CHAPTER 3

CASE STUDY METHOD

3.1. Method

This Final Scientific Work for Nurses (KIAN) uses a study methodA case study using a descriptive approach. The descriptive method aims to provide a systematic overview of an ongoing phenomenon or event based on facts found in the field. In this study, the author focuses on exploring the issues of nursing care for families with disabilities in providing health care for family members with dementia.

The approach used in compiling this case study is the nursing care process approach.atan, which includes the assessment stages, determining nursing diagnoses, preparing implementation plans, and evaluating the results of nursing actions that have been given (Suardi, 2020)

3.2. Location and Time

This case study was conducted in the working area of the Ciptomulyo Community Health Center, Malang City, the implementation time started on May 12-15, 2026, in this case the researcher visited the patient's home for 3 days with a time of approximately 30 minutes.

3.3. Subject

This subchapter contains the characteristics of the case study subjects. The subjects used are families with a member with dementia and an inability to provide family health care.

Subjects were selected based on the family nursing care approach, where the familybecome a major part of the intervention because the family is the primary caregiver for dementia patients.

3.4. Result Criteria

The outcome criteria are in accordance with the nursing problem output of Family Health Management Inability / Ineffective Family Health Management, the outcome criteria refer to the Indonesian Nursing Outcome Standards (SLKI) PPNI and the intervention refers to the Indonesian Nursing Intervention Standards (SIKI) PPNI.

Main Outcome: Improved Family Health Management (L.12105) Outcome Criteria:

1. Ability to explain health problems experienced increases
2. Family activities to address health problems appropriately increase
3. Verbalization of difficulty performing prescribed care Decreased

3.5. Data collection

This sub-chapter explains the data collection methods used:

1. Interview

Interviews were conducted through anamnesis with the patient and family, acting as primary caregivers, to obtain information regarding the patient's health condition and the family's ability to care for a family member with dementia. Interviews were conducted using family nursing

assessment guidelines. Data sources for the interviews were obtained from:

1. Patients, as a source of data regarding health conditions, complaints, and daily activity abilities according to the patient's cognitive abilities.
2. The family/primary caregiver, as the primary source of data regarding the family's ability to recognize health problems, make decisions, carry out care, modify the environment, and utilize health facilities.
3. Relevant health workers, if necessary to obtain additional information regarding the patient's health service history.

2. Observation and Physical Examination

Observations and physical examinations were conducted to supplement the interview data. Observations were conducted onthe patient's condition, ability to carry out daily activities, patient interaction with family, and the family's ability to provide care.

A physical examination is performed to determine the patient's general condition, including vital signs, physical status, mobility ability, and the risk of health problems related to dementia.

3. Documentation Study

The documentation study was conducted by collecting secondary data related to the patient and family's condition through medical records, disease registers, patient progress notes, supporting examination results, and health service data from the Ciptomulyo Community Health Center in Malang City. The data collected included patient identity, medical diagnosis of dementia, past medical history, history of comorbidities (such as hypertension and diabetes mellitus), physical examination results, supporting examination results if available, therapy or medication given, health control history, and patient progress notes. In addition, data was also collected regarding the patient's care history by the family, adherence to treatment, and documentation of home visits related to the implementation of family nursing care.

The documentation data is used as supporting data to confirm the medical diagnosis of dementia, complement the results of the family assessment, assist in formulating the nursing diagnosis of Ineffective Family Health Management, develop Family Empowerment Strategy (FES) interventions, and evaluate the development of the family's ability to manage the health of family members during the nursing care process. Health documentation also serves as a secondary data source that increases the accuracy and validity of research information.