดชายแดนภาคใต้ที่มีประชากรส่วนใหญ่เป็นมุสลิม การให้การดูแลผู้ดูแลมุสลิมแบบองค์รวม จึงควรมีการนำหลักศาสนาอิสลามเข้ามาประยุกต์ให้สอดคล้องกับผู้ดูแลแต่ละราย ดังนั้นคณะผู้จัดทำจึงได้จัดทำคู่มือการดูแลผู้ดูแลมุสลิมแบบองค์รวมเฉพาะกรณีฉบับนี้ขึ้น โดยหวังว่าจะช่วยให้พยาบาลหน่วยล้างไตทางช่องท้องใช้เป็นแนวทางในการดูแลผู้ดูแลมุสลิมได้ครอบคลุมองค์รวม สอดคล้องกับบริบทและวัฒนธรรมของมุสลิม ซึ่งจะนำไปสู่การพัฒนาคุณภาพระบบบริการด้านการพยาบาลในหน่วยล้างไตทางช่องท้องให้มีประสิทธิภาพ ช่วยลดภาระในการดูแลและเพิ่มความสมดุลของชีวิตในผู้ดูแลมุสลิมต่อไปได้

วัตถุประสงค์

1. เพื่อใช้เป็นแนวทางในการดูแลผู้ดูแลมุสลิมของผู้ป่วยที่ได้รับการล้างไตทางช่องท้องสำหรับพยาบาลวิชาชีพที่ปฏิบัติงานในหน่วยล้างไตทางช่องท้องหรือหน่วยงานอื่นที่เกี่ยวข้อง
2. เพื่อให้พยาบาลวิชาชีพที่ปฏิบัติงานในหน่วยล้างไตทางช่องท้อง สามารถให้การบริการทางคลินิกแก่ผู้ดูแลมุสลิมครอบคลุมองค์รวม สอดคล้องกับบริบทและวัฒนธรรมของมุสลิมได้อย่างมีประสิทธิภาพ
3. เพื่อให้ผู้ดูแลมุสลิมของผู้ป่วยที่ได้รับการล้างไตทางช่องท้องได้รับการดูแลครอบคลุมแบบองค์รวม ซึ่งจะนำไปสู่การมีคุณภาพชีวิตที่ดีในระยะยาว

สารบัญ

แนวทางการดูแลผู้ดูแลมุสลิมด้านร่างกาย

ปัญหาด้านร่างกายที่พบบ่อยในผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง

ปัญหาด้านร่างกายที่พบบ่อยในผู้ดูแล ได้แก่ โรคประจำตัว และภาวะอาการที่เกิดจากการดูแลผู้ป่วย เช่น ปัญหาการนอนหลับ อ่อนล้า ปวดตามร่างกาย สูญเสียความแข็งแรงของร่างกาย ความอยากอาหารลดลง และน้ำหนักลดลง เป็นต้น สอดคล้องกับข้อมูลการสัมภาษณ์เชิงลึกรายบุคคลในผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง ณ โรงพยาบาลสตูล จ.สตูล พบว่าผู้ดูแลมุสลิมมีปัญหาด้านร่างกาย สรุปได้ดังนี้

1. ปัญหาการนอนหลับ (การอดนอน นอนไม่หลับ)
2. อ่อนล้า/อ่อนเพลีย
3. ปัญหาโภชนาการ (ความอยากอาหารลดลง น้ำหนักลด พฤติกรรมการรับประทานอาหารไม่เป็นเวลา)
4. การพักผ่อนไม่เพียงพอ

แนวทางการดูแลผู้ดูแลที่มีปัญหาด้านร่างกาย

1. ประเมินปัญหาด้านร่างกายของผู้ดูแลและระดับความรุนแรงของปัญหา
2. ค้นหาสาเหตุและปัจจัยเสี่ยงที่ทำให้เกิดปัญหาด้านร่างกายของผู้ดูแล ได้แก่
   2.1 ด้านผู้ดูแล เช่น เพศ อายุ สถานภาพสมรส สถานะการเงิน ปัญหาสุขภาพ และประสบการณ์การดูแลผู้ป่วย
   2.2 ด้านผู้ป่วย เช่น ระดับความรุนแรงของโรคหรืออาการ ความสามารถในการช่วยเหลือตนเองในกิจวัตรประจำวัน
   2.3 อื่น ๆ เช่น การสนับสนุนทางสังคม
3. ให้ข้อมูลที่เป็นประโยชน์กับการดูแลตนเองและผู้ป่วย เช่น ความรู้เกี่ยวกับโรค วิธีการดูแลตนเอง ตลอดจนเครือข่ายทางสังคม เป็นต้น
4. ให้คำปรึกษา/แนะนำในการจัดการกับปัญหาที่เกิดขึ้น เช่น การปรับสุขลักษณะการนอนให้มีประสิทธิภาพ การจัดการตนเองให้มีเวลานอนและพักผ่อน เป็นต้น
5. แนะนำพฤติกรรมสร้างเสริมสุขภาพที่สำคัญในผู้ดูแล เช่น การพักผ่อนให้เพียงพอ การออกกำลังกาย การรับประทานอาหารที่มีประโยชน์ เป็นต้น
6. แนะนำให้ผู้ดูแลหาเวลาส่วนตัวเพื่อทำกิจกรรมที่อยากทำ และกล้าขอความช่วยเหลือจากคนรอบข้างเมื่อจำเป็น
7. หากพบผู้ป่วยมีความผิดปกติ เช่น กินได้ลดลง นอนไม่หลับ สามารถปรึกษาแพทย์เพื่อรับการรักษา

แนวทางการดูแลผู้ดูแลมุสลิมด้านจิตใจ

ปัญหาด้านจิตใจที่พบบ่อยในผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง

การปฏิบัติบทบาทหน้าที่ผู้ดูแลสามารถส่งผลต่อการดำเนินชีวิตของผู้ดูแลได้ โดยผู้ดูแลเหล่านั้นอาจรู้สึกมีภาระในการดูแล (Caregiver burdens) โดยเฉพาะปัญหาทางด้านสุขภาพจิต เช่น ซึมเศร้า วิตกกังวล เครียด ไม่พอใจ รู้สึกผิด รู้สึกสูญเสีย และรู้สึกโดดเดี่ยว เป็นต้น

จากการศึกษาในประเทศไทยพบว่า ผู้ดูแลหลักมุสลิมมีโอกาสเผชิญกับความรู้สึกด้านลบ เช่น ความเครียด ความวิตกกังวล และความเหนื่อยล้า (มีด๊ะ เหมมาน และคณะ, 2560) โดยมีสาเหตุมาจากการทำหน้าที่เป็นผู้ดูแลเป็นระยะเวลานาน (Limpanichkul, 2004) ตลอดจนการใช้เวลาในการดูแลผู้ป่วยในแต่ละวันที่ยาวนาน (Limpawattana et al., 2013; Netchang, 2012) ก็เป็นสาเหตุหนึ่งที่ทำให้ผู้ดูแลต้องเผชิญกับปัญหาทางสุขภาพจิต สอดคล้องกับข้อมูลการสัมภาษณ์เชิงลึกรายบุคคลในผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง ณ โรงพยาบาลสตูล จ.สตูล พบว่า ผู้ดูแลมุสลิมมีปัญหาด้านจิตใจ สรุปได้ดังนี้

1. ภาวะวิตกกังวล: เกี่ยวกับกระบวนการรักษาผู้ป่วย ค่าใช้จ่ายในการดูแลและภาระด้านเศรษฐกิจของครอบครัว ตลอดจนการทำหน้าที่ผู้ดูแลของตนเองและบุคคลอื่น
2. เครียด: ปัญหาค่าใช้จ่าย การสูญเสียอิสรภาพ การปฏิบัติการดูแลที่ไม่มั่นใจ และภาวะความเจ็บป่วยของผู้ป่วย
3. ภาวะโศกเศร้า: จากการได้รับถ้อยคำเชิงลบจากบุคคลอื่นในครอบครัว
4. ความกลัว: กลัวการทำหน้าที่หรือการรับบทบาทผู้ดูแล กลัวสูญเสียบุคคลอันเป็นที่รัก
5. โดดเดี่ยว: ขาดการสนับสนุนจากบุคคลอื่นในครอบครัว
6. อ่อนล้าด้านอารมณ์/จิตใจ/หมดกำลังใจ: ภาระงานที่เพิ่มขึ้น ผู้ป่วยมีอาการแย่ลง
7. กดดันในการให้การดูแลผู้ป่วย: เป็นผู้รับผิดชอบหลักในการให้การดูแล
8. หงุดหงิด/ไม่พอใจ: การไม่ได้รับความร่วมมือจากผู้ป่วยและสมาชิกในครอบครัว

เทคนิคในการเข้าถึงข้อมูลของผู้ดูแลมุสลิม

1. พยาบาลควรแนะนำตัวเอง ประสบการณ์การทำงาน โดยใช้ภาษา ท่าทาง คำพูดและน้ำเสียงที่เป็นมิตร นุ่มนวล เพื่อสร้างความไว้วางใจให้แก่ผู้ดูแล
2. ใช้ภาษาที่เข้าใจง่าย ไม่เป็นทางการ เพื่อแสดงความเป็นมิตร
3. แสดงออกถึงความสนใจหรือเอาใจใส่ที่จะให้การช่วยเหลือแก้ไขปัญหาของผู้ดูแล ให้ความสำคัญกับปัญหาโดยมีการสอบถาม รับฟังอย่างตั้งใจ มีการติดตามปัญหาทั้งของผู้ดูแลและผู้ป่วยอย่างต่อเนื่อง
4. แสดงความรู้สึกเป็นห่วง เห็นใจ เข้าใจผู้ดูแล

5. กระตุ้นให้ผู้ดูแลเล่าเรื่องของตนเองอย่างต่อเนื่องพร้อมทั้งสังเกตและจับใจความสิ่งที่ผู้ดูแลเล่า โดยพยาบาลสามารถใช้การสะท้อนความรู้สึกของผู้ดูแลด้วยคำถามปลายเปิดที่ผนวกสิ่งที่ผู้ดูแลเล่า เช่น “ฟังจากที่คุณ...เล่าดูเหมือนคุณ....จะเครียด/กังวล/กลัว ที่ต้องทำหน้าที่เป็นผู้ดูแลในครั้งนี้”
6. แสดงออกถึงความเป็นกันเอง รับฟังอย่างตั้งใจและสนใจ ไม่ทำท่าเบื่อหน่าย รำคาญ บางกรณีอาจต้องใช้ภาษากายที่เหมาะสม เช่น การสัมผัสเพื่อปลอบโยน เป็นต้น
7. เลือกวิธีการสื่อสารกับผู้ดูแลที่เหมาะสมกับสถานการณ์ ให้ความสำคัญกับความรู้สึกและอารมณ์ของผู้ดูแล และระมัดระวังกับการจัดการกับอารมณ์ของผู้ดูแล หลีกเลี่ยงการวิจารณ์ การพูดตำหนิ ซึ่งอาจทำให้เกิดปัญหาสัมพันธภาพระหว่างกันได้
8. ช่วยให้ผู้ดูแลตัดสินใจเรื่องต่างๆด้วยตัวเอง โดยพยาบาลทำหน้าที่เป็นผู้สนับสนุนคอยช่วยเหลือให้เกิดการแก้ปัญหา

แนวทางการดูแลผู้ดูแลที่มีปัญหาด้านจิตใจ

1. สำรวจและประเมินปัญหาด้านจิตใจในการให้การดูแล โดยสามารถประเมินได้ 2 วิธี คือ
   1.1 การประเมินโดยแบบวัด เช่น แบบวัดภาระในการดูแลของผู้ดูแลผู้ป่วยโรคเรื้อรัง เป็นต้น
   1.2 การสัมภาษณ์และการสังเกต พยาบาลสามารถประเมินได้ด้วยการถามคำถามปลายเปิด เพื่อให้ผู้ดูแลได้สำรวจและระบายความรู้สึกของตนเอง ตลอดถึงอารมณ์และพฤติกรรมที่เกิดจากความเครียดในการดูแล เช่น “หลังจากดูแลผู้ป่วย คุณ... รู้สึกอย่างไรบ้างคะ” “พอจะเล่าให้พยาบาลฟังได้ไหมคะว่าตอนนี้รู้สึกอย่างไรบ้าง”
2. สนับสนุนให้ระบายความรู้สึกและอารมณ์ โดยพยาบาลต้องมีเวลาในการรับฟังอย่างตั้งใจ
3. ใช้ทักษะในการสื่อสาร เช่น การทวนซ้ำ การสะท้อนคิดอารมณ์ เพื่อยืนยันความรู้สึกที่เกิดขึ้นของผู้ดูแล และทำให้ผู้ดูแลสามารถมองเห็นปัญหาและความรู้สึกที่เกิดขึ้นกับตนเองชัดเจนขึ้น
4. สรุปปัญหาและสาระสำคัญที่ได้จากการสนทนา
5. ช่วยเหลือผู้ดูแลให้สามารถเชื่อมโยงถึงที่มาของปัญหา เกิดความเข้าใจในปัญหาและยอมรับสิ่งที่เกิดขึ้นได้ โดยใช้ทักษะการโต้ตอบดังนี้
   5.1 การให้ข้อมูล เช่น “จากที่ฟังเหมือนคุณ....รู้สึกไม่พอใจญาติที่ไม่ให้การช่วยเหลือในการดูแลญาติ” “คุณ....กังวลเกี่ยวกับอาการของ.....ทำให้นอนไม่ค่อยหลับ”
   5.2 การหาผลจากการกระทำ เช่น “ตอนนี้อะไรเป็นสาเหตุที่ทำให้คุณ....รู้สึกเครียด/วิตกกังวล/กลัว/ไม่พอใจ”

5.3 การให้ข้อมูลย้อนกลับต่อสิ่งที่เกิดขึ้นในมุมมองของพยาบาล เช่น “จากที่คุณ....เล่า แสดงว่าคุณรู้สึกเครียด หลังจากที่คุณต้องทำหน้าที่หลายๆอย่างพร้อมกัน”

5.4 การตีความสิ่งที่เกิดขึ้น

6. การวางแผนในการแก้ปัญหา โดยพยาบาลสามารถกระตุ้นให้ผู้ดูแลมีทางเลือกในการแก้ปัญหา ตระหนักถึงผลที่จะได้รับจากการเลือกการแก้ปัญหาในแต่ละทาง โดยพยาบาลอาจใช้วิธีดังนี้

6.1 การให้ความรู้ เช่น การแนะนำเรื่องที่เป็นสาเหตุของปัญหา และวิธีการปฏิบัติตัว เป็นต้น

6.2 การให้คำแนะนำ เช่น ให้ผู้ดูแลนึกถึงสาเหตุที่เกิดขึ้นว่าปัญหาอยู่ตรงไหน จากนั้นให้ถามตัวเองว่าปัญหาที่เกิดขึ้นตัวเองมีส่วนในปัญหามากน้อยแค่ไหน และจะแก้ปัญหาที่เกิดขึ้นได้อย่างไร

6.3 การแนะแนวทาง เช่น การให้คำแนะนำเรื่องการปรับตัวและกลยุทธ์ที่ใช้ในการจัดการปัญหาทางด้านจิตใจ เป็นต้น

6.4 การชักจูง เช่น การเสนอแนะให้ผู้ดูแลปรับมุมมองหรือวิธีคิดใหม่

6.5 การเสนอแนะและฝึกวิธีการจัดการกับปัญหาทางด้านจิตใจที่เหมาะสม เช่น การฝึกลมหายใจ การละหมาด การอ่านฮัลกุรอ่าน การระลึกถึงและการศรัทธาในพระเจ้า การตระหนักถึงหลักคำสอนทางศาสนา และการปล่อยวาง เป็นต้น

7. พูดคุยให้กำลังใจและลดความรู้สึกที่ไม่ดี หากพบปัญหาให้คำแนะนำเบื้องต้นหรือส่งต่อ

8. ใช้เครือข่ายทางสังคมในการดูแลผู้ดูแล เช่น หน่วยงานในชุมชน อสม. ผู้ดูแลกลุ่มเดียวกัน เป็นต้น

แนวทางการดูแลผู้ดูแลมุสลิมด้านการปรับบทบาท/เศรษฐกิจ/สังคม

ปัญหาด้านความขัดแย้งในบทบาทและปัญหาด้านเศรษฐกิจในผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง

จากข้อมูลการสัมภาษณ์ผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง โรงพยาบาลสตูล จ.สตูล พบว่าปัญหาความขัดแย้งในบทบาทของผู้ดูแลมุสลิมส่วนใหญ่มีสาเหตุมาจากการที่ผู้ดูแลต้องรับผิดชอบในการกระทำหน้าที่หลายบทบาทในเวลาเดียวกับที่ต้องกระทำหน้าที่เป็นผู้ดูแล เช่น บทบาทผู้ทำงานหาเงินเลี้ยงครอบครัว บทบาทการเป็นนักเรียน ภรรยา สามี พ่อ/แม่ เป็นต้น ทำให้ผู้ดูแลต้องมีการปรับบทบาทและแบบแผนการดำเนินชีวิต ส่งผลให้เกิดปัญหาอื่น ๆ ตามมา เช่น ปัญหาด้านเศรษฐกิจ จากรายได้ลดลงหรือสูญเสียรายได้ รวมทั้งการมีภาระค่าใช้จ่ายที่เพิ่มสูงขึ้นจากการดูแลรักษาผู้ป่วย เช่น ค่าบริการด้านสุขภาพ ค่าเดินทางไปกลับโรงพยาบาล และค่าครองชีพประจำวันที่เพิ่มสูงขึ้น

แนวทางการดูแลผู้ดูแลที่มีปัญหาด้านความขัดแย้งในบทบาทและเศรษฐกิจ

1. ประเมินปัญหาด้านความขัดแย้งในบทบาทของผู้ดูแล เช่น ความขัดแย้งระหว่างบทบาทผู้ดูแลกับการทำงานนอกบ้าน ความขัดแย้งระหว่างบทบาทผู้ดูแลกับการเรียน ฯลฯ
2. ค้นหาสาเหตุและปัจจัยเสี่ยงของการเกิดปัญหาความขัดแข้งในบทบาทและเศรษฐกิจ
3. ให้คำปรึกษา/แนะนำในการจัดการกับปัญหาที่เกิดขึ้น
4. ค้นหาแนวทางในการปรับแบบแผนการดำเนินชีวิต แบบแผนการทำงาน แบบแผนการเรียน และแบบแผนการให้การดูแลผู้ป่วย เป็นต้น
5. พิจารณาปัจจัยหรือสิ่งสนับสนุนที่เกี่ยวข้องกับการปรับบทบาทหน้าที่ ได้แก่
   5.1 ด้านผู้ดูแล เช่น ความสามารถของผู้ดูแลในการปรับบทบาท
   5.2 ด้านสิ่งแวดล้อม เช่น แบบแผนการทำงาน/เรียน แหล่งสนับสนุนในครอบครัวและชุมชน
6. ช่วยเหลือผู้ดูแลในการบริหารจัดการเวลาและกิจกรรมของตนเองให้สอดคล้องกับกิจกรรมการ
   ดูแลผู้ป่วย
7. ช่วยเหลือผู้ดูแลในการบริหารจัดการกิจกรรมการดูแลผู้ป่วย เช่น ให้ข้อมูลเรื่องการดูแล จัดระบบการดูแลเป็นเวลา เป็นต้น
8. ช่วยเหลือผู้ดูแลในการบริหารจัดการงานอื่น ๆ เช่น งานบ้าน เป็นต้น

9. แนะนำ/ให้คำปรึกษาผู้ดูแลในการบริหารจัดการการเงิน เช่น การจัดสรรการเงินในครอบครัว การบริหารเรื่องรายได้และค่าใช้จ่ายของผู้ดูแลและครอบครัว แนวทางการเพิ่มรายได้และลดรายจ่ายของผู้ดูแลและครอบครัว เป็นต้น
10. สนับสนุนให้สมาชิกในครอบครัวคนอื่นรับรู้ถึงปัญหาความขัดแย้งในบทบาทและเศรษฐกิจของผู้ดูแลและครอบครัว และมีส่วนร่วมในการให้ความช่วยเหลือผู้ดูแลในการปรับบทบาทหน้าที่
11. แนะนำและค้นหาแหล่งช่วยเหลือสนับสนุน

ปัญหาด้านสังคมของผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง

เนื่องจากผู้ดูแลต้องปฏิบัติหน้าที่ในหลายบทบาท และใช้เวลาส่วนใหญ่ในการทำหน้าที่เป็นผู้ดูแลญาติที่มีภาวะเจ็บป่วยทำให้ไม่มีเวลา ส่งผลให้ผู้ดูแลบางรายต้องเผชิญกับปัญหาทางด้านสังคม ดังนี้

1. มีปฏิสัมพันธ์ทางสังคมกับเพื่อนและบุคคลอื่นในสังคมลดลง
2. มีการแยกตัวออกจากสังคม
3. มีกิจกรรมที่เกี่ยวกับการท่องเที่ยว/พักผ่อน/เดินทางไปร่วมกิจกรรมทางสังคมลดลง
4. มีความขัดแย้งกับบุคคลในครอบครัว เช่น ผู้ป่วย สมาชิกในครอบครัวคนอื่น ๆ เป็นต้น

แนวทางการดูแลผู้ดูแลที่มีปัญหาด้านสังคม

1. ประเมินปัญหา สาเหตุ และปัจจัยของการเกิดปัญหาด้านสังคมของผู้ดูแล
2. ค้นหาแหล่งช่วยเหลือจากบุคคลในครอบครัวและชุมชน เพื่อแบ่งเบาภาระของผู้ดูแล ให้ผู้ดูแลมีโอกาสได้เข้าร่วมกิจกรรมทางสังคม
3. จัดกิจกรรมเพื่อส่งเสริมการรวมกลุ่มทางสังคม เช่น กิจกรรม peer support group กิจกรรมสังสรรในเทศกาลต่าง ๆ เป็นต้น
4. แนะนำแนวทางการจัดการกับความขัดแย้งกับบุคคลในครอบครัว ดังนี้
   4.1 กระตุ้นให้ผู้ดูแลทบทวนหาสาเหตุของความขัดแย้ง เช่น สาเหตุจากผู้ป่วย คนรอบข้าง สภาพแวดล้อมที่ไม่เอื้ออำนวน ปัญหาทางเศรษฐกิจ ปัญหาสัมพันธภาพในครอบครัว ฯลฯ
   4.2 สนับสนุนให้ผู้ดูแลค้นหาทางออกด้วยตนเองหรือร่วมกับสมาชิกในครอบครัว ด้วยการพูดคุยหารือกันในครอบครัวด้วยน้ำเสียง สีหน้าท่าทางที่เหมาะสม
   4.3 พิจารณาขอความช่วยเหลือจากคนกลาง (ถ้าจำเป็น) เช่น คนที่ไว้วางใจ เจ้าหน้าที่สุขภาพ เป็นต้น

แนวทางการดูแลผู้ดูแลมุสลิมด้านจิตวิญญาณ

สิ่งยึดเหนี่ยวจิตใจและความเชื่อในการกระทำบทบาทผู้ดูแลของผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง

จากข้อมูลการสัมภาษณ์ผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง โรงพยาบาลสตูล จ.สตูล สรุปได้ว่าผู้ดูแลมุสลิมส่วนใหญ่ใช้หลักความเชื่อทางศาสนาเป็นสิ่งยึดเหนี่ยวจิตใจเมื่อต้องเผชิญกับความรู้สึกด้านลบจากการทำหน้าที่ผู้ดูแล เช่น

1. การดูแลพ่อแม่/ญาติ เป็นการปฏิบัติตามหลักคำสอนของศาสนาอิสลาม
2. การเจ็บป่วยของผู้ป่วยและปัญหาที่ผู้ดูแลเผชิญอยู่เป็นการทดสอบจากพระอัลเลาะห์ ทุกสิ่งทุกอย่างที่เกิดขึ้นเป็นสิ่งที่พระอัลเลาะห์เป็นผู้กำหนด
3. การดูแลพ่อแม่/ญาติเป็นการแสดงออกถึงความกตัญญู เป็นการทำความดี พระอัลเลาะห์จะให้รางวัลตอบแทนในโลกนี้หรือโลกหน้า
4. ความตายเป็นเรื่องธรรมชาติ พระอัลเลาะห์เป็นผู้กำหนด ทำให้ปล่อยวางและยอมรับสิ่งที่เกิดขึ้น
5. การละหมาดและการอ่านฮัลกุรอ่าน เป็นการขอพร ทำให้รู้สึกใกล้ชิดกับพระอัลเลาะห์และทำให้จิตใจสงบ เป็นโอกาสของการได้สำนึกปาบต่อพระอัลเลาะห์

แนวทางการส่งเสริมการมีสิ่งยึดเหนี่ยวจิตใจและการรับรู้ถึงความหมายของการมีชีวิตของผู้ดูแลมุสลิม

1. ประเมินความต้องการด้านจิตวิญญาณ โดยการสร้างสัมพันธภาพ ให้กำลังใจแก่ผู้ดูแลด้วยการให้ข้อมูลที่เกี่ยวข้องกับผู้ป่วยและครอบครัว
2. อำนวยความสะดวกแก่ผู้ดูแลในการประกอบพิธีกรรมทางศาสนาและความเชื่อ เช่น การละหมาด การอ่านและการฟังฮัลกุรอ่าน เป็นต้น
3. เปิดโอกาสให้ผู้ดูแลได้ระบายความรู้สึก ความเชื่อ ตลอดจนค้นหาและกำหนดเป้าหมายชีวิต
4. ให้คำปรึกษาเพื่อส่งเสริมการรับรู้ถึงความหมายของการมีชีวิตและการมีสิ่งยึดเหนี่ยวจิตใจเป็นรายบุคคลหรือรายกลุ่ม ดังนี้

    4.1 กิจกรรมการให้คำปรึกษาเพื่อส่งเสริมการรับรู้ถึงความหมายของการมีชีวิต มีขั้นตอนดังนี้

    1) พยาบาลกล่าวต้อนรับและแนะนำตัวเอง กรณีเป็นกิจกรรมกลุ่มต้องเปิดโอกาสให้สมาชิกกลุ่มได้แนะนำตนเองเพื่อสร้างสัมพันธภาพและความคุ้นเคยกันภายในกลุ่มตลอดจนเพื่อให้เกิดความรู้สึกไว้วางใจซึ่งกันและกัน

2) พยาบาลเตรียมความพร้อมในการให้คำปรึกษาด้วยการส่งเสริมให้ผู้ดูแลอ่านคัมภีร์ฮัลกุรอ่านหรือรำลึกและสรรเสริญต่อพระเจ้าในการเริ่มต้นกิจกรรม

3) พยาบาลเกริ่นนำเข้าสู่ความสำคัญของการตระหนักรู้ถึงความหมายและเป้าหมายในชีวิต

4) เปิดโอกาสให้ผู้ดูแลได้พูดคุยเกี่ยวกับคุณค่าและเป้าหมายในชีวิตของตนเองในปัจจุบันเพื่อให้ได้เกิดความตระหนักและได้ทบทวนว่าสอดคล้องกับหลักศาสนาอิสลามหรือไม่ อย่างไร

5) พยาบาลช่วยให้ผู้ดูแลหาแนวทางในการนำตนเองไปสู่เป้าหมายชีวิตตามหลักศาสนาอิสลาม โดยพิจารณาเกี่ยวกับข้อจำกัดของตนเอง วิเคราะห์ผลดี ผลเสีย ของแต่ละทางเลือก

6) พยาบาลให้กำลังใจผู้ดูแลและส่งเสริมให้ผู้ดูแลเห็นคุณค่าในการกระทำของตนเพื่อนำไปสู่เป้าหมายที่แท้จริงของชีวิต

4.2 กิจกรรมการให้คำปรึกษาเพื่อส่งเสริมการมีสิ่งยึดเหนี่ยวจิตใจ

1) พยาบาลกล่าวต้อนรับและแนะนำตัวเอง กรณีเป็นกิจกรรมกลุ่มต้องเปิดโอกาสให้สมาชิกกลุ่มได้แนะนำตนเองเพื่อสร้างสัมพันธภาพและความคุ้นเคยกันภายในกลุ่มตลอดจนเพื่อให้เกิดความรู้สึกไว้วางใจซึ่งกันและกัน

2) พยาบาลเตรียมความพร้อมในการให้คำปรึกษาด้วยการส่งเสริมให้ผู้ดูแลอ่านคัมภีร์ฮัลกุรอ่านหรือรำลึกและสรรเสริญต่อพระเจ้าในการเริ่มต้นกิจกรรม

3) พยาบาลให้ผู้ดูแลทบทวนตนเองเกี่ยวกับสิ่งยึดเหนี่ยวจิตใจ ความสัมพันธ์กับพระเจ้า ความสัมพันธ์ต่อตนเอง บุคคลอื่น และสิ่งแวดล้อมในด้านความรัก ความผูกพัน การให้อภัย และความไว้วางใจ โดยเปิดโอกาสให้สมาชิกได้เล่าและสำรวจเรื่องของตนเอง ตัวอย่างคำถาม

ความสัมพันธ์กับพระเจ้า

“ท่านอยากเปลี่ยนแปลงอะไรเพื่อให้เป็นบ่าวที่ดีหรือเป็นที่รักของพระเจ้า”

ความสัมพันธ์ต่อตนเอง

“เล่าความภาคภูมิใจในตนเองของตัวท่าน” “เล่าสิ่งที่คนอื่นเคยชื่นชมในตัวท่าน”

ความสัมพันธ์กับบุคคลอื่น

“ถ้าวันหนึ่งมีคนที่เขาเคยทำให้เราโกรธมากที่สุดมาขออภัยเรา เราจะแสดงออกอย่างไร”

4) พยาบาลให้ผู้ดูแลได้ตระหนักและทบทวนถึงความสำพันธ์กับพระเจ้าว่าสอดคล้องกับหลักคำสอนอิสลามหรือไม่ อย่างไร โดยพยาบาลให้ผู้ดูแลค้นหาแนวทางในการ

นำตนเองไปสู่ความสัมพันธ์กับพระเจ้าในด้านความรัก ความผูกพัน การให้อภัยและความไว้วางใจ ตามหลักศาสนาอิสลาม

5) พยาบาลให้กำลังใจผู้ดูแลและส่งเสริมให้ผู้ดูแลเห็นคุณค่าในการกระทำของตนเพื่อนำไปสู่จุดมุ่งหมายเพื่อพัฒนาความสัมพันธ์กับพระเจ้าให้สอดคล้องกับหลักศาสนาอิสลาม

5. ประเมินสุขภาวะทางจิตวิญญาณ โดยใช้แบบวัดสุขภาวะทางจิตวิญญาณ

แนวทางการส่งเสริมการแสวงหาความรู้ในการดูแลตนเอง/ผู้อื่นของผู้ดูแลมุสลิม

การแสวงหาความรู้ในการดูแลตนเอง/ผู้อื่นของผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง

จากข้อมูลการสัมภาษณ์ผู้ดูแลมุสลิมของผู้ป่วยล้างไตทางช่องท้อง โรงพยาบาลสตูล จ.สตูล พบว่า ผู้ดูแลมุสลิมมีการแสวงหาความรู้จากบุคลากรด้านสุขภาพเป็นหลัก ได้แก่ พยาบาล แพทย์ นักโภชนากร เภสัชกร อาสาสมัครสาธารณสุขหมู่บ้าน (อสม.) เป็นผู้ให้การสนับสนุนด้านความรู้ ฝึกทักษะ ให้คำปรึกษา/คำแนะนำ เกี่ยวกับการดูแลตนเองและผู้ป่วย ทั้งขณะอยู่ที่โรงพยาบาลและเมื่อผู้ดูแลกลับไปดูแลผู้ป่วยที่บ้าน รวมทั้งให้การสนับสนุนแหล่งความรู้ เช่น คู่มือ เอกสาร และแผ่นพับความรู้เกี่ยวกับการดูแลผู้ป่วยที่ได้รับการล้างไตทางช่องท้อง

นอกจากความรู้หรือทักษะที่เกี่ยวข้องกับการดูแลญาติ ผู้ดูแลยังมีความต้องการบุคคลที่คอยให้คำแนะนำหรือคำปรึกษาเกี่ยวกับการบริหารจัดการเรื่องการดูแลญาติ โดยพบว่าผู้ดูแลมีการแสวงหาข้อมูลเหล่านี้จากสมาชิกในครอบครัวหรือญาติเป็นหลัก

แนวทางการส่งเสริมการแสวงหาความรู้ในการดูแลตนเอง/ผู้อื่น

1. สอนและทบทวนความรู้เกี่ยวกับการดูแลตนเองและการดูแลผู้ป่วยล้างไตทางช่องท้องแก่ผู้ดูแลทุกครั้งที่ผู้ดูแลพาผู้ป่วยมาพบแพทย์
2. ฝึกและทบทวนทักษะการดูแลตนเองและทักษะการดูแลผู้ป่วยที่ได้รับการล้างไตทางช่องท้องแก่ผู้ดูแลทุกครั้งที่ผู้ดูแลพาผู้ป่วยมาพบแพทย์
3. เสริมสร้างพลังอำนาจในการดูแลตนเอง/ผู้อื่นของผู้ดูแล กิจกรรมประกอบด้วย
   3.1 กระตุ้นให้ผู้ดูแลค้นหาและวิเคราะห์สถานการณ์จริงของตนเอง ณ ปัจจุบัน
   3.2 ส่งเสริมให้ผู้ดูแลได้มีการสะท้อนคิดอย่างมีวิจารณญาณ ในประเด็นของการตระหนักถึงคุณค่าในตนเองของผู้ดูแล เพื่อให้ผู้ดูแลได้รับรู้ศักยภาพของตนเองที่มีอยู่ เห็นคุณค่าของความสามารถในการดูแลตนเองและผู้อื่น สร้างแรงจูงใจจากการรับรู้ว่าชีวิตของตนเองมีความหมายต่อการดูแลผู้อื่นและตนเอง และรับรู้โอกาสที่จะส่งเสริมสุขภาพของตนเอง

3.3 สนับสนุนให้ผู้ดูแลได้ตัดสินใจเลือกวิธีปฏิบัติในการดูแลตนเอง/ผู้อื่นที่เหมาะสมกับตนเอง โดยพยาบาลสามารถสนับสนุนให้ผู้ดูแลมีทางเลือกที่หลากหลายจากการเข้าร่วมกิจกรรม peer support group

3.4 กระตุ้นให้ผู้ดูแลได้ทบทวนถึงการดูแลสุขภาพของตนเอง/ผู้อื่นที่สามารถทำได้และไม่สามารถทำได้ โดยให้ผู้ดูแลเล่าประสบการณ์ความสำเร็จ ปัญหา อุปสรรคในการดูแลตนเอง/ผู้อื่น

3.5 ให้คำแนะนำ และเสนอทางเลือกในการแก้ไขปัญหา และร่วมกันหาทางเลือก พร้อมทั้งให้การสนับสนุนผู้ที่ยังไม่สามารถดูแลสุขภาพของตนเอง/ผู้อื่นได้ดี ตลอดจนสนับสนุนปัจจัยที่สามารถคงไว้ซึ่งความสำเร็จในการปฏิบัติการดูแลสุขภาพของตนเอง/ผู้อื่นของผู้ดูแลที่สามารถปฏิบัติได้ดีแล้ว

3.6 ติดตามประเมินผลความสามารถในการดูแลตนเอง/ผู้อื่นของผู้ดูแลอย่างสม่ำเสมอ

4. ให้ข้อมูลเกี่ยวกับแหล่งข้อมูลที่น่าเชื่อถือ เพื่อให้ผู้ดูแลสามารถไปค้นคว้าเพิ่มเติมได้
5. สนับสนุนสื่อที่จำเป็นต่อการเรียนรู้สำหรับผู้ดูแล เช่น แผ่นพับ เอกสารความรู้ วิดีโอ ตลอดจนข้อความคำสอนเกี่ยวกับแนวคิด/ความเชื่อทางศาสนาที่เกี่ยวข้องกับการดูแลตนเอง/ผู้อื่นของผู้ดูแล เพื่อให้ผู้ดูแลเกิดความตระหนักในคุณค่าของการดูแลตนเอง/ผู้อื่น
6. จัดหาแหล่งในการแสวงหาความรู้แก่ผู้ดูแล เช่น จัดทำระบบการให้คำปรึกษาโดยบุคลากรด้านสุขภาพตลอด 24 ชั่วโมง เป็นต้น

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ภาคผนวก

แนวทางปฏิบัติในการสร้างเสริมสุขภาพผู้ดูแล

1. สร้างเสริมสุขภาพให้แข็งแรง โดยการรับประทานอาหารที่มีคุณค่า ครบ 5 หมู่ หลีกเลี่ยงอาหารที่มีความเสี่ยงทำให้เกิดโรคต่าง ๆ รับประทานอาหารให้ตรงเวลา ควบคุหรือระวังเรื่องน้ำหนัก
2. เปลี่ยนแปลงสภาพการณ์ที่ทำให้เกิดความเครียด เช่น การปรับปรุงภูมิทัศน์ สถานที่ที่บ้าน ที่ทำงาน เพื่อสร้างบรรยากาศให้ผ่อนคลาย
3. เปลี่ยนแปลงทัศนคติ แนวคิด มุมมอง เช่น คิดบวก ทำให้ตัวเองมีอารมณ์ขัน ไม่ท้อถอยต่ออุปสรรคและความเครียด
4. ฝึกผ่อนคลายความเครียดด้วยวิธีต่าง ๆ ตามที่สนใจ ชอบ ถนัด และเหมาะสมกับตนเอง เช่น การทำจิตใจให้สงบด้วยการละหมาด การอ่านฮัลกุรอ่าน ฯลฯ

การดูแลตนเองของผู้ดูแล มีแนวทางปฏิบัติดังนี้

1. ปรับทัศนคติ ความคิด ความเชื่อของตนเองเกี่ยวกับการดูแลตนเอง
2. ตั้งเป้าหมายในการดูแลตนเอง
3. เอาใจใส่ในการดูแลตนเองให้มากขึ้น ให้กำลังใจตนเอง
4. บันทึกกิจกรรมในการดูแลที่ต้องทำในแต่ละวันให้เป็นระบบ
5. จัดตารางและวางแผนกิจกรรมในแต่ละวัน
6. ปรับกิจวัตรประจำวันให้เหมาะสมกับสถานการณ์ที่ต้องเป็นผู้ดูแลและเวลาที่จำกัด
7. รับประทานอาหารที่มีประโยชน์ และใช้เวลาในการเตรียมน้อย
8. พักผ่อนให้เพียงพอ นอนหลับในเวลากลางคืนอย่างน้อย 6-8 ชั่วโมง จัดสรรเวลาทั้งงานการดูแล การพักผ่อน และหาเวลาพักผ่อนหย่อนใจสั้น ๆ ทุกวัน
9. ควรเริ่มต้นออกกำลังกายและกระทำอย่างสม่ำเสมอ อย่างน้อย 3 วัน/สัปดาห์ ครั้งละ 30-45 นาที หรืออย่างมาก 6 วัน/สัปดาห์ ครั้งละ 10-15 นาที
10. ระวังการบาดเจ็บของตนเองและการบาดเจ็บจากการปฏิบัติกิจกรรมการดูแล
11. ขอคำปรึกษาและยอมรับความช่วยเหลือจากสมาชิกในครอบคัว เพื่อนฝูง เพื่อนร่วมงาน หรือเจ้าหน้าที่ในทีมสุขภาพ
12. ควรได้รับการเข้ากลุ่ม support group

VITAE

Name Miss Sunisa Seephom

Student ID 5810430005

Educational Attainment

Degree	Name of Institution	Year of Graduation
Bachelor of Nursing Science	The Thai Red Cross College of Nursing Bangkok, Thailand	2008
Master of Nursing Science (Adult Nursing)	Ramathibodi School of Nursing, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Thailand	2013

Scholarship Awards during Enrollment

The Thai Red Cross Society, Thailand

Work – Position and Address

Instructor, Division of Adult and Gerontological Nursing, The Srisavarindhira Thai Red Cross Institute of Nursing, Bangkok, Thailand, 10330, Email: sunisa.s@stin.ac.th

List of Publications and Proceedings

Seephom, S. Self-management in chronic kidney disease. *Thai Red Cross Nursing Journal, 6*(1), 12-18.

Seephom, S., Prapaipanich, W., Janepanich, P., & Pichaiwong, W. (2014). The effect of self-management program for slow chronic kidney disease progression on knowledge, health behavior and blood pressure levels. *Thai Journal of Cardio-Thoracic Nursing, 25*(1), 16-31.

Phutharangsi, S. & Seephom, S. (2017). Study of the relationship between selected factors and perioperative nurses' competencies in Thailand. *Journal of The Royal Thai Army Nurses, 18*(1), 94-103.

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