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The Relationship of Family Readiness with the Quality of Life of Patients Suffering from Terminal Disease at Medan Murni Teguh Hospital

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ARTICLEINFO

Keywords:
readiness,
quality of life,
terminal disease,
family

ABSTRACT

This study aims to identify the relationship between family readiness and the quality of life of patients suffering from terminal illness at the Murni Teguh Hospital in Medan. This study uses a descriptive correlational type of research using cross-sectional design. The population of this study were patients suffering from terminal illness who were hospitalized in the Murni Teguh General Hospital Medan using a sample of 30 people by means of purposive sampling. The results showed that 24 respondents (75%) were in the category of not ready to treat terminal illness patients and 8 people (25%) were in the prepared category and all terminal illness patients in the category of moderate quality of life were 32 people (100%). Statistical test results using the Spearman rank Correlation test obtained correlation value of 0.031 with a significance level of 5% (degree of confidence α = 95%). Value of 0.031 <0.05, then Ho is rejected or it can be concluded that there is a relationship between family readiness and quality of life for terminal illness patients with a correlation strength of 0.382. Suggestions for further research are expected to take a sample with a larger sample size so that research results are more representative.

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1. Introduction

Terminal disease patients are patients who are suffering from illness where the level of the disease has reached an advanced stage so that medical treatment is no longer possible to cure. So the terminal state is a state of illness where according to common sense there is no hope for the sick to recover. The illness can be caused by an illness or an accident (Adde, 2012).

At an advanced stage, patients with acute and chronic diseases not only experience various physical problems such as pain, shortness of breath, weight loss, disruption of activity but also experience psychosocial and spiritual disorders that affect the quality of life of patients and their families. Then the needs of patients at an advanced stage of a disease are not only the fulfillment / treatment of physical symptoms, but also the importance of support for psychological, social and spiritual needs which are carried out with an interdisciplinary approach known as palliative care (Doyle & Mac. Donald, 2003). Therefore, terminal illness patients must get palliative care which is to relieve the symptoms of the disease, but no longer functions to cure (Adde, 2012).

Data from the Palliative Care Hospital Margono Soekarjo Purwokerto Hospital states that patients in the Palliative Care Hospital Margono Soekarjo Purwokerto Hospital are increasingly increasing the number of terminal renal failure patients (GGT) lately from 3,962 patients in 1993 to around 4,298 in 2001, increasing 11.34%. Approximately 26.14% of patients aged 45-54 years and 13.56% aged 30-44 years, so about 39.7% of patients with Palliative care at Margono Soekarjo Purwokerto Hospital are people who are of productive age (Mayda, 2015) . Global estimates say, by 2020 there will be an increase to 157 million people suffering from chronic diseases which are also included in the terminal illness category (Partnership for solutions, 2004, in Lubkin and Larsen, 2006).

When someone is diagnosed with a severe illness with an advanced stage where medical treatment is not possible for the patient to accept. Death is an answer for terminal illness patients. Over time, terminal patients are very torturous days because they have to wait for death as a definite answer with extreme pain. (Megawe, 1998). The cause of death is a phenomenon that always experiences the dynamics of change in accordance with the dynamics of human change because death is the end of the stages of the tasks of the development of human life (Pradana, et al, 2012).

Humans who die suddenly without going through a process of death or dying in a relatively short period of time certainly do not show the dynamics as stated by Kubbler Rose (1998) or

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Pattison in Papalia (1977); whereas those who die through a process leading to death in a relatively long period of time such as terminal disease patients will exhibit very complex dynamics.

Various kinds of life roles that are lived so far will surely face obstacles both due to physical, psychological, social, cultural and spiritual obstacles. Likewise, the prognosis of death in terminal patients will have more unique psychological, social, cultural and spiritual conflicts (Fitria, 2010).

Fear and anxiety about death is a common phenomenon experienced by all humans. Fear and anxiety can arise because of the unknown arrival time and the lack of readiness to face death itself. Readiness will leave loved ones, readiness to leave a world that may be full of pleasure, and go to a different place or life. This means that the time of his death was more clearly known and became a certain thing. Although the time of death that can be seen with more certainty, but the feeling of unacceptability, fear, anger, anxiety, and sadness descended on the terminal illness patient after he was diagnosed. Terminal illness diagnosis can cause trauma for patients and their families (Fitria, 2010).

The family as a person who is very close to the patient is very instrumental in providing follow-up care and meeting the patient's self-care needs that cannot be done by him alone (Friedman, 1998). In addition, in the prolonged stress conditions experienced by caring families, the thing that must be considered is the condition of psychological well-being of families, especially caregivers who take full care of patients (Wakhidah, 2011).

Since 1948 the WHO has established a definition of healthy, which is not only free from disease but also in physical, mental, and social. This in general can be said to have a good quality of life.Quality of life is an individual's perception of the limitations, symptoms and psychosocial characteristics of his life in the cultural context and values to carry out his role and function. Patient's quality of life is the patient's perception of the patient's condition according to the cultural context and value system that he adopts, including his life goals, expectations, and intentions (Nofitri, 2009).

Each individual has a different quality of life depending on each individual in addressing the problems that occur in him. If faced with positively it will be good quality of life, but it is different when faced with negativity it will also be bad quality of life (Nofitri, 2009).

Dimensions of quality of life are physical symptoms, functional abilities (activities), family well-being, spiritual, social functions, satisfaction with treatment (including financial problems), future orientation, sexual life, including self-portrayal (Kepmenkes RI Number 812 of 2007). This means that if someone is healthy physically, psychologically, socially and environmentally, that person can be said to achieve satisfaction in his life. (Supryadi, 2012). The quality of a person's life in both the short and long term can be predicted by the patient's own self-efficacy. Quality of life is important to monitor because as a basis for describing the concept of health and is closely related to morbidity and mortality. (Skevington et al, 2004). In a study by Heydarnejad et al (2009), regarding the quality of life of post-chemotherapy cancer patients in 200 cancer patients, 22 (11%) patients had a good quality of life, 132 (66%) patients had a moderate quality of life, and 46 (23%) patients have poor quality of life

The results of observations made by nurses at Medan Murni Teguh Hospital there are an average of 30 cases of terminal patients who die each month and there are no studies on the quality of life of terminal patients and family readiness in dealing with these terminal conditions at Murni Teguh Hospital Medan.

Based on the explanation above, the authors are interested in conducting research on the relationship between family readiness and the quality of life of patients suffering from terminal illness at Medan Teguh Hospital.

2. Research methods

a. Research Types and Design

This study uses a descriptive correlational type of research using cross-sectional design in which the researcher emphasizes the measurement and observation of independent and dependent variable data only once to determine the relationship of family readiness with the quality of life of patients suffering from terminal illness at Murni Teguh Hospital in Medan (Nursalam, 2008).

b. Population

Population is the whole subject of research to be studied (Setiadi, 2007). The population in

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this study were subjects who met established criteria (Nursalam, 2011). The population in this study were patients suffering from terminal illness who were hospitalized in the Murni Teguh General Hospital in Medan totaling 45 people.

c. Sample

Sample is a process of selecting portions of the population that can represent the existing population (Nursalam, 2011). The size of the sample in this study must be representative of the population, then the determination of the minimum sample size of this study was taken with the formula:

$$n = \frac{N}{1 + N.d^2}$$

Information :
n = Required sample size
N = Number of population

d = maximum allowable error

Calculation:

$$n = \frac{45}{1 + 45.0.1^2}$$

$$n = \frac{45}{1 + 0.45}$$

= 31.03 rounded to 31

Based on the above calculation results obtained a minimum sample of 31 people. The sampling technique used in this study is to use a purposive sample technique, which is a sampling technique based on specific objectives and certain conditions, the way is to select a number of respondents based on inclusion criteria (Arikunto, 2006).

The inclusion criteria and exclusion criteria in this research are:

a) Inclusion Criteria
   1) Families who have family members suffer from terminal illnesses
   2) Can communicate and use Indonesian well
b) Exclusion Criteria
   1) Respondents who refused to be interviewed

d. Place and time of research

a) Place of research

The research location is the location where the study was conducted. This research was conducted in the Nursing Room of the Murni Teguh General Hospital, Medan.

b) **Research time**

This research was conducted during the period December 2017 to February 2018.

e. Research Instruments

a) Research Tools

The questionnaire in this study uses a closed questionnaire type, the questionnaire whose answers or contents have been determined, so that the subject does not provide responses or other answers.

Modified quality of life questionnaire from The World Health Organization Quality of Life(WHOQoL) which contained 26 questions, consisting of 5 point scales.Quality of life questionnaire assessment consisted of 26 questions using a Likert scale consisting of favorable questions with a classification rating if answering Very Poor is worth 1, Poor is worth 2, Medium is worth 3, Good is value 4, Very Good is value 5 and unfavorable with rating classification if

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answering Very Poor is 5, Bad is 4, Medium is 3, Good is 2, Very Good is 1. Total score in this questionnaire is 130 with the highest value 130 and the lowest value is 26 with classification if the respondent is able to answer correctly with a score of 26-47 categorized as quality life is very bad, score 48-69 is categorized as poor quality of life, score 70-91 is categorized as moderate quality of life, score 92-113 is categorized as good quality of life, score 114-133 is categorized as very good quality of life

While the readiness questionnaire consists of 15 items with a choice of yes or no answers. The highest score on this questionnaire is 30 and the lowest score is 15. In this study if the score is in the range of 15-22, it is categorized as "not ready" and if the respondent's score is in the range of 23-30 is categorized as "ready".

b) Validity Content

Content validity is another type of validity that depends very much on personal interpretation, and refers to whether the instrument contains all the dimensions that the observer will consider to be important in measuring the desired results. If the instrument has a high content of validity, one can draw broader conclusions about individuals that are measured in relation to the larger community (Jennings, 2012).

f. Data Collection Methods

Data collection in this study was carried out by:

a) Administrative
   1) The researcher submitted a request for a research permit from the institution to the Director of the Murni Teguh Hospital in Medan.
   2) After obtaining an approval letter from the Director of Murni Teguh Medan Hospital, the researcher conducted a preliminary study.
   3) Researchers conducted research with a questionnaire that was valid at the Director of the Murni Teguh Hospital in Medan by way of questionnaires being consulted and determined by the supervisor.
   4) The data that has been obtained at the entry is then collected into one and then given a coding mark.

b) Technical

Respondent demographic data including: age, sex, level of education, work experience and questionnaires about the relationship of knowledge about patient safety with nurse compliance in implementing six patient safety goals are given to each respondent and the results are collected into one and then analyzed.

g. Processing Techniques

In this research, data processing is carried out with the following stages:

a) *Editing*
b) *Coding*
c) Data entry
d) *Cleaning*
e) *Tabulating*

h. Operational Definition

The operational definitions in this study are:

a) Independent Variable

Family Readiness is family preparedness to react or respond to the worst thing that happens to patients as assessed by the quality of life of patients.

b) Dependent Variable

Quality of life is abilityfunctional disease and treatment given according to the views or feelings of patients as measured by physical health, psychology, social relations, environment (physical security, home environment,financial resources, health facilities, ease of getting health, recreation and transportation information.).

i. Data analysis

Data analysis was performed to answer the research hypothesis. The data obtained were analyzed using quantitative statistical techniques using unvariate analysis. In this study using a computer system in calculating data. This study uses univariate analysis.

Univariate analysis is an analysis used to analyze each variable from the results of research that produces a frequency distribution and percentage of each variable (Notoatmodjo 2005).

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Univariate analysis is also used to describe the mean value used for data that are not grouped or data that has been grouped, the median value which is the value in the middle of a value or observations compiled, and the mode value used to express the most occurring phenomena. (Hidayat 2007). The univariate analysis in this study is the distribution of, level of education, age, sex, occupation, the results of which will be displayed in tabular form. Bivariate analysis was carried out on two variables that were thought to be related or correlated (Notoatmodjo, 2005), which included independent variables namely the quality of life of terminal patients and the dependent variable, namely the readiness of the patient's family.

Bivariate analysis was carried out on two variables that were thought to be related or correlated, which included the independent variables, namely readiness and the dependent variable, namely the quality of life of patients. The statistical test used to determine the relationship of family readiness with the quality of life of terminal illness patients in Medan Teguh Murni Hospital is Spearmen correlation (Notoatmodjo, 2010). The requirement to use the non parametric Spearmen test is that data must be categorized on a scale.

Criteria for the calculation of the test is if p <0.05, then Ho is rejected and Ha is accepted. The results of the statistical test will be interpreted into the value of r. The largest value of r is +1 and the smallest r is -1. r = +1 indicates a perfect positive relationship, while r = -1 indicates a perfect negative relationship. Nilair has no units or dimensions. The + or - sign only indicates the direction of the relationship. The interpretation of the value of r is as follows: (Machfocdz, 2014)

Table 1
statistic test

r	Interpretation
0	Does not correlate
0.01-0.20	Very Low Correlation
0.21-0.40	Low
0.41-0.60	A little low
0.61-0.80	Enough
0.81-0.99	High
1	Very high

3. Research result

a. Univariate Analysis

1) Characteristics of Respondents

Characteristics of respondents in this study discussed about age, gender, ethnicity, recent education, occupation, income, relationship with patients and patient diagnoses at Murni Teguh General Hospital, Medan.

Table 2.
Distribution of Age Frequency, Gender, Ethnicity, Latest Education, Occupation, Income, Relationship with Patients and Patient Diagnosis (n = 32).

No	Characteristics of Respondents	Frequency	Percentage (%)
1	Age (years)		
	1. 20-29	5	15.63
	2. 30-39	6	18, 75
	3. 40-49	15	46.88
	4. 50-59	3	9.37
	5. 60-69	3	9.37
amount		32	100
2	Gender		
	1. Male	9	28.1
	2. Girl	23	71.9
amount		32	100
3	Suku		
	1. Batak	21	65.63
	2. Java	5	15.63
	3. Malay	4	12.5
	4. And others	2	6.25
amount		32	100
4	Last education		
	1. Elementary school	6	18.8

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No	Characteristics of Respondents	Frequency	Percentage (%)
	2. Middle School	7	21.9
	3. High school	11 6	34,418,8
	4. Diploma	2	6.2
	5. Bachelor		
	amount	32	100
5	Profession		
	1. Civil servants	2	6.2
	2. Private employees	3	9.4
	3. entrepreneur	13	40.6
	4. Farmers	2	6.2
	5. Housewife	8	25
	6. Do not settle	4	12.5
	amount	32	100
6	Earnings per month		
	1. <Rp. 2,200,000	24	75
	2. Rp. 2,200,000 to 5,000,000	6	18.8
	3. Rp. 5,000,000. 10,000,000	2	6.2
	amount	32	100
7	Relationship with Patients		
	1. Husband and wife	15	46.9
	2. Son	12	37.51
	3. Parents	5	5.6
	amount	32	100
8	Diagnosis of Disease		
	1. Cancer	22	68.8
	2. Leukemia	3	9.4
	3. Hemophilia	6	18.8
	4. Neuroblastoma	1	3.1
	amount	32	100

Data shows that as many as 15 respondents (46.88%) aged 40-49 years with a mean of 41.81 and SD + 12.37 where the minimum age is 22 years and the maximum age is 68 years. Respondents who were male were 9 respondents (28.1%) and female were 23 people (71.9%). Most of the respondents with a Batak ethnic group were 21 people (65.63%) and Javanese as many as 5 people (15.63%). As many as 11 people (34.4%) with high school education background and 7 people (21.9%) with junior high school education. The occupation of respondents is 13 entrepreneurs (40.6%) and as many as 8 housewives (25%). The income of respondents is around <Rp. 2,000,000 per month as many as 24 people (75%). The relationship of respondents with patients is as husband / wife as many as 15 people (46.9%), as children 12 people (37, 5) and as many as 5 parents (15.6%). Most of the patients diagnosed with stage 3 and 4 cancer were 22 people (68.8%) and diagnosed with hemophilia as many as 6 people (18.8%).

b. Family Readiness of Terminal Disease Patients at Murni Teguh Hospital Medan

The results of the frequency distribution of family preparedness for terminal patients at Murni Teguh Hospital, Medan

Table 3.
Family Readiness of Terminal Disease Patients at Murni Teguh Hospital Medan (n = 32)

Readiness	Frequency	Percentage (%)
1. Ready	8	25
2. Not ready	24	75
amount	32	100

Based on the data obtained from 24 respondents (75%) are in the category of unprepared in dealing with the worst possible terminal illness patients and 8 people (25%) in the ready category.

c. Quality of Life for Terminal Disease Patients at Murni Teguh Hospital, Medan.

The results of frequency distribution of quality of life of terminal illness patients at Murni Teguh Hospital Medan.

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Table 4.
Quality of Life for Terminal Disease Patients at Murni Teguh Hospital Medan (n = 32)

Quality of life	Frequency	Percentage (%)
1. Very bad	0	0
2. Bad	0	0
3. Is	32	100
4. Good	0	0
5. Very good	0	0
amount	32	100

Based on the data obtained that the quality of life of all terminal illness patients in the category of moderate quality of life is 32 people (100%).

d. Bivariate Analysis.

The following is a comparison between the frequency of family readiness and the quality of life of terminal illness patients.

Table 5.
Family Readiness for Quality of Life

Survey Tabulation		Quality of life	Total
		Is	
Readiness	Ready	8	8
	Not ready	24	24
Total		**32**	**32**

Based on the data above, it was found that respondents who were prepared to face the worst possibility that occurred in patients with quality of life for patients in the moderate category numbered 24 people and respondents who were not prepared to face the worst possibility that occurred in patients with quality of life in patients in the moderate category were 8 people.

This study uses the Spearman rank correlation test with the help of the SPSSfor Windows Version 16.0 program to determine the relationship of family readiness with the quality of life of patients suffering from terminal illness at Murni Teguh Hospital in Medan. The criterion for test calculation is if p <0.05, then Ho is rejected and Ha is accepted. The test results obtained are as follows:

e. Correlation Test Results Relationship of Family Readiness with Quality of Life of Patients Suffering from Terminal Disease at Murni Teguh Hospital, Medan

Table 6.
Correlation Test Results

Variable	P value	Correlation coefficient
Readiness Quality of life	0.031	.382

Based on the data above, it can be seen that by using the Spearman rank Correlation test, the correlation between readiness and quality of life is 0.031 with a significance level of 5% (degree of confidence α = 95%). Value of 0.031 <0.05, then Ho is rejected or it can be concluded that there is a relationship between readiness and quality of life. The correlation strength is equal to 0.382 or low correlation (Machfocdz, 2014). With the direction of a positive relationship where the higher the readiness, the better the quality of life.

3. Discussion

a. Family Readiness of Terminal Disease Patients at Murni Teguh Hospital Medan

Based on the results of the study found that most of the respondents were in the category of unprepared as many as 22 people (75%) and the ready category as many as 8 people (25%). This is influenced by various factors including age, sex, ethnicity or culture, education, family relationships and diagnosis of disease. In this study the condition of terminal illness patients was in the final stages of the disease process (stages 3 and 4) while the results of the study of the majority of families were in the unprepared category. The family's preparedness or unpreparedness in caring for sick family members is also influenced by the length of time the patient has suffered from

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terminal illness and knowledge that includes information on caring for terminal patients. The longer the patient suffers from terminal illness, the more ready the family is in caring for the patient.

The patient's family is classified as ready and not ready to treat terminal illness due to the age of the respondent. The more a person ages, the more mature a person is to make a decision so that it will affect the readiness to face even the worst. In this study as many as 6 respondents (18.75%) were> 39 years of age and in the category of being ready to face the worst possibility that patients would experience (Dalyono (2011).

Gender differences can also be one of the factors that influence a person's psychology so that it will have an impact on the form of adaptation used (Tamher & Nurkasiani, 2009). Women are more sensitive and have weak souls and don't like unpleasant emotional conditions. While men have an aggressive nature and always think logically (Indriyawati & Zulkaida, 2006). Based on the character between men and women, it can be assumed that women have a higher level of anxiety than men. This anxiety is in line with one's unpreparedness.

Bailon and Maglaya (1998) explained that families who are ready to carry out health and health care tasks are able to solve health problems so that they can improve health status, in this case families are ready to deal with terminal patients' health problems so as to improve the quality of life of patients.

Cancer diagnosis is a disease that requires treatment in a very long period of time, must receive chemotherapy treatment with various side effects that make the patient feel uncomfortable, sometimes accompanied by a sudden decrease in the condition and the fatal result is death and this is the biggest challenge for families to be ready in treating terminal illness patients (Amalia. 2014).

Research conducted by Shaheen et al (2011) found that the husband's reaction to the diagnosis of his wife depends on the level of education and awareness of the presence of cancer. 44% of patients said that when they heard the news about this diagnosis, their husbands were disturbed and showed a lack of cooperation, 32% showed a cooperative attitude, 32% of the husbands asked for divorce, and the rest showed full support and encouragement to fight the disease.

b. Quality of Life for Terminal Disease Patients

The results of this study found that all respondents belonged to the category of moderate quality of life (n = 32). In this study quality of life was measured by assessing physical health, psychological well-being, level of independence, social relations, relationships with the environment and spiritual conditions. Most of the patients in a state of total bed rest with the condition of the course of the disease in the final stages. With poor physical health conditions causing psychological well-being to decline, the level of independence must be assisted by nurses and families in meeting their needs, social and environmental relationships are reduced and make spiritual relationships of worship become hampered.

Kreitler et al. (2007) suggested that the decrease in quality of life in cancer patients is influenced by various factors, such as symptoms, the type of care the patient receives, the patient's appearance status, depression, and spiritual beliefs.

Treatment of cancer at an advanced stage is very difficult and the results are less satisfying (Manuaba, 2008). At an advanced stage, cancer patients not only experience a variety of physical problems, but also experience psychosocial and spiritual disorders that affect the quality of life of patients.

This study was supported by research by Heydarnejad et al (2009), regarding the quality of life of post-chemotherapy cancer patients in 200 cancer patients, found as many as 22 (11%) patients had good quality of life, 132 (66%) patients had moderate quality of life, and 46 (23%) patients had poor quality of life. Therefore, the patient's needs are not only in the fulfillment or treatment of physical symptoms, but also the importance of support for psychological, social, and spiritual needs which are carried out with an interdisciplinary approach. (Minister of Health RI, 2013).

Moons, Marquet, Budst, anddeGeest (2004) says that gender is one of the factors that affects the quality of life .ain, et al (2003) find there are differences in the quality of life between men and women, where the quality of life plays a role in the role of patients (male and female). .

Contrary to the discovery of Bain,Wahl, Rustoen, Hanestad, Lerdal & Moum (2004) found that the quality of life of women tends to be higher than men. Faddadan Jiron (1999) said that men and women have differences in the role and access and control of various sources so that the needs / things that are important for men and women will also be different. This indicates the different

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aspects of life in relation to the quality of life in men and women.

c. The Relationship of Family Readiness with the Quality of Life of Patients Suffering from Terminal Disease at Murni Teguh Hospital, Medan

The results showed there was a relationship between family readiness and quality of life of terminal illness patients at Murni Teguh Hospital, Medan. The more ready the family in treating terminal illness patients will be followed by the high quality of life of patients as well. In this study most respondents were not ready to treat terminal illness patients and evidenced the quality of life of patients in the spring category.

The results of this study are supported by another research conducted by Wahyuni (2014) namely that there is a significant relationship between the readiness of parents to the quality of life of children suffering from terminal illness in palliative care of children. In the research it was said that efforts needed to improve the readiness of parents in influencing the quality of life of children must be improved.

Research conducted by Sari (2015) shows that there is a significant relationship between the level of spirituality and the readiness of the elderly in the face of death which improves quality of life. The higher the level of elderly spirituality, the more prepared it will be to face death. Because with the existence of spirituality in the elderly can improve the quality of life in the elderly and will be more prepared in the face of death.

Qualitylife is related to the attainment of an ideal human life or something that is desired (Diener and Suh, in Friends, Diener, & Schwarz, 1999). In general life quality describes individual well-being from a community (Chamberlain; Diener; Oppongdkk; Shuessler & Fisher, in Liao, Fu, & Yi, 2005). The higher the family's readiness in treating terminal illness patients, the higher the quality of life of patients. In this study it was found that families who tend not to be ready in treating terminal illness patients thus affecting the quality of life of patients classified as moderate.

Family members play a vital role as the main service provider for family members who experience chronic physical illness or mental illness. The family health function is responsible for monitoring or overseeing and anticipating any changes that occur in sick family members. The consequences of the family as a service provider to members who are sick can be potentially positive or negative. The positive potential is that families feel responsible and closer to their family members, and have a negative impact, if the family feels an increase in needs and activities that are not balanced so that it causes stress, resulting in low quality of life for sick family members.

Families who can develop positive coping strategies will be able to adapt to changes in the family. But if maladaptive, the family will reject the problem, without a prolonged solution (Fridemann, 1999). In this case a positive coping strategy that is ready to treat terminal illness patients and ready to face the worst health risks.

The ability to adapt to change is essential to maintaining the optimal functioning of the family system. Change is inseparable from terminal illnesses which have a profound effect on the family. In difficult conditions a family presence will help provide the emotional and spiritual support that a patient needs, giving strength to sick family members (Davidson, 2009).

4. Conclusion

The results showed that 24 respondents (75%) were in the category of not ready to treat terminal illness patients and 8 people (25%) were in the ready category and all terminal illness patients in the category of moderate quality of life were 32 people (100%). Statistical test results using the Spearman rank Correlation test obtained correlation value of 0.031 with a significance level of 5% (degree of confidence α = 95%). Value of 0.031 <0.05, then Ho is rejected or it can be concluded that there is a relationship between family readiness and quality of life for terminal illness patients with a correlation strength of 0.382. Suggestions for further research are expected to take a sample with a larger sample size so that research results are more representative.

Reference

Adde. F. 2012. PerawatanTerminal Illnes. Diakses tanggal 20 Oktober 2016.

Ahyar. (2010). Konsep diri dan mekanisme koping diambil tanggal 28 April 2011 dari http://www.konsepdiridanmekanismekopingdalamaplikasiproseskeperawatanhtm.

Contents lists available at iocspublisher

Science Midwifery

journal homepage: www.midwifery.iocspublisher.org

Amalia. 2014. Kesiapan keluarga menghadapi kepulangan pasien rawat inap. (Studi kasus pada keluarga pasien rawat inap). Jurusan Psikologi Fskultas Ilmu Pendidikan Universitas Negeri Semarang. Skripsi.

Anggraeny, Sivya. 2009. Faktor-faktor Kecemasan Menghadapi Kematian Pada Lansia Di Panti Jompo Kelurahan Kalirejo Kecamatan Lawang. Skripsi. Malang. Fsultas Psikologi Universitas Malang.

Angriyani, D. (2008). Kualitas Hidup pada Orang dengan Penyakit Lupus Erythematotus (Odapus). Skripsi Fakultas Psikologi Universitas Airlangga.

Bulan, S. 2009. Faktor-faktor yang berhubungan dengan kualitas hidup anak Thalasemia Beta Mayor. Tesis Program Pasca Sarjana Megister IlmuBiomedik dan Program Pendidikan Dokter Spesialis I Ilmu Penyakit Saraf Universitas Diponegoro.

Dalyono, M. 2001. Psikologi Pendidikan. Cetekan ke 2. Jakarta : Rineka Cipta. Direktorat Kesehatan Jiwa. 1990. Hasil penilaian ; Disabilitas psikososial pasien.

Dochterman, J.M., Bulechek. 2004. Nursing intervension classification. St.Louis : Mosby

Doyle, Hanks and Mcdonlad, 2003. Oxford Texbook of Palliative Medicine. Oxford Medical Publications (OUP) third edition 2003.

Fitria. 2010. Paliative care pada penyakit terminal . AKPER PKU Muhamadiah Surakarta . GASTER Volume 7 M NO.1.

Friedeman , M.L 2005 . The Framework of Systemic Organization : Conceptual approach to families and nursing . Newbury park , CA: Sage

Haan R, Faronson N. 1993. Measuring Quality of life in stroke . Stroke

Hermann BP . 1993 . Developing a model of Quality of life in epilepsy the contribution of neuropsychology . Epilepsia . 34 (suppl)

Heydarnejad et al. 2009. Factors affecting Quality of Life In Cancer Patients Undergoing Chemotherapy, (online), (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3158510/pdf/AFHS1102-0266.pdf,diakses 30 Oktober 2016

Kepmenkes RI Nomor: 812/ Menkes/SK/VII/2007 Tentang Kebijakan Perawatan Paliative Menteri Kesehatan Republik Indonesia

Koentjaningrat.2002. Pengantar Ilmu Antropologi. Jakarta : Rajawali Press

Koesmanto,S. Dalam Novandhori , D.R. 2013 Hubungan Peran Keluarga Dengan Kualitas Hidup Lansia Yang Mengalami Gangguan Fungsi Kognitif Di Desa Windunegara Kecamatan Wangon Kabupaten Banuyumas. Skripsi Universitas Jenderal Soedirman

Kreitler et al. 2007. Stress, Self-efficacy and Quality of Life in Cancer Patients, (online), (http:///online library.wiley.com/doi/10.1002/pon.1063/pdf,diakses 17 Februari 2012).

Larasati, T.A 2012. Kualitas Hidup Pasien Diabetes Melitus Tipe 2 di RS Abdul Moeloek Propinsi Lampung. Jurnal Kedokteran dan Kesehatan Universitas Lampung, Vol.2, No.2,17-20

Lubkin, I.M & Larsen,P.D. (2006). Chronic Illness;impact and intervention. USA;Jones and Bartlett Publisher, Inc.

Mayda. 2015. Penyakit Terminal. Diakses tanggal 20 Oktober 2016

Moons, P. , Marquet K., Budts W., Geest, Sabina.2004.Validity, Reliabity,and Responsiveness of the Schedule for the evaluation of individual Quality of live- Direct Weighting (SEIQOL-DW) in 176 Congenital Heart Disease. Health and Quality of Life Outcomes,2 1-8. USA: BioMed Ltd.

Murray, Ruth Becmann, Huelskoetter.M, Marilyn Wilson.1987.Psychiatric/Mental Healthnursing: Giving Emotional Care 2nd Edition.Missouri:Norwark Appleton & Lange.

Nies, M.A.,McEwen,M. (2007). Community/public health nursing:Promoting the health of populations. Fourth ed. St.Louis; Saunders Elsevier.

Nofitri NFM.2009. Gambaran Kulaitas Hidup pada Individu Dewasa Berdasarkan Karekteristik Budaya Jakarta. Depok: Universitas Indonesia

Nursalam. (2008). Konsep dan Penerapan Metodologi Penelitian Ilmu Keperawatan Pedoman Skrisi, Tesis dan Instrumen Penelitian Keperawatan.Edisi 2. Jakrta: Salemba Medika

Papalia , Sterns , & feldam . 1997 . Adult develompmet Psychology and Aging . USA : Mc. Graw Hill Company.

Potter perry , 2005 fundamental keperawatan edisi 4 . jakarta , EGC

Power, M.J. Bullinger,M., HARPER,A.M, & WHOQOL Group. 2003. The world Health Organization WHOQOL-100: Tests of the university of quality life in 15 ifferent cultural groups world wide. Health Psychology.

Pradanan, dkk . 2012 . hubungan kualitas hidup dengan kebutuhan perawatan paliatif pada pasien kankker RSUP Sanglah denpasar. Program studi ilmu keperawatan faklutas kedokteran universitas udayana.

Rasmun (2004) . stres , koping dan adaptasi teori dan pohon masalah keperawatan. Jakarta : CV Sagung Seto

Sari . 2015. Hubungan anatara tingkat spritualitas dengan kesiapan lanjut usia dalam menghadapi kematian di desa puncangan kecamatan kartasura. Fakultas ilmu kesehatan universitas muhamadiyah surakarta. Skripsi

Skevington ,S.M, Lofty , M.,& O'connel ,K.A 2004. The World health organization 's WHOQOL-BREF Quality of life assement : psychometric properties and result of international field trial a report from the WHOQOL group. Qality of Life Research

Smeltzer ,S.C & Bare . 2002 . buku ajar keperawatan medikal bedah edisi 8. Vol 2 . Jakarta: EGC

Stuard, Gail Wiscartz, Sundeen, Sandra J . 1983. Principles And Practise of psychiatric Nursing . Second Edition . USA: Mosbly Company

Supriyadi , Wagiyo & Widowati , S.R . 2011 . Tingkat kualitas hidup pasien gagal ginjal kronik terapi hemodialisa. Jurnal kesehatan masyrakat

Wahyuni . 2014 . hubungan kesiapan orang tua dengan kualitas hidup anak yang menderita penyakit terminal dalam keperawatan paliatif di yayasan rumah Rachel . Program studi ilmu keperawatan fakultas ilmu-ilmu kesehatan universitas Esa unggul Jakarta. Skripsi.

Wakhidah. 2011 . Psychology Well-Being pada caregiver penyakit terminal di kota malang.

Ware JE, Sherbourne CD. 1992 . The MOS 36-Item Short form health survey (SF 36). Conceptual Framework and item swelection . Medical Care

WHO . 1993 . Quality of Life –BREF . http://.who.int/substance_abuse /research_tools/whoqolbref/en