RESIDENTIAL CARE FOR THE ELDERLY IN ETHEKWINI METROPOLITAN MUNICIPALITY:

A CASE STUDY APPROACH

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ABSTRACT

Title: Residential care for the elderly in eThekwini Metropolitan Municipality: a case study approach

Aim: This study explored and described residential care for the elderly in eThekwini Municipality in terms of the organizational structure, staff and residents, and determined how those factors influenced elder care. This was aimed to make recommendations for residential care in eThekwini Metropolitan Municipality.

Methodology: A descriptive explorative case study design, using both quantitative and qualitative approaches was adopted for this study. The study participants included eight administrators, twenty elderly residents and thirty nursing staff from four residential care facilities (RCFs) in eThekwini Municipality, Durban. Data were collected through interviews, questionnaires, record review and observation based on the structure, process and outcome of the study's conceptual framework. Qualitative data were gathered from administrators and elderly residents. The data were transcribed and analyzed manually using Framework Analysis (Ritchi & Spencer, 1994). Quantitative data was obtained from nursing staff using questionnaires, and analyzed using SPSS.

Findings: Administrative findings followed the structure, process and outcome of the study. The structural findings were focused on facility philosophy and human-material resources, as well as on emerging themes from the data. The emerging themes from facility philosophy were assisting vulnerable people across age groups, document review, quality indicators, admission criteria and reasons for admission to each facility. Emerging themes from human-material resources were financial sustainability, staff-resident ratio and material resources. The process findings were focused on care and service delivery to the elderly and the emerging themes were one big family, incidence of abuse, methods of elder care and service delivery, knowledge about elder care, relationship of control, being there, gentle restraint, setting boundaries with the residents, medication safety, common religious belief and resident satisfaction. Findings from the outcome were focused on success and challenges of elder care, experiences of the elderly and nursing staff care experiences. Thus, emerging themes from success and challenges were strong bond, retaining staff, maintenance of physical structure, location of care centre; success and its dependence and challenges of procuring basic medical equipment. Findings from experiences of the elderly were reasons for admission, relationship, experiences of the elderly, response shift, psychosocial support and satisfaction with care, cultural belief and well respected. Emerging themes from nursing staff's experiences of caring for the elderly was mainly focused on their professional knowledge about elder care. Details of these findings are written down in Chapters Four and discussed in relation to literature in Chapter Five.

Conclusion: The study concluded by making recommendations for the care of the elderly in RCFs in eThekwini Municipality in line with the findings of the study. The recommendations have implications for the government, policy makers, nursing education and nursing research. Moreover, those concerned are encouraged to adopt and use the recommendations where applicable to promote residential care quality for the elderly in eThekwini Metropolitan Municipality.

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DECLARATION

I, Meiko Josephine Dolo declare that:

This thesis, **Residential Care for the Elderly in eThekwini Metropolitan Municipality: a Case Study Approach** is my own work and it has not been submitted to any other university other than the University of KwaZulu-Natal (Durban). All sources of information that have been utilized or quoted have been acknowledged by a complete reference.

Meiko J. Dolo

Dr. Petra Brysiewicz

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CHAPTER ONE: INTRODUCTION

1.1 Background to the study

The international and national policies on ageing are now aimed at keeping the elderly person in the community for as long as possible. Research suggests that older people want to remain in their own homes for as long as possible, depending on their health and well-being, as well as their ability to live independently with formal or informal care services (Barratt, 2007; Australian Local Government Association, 2006). However, there will always be some elderly people who, for various reasons explained below, will require residential care on an ongoing basis.

Demographically, the global population is ageing. Krug, Dahlburg, Mercy, Zwi and Lozano (2002) argued that in many developing countries, demographic, social, economic and cultural changes are taking place, leaving many families unable to care for their frail relatives at home. This phenomenon indicates an increasing demand for residential care. In a population study conducted by the United States National Institute on Aging, Dobriansky, Hodes and Suzman (2007) found that in 2006, almost 500 million people worldwide were aged 65 years and older, accounting for 8 percent of the world's population. By 2030, that total is projected to increase to 1 billion, accounting for 13 percent of the total population. Significantly, the most rapid increases in the 65-year old and older population are occurring in developing countries, which will soar to 140 percent by 2030 (Dobriansky, Hodes and Suzman, 2007). In proportion, the elderly population of South Africa is projected to double in the next 30 years (2000-2030), from 7 to 11.5% (Makiwane, Schneider and Gopane, 2004) of the total population.

Traditionally, the use of residential care used to be associated with the white race (Wallace, Levy-Storms, Kington & Andersen, 1998), while most Black Africans lived in multigenerational families, with their elderly receiving help from their adult children or extended family. Help includes monetary, physical and emotional concerns in Africa, where old age is revered as it is seen to bring wisdom (Makiwane, Schneider & Gopane, 2004). This kind of respect for the elderly is evident, for example, in the philosophy of *ubuntu* in South Africa. As recorded in Ramose (2003), *ubuntu* speaks about human interconnection, a common humanity, and the responsibility to each other that flows from those who are connected. *Ubuntu,* which has its origin in the Bantu languages in Southern Africa, is still being reinforced today.

As cited in a presentation on "Challenges of Care of the Elderly" by Professor Klopper (2006) of the University of North-West, the *ubuntu* philosophy was deeply entrenched during the apartheid era since community support between Black Africans was essential. However urbanization of traditional African is currently causing a great threat to *ubuntu* in this group's communities. For example, young adults move away from their homes in search for work, leaving the elderly person with little or no support. Joubert and Bradshaw (2006) noted that there is also a growing shortage of informal family care givers due to the weakening of intergenerational relationships. In addition, the AIDS pandemic is also significantly affecting the lives of older people. In South Africa, as well as in many parts of Sub-Saharan Africa, children are orphaned in large numbers as their parents die of AIDS-related disease. Older people who had anticipated to be supported by

their children in old age are finding themselves as the main caregivers, without a family to support them in their old age (Krug et al., 2002).

In the United States of America, large-scale national studies found that older African Americans were less likely to use residential care. This is because the use of old age homes has been replaced by informal care like home help provided either by members of the person's family or friends, paid home care, or no care at all (Akamigbo & Wolinsky, 2006; Gaugler, Leach, Clay & Newcomer, 2004; Gaugler, Kane, Kane, Clay & Newcomer, 2003). In comparison to the above findings, the use of residential care in many East Asian countries are significantly lower than in other parts of the world (Ikegami, Yamauchi, & Yamada, 2003; Kim & Kim, 2004). Care giving is a global phenomenon, and women in both developed and developing countries are still the main care givers. In addition to caring, functional dependency also has emotional consequences for family members, and for their relationships with each other. Caring for the disabled elderly has proven to be a heavy burden for family caregivers in general, particularly if the frail elderly is unable to participate in self-care activities (Akamigbo & Wolinsky, 2006; Arai, Kumamoto, Washio, Ueda, Miura & Kudo, 2004). Care giving can result in social isolation, psychological stress and high rates of depression among care givers, and sometimes leading to abuse of the elderly (Fatoye, Komolafe, Adewuya & Fatoye, 2006).

Throughout the world the population of older persons is increasing at a very rapid rate. The increase in this population group is the result of advances in science and technology,

improvements in health services available and the rise of life expectancy at later ages (Dobriansky, Hodes & Suzman, 2007; Legido-Quigley, 2003). As human populations continues to age, issues surrounding residential care and support for the elderly are also becoming a concern. Thus residential care is no longer considered unacceptable for older people, but as alternatives for families (Brodsky, Habid & Hirschfeld, 2002; Casarett, Hirschman & Henry, 2001). There is a growing awareness of the relationship between the person's health status and their home environment. Research suggests that the home environment of older adults is an important determinant of their health and longevity (Gu, Dupre & Liu, 2007; Kawachi & Berkman, 2003).

The framework for ensuring the highest possible standards of care for elderly people in residential care and communities in South Africa has been laid down by the national government. Legislation includes the 1996 Constitution of the Republic of South Africa; The Aged Persons Act No. 81 of 1967; The Aged Person Amendment Act no. 100 of 1998; The Domestic Violence Act no. 116 of 1998; The Older Persons Bill no. 68 of 2003; and The Older Persons Act no. 13 of 2006). The most recent framework related to the standard of care for the elderly in residential care and in the community is set out in the Older Persons Act (Act No. 13 of 2006). As stipulated in the Act, the responsibility for formulating standards and regulations in residential care is retained by the Minister of Social Welfare; failure to meet standards can be used as evidence to prosecute individuals who fail to comply with regulations. The responsibility for ensuring that the services are of high quality and appropriate to individual needs of each resident remains with the authorities of each residential care facility (RCF).

1.2 Rationale for the research

- The national and international policies on ageing are now aimed at keeping the elderly person in the community for as long as possible.
- There will always be some elderly people who will require an ongoing residential care.

- The Older Persons Act (Act No. 13 of 2006) acknowledges the role and functions of RCFs (Chapter 4). Chapter 2 Sections: 6 (1) stipulates that the Minister of Social Welfare may, from time to time, by notice in the Gazette prescribe national norms and standards to define acceptable levels of care and services that may be provided to older persons. The legislation also prescribes which services must be monitored and evaluated. However, **there appears to be no national norm available at the moment**. As the result, services provided to the elderly in both community-based and institutions may likely be fragmented due to the lack of a national standard and uniform code of practice.
- Furthermore, Chapter Four of the Act deals with residential homes and the rights of the older person living in those homes, the service provision and particularly monitoring of registered residential facilities. Again, the **Act does not say anything about the type and standard of services, and it does not say how and for what the homes should be monitored.**
- Chapter Five speaks about protection for the elderly against abuse; the notification of abuse; procedure for bringing alleged abuser of older persons before magistrate; prohibition of abuse; and special measure to combat abuse of older persons in nursing

homes. However, it **is not known whether those who operate nursing homes are complying with the regulations of the government regarding the abuse of the elderly.** Reliable data on the situation of abuse or neglect of the elderly in nursing homes within the South African context is lacking (Ferreira, 2005b; Velkoff & Kowal, 2003).

- Chapter Three section 14 (1) of the Act stipulates that persons who provide residential care must ensure that caregivers receive the prescribed training. However, **it is not known whether those who provide residential care are complying with the South African government's regulations or not.** One of the factors that is generally viewed as causing, or significantly contributing, to elder abuse in residential facilities is poor staff training, particularly about the impact of dementia on both the elderly and the caregivers, and how to interpret and manage challenging behavior (Hawes, 2003). Effective training of caregivers is necessary to increase their knowledge in handling the elder with challenging behavior (SAQA, 2001). The point of view of the person with dementia or anyone with cognitive impairment is usually unknown. Therefore, proper training of care givers is important to help them to identify the particular behavior in order to offer proper intervention (Cohen-Mansfield, 2001).
- Additionally, **the Act does not provide a mechanism for determining the capacity of the sector and planning services to meet the needs of residents in each home.** Research in the United States and Australia has shown that having low numbers of staff is associated with poor quality care and staff burnout (Braithwaite, 2001).

- Personnel at the Department of Social Welfare were asked for any resources that could contain information regarding the above mentioned gaps. There was no information was submitted in response. The researcher contacted a social worker from The Association for the Aged (TAFTA) who informed her that a working document for the use of the Act has been drafted. However, **it is not known whether the working document for the Act has been prepared by professionals or on the basis research.**

It was therefore of importance to do this research on residential care for the elderly in eThekwini District in order to explore and describe residential care in terms of its organizational structure, staff and residents and determine how these factors can influence elder care; and strengthen the Older Persons Act through research in order to make it successful.

1.3 Problem statement

Despite the demographic impact of the AIDS epidemic on the country, South Africa has been found to be one of the most rapidly ageing populations in Africa (Joubert & Bradshaw, 2003/2004). This segment of the population is projected to continue ageing over the next two decades (Joubert & Bradshaw, 2006). According to statistics on population and ageing in South Africa, the authors note that the annual growth rate of the group aged 60 and above population is estimated to have increased from around 1% in the late 1980s to 2.3% in 2005. This growth rate is now estimated to be four times higher than that of the population as a whole. The difference between these rates is projected to increase for most of the next 15 years (Actuarial Society of South Africa, 2004).

According to Statistics South Africa Census (2001), the country accommodated 3, 28 million older persons (60 years or older) during the 2001 population census, accounting then for 7, 3% of the total population. These figures make the South African population one of the demographically oldest populations on the continent (Joubert & Bradshaw, 2006). In 2003, the Encyclopedia of the Nations (2003) estimated the population of Nigeria to be 124,009,000 and at least 3% of that population was over 65 years of age. In 2025, that figure is projected to increase to 202, 957, 200. Nigeria's elderly (60 years +) is also projected to increase to 9, 747.7(5.7%) of the total elderly population. According to Yin (2009), in 2007, the total population of Nigeria was 140 million. Apart from the elderly population of Nigeria, only the island populations of Reunion (9, 9%) and Mauritius (9%) have higher proportions of older persons (United Nations, 2000). Thus, South African's population displays similar levels of ageing as those in countries such as Brazil, India, Mexico and Samoa (United Nations, 2002). It is projected that, by 2025, the proportion of older South Africans will increase to 10, 5% and the number of older people to 5, 23 million (Actuarial Society of South Africa, 2004).

As the population continues to age, it is expected that large numbers of the elderly will be residents of RCFs due to the changes that are taking place in some families and societies. Literature suggests that the characteristics of the elderly living in RCFs include frailty, cognitive impairment, and communication difficulties (Mandiracioglu & Cam 2006; Gaugler, Leach, Clay & Newcomer 2004). These studies found that the indicators of frailty and dependency among the elderly were significant predicators of staff burnouts and mistreatment of the elderly. On the other hand, some burnt-out caregivers having a

low level of knowledge of dementia, may believe that treating demented residents roughly is acceptable, particularly if the caregivers think that the elderly were out to harm them (Hawes, 2003).

Furthermore in Africa, ageing has become recognized as a focal issue at continental level (African Union/HelpAge International, 2003). However, African universities have very few people who have been trained in gerontology who could provide leadership on research on ageing. This is evident at the University Of KwaZulu-Natal School of Nursing that resumed a graduate programme in gerontology in 2008. As the result of this skilled capacity gap, it is likely that many health workers in South Africa have little or no skills in the care of the elderly.

The Older Persons Act (Act No. 13 of 2006) of South Africa establishes new regulatory frameworks for all RCFs in the country. The basic elements of the Act include regulations and standards, monitoring and inspection, and enforcement, but it does not have any prescribed norms and standard to enforce a uniform code of practice. If the Act is to protect residents in RCFs, it must be strengthened through research in order to ensure adequate staffing, monitoring, enforcement, and accountability.

In addition to the gaps identified in the Older Persons Act, very little is known about residential care in terms of its structure, process and outcome, and how those characteristics could affect the care of the elderly in Ethekwini District. Very little information is available about the characteristics of residential care in terms of the staffing, residents and organization, and how these characteristics can affect elder care

within the South African context as well as in sub-Sahara Africa (Ferreira, 2005b; Velkoff & Kowal, 2003).

1.4 Purpose for the study

In light of the above statement, the purpose of this study is:

1. To explore and describe residential care for the elderly in eThekwini Municipality in terms of its organizational structure, staff and residents, and determine how these factors can influence the elder care.
2. To draw up recommendations for residential care for eThekwini Municipality.

1.5 Research objectives

In order to fulfill the purpose of the study, the following objectives were developed. The objectives were directed toward the structure, process and outcome of the study's conceptual framework.

1.5.1 The structure

- To analyze the organizational philosophies, mission, vision and objectives, roles and functions as well as the legal framework of the RCFs under study;
- To compare the various structures, nature and composition of the resources of each facility in terms of the material, human and financial resources;
- To analyze the physical infrastructure and demographic profiles of each RCF in terms of the characteristics of the organization, nursing staff and clients;
- To analyze the financial and material resources of each facility in terms of funding and sustainability;

- To analyze the level of staff-client ratio and relationship in each facility.

1.5.2 The process

- To compare the process of care and service delivery to the elderly in each facility;
- To evaluate the levels of service delivery in relation to how individual needs are targeted; and
- To analyze the different challenges and barriers encountered in the care of the elderly in each facility.

1.5.3 The outcome

- To analyze the outcome of the elderly in terms of their health status, quality of life and level of satisfaction;
- To identify gaps and weaknesses in the care and service delivery of the program on the basis of the perception of the elderly who are users of the care and services in each facility;
- To determine how well the objectives are achieved;
- To analyze and compare key findings from each facility in relation to their structure, process and outcome toward making recommendations for residential care in eThekwini Municipality.

1.6 Significance of the study

No research findings were available on residential care for the elderly in eThekwini Municipality. However, knowledge acquired from research conducted in other countries

on this topic indicated it was imperative to explore and describe residential care in eThekwini. Thus, the findings of this research could facilitate the following:

- enable directors, chief nursing officers, nurses and care givers to determine if their nursing care plans and programs are meeting the needs of the elderly based on characteristics similar to those described in the literature;
- Identify gaps in the study to form the basis for future training and education for all those who are involved in the care of the elderly in RCFs, to promote quality care;
- provide evidence-based scientific rationale for nursing practice in relation to elder care, thus adding to the body of knowledge on the care of the elderly;
- gathered information to disseminate with the aim of increasing awareness about residential care for the elderly as well as in other settings; and
- inform policy makers, particularly the Department of Social Welfare, for subsequent inclusion into their district plan for the elderly in residential care to ensure they enjoy longer periods of disability-free old age.

1.7 Operational definitions of concepts

1.7.1 Case study is defined as in-depth investigations of a single entity or a small number of entities which may be an individual, family, group, institution, community or any other social unit (Polit and Beck, 2004). In this study, "case" refers to the "four-cases" or RCFs where the study was conducted.

1.7.2 Residential care describes a living arrangement in which people with special needs, especially older people with disabilities, reside in a facility that provides help with everyday tasks such as bathing, dressing, and taking medication.

1.7.3 Institutional care describes in-patient services that are provided for people who are maintained in a hospitals, convalescent home, or home for persons suffering from physical or mental disability or in residential accommodations.

1.7.4 Nursing staff in this study will include registered nurses (RNs), enrolled nurses (ENs) and enrolled nursing assistants (ENAs).

1.7.5 The elderly refers to individuals 60 years and older, who by reasons of old age, physical, mental disability, or chronic disease are unable to care properly for their person or their own interests (Older Persons Act no 13 of 2006).

1.7.6 Characteristics of the elderly include age, gender, marital status, level of independence/dependence, cognitive status and the presence of a chronic disease.

1.7.7 Frailty means being weak in mind or body especially as the result of old age.

1.7.8 Structure measure of quality encompasses the professional and organizational resources associated with the provision of care, such as staff components and the facility operating capacities (Donabedian, 1991).

1.7.9 Process measures of quality refers to the things done to and for the patient by practitioners during the course of treatment (Lilford, Brown & Nicholl, 2007).

1.7.10 Outcome measures of quality comprise the desired states resulting from care processes, which may include reduction in morbidity and mortality, and improvement in the quality of life (Lilford, Brown & Nicholl, 2007).

1.7.11 Vulnerable people in this study, vulnerable people were those people who were elderly and frail, or had physical or mental disability in all age groups.

1.8 Conclusion

This chapter had outlined the background to the research problem, the rationale, problem statement, purpose and objectives, as well as the research questions, the significance and the operational definition of the study. The study was conducted to explore and describe residential care for the elderly in eThekwini Municipality, KwaZulu-Natal, South Africa. Components of the study include its organizational structure, staff and residents, and determine how these factors could influence elder care. It has been suggested that frailty and dependency among the elderly are significant predicators of staff burnout and mistreatment of the elderly in RCFs. Moreover, relatively few people have trained in gerontology to provide leadership on ageing research within the South African context. Furthermore, many health care workers in South Africa have little or no skills in the care of the elderly. Above all, the Older Persons Act (Act No. 13 of 2006) of South Africa that contains new regulatory frameworks for all home care in the country does not have any

prescribed norms and standard to enforce a uniform code of practice. It was hoped that the findings of this study would be suggested to bridge the identified gaps.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Studies of residential care for the elderly are quite common in developed countries compared to developing ones due to perceived strain on social security caused by increasing population ageing. According to the United States National Institute on Aging (2007), the ageing of population represents one of the major achievements of the last century; however, it also poses tremendous challenges. It is characterized by changes in family structure and living arrangements. The ageing of population is mainly caused by a decline in fertility and increased life span due to improved medical care and services (United States National Institute on Aging, 2007).

As the world population ageing continues, the choice of living, especially for the elderly, is gaining increased attention. Yet, geriatric nursing is a relatively new area of specialization in South Africa. This chapter focuses on the review of relevant literature in relation to residential care for the elderly. Much of the content of the literature is drawn from studies carried out in the United States, United Kingdom and elsewhere due to the scarcity of data on residential care programmes for the elderly within the South African context.

2.2 Residential care

Residential or institutional care is intended for people who are unable to continue living in their own homes, even with support from home care services. Stone (2000) notes that sometimes people can stay in residential care for a short time, known as respite care, over

a long period or permanently. Residential care facilities are normally intended to provide accommodation, meals, and 'personal care' including assistance in getting up or going to bed, eating, washing, dressing, and using the toilet. The services may also help with instrumental activities of daily living (IADLs), including household chores like meal preparation and cleaning; life management such as shopping, money management, medication management; and transportation. Other services include hands-on and stand-by or supervisory human assistance; assistive devices such as canes and walkers; and technology such as computerized medication reminders and emergency alert systems that warn family members and others when old people with some form of disability are unable to respond. Sometimes home modifications that may include installing ramps, grab bars and door handles may be used in providing residential care. Residential care facilities may also include nursing homes, rehabilitation facilities, inpatient behavioral health facilities, and long-term chronic care hospitals (Stone, 2000). It includes facilities for people of all ages with a number of chronic conditions that limit their ability to perform activities of daily living.

Internationally, the philosophy of care for the elderly is that old people should remain in their own homes and live independently for as long as possible and feasible. The origin of this viewpoint is that given the choice, most elderly would prefer to remain in their own homes. In the United Kingdom, this philosophy is supported by a legislation called the Community Care Act (Mandelstam, 2005). The rise in the belief that community care is superior to residential care has resulted in an unfair criticism of residential care. The emphasis on community care may reinforce the negative public perception of residential care.

In South Africa, the family is being promoted for the elderly as the core of society because the older generation is needed to play a role in moral regeneration. In one research done by the Department of Social Development of South Africa (Senior World Chronicle, 2008) to determine the elderly perception on residential care, rural dwelling old people said they did not want to go to nursing homes because it takes away a sense of "pride". Rural seniors also feel that old age homes are for "abandoned" people. Despite this belief, the Senior World Chronicle (March 7, 2008) further reported that many senior citizens are now queuing up to get into old age homes where life is kind compared with their homes. "Township residents who had in the past shunned old age homes are now desperate to get their loved ones admitted as they cannot look after them because of work commitments". The Senior World Chronicle (2008) further reported that in urban areas, elderly people find themselves waiting, while their children are at work and their grandchildren are at school. They experience a very lonely life since they are unable to do certain things for themselves, such as going to the shops. Besides, crime is increasing and it is no longer safe to leave the elderly alone at home. Elderly residents were reported that they were relieved to be living in the homes, as it was an open secret that they needed to find shelter from the abuse of not only criminals but also their own children.

Regardless of the wish to keep the elderly in the community for as long as possible, the reality is that some elderly will need to be in residential care. One of the principles approved by the United Nations General Assembly in 1991 was, that older persons should be able to utilize appropriate levels of residential care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment

(United Nations, 1991). This piece of legislation aims at safeguarding and improving the quality of residential care that is critical in caring for the elderly.

2.2.1 Historical perspective of residential care

In order to understand the present, one has to study what happened in the past. History suggests that residential care for the elderly evolved from state hospitals, almshouses, private boarding homes to retirement villages, including private and public nursing homes (Macmillan, 1985). The story of this evolution is one of the saddest and most triumphant occurrences of the past. This paper will provide discussion the historical development of residential care in South African, which involves identifying some of the outstanding contributions made by Egypt, Greece, Rome, the Church and the people whose effort have helped to shape the residential care industry of our time.

During ancient times, religion and medicine were linked. According to Macmillan (1985) Encyclopedia on Institutions, Egyptian temples were the earliest known institutions that provided cure for illnesses. Similarly, Ehrman, (2005) also indicated that the Greeks who were dedicated to the healer-god known as Asclepius, also admitted the sick. These Greeks were known for waiting for guidance from their god in a dream. This type of practice was also adopted by the Romans under Æsculapius, who built a temple on an island in the Tiber in Rome in 291 BC, where similar rites were also performed. Macmillan (1985) Encyclopedia on Institutions further documented that the Romans created valetudinaria for the care of sick slaves, gladiators and soldiers around 10 B.C.,

and many were identified by later archeology. Although their existence is considered proven, there is some doubt as to whether they were as widespread as was once thought. Many of these structures were identified only according to the layout of the remains of the building, and not by means of surviving records or medical tools.

In the book "Lost Christianities: The Battles for Scripture and the Faiths We Never Knew", Ehrman, (2005) indicated that the adoption of Christianity as the religion of the Roman Empire drove an expansion of the provision of care. For example, in 325 A.D., the First Council of Nicaea urged the Church to provide for the poor, sick, widows and strangers and ordered the construction of hospitals in every major town. Among the earliest were those built by the physician Saint Sampson in Constantinople and by Basil, Bishop of Caesarea. The latter was attached to a monastery, which was used to provide lodging for the poor and travelers, and there was also a separate section for treating the sick and for those who had leprosy (Ehrman, 2005).

After the fall of the Roman Empire, Morrissey, Bowman and Carpenter (2006) reported that there was a gradual spread of Christianity throughout Europe and the care of sick people was taken over by the Church as part of charity. This led to the development of convents and monasteries with the monks caring for the sick and the medical services. In the centre of Exerter, England, the ruined walls of thirteenth-century almshouse still stands as an illustration to the above. Almshouses were European Christian institutions. Alms, in the Christian tradition are monies or services donated to support the poor and needed.

The development of institutional care started from Almshouses, which were established from the tenth century in Britain, to provide a place of residence for the poor, old and the distressed. According to Caffrey (2006), the first recorded Almshouse was founded in York by King Athelstan, and the oldest still in existence is the Hospital of St. Cross in Winchester. Morrissey, Bowman and Carpenter (2006) further notes that in France, the Church was closely associated school the Faculty of Medicine was part of the Cathedral (Caffrey, 2006). In those areas, the academic dress of doctors is the same as that of the clergy. In Italy, the Church is still closely associated with residential care. The overall pattern was of dormitory wards and the twelfth-century hospital in Angers, France, still stands. As reported in Beck, Gilbert, Lortie and Kerby (1911), the sixteenth century Reformation in England destroyed the monasteries under King Henry VIII. In the absence of these institutions, local parishes were given the responsibility to care for those who could not care for themselves under the Elizabethan Poor Law of 1601. This Law established a system of local government to care for the poor and destitute, in order to restrict aid to those who were truly in need. Recipients comprised the lame, the impotent, the old, the blind and the widowed, thereby excluding the able bodied poor (Gilbert, Lortie & Kerby, 1911). This law required a six-month residential qualification before admission, and large institutions called workhouses were built to care for needed orphans, the sick and the elderly (Morrissey, Bowman and Carpenter (2006).

The workhouses expanded considerably in the 19th century. Gilbert, Lortie and Kerby (1911) point out that in the 19th century, relatively more sick people were housed in workhouses than in the hospitals for both the old and the young. In the British history, the workhouse is colloquially known as the 'spike', meaning a place where those who could

not support themselves lived and worked. Barton and Mulley (2003) argued that the coming of the British National Health Services in 1948 created a shift in residential care, so that the responsibility for the care of the sick elderly was placed with the Health Services, under which the department of geriatric medicine was introduced. Thus, the responsibility for the frail elderly was left with local authorities, and consequently various forms of sheltered housing and residential care were developed.

In the United States, the first almshouse (institution for the poor) was built in Boston U.S.A. in 1664 (Schneider & Macey, 2002). After the political separation of United States of America from Britain, the New York State used the English Poor Law as a model to ensure that each town within the state to establish an almshouse (Hunt, 1988). As the population grew during the nineteenth century, so did the cities and the number of almshouses. However, between 1820 and 1860 more than five million immigrants entered the United States; without jobs, many of them became a problem, and ended up living in almshouses. Between 1820 and 1840, 144 new almshouses were erected in Massachusetts alone (Schneider and Macey (2002). The numbers of almshouses increased and not only became crowded, but were also in very bad condition. In 1857, a committee was set up to investigate every city and country almshouse in the State of New York. The committee informed the legislature that the almshouses were the most disgraceful memorials of public charity (Kayser-Jones, 1981). At the end of the nineteenth century, one-third of almshouse residents were aged (Schneider and Macey (2002). Eeventually, the almshouses were converted into old-age homes, establishing what is now the nursing home industry of today.

The great move toward residential care of the elderly in the United States took place following the enactment of the United States Social Security Act (1935). The Act made public assistance funds available to the elderly in need, and expressly prohibited the payment of such assistance to any individual house in a public institution. Not until the 1950's did amendments to the Social Security Act made state welfare departments negotiate with private nursing homes for the care of the aged. The nursing home industry expanded again after the Medicare (for the aged) and Medicaid (for the poor) programme were enacted in 1965 in the United States, consequently, early 1970's, over a million older people were residents of nursing homes (The United Social Security Act, 1935).

2.2.2 South African perspective of residential care

Hunt (1988) noted that in South Africa, the construction of residential care for the elderly began with the arrival of White settlers at the Cape in 1652, and it continued throughout the time of the Dutch East India Company. She further noted that by 1794, about four hospitals were built in Cape Town as the need to accommodate sick company workers increased. Meanwhile, families were expected to care for their own sick and worn out slaves just like what was done by the company regarding the care of slaves. However, in 1794, the Dutch East Company closed down due to bankruptcy, which was followed by a change of administration in Cape Town, when it became a British Colony in 1806 (Hunt, 1988).

In addition to the four hospitals in Cape Town, Searle (1965) reported that another hospital known as 'old' Somerset Hospital was opened in 1818 to accommodate every

race, particularly the vulnerable, including those without families or friends. Searle (1965) further reported that evidence from hospitals in Cape Town showed that caring for the sick and the elderly was intertwined. In one report that emerged during the 1940's, Laidler and Gelfand (1971) indicated that on Robben Island, an infirmary was built to accommodate the chronically sick, the lunatics and those with leprosy to prevent the people of the town from objectionable sights and nuisances. However in 1854, Sir George Grey, the Governor at the Cape, observed that although the residents on Robben Island were well taken care of, their isolation produced a state of "mental depression" which he considered highly prejudicial compared to their bodily improvement (Laidler & Gelfand, 1971). During the period 1853 to 1855, a number of hospitals were built in many towns throughout South Africa under the general supervision of the Somerset Hospital. The patients in those hospitals were classified as chronic sick, lepers and lunatics (Laidler & Gelfand, 1971, p. 352).

As cited in Hunt (1988), the South African Government in 1924 appointed a Committee of Inquiry into the Public Hospitals and Kindred Institutions. In its report, the committee recommended that more accommodation was needed for the chronic sick. It further reported that although the hospitals were termed chronic, they were of the nature of almshouses than hospitals. The bulk of the patients were aged paupers who have been gathered in from all parts of the Union; and who would simply remain there till they die because their relations and friends were not able to look after them (Para in Hunt, 1988). The committee also recommended that the provision of chronic sick hospitals should be

regarded as one of the burdens of the State and should receive first and serious consideration.

In view of the above discussion, Droskie (1976) indicates that the earliest mention of a home specifically for women of respectable social class was in 1876, known as the Aged Ladies Christian Home in Cape Town. Laidler and Gelfand (1971) also reported that during the 1960s, the Nazareth House in Cape Town provided care for orphaned children and sheltered 21 old women and 19 old men, as evidenced by their record. In 1983, the Dutch Reformed Church provided the Dorcas House for needy elderly women in Cape Town. This home was later extended and became the Deaconess Hospital in 1892 (de Villiers & Kayser, 1983). Droskie (1976) reported that during the early 1900s, welfare organizations such as the Rand Aid Association and the Four Afrikaans Women's Organization began to emerge to help the aged and the needy.

Over the years, there has been an increase in the number of institutions for the elderly in South Africa. According to van Zyl (1980), there was a rapid growth of institutions sheltering particularly the white elderly prior to the 1900s due to the past political dispensation of South Africa with its apartheid policy of segregation of race groups. Hunt (1988) South Africa is one of the countries in which there has been the greatest increase in residential homes, for the aged, particularly for the white elderly. For example, of the 336 000 White elderly (65+) living in South Africa in 1982, 27 000 (11%) were living in nursing homes. One of the reasons suggested by van Zyl (1980) for the high incidence of the institutionalization of elderly Whites at that time was the generous state financial aid

supplied to welfare organisation for the construction and maintenance of homes, particularly for the White elderly.

The result of this discrimination was also felt within all areas of health care services (Legido-Quigley, 2003). It also affected the quantity and quality of services available to the elderly, particularly with respect to the Black racial group. In 1937 however, the provision of homes for the elderly was brought under the control of the central governmental authority with the establishment of the Department of Social Welfare, which began to subsidize old age homes in 1942 on an initial basis of 40 cents per week per needy resident (Hunt, 1988). A resident was designated 'needy' if he/she was not able to pay more than R10 per month for board. This amount has steadily increased in spite of the fact that the Department has adopted the principle that the building and maintenance of old age homes was properly the task of the community welfare initiative (van Zyl, 1980). Currently, old age homes received a R2500 subsidy for each elderly resident drawing a state pension. The policy of the Department of Health and Welfare is to admit to institutions (nursing homes) only the frail elderly who are unable to care for themselves (Older Persons Act no. 13 of 2006).

2.3 Definition of the elderly

There are many ways to define the elderly. As recorded in WHO (2007), most developed countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person, which is often associated with the age at which one can begin to receive pension benefits. At the moment, there is no United Nations standard numerical criterion,

but the UN agreed cut off age is 60+ years to refer to the older population. The common use of a calendar age to mark the threshold of old age assumes equivalence with biological age, yet at the same time, it is generally accepted that these two are not necessarily synonymous (WHO, 2007). In Britain as far back as 1875, the Friendly Societies Act, enacted the definition of old age as, "any age after 50" (Roebuck, 1979 as cited in WHO, 2007), yet pension schemes mostly used age 60 or 65 years for eligibility (WHO, 2007). However, a realistic definition for the elderly in many African communities is sometime challenging.

In South Africa, the elderly are legally defined by the Older Persons Act (Act No. 13 of 2006) as a person who, in the case of a male, is 65 years of age or older and, in the case of a female, is 60 years of age or older. The classification has been done for the purpose of clarifying who is entitled to receive a state pension.

The more traditional African definitions of an elder or elderly person correlate with the chronological ages of 50 to 65 years, depending on the setting, the region and the country (WHO, 2007). However many indigenous Africans are disadvantaged in this respect since establishing actual birthdates was often not done in the past. As a result, many individuals on the continent do not have official record of their birthdates. In addition, chronological or official definitions of ageing can differ widely from traditional or community definitions of when a person is older. While a single definition for the elderly, such as chronological age or social/cultural/functional markers, is commonly used, it seems more appropriate in Africa to use a combination of chronological, functional and social definitions (WHO, 2007).

2.4 Ageing and the elderly: international and national perspectives

WHO (2007) noted that in the developed world, the chronological age of 60 or 65 is equivalent to retirement age marking the beginning of old age. Moreover, in many parts of the developing world, chronological age has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant, such as the roles assigned to older people. In some cases it is the loss of roles accompanying physical decline which is significant in defining old age. Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active social and economic contribution is no longer possible (Gorman, 1999).

Some study results published in 1980 formed a basis for a definition of old age in developing countries (Glascock, 1980 as cited in WHO, 2007). An international anthropological study, which covered many areas in Africa, was conducted in the late 1970's. The definitions fell into three main categories:

- Chronology
- Change in social role (i.e. change in work patterns, adult status of children, and menopause)
- Change in capabilities (i.e. invalid status, senility and change in physical characteristics)

Results from this cultural analysis of old age suggested that change in social role is the predominant means of defining old age in Africa. When the preferred definition was

chronological, it was most often accompanied by an additional definition (Glascock, 1980 as cited in WHO, 2007).

From a chronological view point, old age can further be defined as young old and the old old. The young old are those between the ages of 60-74 years, and the old old often defined as people aged 75- 85 and over. This definition is important because it is the old old who are usually at greatest risk for severe illness, chronic diseases and disabilities that require residential care (United States National Institute on Aging, 2007). They continue to explore that the old old constitutes about 7% of the world's 65-and-over population. More than half of them live in six countries: China, the United States, India, Japan, Germany and Russia. In many countries, the old old are now the fastest growing portion of the total population. On a global level, the 85-and-over population is projected to increase 151 percent between 2005 and 2030, compared to a 104-percent increase for the population age 65 and over and a 21-percent increase for the population under age 65. Past population projections often underestimate decreases in mortality rates among the old old; therefore, the number of tomorrow's oldest old may be significantly higher than anticipated (United States National Institute on Aging, 2007). The old old accounted for 14 percent of all older people in 2005. By 2030, this percentage is unlikely to change because the aging baby boom generation will continue to enter the ranks of the 65-and-over population. In Europe, it is estimated that some countries will experience a sustained rise in their share of oldest old, while others will see an increase during the next two decades and then a subsequent decline. The most striking increase will occur in Japan, where it is projected that by 2030, nearly 24 percent of all older Japanese are expected to be at least 85 years old. Most less developed countries should experience modest long-

term increases in their 85-and-over population (United States National Institute on Aging, 2007).

South Africa has one of the most rapidly ageing populations in Africa. During the 2001 Census, the total population of the elderly (60+) was over 3 million, which was 7.3% of the total national population. (Statistics South Africa, 2001); although lower than in the developed nations, it is higher than in any other part of the African region (Joubert & Bradshaw, 2004). Persons 70+ and 80+ respectively constitute 3.2% and 1% of the South African population (Joubert & Bradshaw, 2003/2004).

Additionally, among the country's four population groups (African, White, Coloured and Indian), there is a considerable diversity in the ageing patterns. The age structure of the African population corresponds with that of demographically young populations in the early stages of demographic transition, with a large proportion of children under age 15 (34%), and a small proportion of older persons (6%). Comparing to African, the White age structure has younger children 15 (19%) and 16% of persons 60+, while the Coloured and Indian have similar pattern between these two groups (Moster, Hofmeyr, Oosthulzen and Van Zyl, 1998 as cited in Joubert and Bradshaw 2004). Although ageing is more pronounced in the White population, Joubert and Bradshaw (2003/2004) argue that the large majority (69%) of the country's 60+ or 2.26 million are African, who constitute the largest proportions in the oldest old. However, in relation to increase in life expectancy, a crucial question to ask oneself is whether the proportion of life spent in disability is expanding or decreasing.

2.5 Trends in life expectancy

Life expectancy is a statistical measure of the average length of survival of a living thing. It is often calculated separately for differing gender and geographic locations (Sullivan & Sheffrin, 2003). Technically, life expectancy means the expected time remaining to live, and it can be calculated for any age (WHO, 1998). People are living longer, and there have been some isolated individuals in some communities who have lived beyond one hundred years (Vallin & Mesle, 2001). In 1998, the World Health Organization (WHO, 1998) predicted that:

- worldwide, premature deaths - defined as occurring before the age of 50 will be cut by half by the year 2025;
- in 1998 over 7 million adults would die before reaching age 50, and 10 million children would die before their fifth birthday;
- life expectancy previously predicted to be 66 years in the 20th century would rise to 73 years by 2025; many thousands of people born at the end of the 20th century would live throughout the 21st century and see the advent of the 22nd century; and
- France would have 150 000 centenarians by the year 2050, compared to only 200 in 1950 (WHO, 1998).

These predictions tend to be consistent with current global pattern of ageing as it is evident in the growing number of the elderly and the number of premature deaths due to HIV and AIDS.

According to U.S. Department of State (2007) life expectancy at birth in the United States in the 1900s was 47 years, while at the end of the 20th century it was 77 years, and in 2006 it was 78.2. Similar gains have been seen in other parts of the world. For example life expectancy in China was around 35 years in 1950. By the end of that century it had risen to around 71 years, while in 2006, it was 73.0. The major exception to this general pattern has been the countries most affected by AIDS, especially Sub-Saharan Africa, which has seen significant decrease in life expectancy report (United States National Institute on Aging, 2007).

Statistics South Africa (2009) notes that the average life expectancy for South Africans in 1995 was 66 years (. Life expectancy for women was 68 years and 63 years for men. The current life expectancy has reduced to 49 years for women and 47 years for men. The reduction in life expectancy is the result of AIDS-related death rates, with mortality among females aged 20 – 39 years more than tripling between 1997 and 2004. Over the same period, deaths due to AIDS-related conditions, in the age group 25 – 29 years, have increased six fold among females and tripled among males (Joubert, & Bradshaw, 2006). Life expectancy for (both sexes at birth) is 82.6 years in Japan and 39.2 years in Swaziland (United Nations World Population Prospect, 2006). The most dramatic gains have occurred in East Asia, where life expectancy at birth increased from less than 45 years in 1950 to more than 72 years today. The country with the highest average life expectancy since 1840 had been Sweden, and currently it is Japan.

From the above figures, it is clear that the average life expectancy in South Africa is lower than Japan, Sweden, East Asia and the United States. Despite the figures given above, the elderly population in South Africa is ageing. However, as age increases, so does the need for more support services in the face of increasing disability because increasing age also increases the risk of disability and residential care (Vallin & Mesle, 2001).

2.5.1 Health expectancies

Although there have been rises in overall life expectancy, UK Parliamentary Office of Science and Technology (2006) argue that there are concerns that not all years gained are in good health, and that the proportion of life spent in good health has generally fallen slightly. A recent survey of South Africa (2008/2009) showed that the average life expectancy declined from 62 years in 1990 to 50 years in 2007. It was further projected is projected to fall by 2011 to 48 years for men and 51 for women. The authors noted that in South Africa, life expectancy fell between 1990 and 2007. Meanwhile, disability data suggests there has been an increase in the proportion of 65+ year olds who are able to carry out most daily activities, such as stair climbing and personal care activities. However, the general consensus in the academic community is that these trends reflect increased years of mild disability, and a decline in severe disability. As reported in UK Parliamentary Office of Science and Technology (2006), two notable findings that emerge from the substantial range of analyses that has now been carried out on healthy life expectancy are gender differences: firstly, while women live longer, they experience proportionally more chronic ill health and disability than men at all ages. Secondly,

socio-economic differences feature with those in the richest 10% of electoral wards having 16.9 more years of healthy life expectancy than those in the poorest 10% (UK Parliamentary Office of Science and Technology, 2006). In many instances, chronic ill health usually require long term care placement in institutions.

2.6 The Need for residential care placement

Residential care need is a global phenomenon for many elderly persons. In many instances this need is created as the result of dependency. Brodsky, Habib and Hirschfeld (2003) highlight dependency as creating the need for a range of services in diverse settings. When an elderly or disabled person develops long term health care needs that require assistance with medical, nursing or personal care needs, an out-of home placement is one possibility. People who are dependent usually have chronic conditions that make it difficult for them to access health care and comply with health care regimes. Dependency impacts on the ability of the individual to maintain a healthy lifestyle, and to prevent deterioration in health and functional status. Thus in residential care, services are designed to compensate for the needs mentioned above, as well as those needs that limit the individual's capacity to carry out activities of daily living (ADLs) (Stone, 2000). Brodsky, Habib and Hirschfeld (2003) also highlighted that unique health problems arise in part from the fact that either single or multiple chronic diseases may be the source of the disability, which in themselves may require complex health services and chronic care. Most obvious among these conditions are mobility limitations and cognitive impairment which often impair a person's self-care ability, thus increasing the challenges involved (Brodsky, Habib & Hirschfeld, 2003).

Yi and George (2000) found that social situations can also increase an individual's need for residential care. Such situations could be homelessness, living alone with no immediate support system, required care that family and friends cannot provide, and lack of support systems in the community. In one study, Stone (2000) found that over 85 percent of nursing home residents were single or have outlived their spouses, and 50 percent had no living children. This lack of family who could help to provide adequate home care for an elderly person may be a decisive factor in determining if someone needs the all- inclusive care and social environment of a residential care setting (Stone, 2000).

In one study conducted in South Africa, Makiwane, Schneider and Gopane (2004) noted that many studies mostly portray old people as a burden on society, particularly in developing countries. Sometimes the elderly are placed in long-term care (LTC) institutions and separated from the rests of the family because of physical decline when they can no longer carry out their family and society roles. Yet in those institutions, the elder is afforded specialized care, while on the other hand gaining an image of discarded people whom society is no longer interested (Makiwane, Schneider & Gopane, 2000). However, if the elder is indigent he/she can receive subsidy from the government (The Older Persons' Act, 2006).

The need for long term care for the elderly may be affected by many factors. According to Stone (2000), a number of factors will converge to shape the magnitude, scope, and nature of the demand for residential care. These include changing demographics and the health and functional status of the population, the availability of family members and other unpaid, "informal" caregivers. Other factors are financial status of various

generations and the degree to which they plan in advance for long-term care; and the availability and cost of institutional care and community-based alternatives.

2.7 Characteristics of the elderly

In South Africa, the average characteristics of the elderly range from age to gender, marital status, level of independence/dependence, cognitive status, the presence of a chronic disease and frailty (Bradshaw & Joubert, 2006). Other characteristics of the elderly include disability, poverty, unemployment and lack of education. Normal biological ageing occurs to some extent in all people groups. However, ageing increases the probability that old people will be permanently afflicted with chronic illnesses that will impair their abilities.

As life expectancy increases, disability and morbidity also increase, sometimes resulting to placement in nursing homes. Many elderly people will become dependent on their families as well as on others for some form of care and support in their own homes, while others will be placed in nursing homes. In one report prepared by South African Department of Health (DOH) (2000), asthma (airflow limitation) was the most common respiratory condition experienced by persons 65+, and the symptoms of chronic bronchitis was reported by about one in every 20 persons. In another report by Statistics South Africa (2001), of the 60+ population, about 16% had a disability, and the most common disabilities were sight and physical disability, followed by hearing, emotional, intellectual and communication difficulties. The prevalence of disability increases with age, with 13% among persons 60-69, 17% among persons 70-79, and 27% of persons

80+ being disabled. About 18% of African, 14% Coloured, and 12% each of Indian and White groups reported disabilities. However, the report did not include an objective measure of cognitive functioning or the competency to perform ADLs (Statistics South Africa, 2001).

The African Union's (AU) Policy Framework and Plan of Action on Ageing (HelpAge International, 2002) highlights the fact that while older persons are consistently counted among the poorest of the poor in different nations, their needs are seldom acknowledged in poverty reduction initiatives. They are usually denied access to credit, employment, training and other services that could improve their income. A report on poverty and older persons in South Africa by Joubert and Bradshaw (2003/2004) found that during 1999, 30% of persons 50+ lived in households earning less than R800.00 per month. A further quarter were chronically poor, meaning that they lived in households earnings less than R400.00 per month, and they were least likely to experience the benefits of development initiatives and growth. Some 33% of the African 50+ were identified as being chronically poor compared to 7% of whites (May, as cited in Joubert and Bradshaw, 2003/2004). In terms of formal education, the report states that a large proportion of older persons (43%), mostly Africans (58%) have no formal education, particularly in Limpopo, 74%, and in Mpumalanga, where 66% of the older population had no formal education. Additionally, many Africans neither live in formal housing, nor have access to basic facilities such as water and sanitation. Generally, older Africans are poorer than other racial groups, with those living in the Eastern Cape or Limpopo are poorer than those in other provinces (Statistics South Africa Census, 2001).

In many instances, a household with an elderly person could benefit from the old age pension. In order to deal with poverty among the elderly, the South African government is providing them with a means-tested non-contributory social old age pension. The old age pension is currently the largest of the social grant programmes in South Africa (Maitra & Ray, 2003). Legido-Quigley (2003) argues that though old age pension was intended as poverty relief program for the aged, it has turned out to be poverty alleviation programme within households. Although it targets the elderly, it is also largely benefiting the younger generation. The author further observes that while the availability of the grant may promote health benefits in the elderly, pension sharing prevents many elderly from meeting their own financial needs, resulting to recipients frustration and perception that they are poor.

Widowhood and singlehood are other characteristics among the elderly. Globally, average women outlive men, and tend to marry men older than themselves. Thus, the rates of widowhood increase with age in most countries of the world. South Africa is no exception, and indeed the gender difference is striking. According to Joubert and Bradshaw (2006), almost half of women aged 60 and over are widowed, compared with only 12 percent of elderly men. The absolute number of widows aged 60 and over increased nearly 100,000 between 1985 and 1991 (to a total of 559,000). South Africa also has relatively high percentages of persons 60+ who are never-married or divorced at 9 and 8 percent for women and men, respectively. This suggests the possibility that significant numbers of elderly are without the family support network that is commonly assumed to be prevalent throughout the region (Joubert and Bradshaw, 2003/2004).

2.8 Impact of disease and disability on care

The demographic projections of South Africa pose clear challenges to the health sector. Joubert and Bradshaw (2003/2004) note that not only is there a need to plan for the increase in the numbers in older persons, but there is also the need to recognize and plan for an expected increase in chronic morbidity and disability. This statement is supported by the WHO (2002); United Nation Population Fund (UNFPA, 2002) because having more older people than before implies that there will be increases in the prevalence of chronic diseases, disability and frailty. Increased numbers of older persons and increased levels of chronic ill-health, frailty and disability are expected at a time when geriatric care at public facilities have been reported to deteriorate, when only 13% of persons 65+ have access to medical aid fund; and when escalating costs render private care out of reach for the majority of the country's older persons (Joubert & Bradshaw, 2004).

In addition, the elderly are more prone to certain diseases. Some diseases will enhance the likelihood of the need to admit them to residential care. For example, Jorgensen, Nakayama, Raaschou and Olsen (1997) found that after a stroke, the chances of being admitted to a nursing home during a five year period is 68%, while those with dementia have a 76.9% probability of being admitted to a nursing home in a five year period. Those who had a hip fracture are also at a higher risk of ending up in a nursing home than other elderly.

For both males and females, the prevalence of most health conditions declined with age (Science Daily, 2010). The United States National Vital Statistics Report (2004) suggests

that in industrialized countries, most common causes of death among the elderly are cardiovascular disease, cancer, Alzheimer's disease and accident. However, people with Alzheimer's disease usually die as the result of pneumonia, a lung condition or a cerebrovascular condition. Moreover, many older people suffer from several chronic diseases that lead to limitation in physical functioning, thus dependent on others for assistance in the most basic daily activities such as bathing, dressing, eating and using the toilet. In, another report from the United States, the top ten leading causes of death for women ages 65 or older were heart disease, cancer, stroke, chronic obstructive pulmonary diseases (COPD), pneumonia and influenza, diabetes, Alzheimer's disease, unintentional injuries, kidney disease, and atherosclerosis (Older Americans, 2000).

2.8.1 Elder Abuse

Evidence suggests that residents in RCFs are at particular risk for abuse and neglect (Hawes, Rose & Phillips, 1999; Moraru, 2006). Due to the predicted rapid growth of the elderly population worldwide, it is noteworthy that the problem of elder abuse is likely to increase. Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult. It was first described in British scientific journals under the term granny battering in 1975 (Baker, 1975; Burston, 1975). But it was the United States Congress that first identified it as a social and political issue followed by discussions in the literature in Eastern and Western countries (Choi & Mayer, 2000; Jamuna, 2003). Later, it was described by the (WHO 2001) as any violation of human rights and a significant cause of injury, illness, lost productivity, isolation and despair to the elderly. It can also

take the form of financial exploitation or intentional or unintentional neglect of an ageing adult by the caregiver.

In South Africa, elder abuse tends to be a hidden and an under-reported issue. Yet, anyone who has witnessed any form of elder abuse is encouraged to report the matter to a Social Worker at the Social Development office or at a nearest police station. The matter may also be reported anonymously to HEAL (Halt Elder Abuse line) (South African Department of Social Development, 2009) Like in many other societies worldwide, there are unavailability of reliable data on the prevalence of elder abuse, as well as empirical studies on the health consequences and mistreatment of the elderly (Joubert & Bradshaw, 2003/2004). Similarly, relatively scanty knowledge exists on the situation of older persons in sub-Sahara Africa (Ferreira, 2005b; Velkoff & Kowal, 2003). The Halt Elder Abuse Line (HEAL), a toll-free national help-line, provides some evidence that elder abuse is widespread throughout South Africa (Joubert & Lindgren, 2003).

Regardless of its form, abuse is usually a hidden problem since both the abused and the perpetrators frequently feel ashamed, thus hiding the incidents from investigators. Yet, studies from developed countries have found that staffing shortages, staff burnout and poor staff training are the major causes of elder abuse in residential long-term care facilities (Hawes, Blevins & Shanley, 2001; Goergen, 2001; Vida, Monks & Rosier, 2002). Evidence from the United States suggests that two-thirds of nursing home residents and an estimated 40 percent of residential care residents have significant cognitive impairment, many from diseases such as Alzheimer's (Hawes, Blevius &

Shanley, 2001). These resident characteristics, particularly a diagnosis of Alzheimer's or other dementias, or challenging behaviours have been found to place residents at greater risk for abuse. In a survey in the United States, Hawes (2003) found 12% – 13% of the residents to be married, while many of the others lack a close family member who may be living nearby. These individuals are extremely vulnerable, largely unable to protect themselves, and dependent for their care on the kindness of strangers.

A study in elder abuse is important because for older people, the consequences of abuse can be especially serious because their bones are more brittle and recovery takes them longer. A relatively minor injury can cause serious and permanent damage to the elderly. Nevertheless, evidence-based research is required to improve practice and care for the elderly living in residential care to ensure that they will enjoy longer periods of disability-free old age, diseases will be avoided or their impact lessened through better health care strategies. There is need to emphasize that the resulting large numbers of older people are a boon of a society, since they constitute a great reservoir of experience and knowledge (Krug, Dahlberg, Zwi & Lozano 2002).

2.9 Population Ageing

Population ageing is the term used to describe shifts in the age distribution of a population toward older ages. Since the beginning of recorded human history, young children have outnumbered older people. However, the US National Institute on Aging (2007) had revealed that for the first time in history, people aged 65 and over will outnumber children under age five around the globe. Today almost 500 million people

are age 65 and over, accounting for 8 percent of the world's population. By 2030 the world is likely to have a billion older people, accounting for 13 percent of the total population, with the most rapid increases occurring in the less developed world. Between 2006 and 2030, the number of older people in less developed countries is projected to have increased by 140 percent, as compared to an increase of 51 percent in more developed countries (US National Institute on Aging, 2007).

Population ageing is the result of ongoing global decline in fertility and mortality at older ages (Gavrilov & Heuveline, 2003), and is considered among the most prominent global demographic trends of the 21st century (US National Institute on Aging, 2007). It is reflected in a health transition occurring around the globe at different rates. One major characteristic of this health transition is a shift from the predominance of infectious and parasitic diseases to the growing impact of non-communicable diseases and chronic conditions. This has implication for long term care. In response to this trend, the US National Institute on Aging (2007) recommends that institutions adapt quickly to accommodate the new age structure. In this respect, some less developed nations will be forced to confront issues, such as social support and the allocation of resources across generations.

2.10 Gerontology Nursing

Barton and Mulley (2003) define gerontology as the study of the biological, social, psychological and spiritual aspects of the aging process. It is the science of aging and the effects of time on human development, specifically aging, and gerontology is the

preferred term for the study of normal aging. The authors noted that although gerontological nursing has taken several centuries to become acknowledged as a separate nursing specialty, generally its rise should be understood within the context of the emergence and development of the nursing profession. Geriatrics is the branch of medicine that focuses on health promotion, and the prevention and treatment of disease and disability in later life. According to Barton and Mulley (2003), the term originated from the Greek word geron which describes an old man and iatros which describes a healer; the term was proposed in 1909 by Dr. Ignatz Leo Nascher. It describes the area of study related to diseases of the elderly (Barton and Mulley).

The history of gerontological nursing in South Africa was lacking in the literature. However, according to Barton and Mulley (2003), sick people were cared for in monasteries in medieval times, and some religious orders built hospital wings where the elderly and infirm patients received better food and received special care. Later, convents adopted a nursing role. In the United Kingdom, Barton and Mulley (2003) noted that the Mother of Geriatrics is Dr. Marjorie Warren, who emphasized that rehabilitation was essential to the care of older people. Using her experience as a physician in a London Workhouse infirmary, she advocated that merely keeping older people fed until they died was not enough; they needed diagnosis, treatment, care and support. She found that some of the patients who had previously been bedridden, were able to gain some degree of independence with the correct assessment and treatment. The practice of geriatrics in the UK is also one with a rich history of multidisciplinary working, valuing all the professions and not just medicine, for their contribution in optimizing the well-being and independence of older people (Barton & Mulley, 2003).

Another hero of British Geriatrics is Bernard Isaacs, who described incontinence, immobility, impaired intellect and physical instability as "giants" of geriatrics (Cannon, Choi & Zuniga, 2006). Isaacs asserted that all common problems with older people relate back to one of these giants.

Gerontology as a field of study was notable in Europe prior to North America. According to Steffle (1984), it began as an inquiry into the characteristics of long-lived people. In North America, gerontological nursing began its rise with the acknowledgment of this new nursing specialty by the American Nurses Association in 1962 and the formation of the National Gerontological Nursing Association in 1984. In Canada, the Canadian Nurses Association recognized the Canadian Gerontological Nursing Association as a specialty in 1985. Other nursing specialty organizations developed in Australia and Great Britain. In contrast to the continued use of the term geriatric, the term gerontological nursing came into use in the early 1980s to reflect the provision of care and the treatment of the whole person, as opposed to care of disease in a medical setting only. The assessment of the health needs of older adults, the planning and implementing of health care to meet those needs, and the evaluation of the effectiveness of such care are critical activities in assisting older adults to optimize their functional abilities. Such assessment helps maximize independence and promote well-being among the elderly, prime directive for gerontological nurses. A more recent term, gerontic nursing, refines the sphere of responsibility of gerontological nurses who care for the elderly by encompassing the art and intuition of caring and maintaining the well elderly, as well as emphasizing illness and scientific principles of care (Steffle, 1984).

Cannon, Choi and Zunig (2006) cautioned that gerontological nurses must have the knowledge and skill to manage care focused on normal and abnormal age-related physical changes, such as musculoskeletal, sensory and neurological alterations. Age-related psychosocial and spiritual changes, which include developmental, intellectual capacity, learning and memory losses also feature. Gerontological nurses must be educated concerning care strategies about wide-ranging basic and complex physiological and behavioral issues such as pain, pressure ulcers, cognitive impairment, lowered self-esteem, bereavement, fluid and electrolyte imbalance and caregiver stress, among other issues. Gerontological nurses must also have expertise in navigating the health care system to act as advocates for their clients (Cannon, Choi & Zuniga, 2006).

2.11 The Older Person's Act of South Africa

Like the rest of the world, the population of South Africa is ageing. Along with the ageing of population, there are changes taking place that are leaving many families less able to care for their frail relatives at home. In the face of these changes, ideally many of the elderly could be residents of nursing homes where health workers provide care. Sustaining a growing older population is institutions are the responsibility of the government, as well as the private sector, families and the individuals themselves. The Older Persons Act (Act No. 13 of 2006) is a framework that set a new standard for the care of the elderly in communities as well as institutions. This new legislation was developed in 2006 by the Department of Social Development to repeal The Aged Persons Act 1967 (Act No. 81 of 1967), The Aged Persons Amendment Act 1998 (Act No. 100 of

1998) and The Older Person's Bill (August 13, 2003). These pieces of legislation, however, fail to meet the Constitutional demands that all South Africans, including older persons, shall realize human rights and its fundamental freedoms to the fullest extent possible (South African Council of Churches, 2003). Thus, the Older Persons Act was developed to fill in the gap.

The goal of the new Older Persons Act (Act No. 13 of 2006) is to deal effectively with the plight of the elderly by establishing a framework aimed at the empowerment and protection of older persons and at the promotion and maintenance of their status, rights, well-being, safety and security; and to provide for related matters. The Act is an expression of the government's effort to redress the effects of inequity in social and human development planned by successive apartheid regimes. It is an indication of the government's further commitment to redress these inequities and to uphold the Constitutional values of respect, dignity and well being of all, especially of the vulnerable, marginalized and older persons. Chapter One of the Act outlines its objectives its implementation, application as well as its general principles. The chapter also recognizes the skills and wisdom of older persons in the community, as well as in institutions and shifts the emphasis from institutional care to community-based care. The acknowledgements ensure that the older person stays in his/her home in the community for as long as possible and feasible.

Chapter two speaks about creating an enabling and supportive environment for older persons. The focus is on the development of norms and standard for quality service delivery and the enforcement of punitive measures for deviation for the norm. It

emphasizes that the services to the elderly should be provided in an environment that recognizes the cultural, social and economic contributions of older persons; promotes communication networking between nongovernmental organizations (NGOs) and other structures in the community; and ensures access to information through educating and training of the elderly as well as preventing them from exploitation.

Chapter three speaks about the possibility of providing community-based care and support services for the elderly who wish to remain in the community for as long as possible, and the legislation that ensures the community based care and support services are provided. The community-based programs for the elderly should fall into two broad categories:

1). Prevention and promotion programs that ensure independent living for the elderly in the community; the programs should be aimed at ensuring that the elderly are economically and socially empowered. It further ensures that older persons have access to information, education and counseling especially in HIV/AIDS.

2). Home-based care that ensures the frail older person receives maximum care within the community through a comprehensive range of integrated services. These services should include home based care information; education on how to take care of the older person; and counseling for family members; care givers and the community regarding ageing and associated conditions. The chapter further emphasizes the importance of registration of

community based care services and training of caregivers as well as the registration of professionals with relevant statutory bodies to ensure protection of older persons.

The focus of chapter four is on residential or institutional facilities. It emphasizes that the homes have to be registered, and should meet certain requirements as stipulated by the norms and standards. In addition, it stipulates that older persons in residential facilities enjoy the rights in the Older Persons Bill. The Bill also stipulates that the elderly have the rights to appoint representatives to act on their behalf; have reasonable access to assistance and visitation; keep and use personal possessions, be informed about the financial status of the residential facility; and changes in management and be given at least 30 days notice of a proposed transfer or discharge. It emphasizes the need for a 24-hour care and support services to frail older persons and those who need special attention. All residential facilities have to have residents committees especially if more than 10 older persons reside in such a facility.

The legislation made provision on the admission clause to protect older persons. The following clause is critical to prevent forceful admission and minimizing the dumping of older persons in residential facilities. On the other hand however, no older person should be refused admission to the residential facility. If so, the manager of that facility has to do it in writing giving the reasons for non admission. It also made provision for monitoring of registered residential facilities by the State Social Worker or any person designated by the Director-General. The legislation, however, promotes the multi-disciplinary approach in monitoring of residential facilities. It further emphasizes that the operator of a registered residential facility (nursing home) must within 60 days after the end of the

financial year of that facility submit to the Minister a report covering that financial year in respect of prescribed service standards. The communication should also include details on measures to prevent and combat abuse of older persons and the provision of the prescribed service level agreements concluded during that financial year.

The focus of chapter five is on protection of older persons in both the community and the residential facilities. It firstly describes an older person in need of care. It further stresses that all people have a duty to report elder abuse including community members. The procedure for bringing complaints of abuse against an older person in the community before the magistrate are discussed at length in the legislation also the enquiry into abuse of older person. It further requires the Department of Social Development to keep a register of persons convicted of abuse or any crime pertaining to older persons. A person whose name appears in the register is prohibited to operate a residential facility or be employed at any residential facility or provide any community –based care and support service to an older person. Chapter Six provides for the delegation of powers. The Minister has the right to delegate powers to any officer of the Department.

The Department is hereby commended for developing such legislation that seeks to assign the process of care and protection of the older person within the community and institutions. However, there seems to be areas that the Act does not address. For example, in terms of a national norm and standards of practice as stipulated in Chapter One, there appears to be no national norm available at the moment. In Chapter Four the Act is quiet about the type and standard of services that should be provided for the elderly in nursing

homes, and it does not specify what the homes should be monitored for, just to mention a few. Thus, the Act needs to be strengthened through research in order to be effective.

2.12 The conceptual framework

The conceptual framework that underpinned this study was a modified Structure, Process and Outcome (SPO) measures of healthcare quality model (Donabedian, 1966; Honig, Horner, Duncan, Clipp, & Hamilton, 1999; Zinn & Mor, 1994). These three components (SPO) were originally formulated by Donabedian (1966) as a relevant sector for quality assessment. Quality assessment involves assessing the strengths and weakness of programs, policies, personnel or products and organizations in order to improve their effectiveness. It involves the systematic collection and analysis of data needed to make decisions about something (Donabedian, 1992). This framework was selected as most appropriate model to address the purpose and objectives of this study.

Donabedian (1966) asserted that these three categories of quality measures are not independent but are linked in an underlying framework because good structure should promote good process and good process in turn should promote good outcome (Donabedian 1988). This provides a theoretical rationale for linking structure, process and outcome within this study in order to have a holistic view of the phenomenon under investigation.

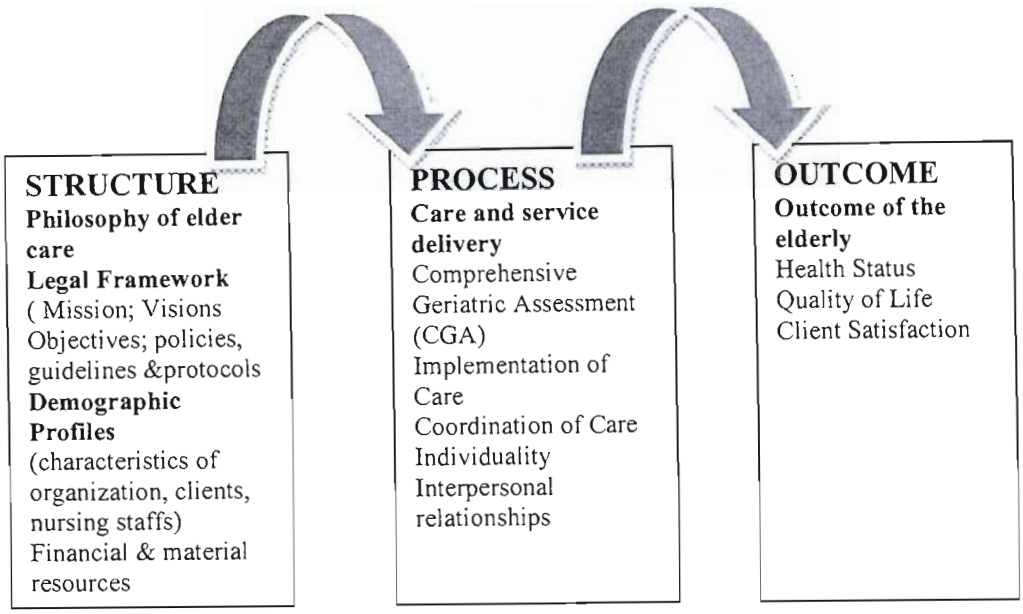

Figure 2.1: A modified structure, process and outcome (SPO) Framework on measures of healthcare quality (Donabedian, 1966; Honig, Horner, Duncan, Clipp & Hamilton, 1999; Zinn & Mor, 1994). The SPO components are linked in an underlying framework because good structure should promote good process and good process in turn should promote good outcome.

2.12.1 Application of Donabedian's SPO framework to the study

I. The Structural component

Structure is the first component of the proposed framework. Donabedian (1966) described structural measures of quality as the professional and organizational resources associated with the provision of care, such as staff components and the facility operating capacities. It includes the philosophy and needs assessment of a target population, the legal framework of an organization including its policies, guidelines and protocols,

objectives, mission and visions. Also included are the physical infrastructure, environmental setting, types of services provided, and the internal composition of the human resources which collectively provide the required services needed for an organization to function effectively. The following topics will be discussed under the structural component:

1. Philosophy of elder care in relation to nursing
2. Legal Framework
    - Policies
    - Mission
    - Visions
    - Objectives
    - Guidelines & Protocols
3. Demographic Profiles
    - Characteristics of organization
    - Characteristics of clients
    - Characteristics of nursing staffs
    - Financial & material resources

The philosophy of the care of the elderly is drawn from the philosophy of nursing which includes human beings, environment, health and nursing. The concept that applies to the care of the elderly is the concept of "a person". It relates directly to the elderly, and it should be the center of their care. The elderly person should be considered first and

foremost as a person. The word person aims to capture those attributes of a person that represents the humanness and the factors which are regarded as most important and most challenging in life. As cited in McCormack (2004), Kent argues for the supreme equal value of persons and their intrinsic worth. Kent's idea of persons is that they should always be treated as ends in themselves, and not as a means to another's end, which is the guiding principle in many ethical, legal and moral frameworks in many societies (McCormack, 2004). McCormack had supported a person-centered nursing for the elderly and suggested four core concepts that are at the heart of geriatric nursing: being in relation, being in a social world, being in place and being with self (McCormack, 2004).

The legal framework: The legal framework that is applicable to this study is the Older Persons Act (Act No.13 of 2006). All nursing homes are subject to rules and regulations laid down by the national heath authorities (National and Local Department of Health & Department of Social Development) of South Africa.

Policies: Smith (2002) described policy as a deliberate plan that guides decisions actions to achieve rational outcome(s). The term may apply to government, private sector organizations and groups, and individuals. Policies can be understood as political, management, financial, and administrative mechanisms arranged to reach explicit goals. A policy is typically instituted in order to avoid some negative effect that has been noticed in the organization, or to seek some positive benefit.

Mission, Vision and Objectives: The mission, vision and objectives of programmes are relevant components of its structure. Mission defines where the organization is going, basically describing its purpose and why the organization exists (Lorenzen, 2006). Its

concentration is on the present; it defines the customer(s), critical processes and it gives information about the desired level of performance. Vision defines where the organization wants to be in the future, reflecting the optimistic view of the organization's future. A 'vision statement' outlines where the organization wants to be. Its concentration is on the future and it is a source of inspiration, providing clear decision-making criteria for the organization (Lorenzen, 2006). Organizations sometimes summarize goals and objectives into a mission statement and/or a vision statement. A key challenge is for an organization to have a clear mission and vision statements, as well as the objectives in order to keep staffs and others motivated (Lorenzen, 2006).

Guidelines & Protocols: The care and service to the elderly must have guidelines and protocols drawn by professionals on the basis of research, including care maps, and other systematically developed statements to help with decisions about appropriate interventions for specific clinical conditions (Hoenig et al., 1999). In South Africa, there are treatment guidelines and protocols, some of which have specific emphasis to the elderly that guides the actions of practitioners.

Demographic profile: refers to the characteristics of the nursing home care including the organizational structure, staff and elderly.

Characteristics of Organization: (physical setting, material and financial resources)

Physical Setting: The infrastructure or the environment in which the services are offered is part of the structure component of a program (**Booyen, 1997**). It includes the layout of the physical site where the patient receives care, and the specific kinds of equipment used

to provide such care. Housing is not merely a shelter, rather for the older person, it is associated with "place", identity and relationships (Barratt, 2007). There is a growing relationship between health status and the living environment. Living environments can help an older person to remain connected to the community, friends and networks and also access essential support services (Zofar, Ganatra, Tehseen & Qidwai, 2006; Barratt, 2007).

Material Resources: The availability of functioning facilities, diagnostic equipment, and medications are crucial to the quality of services rendered by services providers. Because of the physical needs of older persons, a fit between their abilities and environmental demands is very important (Cavanough & Blanchard-Fields, 2006). For example, rehabilitation helps stroke survivors relearn skills that are lost when part of the brain is damaged. For example, these skills can include coordinating leg movements in order to walk or carrying out the steps involved in any complex activity. Rehabilitation also teaches survivors new ways of performing tasks to circumvent or compensate for any residual disabilities. Patients may need to learn how to bathe and dress using only one hand, or how to communicate effectively when their ability to use language has been compromised. There is a strong consensus among rehabilitation experts that the most important element in any rehabilitation program is carefully directed, well-focused, repetitive practice - the same kind of practice used by all people when they learn a new skill, such as playing the piano or pitching a baseball (U.S. National Institute of Health (2010).

Financial Resources: The role of government and funding agencies in sustaining RCFs cannot be underestimated in developing countries. RCFs in Durban are either private, semi private or NGOs, run by board of directors. The private ones do not receive any subsidy from the government, but the elderly or their families must pay the rate for accommodation and services. The NGO or semi private ones receive 50% subsidy from the government for each elderly, but many of the elderly live of a State Old Age Pension of R960.00 per month. Only 48 % of this income is used to pay for accommodation (TAFTA, 2007). Usually, there is a monetary shortfall that needs to be made up to cover the cost of running the NGOs or semiprivate homes. Therefore in many instances, the facilities have to raise funds and ask for donations. The Association for the Aged (TAFTA) and Durban Association for the Aged (DAFTA) are both registered charity organizations in Durban. TAFTA provides essential services to the elderly of Durban and its surrounding areas. Some of TAFTA's services include Accommodation for the Fit & Frail, Social Services, Meals on Wheels, Home Help and transport to and from clinics and hospitals (TAFTA, 2007).

Characteristics of nursing staff include staffs' level of training, staffing levels and composition. The South African Qualification Authority (SAQA, 2001) has identified education and training of providers as the basis of quality care and service delivery. Education and training of nursing staff of RCFs are at the base of the education and training system in that they are those that are actually engage in the daily care of the elderly, whom the education and training system is meant to serve. It is therefore of critical importance that providers develop quality management systems (QMS), and that

they receive the necessary support in order to operate within the National Qualifications Framework (NQF) (SAQA, 2001).

Mofomme (2001) also identified training, education and development as closely related concepts that lead to the desired outcomes. Thus, in order to deliver quality care to the elderly in RCFs, education, learning and training are seen in an integrated manner in line with the NQF as required by the SAQA to attend to specific issues in a holistic manner.

Staffing level and composition: There were no South African data found in the literature on nursing home staffing level, but it is popularly believed that many RCFs are understaffed. For example, a U.S.A. federal study of nursing homes showed a severe shortage of nurses and nurse assistants in its RCFs, and up to 90 percent of those homes did not have enough nurses and nursing assistants to provide high quality care to the patients (U.S. Department of Health and Human Services, 2006). In another U.S.A. research, Hawes (2002) found that staffing shortages caused neglect and create stressful working conditions in which abuse is more likely to occur. Staff burn-out was often a product of staffing shortages, mandatory overtime, and the fact that many staff must work two jobs to survive financially.

Staff Composition: The use of multiple different providers in the care of the elderly is based on the belief that the individual providers themselves and their group interaction offers significant benefits to patients; that is, their combined expertise of multiple professionals results in better problem solving, and that mutual treatment of functional

mobility by a social worker, occupational therapist, physiotherapist and nursing acts to enhance the outcome of the elderly (Lowe, 2007).

Characteristics of the elderly include age, gender, sex, marital status and physical and mental status. Ageing increases the chance that the elderly person will develop some form of disability. Research suggests that the characteristics of the elderly in nursing homes sometimes make them vulnerable to abuse and neglect (Hawes, 2002; Hawes, Rose & Phillips, 1999; Moraru, 2006). Most suffer from several chronic diseases that lead to limitation in physical functioning and are thus dependent on others for assistance in the most basic daily activities such as bathing, dressing, eating and using the toilet. Others have significant cognitive impairment, many from diseases such as Alzheimer's (Hawes, Blevius & Shanley, 2001). These resident characteristics have been found to place residents at greater risk for mistreatment.

II. The Process component

Process is the second component of the proposed framework. Gustafson and Hundt (1995) described process measure of quality as the things done to and for the patient by practitioners during the course of treatment. It includes those activities, content, service delivery, strategies, interventions and methods adopted for the purpose of meeting the identified needs of the elderly in RCFs.

The following are components of the process of care to the elderly.

- The Comprehensive Geriatric Assessment (CGA) Mulhausen, 2005).
- Implementation of Care and individuality (Gross & Battie, 2006)

- Coordination of Care (Ellis & Langhorne, 2005; Hoenig et al., 1997)
- Intervention and interpersonal relationships (Aminzadeh, 2000).

The Comprehensive Geriatric Assessment (CGA): The comprehensive geriatric assessment (CGA) is a major part of the process of the care of the elderly. Research evaluating the CGA demonstrates its ability to improve the health status and quality of life of frail older adults across the spectrum of health care settings (Ellis & Langhorn, 2005). It is a multidisciplinary evaluation of the elderly in the medical, psychological/psychiatric, functional and social domains, through which their multiple problems are uncovered, described and explained; the resources and strengths of elderly are catalogued; need for services assessed and coordinated care plan developed to focus interventions on the person's problems (Mulhausen, 2005).

Components of (CGA): The CGA is a screening tool, with more-specific instruments used for evaluating the geriatric patients. The main areas of focus are:

1. Medical assessment includes assessment and listing of problems, co-morbid conditions and disease severity, medication review and nutritional status;
2. Assessment of functioning includes assessment and review of basic activities of daily living, instrumental activities of daily living, activity / exercise status and gait and balance;
3. Psychological/psychiatric assessment includes mental status (cognitive) testing and mood / depression testing;

4. Social assessment includes information about informal support needs and assets, care resource eligibility / financial assessment
5. Environmental assessment includes information about home safety transportation and tele-health.

Coordination of Care: Coordination of elder care and service among providers and across the continuum of care may be an important factor affecting their outcomes. For example, literature indicate that coordination of care has an independent effect on clinical outcomes (Ellis & Langhorne, 2005; Hoenig et al., 1997) and many care providers believe in its importance (Duncan, Zorowitz, Bates, Choi, Glasberg et al., 2005), most stroke rehabilitation studies do not isolate activities that affect coordination of care from other simultaneous interventions. Because the care of the elderly in RCFs is complex, it requires multidisciplinary/multisectoral team approach as proposed by Lachs and Pillemer (2004).

Implementation of Care & Individuality: Implementation is the carrying out, execution, or practice of a plan, a method, or any design for doing something. Gross and Battie (2006) described implementation as the action that must follow any preliminary thinking in order for something to actually happen. It describes the extent to which the care and service is tailored to the patient's unique needs. According to Gross and Battie (2006), functional outcomes are determined by the patient's functional capacity, the environmental demands, and the patient's willingness to engage in the activity. Individuality may be beneficial in a number of respects. For example, Hienig et al (1999) suggested that individuality of therapy can take place through eliciting, responding and

involving the elderly in their treatment decision. Bringing the patient into the process potentially increases the likelihood that the therapy will be directed to areas of concern to the patient and that it will be appropriate to the patient's needs, thus improving both compliance and effectiveness (Hienig et al., 1999).

Intervention and interpersonal relationships: The relationship between service providers and the elderly is critical to the success of care outcomes. Knowledge of good communication skills is needed to enable practitioners care and support the elderly in RCFs. (Aminzadeh, 2000) emphasized communication is an important determinant of client satisfaction, which also influences their health outcomes. Among factors consistently reported to have a negative effect on patients' satisfaction in nursing homes were brevity of encounter, lack of rapport and long interviews without provision of adequate feedback. On the other hand, expression of caring, positive feedback, providers' recognition of the older person's difficulties and their desires to facilitate implementation promoted their satisfaction (Aminzadeh, 2000). Thus, there is a crucial need for staff of RCFs to strengthen levels of interpersonal relationships with the elderly in care facilities, which can be facilitated through communication.

III. The Outcome component

Outcome is the third component of the proposed framework. It includes the desired states resulting from care processes, which may include reduction in morbidity and mortality, and improvement in the quality of life (Kane & Kane 1988). Castle (2002) noted that outcomes are the status achieved by residents including clinical symptoms, mortality, and quality of life. Outcome measures are considered ideal quality indicators since deviations

from proper care theoretically should affect residents' health status outcome. As Donabedian (1988b) hypothesized, good structure may promote good process and good process in turn may promote good outcomes. The following topics will be discussed under the outcome component:

- Health Status
- Quality of Life
- Client Satisfaction

Health Status: Leung, Luo, So and Quan (2007) described health status as the current state of one's own health, which includes the status the person's wellness, fitness, and any underlying diseases or injuries. It includes such influencing factors as weight, nutrition, ability and flexibility, or ability to move, smoking, alcohol consumption, caffeine consumption, compliance with prescribed medications, treatments activity diet, etc, (Leung, Luo, So & Quan, 2007). The trend in health today holds the person responsible for their own health status.

Quality of Life: Quality of life (QoL) usually describes a person's standard of living. In gerontological research, QoL has two distinct domains: health-related quality of life (HRQoL) and non-health or environment-based quality of life (Albert, 2002). HRQoL encompasses domains of life directly affected by changes in health. For example in functional status, it may be determined by a person's ability to manage a household, use the telephone, or dress independently. In mental health or emotional wellbeing, it may involve depressive symptoms or positive affect. In social engagement, it may be

determined by the person's involvement with others or engagement in activities and symptom states may be determined by the presence of pain, shortness of breath or fatigue. These domains represent typical outcomes in medical and social science research. However non-health-related QoL domains include features of both the natural and the created environment, including economic resources, housing, air and water quality, community stability, access to the arts and entertainment and personal resources such as the capacity to form friendships, appreciate nature, or find satisfaction in spiritual or religious life. Although these factors affect health-related QoL, but unlike health-related QoL domains, they are less likely to improve with appropriate medical care (Albert, 2002).

Client Satisfaction: Measuring client or patient satisfaction has become an integral part of health facility management strategies across the globe. According to Kumar and Rajwal (2006), client satisfaction reflects the gap between the expected client satisfaction with a service and the experience of the service, from the client/patient's point of view. It is recommended that as the expectations of clients increase over time, the quality of the service has to keep on improving to maintain or increase their level of satisfaction.

2.13 Conclusion

The chapter has explored and described related literature on residential care for the elderly in terms of the historical background of residential care from a global perspective. It has also defined ageing and the elderly from the international and national points of view. Literature suggests that people are placed in residential care when they become dependent as the result of chronic conditions that require a long term care. It further

suggests that the characteristics of the elderly, particularly the presence of chronic diseases that lead to limitation in mental or physical functioning are the cause of abuse of the elderly in RCFs. It therefore suggests that health workers and all stake holders of residential care acquire the requisite knowledge and skill in gerontology in order to provide quality care to sustain the elderly. It urges institutions to adapt quickly to accommodate the ageing of populations by confronting issues such as social support and allocation of resources across generations. The government of South Africa has taken the lead by providing the Older Persons Act (Act No. 13 of 2006) that contains new regulatory frameworks for all nursing homes in the country. However, the Act has its own shortcomings in that it has many identifiable gaps that must be collectively strengthened through research. The conceptual framework that underpinned this study was a modified Structure, Process and Outcome (SPO) measures of healthcare quality model that were originally formulated by Donabedian (1966) as a relevant sector for healthcare quality.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This section gives an overview of the research process used to explore and describe residential care for the elderly in eThekwini Municipality, KwaZulu-Natal, South Africa. The methodology of any research is an integral part of that research process, thus, an important aspect of any scientific study (Polit & Beck, 2004). A study of residential care for the elderly that addresses administrators, nursing staff and elderly residents is an undertaking that requires a comprehensive research approach. Thus, Polit and Beck (2004) emphasize that the nature of the inquiry and the case will determine the most suitable methodology. This study's conceptual framework has three dimensions: structure, process and outcome, which required a research approach that would accommodate those dimensions.

The research methodology section includes discussions on the research design, setting, sample and sampling procedure, instrumentation, data collection, data analysis, and ethical considerations. Other aspects of this chapter include sections on reliability and validity of instrument for data collection and academic rigour.

3.2 Research design

Research design may be defined as the overall plan for addressing a research question, which includes specifications for enhancing the study's integrity by Polit and Beck (2004). Meanwhile, Trochim and Donnelly (2006) described it as the glue that holds the research project together and Brink (2006) indicated further that the best design is always

the one that is most appropriate to examine the research problem and purpose. Zach (2006) indicates further that the research design structures the research, and show how all of the major parts of the research can work together to address the central research questions.

The purpose of this study was to explore and describe residential care for the elderly in specific locations in eThekwini Municipality in terms of its residents, staff & organizational structure, aimed to make recommendations for residential care in the eThekwini. Thus, selecting the best research design was critical to achieving the study's objectives. Terre Blanche and Durrheim (2004) suggest that the choice of a research design be based on the purpose of the research. To this end, the theoretical paradigm should inform the research, the context or situation within which the research is carried out, the application of the research techniques to collect and analyze the data. Based on the above statement, a descriptive explorative case study design, using both quantitative and qualitative approaches was adopted as the best design for this study.

Case studies provide a relatively richer and more vivid picture of the phenomena under study than other designs (Zach, 2006). Through this design, the researcher was able to know about her research participants' condition, thoughts, feelings, actions (past and present), intentions, and environment (Polit & Beck, 2004). The need for this design was born from the researcher's desire to describe and explore the three dimensions of the study's conceptual framework; the structure, process and outcome of residential care. Case study approach is also useful in providing significant amounts of descriptive

explanation about the 'why', 'how' and 'what' (Yin, 2003) of a study. In addition, the information obtained through this design, together with the literature was used to make recommendations for residential care for the elder in the four facilities studied.

The crucial aspect in justifying the use of both quantitative and qualitative research approaches is that each methodology has strengths and weaknesses (Burns & Groves, 2001). Philosophically, quantitative research is underpinned by a positivist paradigm that proposes that scientific truths exist, and these truths can emerge from what can be observed and measured or studied as objects (Gerrish & Lacey, 2006). Methods which minimize or are free from bias are used to do this so that greater confidence can be given to any findings. This approach is often referred to as the scientific or empirical method. On the other hand, qualitative research fits more neatly within an interpretive approach based on the assumptions that in order to make sense of the world, human behavior should be interpreted in interaction with others (Gerrish & Lacey, 2006). Since it is not always possible to recognize all these characteristics in either quantitative or qualitative research approach, the researcher utilized both paradigms so that the weakness of one method can balance out the other (Gerrich & Lacy, 2006).

The mixed method can also ensure data triangulation by the use different data sources (numbers and words), to increase the type of information obtained from participants, and produce a more holistic picture that information (Gerrich & Lacy, 2006). Since many variables are involved in the study of RCFs, Yin (2003) emphasized the need for researchers to rely on multiple sources of evidence to ensure triangulation; which come largely from interviews, documents review, direct observations, participant observation

and physical artifacts (Yin, 2003). Case study design is lacking in rigour, and Yin (2003) further emphasized the use of mixed methods to enhance its strength.

During data collection, the researcher utilized direct observation, focus group discussion, semi-structured interview, document review and questionnaire to ensure triangulation. As it is not always easy to collect quantifiable data for all variables, (Brink, 2006) cautioned that variables such as the number of caregivers, number of resident education, etc can be readily expressed in numerical terms, but other variables such as staff attitude and philosophy of life are not so easily quantified. Such variables lend themselves more appropriately applied to qualitative measures, such as detailed verbal descriptions, than numerical summaries (Zach, 2006). According to Creswell (2003) qualitative data often capture the subjective "human" side of a question in a way that is not possible through the use of quantitative methods alone. This type of information can provide examples of important conceptual phenomena and nuances, the full impact which may not be conveyed solely through quantitative data.

Utilizing the mixed method can be challenging to researchers as interviews usually yield rich data, details and new insights about the research problem and provides an opportunity for the researcher to explore topics in depth. Due to the flexible nature of interviews, the interviewee may distort some information through recall error. Moreover in a document review, gaining access to or locating suitable documents for review and analysis of the documents may be difficult and time consuming. These are some the challenges that researchers utilizing mixed methods encounter.

The study was a "four-case" or "multiple-case" study. Case studies can be one case, where one subject is studied in depth, or multiple cases, where more than one subject is examined repeatedly in order to enhance the validity and reliability of the findings (Yin, 2003; Zach, 2006). The design was appropriate to explore the phenomena under study through the use of a replication strategy, which was recommended by Yin (2003) as useful when variables as well as differences between or among two or more programs are present. The study design was used to explore and describe residential care for the elderly in eThekwini Municipality in terms of its residents, staff and organizational structure and determine ways in which those factors influenced elder care on a comparative basis using four RCFs.

In multiple-case studies design, there are no rigid rules about how many cases are required to satisfy the requirements of the replication strategy. However, Yin (2003) suggested that if the results turn out as predicted, then the number of cases chosen is sufficient to "provide compelling support for the initial set of propositions" (p. 46). As the multiple-case studies approach does not rely on the type of representative sampling logic used in survey research, Yin (2003), noted that the criteria regarding sample size are irrelevant" (p. 50); instead, sample size should be determined by the number of cases required to reach saturation. The sample participants should be selected explicitly to encompass instances in which the phenomena under study are likely to be found.

3.2.1 Components of case study

Yin (2003) suggested that a case study design must have five components: the research questions, proposition of the study (if any), unit of analysis, logic linking the data to the propositions and criteria for interpreting the findings.

3.2.1.1 The research questions: The research questions were directed at the structure, process and outcome of the conceptual framework (Donabedian, 1980), using "how", "what" and "why" questions as proposed by Yin (2003).

3.2.1.2 The study's propositions if any: The study design is focused on exploring and describing residential care for the elderly, and not on formulating propositions. Moreover, the rationale for undertaking the study was supported by the review of relevant literature of the phenomenon under study.

3.2.1.3 Unit of analysis: Bless, Higson-Smith and Kagee (2006) describe the unit of analysis as the person or object from whom the researcher collects the data. Yin (2003) suggests that operationally defining the unit of analysis can assist with replication and efforts at comparison. For instance, individuals, groups, artifacts (books, photos & newspapers), geographical units (town, census tract, state) and social interactions could be defined as units of analysis. In this study, the unit of analysis was the facility as measured by administrative and nursing staff of the study's four RCFs, the elderly residents, as well as physical infrastructure and documents as part of the material resources. Specific persons and objects within the programmes provided relevant data about the structure, process and outcome of each nursing home.

3.2.1.4 Logic linking the data to the propositions: The conceptual framework guided the process of data collection and laid the foundation for data analysis and the reporting phase; it also helped to create linkages within the study.

3.2.1.5 Criteria for interpreting the findings: The structure, process and output of the study's conceptual framework formed the basis for comparing and interpreting the findings from the four RCFs. These five components of the case study were applied to the relevant sections of the study.

3.3 Population

The population of a study describes the entire set of individuals, elements or subjects that meet the criteria for inclusion in a study (Burns & Groves, 2001). It comprises the entire group of persons or objects that the researcher is interested in studying (Polit & Beck, 2004). For this study, the population were the administrative staff of the four RCFs, the nursing staff and the elderly residents who were using those facilities. Social artifacts such as the physical structure and documents also provided relevant information regarding the structure, process and outcome of each RCF. The sample for this study was selected from this population.

3.4 Sampling and sample size

Sampling is the process of selecting a portion of the population to represent the entire population (Polit & Beck, 2004). Sample describes a part or a fraction of a whole, or a subject of a larger set, selected by the researcher to participate in a research study (Brink, 2006). The sample was selected from the study population according to the structure,

process and outcome of the conceptual framework. Specific sampling methods were selected for the relevant participants from the population of the study.

3.4.1 Sampling of the residential care facilities

The selection of the four RCFs was based on a multi-stage sampling technique, a complex form of cluster sampling. Czaja & Blair (2005) described multi-stage sampling as the process where the researcher divides the population into strata, samples the strata, and stratifies the samples, and then re-samples, repeating the process until the ultimate sampling units are selected at the end of the hierarchical levels. For this study, a list of state-sponsored and private RCFs for the elderly was downloaded from the Internet. Another list of similar nature was obtained from a social worker at the Department of Social Welfare. The facilities were all accredited by the Departments of Social Welfare, and have been in operation for at least six months. The second list included some of the names of the facilities that were on the first list. The first list had 63 items while the second had 50. The researcher then compiled a complete list of all the facilities available in the various district of KZN, but she focused on those RCF in Durban Metro area and phoned 35 of the persons in charge. However only 7 expressed interest in taking part in the research. The 7 RCFs were then stratified into social-cultural groups, NGOs, private, government subsidy and geographic locations. From that stata, the researcher purposefully selected four RCFs based on social-cultural and geographic locations. Finally, the researcher selected the frail sections of each RCF purposefully because she was interested in frail residents. Purposive sampling technique is a form of non-probability sampling based on the judgment of the researcher regarding the characteristics of a representative sampling (Bless, Higson-Smith & Kagee, 2006).

Purposive sampling of each administrative staff was made through a set of criteria for selection. That is, all the RCFs had both administrators and nursing managers who were all included in the study. These key persons provided information on the structure, process and outcome of each facility because they were expected to be knowledgeable about the history, administrative, as well as every aspect of the respective facility they head.

3.4.2 Sampling of nursing staff: The nursing staff were purposively sampled since they are directly involved in the care of the elderly. They were included if they were registered with the South African Nursing Council (RN), enrolled nurses (EN) or enrolled nursing auxillaries (ENA); as they were deemed able to provide information on the types of care and services provided to the elderly in each facility, including challenges and successes in providing such care. However after the pilot study involving 3 RNs and three ENAs, it was found that the ENAs could not complete the questionnaire due to their low level of knowledge. They were therefore excluded from the entire study as they usually receive only four to six months training. Moreover in Case Three, one ENA completed the nursing staff questionnaire, but she was later excluded because she did not meet the inclusion criteria.

3.4.3 Sampling of elderly residents: Selection of the elderly residents was also based on the purposive sampling technique because they were the consumers of the care and services in each RCF. The elderly, both males and females, provided feedback or "outcome" of the care and services that they receive in relation to their health status,

quality of life and their level of satisfaction. They were selected on the basis of their age (60 yrs +); they were frail, but mentally competent to give informed consent to participate in the study. The residents who were too frail to withstand the stress of being interviewed or were mentally incapacitated were excluded from participating in the study because they could not fully understand the rationale for conducting the research.

3.4.4 Review of facility record: The record review focused on the facility's mission statement, vision, goals and objectives, protocols/guidelines for admission, care giving and physical infrastructure. These were selected as secondary data to give a clear picture of the phenomenon under study through the purposive sampling technique. Other relevant records and documents were revealed where applicable.

3.5 Sample size

3.5.1 Qualitative sample size was determined on the basis of data saturation (Polit and Hungler, 1999). That is the point where new information is no longer forthcoming.

3.5.2 Quantitative sample size: The researcher used a convenient sampling technique to select the most readily available nursing staff members as participants in the study. The researcher invited all the nursing staff that were available on both day and night shifts at each RCF who met the selection criteria to participate in the study. She distributed questionnaires to those who agreed to participate in the study. The sample size was determined by the response rate of those who completed and returned the questionnaire.

3.6 Description of cases

The study was conducted in four RCFs in eThekwini, KwaZulu-Natal Province, South Africa, represented as ***"Case one to four"*** throughout the study.

3.6.1 ***"Case One"*** is located four kilometres away from eThekwini. It was established as an independent non-governmental organization (NGO) in 1949 for the care of frail elderly. However, in the past 10-12 years, its services have changed to accommodate people with physical and mental disabilities of all age groups. The total capacity of the facility is 500 beds, with about 200 elderly. It is partly subsidized by the South African government. The total number of staff is 340, including RNs, enrolled nurses, enrolled nurse auxiliaries (ENAs) and general orderlies (janitorial staff). It has a training college where care givers are taught, as well as a clinic that provides health care services to its residents. The facility also has self-catering flats for the elderly who are able to look after themselves, and shared houses for people with mental and physical disabilities. This research was conducted in one of the shared houses, where many of the residents who had mild to severe mental or physical impairment stayed. Some of these residents and were partially or totally dependent on their caregivers to meet their activities of daily living (ADLs) needs. Seventeen persons participated in Case One, including two administrative staff members, ten nursing staff and five elderly residents.

3.6.2 ***"Case Two"***, is located in one of the townships of eThekwini, 20 Km away from the city centre, it is a NGO partly subsidized by the national government. It was established in 1921 by a group of inspired men and women to alleviate suffering humanity. Its services target vulnerable people in all age groups, having physical, social,

medical, educational and spiritual needs. The total capacity of the facility is 550 beds, with a workforce of 250 staff. It also has a training institution where most of its nurses are trained, and a clinic that provides health care services to their residents. The organization is run by a board of managers. A chief executive officer (CEO) oversees the different projects of the facility, while the nursing service manager is responsible for the nursing aspects. This research was specifically conducted in the home for the elderly who have physical and mental challenges. Seventeen persons participated in Case Two, including two administrators, 10 nursing staff and five elderly residents.

3.6.3 "Case Three" is a private frail care centre that is attached to a private retirement home in eThekwini. The business is run by six directors: three accountants, one attorney, one executive country club manager and one executive company director, on a share block basis. The owners of this RCF are the residents who live there, who are also the shareholders in the business. The centre has 16-bed capacity. It is run by a senior registered nurse. The purpose for establishing the centre was to provide emergency assistance, post operative and frail care to residents of the retirement home. Eleven (11) persons participated in Case Three including two administrative and four nursing staff and, five elderly residents.

3.6.3 "Case Four" " is an old age home also situated in one of townships in Ethekwini; about 25 km away from the city centre. It was established in 1996 as a NGO, and it is run by a nine-member board of directors. The administrator of the home is an ex-police officer and a pastor. The institution has only one registered nurse and as the result, she

functions as a chief nursing officer and a unit manager/supervisor and the RN. Though busy, she is well organized and always works hard to promote the residents' comfort. The total capacity of the home is 50 beds. The purpose for establishing the home was to cater for the needs of the vulnerable aged. Twelve (12) persons participated in Case Four, comprising two administrative staff, five elderly residents and five nursing staffs.

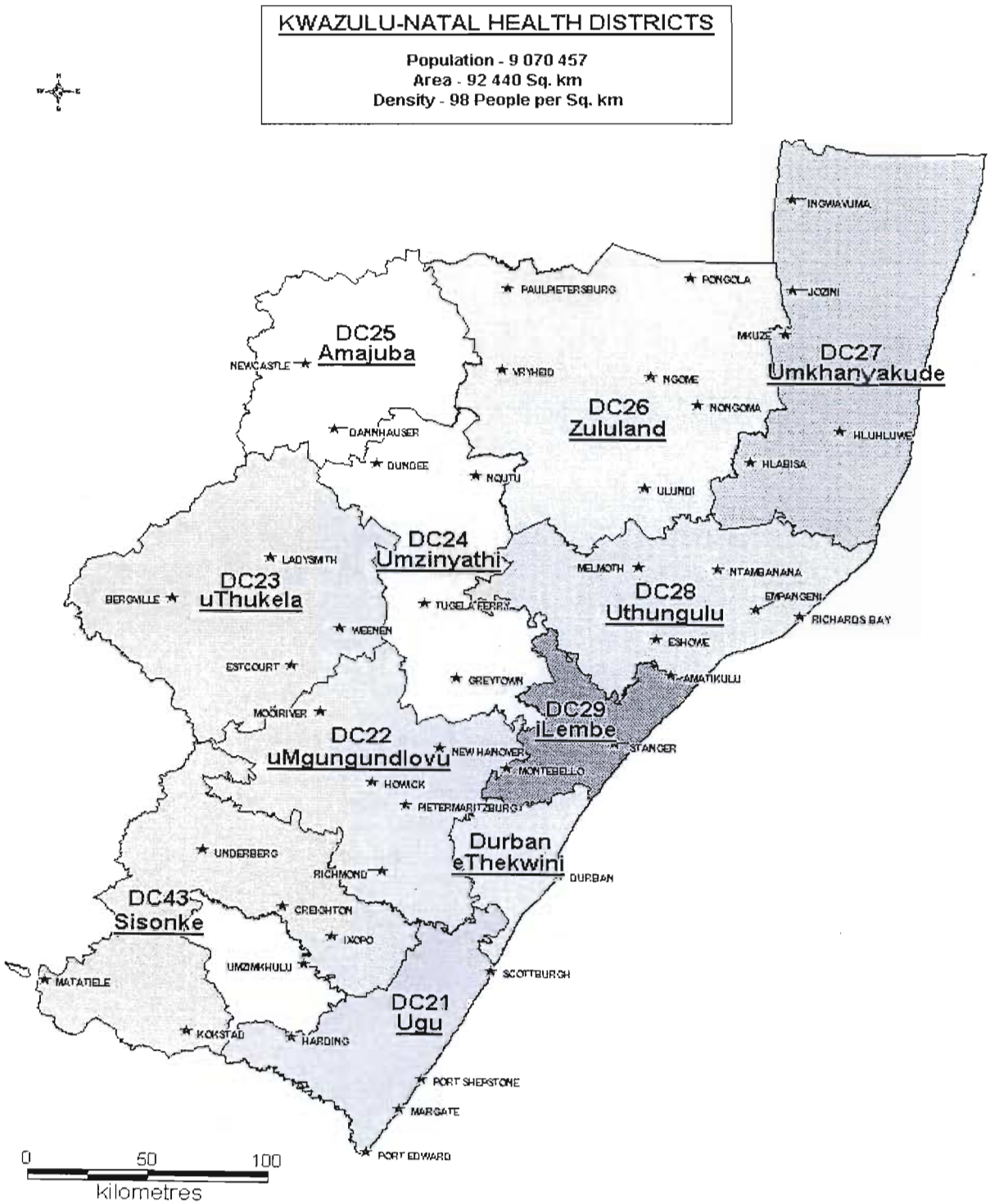

Figure 3.1: Map of KwaZulu-Natal

3.7: Instruments for data collection

The instruments were developed in English by the researcher, based on an extensive review of the literature. The researcher, being aware that the target population of one of her cases was based in a setting where isiZulu is spoken exclusively, a research assistant, an isiZulu-speaking social worker, was recruited to assist the researcher when necessary. Refer to Table 3.1

Table 3.1: Instrument for data collection

Instrument for data collection	Participants
1. Semi-structured Interview schedule	1. Administrative staff 2. Elderly residents
2. Questionnaire	• Nursing staff (RNs & ENs)
3. Record Review Checklist	• **Relevant Records including** • Institutional constitution Checklists for: • Admission & assessment • Referral to hospital • Infection Control • Informed consent • Discharge • Death and burial • Transfer • Referral • Quality indicators • Others
4. Observation Checklist	• Characteristics and descriptions of caring environment • Description of caring interactions between nursing staff and the elderly • Communicating with the elderly

3.7.1 Semi-structured interview schedule: Two types of semi-structured interview schedules were used to collect qualitative data from the administrative staff and the elderly residents. The administrative staff's instrument contained 42 items divided into three sections: the first section dealt with demographic information of the facility; section two covered background information of each RCF; and section three was the main interview schedule covering questions on the structure, process and outcome of each RCF. The contents of the questions addressed the research objectives **(see Appendix II).**

3.7.2 Questionnaire: A self-administered questionnaire was used to collect quantitative data from nursing staff of each of the four RCFs. The questionnaire contained 25 items with three sections, containing both open and close ended questions **(see Appendix IV).** The questions aimed to provide information on the process and outcome of each RCF, from the perspectives of those who are directly involved in caring for the elderly. The first section was designed to provide demographic information such as age, gender, marital status and level of education of the nursing staff. The second section covered care and service delivery strategies and methods, while the third section covered staffs' experiences of caring for the elderly.

The elderly residents' instrument was directed at their health outcome, including their health status, quality of life and level of satisfaction. The instrument contained 13 items, which was divided into two sections. The first section dealt with demographic information of the elderly. Section two was the main interview schedule, directed toward the outcome of the elderly **(see Appendix IV).**

3.7.3 Facility record review checklist: The instrument for record review was a checklist that was designed based on the literature. It contained four columns, indicating the type of record, the availability, its purpose, topics and contents. A specification of the types of documents was made in the rows, when an allowance was made to write information gained on review of the documents **(Appendix VII).**

3.7.4 Observational checklist was used to capture unique data in a pre-specified and objective manner as some phenomena are best studied in their natural settings (Polit & Beck, 2004). Nursing staff members were observed while interacting with the elderly. The care giving environment was also observed as indicated in the checklist:

1. A description of the environment (single room, dormitory, other);
2. Characteristics of environment (tidy, dirty, other);
3. Caring interactions during activities of daily living (ADL) (feeding, bathing, dressing) interaction;
4. Communicating with the elderly;
5. Other: Specify **(Appendix VIII).**

3.8 Reliability and validity of data collection instrument

Research studies adopting a quantitative approach are guided by two scientific principles: reliability and validity, which are used to evaluate the instrument for data collection.

Reliability was defined by Creswell and Miller (2000) as the consistency of a measurement, or the degree to which an instrument measures the same way each time it is used under the same condition with the same subjects, or the repeatability of a

measurement. In order to address the issue of reliability, this study's questionnaire was piloted among the nursing staff (3 RNs and three care givers). The result showed that the care givers had difficulty responding to the questions. As the result, caregivers in all the RCFs were excluded from the study. The final instrument was produced based on the result of the pilot study. The pilot study was carried out to investigate the feasibility of the study and to detect any problems with the instrument for data collection in order to enhance its reliability (Creswell & Miller, 2000). The conceptual framework also served as a useful protocol to ensure that relevant concepts were addressed in each of the cases, thus enhancing the strength of the reliability of the study.

Validity Validity is the strength of the conclusion of the study, inferences or propositions. More formally, Cook and Campbell (1979) defined the term as the best available approximation to the truth or falsity of a given inference, proposition or conclusion. It refers to whether an instrument accurately measures what it is supposed to measure, given the context in which it is applied (Bless, Higson-Smith & Kagee, 2006). It is seen as a more complex concept that is generally concerned with the soundness of the evidence of the study, indicating, whether the findings are cogent, convincing, and well grounded (Cameron, Wise, & Lottridge, 2007). According to Yin (2003), the following three aspects of the quality of research design should be maximized in terms of validity: construct validity, internal validity and external validity.

Construct validity is the extent to which scores on an instrument reflect the desired construct rather than some other construct (Cameron, Wise, & Lottridge, 2007). The methodology chosen for this study provided a platform for its construct validity to be

ensured: the mixed of qualitative and quantitative methods. Secondly, through the technique of triangulation, the researcher ensured the use of more than one method of data collection: questionnaires, semi-structured interview schedule, on site observation and document review. The purpose of triangulation is to provide a basis for convergence of the truth by using multiple methods and perspectives to ensure a study's validity (Risjord, Moloney & Dunbar, 2001). Moreover, the researcher established a clear operational definition for each of the concept of the study in order to ensure and strengthen the consistency of the application of the concepts in each case study.

In discussing content validity, Bless, Higson-Smith and Kagee (2006) suggest that a researcher should link information and items to the theoretical components of the research topic with a view of providing some information on all its different components. Documents were used as secondary sources to supplement the data sources, and increase the comprehensiveness and validity of the study. The research instruments (qualitative and quantitative) cover all variables in the study appropriately and addressed the structure, process and outcome of the conceptual framework.

External validity refers to the generalizability of the research findings to other settings or samples. According to Risjord et al., change (2001), if a nursing intervention under investigation is found to be successful, others will want to adopt it. However, an important question is whether the intervention will work in another setting and with different patients. There are three major threats to external validity because there are three ways the researcher could be wrong: people, places or times (Bless & Higson-Smith, 2006). This study's researcher therefore ensured generalizations by conducting the

study in four RCFs, with different people (program managers, nursing managers, RNs, ENs, ENAs and the elderly), and at different times (days & nights) as well as on different days of the week: thereby ensuring the strength of the study's external validity.

3.9 Trustworthiness

The academic rigor of qualitative studies is measured by their trustworthiness, or by their being true to the data and their context (Polit and Beck, 2004). Trustworthiness is the procedure used by qualitative researchers to evaluate and qualify their data and findings. The potential strength of qualitative research may be lost if appropriate strategies are not followed to reduce careless handling of data and researcher's biases (Khalifa, 1993). According to Lincoln and Guba (1985), there are four criteria for establishing the trustworthiness of qualitative data: credibility, transferability dependability and confirmability.

3.9.1 Credibility is one of the processes through which qualitative data is evaluated, referring to the truth of the data. The researcher ensured credibility through data triangulation, peer debriefing, and the use of purposive sampling methods. The researcher utilized more than one method of data collection: questionnaires, semi-structured interview schedule, on site observation and document review, to provide a basis for convergence on the truth by using multiple methods and perspectives (Lincoln &, 1985). The researcher completed the data collection process and validated the accuracy of the data through the use of member check.

3.9.2 Transferability refers essentially to the generalizability of the data; that is the extent to which the findings from the data can be transferred to other settings or groups (Guba and Lincoln 1985). The researcher provided sufficient information about the phenomenon under study to ensure transferability and judgements about its contextual similarity while evaluating its applicability to other contexts. The study was conducted in four residential care facilities, with different people (administrative staffs RNs, ENs ENAs, and elderly residents) at different times (days & nights) as well as on different days of the week.

3.9.3 Dependability of qualitative data refers to the stability of data over time and over conditions. The research proposal was first scrutinized by the School of Nursing during the presentation for its validation and later approved by the UKZN Ethics Committee. Furthermore, the process of data collection, analysis and interpretation was monitored by the research supervisor and co-supervisor. Finally, the data and other supporting documents were scrutinized by external and reviewers chosen by the authority of the UKZN's School of Nursing.

3.9.4 Confirmability refers to the objectivity or neutrality of the data, so that there is agreement between two or more independent people about the relevance and meaning of the data (Polit & Beck, 2004). The focus of confirmability of qualitative data is on the characteristics of the data (are the data confirmable?). The researcher developed an audit trail in which audio recordings of the interviews and documentation (ethics clearance and letters of permission from the institutions where the study was conducted) are attached as

appendixes in this completed document. This was done so that the research supervisor and examiners (internal and external) would come to conclusion about the data. The transcript of the data was also preserved, together with the completed questionnaires as well as any other document that formed part of the data analysis for review.

3.10 Data collection

The data was collected by the researcher over the period of sixteen months (July 2008 – October, 2009). The method for the data collection was the same for the four RCFs: questionnaires, interview schedule, record review and observation. The researcher developed the following four-phase protocol in preparation for data collection as suggested by Yin (2003): overview of case project, field procedure, case study questions and a guide for the case study report.

3.10.1 Phase One: overview of case project

The researcher fulfilled this phase by first establishing a cordial working relationship with the administrative staff of the selected RCFs. The researcher initially phoned the administrators of each RCF and explained the nature of the study to them. This aimed to establish the initial relationship and solicit their interest in the study. Several other follow-up phone calls were made to maintain a relationship with the administrators and to keep them reminded about the research project. The researcher went further and made an appointment, and paid a one-day visit to each of these facilities. During the course of the visit, the researcher provided a face-to-face rationale for conducting the research and answered pertinent questions of concern to foster cooperation. Following that visit, the

researcher continued to phone the administrators, to keep them reminded of her and the project. The visit was also aimed to overcome the potential lack of cooperation, and prevent the probing-related threat that people providing care usually face during interview (Yin, 2003).

3.10.2 Phase Two: field procedure

The researcher went to the field and gained access to the "cases". She orientated the administrators of each institution and discussed the data collection plan with them before the actual data collection process began. The researcher also provided detail explanation of the data collection process to the nursing staff and the elderly residents, and clarified misconceptions. Before each interview, the purpose and objectives of the research were explained to the participants and the importance of their participation in the study was stated to them prior to the actual data collection. All the interviews were conducted by the researcher at the study setting, in environments that provided for privacy and quietness, free from distractions or interruptions.

3.10.3 Phase Three: case study questions

This phase involves those case study questions that reflect the researcher's line of inquiry (Yin, 2003). It involves two levels of questions: 1). Questions asked of specific participant (verbal line of inquiry) and 2). Questions asked of the individual case (mental line of inquiry). Level one question mainly involves the specific questions that the researcher will ask the participants in the field and level 2 involves the researcher's questions of inquiry. According to Yin (2003), explicitly articulating the level 2 questions

is of much greater importance than any attempt to identify the level 1 questions. To this end, the researcher developed questions to remind herself about the data she would collect and why. Those questions served as prompts during the interviews; to keep her on track during the data collection process. After each interview, the researcher thanked all the participants and wrote key points on each interview on the same day away from the interview scene, while the information was still fresh on her mind.

3.10.4 Phase Four: guide for case study report

Reporting a case study refers to bringing its results and findings to a closure. According to Yin (2003) this refers to identifying the audience for the report, developing compositional structure and following certain procedures (such as having the report review by informed persons who have been subject of the case study). The researcher is obliged to inform the participants about the research findings; therefore, a copy was given to each of the RCFs where the study was conducted. Moreover, two copies of the written report were submitted to the School of Nursing of the University of KwaZulu-Natal.

3.11 Data analysis

According to Yin (2003), this aspect of case study methodology is usually the least developed and hence the most difficult. He further suggest the possibility of integrating sampling with data collection and analysis, each informing the other in an ongoing manner. Thus, the data collection and analysis of this study occurred as an iterative process, wherein the researcher can moved from the literature and field notes, and back to the literature (Zucker, 2001). First, the data from each RCFs was transcribed and

organized into manageable format before the analysis. Data obtained through record review and observations were also analyzed in similar manner. Later, the findings were presented in a systematic case format according to the unit of analysis of this study and guided by the conceptual framework of the study.

3.11.1 Qualitative data analysis

According to Lacey and Luff (2007), there are no 'quick fit' technique in qualitative data analysis, because qualitative research is an interpretative and subjective exercise, and the researcher is intimately involved in the process, not aloof from it (Pope & Mays, 2006). Thus, the process of the data analysis began with transcribing the interviews from the four RCFs. At the beginning, notes made from each interview during and immediately after were reviewed and highlights or new concepts were identified. Information obtained through record review and observation was also analyzed qualitatively based on the framework provided and the literature. The participants for the qualitative data were the administrators and elderly residents of the four RCFs.

The qualitative data were analysed manually using the *"Framework Analysis"* approach developed by Ritchie and Spencer (1994) to assist qualitative researchers to arrive at the holistic and humanistic views of the findings of their studies (Lacey & Luff, 2007). This approach involves five distinct, but interconnected stages which include familiarization, identifying a thematic framework, indexing, charting and mapping and interpretation.

First, the interviews were transcribed and analyzed manually by assembling the transcript from each interview and utilized to form major themes and categories that emerged from the data according to the study's structure, process and outcome, in order to answer the original research questions. A thematic analysis of issues recurring in each study setting was done and emerging themes from various aspects of the data were conceptualized into meaningful themes on the basis of regularities and convergence in the data using the five stages of the framework approach (Ritchie & Spencer, 1994).

Five stages of framework analysis

1. **Familiarization** involves the whole or partial transcription and reading of the data in order to get an initial feel of the emerging themes and issues within the data.
2. **Identifying a thematic framework:** The initial coding and identifying key issues, concepts and themes and setting up a framework which is developed both from a priori issues and from emerging issues from the familiarisation stage which is developed and refined in subsequent stages.
3. **Indexing:** The process of applying the thematic framework to the data, using numerical or textual codes to identify specific pieces of data which correspond to differing themes (commonly called coding in other qualitative analysis approaches.
4. **Charting:** The process of using headings from the thematic framework to create charts of your data so that you can easily read across the whole dataset. The charts can either be thematic for each theme across all respondents and cases or by case for each respondent across all themes.

5. **Mapping and interpretation:** The charts are used as a means to define concepts, map the range and nature of phenomena, create typologies, find associations with the data provide explanations or develop strategies depending on either the emerging themes or on the original research question (Ritchie & Spencer, 1994).

The instrument was divided into two sections: the demographic section and the interview guide. The administrators' interview guide was focused on the structure, process and outcome of each institution. The structural section focussed mainly on background information about the organization and demographic information about the residents and nursing staffs. The focus of the process section was on approaches of care and service delivery to the residents, and the outcome focussed on the result of the process. The findings for each institution are presented in Chapter Four. The interview schedule was utilized to obtain rich descriptions of residential care for the elderly in individual one-on-one interviews. The instrument for the residents was also divided into two sections: 1) the demographic section and 2) Outcome of the elderly (the main interview schedule). The interview guide was also utilized to obtain rich descriptions of resident care outcome in those institutions from the perspective of the residents through focus group discussion and individual interviews.

3.11.2 Quantitative data analysis

Descriptive statistics were used to summarize the data obtained from nursing staff. Data obtained through questionnaires were analyzed using the Statistical Package for Social Sciences (SPSS 15.0) for Windows. The explorative and descriptive components of

specific aspects, including the close ended questions of the study were also analyzed in the same way. However due to the sample size, the results were displayed using descriptive statistics. The open-ended questions, document and record reviews as well as observations were analyzed using descriptive statistics.

3.12 Ethical considerations

Research is one of the key methods for producing valuable knowledge that has improved how healthcare providers and society understand the aging process, and disease associated with aging. Research also raises awareness on how healthcare providers diagnose and care for patients with geriatric syndromes, and how patients and healthcare providers appreciate the every presentation and care of diseases in geriatric patients (Goldstein, Sachs, & Mouton 2007). However, geriatrics research presents ethical challenges for the elderly due to issues of life limitations. For example physicians are usually challenged to perform procedures that require the use of surgical interventions due to their limited life expectancies, and the use of screening programs is also very limited due to their age (Lucente, 2009). In order to safe guard against elderly ethical dilemmas, the researcher ensured that various ethical considerations were put in place throughout all phases of the study to ensure that the rights of all the participants of the study were respected and protected. The principles of beneficence, respect for human dignity and justice were recognized and embraced throughout the research process. In addition, the prescribed standard for the Research Ethics Committee of the University of KwaZulu-Natal was applied in the relevant areas.

3.12.1 Ethics approval and permission to conduct research

The research proposal was submitted to the University of KwaZulu-Natal Research Ethics Committee for ethical approval and written clearance was obtained before data collection commenced. Permission to conduct the research was obtained from the four institutions where the research was conducted. A copy of the research proposal was submitted to the appropriate authorities requesting permission to conduct this research. When humans are used as study participants – as they always are in nursing research, care must be exercised to ensure that the rights of those humans are protected (Polit & Beck, 2004). For this reason, permission to enter the old age homes was sought from the person in charge as well as from the participants themselves. The participants were contacted from the four old age homes requesting their permission to participate in the study. A letter of introduction was read to them, stating the goals and objectives for the study. Following that, clarifications were made regarding participants' concerns. Those who volunteered to participate in the study signed the consent page of the letter of permission. Confidentiality was respected and the names of the participants are not mentioned anywhere in the written document.

Informed consent was sought from all the participants for the study. General information about the nature and the purpose of the study including the background and contact details of the researcher was included in the participants' information document. The researcher acknowledged that because of the opened, emerging and unpredictable nature of qualitative research, informed consent is complicated (Polit & Beck, 2004). As a way forward, consensual decision-making or process-informed consent was utilized and

consent was re-evaluated throughout the research process (Streubert & Carpenter, 1999). The participants were free to quit whenever they wished or not to answer any question that they felt were sensitive to them. The principle of beneficence was adhered to in order to prevent the participants from harm and exploitation. The purpose and contribution of the study was outlined to the participants.

3.13.2 Ethical considerations for vulnerable groups

Geriatrics research presents ethical challenges; therefore, the researcher used caution in conducting the research to avoid and prevent potential conflicts and promote trust in the research process. In each RCFs, the researcher contacted the RN/social worker in charge to request permission to interview the residents. Three of the facilities did not have a social worker. Instead, the RNs-in-charge granted permission and identify the residents that participated in the research. The residents who were too frail to withstand the stress of being interviewed or were mentally incapacitated were excluded from participating in the study because they could not fully understand the rationale for conducting the research.

3.12.3 Management of research data

The researcher followed the regulations of UKZN Ethics Committee recommendations to ensure that the data was managed ethically. In order to ensure the safety and integrity of the data, it is being kept at the School of Nursing in a locked place known to only the researcher and her supervisors before the result is published. When the research is in the public domain, the researcher will ensure that the data is available to other researchers

upon request, but it will be kept at the School of Nursing for five years after its publication. Following that, the researcher and her supervisors will destroy it.

3.15 Conclusion

This chapter provided a detailed description of the data collection process that was followed to achieve the study's purpose and objectives. The study was a descriptive explorative case study that utilized both quantitative and qualitative approaches to achieve the objectives. Details of the processes involved in an empirical study have been discussed in an attempt to give a systematic flow of information considering the purpose of the study. The information derived from the first part of the study was also presented to give an idea of the sample description and socio-demographic data. Ethical consideration was observed throughout the study as the nature of the study required an atmosphere of trust, openness and confidentiality.

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1 Introduction

This section presents findings from the case studies of four residential care facilities (RCFs) for the elderly in eThekwini Municipality in KwaZulu-Natal. The data were obtained through multiple data collection techniques, both quantitative and qualitative methods; the researcher gathered a variety of information about the research subject. Other sources of data were record facility review and observation of care interaction. The data was then combined to form a more comprehensive picture of the whole as discussed at length in Chapter Three. The study's conceptual framework guided the data analysis and reporting (Donabedian, 1966).

Qualitative data was obtained from administrative staff and elderly residents of each RCF through the use of semi-structured interview schedule. The framework analysis technique developed by Ritchie and Spencer (1994) was then utilized to analyse the qualitative data. Survey data was obtained from the nursing staff of each facility through questionnaires, and the data was analyzed using the Statistical Package for Social Sciences (SPSS version 15.0). Excerpts from the record review and observations were used together with other sources of information as supporting evidence. This chapter will review each case individually.

4.2 CASE ONE

4.2.1 Introduction

Case One, as described in Chapter Three, has a total number of 500 residents and 17 buildings. There are 374 staff members who provide care to residents. The research plan included interviews with administrators, residents and surveys with 10 nursing staff members (registered nurses and enrolled nurses). The researcher initially planned to include caregivers in the research. Three caregivers were then approached to participate by completing the nursing staff questionnaires; however, the caregivers were not able to answer the questionnaire due to their low level of knowledge regarding certain aspects of elder care. The caregivers were then excluded from the study in all the RCFs. Thus only a total of 10 nursing staff (3 RNs and 7 ENs) were included in Case One.

Permission to enter the RCF was obtained from the manager of the entire facility. The manager and the nursing administrator were interviewed together in the manager's office at their administrative building as per their request. Permission to audiotape the interviews was obtained before the one-hour interview. Once the interview was complete, the researcher interviewed residents of the frail care unit. The frail care unit is located on the first floor of one of the two-storey buildings of the RCF. The RN in charge of the frail care unit identified those frail residents who met the study inclusion criteria and also contacted the nursing staff who were directly involved in the care of the elderly in the frail care unit to participate in the study.

4.2.1.1 Findings from RCF administrators, confirmation from facility record and observation

The findings from the administrators of the RCF, record review and researcher's observation of Case One are presented in Table 4.1 below. Eight themes emerged from the data namely; assisting vulnerable people, confirmation from facility record, maintaining financial sustainability, staff-resident ratio, material resources, one big family, incidence of abuse, and strong bond.

Table 4.1: Findings from RCF Administrators, Record Review and Observation

Concepts from the Conceptual Framework	Emerging Themes	Data Sources
STRUCTURE **Facility Philosophy**	Assisting vulnerable people Confirmation from facility record Absence of quality indicators	Facility Record Interview Procedure Manual The Constitution
Human and Material Resources	Maintaining Financial Sustainability Staff-Resident Ratio Material Resources	Interview Observation of facility
PROCESS **Care and Service Delivery to the Elderly**	One Big Family	Interview Observation of facility Record review
OUTCOME **Success and challenges of the program**	Incidence of Abuse Strong Bond	Interview

4.2.2 Findings from the administrators

4.2.2.1 Assisting vulnerable people

Following the establishment of this non-governmental organization (NGO) in 1949, the management board of Case One adopted a constitution, which contains the mission and objectives of the facility. The facility also provides services in the area of frail care, counselling, and other related activities that address the social, health, economic justice, and other related issues. This is achieved on a daily basis during the care giving interaction between the nursing staff and the residents. Moreover, this facility provides training and technical support to partner NGOs and community-based organizations (CBO) in the skills they need to plan and implement effective community-based activities such as home-based care and HIV/AIDS nursing. These goals are achievable through the facility's nursing college.

The mission acknowledges the facility's primary stakeholders (the residents and their families, the staff, board of directors, donors, and the government of the country) and the responsibilities of the facility, such as dissemination of information, towards those stakeholders. The facility strives to be family-centered in that the family of each resident is recognized and respected by the facility, sharing with them information regarding the wellbeing of their family members who are residents of the RCF. Furthermore, the mission statement outlines the products and services that are offered by the facility and provides a method by which differences between the stakeholders within the facility and the community can be resolved.

Admission to Case One depends on the Department of Welfare's admission criteria known as the Dependency Questionnaire 98, commonly known as "DQ 98". In the South African communities, there are autonomous RCFs that are run by NGOs. Those facilities, like Case One, Two and Four determine their own constitution, but the Department of Welfare contributes to the care of residents in those facilities who are old and frail or have disabilities, in the form of subsidies. The DQ 98 is the tool used to monitor the admission and payment of these subsidies. Admission therefore depends on the person's age and dependency needs as well as their mental and physical disabilities, and not only on the medical diagnosis, social or health problems alone. Apart from the DQ 98 criteria, there appeared to be different admission criteria regarding people with psychiatric disorder. This is illustrated by one of the administrators;

> *We are not a psychiatric unit, so we won't take people that won't fit in here; the person with a psychiatric disability must also be fully stable on their medications before we can take you.*

The care of the poor and vulnerable also extends to their care after death. Each resident has a burial policy to ensure that once they die, money is available for a dignified funeral. Some residents come into the RCF with their existing policy, but for those who don't, the facility uses a portion of the residents' disability grant, frailty subsidy or old age pension in order to do so.

The administrators reported that the RCF did not have any formal quality monitoring system in place, except daily staff supervision of daily nursing care by senior and experienced RNs as indicated by the following quotation: *"we don't have such things, only basic nursing care plan".*

4.2.2.2 Confirmation from facility record

A review of the facility record confirmed that the disadvantaged, most vulnerable of that societies benefit from the activities of this facility. The mission included caring for people with physical and mental disabilities as well as homeless people. The documents further showed that there were two facility registers in use, one contained information regarding residents' names, date and time of admission, transfer or death, home addresses and contact persons' details. In the second register, staff signed against their names when they went to work each time. Additionally, there were admission checklist, procedure manuals, activity schedule and job description for each category of staff. Some of the procedure manuals or guidelines of each RCF were compiled and maintained by unit managers and RNs of the facility.

A review of the facility record and information from the interview further revealed that the facility did not have any quality indicators in place as suggested by the below statement: *"No we don't have such things, only policies basically just basic nursing care plan"*.

4.2.2.3 Maintaining financial sustainability

Maintaining financial sustainability of such facility is an enormous task, which is the burden of the administrator. Case One is partially subsidized by the provincial government of KwaZulu-Natal through the frailty subsidy. Thus, the facility has to attract additional sources of funding. Donations are a major part of its financial sources as well

as various fund raising activities like flea markets and jumble sales, etc. However, there is much difficulty due to increase donor fatigue and;

> *There is so much competition out there as a lot of people aren't interested in the elderly. (Nursing administrator)*

The training facility attached to the RCF also generates some income from student fees. The workforce of the facility was downsized in 2006 from 374 to 90 staff members due to financial constraints. This however, resulted in huge staff shortages, particularly on night duty, and temporary staff members had to be employed from out-sourced providers and the trainees from their nursing college can sometimes fill in the gap.

4.2.2.4 Staff-resident ratio

Within Case One frail care center, there were a total number of 17 staff members (7 in the morning, 7 in the afternoon and 3 at night) and 48 residents, although there is bed capacity for 58 residents. The nursing staff members were composed of three RNs, eight EN, six ENAs and student nurses. All of the RNs and EN completed grade 12 before their professional training, but some of the ENAs did not complete high school. This gives a current total of 5.67 nurse staffing hours per resident day. The number of the staff is sometimes increased by students from the facility's own training facility who work in the frail care unit when they are allocated there for a 3-month period and after that, they are allocated to other units. Students (approximately 4 or 5) from the University of KwaZulu-Natal Westville Campus also go to the frail care unit to complete their clinical hours, although they are not available everyday. With this additional staff, one of the

administrators said; *"...so I would say that the staff resident ratio is pretty high, about one to one".*

There were more female than male residents and according to one of the administrators, this is due to a higher mortality among the males compared to the females. As indicated by her, the reason for this disparity is that males die quickly due to depression. From her experience, she explained that males usually feel useful when they are able to provide for their families and become depressed when they are no longer able to fulfill this role.

In terms of age, it was reported that the residents of Case One are those individuals who are frail or aged, mentally and physically challenged of all age groups as the RCF is a care centre. The researcher also noted that the residents of the frail care were a mix of both the young and elderly. One of the administrators of Case One described the residents of the entire facility as being quite diverse;

> *Our youngest is about 6 years old; and last year, a lady passed away in November who was about 103 years old.*

All the racial groups of South Africa (Black, White, Indian and Colored) were represented in the frail care unit, but the most dominant group was Black. There were 23 Black South Africans (8 males and 15 females), 12 Whites (4 males and 8 females), 8 female Indians and 5 Colored women. The residents' marital status include engaged, single or widowed. Due to their age and level of frailty, the majority of the elderly were impaired in ADLs, while some of them had cognitive impairment.

The facility is currently in contact with one part-time psychiatrist who assesses and prescribes medications for the residents once in six months. Apart from that, there were no expertise services. Moreover, the facility does not provide any rehabilitation services, but the University of KwaZulu-Natal Westville Campus students usually provide some medical and rehabilitation (physiotherapy and occupational therapy) services for those residents needing expertise attention as part of their clinical experience hours.

From the researcher's own observation, every resident who required help was attended by at least one or two staff members during meals, and no resident was observed waiting for assistance.

4.2.2.5 Material resources

Case One is made up of 17 separate buildings namely 6 self-catering flats and 11 two-storey buildings for different categories of residents. Each flat has one room, one kitchen and a lounge. The monthly rent for each flat ranges from R 2, 600 to 4, 000 and the storey buildings have different rates as well. The frail care unit has 35 rooms: 1 large room with a 12-bed capacity for critically ill residents. It had minimal equipment including a blood pressure monitor and one portable oxygen tank. The room was attached to the nurses' station to ensure close observation and monitoring by the nursing staff. The nurses' station has two large glass windows overlooking the room in two directions. The room had few office equipment including one large table, five locked cupboards, one poison cupboard for scheduled medications, a fridge, and microwave. In addition, there was one appointment board where residents' scheduled appointments were written for quick

reference. There were notices displayed on another board, including memos and staff work schedule. Of the remaining 34 rooms, only six were not large enough for two beds. Eight children occupied one large room, and yet another room was used for lounge and dinning.

The care environment of the frail section was clean and safe for the residents. For example, the lights in all the bathrooms were adequate. Although there were bathtubs, the residents who bathed themselves used showers to prevent falls. There were adequate hand rails/bars in the bathroom areas and along all the stairs to prevent fall. Moreover, a lift was in place to ensure safety from one floor to another. There were no carpets on the floor.

Most of the mobility devices used by the residents like wheelchairs, crutches, canes or walking frames were mainly donations, while few of them were purchased by the facility. Residents who undergo hip replacement surgery get their wheelchairs from the hospitals where the operation occured. All medications for the recipients of either a disability grant or frailty subsidy of Case One were procured from government-owned pharmacies, but residents who have private doctors get their medications directly from private pharmacies.

The administrators reported that Case One has its own vehicle to take residents to hospitals for appointments, to collect their pensions or disability grants, for weekly visits to market places and elsewhere, and the elderly were always accompanied by escort

nurses. Each week, a nearby Church volunteer a vehicle to take the residents out for shopping and bring them back again. The RCF has contact with ambulance services in case of emergencies to transport residents to hospitals.

The nursing college attached to the RCF trains ENAs and Home-Based Care givers. The college is also the main provider of in-service training for the nursing staff in the RCF. Trainees learn to provide high quality and individualized care to the elderly, with the RN-in-charge of the unit sometimes doing the training. The nursing college attached to the RCF has several training manuals for their students, which are also used for in-service training.

The administrators reported the lack of resources and services for the elderly in hospitals as the most common challenge faced by the RCF. According to one administrator:

> *The biggest problem is the lack of services for them in the hospitals; they spend hours waiting to be seen. Many times, they are sent back without being seen and we've got to send them back the following day or so. You understand, when the clinic closes, the clinic closes.*

In the above section, the researcher presented findings of the philosophy of the facility under the following theme: "assisting vulnerable people" and "confirmation from facility record review" according to the structure of the study's conceptual framework. Findings from the human and material resources of the facility were also presented under three themes: "maintaining financial sustainability" "staff-resident ratio" and "material resources" based on the structure of the study's conceptual framework. The next section

presents findings of care and service delivery to the elderly, encompassing programme care and service delivery to the elderly.

THE PROCESS

4.2.2.6 One big family

The relationship between staff and residents was reported by the administrators to be like that of one big family. For example, the researcher observed that the sister-in-charge ordered a birthday cake for a resident who did not have any family member to give her a gift. On many occasions when the management team held social events at the RCF, it was reported that staff would visit, volunteering time to serve the residents. It was further reported that resident's families know the staff and vice versa. The administrators also reported that nursing staff members continued to work at the facility because they love their work. Staff members often went beyond the call of duty and were engaged in doing extra things for the residents, like painting their nails and styling their hair, indicating the close bonds between staff and residents as indicated by the following:

> *If you spend time on the floor, you actually find that certain nurses have their own mothers or their grannies and they see the other person like their mothers and grannies in the way that you normally find them doing extra for them.*

Many residents of the frail care unit were moderately to severely dependent on their care givers for different types of care including feeding, bathing and grooming. Although residents live together in the same building, the care was individualized as described below:

> *We have in general what needs to be done, but as it applies to each person, it changes.*

The researcher was present during many meal times where she observed how staff served each resident with much love and respect, and smiling faces. Those residents who could not feed themselves were always assisted by the nursing staff or a family member. Every resident was served and fed at the same time so none had to wait. The researcher did not observe any shouting or calling of names by the nursing staff while serving residents.

According to the administrators, the residents were very happy with the level of care that they receive and they usually expressed their gratitude to staff members through, hugs, kisses, letters and cards.

THE OUTCOME

4.2.2.7 Incidence of abuse

It was reported that this institution has not experienced any form of abuse due to policies regarding behaviors depicting abuse. The incident reporting policy showed that each staff member is required to sign an incident record indicating his/her involvement in a certain behavior contrary to normal. The above statement is supported by the following illustration made by one of the administrators:

> *We are very straight on that, we have what we call incidence report and we follow-up on any complaint that may lead to an abuse and anything like that. If we even suspect, that person is disciplined.*

4.2.2.8 Strong bond

The administrators reported that during the care giving process, a strong bond usually develops between residents and staff. However as the result of that bond, residents are usually unwilling to leave the RCF as supported by the following statement.

The family members and the residents actually don't want to go away even if they are ill they rather ask us to look after them up to the end; we even got people that have got cancer; they rather stay here, than go to the hospice.

In the above sections, the researcher presented findings of the care and service delivery to the elderly under the following two themes: "one big family" and "incidence of abuse". The researcher also presented findings of success and challenges of the program under one theme: "strong bond" in keeping with the outcome of the study's conceptual framework.

4.2.3 FINDINGS FROM THE ELDERLY RESIDENTS

Findings under the frail care unit of Case One included socio-demographic data and the main interview schedule. The findings followed the "outcome" of the study's conceptual framework. The data were elicited through demographic data and interview. Five themes emerged from the data: reasons for admission, interactive relationship, response shift, receiving visitors and satisfaction with care.

4.2.3.1 Findings from interview with elderly residents and observation

The demographic variables of interest were age, gender, cultural group and marital status. The ages of participants ranged from 60 to 85 years. In relation to gender distribution, four were females. Regarding cultural group, they were all from the white race, who were engaged and widowed. A summary of the qualitative findings are presented in Table 4.3. Four themes emerged from the data namely; perceived care giver stress, interaction with staff and residents, receiving visitors and satisfaction with care

Table 4.2: Interview with elderly residents and observation

Concepts from the Conceptual Framework	Emerging Themes	Data Sources
OUTCOME **Experiences of the Elderly**	Reasons for Admission Interactive Relationship Response Shift Receiving Visitors Satisfaction with Care	Individual interview Observation

4.2.3.2 Reasons for admission

The reasons for admission into the RCF were varied. One participant reported that she was staying with her brother and his family in the same flat and due to social reasons, she chose the RCF as a way of preventing perceived care giving stress as indicated by the following quotes:

> *My sister-in-law and my brother were also living in the house and they were having a baby, so they had to get up for me; so I said to them even before they had the baby, I think it will be better I stayed somewhere else because I knew it would be stressful to look after me and the baby at the same time. (By Participant #I)*

Two participants reported that they were staying in another RCF for younger people until they became senior citizens and they were asked to transfer to another facility as illustrated below:

> *I was transferred from Sherwood Center because I was too old to stay there. (By Participant #4)*
> *I was living at Wentworth, in a children's home and because of my age, I had to relocate here. At that time, I was still younger than 60 years. (By Participant # 5)*

Another participant reported that he lacked family support because his mother was too old to care for him, and his siblings were also busy working. One female participant reported that in the past, she lost her last child and that death overwhelmed her coping

ability. As the result, she was taken to Town Hill (mental health facility) where she stayed for many years, until she was discharged to the current RCF. Another participant reported that she was admitted due to her physical disability that her family could not cope with.

4.2.3.3 Interactive relationship

The participants reported that they were all happy at the RCF because the nursing staff members were always very good to them and assisted them with all their needs. While the researcher observed many positive interactions between the staff and the residents, one participant however had this complaint: *"They shout and scream; they are full of nonsense"*.

The participant further reported that their own attitude towards the nursing staff was generally friendly. Nevertheless, one of them stated that his attitude towards them was sometimes unfriendly as illustrated below:

> *I turn them off; I tell them if they don't stop I will sort them out, but sometimes I can talk to them nicely. (By participant #4)*

4.2.3.4 Response shift

Some participants reported that they suffer many health-related problems including inability to stand and walk. They also complained about having various medical conditions that require taking 4-5 tablets daily. However, the participants seemed to have accepted those conditions despite the seriousness. They appeared to have constructed

meanings from their health conditions, and seemed to have adapted to the changes in their circumstances, as depicted by one of the participants below:

> *My health is good, only that I suffer from blood pressure and my bladder is prolapsed.*

Despite their poor health, the participants reported that they were well taken care of by the nurses, and that their current health status did not in any way affect the care that they receive.

4.2.3.5 Receiving visitors

Most of the participants reported that they did not have any living siblings, although few of them still had some families alive. Some of them reported that they received many visitors weekly, while others got none. Many of the participants who reported having children also expressed regret that their children did not visit them as often as they expected. Receiving visitors seemed an important aspect of their wellbeing, as reported below:

> *I do not get any visitor; sometimes my one son and daughter come to visit, but other times they do not come at all. (By participant # 1)*

> *My brother visits me once every Sunday and I am happy. (By participant #2)*

Living away from one's biological family appeared to affect different participants in different ways. For some participants, living away from one's family of origin was acceptable as long as family members visited regularly;

> *I am happy to live away from my brother. As long as he sees me once a week on Sunday, it is fine and I am satisfied. (By participant # 2)*

One participant responded to living away from the family with tears: "*I miss them a lot. I have been crying for my sister many times". (By participant # 3)*

4.2.3.6 Satisfaction with care

Some of the participants reported they were satisfied staying in the RCF. Despite their current health status, many of them reported they were satisfied as long as they were visited by relatives or friends. However, one participant reported paradoxically that while she was not satisfied to live away from her family, she continued to reside in the current RCF because her fiancée who is also a resident of that RCF loves and cares for her:

> *I'm not satisfied, but I can't go away. All I've got is love and affection from my fiancée, and I get stuffs like coffee, biscuits, cakes or something like that from him.*

Most participants did not see the need for any changes to be implemented in the RCF because in their view, everything was just fine. However, some of them wished love and happiness for all, while those who ascribed to Christianity wished that every resident would go to Church.

The above findings were obtained of the experiences of the elderly under three themes, namely: interaction between staff and residents, receiving visitors and satisfaction with care. In the next section, the researcher presents findings of ten nursing staff who participated in completing the questionnaire on the quantitative aspect of Case One.

4.2.4 FINDINGS FROM NURSING STAFF

The following findings were obtained from ten nursing staff (3 RNs and 7 ENs) who participated in the quantitative aspect of Case One. The findings followed the "process" and "outcome" of the study's conceptual framework. The data were elicited through semi-structured questionnaire, comprising both closed and opened-ended questions. Data components include demographic data, caring for the elderly, professional knowledge about elder care and nursing experiences of caring for the elderly. Because the sample size was small, the researcher used descriptive statistics to present some of the findings in this section.

4.2.4.1 Demographic data of nursing staff

The demographic variables of interest were age, gender, marital status and level of education. The ages of the participants ranged from 30 to 50 years and above. 1 (One) participant was between ages 30 - 39; five were between 40-49 years; and four were 50 years and above. In relation to gender distribution, all the participants were females. With regard to marital status, three participants were married, four were never married, two were divorced and one was widowed. Six of the participants reported that they completed grade 12, while four did not, and two of them also had tertiary education in nursing.

4.2.4.2 Caring for the elderly

In this section, the nursing staff of Case One were asked six questions to determine the types of things that they do in caring for the elderly residents in this RCF. The first question was: What are the different methods and approaches that you use in the care and

service delivery to the elderly? The nursing staff reported that the principle element of caring for the elderly involved providing holistic ADLs and basic nursing care to them with respect. The second question: What strategies do you use to manage challenging behaviour such as aggression? They managed aggression in the elderly residents by first assessing the cause of the behavior to change the situation with love and respect; and remaining calm, while speaking clearly to them without aggression. Question three: How do you usually manage those elderly suffering from confusion? The management of elderly residents suffering from confusion involved making clarification and being patient as illustrated below:

> *Clarify any misunderstanding in a calm way, without rushing and talking to them like a friend.*

In question 4 and 5, the nursing staff were asked to determine whether they had skills in counselling and problem-solving and the findings of the closed ended questions were displayed in Table 4.4 below. In question 6, they were further asked to determine how problem-solving skills can help them in caring for the elderly with challenging behaviour and they reported that having problem-solving skills can help to reduce work stress, enhance better work production and helped staff to listen to the residents' problems and work with them to solve those problems.

4.2.4.3 Nursing staff self-reported knowledge about elder care

In this section, sixteen objective questions were used to determine if the nursing staff had knowledge regarding various aspects of elder care including medication management,

infection control, universal precautions, wound care, etc. Summary of the findings from the close-ended questions are presented in Table 4.3 below.

Table 4.3: Nursing Staff Self-reported Knowledge About Elder Care

Questionnaire items	*Yes*	*No*	*Total*
1. Do you have skills in counseling?	8	2	10
2. Do you have problem-solving skills?	8	2	10
Indicate your Knowledge about the following			
1. Medication management	7	3	10
2. Infection Control	9	1	10
3. Universal Precautions	7	3	10
4. Wound Care	9	1	10
5. Management of Incontinence	9	1	10
6. Prevention and management of pressure sores	10	0	10
7. Patient safety and protecting the residents from hazards	10	0	10
8. Preventing the residents from falls in RCFs	10	0	10
9. Nutritional needs of the elderly	9	1	10
10. How to connect residents to services	8	2	10
11. Rehabilitation needs of the elderly	7	3	10
12. The need for exercise for the elderly	9	1	10
13. Recreational need for the elderly	9	1	10
14. The need for respite care for elderly care givers	6	4	10
15. Palliative care and dying	9	1	10
16. Spiritual needs of the elderly	10	0	10

From the information presented above it is apparent that the nursing staff in this RCF reported very good nursing knowledge of the various aspects of elder care. It was however surprising to see that 3 out of the 10 nurses reported that they did not have skills in universal precautions.

The participants were further asked two open ended questions namely: 1). How did you acquire this knowledge? 2). How does the knowledge affect your care to the elderly? In response to the first question, the participants reported that they acquired the above

professional knowledge regarding the care of the elderly through experience, in-service training, during professional training and through working in the community with the elderly. In response to the second question, they reported that the above professional knowledge has affected their care to the elderly by giving them better understanding of the problems of the elderly and their needs, and the knowledge had further made them to become better care providers.

4.2.4.4 Nursing staff experiences of caring for the elderly

The nursing staff were asked to describe their experiences in caring for the elderly and the following themes emerged from the data. The participants reported that caring for the elderly residents was a challenging, but rewarding experience because the elderly usually need much of the caregivers' time, patience and engaging. One participant noted from her experience that old people like to eat meat and other things between their meals, but sometimes they do not have the money to buy what they like. Another participant reported that many elderly people sometimes behave like children and other times when they are depressed, they need love and reassurance. One participant also noted from her experience that there is a need to provide holistic care to the elderly as reported in the following statement:

> *One has to understand each individual and provide the necessary needs, medical, social and spiritual, mostly I feel good, sometimes sad and sometimes inadequate having not totally assisted the patient.*

4.3 CASE TWO

4.3.1 Introduction

Case Two is described in Chapter Three; it has a total of 300 residents and 150 staff members. It also has a total of 16 physical structures. The researcher entered the RCF through the social worker of the facility, who first linked her to the unit manager of the department where the research was conducted and later to the nursing service manager of the entire RCF. The researcher first interviewed the unit manager, but during the interview, it was noted that the unit manager lacked some vital information regarding certain aspects of the RCF. The nursing service manager was then interview to complete the missing information. Once that interview was completed, the researcher again requested the social worker to assist with identifying residents meeting the inclusion criteria to participate in the study. They were males and females, aged 60 years and above, mentally competent, who consented to the interviews before participating in the study. The social worker also put the researcher in contact with the nursing staff who were directly involved in the care of the residents.

4.3.2 Findings from administrators, confirmation from facility record and observation

The findings from the administrators of the RCF, record review and researcher's observation of Case Two are presented in Table 4.4 below. Twelve themes emerged from the data namely, assisting vulnerable people, confirmation from facility record, maintaining financial sustainability, staff-resident ratio, material resources, relationship

of control, caring for the elderly, incidents of abuse, retaining staff and maintenance of physical structure.

TABLE 4.4: Findings from RCF Administrators, Record Review and Observation

Concepts from the Conceptual Framework	Emerging Themes	Data Sources
STRUCTURE **Facility Philosophy**	Assisting Vulnerable People Confirmation from facility record Absence of quality indicators	Record Review Interview Information Document The Constitution
Human and Material Resources	Maintaining Financial Sustainability Staff-Resident Ratio Material Resources	Interview Observation of Facility
PROCESS **Care and Service Delivery to the Elderly**	Relationship of Control Caring for the Elderly Experiences of Abuse	Interview Observation of Facility
OUTCOME **Description of the successes and challenges of the program**	Retaining Staff Maintenance of Physical Structure	Interview

THE STRUCTURE

4.3.3 Findings from the administrators

4.3.3.1 Assisting vulnerable people

The mission, vision and objectives of the facility are centered on caring for vulnerable people, which includes children and the elderly, providing for their physical, social, medical, educational and spiritual needs in terms of the relevant Acts and Regulations of South Africa. The nursing service manager reported that the facility provides a safe,

loving and caring home for over hundred children who are orphaned, destitute, abused or neglected. The children are placed in family cottages (10 – 12 children in each cottage) that are run by house mothers to ensure a normal upbringing, which includes time for play and work.

A review of Case Two's information document showed that the children are encouraged to contribute to house chores including washing dishes, making up their beds, tidying the area around the cottage and making sure their shoes are clean for school in the morning. The mission and objectives further acknowledge the facility's primary stakeholders (i.e., the residents, their families, the staff, etc), and the responsibilities of the facility, such as disseminations of information, towards those stakeholders. The facility offers a comprehensive range of services such as occupational therapy, physiotherapy, psycho-psychiatric services and other paramedical services. It also strives to promote social well-being of all the residents and others while preserving their independence and dignity daily through the care giving interaction between the staff and the residents. Furthermore, it provides crèches nursery/pre-schools; adult and other educational/training facilities, preventative services, occupational training; and social and cultural opportunities for children and adults in need.

Admission to Case Two depends on the Department of Welfare admission criteria known as the "DQ 98", which is the tool that the South African government uses to monitor admission and payment of subsidies to frail residents in RCFs that are run by NGOs. The nursing service manager reported that residents are also admitted from various places;

> *We also take clients from all the other provinces, as well as from overseas; recently, we had two clients from India, who passed on a couple of months ago.*

Each resident of this RCF is expected to have a burial policy. But if a resident does not have a burial policy, it was reported that the home sometimes takes on a funeral policy for such residents using a small portion of their grant. When a resident dies, the families/relatives are expected to take the bodies and do their funerals at home. However, if the bodies are not claimed by their relatives, then it will be advertised in the papers for days. Following that, if there is no response, then the facility will carry out the funeral as described in the following quotation:

> *It is a small portion, sometimes R20 a month; so when they demise, we use that policy and we have our contact with the undertakers; normally they do a very dignified funeral in a special place where the nurses and all of us get together for that. (Unit Manager)*

The unit manager further reported that there is a formal orientation program for nursing staff currently in place. However, she indicated that the RCF did not have any formal quality monitoring system in place, but there were some technical qualities in place.

Record review showed that the facility's constitution was compiled and maintained by the board of directors. Other documents that were also available are protocols for infection control, admission, informed consent, death and burial, transfer, referral and discharge, etc. Activity schedule was displayed including meal time, medication schedule, social outings, religious meetings and bed time schedule. The protocols were compiled and maintained by unit managers and RNs of the RCF, as well as procedure manuals and guidelines.

4.3.3.2 Confirmation from facility record

A review of the facility's document showed that following the establishment of Case Two in 1921, a constitution was adopted to be the legal document and govern its

operations. Information from the administrative interviews and review of the facility documents confirmed that the emphasis of care is placed on it being a RCF for vulnerable people of all age groups.

The review of the facility's document and information from the administrative interview showed that the facility did not have any quality indicators in place as indicated by the following statement made by the nursing administrator. *"We have technical qualities in place"*.

4.3.3.3 Maintaining financial sustainability

Case Two is an NGO, but 45 – 50% of the running cost comes from the Welfare Department of KZN in the form of a subsidy. 10 – 15% (ten to fifteen percent) of the cost also comes from the patients' grant/subsidy/pension, and the balance 35% comes from a variety of fundraising activities such as an annual fair, meal donations, tin collection and the training facility attached to the RCF. The facility's rehabilitation services can sometimes generate some income for the facility from out-patient charges.

The nursing service manager further described the RCF's ability to attract donors and its current financial stability. He described how from the inception of the RCF, the organizers worked hard to attract donors, but now they are doing fine and donors are coming to them, although some of the donors have been falling short as described in the following quote:

> *From what we were, going out and begging from each home in order to take care of the residents, to now where people are coming in and offering their monies for us to keep and take care of the people, success is like far beyond...with the*

current inflation all the time, our funders are gradually dropping, but hopefully, this doesn't pose a problem to us.

Unlike employed staff, volunteer workers are not paid for the work that they do. However, the nursing service manager of Case Two reported that he usually compensates the volunteer workers by training them for free.

So I did the volunteer training myself for free for four months and then later, we came up with a certificate and full training; some of them were employed with us ... in fact, majority of them are employed with us as the years go by ... one good thing we also did was that instead of money, we offered some meals ... we offered some sandwiches and tea for them at our facility.

4.3.3.4 Staff-resident ratio

Case two has several departments, including nursing, administrative, physiotherapy, occupational therapy, speech therapy, psychology and rehabilitation center. The nursing department is further divided into the following units: medical or frail care, young and the elderly with physical and mental disability. The psychiatric or psycho-geriatric unit has those elderly with mental disability. The medical / frail ward is for those elderly residents with medical conditions like hypertension, diabetes, Alzheimer's and Parkinson's diseases, strokes, as well as the blind. There is another ward for the fit elderly who have passed the ages of 65 and 70, but are homeless; they are brought into the RCF either by friends or relatives. There is also a safe house, where women that have been abused either by their families or husbands go with their children, they stay until alternative arrangements are made for them.

This research took place in the medical / frail ward. Each ward has at least 50 patients, three RNs, eight ENs and 10 ENAs and 10 caregivers. The resident staff ratio on each

ward was 31 staff: 50 residents, which is actually 1:1.6 nurse staffing hours per resident day. The RCF reported having 150 nursing staff and 300 patients. Other staff were two psychologists, a physiotherapist, one speech therapist and an occupation attendant all employed on part-time basis. In addition, students from the training facility attached to the RCF usually provided some temporary care for the residents during week days as part of their practical experience. People from the community also volunteered their services in caring for the residents.

Majority of the residents were females, whose marital status ranged from married, widowed to never married. The physical and mental characteristics included people who were frail or old as well as people with physical and mental disabilities. According to the nursing service manager, the death rate of the residents was generally low, except during winter. *"When five or six death occur"*.

According to the nursing service manager, the facility offers a variety of excellent rehabilitation services to its residents. Several specialists were reported to be employed by the facility on part-time basis. For example, one doctor is available to see patients daily during working hours, and after hours he volunteers on call. The unit manager also indicated that all the residents are assessed, but emphasis is placed on those who are sick. Where patients require further medical intervention, they are encouraged to seek hospital treatment, but if the person declines, the nurse cannot use force. Two psychologists are available on request, while the physiotherapist is available only on Saturdays. The speech therapist also works on Saturdays and the occupation attendance is available on Saturdays

of each week. It was further reported that the rehabilitation services usually restore people with functional disabilities as illustrated by the following quotations:

> *There are many clients who have been rehabilitated through our physiotherapy services, and have gone back home to their families after they have had a stroke, and some kind of disability. (By the nursing service manager)*

The nursing service manager reported that there was increasing demand for residential care due to a lack of care givers in communities. To alleviate this problem, the facility is currently involved in training volunteers to become home-base caregivers in their communities, minimizing the number of people requesting residential care.

> *We actually train volunteers to become caregivers in the home-base care category; they are trained in order to go back to the community and take care of the people at home.*

4.3.3.5 Material resources

The administrator reported that Case Two has 16 physical structures, including one old age home for the elderly with physical and mental disabilities; a children's home that is attached to a crèche for children with and without physical and mental disabilities; a nursing college that trains ENs and ENAs; two cottages that are occupied by the CEO and the president of the facility; and 10 guest flats at times used by staff. It was further reported that most of the mobility devices like wheelchairs, crutches, canes or walking frames were donations, and few of them are purchased by the RCF. Most of the medications are purchased from a government-owned pharmacy and small amounts of medications are also obtained from other sources like state hospitals when residents are referred there for consultation. The RCF has a number of its own vehicles, including an ambulance service to take patients to and from hospitals.

The RCF nursing department has four wards and seven nurses' stations. The nurses' stations are enclosed by transparent glasses all around for maximum visibility, facilitating observation of resident-staff interactions. The wards are sub-divided into 11 open wards having 42-bedded cubicles and a few single rooms. Outside the wards were special rooms for different types of activities such as art and craft, which include bead work, sewing, knitting and crocheting. Another room is reserved for religious activities where Hindu priests visit residents and pray for them. A kitchen where all meals are prepared adjoins the dining room, a large single room, where all the residents' meals were served. The same room serves as a recreation centre, where staff and residents play games and watch video or television together.

Several measures were taken to ensure comfort for elderly in this RCF. For example, if any of them need clothing, the facility provides money for that; blankets and bed sheets are provided every two to three years, and mattresses are also changed on a four to five year basis. *"From top to bottom, whatever they need, they've got". (Nursing service manager)*

Social events are usually organized for the residents, especially for those who are not so frail. To minimize boredom, frequent activities include Churches, temples or shows, where residents sometimes get complimentary tickets. Due to their medical conditions, most residents were completely dependent on care givers for their ADLs need. For example, on many occasions, the nurses were observed assisting the frail elderly with bed

bath, doing pressure care, dressing and feeding them. During these interactions, the researcher observed a caring attitude displayed by the nursing staff.

The findings of the human and material resources of the facility were presented as three themes: "maintaining financial sustainability" "staff-resident ratio" and "material resources" according the structure of the study's conceptual framework. The next section presents findings of care and service delivery to the elderly, including the successes and challenges.

THE PROCESS

4.3.3.6 Relationship of control

Caring for people with physical and mental disabilities can pose challenges, and depending on the degree of the disability, the caring relationship can, sometimes become controlling to ensure comfort and safety of the elderly, as indicated in the following statement:

> *You need to take total control of them, bathing them cleaning them, feeding them, dressing them and making sure that they are well groomed. (Nursing service manager)*

The nursing service manager described resident-staff relationships as excellent. However, the relationship was likened to that of parent-child, instead of professionals and patients.

> *...so although we do our professional duties as required, but when it comes to interacting and talking to the patients, we do it on a very parental and child level. (Nursing service manager)*

The reason offered for this kind of paternalistic relationship is that most residents do not have any family support. On several occasions, the researcher observed some of the staff and the residents watching movies and playing games together just like a typical family. As the result, the nursing service manager reported that he was committed to caring for the elderly residents because its gives him fulfillment:

> *...I think taking care of the elderly is really a blessing to us in disguise, and I'm really dedicated to taking care of them. (Nursing service manager)*

4.3.3.7 Caring for the elderly

The researcher usually observed many residents in the office of the social worker discussing different issues. The social worker, together with the nursing service manager, plan social activities for the residents. The resident committee representatives usually attend weekly staff meetings, to ensure that the residents contribute to making decisions on issues that affect them as illustrative in the following sentences:

> *Representatives from this committee usually attend our staff meetings, but most of the time, the social worker and I sit and discuss with them to come up with solutions to their problems. (Nursing service manager)*

Four in-service training sessions are held each month to empower all the nursing staff to target individual needs of each resident. To enrich learning, the training college attached to the RCF usually conducts in-service training, whereby outside speakers are invited to speak on different topics.

Incidence of abuse

The nursing service manager did not report any recent case of abuse, however, two separate incidences of physical and emotional abuse by residents involving staff and other residents occurred long ago as reported in the following quotations:

> *...abuse from patient to patient is one common thing; we had two of such incidents about 10 years ago. One client assaulted another and the abuser was sent to Town Hill mental hospital. The second incidence was involved female resident who was physically and verbally abusive to all the staff and she was also sent to Town Hill; she was later discharged to her family; that client was demented. (Nursing service manager)*

The nursing service manager reported that the facility has an indemnity policy to ensure that staff and residents are liable for any deliberate, malicious or vindictive actions they take which may result in harm.

> *We have consent to sign by different categories of staff and residents that are admitted in order to protect the facility... example of such is patients who become violent and attack nurses or other patients, so, we get consent for those types of things to protect everyone.*

THE OUTCOME

4.3.3.9 Retaining staff

The RCF's ability to retain its staff during difficult times was reported by the nursing service manager to be one of its successes. The staff are loyal mainly is because the RCFs assists them in case of need;

> *At times when there is a strike and the hospitals have no staff, we usually retain our normal staff because during times of desperation we help them; when there is no transport, we pick them up from the surrounding areas; or when they do not have food, we provide them with hampers all the time.*

Finally, the nursing service manager reported that the residents usually express satisfaction with the level of care that the RCF provides. Resident satisfaction is evident in their willingness to help staff carry basic items things, like pushing trolleys and feeding patients who cannot feed themselves. The manager also reported that the board of directors is satisfied with the standard that is kept at this facility and their usual response to the staff is: *"...keep up the good work"*.

4.3.3.10 Maintenance of physical structure

In terms of challenge, it was reported that a lot of funding is required for running and maintenance of the RCF because the building belongs to the facility and it needs to be maintained.

In the preceding sections, the researcher presented findings of the care and service delivery to the elderly as three themes, "relationship of control", "caring for the elderly", and "incidence of abuse" following the process of the study's conceptual framework. Findings of the success and challenges of the program are also presented as two themes, "retaining staff"and "maintenance of physical structure" following the outcome of the study's conceptual framework. The next section presents findings from five elderly residents of Case Two also in keeping with the study's conceptual framework.

4.3.4 FINDINGS FROM ELDERLY RESIDENTS

Findings from five elderly residents of Case Two comprising socio-demographic data and data from interview are presented. A summary of the qualitative findings are presented in

Table 4.5. Five themes emerged from the data, namely: reasons for admission, interactive relationship, experiences of the elderly, psychosocial support and satisfaction with care.

4.3.4.1 Demographic data

The following findings were obtained from five elderly residents of Case Two. The findings followed the "outcome" of the study's conceptual framework. Data sources were demographic information and interview. The demographic variables of interest were age, gender, cultural group and marital status. The ages of the participants ranged from 69 to 80 years. In relation to gender, two were females and three were males. Regarding cultural group, they were all Indians, who were never married and widowed.

4.3.4.2 Findings from Interview with elderly residents and observation

Table 4.5: Interview with elderly residents and observation

Concepts from the Conceptual Framework	**Emerging Themes**	**Data Source**
OUTCOME **Experiences of the Elderly**	Reasons for admission Interactive Relationship Experiences of the elderly Psychosocial Support Satisfaction with care	Interview Observation

4.3.4.3 Reasons for admission

The reason for admission into the RCF was varied among participants. One participant said he was admitted after the death of his older brother, who had been his only source of support. He discloses:

> *I was staying with my brother and his wife, but after he died, his wife told me to come to this facility.*

Other participants reported that they previously stayed in assisted homes for younger people, but when they became senior citizens, they were asked to relocate to the current RCF. Multiple health-related problems were reported by many participants as a major reason for their admission such as poor eyesight, heart condition, shortness of breath, chronic fatigue, diabetes and arthritis. One participant reported that she was admitted due to lack of a family caregiver because her children live overseas; as indicated below:

> *I have been alone all the time; I decided to come live here because my children are overseas, four of them; I only got one daughter here and the family is getting too small now; so I don't have anyone to care for me.*

One male elderly resident wanted to stay away from his adult children because staying away from them gives him a sense of independence. Another participant reported that he decided to become a resident due to perceived lack of future caregivers because he thinks his children will not be able to look after him in the future when he will need people to care for him:

> *I decided to come here myself because nowadays children do not look after their parents. So I came here because my children are grown and they got to live their lives and I do not want to be a burden to anyone.*

Findings of the reasons for admission to the RCF were death of a brother, lack of support, growing beyond age limit, multiple and chronic health-related conditions, lack of family caregivers and the desire to gain independence from family.

4.3.4.4 Interactive relationship

Interacting with other residents was reported to be therapeutic for the elderly. One participant disclosed that such relationships can help residents to overcome their past experiences in order to embrace their current circumstances. She further explained that interacting with others can help residents learn from others' experiences with the view of overcoming personal shortcomings.

> *We join everyone; it keeps us going and we can forget the past; when you keep to yourself, you do not learn anything; that is why we are living here for. By getting together in groups, we joke, talk and we learn so much of things from each other.*

4.3.4.5 Experiences of the elderly

The participants reported good experiences of living in the RCF because they were well looked after by the staff. The researcher also observed that most of the residents looked happy and willing to participate in this study. However, some of them had some unique experiences. For example, one participant reported that sometimes the food is a bit too strong for old people probably due to a toothache or missing teeth. Another participant reported that he sometimes feels like going away from the current RCF because his roommate always mistreats him as illustrated by the following quotations:

> *I'm pleased to be here, but my roommate, you know, he is annoying. He is a little cheeky; he makes me feel like leaving and going somewhere else, you know.*

4.3.4.6 Psychosocial support

The participants reported several means of psychosocial support which they considered crucial to their well-being. For example, love and care by family was reported by one male participant, whose daughter is married with children, but stay in another province. According to him, his married daughter and her family love and care for him; always providing him emotional, financial and material support. Contact with people seemed important even if a resident does not have a family of origin. According to one resident:

> *I actually contacted a couple, a family, a husband and a wife and their two little kids; they came here to visit me, talk to me; the same couple invited me recently to their home when they were having a family reunion and they said I was a part of their family.*

Cell phones were also significant since residents use them to keep in touch with family and friends. A relationship with God gives some people a sense of spiritual support. One participant reported his desire to get closer to God as a means of spiritual support. *"I only look for the good in life and I want to get close to God".*

Another participant reported that he was once blind, but his sight was restored through spiritual healing which he described as "God's miracle". He further reported that the Hindu priest asked his parents to give him a new name and the name change effected the restoration of his sight.

4.3.4.7 Satisfaction with care

Four of the research participants reported that they were satisfied with the RCF, giving many reasons for their satisfaction. For example, one participant described her satisfaction in terms of attending high quality entertainment, and going out to visit places.

Another participant said he was satisfied with the RCF because it was more affordable compared to other places.

> *Today the cost of living out in the open place, I tried once and I failed; I am very thankful I have been accepted in this place and I like staying here; I will stay here until I die.*

Four participants did not see the need for any changes to be implemented because in their view, they were satisfied with the place as it was. However, one participant said he wished there were additional wheelchairs for those who had physical disabilities. Another participant wished there would be more outings for the residents.

> *They must take us more on outings, beaches, open picnics, and whatever; that is what I would like to have more.*

The above findings were obtained of the experiences of the elderly under four themes, "interactive relationship", "experiences of living in RCF", "psychosocial support", and "satisfaction with care". In the next section, the researcher presents findings on the 10 nursing staff who participated in the quantitative aspect of Case Two.

4.3.5 FINDINGS FROM NURSING STAFF

The following findings were obtained from 10 nursing staff (three RNs & seven ENs) who participated in the quantitative aspect of Case Two. Data was elicited using semi-structured questionnaires, composed of closed and opened-ended questions. The presentation includes demographic data, caring for the elderly, professional knowledge about elder care, and nursing experiences of caring for the elderly. Because the sample size was small, the researcher used descriptive statistics to present some of the findings in this section.

4.3.5.1 Demographic data of nursing staff

The demographic variables of the participants were age, gender, marital status and level of education. Their ages ranged from 30 to 50 years and above. Five participants were between ages 30 and 39 years; Four were between 40 and 49 years; and one was in the category of 50 years and above. All of them were females. Regarding marital status, five were married; two were never married and three were divorced. All of them completed grade 12, and three also had tertiary education in nursing.

4.3.5.2 Caring for the elderly

Six questions were used in Case Two to determine what nursing staff do to manage challenging behavior and confusion among the elderly. They reported supervision and assisting with ADLs as the focus of care. The strategies reported to manage aggression in the elderly were listening and speaking to them clearly, while reassuring and calming them down. Staff managed elderly residents suffering from confusion by repeating instructions and reassuring the elderly. One of the RNs summed up this approach as follows: *"...making clarifications, orientation and family involvement and trying to understand them"*.

The staff were asked to determine whether they had professional skills in counseling and problem-solving and how such skills could help them in caring for the elderly with challenging behavior. Summary of findings from the close-ended questions are displayed in Table 4.8. Having problem-solving skills helped nursing staff members to gain patients' confidence and trust. It also helped them to deal with the residents' problem and

not the behavior, thereby enabling them to understand the patients' needs and intervene properly.

4.3.6 Nursing staff self-reported knowledge about elder care

Sixteen objective questions were used to determine from the nursing staff of Case Two whether they had different levels of professional knowledge on elder care over concerns such as medication management, infection control, universal precautions, wound care, etc. Summary of findings from the close-ended questions are also presented in Table 4.6 below.

Table 4.6: Nursing Staff Self-reported Knowledge About Elder Care

Questionnaire items	*Yes*	*No*	*Total*
1. Do you have skills in counselling	5	5	10
2. Do you have problem-solving skills	10	0	10
Indicate your Knowledge about the following			
3. Medication management	10	0	10
4. Infection Control	10	0	10
5. Universal Precaution	10	0	10
6. Wound Care	10	0	10
7. Management of Incontinence	10	0	10
8. Prevention and management of pressure sores	10	0	10
9. Patient safety and protecting the residents from hazards	10	0	10
10. Preventing the residents from falls in RCFs	10	0	10
11. Nutritional needs of the elderly	10	0	10
12. How to connect residents to services	10	0	10
13. Rehabilitation needs of the elderly	10	0	10
14. The need for exercise for the elderly	10	0	10
15. Recreational need for the elderly	10	0	10
16. The need for respite care for elderly care givers	10	0	10
17. Palliative care and dying	10	0	10
18. Spiritual needs of the elderly	10	0	10

The above data presents evidence that the nursing staff in this RCF have very good nursing knowledge of the various aspects of elder care. Ten out of 10 nurses reported that they have the above skills required for the care of the elderly.

The participants were again asked the following two subjective questions: 1). How did you acquire this knowledge? 2). How does the knowledge affect your care to the elderly? In response to the first question, the nursing staff reported that they acquired the above knowledge through experience, as well as during their professional training, and through doctors and nurses. In response to the second question, the nursing staff reported that their professional knowledge had equipped them not only on the needs and beliefs of the elderly, but also on the ability to understand and respond to the changes that take place in the elderly resident's behavior.

4.3.7 Nursing staff experiences of caring for the elderly

The participants described their experiences about caring for the elderly in a number of ways. One of them reported her sad experience of how emotional it can be when a mother or father longs to see her daughter or son before passing away. Another participant reported how much the elderly residents at that facility can trust their caregivers. Their expectation in this respect, had changed her life, prompting her to strive towards excellence, as captured in these sentences: *"thus making me a more responsible and a better person."*

Nursing staff described the caring experiences as challenging, but at the same time service to the elderly brings fulfillment to the carers. Echoing the nurse above, this one confesses her vocation: *"it is challenging, but it makes me a better person at the end of the day"*.

4.4 CASE THREE

4.4.1 Introduction

Permission to enter the frail care was obtained from the nursing service manager (matron) of the frail care center. Following that, an appointment was made and she was interviewed in her office. The interview was successful, but the matron lacked some vital information about the care centre as well as the retirement home. Therefore another interview was conducted with the general manager of the retirement home to fill in the information gap. Because the residents of the care centre were very frail, they did not meet the inclusion criteria of the study and were therefore excluded. The nursing service manager therefore identified five residents who met the inclusion criteria from the retirement home to participate in the study. These residents were interviewed in a focus group discussion due to time constraint on their part. The matron also contacted four nursing staff: (three RNs and one EN) who participated in the quantitative aspect of the study. Case Three has a total number of 10 staff members and 16 residents. The RCF has only one building, adjoining the main retirement home.

4.4.1.1 Findings from RCF administrators, confirmation from facility record and observation

The findings from the administrative interviews, record review and researcher's observation of Case Three are presented in Table 4.7 below. Eight themes emerged from the data namely, assisting frail residents of retirement home, Confirmation from facility Record, maintaining financial sustainability, staff-resident ratio, material resources, being there, gentle restraint and description of care center.

Table 4.7: Findings from RCF Administrators, Record Review and Observation

Concepts from the Conceptual Framework	Emerging Themes	Data Sources
THE STRUCTURE **Facility Philosophy**	Assisting Frail Residents of Retirement Home Confirmation from facility record	Operational Manual Interview Observation
Human and Material Resources	Maintaining Financial Sustainability Staff-Resident Ratio Material Resources	Interview Observation
THE PROCESS **Care and Service Delivery to the Elderly**	Being There Gentle Restraint	Interview Observation
THE OUTCOME **Success and challenges of the program**	Description of Care Centre	Interview Observation

THE STRUCTURE

4.4.2 Findings from administrators

4.4.2.1 Assisting frail residents of retirement home

Evidence from the interviews and review of the facility's operational manual indicated that the purpose for establishing the centre was to provide emergency assistance, post operative and frail care to residents of the retirement home. The RCF catered for individuals who had developed some health-related problems, or have become frail due to the ageing process.

The mission statement guides the activities of the care centre and commits the staff to be totally dedicated to the wellbeing of the residents, doing everything possible to ensure

that they get the very best out of the home. The mission statement explains why the facility exists, and what it hopes to achieve in the future, which is to ensure quality care for the residents of the retirement village as well as those in the frail care centre. All the residents have insurance policies for burial. However, the beneficiaries (residents) of the retirement home are those elderly (60 years and above) who are fit and financially capable to buy flats from the village, and able to look after themselves, as seen in the quote below:

> *Prospective buyers have to be at least 60 years of age and above to qualify for residency and the prices to pay range from R600, 000 to R 1.800 000; they should be able to look after themselves, that is, they should be fit". (Manager of the retirement home)*

4.4.2.2 Confirmation from facility record

There were no formal documents other than registers for residents' data and nurses' daily attendance. The nurses recorded the progress of the patients in another book, but there were no quality indicators.

4.4.2.3 Maintaining financial sustainability

The matron reported that the frail care was financially maintained by the shareholders' monthly levies just like the retirement home.

> *This place is financially sustained by the people who stay here because they pay to be here ... a daily charge is levied to residents requiring accommodation in the care centre and is payable over and above all other levies. (Matron of Case Three)*

4.4.2.4 Staff-resident ratio

The total workforce of the care centre was reported to be 10 females, all of whom were full time employees, including one nursing service manager (the matron), three RNs, one EN, three ENAs caregivers in the day and two at night. The staff-resident ratio was estimated to be 10 staffs to 16 residents in the care center, which is 5 nursing hours per resident day. However, the center also caters for the other residents in the retirement home upon request.

It was further reported that the RNs and staff nurses completed high school prior to their professional training. In addition, the RNs had a four-year general nursing degree, including community and midwifery nursing. Besides the RNs, there were no specialized staff, but the residents had their own private doctors to whom they were referred in case of any complications. It was also reported that there were no formal staff empowerment or staff orientation program.

The age of the residents of the frail care centre ranged from 81 years to 94. Although the total capacity of the care center is 16 beds, there were six residents (three males and females) in the frail care at the time of data collection. It was reported that the home admits all cultural groups, but during the time of data collection, the researcher observed mainly White residents. There were three widows, one married woman and two widowers. One female was reported to have both Alzheimer's and Parkinson's diseases and the others were old and frail, without specific diagnosis.

The care center was observed to be clean and safe for the residents. For example, the lights in all the bathrooms were adequate, but most of the residents were too frail or sick to move around on their own. Due to their physical conditions, they were bathed in their beds.

4.4.2.5 Material resources

Data from the interview and the researcher's observation showed that the total capacity of Case Three was 16 beds. Most of the residents were frail and they were usually seen either lying down or sitting in wheel chairs. It was reported that most of the mobility devices like wheelchairs, crutches, canes or walking frames belonged to the individuals who used them, although a few of those devices belonged to the centre. Certain types of medications were purchased by the centre, but the rests were owned by the residents who procured them from private pharmacies through their private doctors.

The preceding section presented findings of the human and material resources of the facility as three themes: "maintaining financial sustainability" "staff-resident ratio" and "material resources" according the structure of the study's conceptual framework. The next section presents findings of care and service delivery to the elderly according to the process of the study's conceptual framework.

4.4.2.6 Being there

The nursing service manager reported that the relationship between the staff and the residents was cordial. On several occasions the researcher observed the staff and the residents in the common room watching TV together, although some of the residents were usually too weak to talk. However, the nurses never left them alone, rather, they were simply being there for them. This kind of interaction proved to the researcher that the relationship between the staff and the residents was cordial.

4.4.2.7 Gentle restraint

Staff members from the frail care centre were often requested to supervise medications and personal care for the residents in the retirement home. In case of violence, the staff used physical restraints to control the residents instead of medication as confirmed by the below statement.

> *We use gentle restraint for violent residents; we do not have any medication to subdue them; rather, we refer them to the hospital when there is a need.*

It was also reported that there has never been any known case of abuse in Case Three. The residents were satisfied, as reported by the RN, with their care and the staff members were also pleased, although they do not always talk about it. The researcher observed that both residents and staff members were well fed by the RCF. Moreover, the residents were always asked about their likes and dislikes. Furthermore, they were always included in areas of decision-making. They were always encouraged to go for a walk in the gardens to get some fresh air.

4.4.2.8 Location of care centre

The care centre was reported to be successful, but the nursing service manager did not like its location. She believed that an ideal frail care centre is a one which is open and well-lighted with lots of space for recreational purposes as reported below:

> *This place was not planned to be a frail care center because the place is enclosed; it is not an ideal place for a frail care.*

The findings of the care and service delivery to the elderly were presented as two themes: "being there" and "gentle restraint" following the process of the study's conceptual framework. The findings of the outcome of the program were also presented as one theme: "location of the care center". The next section presents findings from five elderly residents of Case Three following the outcome of the study's conceptual framework.

4.4.3 FINDINGS FROM ELDERLY RESIDENTS

The findings from five elderly residents of Case Three that include socio-demographic data and data from interviews are presented. Summary of the qualitative findings are presented in Table 4.8. Four themes emerged from the data, namely reasons for admission, interactive relationship, psychosocial support and satisfaction with care.

4.4.3.1 Interviews with elderly

These findings were obtained from five elderly residents of Case Three. Data sources were demographic information and interview. The demographic variables of interest were age, gender, cultural group and marital status. The ages of the participants ranged from

83 to 90 years. In relation to gender, there were two males and three females. Regarding cultural group, they were all whites who were never married and widowed. (See Table 4.8).

Table 4.8: Interview with elderly residents and observation

Concepts from the Conceptual Framework	Emerging Themes	Data Sources
Experiences of the Elderly	Reasons for Admission Interactive Relationship Psychosocial Support Satisfaction with RCF	Interview Observation of facility

4.4.3.2 Reasons for admission

The reasons for admission into the RCF were varied. For example, one participant considered the RCF while figuring out where he would be in the future, and who would look after him when he became old and frail. This decision was prompted by the death of his wife:

> *I was widowed and after 18 months, it seemed appropriate to come here because all of my families live in England; thinking ahead I felt it was time to make a decision when I could make a decision about where I would go to because I have no family here. (by participant #4)*

Two participants reported that they needed people to look after them in case of illness since they lacked family support. Another participant reported that although his family lives in Durban, he moved to RCF because the food is nutritional. Three of the

participants reported that they were healthy, but two reported a number of current health-related problems including deafness and bronchitis. Although the participants were aged above 80, they did not need anyone to look after them because one of the criteria for admission to Case Three is that the elderly person is fit enough to look after him/herself.

In the preceding section, findings of the reasons for admission to the RCF were presented as reported by the residents. The reasons for admission were thinking about the future, the need for carers in case of illness and good food.

4.4.3.3 Interactive relationship

Due to the physical conditions of the residents of the frail care centre, the researcher did not observe much resident-staff interaction, except when the staff were performing the following activities including bathing, dressing, feeding and assisting them with other basic ADLs. However in the retirement home, there were relatively more people-to-people interaction involving families, friends, loved ones and well wishers or visitors. There were also more sharing of fun and laughter in the retirement home, where the researcher observed a greater level of generosity. During data collection, the researcher noted that she was always served with food when the staff and residents were being served and she would decline and the usual response was: *"You are our guest"*.
That happened all the time when the researcher was present during meal times. On the other hand, the environment was clean and well organized all the time.

4.4.3.4 Psychosocial support

The participants reported several means of psychosocial support that are important to them. For example, receiving visitors was reported to be important to most of the participants. Some of them occasionally invited friends for visit and they sometimes share meals with them. One participant expressed that although she gets visitors, many of her friends have passed away and only few of them are still alive. Other participants reported that staying away from their families was not a problem because they always keep in touch by phone or letters. Those residents who did not have families see their friends as their own families, while those who have lived away from their families for a long time reported that they have lost the meaning of a family as conformed by the below statement. *"I've been away from family for so long and I almost forget what it's like"*

4.4.3.5 Satisfaction with RCF

Majority of the participants reported total satisfaction with the RCF. Some of them reported that being able to live independently was a source of happiness for them. Although satisfied, some residents had difficulty describing their own quality of life due to their current health-related problems, as evident below:

> *I don't know eh, no I don't know; we sound happy here, but I don't know, eh, whether I will be, I mean I have problems you know, as we get older we get more problems.*

The residents did not report need for any major change in the RCF, except for minor concerns as indicated by the following statements from residents:

> *I wish that some young people are introduced to the home.*
> *I would like to have a garage for my motor car.*

I would like to see some trees planted because we've lost 19 trees since I have been here.

The above findings were obtained from "experiences of the elderly" under four themes, namely, "interactive relationship", "psychosocial support" and "satisfaction with care". In the next section, the researcher presents findings from five nursing staff who participated in the quantitative aspect of Case Three.

4.4.4 FINDINGS FROM NURSING STAFF

The following findings were obtained from four nursing staff (three RNs and one EN) who participated in the quantitative aspect of Case Three. The findings also followed the "process" and "outcome" of the conceptual framework of the study. Semi-structured questionnaires combining both closed and opened ended questions were used to gather the data. The presentation includes demographic data, caring for the elderly, professional knowledge about elder care and nursing staff's experiences of caring for the elderly. The researcher used descriptive statistics to to describe and summarize the main features of the quantitative data.

4.4.6.1 Demographic data of nursing staff

The demographic variables of the participants were age, gender, marital status and level of education. The ages of the participants ranged from 30 to 50 years and above; one fell into the category of 30 - 39 years; one was between 40 – 49 range; two were 50 years and above. They were females who never married. Three of them completed grade 12 and 1

did not. In addition, one of them had a tertiary education in nursing. Three of them completed grade 12, and one also had tertiary education in nursing.

4.4.4.2 Caring for the elderly

The nursing staff of Case Three were asked six questions (subjective and objective) to determine the types of things that they do in caring for the elderly residents in this RCF. Question 1: What are the different methods and approaches that you use in the care and service to the elderly? In response they reported that they mainly assisted the elderly in providing for their ADLs and serving their medications. Question 2: What strategies do you use to manage challenging behavior such as aggression? They reported that they managed aggression in the elderly by being patient with them, talking with them politely, and explaining things to them in a way that they understand; sedating them; and leaving them alone until they can quiet down. Furthermore, they managed those elderly suffering from confusion by maintaining calmness and asking them softly as confirmed by the below statement.

> *Communicating with them softly, and asking them some questions about their families without aggression.*

The staff were further asked to determine whether they had professional skills in counseling and problem-solving. Table 4.12 displays findings of the closed ended questions. In response to how problem-solving skills could help them care for the elderly with challenging behavior, staff reported that they managed aggression in the elderly by being patient with them, talking with them respectfully and convincingly, sedating them and leaving them alone until they quiet down. Having problem-solving skills helped

nursing staff members to understand both the elderly and themselves in order to work more efficiently.

4.4.4.3 Nursing staff self-reported knowledge about elder care

The nursing staff of Case Three were asked the following sixteen objective questions to determine from them if they had different levels of professional knowledge about elder care including medication management, infection control, universal precautions, wound care, etc. Summary of findings from the close-ended questions are also presented in Table 4.9 below.

Table 4.9: Nursing Staff Self-reported Knowledge About Elder Care

Questionnaire items	*Yes*	*No*	*Total*
1. Do you have skills in counseling	3	1	4
2. Do you have problem-solving skills	3	1	4
Indicate your Knowledge about the following			
1. Medication management	4	0	4
2. Infection Control	4	0	4
3. Universal Precaution	3	1	4
4. Wound Care	3	1	4
5. Management of Incontinence	4	0	4
6. Prevention and management of pressure sores	4	0	4
7. Patient safety and protecting the residents from hazards	3	1	4
8. Preventing the residents from falls in RCFs	4	0	4
9. Nutritional needs of the elderly	4	0	4
10. How to connect residents to services	4	0	4
11. Rehabilitation needs of the elderly	3	1	4
12. The need for exercise for the elderly	4	0	4
13. Recreational need for the elderly	3	1	4
14. The need for respite care for elderly care givers	3	1	4
15. Palliative care and dying	4	0	4
16. Spiritual needs of the elderly	3	1	4

The above information suggests that the nursing staff in this RCF reported above average nursing knowledge on the various aspects of elder care. It was however note worthy, nevertheless, that two out of the four nurses reported they did not have skills in counseling, problem-solving, universal precautions, wound care, patient safety, rehabilitation, recreational needs and the need for respite care.

The participants were further asked the following two subjective questions: 1). How did you acquire this knowledge? 2). How does the knowledge affect your care to the elderly? In response to the first question, the nursing staff reported that they acquired the above professional knowledge regarding the care of the elderly through in-service training, experience and during their professional training. In response to the second question, they reported that their professional knowledge equipped them to look after the elderly and made treatment compatible and safe, thereby promoting better patient care.

4.4.4.4 Nursing staff's experiences of caring for the elderly

The participants described their experiences about caring for the elderly in a similar manner. They all reported the same ADLs experiences including walking some of them outside for fresh air and doing pressure care for them every two hours. The nurses further reported that for those elderly who were immobile, they (the nurses) spent time with them, and engaged serving them as summarized by one RN:

> *Sometimes you find difficulty in looking after the elderly, but at the end of it all, you get relieved because of the love for your job.*

4.5 CASE FOUR

4.5.1 Introduction

Permission to enter the RCF was obtained through the administrator of the entire facility, who first linked the researcher to the unit manager (matron). Later, the manager was interviewed in her office, but because she lacked some information regarding certain aspects of the facility, the administrator of the RCF was also interviewed to complete the mission information. Both interviews lasted for one hour each. Since the administrator was not a health practitioner, each interview complemented each other. Following that, the unit manager helped to identify those elderly residents who met the inclusion criteria to participate in the study. For the purpose of the qualitative aspect of the study, she also identified nursing staff who were directly involved in the care of the residents to participate in the quantitative aspect of the study. Case Four, which has a total capacity of 50 beds and 29 staff members, also has a total number of two buildings housing the RCF.

4.5.2 Findings from RCF administrators, confirmation from facility record and observation

The findings are presented in Table 4.10 below. Ten themes emerged from the data, namely: assisting the vulnerable, Confirmation from facility record, maintaining financial sustainability, staff-resident ratio, material resources, relationship of control, caring for the elderly, common religious belief, incidents of abuse, retaining staff and maintenance of physical structure.

Table 4.10: Findings from RCF Administrators, Record Review and Observation

Concepts from the Conceptual Framework	Emerging Issues	Sources of Data
STRUCTURE **Facility Philosophy**	Assisting the vulnerable elderly Confirmation from facility record	Interview
Human and Material Resources	Financial Sustainability Staff-Resident Ratio Material Resources	Interview Observation of facility
PROCESS **Care and Service Delivery to the Elderly**	Setting boundary with residents Medication Safety A common religious belief	Interview
OUTCOME **Success and challenges of the programme**	Resident satisfaction Procurement of Basic Medical Equipment	Interview

THE STRUCTURE

4.5.3 Findings from the administrators

4.5.3.1 Assisting vulnerable elderly

Case Four was established by a Church organization in 1996 as a NGO. Information from the interviews with the two administrators confirmed that the legal document is a constitution; and the emphasis of care is placed on assisting the vulnerable elderly (60 and above) of those with or without physical and mental disabilities from the local township. The administrator hoped that the home can be made available for all vulnerable elderly in the local community, but due to financial constraints, this has not been achievable:

we have difficulty in making it as successful as we would want it to be, but if we can get adequate funding, we can make it not only for the residents inside, but for those elderly that are outside in the township. (The administrator of Case Four)

4.5.3.2 Confirmation from facility record

The administrator reported that the facility has a constitution as well as many protocols and policies in place for running the facility, but the researcher was not permitted to have copies of those documents as illustrated below:

We have a constitution which has our aims and objectives, which guides us as to what we should do as an organization, but I need to get permission from my chairman before I can give any document to anyone.

Admission to Case Four was reported to be based on "DQ 98", a tool that the South African government uses to monitor admission and payment of subsidies to frail residents in RCFs that are run by NGOs. Residents who pass the "DQ 98" do receive a monthly frailty subsidy of R 2, 500.00 from the government and those who are not frail pay their pensions or disability grant monies to the RCF for residency.

Residents' death rate was reported to be generally low, and each resident had a funeral policy so that in case of death, the family of the person is notified to take care of the funeral. However, in case the person did not have a funeral policy, it was reported that the administration had made provision for such cases.

4.5.3.3 Financial sustainability

Case Four is also subsidized by the Provincial Department of Social Welfare as well as by it founder, the Anglican Church's Mother Union, but it also relies on external donations for its financial sustainability. In addition the facility is attached to a

multipurpose hall and the administrator reported that the hall is available for hiring. It was observed that the hall is quite large and ideally located, just beside the RCF, with about 700 to 1000 seating capacity. The hall is being advertised to raise additional income to keep the facility running. The facility has financial challenges, but despite those challenges, the administrator admitted that there is a way out of every situation as illustrated by the following quotations:

> *We find a way to solve our problems what ever it may be because even if it is financial, we are standing writing proposals to address the situation; there is no problem that cannot be solved.*

4.5.3.4 Staff-resident ratio

Case Four had a total workforce of 29 staff (one RN, four ENs and 10 ENAs, four kitchen staff, five volunteers, three laundry staff, one administrator and one secretary. The total number of nursing staff was 15 and five volunteers. The staff-resident ratio was 4 nursing hours per resident day. Most of the staff were reported to be females. In terms of qualification, it was reported that the RNs and the ENs completed grade 12 before their professional training, and most of the caregivers were below grade 12.

The total number of residents during the time of data collection was 40, but the total bed capacity is 50. Their age ranged from 60 years upwards; twenty four of them were females and 16 were males. It was further reported that the RCF admits people from all the racial groups of South Africa, but there were mainly black South Africans who were married, widowed or never married. Some of them had dementia and others had physical disabilities.

According to the RN-in-charge, Case Four offers physiotherapy services to its residents two times each month and plans were also underway to include other services. Medical service is provided by one general practitioner (GP) who usually goes to see the residents upon request by the RCF. However, the RN reported dissatisfaction regarding that service because whenever the GP is called, he wants to see more than one patient because he gets paid depending on the number of patients he sees. Therefore, when there is just one sick resident, it is difficult to call him as illustrated by the following sentences:

> *We have only one doctor who comes here when we call him; when he comes, he wants to see many residents because he's paid more for seeing more people. He does not like to be called for just 1 or 2 persons. (RN Case Four)*

The RN further reported that she usually conducts in-service training for the nursing staff in basic nursing skills like oxygen administration, BP checks, etc. She also does orientation for new staff.

4.5.3.5 Material resources

Data from the interview and the researcher's observation showed that Case Four has 2 physical structures, the main RCF and the administrative building that is attached to the multi-purpose hall. Within the administrative building, there are two offices that were being used by the administrator, one kitchen where the residents' meal is prepared, one laundry and storage facilities.

In the RCF, the residents stay together in large rooms. There were a total of 10 large rooms (4 single beds in each room), attached to the nurses' station. Six of the rooms are allocated to females and 4 are allocated to males. The nurses' station is a single room that

has one glass widow for visibility and observation. It had few basic office furniture including a table, few chairs, a wall clock, one portable oxygen tank, blood pressure monitoring equipment, etc. The nurses' station faces a large open area used as the TV/sitting/dining room, where residents and staff were usually seen watching television or interacting with each other, and where the meals were also served. The researcher observed in the nurses' station a register in which information about the residents including their names, date and time of admission, transfer or death, home addresses and contact persons' details were recorded. There was another register in which the staff signed upon arrival at work each morning.

Several checklists for different procedures were observed on the wall of the nurses' station, including house rules, fire evacuation procedures, glucose monitoring, management of fever, job description for the staff, etc. There were protocols for infection control, admission, informed consent, death and burial, transfer, referral and discharge. There was an activity schedule which was displayed including meal time, medication schedule, prayer time, bed time, etc. It was reported that these protocols were compiled and maintained by RN-in-charge and the other nurses, particularly the ENs.

All the mobility devices like wheelchairs, crutches, canes or walkers were reported to be donations. However, the residents who undergo hip replacement surgery get their wheelchairs from those hospitals. Esplemed, a government-owned pharmacy supplies all the medications for the recipients of grant or subsidy of this RCF. However, those residents who have private doctors get their medications from private pharmacies.

The care environment was observed to be clean and safe for the residents. For example, the lights in the entire RCF as well as in all the bathrooms were adequate. There were showers in all the baths for the residents to use instead of bathtubs to prevent falls. Hand rails were present in the bathroom areas to further prevent falls and support the residents as they walk around. The researcher was present during some meal times and she also observed that the residents were served with love and respect. Yet, she noticed that the RCF had serious financial deficiency. For example, the meals mainly consisted of carbohydrates like porridge (maize meal and potatoes), sometimes with and other times without any animal protein. Fruits and vegetables were usually missing from the menu, which was probably due to financial or other constraints.

The residents were served at the same time, but some of them had to wait. The researcher did not observe any shouting or calling of names by the nursing staff. There was no formal structure for monitoring quality of the residential care. The facility is connected to Prince Msheyeni Memorial Hospital and has contact with its ambulance services in case of emergency.

In the above section, the researcher presented findings of the philosophy of the facility under the themes, "assisting the vulnerable elderly" and "document review" according to the structure of the study's conceptual framework. The findings of the human and material resources of the facility were presented under three themes: "maintaining financial sustainability" "staff-resident ratio" and "material resources" according the

structure of the study's conceptual framework. The next section presents findings of care and service delivery to the elderly and success and challenges of the program.

THE PROCESS

4.5.3.6 Setting boundary with residents

The relationship between the staff and the residents was reported to be good, although sometimes it was challenged, particularly in the area of boundary setting. For example, visitors are not allowed in the residents' rooms because the residents stay together in large common rooms. Yet the residents always want to take their guests in their rooms, but the nurses are vigilant as indicated by the following quotations:

> *Sometimes they want to take their visitors in their rooms, but that is not allowed, the house rules stands. (RN of Case Four)*

4.5.3.7 Medication safety

The RN reported that medication safety was a critical issue in RCF. For example, she reported that the residents' medications are kept safely by the nurses to prevent medication-related problems as illustrated in the following quotations:

> *Some of the residents usually want to keep their medications, but we always refuse; we keep the medications for safety. (RN Case Four)*

4.5.3.8 A common religious belief

Elder abuse was reported to be uncommon in this facility because the staff and residents shared a common religious belief that enables them to resolve their differences and prevent abuse as reported by the following quotations:

We do not have elder abuse in this facility because most of them are Christians and they fall under the same category of religious group. So it is easy to find solution into their problems. (Administrator Case Four)

The administrator continued to report that the residents feel secured while they are in the RCF because many of them come from environment where abuse by family or friends was a common thing, but the facility was safe for all the residents.

THE OUTCOME

4.5.3.9 Resident satisfaction

Resident satisfaction was reported to be a major success for the facility. That is, there has neither been any negative report from individual resident nor from the residents' committee regarding anyone or anything wrong thing at any given time. This was reported to be something positive for the RCF. The below sentences are illustrative:

They are pleased with their services because what we do when we have the committee for the residence, which meets weekly, there is a report on any inadequacies or any incorrect things about food or about anything that is going on so that we are able to quickly identify the problems and address them. (The administrator of Case Four)

Resident satisfaction was reported to be a major success for the facility. That is, there has neither been any negative report from individual resident nor from the residents' committee regarding anyone or anything wrong at any given time. This was reported to be something positive for the RCF. The below sentences are illustrative:

They are pleased with their services because what we do when we have the committee for the residence, which meets weekly, there is a report on any inadequacies or any incorrect things about food or about anything that is going

on so that we are able to quickly identify the problems and address them. (The administrator of Case Four)

In addition, the administrator reported that the residents are humble people who are always thankful for all the services that are rendered to them. He further reported that although the salaries are low, the nurses were also satisfied and happy with their job based on the quality time that they spend with the elderly and their years of experience.

The board was also reported to be pleased about the quality of work being done by the staff and during the quarterly board meetings, the board members usually make innovative suggestions that will further improve the standard of the RCF;

Because most of them are professional people, they come up with ideas that can help to have this home running in a way that is the best possible way. (The administrator of Case Four)

4.5.3.10 Procurement of basic medical equipment

In terms of challenge, the RN reported that it is usually difficult to obtain some basic equipment like glucose monitor and others because they are costly. As the result, residents presenting with simple cases like hyperglycemia are usually referred to the hospitals where, according to her, the residents' conditions are not managed adequately:

Sometimes when there is a case of elevated blood sugar level, the residents are not properly managed by the hospital. (RN of Case Four)

The findings of the care and service delivery to the elderly were presented as 3 themes: "setting boundary with residents", "medication safety", and "a common religious belief" following the process of the study's conceptual framework. Findings of the success and

challenges of the program are presented as two themes: "success depends on funding" and "procurement of basic medical equipment" following the outcome of the study's conceptual framework. The next section presents findings from five elderly residents of Case Four following the outcome of the study's conceptual framework.

4.5.4 FINDINGS FROM ELDERLY RESIDENTS

The findings from five elderly residents of Case Four were obtained through the following demographic data and The summary of the qualitative findings are presented in Table 4.15. Four themes emerged from the data, namely Reasons for admission, interactive relationship, psychosocial support and well-respected.

4.5.4.1: Findings from Interview with elderly residents

These findings were obtained from five elderly residents of Case Four. Data sources were demographic information and interview. Demographic variables were age, gender, cultural group and marital status. Participants' ages ranged from 76 to 89 years. In relation to gender, there were three females and two males. Regarding cultural group, all the participants were indigenous South Africans. (See Table 5.11 below)

Table 4.11: Interview with Elderly Residents and Observation

Concepts from the Conceptual Framework	Emerging Issues	Data Source
OUTCOME **Experiences of the Elderly**	Reasons for Admission Interactive Relationship Psychosocial Support Well-respected	Interview Observation

4.5.4.2 Reasons for admission

The reasons for admission into the RCF were varied between the participants. For example, one woman reported that she lost her adult daughter and she was staying alone in her flat. Another participant reported that due to her cultural belief, she is not allowed to live in the same house with adult daughters when they are married as reported by the following statement:

> *It was my own decision to come here; you know, we the black people, we do not stay with our children when they are married; I had to think ahead that I was going to disturb my children ... so I had to come here.*

Another participant reported that she did not want to stay with strangers when her children were at work due to her past experiences with caregivers who were unkind to her as recorded in the statement below:

> *The servants used to leave me alone to go to town during the day when my children are gone to work; they will only return when my children are about to come from work, so I decided to come to the nursing home.*

In the preceding section, reasons for admission to the RCF were presented as reported by the residents. The reasons for admission reported were lack of a caregiver, cultural belief and fear of strangers.

4.5.4.3 Interactive relationship

The researcher observed some level of interaction among the nurses and the residents during the time of data collection. Sometimes the residents and staff were keeping conversation and other times they were watching TV together in the common room. Some other times the residents were doing just what they wished. One of the participants was always observed doing some bead works. The researcher bought some items from this resident after the interview was completed as a sign of appreciation for participating in her study. All residents reported that they were happy to be in the home due to the attitude of the staff and due to the physical environment of the facility as reported in the following sentences:

> *"I am very happy to stay in this home ... the baths are also very good".*

Moreover, the residents reported that they are well taken care of by the nursing staff and they were happy to be in the home. They further reported many health-related problems including arthritis, high blood pressure, fracture and difficulty to walk, but those conditions did not affect the quality of care that they received.

4.5.4.4 Psychosocial support

The participants reported several means of psychosocial support that were important to them including visit by family and friends. Some of them reported that they had very good family support system, although some of them did not have any family members. One participant reported that she considered the nurses to be her family because she did not have any biological family. Another participant reported that although staying in the home was very good, yet staying away from the family was not nice;

> *"...I remember especially my grand children; they are going to school and sometimes they are studying and they cannot come to see me many times ... so I need them".*

4.5.4.5 Well respected

The participants reported satisfaction with the RCF and described the reasons for their satisfaction. Two participants reported that they were satisfied because they were well respected by all the nurses as indicated by the following sentences:

> *We are well respected by everyone here; I am also very satisfied because I am the old mother here; there is nothing that is disturbing me.*

The participants reported that they were satisfied with everything and they did not want any changes to be made. However, one participant reported that at the end of each month, she would like to make arrangement with someone who would go to shop for her because she is unable to walk.

The above findings were obtained of the experiences of the elderly under four themes, "cultural belief", "interactive relationship", "psychosocial support, and "well respected

by nurses". In the next section, the researcher presents findings of five nursing staff who participated in the quantitative aspect of Case Four.

4.5.5 FINDINGS FROM NURSING STAFF

The following findings were obtained from five nursing staff (one RNs & four ENs) who participated in the quantitative aspect of Case Four. The data were obtained through the use of semi-structured questionnaires (closed and opened-ended questions). The presentation includes demographic data, caring for the elderly, professional knowledge about elder care and nursing experiences of caring for the elderly. The researcher used descriptive statistics to to describe and summarize the main features of the quantitative data.

4.5.5.1 Demographic data of nursing staff

Five nursing staff participated in answering the nursing staff questionnaires. One participant was between ages 40-49 years and 4 were 50 years and above. They were all females; three were married and two were divorced. All 5 of them completed grade 12 prior to their nursing training; the RN had a 3-year nursing training and the ENs had 2-year training.

4.5.5.2 Care and service delivery methods and strategies

The nursing staff of Case Four were asked six questions (subjective and objective) to determine the types of things that they do in caring for the elderly in this RCF. 1). What are the different methods and approaches that you use in the care and service to the

elderly? The nursing staff reported that the main care interaction with the elderly residents involved providing them with holistic patient and medical care. 2). What strategies do you use to manage challenging behaviour such as aggression? They managed aggression in the elderly by being firm and setting boundaries, including patience, speaking calmly, listening and making clarifications. 3). How do you usually manage those elderly suffering from confusion? For those elderly who become confused, the nursing staff managed them by making clarifications, orientation and seeking information about the cause of the confusion. In question 4 and 5, the nursing staff were asked to determine if they had professional skills in counselling and problem-solving, and the findings of those closed ended questions were displayed in Table 4.16. In question 6, the nursing staff were asked about how problem solving skill can help them to manage those elderly with challenging behaviour. In response, they reported that having problem-solving skills assisted them to understand themselves as well as the residents. It also gave them confidence as they provided optimal patient care.

4.5.5.3 Nursing staff self-reported knowledge about elder care

Sixteen questions were used in Case Four to determine from the nursing staff if they had different levels of professional knowledge about elder care including medication management, infection control, universal precautions, wound care, etc. Summary of the findings from those close-ended questions are also presented in Table 4.12 below.

Table 4.16: Nursing Staff Self-reported Knowledge About Elder Care

Items	*Yes*	*No*	*Total*
1. Do you have skills in counseling	4	1	5
2. Do you have problem-solving skills	4	1	5
Indicate your Knowledge about the following			
1. Medication management	5	0	5
2. Infection Control	5	0	5
3. Universal Precautions	5	0	5
4. Wound Care	5	0	5
5. Management of Incontinence	5	0	5
6. Prevention and management of pressure sores	5	0	5
7. Patient safety and protecting the residents from hazards	5	0	5
8. Preventing the residents from falls in RCFs	5	0	5
9. Nutritional needs of the elderly	5	0	5
10 How to connect residents to services	5	0	5
1. Rehabilitation needs of the elderly	5	0	5
2. The need for exercise for the elderly	5	0	5
3. Recreational need for the elderly	5	0	5
4. The need for respite care for elderly care givers	5	0	5
5. Palliative care and dying	5	0	5
6. Spiritual needs of the elderly	5	0	5

The above data shows that the nursing staff in this RCF reported very good nursing knowledge of the various aspects of elder care. It shows that five out of the five nurses reported that they had very good skills in the care of the elderly.

The participants were again asked the following two subjective questions: 1). How did you acquire this knowledge? 2). How does the knowledge affect your care to the elderly? In response to the first question, the participants reported that they acquired those different types of professional knowledge regarding the care of the elderly through experience, in-service training, during their professional training and through the church.

In response to the second question, they reported that the above professional knowledge assisted the nursing staff to understand how to provide total patient care to the elderly.

4.5.5.4 Nursing staff's experiences of caring for the elderly

The nursing staff described their experiences about caring for the elderly in different ways. Some of them reported that they used to fear people with dementia, but after many years of caring for the elderly, they now have confidence to continue caring for them. Another participant reported that the elderly are stubborn in their ways and one of them further reported that from her experience, some of the elderly live with regrets. Finally, two participants reported that many of the elderly need people to socialize and connect with.

4.6 Conclusion

This chapter presented findings of multiple case studies of four residential care facilities (RCFs) for the elderly in the eThekwini Metro Municipality in KwaZulu-Natal, guided by the structure, process and outcome of the study's conceptual framework. Data were gathered using mixed qualitative and quantitative method of data collection from eight administrative staff, twenty elderly residents and thirty nursing staff. Other sources of data include review of existing facility records and the researcher's observations.

Qualitative data were obtained from administrative staff and elderly residents of each RCF through interviews facilitated by semi-structured interview schedules that were prepared for the study. The framework analysis technique developed by Ritchie and

Spencer (1994) was then utilized to analyse the qualitative data. Emerging themes from the administrative staff and the elderly residents were also presented and excerpts from the document review and observations were used together with other sources of information as supporting evidence. Quantitative data were obtained through semi-structured questionnaires and analyzed using SPSS version 15.0. Discussion of the major findings are presented in Chapter Five.

CHAPTER FIVE: CASE STUDY REPORT

5.1 Introduction

Considering the changes that are taking place in societies, such as population ageing, HIV/AIDS, urbanization of young adults in search for jobs, singleness and lack of children, etc, it is envisioned that many old people will seek to be in residential care (Dobriansky, Hodes & Suzman, 2007). Thus, the need to ensure quality residential care for the elderly becomes a critical issue. The purpose of the study was to explore and describe residential care for the elderly in eThekwini Metro Municipality in terms of its residents, staff & organizational structure, and to determine how these factors could influence elder care. The ultimate goal was to make recommendations for residential care facilities for the elderly in the Municipality.

The report draws on the analyses of the findings from four residential care facilities (RCFs) in eThekwini Metro Municipality, which was aimed at highlighting the common features, similarities, variations, differences and uniqueness of each facility studied. It was guided by concepts from the conceptual framework of the study (Donabedian, 1966) and the emerging issues observed from the data of each facility. The data were collected from eight administrators and 20 elderly residents through interviews. The interviews were based on the structure, process and outcome of the study's conceptual framework (Donabedian, 1966). Thirty nursing staff of the four RCFs participated in the quantitative aspect of the study through questionnaires. Other data sources included existing records in the RCF's as well as the researcher's observations. The data was then analysed; Table 5.1 below illustrates the comparison of the finding from the four cases.

Table 5.1 Comparison of the findings from the four cases

Concepts from the Conceptual Framework	Emerging Themes Case One	Emerging Themes Case Two	Emerging Themes Case Three	Emerging Theme Case Four
STRUCTURE Facility philosophy	• Assisting Vulnerable people • Document review • Quality indicators • Admission criteria • Reasons for admission	• Assisting Vulnerable people • Document review • Quality indicators • Admission criteria • Reasons for admission	• Assisting frail residents of retirement home • Document review • Admission criteria • Reasons for admission	• Assisting vulnerable elderly • Document review • Admission criteria • Reasons for admission
Human and Material Resources	• Financial Sustainability • Staff-Resident Ratio • Material Resources	• Financial Sustainability • Staff-Resident Ratio • Material Resources	• Financial Sustainability • Staff-Resident Ratio • Material Resources	• Financial Sustainability • Staff-Resident Ratio • Material Resources
PROCESS Care and Service Delivery to the Elderly	• One big family • Incidene of Abuse • Care and Service Delivery Methods • Knowledge about elder care	• Relationship of Control • Incidence of Abuse • Care and Service Delivery Methods • Knowledge about elder care	• Being There • Gentle Restraints • Care and Service Delivery Methods • Knowledge about elder care	• Setting boundaries with the residents • Medication Safety • A common religious belief • Resident Satisfaction • Care and Service Delivery Methods • Knowledge about elder care
OUTCOME Success and challenges of the program Experiences of the Elderly Nursing staff's experiences of caring for the elderly	• Strong Bond • Reasons for admission • Interactive Relationship • Response shift • Psychosocial support • Satisfaction with care • Experiences of providing the care	• Retaining Staff • Maintenance of Physical Structure • Reasons for admission • Interactive Relationship • Experiences of the Elderly • Psychosocial Support • Satisfaction with Care • Experiences of providing the care	• Location of the Care Centre • Reasons for Admission • Interactive Relationship • Psychosocial Support • Satisfaction with RCF • Experiences of providing the care	• Success depends on funding • Procurement of Basic Medical Equipment • Reasons for Admission • Interactive Relationship • Psychosocial Support • Well respected • Experiences of providing the care

5.2 The Structure

The structure of any organization is its main foundation, and it plays a critical role in the realization of its goals and objectives. Donabedian (1966) describes structural measures of quality as the professional and organizational resources associated with the provision of care, such as staff components and the facility's operating capacities. The comparison of the findings on the organizational structure of the four cases is focused on two concepts from the conceptual framework and the emerging themes from the data: "facility philosophy" and "human and material resources" (See Table 5.1).

5.2.1 Facility philosophy

The purpose for establishing a philosophy for any organization is to ensure that the way the mission of that body is pursued is compatible with the organization's fundamental beliefs. Case One and Two have similar mission statements which focused on assisting vulnerable people in all age groups, including people with mental and physical disabilities, as well as the homeless. However, Case Two was unique because it also accepts people from outside South Africa, compared to Case One whose residents were all local South Africans. Case Two is predominantly Indian so it was not surprising that the RCF also accepts people from overseas, particularly from India.

Grundy (2006) defines vulnerable older people as those whose reserve capacity falls below the threshold needed to cope successfully with the challenges they face. The difference may arise either from severe depletion through lack of reserve resources, or from other particularly serious challenges. The definition of vulnerability, as explored by

Cattan, White, Bond and Learmouth (2005) takes into account the importance of preventing and alleviating social isolation and loneliness among older people. Grundy (2006) asks these questions: vulnerability to what? The obvious answer could be death, which is inadequate as death is inevitable. Instead, a multifaceted but specific conceptualization is employed, namely, vulnerability to a very poor quality of life, or to an untimely or degrading death (Grundy, 2006). As far as the definition of vulnerable is concerned, majority of the elderly in the four cases were vulnerable, specifically in terms of their health status. Most of them had a number of chronic physical and mental disabilities.

Case One and Two are attached to nursing colleges which train caregivers and support community-based organizations (CBO) in areas such as home-based and nursing care. The facility also offers a range of comprehensive rehabilitation services to the needy and provides adult education to its residents as well. Case Three's mission is to assist the residents of the retirement home when they develop some health-related problems or when they become frail. The mission of Case Four emphasized assistance to the community's vulnerable elderly aged 60 and above, either with or without physical and mental disabilities. From the researcher's observation and through the interviews with the administrators and the elderly as well as the findings from the nurses, each RCF tried to implement its specific philosophy of care to the elderly. That is, they tried to promote care through relationships that respect individuality, diversity, and honour to the whole person, body, mind and spirit (Case One & Two philosophy). Each facility also tried to support the residents to participate meaningfully in their own health and wellness.

5.2.2 Confirmation from facility record

Three of the RCFs had many checklists and protocols to guide their caring activities, but one of them did not have any written document. The RN-in-charge said that caring comes from the heart and does not require any formula. This is sometimes true, but the South African Department of Health (DOH) (2000) has emphasized that clinical practice guidelines are based on research and expert opinion for patient care in specifically identified areas needing clinical intervention in RCFs and other health facilities. They are helpful in directing care processes and guiding people in making personal evaluations of specific facilitities. In one study, Singh (2010) emphasized that using guidelines in RCFs is considered a first step toward ensuring quality nursing care. Thus standardized clinical practice guidelines can be integrated with assessment and care plans to improve care delivery in RCFs (Singh, 2010). The above statement is in line with the findings of the study, which also suggests the need for those RCFs that did not have protocols or guidelines to procure and use practice guideline as they are useful in the care of the elderly in RCFs.

The four RCFs have their own constitution, which are compiled by the board of directors and periodically reviewed by the same body. Documents that were available in Case One, Two and Four, included admission checklist, protocols for infection control, informed consent, death and burial procedure, transfer, referral and discharge, as well as various clinical procedures. These documents were compiled and regularly maintained by the unit managers and registered nurses (RNs) of each RCF. In Case Four, meal and medication schedule as well as social outings, religious meetings and bed time were displayed on the

wall of the nurses' station. These documents were generally for running the RCF, and not just for the care of the elderly.

In contrast, Case Three did not have any document or checklist for care of their residents. According to the RN in charge, the care provided to the frail elderly is based on their presenting symptoms and does not require a formula. Moreover, the researcher did not observe the nursing staff using any checklist or protocols in all the RCFs. However, most of the required procedures were carried out according to what was written. Based upon that, the researcher became convinced that with constant use, the staff had mastered those documents so well that they no longer had to constantly refer to them. The government of South Africa (SA DOH, 2000) has developed a policy on quality in health care in order to translate the constitutional rights and aspirations of all citizens into a strategic framework for practical action. The main objectives of the framework are to assure quality in health care and continuously improve the care that is being provided.

This document is relevant for the care of the elderly in RCFs since it became evident that the residents were provided accommodation in safe and a supportive environment that promotes and safeguards their well being and interest at all times. This is in keeping with the following key aims of the above policy:

- Addressing access to health care;
- Increasing patients' participation and the dignity afforded to them;
- Reducing underlying causes of illness, injury, and disability;

- Expanding research on treatments specific to the needs of South Africa and on evidence of effectiveness;
- Ensuring the appropriate use of health care services; and
- Reducing health care errors (SA DOH, 2000)

In the four RCFs, there were no formal quality indicators in place. When the researcher asked one of the administrators about quality indicators, she was told that there was only daily staff supervision by senior and experienced RNs. The administrators as well as the RNs did not understand the word, "quality indicators" and they did not know anything about their usefulness. Quality indicators (QIs) are markers of potentially poor or excellent health care quality. Nursing facility quality is multidimensional, encompassing clinical, functional, psychosocial and other aspects of residents' health and well being. According to Zimmerman (1997), multidimensional quality factors make it unlikely that a single measure would be capable of capturing every facet or change in the quality of services provided by a nursing home. They may include such elements as staff-resident ratio, mortality rates, avoidable complications, and various health care processes such as implementation of effective treatment protocols. In contrast, there were no observable quality indicators in this study. However, literature suggests that there are quality indicators in RCFs in some places overseas (Zimmerman, 1997; Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000). Moreover, the South African Department of Health (2000) had also endorsed quality indicators as useful in determining shortcomings in health care systems that could endanger the health and lives of all patients as well as residents in RCFs. Hence the health department proposes that the critical area of need

now is a national commitment to measure, improve, and maintain quality care for all its citizens (SA DOH, 2000).

5.2.3 Admission criteria

Admission to Case One, Two and Four depend on the disability questionnaire, commonly known as the "DQ 98", which the Department of Welfare uses to monitor admission and payment of subsidies to RCFs that are NGOs, which provide care for frail residents. Based on the researcher's observation and the data collected, the "DQ 98" is an effective instrument to screen prospective residents. The process is strictly controlled by the Department through its service offices and monitored by the sub-directorate to ensure that only those frail elderly who meet admission criteria benefit. Case One and Two admits people from all age groups, but for Case Three and Four only the elderly aged above 60 years for females and 65 years for males are admitted. In addition to the above stipulations, Case Three charges between R600, 000 to R1.800 000 for a flat/apartment, and prospective residents should be healthy enough to look after themselves. These stipulations follow this RCFs policy as a private facility.

In the four RCFs, the reasons for admission reported by the elderly were similar, but there were unique differences in each facility. In Case One, one elderly female with physical disability reported that she became a resident due to an anticipated problem she thought she could be to her brother and wife, who were her primary care givers as expressed in the sentences below:

> *My sister-in-law and my brother were also living in the house and they were having a baby, so they had to get up to help me ... so I said to them even before*

they had the baby, I think it will be better I stay elsewhere since I knew it would be stressful for them to look after me and the baby at the same time.

Perceived care giving stress has also been reported by some studies. For example, Buhr, Kuchibhatla and Clipp (2006) conducted one study in which they identified reasons for residential placement and examined the relationship between caregivers and their reasons for placement in RCFs. In that study, the reasons given for admission by the carers were significantly related to characteristics of caregivers and patients, which include care-giving burden and resident's physical and mental disabilities.

Factors that determine the use of residential care have been widely researched. For example, it is well documented that females, whites, and the frail elderly in the United States are more likely to be institutionalized than males, blacks and those elderly who are not frail (Gu, Dupre & Liu, 2007; Ness, Ahmed, & Aronow, 2004). Other studies also show that married persons, and those with a greater number of living children, are less likely to enter residential care than individuals with fewer family care-giving resources (Aykan, 2003; Vida, Monks and Rosier, 2002). In terms of health, functional dependency, cognitive impairment, and other physical ailments are often the leading risk factors for institutionalization (Gaugler, Duval, Anderson & Kane, 2007; Bharucha, Pandav, Shen, Dodge, & Ganguli, 2004; Miller & Weissert, 2000). A review of nearly 80 studies by Miller and Weissert (2000) revealed that age, race, disability, and cognitive functioning were the most robust predictors of institutionalization found in the literature. The above research findings are consistent with the findings of this study in that the reasons for admission reported were varied among study participants.

In East Asian countries, many old people are not admitted to residential care. The major reason is that filial piety is a commonly practice in those places, whereby frail parents receive care from their children (especially from daughters or daughters-in-law). Filial piety is a regulation that is enshrined in the constitution of East Asian countries that enforces the relationships between parents and children. "Parents are responsible to rear and educate their minor children, and when those children become adults, they are also responsible to support and assist their parents" (Article 49 of the 1982 Constitution of the People's Republic of China in (Chow, 2006). Research in these countries generally show that advanced age, females, the absence of a spouse, being childless and/or having small number of living children, are all strongly associated with the use of residential care (Kim & Kim, 2004). This trend is consistent with findings of this study in that some residents were residents due to age, separation from their family of origin, childlessness and absence of spouse.

Other reasons reported by the elderly in Case One were severe depression due to the death of a child, exceeding age limit in RCFs and lack of family care giving support. In Case Two, the reasons for admission included death of a primary family support, homelessness and chronic health-related conditions. Other reasons for admission were children living overseas, lack of future caregivers and the desire to live independently away from adult children. The reasons for admission in Case Three were: apprehension about availability of caregivers when old and frail; lack of family support in case of illness; fear of future eventualities related to ageing and availability of nutritional food. The researcher also observed that the food at that RCF was nutritional; it included a

variety of fruits and vegetables. Dietary variety is one of the most important ways to ensure a balance of nutrients for people of all ages, particularly the elderly (American Dietetic Association (ADA) Reports, 2003). Other studies have shown that the intake of nutrient is positively related to the number of different food consumed (Evans & Crogan, 2006; Bernstein, Clements, Evans, Tucker, Ryan, Nelson, Sing, Fiatarone and O'Neill, 2002). These authors found dietary variety to be associated with biochemical measures of nutritional status, including fewer cases of macro-vascular disease, decreased cardio vascular risk factors and obesity, due to increased consumption of fruits and vegetables. The above authors further found that consuming inadequate amounts of food may lead to lower pre albumin, poor nutrition status, which was linked to higher death rates in certain residential care.

In Case Four, among the reasons for admission reported were cultural belief and fear of strangers. According to one female participant, the Zulu culture forbids mothers to live in the same house with their married daughters: "*You know, we the black people, we do not stay with our children when they are married*".

Cultural beliefs and practices play significant role in health perception and health maintenance. Although a general understanding of cultural factors is important, the best source of accurate information about a person's belief and practices is that individual (Wold, 2004). Beliefs influence how health and illness are perceived. Thus, in order to effectively communicate with patients and their families, the nurse must take cultural variations into account.

Other reasons reported for admission to residential care was abuse by domestic workers as reported by one female participant from Case Four.

> *They had to get servants who were foreign people to take care of me. I cannot stand and I cannot get out, but they will say to me come and stand with me. They used to also go to town during the day when my children were gone to work. They will only return when my daughters are about to come from work. They used to leave me alone, so I decided to come to the nursing home.*

Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult. It was first described in British scientific journals under the term "granny battering" in 1975 (Baker, 1975; Burston, 1975). But it was the United States Congress that first identified it as a social and political issue followed by discussions in the literature in Eastern and Western countries (Choi & Mayer, 2000; Jamuna, 2003). Later, it was described by the World Health Organization (WHO) (2001 in Krug, 2002) as any violation of human rights and a significant cause of injury, illness, lost productivity, isolation and despair to the elderly.

In South Africa, elder abuse tends to also be a hidden and under-reported issue just like in many societies. There is no available and reliable data on the prevalence of elder abuse, nor any empirical studies on the health consequences and mistreatment of the elderly (Joubert & Bradshaw, 2003/2004). Similarly, relatively scanty knowledge exists on the situation of older persons in sub-Sahara Africa (Ferreira, 2005b; Velkoff & Kowal, 2003). Even though there are unreliable data on elder abuse in South Africa, Halt Elder Abuse Line (HEAL), a toll-free national help-line provides some evidence that elder abuse is widespread throughout this country (Joubert & Lindgren, 2003). Regardless of

its form, abuse is usually a hidden problem since both those abused and the perpetrators frequently feel ashamed and thus hide the incidents from investigators. The findings of this study concur with the literature in that in each of the RCFs, abuse was reported by only one resident.

5.2.4 Human and material resources

5.2.4.1 Maintaining financial sustainability

Many RCF's have difficulties in remaining financially viable and that they have to struggle on a yearly basis to make enough money to keep the facility running. This was also the case with the RCFs that participated in this study. Case One, Two and Four had some staff members who were responsible to fundraise for their facilities. Case Three is a private entity that is financially sustained by the residents' monthly levies. Case One, Two and Four are partially subsidized by the provincial Department of Social Welfare, while they also depend on donations from national and international donor organizations for financial sustainability. Case Four is also financially supported by a local Church within the community. However, the main sources of funding for Cases One, Two and Four are various fundraising activities. Although the three RCFs are involved in fundraising activities, it is still very difficult to access sufficient funds as very few people are interested in donating money to the elderly. Moreover, donor organizations prefer to give funds towards HIV/AIDS programs rather than to organizations for the elderly. Other sources of income in Cases One and Two were school fees collected from the facilities' training colleges, respectively. In addition, Case Two generate additional income through its rehabilitation services.

To cut costs in 2006, the number of staff in Case One was downsized from 374 to 90. This huge staff reduction impacted particularly on night duty personnel. However, the same number of staff were then re-employed from out-sourced providers. This initiative helped the facility to save on insurance and other staff-related costs. Outsourcing staff is an initiative that can help many organizations to reduce their operational cost. Erber and Sayed-Ahmed (2005) outlined a number of advantages of outsourcing staff, and the primary benefits are to cut-cost and hire expert professionals to help run a business. In addition to cost reduction, out-sourced staff can offer benefits to customers at lower costs on goods or services, and enhance economic expansion that has the potential to raise productivity and job creation. Holcomb & Hitt (2007) also found contracting outside performance as a means to increase efficiency in institutions. Some of the out-sourced employees reported that initially, they were apprehensive in terms of their job security because the current facility is not their employer. However, with time, they were satisfied with their jobs which offered better opportunities for them to build their careers through the nursing college of the RCF, compared to their previous jobs.

5.2.4.2 Staff-resident ratio

The human resource of any organization represents the staff who operate that organization. Case One frail care had a total of 17 staff members including three RNs, one EN, 13 ENAs and student nurses, and 48 residents. However, the total bed capacity was 58 residents, this gives a current staff resident ratio of 1: 2.08 or 2.83 nurse staffing hours per resident day. In Case Two, the medical / frail ward where the research was conducted had 50 elderly residents, 31 staff members, including three RNs, eight ENs and 10 ENAs and 10 caregivers. The staff resident ratio on each ward was 31 staff: 50

residents, which was equal to 1 staff: 1.6 residents or 4.56 nurse staffing hours per resident day, respectively. In Case Three, there were 10 staff members who were all females, including one nursing service manager (Matron), three RNs, one EN, three ENAs in the day and two at night. The capacity of the care centre is 16 beds, which presents an estimated staff resident ratio of 10 staffs to 16 residents in the care centre or five nurse staffing hours per resident day. Case Four had 29 staff members including one RN, four ENs and 10 ENAs, four kitchen staff, five volunteers, three laundry staff, one administrator and one secretary; 20 nursing staff (15 employed staff and five volunteers), who were mostly females. There were 40 residents during the data collection period, with a total bed capacity of 50, which, when calculated, puts the current staff resident ratio of one staff to two residents, to eight nurse staffing hours per resident day.

In Case One, all of the RNs and EN completed grade 12 before their professional training. Students from the facility's own training facility sometimes work in the frail care unit when they are allocated there for a 3-month period. Students (approximately five) from the University of KwaZulu-Natal Westville Campus sometimes go to the frail care unit to complete their clinical hours (at lease 2-3 days each week). Apart from that, there were no specialized practitioners. In addition to nursing care for the residents, in Case Two, doctors are available daily and para-medical services, such as speech, occupational therapy (OT) and physiotherapy are also available. According to the RN-in-charge, students from the training facility usually help to care for the residents during week days as part of their practical experience. People from the local community (mostly women) also volunteer to care for the residents.

All the RNs and staff nurses of Case Three completed high school prior to their professional training. In addition, each RN had a four-year general nursing degree, including community and midwifery nursing. Besides the RNs, there were no specialized staff. Case Four had only one RN. Physiotherapy services were available to residents twice monthly and medical service was provided by one government employed general practitioner (GP).

The provision of quality service seems to be a concern for every RCF. For instance in 1987, the United States Congress passed the Nursing Home Reform Act in order to improve the quality of care in nursing homes, so that any RCF wishing to be certified for participation in Medicare or Medicaid provides a minimum of eight hours per day of registered nursing (RN) service and 24 hours per day of licensed nursing (LN) service. According to Dorr, Horn, Randall and Smout (2005), staff-resident ratio is one of the issues of greatest importance in health care. However, the South African Older Persons Act (2006) does not mention anything about resident-staff ratios. Yet, research reports from the United States and Australia have shown that having low ratios of staff is associated with poor quality care (Schnelle, Simmons, Harrington, Garcia, & Bates-Jensen, 2004; Unruh & Wan, 2004; Zhang, Unruh, Liu & Wan, 2006). The specific means by which health care is reformed varies from one facility to another, but in relation to the global health care system, Zurn, Dal Poz, Stilwell Adams and Buchan, (2004) conclude that increasing staffing level in RCFs is essential to maintaining quality and efficiency for stakeholders. None of these sources recommended a specific nurse-resident

ratio, but WHO (2003), has endorsed that an effective staff-resident ratio will play a vital role in the success of RCFs as well as other facilities.

The relationship between nurse staffing levels and the quality of nursing home care has been demonstrated widely (Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000; Schnelle, Simmons, Harrington, Garcia, & Bates-Jensen, 2004; Unruh & Wan, 2004). Nurse staffing ratio has received lots of attention as a solution to improving residential home care quality (Harrington, Kovner et al., 2000). To control cost and improve efficiency, RCFs needs to decide on possible minimum staffing levels for providing quality care in their facilities. However, one of the difficult areas has been establishing evidence-based minimum staffing ratios. Assuming that increasing nurse staffing levels facilitates enhancement of the outcomes of nursing home care, identification of recommended nurse staffing levels becomes very important.

As indicated in Harrington (2001), the United States federal Nursing Home Reform Act (NHRA) of 1987 required minimum staffing levels for registered nurses (RNs) and licensed practical nurses (LPNs); and it also required a minimum educational training for nurse's aides (NAs). The NHRA requires Medicare and Medicaid certified nursing homes to have an RN as director of nursing (DON), an RN on duty at least eight hours a day and seven days a week. On the contrary however, one of the nursing homes where this research was conducted did not have an RN as its director. The NHRA further requires a licensed nurse (RN or LPN) on duty the rest of the time and a minimum of 75 hours of training for nurse's aides, which was the same in all the RCFs of this study. The law allows the DONs to also serve in the capacity as the RN on duty in facilities with less

than 60 residents. Moreover, the law requires residential facilities to provide sufficient staff and services to attain or maintain the highest possible level of physical, mental, and psychosocial well-being of each resident (Harrington, 2001; OBRA, 1987). Total licensed nursing requirements converted to hours per resident day (HPRD) in a facility with 100 residents are around 0.30 HPRD (Harrington & Millman, 2001), or 30 hours per day. Harrington (2001) further indicated that despite setting a precedent, the Act does not provide specific nurse-to-resident staffing ratios for RNs, LPNs, or NAs, and does not require any minimum level of staffing for NAs. Rather, it instructs that "sufficient" staff be provided, and the fact that a facility of 50 residents has basically the same staffing requirements as a facility of 200 indicates the lack of specificity and adequacy of these federal requirements (Zhang, Unruh, Liu & Wan, 2006). This statement is consistent with the findings of the research because the researcher did not see any specified or standardized staff-resident ratio in the four RCFs.

Evidence from the data collected and the researcher observation confirmed that three of the RCFs had sufficient nurses including RNs, ENs, ENAs, etc, except for Case Four that had only one RN. Yet, there was no standard national staff resident ratio, but the highest overall staffing requirement in the United States was found in California, at 3.2 RN hours per resident day, excluding administrative nurses (Harrington, 2001).

The researcher did not find any data stipulating how to calculate residential staffing levels for residential care facilities in South Africa. However, the United States federal government requires that staffing levels can be calculated using the following information provided by Minimum License Nurse Requirement (Undated):

Step 1: Determine the midnight census for the date the shift begins.

Step 2: Divide the census by the ratio of direct-care staff required for the shift being computed.

The result will determine the total number of direct-care staff required for the shift.

Step 3: Divide the census by the required ratio of licensed personnel for the shift being computed. The result will be the total number of licensed direct-care staff required for the shift.

Step 4: Subtract the results of Step 3 from the results of Step 2. The calculated figure will be the total number of remaining direct-care staff required for the shift.

The document suggests that the sum of all the calculations shall be carried to the hundredth place. If the computations result is other than a whole number of direct-care staff for a shift, then the number shall be rounded up to the next whole number when the computation, carried to the hundredth place, is fifty-one hundredths (Minimum License Nurse Requirement, Undated).

5.2.4.3 Material resources

Material resource refers to the property or financial resources of any organization. It is a critical component of the structural input of any organization (Donabedian, 1980), and it plays a significant role in the quality of service provision as well as in the long-term sustainability. Case One has 17 buildings including six self-catering flats and 11 two-storey buildings for different categories of residents. Case Two has 16 buildings, which includes one old age home, one children's home which is attached to a crèche, one

college that trains ENs and ENAs, two cottages which are occupied by the CEO and the president of the organization and 10 flats. Case Three has only one building and the second building was the retirement home. Case Four also has two buildings. The data collection setting in Case One was situated on the top floor of one of the two-storey buildings and a lift was in place to ensure safe movement from one floor to another to prevent falls.

In Case One, Two and Four, most of the wheelchairs, crutches, canes or walking frames used by the residents were donations, with a few being owned by the RCFs. Case Four had shortages of certain mobility devices (wheel chairs) as well as some medical equipment such as glucometer, and the administrator was trying to attract donations. In Case Three, those devices belonged to the residents who used them. In Case One, Two and Four, the medications used by residents were purchased from government pharmacies. In Case Three, the residents procured their medications from private pharmacies. Clothing is purchased for any resident in need; including blankets and bed sheets, which are changed every two to three years. In the same way, mattresses are changed every four to five years. The care environment of the four RCFs was clean and safe for the residents. There were adequate lights in the rooms, bathrooms and corridors. Showers are used instead of baths to prevent falls, handrails are installed in all the bathroom areas, as well as down the passages. Wheelchairs and walking frames are available to assist those having mobility impairment. In Case Two, benches and chairs are placed all around the nurses' station to assist those elderly who are unable to stand or walk for long. There were no loose carpets on the floors to safeguard residents from slipping or falling.

One of the primary issues to consider when making a decision to admit an elderly person to a RCF is the safety of the physical environment. RCFs are places where most residents will stay until they die (Kapp, 2003), therefore a safe environment should be designed to minimize falls and other hazard or risk factors (Newton, 2006). Morley and Flaherty (2002) further cautioned providers of RCFs to provide residents with a care environment that is not only medically and physically safe, but also has a homely atmosphere. There is a growing awareness on the relationship between health status and the living environment. Living environment can ensure an older person remain connected to the community, family and friends, and also access essential support services. Such an environment consequently enhances both resident and staff relationships and well-being (Minkler, Schauffler & Clements, 2000; Zofar, Ganatra, Tehseen, & Qidwai, 2006). Similarly, the staff of this study tried to make the living environment homely, for example, there were pictures on the walls. Some residents also reported that the RCF atmosphere resembled their own homes.

5.3 The Process

Donabedian (1966) describes the process of any health care system as the activities that are carried out to care for patients or clients. The resources within the structure are used to provide or support patient care such as the activities of governance, management and clinical and support personnel. The focus is on the nature and level of care nurses provide for patients/clients during hospital stay. According to Hepler and Segal (2003), process is somewhat more difficult to observe than are structures, but if structural requirements include appropriate documentation of care, then evaluators can use documentation to

represent the process of care because it is commonly said, "if you did not document it, then you did not do it" (Hepler and Segal, 2003).

The comparison of the findings on the process of the four RCFs was focused on one concept from the conceptual framework "Care and service delivery to the elderly" and the emerging themes from the data. (See Table 5.1):

5.3.1 Care and service delivery to the elderly

5.3.1.1 One big family

The relationship between the staff and the residents of the four RCFs was described in unique ways. In Case One, the relationship was like that of one big family. The nursing staff also developed close bonds with some of the residents, and were seen to be getting along very well. Moreover, the staff and the residents' families knew each other by name and they seemed like one family. The residents expressed how much they appreciated the staff through letters, hugs and kisses and giving them cards. Meaningful relationships are considered helpful to improve both residents' quality of life and caregivers' job satisfaction (Bowers, Esmond, & Jacobson, 2000). Examining the benefits of restructuring the provision of care that could enhance care giver's relational behaviour, which in turn could lead to meaningful relationships, McGilton, et al. (2003) found that an empathic, reliable, and consistent provider could improve the quality of care regardless. These authors outlined three potential approaches that could enhance the care provider's relationships and behaviour towards residents. The first approach is aimed at training providers to improve their skills of interaction with residents. The approach

encourages staff to use positive statements more frequently and initiate more verbal contact.

The second approach is achieved through continuity of care providers, to improve the general quality of care to residents. The third way is through the establishment of clinically supervised environments. This could be done through the establishment of staff motivational systems to ensure and maintain newly developed interactional-based interventions. It is believed that supportive supervision of staff can enhance nursing assistants' rate of positive statements to residents, and encourage nursing staff to view the residents as more responsive (McGilton, O'Brien-Pallas, Darlington, Evans, Wynn and Pringle, 2003). This type of relationship was observed in all the RCFs, with resident-staff relationship like that of one family.

5.3.1.2 Being there

In Case Three, the residents were very frail and were usually too weak to move around or talk. However, the nurses never left them alone, rather, they were simply "being there" for them, which is therapeutic. According to Basford and Stevin (2003), human caring is not limited to an emotional response such as a "touchy-feely". It encompasses emotions and feelings, thinking and acting (Basford & Stevin, 2003). This requires the nurse to be knowledgeable and skilled in order to be competent to effect informed change, compassionate and skilled caring.

5.3.1.3 Relationship of control

To ensure comfort and safety for residents in Case Two, the nursing staff took total control of the residents depending on their level of disability. Such an association could be likened to that of a parent-child relationship.. Tuckett (2006) describes such a relationship between providers and clients in caring relationships as benevolent paternalism. Paternalism is described as a benevolent decision-making by an adult child for an elder parent, or in the place of a parent by a caregiver for a resident (Tuckett, 2006). The decision for paternalism could perhaps be due to the elder persons' levels of frailty and vulnerability, causing the provider to patronize the resident; preventing him or her from making their own life decisions. In further argument, Harper (2002) noted that a comparison of an elderly resident with a child by the caregiver reduces that resident from his original status and identity. Moreover, over protecting the elderly from risk could also deny them the dignity and capacity for self-determination or autonomy (U. S. Commonwealth Department of Health and Ageing, 2002). Other authors have argued that limiting autonomy leads to potentially negative health outcomes because the ability and opportunity to exercise autonomy is important for physical health, psychological health for all persons (Hummert & Morgan, 2001; Tuckett, 2005), and is generally a component of good quality life (Harper, 2002). In their role as patient advocates, nurses are cautioned to reflect on their views of benevolent paternalism since they possess power that vulnerable residents lack. However, if the advocacy role accommodates any degree of bias, Tuckett (2005) argues that such bias must only favour the patients or the nursing home residents. In the context of residential care, any knowledge and familiarity with the system ought to favour only the residents, as opposed to the health-care professionals.

In Case Four, the relationship of control was challenged occasionally, particularly in enforcing institutional rules and regulations, when residents chose to entertain their guests in their rooms, contrary to the rules of the facility. According to Ryvicker (2009), the rules intended to protect individuals and improve quality of care can sometimes threaten residents' sense of self identity. For example, although Case Four offers shelter and other services to the residents, depriving them of the right to entertain their guests freely is likely to threaten their sense of self identity. Fagan (2003) Thomas (2003); Ryvicker (2009) have argued that institutional approach to care promotes depersonalizing practices that depersonalizes and interferes with residents' psychosocial well-being, whereas an informal home-like approach to care creates more opportunities for residents to preserve a sense of self-identity. The authors argue that such a prohibition at a medically oriented facility is counter productive as residents are viewed as instruments of work regimen of nurses, which could sometimes endanger resident's social and emotional support. Ryvicker (2009) further criticizes the popular view that a person's identity is rooted in intrinsic, fixed "personal" selves. She indicates that the proliferation of institutions devoted to the construction of "self" suggests that self is also constructed through social interactions. In terms of residential care, the author argues that residents are caught between two identities: that of the autonomous adult and that of a sick, dependent person. She explains further that residents interact with multiple versions of "trouble" identity, cautioning nurses to instead play a role in assisting residents to preserve a sense of self.

5.3.1.4: Gentle restraint

In this study, the researcher did not observe physical restraint being applied on any resident. However, the RN in charge of Case Three admits that when a resident became violent, physical restraints were used instead of medication. The need to reduce the use of physical restraint in RCFs is often recommended in the literature (Hamers & Huizing, 2005; Hamers, Gulpers & Strik, 2004). Yet, its use for residents in psycho-geriatric facilities is a common practice (Evans and FitzGerald, 2002), which is usually associated with cognitive and mobility impairment (Hamers, Gulpers & Strik, 2004). Other studies have found the use of physical restraints to be ineffective in preventing falls and fall-related injuries and have concluded that its use may lead to physical, psychological and social consequences, such as pressure ulcers and depression (Capezuti, Wagner, Brush, Boltz, Renz & Talerico, 2007; Hamers & Huizing, 2005). These authors suggests that transition to restraint-free care requires nursing staff to change their views about residents' behaviour, such as fall risk and wandering, or violence as a problem to be controlled with physical restraints. Rather, they urged nurses to consider residents' abnormal behaviour as an indication of health-state change or unmet need (Capezuti, Maislin, Strumpf, and Evans, 2002). Thus according to Huizing, Hamers, Gulpers and Berger (2007), reducing the use of restraints in RCFs requires education for nursing staff of RCFs, which may be a first step in the transition to restraint-free care. They believe that nursing staff education on restraint-free care will enable them to implement individualized care and break with their routines concerning restraint use. Apart from Case Three, there was no mention of the use of physical restraint in the other three RCFs.

5.3.1.5 Medication safety

Medication safety was a common practice in the four RCFs, which was specifically, reported by the RNs in charge of Case Four. Most residents depend on medication to treat illnesses and maintain health. The nurse in charge usually procured drugs from prescribed chemists or hospitals and kept them under lock and key because despite the detailed standards of disbursing medication, errors are common (Bolton, Tipper & Tasker, 2004).

Bolton, Tipper and Tasker (2004) identify medication review as an important tool for the management of poly-pharmacy in older adults, since this causes significant morbidity and mortality in the elderly (Shrank, Polinsky & Avorn, 2007). Poly-pharmacy is defined as prescribing multiple medications for patients (sometimes being on nine or more medications), especially when tablets or injections are taken at the same time, because old people tend to have several health conditions concurrently (Bolton, Tipper & Tasker, 2004). These authors suggest that in order to reduce polypharmacy, a comprehensive medication review should be conducted. The review must include an accurate medication history, verification of the purpose and actual use of medications, shared GP-patient confirmation, reinforcement of expected outcomes and follow-up. In two studies conducted by Krass and Smith (2000), it was found that collaboration between GPs and community pharmacists in the medication review was improved patients outcomes.

Case Three is a frail care centre that provides post operative care and manages acute conditions; supervises medications for residents and makes referrals when in case of need. The RCFs did not review medications regularly. However, literature suggests that

regular review of medications in residential facilities will ensure better management of medications and its appropriate use in care facilities are important indicators of quality care (Nishtala, Hilmer, McLachlan, Hannan and Chen, 2009). Although polypharmacy is common in RCFs, the researcher did not observe any sign of it. All the patients' medications were kept safe by the RNs in charge and given to the residents according to prescribed times. Health workers can also use a system known as "Beer's Criteria" to prevent poly pharmacy in RCFs. The Beers criteria are a written guideline and reference guide, developed by Beers and his colleagues (1991), for health workers to improve the use of medication and minimize or prevent polypharmacy in the elderly. The criteria are based on the risk-benefit definition of appropriateness, which helps to determine if a medication is appropriate or if its use has potential benefits that outweigh potential risks. Beers first set of criteria was developed specifically with the frail elderly nursing facility residents in mind. Then .in 1997, the criteria was updated to include medication therapy inappropriate in all patients over 65 years. Pharmacists can also use the same criteria to in the process of prescribing to improve the system of treatment regimens for the elderly. However in this study, the nursing staff reported locking of residents' medications as the only means safe medication safety.

5.3.1.6 Incidence of abuse

The administrators of the four RCF's stated that no abuse of residents by staff occurred within their institutions. The administrator of Case One admitted that their facility has a policy describing abusive behaviours and all staff guilty of this offence are asked to sign an "incident form" explaining their action. The incident is then investigated and the staff

member is duly disciplined. In Case Two, the nursing service manager confirmed two separate incidences of physical and emotional abuse of residents by fellow residents who had dementia rather than by staff. Those residents were sent to a mental health institution and subsequently sent home to their families. Abuse was also uncommon in Case Four because according to the administrator, the staff and residents share Christian religious values to resolve their differences and pre-emptying abuse through forgiveness and dialogue. The administrator of Case Four stated further that the residents feel secure in the RCF where staff are loving and protective toward them. Most of the residents came from abusive environment where they were vulnerable to abuse by family members.

World Health Organization (2002) confirmed many cases of elder abuse by adult offspring who are spend their parents' pensions on alcohol, leaving them without food. There are also reports of alcohol-related physical and sexual assault of elderly women in the community. Literature suggests that abuse of the elderly is a recognized social phenomenon (Lowenstein, 200). This form of abuse remains largely private and an invisible issue in many countries where it is tolerated in some instances (Lowenstein, Doron & Winterstein, 2003). The World Health Organization (WHO, 2002) also confirmed that up to 6% of older people have experienced some form of abuse in their own homes. On the contrary, there was no abuse in each of the four RCFs.

5.3.1.7 Nursing staff self-reported knowledge about elder care

The nursing staff of the four RCFs had fair to good professional knowledge and skills about the care and service delivery to the elderly. However, some areas of concern were raised, particularly in Case One and Three. In Case One, some of the nursing staff

members were not knowledgeable about certain significant aspects of the care of the elderly in RCFs. These areas included counselling, problem solving, infection control, universal precautions, medication management, rehabilitation needs of the elderly, and the need for respite care for elderly care givers. In the same way in Case Three, many of the nursing staff members were not knowledgeable about medication management, infection control, wound care, management of incontinence, nutritional needs, how to connect residents to services and their spiritual needs. (Please refer to Tables 4.4; 4.8; 4.12; 4.16). The above mention areas of knowledge deficit in Cases One and Three nursing staff requires careful consideration calling for remedial action by the administrations of the RCF concern.

5.4 The Outcome

Donabedian (1980) describes outcome as a change in health status as the result of the process carried out within the structure of health care. Outcome is the description of the changes in a patient's status at a defined time, following care interventions and it is also used to measure the result of care processes (Donabedian, 1980). Outcome measure is considered an ideal quality indicator specifically because deviation from proper care can affect a person's outcome, including the clinical, functional and psychosocial health status (Zimmerman, 1997). The discussion of the findings on the outcome of the four cases is focused on three concepts from the conceptual framework:

1. Success and challenges
2. Experiences of the elderly

3. Nursing staff's experiences of caring for the elderly, along with the emerging themes from the data of the four RCFs.

5.4.1 Success and challenges

The success and challenges of the RCFs were unique for each facility. In Case One, the administrators considered the strong bond that usually develops between residents and staff as success. As the result of such bond, residents are usually unwilling to be discharged from each RCF even after being diagnosed of terminal illnesses that require hospital admission. This finding supports other findings in the literature that speaks about social support. For example, Carpenter (2002) examined the associations among social support from institutional peers, staff as well as family members using 32 patients. The results of that study suggest that peer and staff support can contribute to the well-being of older adults and may also complement family support during inpatient admissions to care facilities. Carpenter further (2002) noted that clinical and programmatic interventions that facilitate peer and staff support could enhance patient well-being and stimulate participation in self-care. Park (2009) conducted another exploratory study to determine the relationship between social engagement and the psychological well-being of 82 older adults residing in assisted living. In that study, close bond between residents and staff was closely related to life satisfaction, which helped to control depressive symptoms. Other findings suggest that close associations with animals have positive impact on the psychological health of older adults, which could promote their psychological well-being (May, 2007).

In Case Two, the organization's ability to attract donors was considered a major success. In the past, staff worked hard to attract donors to the RCF, walking from home to home, requesting food and money to care for the residents. However currently, people bring in donations without being requested, which has contributed to the facility's financial sustainability. The facility's ability to retain staff during a labour strike was also considered to be a sign of success in Case Two. This could probably be attributed to the organization's helpfulness to the staff during difficult times.

In Case One, poor service delivery to the elderly in hospitals and clinics was the most common challenge reported. Residents usually waited for hours to see doctors, who were often not seen on the same day. Maintaining the facility was expensive, but the residents, staff and the board were satisfied with the quality of services provided by each facility. Board members were also satisfied with the facility's standard and their usual response to the staff is: "keep up the good work".

5.4.1.1 Location of care centre

When considering the challenges that RCFs face, the sister-in-charge of Case Three did not approve the location of the frail care centre because she considered it enclosed, not well-lighted, and lacking in adequate recreational space. The location of a place is important to everyone, particularly the elderly. In support to this view, Barrat (2007) noted that housing is not merely a shelter, but it provides protection from hazardous elements and also provides space for sleeping and leisure. In relation to the elderly in particular, housing is associated with a 'place', identify and relationship. Moreover, it is

important that the home is safe for the elderly to prevent fall and injury. Thus a well lighted and safe home environment may reduce the risk of accident.

The administrator of Case Four thought that the facility was not successful due to lack of funding. He however hoped that somehow, there would be sufficient funding to accommodate all the vulnerable elders in the local community. Moreover, the sister-in-charge of Case Four did not like the attitude of the government-assigned general practitioner (GP) responsible for providing medical services for the residents. The GP did not like to be inconvenienced by seeing only one patient at a time because he receives more pay depending on the number of patients he sees. He therefore, considers it too much trouble to visit a single resident. His refusal to see a single resident at a time poses a major challenge to the facility.

According to the administrator of Case Four, the absence of any negative report from the residents' committee about the services in the RCF was a major success for the facility. Literature suggests the voice of residents as a strong outcome indicator of quality of life (QoL) and satisfaction among vulnerable people in RCFs (Gorman, 2009; Luceci, Hey & Subasi, 2008; Nygren, Iwarson & Dehlin, 2000). Patient's QoL and standard of care can be measured by what care users say; and it is particularly appropriate when applied to dying persons, who usually prefer health care designed to enhance physical comfort and quality of life in the context of a decline in functional ability (The American Geriatric Society, 2002). In the four RCFs, it was noticed that residents' described their quality of life in terms of their personal satisfaction. When they were asked to describe their quality of life, the usual response was *"I am satisfied" or "My life is good"*.

The administrator of Case Four believed that the staff members were happy and satisfied with their jobs despite their low salaries. During the quarterly board meetings, board members usually make innovative suggestions to further improve the RCF care standards, such as the need to acquire equipment like basic equipment like glucose monitor. A key challenge is that some of the required equipment is too costly for the RCF. As the result, residents presenting with simple cases like hyperglycemia have to be referred to the hospitals where, according to the RN-in-charge, the residents' health conditions are not managed adequately.

5.4.2 Experiences of the elderly in RCF

5.4.2.1 Interactive relationship

The relationship between the staff and residents was good in all the facilities. In Case Two, one participant indicated that such relationship helped her to overcome some of her past life experiences to embrace her current circumstances. It also helped her to overcome some personal shortcomings, like selfishness. However, due to the physical conditions of the residents of Case Three, there was minimal resident-staff interaction, except during care processes like bathing and feeding. In Case Four, the researcher usually observed the residents and staff conversing or watching TV together in the common room. Other residents were seen sitting outside in wheelchairs or doing just what they liked. One female participant was always seen doing some beadwork in Case Four.

There were no literature found on interactive relationship in RCFs within the South African context, but studies from United States and United Kingdom have shown that increased social interaction in RCFs can also increase residents' self-esteem (Ice, 2002).

However, most of the activities in RCFs are planned and not all residents appreciate group activities enough to engage in them, and not all those who attend planned activities are engaged in them. Ice (2002) describes relying on planned activities for residents' as the only source of social activities, as encouraging "instrumental passivity and learned helplessness" (p. 355). The author therefore suggests innovative ways to increase social interaction and self-esteem in RCFs. One way is to use memory journals. In such an approach, residents are encouraged to take along books throughout the day and fill them with information of their past, using photos, letters, drawings, or their own written notes. In one intervention study using memory journals conducted by Allen-Burge, Burgio, and Bourgeois (1987), staff were trained to review memory book(s) with residents. The study was the first of its kind; it showed that social interaction was enhanced while agitation was reduced.

5.4.2.2 Response shift

In Case One, the participants reported many chronic health-related conditions, but were happy despite the seriousness of their health problems. They have probably constructed meanings from their health conditions and have adapted to the changes in their circumstances. Their joyous state could probably be attributed to what researchers have recently drawn their attention to as a highly significant phenomenon known as response shift. Ring, Höfer, Heuston, Harris and O'Boyle (2005) describe response shift as a change in the meaning of someone's evaluation as the result of changes in their internal standard and values of life. Human beings are believed to always construct meanings from their environment, and display a range of cognitive mechanisms to continually

adapt to changes in their circumstances (Sprangers & Schwartz, 1999). This means that people could report different answers for patient reported outcomes (PRO) measures over time, not only because their health or quality of life (QoL) has changed, but also because they might have changed their perception on what health or QoL means to them (Echteld, Deliens, Ooms, Ribbe, 2005).This is consistent with the results of this study, evident in that although most of participants were experiencing some serious health-related conditions, they chose to say that their lives were good.

5.4.2.3 Psychosocial support

In the four RCFs, majority of the participants did not have any living siblings. In Case One, some of the elderly, including those who had families did not receive visitors, although few of them did receive visitors. Whether a resident had a biological family or not, receiving visitors was an important aspect of their psychosocial wellbeing. In Case Two, love, care and having a good family support system were important means of psychosocial support. Nurses from the RCF provided psychosocial support to those residents who did not have biological family members. Furthermore in Case Two, social contact with a Church family was also important even if a resident had his / her own family of origin. Psychosocial support is as important aspect of everyone's wellbeing, particularly as people grow older, with ageing being associated with various mental and physical changes. According to D'Arcy (2002) most elderly sometimes think of death when they become ill and some may experience a diminished or complete memory loss due to cognitive decline that is usually present in dementia. Thus, psychological support is an important component of the care of the elderly.

The social support component is also as important as the psychological aspect because participating in different activities creates in people a feeling of belonging to a group, which promotes a sense of wellbeing in people (Liu & Yeh, 2003). Moreover, the absence of a significant person in one's live predisposes the person, particularly the elderly, to loneliness. Nurses can offer social support to lonely residents through celebrating events together, like singing, walking and participating in arts and crafts. Moreover, residents' families can provide social support to them through regular visits or through some form of contact. This is consistent with the findings in Liu and Yeh (2003), which suggest that maintaining social contacts and constantly experiencing social support from family members and other loved ones are important in meeting social needs to the elderly in RCFs.

Spiritual support was achieved through making attempts to get closer to God. In Case One, Two and Four, there were scheduled times for religious activities. In Case One, Christian pastors were usually seen conducting Church services for those residents who were Christians. Case Two was predominantly Indian, and Hindu priests were also observed conducting services and praying for the residents. The residents valued those times and looked forward to further meetings. In one spirituality study, Dolo (2006) found that connection with God, usually achieved through prayer, was an important aspect of the psychosocial well-being of the lives of people living with HIV /AIDS. In another study Hodge (2003) found that the interactive process of prayer serves to reinforce the sense of connection to others as well as to the Divine. This sense of bonding facilitates a cathartic response through which painful emotions can be brought to

consciousness and relieved or expressed when they emerged from the sub-conscious, which in turn fosters wellness.

5.4.2.4 Satisfaction with RCF

Majority of the participants of the four RCFs were generally satisfied to be residents of those facilities, however, individual satisfaction was unique to each person. The factors that determined participants' satisfaction included visitation by friends or relatives, love and affection from fiancée, independence from family, respect, visiting places, and going out for entertainment. Others residents were satisfied because the RCF was affordable, compared to other places of accommodation. Literature suggests that resident satisfaction with life in the RCFs is a key indicator of the quality of care provided by that facility. In a study to identify factors that could promote satisfaction among healthcare proxies of nursing home residents with advanced dementia, Engel, Kiely & Mitchell (2008) concluded that increased communication and comfort are two factors that could promote satisfaction with care for residents with advanced dementia. Other factors identified to promote resident satisfaction were no tube feeding and specialized dementia care in dementia unit. Staff job satisfaction is as important as that of the residents; and it has unique implications for specific facility, the nursing home industry, and quality of care. In determining nursing home staff satisfaction, Castle, Degenholtz, & Rosen, (2006) concluded that nursing absenteeism, turnover, and quality of care are factors that are associated with nursing home staff satisfaction, and those facilities that try to improve their quality are likely to increase job satisfaction for their staff, thereby reducing staff turnover rates.

However in this study, the participants who were satisfied with the services rendered did not see the need for any changes to be implemented except for minor wishes. For example in Case One, those participants who were Christians wished that every resident would go to Church. The participants of Case Two wished for the administration to increase social outings for the residents, in Case Three one resident wished for some young people to be introduced to the home and more trees to be planted in the RCF vicinity. In Case Four, some residents expressed the desire to have someone to do their grocery shopping at the end of each month.

Conversely, individual dissatisfaction was also unique to each person. In Case One, one participant was dissatisfied with the attitude of the nursing staff toward him. In Case Two, the food was sometimes a bit hard or strong for old people probably due to a toothache or missing teeth. Moreover, one male patient was consistently mistreated by his roommate, which he did not report, although it had caused him extreme psychological pain in the process. The findings are consistent with other findings from the literature. For example, agitation and disruptive behaviors by residents with dementia in RCFs can cause physical and psychological trauma to other residents and staff (Leonard, Tinett, Allore and Drickamer, 2006; Gray, 2004; Brodaty & Low, 2003). Resident-to-resident aggression and violence (RRAV) commonly identified in RCFs include male gender, behavioural disturbance (especially wandering), moderate functional dependency; and cognitive impairment. The most common site of RRAV is the patients' rooms, hallways

and dining room (Brodaty & Low, 2003). This is consistent with the findings of this study with residents mentioning abuse occurring in their rooms.

5.4.3 Nursing staff's experiences of caring for the elderly

The nursing staff of the four RCFs described their experiences of caring for the elderly in unique ways. In Case One, the participants reported that despite caring for elderly residents proved challenging, it was nevertheless rewarding. The participants also noted that old people appreciate love, and reassurance, where staff promised to ensure holistic care to them by providing the necessary medical, social and spiritual needs. One staff of Case Two described how sad it can be when a mother or father wants to see their children before the person passes away. Some staff stated how their lives had changed for the better in response to the expectation and trust the residents have in them.

In Case Three, the nurses experienced caring for the elderly in the following ways: walking them outside for fresh air and doing pressure care. Although most residents were immobile, the staff stayed and talked with them with compassion. Walking is good for everyone. Studies have shown that walking reduces the risk of coronary heart disease and stroke, lower blood pressure, enhance mental well being and control body weight. According to Derman, Whitesman, Patel, Nossel and Schwellnus (2008). Participation in physical activity (like walking) is associated with reduced mortality rates for both older and younger adults. In other words, walkers live longer! Moreover, Cavill, Biddle, and Sallis, (2001) noted that walking can improve self esteem, relieve symptoms of depression and anxiety, and improve mood. Walking, particularly in pleasant

surroundings, and with other people, offers many opportunities for relaxation and social contact.

In Case Four, individual staff who had previously feared people with dementia now had confidence to continue caring for them. The need for the elderly to socialize and connect with others was also reported by the staff of Case Four. Finally, some of the nurses were exposed to how most of the elderly live with regrets due to their past life experiences, hence the need for counselling services in RCFs.

5.5 Conclusion

The chapter presented discussion of the findings from four RCFs in EThekwini District in terms of common features, similarities, variations, differences and uniqueness of the findings from each institution. It was guided by the six concepts from the conceptual framework of the study (Donabedian, 1966) and a number of emerging issues that were observed from the data of each facility. These emerging issues were discussed in relation to relevant literature, and recommendations for RCFs were made eThekwini based on these findings in Chapter Six.

CHAPTER SIX: SUMMARY, RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

This chapter represents the summary of the research findings from four RCFs where the research was conducted according to the structure process and outcome of the conceptual framework of the study. It further makes recommendations for residential care and presents the limitations and conclusion of the entire study.

6.2 Summary of key findings

6.2.1 The structure

6.2.1.1 Assisting vulnerable people

Vulnerable people were assisted in all the four RCFs. Vulnerable people are those in all age groups, who are in need of services by reasons of mental or physical disability, age or illness, or are unable to take care of or protect themselves against significant harm or exploitation (Mechanic & Tanner, 2007). The vulnerable people of Case One and Two were residents (both old and young) who were frail, with physical and mental disabilities, as well as the homeless. The facility provided frail care, counselling, and other related services that addressed residents' social and other health related issues such as home-based care and HIV/AIDS nursing, mainly through the facility's nursing college. Moreover in Case Two, a safe home is available for children who are orphaned, destitute, abused or neglected. The homes are run by house mothers to ensure normal upbringing for the children. Yet, there are many more vulnerable people who may require residential care in other local communities eThekwini.

6.2.1.2 Confirmation from facility record

Three of the RCFs had several documents (checklists, guidelines and protocols) for running their facilities, except for one. According to RN-in-charge of that facility "caring does not require a written formula, because it comes from the heart". However according to the South African DOH (2000), practice guidelines are documents which are aimed to guide treatment decisions and criteria regarding diagnosis, management, and treatment in specific areas of healthcare. Practice guidelines have been in use for thousands of years during the entire history of medicine. Guidelines and protocols are essential because they direct care processes and guide people in making personal evaluations of specific facilities. Evidence suggests that some simple clinical practice guidelines are not routinely followed to the extent they might be, but its use can benefit the user in a number of ways (Kolata, 2004). South African DOH (2000) has endorsed the use of checklist for recommended procedures because it helps to remind health workers about procedures that might have been overlooked in a timely manner.

6.2.1.3 Absence of quality indicators

In the four RCFs, there were no formal quality indicators in place. When the researcher asked the administrators about quality indicators, she was told that there was only daily staff supervision by senior and experienced RNs. The administrators as well as the RNs did not understand the word, "quality indicators" and they did not know anything about its usefulness.

6.2.1.4 Financial sustainability

Maintaining financial sustainability was a chief concern for three of the four RCFs. These RCFs were financially sustained by subsidy from the provincial government of KwaZulu-Natal. Other sources of income were donations and various fund raising activities like marketing donated goods, annual fair, cost cut, tin collections, etc. Two of the above mentioned facilities were financially stable, while one of them had less income comparatively. Beside the low income, that RCF was struggling financially. The findings of this research suggest that various fundraising activities assisted two of the RCFs to ensure financial stability. According to Flanagan (2002), fundraising is a tedious activity, which requires a team with four Ws: Work, Wealth, Weight and Wisdom. Work stands for people who are willing to work and ask for money, organize events and recruit new fundraisers; Wealth stands for people who are able and willing give big money; weight are people with power in the community whose names can open doors such as the city mayor, the owner of the most successful business, or the hottest local celebrity; and Wisdom, stands for people who are expert in the field. Because all of these qualities cannot be found in one person, a team whose members have the following qualities to accomplish this.

6.2.1.5 Resident staffing ratios

There was no standardized national or provincial resident staffing ratio in the four RCFs. All of these facilities had different resident-staffing ratios that suited the specific facility. Yet, it had been established that resident staffing ratio is one of the issues of greatest importance in health care (WHO, 2003) which is necessary to avoid bad outcomes in

RCFs (Unruh & Wan, 2004; Zhang, Unruh, Liu & Wan, 2006). There is need to determine a minimum resident staffing ratio that will be appropriate (Zurn, Dal Poz, Stilwell and Adams, 2004) to the need of each of the four RCF where the study was conducted.

6.2.1.6 Material resources

There was no provincial uniform standard regarding the material resource requirement for the RCF studied. There was no standard on the quality and quantity of resources that should be available in a RCF. Although all the facilities had similar material resources, the researcher did not see any national or provincial document suggesting that RCFs should have specific number or type of material resources. This was also a matter of concern to the researcher, and this requires national and local government intervention. In addition, the researcher did not find any policy regarding how to arrange furniture in RCFs. However, there were some written about how to manage the care environment to prevent fall and injuries as well as promotion of active ageing.

6.2.2 The process

6.2.2.1 Therapeutic relationship

The relationship between the staff and the residents of the four RCFs was cordial and was described as therapeutic; it developed from being interpersonal to become like that of one family. Therapeutic relationship is essential to successful care for people in any setting, particularly for people in residential care facilities. This type of strong and genuine

relationship is grounded in Rogers (1957), helping relationship, without which no treatment techniques are likely to be successful. Singer (2006) suggests that denying the importance of therapeutic will lead to unsuccessful treatment outcome. In the same way, the staff of the four RCFs realized that a cordial resident staff relationship promoted quality of care for their residents.

6.2.2.2 Incidence of abuse

Abuse was uncommon in the four RCFs due to the incidence reporting policy in those facilities. Two separate incidences of physical and emotional abuse by residents involving staff and other residents occurred. Moreover, one elderly male resident revealed how he had been abused or mistreated by his roommate, although he had not reported the mater to anyone. A study done by Pillemer and Lachs, (2008) suggests that resident to resident aggression and violence is common in residential care facilities They suggests that residents who are victims of aggression are more likely to be: male, have behavioral symptoms (especially wandering), and cognitively impaired, who tend to be more physically independent. This requires nursing staff to actually determine from residents their experiences of living in RCF.

6.2.2.3 Knowledge about elder care

Of the four RCFs, some nursing staff had knowledge deficit about certain fundamental professional skills regarding the care of the elderly including universal precautions,

counseling, problem-solving, wound care, patient safety, rehabilitation, recreational needs and the need for respite care. This suggests the need to increase professional development for health care providers in RCFs. Nurses' professional knowledge about elder care is essential because they are the front-line workers in residential care. The well-being of residents in RCFs depends not only on the relationship that develops between the nurses and the resident, but also on the skills of the staff. This suggests the need for enhanced nurses' professional development in RCFs.

6.2.3 The outcome

6.2.3.1 Care and services for the elderly at clinics and hospitals

Two out of four of the RCFs studied reported some dissatisfaction regarding the medical service for their elderly residents at their referral hospitals. Data from the research suggests that the elderly were made to wait in hospitals and clinics just like everyone else. They were not given preference regarding treatment, and many times they did not see doctors on their appointment days.

6.2.3.2 On-call general practitioner (GP) for RCFs

The personnel in charge at one of the study sites expressed dissatisfaction regarding the attitude of the government employed on-call GP, who is assigned to that RCF. The GP is usually unwilling to be called for only one sick resident, because he receives more money depending on the number of patients he sees.

6.2.3.3. Family commitment to elders in RCFs

Evidence from the four RCFs suggests that family visitation was helpful to the residents. However, majority of the residents did not receive visitors, including those who had children. Living away from one's biological family also affected different the participants in different ways. Some of them were usually seen crying, although others have adapted to being away from their families.

measures of healthcare quality model as a framework for making the recommendations, which was the same as the one she used in the main research project. Researchers have concluded that residential care quality must be measure by examining the interaction between structural, process and outcome measures (Donabedian, 1980; Sainfort et al, 1995; Zimmerman et al, 1995, Ramsey et al, 1995; Morris et al, 2003). The (SPO) were originally formulated by Donabedian (1966) as a relevant sector for quality assessment. This framework was selected as most appropriate model because the three main elements addressed the purpose and objectives of this study.

6.3 Making the recommendations

The recommendations for this study are based on several sources, including the findings from the study; researcher's own observation, document review and literature review (see Chapters Four and Five). The researcher used the conceptual framework of the study to guide the recommendations.

The researcher collected and compared data from the four RCFs where the research was conducted in order to raise questions on elder care differences across those institutions.

Next, she did a review of the literature and the following resources were obtained: 1. Quality Indicators for the Management and Prevention of Falls and Mobility Problems in Vulnerable Elders; 2. Assessing Care of Vulnerable Elders; Methods for Developing Quality Indicators; 3. Guide to Clinical Preventive Services; 4. South African National Guideline for the Prevention of Falls of the Elderly; 5. Medication Review by GPs reduces polypharmacy in the elderly: a quality use of medicines; 6. SA Family Practice.

The recommendations were then developed and submitted to a gerontologist for her review and comments.

6.4 Recommendations

At the Department of Social Welfare level, the Minister should:

- Construct more residential homes for vulnerable people in all age groups in many communities in eThekwini Municipality. The demand for residential homes is high, which is driven by population ageing, mental and physical disability, homelessness, lack of support, etc. Not only that residential homes need to be built, but the right kind of homes, which are suited for vulnerable people of all ages.
- Through research, identify and incorporate standard provincial minimum resident staffing ratios for RCFs in eThekwini. This requires the Department of Social Welfare to consider the potential cost and the possibility of this exercise, which also requires careful consideration when assessing the need and its appropriateness. However, this will require an analysis of the relationship

between staffing ratios and quality service/care in order to determine if such relationship exists or not.

- ❖ Develop quality indicators (QIs) into residential care guideline. QIs are currently used overseas by care providers for improving care, by governments to monitor care, and for public reporting (interRAI, 2008).
- ❖ Ensure more than one government on-call GPs at RCFs, and stipulate their job description and acceptable practice for each facility at all times. More than one GP will ensure that someone is always available to see the residents in case one GP is away. Ensuring GP's stipulated job description and acceptable practice or behavior will ensure that the residents are treated well to promote satisfaction for the residents and staff.

At institutional level, hospital management should appoint people to look out for the elderly:

- ❖ To ensure improved care and services for the elderly in clinics and hospitals in the following areas:
    - Preference in terms of consultation to prevent long waiting periods for the elderly
    - Ensure that someone is always looking out for an elderly person to identify them for early/timely consultation and treatment
    - Ask the elderly person if he/she was satisfied with the care and service provided. Research suggests that the perceptions of patients regarding health practitioners and factors influencing their level of satisfaction are

good indicators of quality care (Edwards, Courtney & Spencer, 2003; Robinson, Lucas, Castle & Lowe, 2004). Research has also emphasized that the resident's voice is central in measuring their QoL (Robinson, Lucas, Castle & Lowe, 2004).

1. At residential level administrators of those facilities that have financial struggles should: Connect with and engage administrators of other facilities that have successful ongoing fundraising activities to learn from their success stories and see how well they can also organize themselves to become successful fundraisers. One of the RCFs used tin collection technique and annual fund fair. Such innovative ways can also be adopted by other facilities.

Administrators of RCFs are urged to:

2. Introduce geriatric nurse in RCF. Evidence from the study suggests that the RCFs did not have geriatric nurses; yet research suggests that introducing a geriatric nurse practitioner into a nursing home leads to reduction in hospital admission, improvements in pressure ulcers, incontinence, depression and aggressive behavior (Oeseburg, Wynia, Berry, Reijneveld & Sijmen, 2009; Werner, 2005;)

3. Ensure in-service training for nursing staff members who are directly involved in the day-to-day care of the elderly. The in-service training should incorporate basic skills in infection control, universal precautions, medication management, etc, according to the deficiencies that were identified. It is therefore recommended that nurses be:

a. educated and trained in areas such as food preferences for the elderly, patient satisfaction and QoL issues, etc.

b. trained to develop skills in the care of the elderly because care of the elderly is a new area in Africa and so staff of RCFs need to be trained.

4. Some administrators of RCFs of this study were not health practitioners, and so those administrators are urged to acquire training in the care of the elderly to enable them understand how to care for the elderly

5. Administrators of RCFs are encouraged to develop a public information campaign with educational materials targeted to residents of RCFs and their care providers. The information provided should include:

- how to be an effective advocate for the elderly
- what to expect in RCFs
- why should family consider the availability of RCFs for the elderly
- how the old age pension and grant can benefit the elderly in RCFs
- strategies for communicating effectively with doctors and other health professionals
- educational resources for learning more about the RCFs for the elderly.

6 Document actual care processes which include what each resident actually say regarding what constitutes his or her individual well-being, quality of life (QoL) and satisfaction.

7. Encourage walking, gardening, handiwork, etc, in RCFs in eThekwini District to enhance residents' wellbeing and QoL. Research suggests that QoL is higher for those elderly who have higher leisure and social activities such as walking, gardening, handicraft and reading (Sato, Demura, Kobayashi & Nagasawa, 2002).

6.5 Recommendation for nursing research

The study explored and described four RCFs for elderly in Ethekwini District in terms of its organizational structure, staff and residents according to the structure, process and outcome of the study's conceptual framework. The following recommendations are made with regard to nursing research:

- The findings and recommendations made by the researcher require further investigation and testing in order to determine how those factors can influence the care of elderly in reality.
- The recommendations made by the researcher needs to be further tested for its practicality in clinical practice and in education. The recommendations also need to be tested in reality in different clinical settings within the South African context. A larger sample may be appropriate in subsequent studies to strengthen the validity and reliability of the findings, to get the opinions of nurses, residents, religious leaders, teachers and others, about residential care for the elderly in other settings or other provinces as well.
- Quantitative research would be appropriate in testing and measuring the specific areas of residential care (national norms and standards for RCF in the Older Persons Act (Act no 13, 2006, standard resident-staffing ratios for RCFs, services

for the elderly in hospitals and clinics) to establish the efficiency and effectiveness of those recommendations, to replicate the study on a large scale in eThekwini District, KZN or other provinces.

Recommendation for policy makers: This research has vital implications for policy makers. If national as well as international health organizations must deal effectively with the increase demand for RCFs due to the increase in the elderly population, there is an urgent need for them to include in their policies the recommendations that have been made. Stakeholders therefore can either support these investigations in terms of funding or undertaking further research to broaden knowledge.

6.6: Limitations to the study

Limitations of a study are restrictions in a study that may decrease the generalisability of the findings, which may be theoretical, or methodological (Polit & Beck, 2004). In this study, the limitations were on generalisability, since the study was conducted in only four residential care facilities (RCFs) in eThekwini, KwaZulu-Natal, which means that issues may be unique in other RCFs in eThekwini as well as in KZN. Therefore the findings cannot be applied to all RCFs in eThekwini and KwaZulu-Natal. In addition, in each facility and within facilities, there are unique differences which results from unique cultural practices in those facilities that may be unfamiliar to the facilities studied.

Moreover, the study utilized mixed (qualitative and quantitative; documents review; direct observations; participant observation) methods of data collection to ensure data triangulation and increase the type of information obtained from participants, and produce a more holistic picture that information (Gerrich & Lacy, 2006). However,

utilizing the mixed method was challenging to the researcher. The interviews yielded rich data, details and new insights about the research problem and enabled the researcher to explore the research questions in depth. Yet analysis of the qualitative data was time consuming. In addition, gaining access to the documents of one of the cases was not possible. Regardless of the above mentioned limitations, the scientific merits of the study are still maintained, and the researcher is of the opinion that this has not detracted from the quality of the research.

6.7 Conclusion

The following recommendations contained in this document are intended to be adapted to the needs and resources of each RCF according to each facility's need and resources. Thus, implementation of the recommendations may differ from one facility to another depending on the circumstances of each RCF. The result of this research suggests the need for improvement of some aspects of the care of the elderly in RCFs. Achieving this goal will require a sustained effort on many fronts, including policy modification, and enhance training of staff of RCFs and better public information about the care of the elderly.

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ANNEXURE A:

COPIES OF LETTERS REQUESTING PERMISSION TO CONDUCT RESEARCH

APPENDIX I: LETTER OF REQUEST

For: Program Directors and Matrons
Code: ----------
Program/Facility location: ----------

Introduction and purpose of the research

Dear Sir/Madame;
My name is Meiko Josephine Dolo. I am currently studying at the University of KwaZulu-Natal pursuing a PhD degree in Nursing, and this research is undertaken in fulfillment of this degree.

The title of my research is RESIDENTIAL CARE **FOR THE ELDERLY IN ETHEKWINI MUNICIPALITY: A CASE STUDY APPROACH**. The purpose of the study is to explore and describe nursing home care for the elderly in Ethekwini District in terms of the residents, staff and the organizational structure and to determine how these characteristics could influence the quality of elder care.

I therefore request your participation in this research study by permitting me to interview you. This instrument contains 43 items and is divided into 3 sections.The first section deals with background information of each nursing home, section two covers demographic information of the nursing homes and section three is the main interview guide covering questions on the structure, process and outcome of each nursing home. The contents of the questions are directed to address the research objectives and questions. The information you will provide will help me to better understand what goes on in the running of this program and its appropriateness. The information will also assist me to recommend a guideline for nursing home care for Ethekwini District. Participation in this study is voluntary and you have the right to withdraw from the interview at any time. Confidentiality will be respected and your name will not be mentioned anywhere in the completed document.

Your participation in this regard is highly appreciated.

Very truly yours,

Meiko J. Dolo
Contact details of researcher: 031 260 1486; Cell: 073 881 6640

Permission from participants
I would like to participate in the above research. I understand that this is voluntary.
Signature of participants:

APPENDIX V: INFORMATION SHEET

Code: ----------

Program/Facility location: ----------

For: The Elderly

Title of the study: RESIDENTIAL CARE FOR THE ELDRELY IN ETHEKWINI MUNICIPALITY: A CASE STUDY APPROACH

Greetings. My name is Meiko Josephine Dolo, a nursing student from the University of KwaZulu-Natal, Howard College Campus. At the moment, I am doing a research project on nursing home care for the elderly in Ethekwini District. The purpose of this research is to explore and describe nursing home care in Ethekwini District in terms of its residents, staff & organizational structure, & determine how these factors could influence the appropriateness of placement & quality of elder care.

Quality assessment involves identifying the strengths and weaknesses of programs, the policies, personnel, or products, and organizations to improve their effectiveness. It involves the systematic collection of information and using the information to make decisions about something. Through quality assessment, those who provide or administer services determine what to offer and how well they are offering those services. In addition, quality assessment can help to identify program effects, so that staff and others are enabled to find out whether their programs have impacted on participants' knowledge or attitudes

I would like to know about your condition in general and how your condition has affected your care. I would also like to know your experiences of living in a nursing home.

I therefore request your participation in this research study by allowing me to interview you. The information you will provide will help me to better understand the association between your condition and your care provision. The information will also assist me to recommend a guideline for nursing home care for the elderly in Ethekwini District. Participation is voluntary and you have the right to withdraw from the interview at any time. Confidentiality will be respected and your name will not be mentioned anywhere in the completed document.

There are no funds available for conducting this research. For this reason, the researcher will not be able to provide any financial assistance to any one.

Contact details of researcher: 031 260 1486; Cell: 073 881 6640
Thank you.

Permission from participants

I would like to participate in the above research. I understand that it is voluntary.

Signature of participant

APPENDIII: INFORMATION SHEET

Code: ----------

Program/Facility location: ----------

For: Care givers

Title of the study: INSTITUTIONAL CARE (IC) FOR THE ELDERLY IN ETHEKWINI DISTRICT: A CASE STUDY APPROACH

Greetings. My name is Meiko Josephine Dolo. A nursing student from the School of Nursing, University of KwaZulu-Natal, Howard College Campus. At the moment, I am doing a research project on Institutional Care (nursing home care for the elderly in Ethekwini District). The purpose of this research is to explore and describe nursing home care for the elderly in Ethekwini District in terms of its residents, staff & organizational structure, & determine how these characteristics could influence the quality of elder care.

Quality assessment involves identifying the strengths and weaknesses of programs, the policies, personnel, or products, and organizations to improve their effectiveness. It involves the systematic collection of information and using the information to make decisions about something. Through quality assessment, those who provide or administer services determine what to offer and how well they are offering those services. In addition, quality assessment can help to identify program effects, so that staff and others are enabled to find out whether their programs have impacted on participants' knowledge or attitudes.

I therefore request your participation in this research study by completing this questionnaire for me. The questionnaire is designed to be self-completed. It contains 25 items with three sections. The questions are aimed to provide information from the process and outcome of each nursing home from the perspectives of those who are directly involved in caring for the elderly. The first section is designed to provide demographic information such as age, gender, marital status, level of education. The second section covers care and service delivery strategies and methods. The third section covers staffs' experiences of caring for the elderly.

The information you will provide will help me to better understand the type, method and process of care and service delivery to the elderly in this nursing home. The information will also assist me to recommend a guideline for nursing home care for the elderly in Ethekwini District. Participation is voluntary and you have the right to withdraw from the interview at any time. Confidentiality will be respected and your name will not be mentioned anywhere in the completed document.

There are no funds available for conducting this research. For this reason, the researcher will not be able to provide any financial assistance to any one.

Contact details of researcher: 031 260 1486; Cell: 073 881 6640

Thank you.

Permission from participants

I would like to participate in the above research. I understand that this is voluntary.

Signature of participants:

ANNEXURE B:

LETTERS OF PERMISSION TO CONDUCT RESEARCH

NATAL SETTLERS' HOMES

F.R. No 06-600-206-000-6

17 Hutchinson Road
Umbilo
Durban
4001

Ph: 031-2051351

HELP US TO HELP THEM

P.O. Box 17079
Congella
4013

Fax:031 2054288

Meiko J. Dolo
School of Nursing
University of KwaZulu-Natal
Durban
4001

Request to conduct research at Natal Settlers' Homes
Protocol: Institutional Care Of The Elderly in Ethekwini: A Case Study Approach.

Your application received on May 12, 2008 is approved.

Please ensure the following:

That Natal Settlers' Homes receives full acknowledgement in the study on all publications and reports and also kindly present a copy of the publication or report on completion.

The Management of Natal Settlers' reserves the right to terminate the permission for the study should circumstances so dictate.

The Home wishes you the best of luck with your research.

Yours faithfully

P. Willson
General Manager

1 June 2009

Enquiries: Ms K Govender

The Dean
School of Nursing
University of Kwa Zulu Natal
Durban
4001

Dear Sir/Madam

RE: ACCEPTANCE OF RESEARCH STUDENT AT INSTITUTION

This serves to confirm that our institution will accept the PHD Research Student, MEIKO DOLO, to conduct research on:

RESIDENTAL CARE FOR THE ELDERLY IN THE ETHEKWINI DISTRICT : A CASE STUDY APPROACH.

Dolo will be liaising and gathering information on her research topic with our Senior Sister, Sister Maharaj, during the period of research.

It has been agreed at our initial interview with Ms Dolo that:

1. All confidentiality issues will be respected.
2. ABH's protocols and procedures will be followed.
3. A final copy of the research document will be submitted to ABH, and the institution will receive full knowledge of the study upon completion.
4. The ABH Council reserve the rights to terminate the permission of the study should the circumstances dictate.

We wish Ms Dolo the best of luck for her research in the full knowledge that it will benefit our institution and its residents.

Yours faithfully

.....
Ms K GOVENDER
SOCIAL WORK MANAGER

.....
SISTER MAHARAJ

CAISTER LODGE
264 Musgrave Road
Durban. 4001

1st June, 2009

The Dean
School of Nursing
University of Kwa Zulu Natal
Durban
4001

Dear Sir/Madam,

RE: ACCEPTANCE OF RESEARCH STUDENT

This letter serves to confirm that we have agreed to allow Meiko Dolo to conduct part of the research for her PhD at our retirement complex.

She will conduct interviews with residents and staff as she requires.

She will liase with Matron V. Glaum at all times.

We wish her well in her studies.

Yours Sincerely,

Glaum R/N

Mrs. Valmai Glaum

W 433
Mafumbuka Avenue
Umlazi
4031

NPO 031-415

PO BOX 54279
Umlazi
4031
TeleFax: 031-9063317
Tel: 031-9069141

1 June 2008

Enquiries: Mr. Mjaja

The Dean
School of Nursing
Universitty of KwaZulu Natal
Durban
4001

Dear/Madam

Re: Acceptance Of Research Student At Institution

This serves to confirm that our institution will accept PHD Research Student , MEIKO DOLO ,to conduct research on:

RESIDENTIAL CARE FOR THE ELDERLY IN THE ETHEKWINI DISTRICT : A CASE STUDY APPROACH .

MEIKO DOLO will be lialising and gathering information on her research topic with our Sister in Charge Mrs Mbuyazi and the Administrator Mr Mjaja during the period of research .

It has been agreed at our initial meeting and interview with Ms Dolo that :

1. All confidential issues will be respected .
2. E.O.A.H. procedures and protocols will be followed .
3. A final copy of the research document will be submitted to E.O.A.H.
4. The Board of Management reserves a right to terminate the permission of the study should the circumstances so require.

I wish Ms Dolo all the success in her research knowing that our institution, staff and residents will benefit from her research.

Yours faithfully

T.T.Mjaja
(Administrator)

ANNEXURE C:

ETHICAL CLEARANCE FROM UNIVERSITY OF KWAZULU-NATAL

UNIVERSITY OF
KWAZULU-NATAL

ESEARCH OFFICE (GOVAN MBEKI CENTRE)
/ESTVILLE CAMPUS
ELEPHONE NO.: 031 – 2603587
MAIL : ximbap@ukzn.ac.za

4 JUNE 2008

MS. MJ DOLO (203514805)
SCHOOL OF NURSING

Dear Ms. Dolo

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0160/08D

I wish to confirm that ethical clearance has been approved for the following project:

"Institutional care for the elderly in eThekwini District: A case study approach"

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully

Ximba
.....
MS. PHUMELELE XIMBA

cc. Supervisor (Dr. P Brysiewicz)
cc. Prof. O Adejumo
cc. Post-Graduate Office

ANNEXURE E:

DATA COLLECTION TOOL

INSTRUMENT FOR DATA COLLECTION

APPENDIX II: INTERVIEW SCHEDULE
QUALITATIVE INSTRUMENT
STRUCTURE AND PROCESS ASSESSMENT

For: Program Directors and Nursing Managers (Matrons)
Date: ----------
Code: ----------
Program/Facility location: ----------

STRUCTURE OF INSTITUTIONAL CARE FOR THE ELDERLY

BACKGROUND INFORMATION OF THE ORGANIZATION (Organizational structure; philosophy of elder care; Legal framework; policies; Mission; Visions & Objectives; Demographic profiles: characteristics of organization, clients and nursing staffs)

The organizational Structure

1. What is the name of this institution and what year was this institution established? ----------
2. What is the organization al structure? How is the organization run? (Prompt: What is the composition of the board of directors? How many are they)?
3. What is the legal framework of the organization? (Prompt: Is the organization registered; does the organization run according the rules and regulations laid down by the Older Person's Act? Prompt: Do you have written policies, manuals, handbooks, protocols or guidelines on the care of the elderly for the nursing the nursing staffs?
4. What are the quality indicators for the institution?
5. What is the qualification of the person running thin home? Is the person a registered health practitioner?
6. What are the mission, vision, goals and objectives of this program? Can I have a copy of each?
7. How is the program financially sustained (Who are the donors)? How much money does the program receive? Is the money enough for the smooth operation of this home? What happens if the money is not enough? Do you sometimes fund raise? How successful is fund raising activities?
8. What is the admission requirement / process of this institution? What is the initial entrance free? How is the money paid?
9. What is the total capacity of this home?
10. What are the different services that are provided?
11. How can you describe these services? (Is rehabilitation a part of the services)?

DEMOGRAPHIC INFORMATION

The Residents (Elderly)

1. Age group of the elderly: 60 – 70: ------; 71 – 80: --------; 81 – 90: -------; Above 90: --------

2. Gender: Male: ----------; Female: ---------
3. Race: Black: ----------; Coloured: ----------; Indian: ----------; White: ----------; Other (Specify): ----------
4. Marital status: Married: ----------; Divorced: ----------; Never married: ----------; Widowhood: ----------
5. Describe the physical and mental characteristics of the elderly in this nursing home: ----------

The Staff (Nurses and Care givers)

6. What is the total number of nursing staffs: ----------
7. How many staffs are male: ------- and female: -------?
8. How many staffs are: employed: --------- volunteers: ----------
9. What is the staff composition? How many staffs are: RNs: ----------, ENAs, ----------, Physicians: ----------, Psychologists or psychiatrists: ----------, Social workers: --------, Occupational therapists: ---------, Religious persons: ----------, Other: specify: ----------
10. What is the staff-patient ratio: ----------
11. What are the qualifications of the program staffs (including paid, contract, and volunteer staff members)?
12. 9 – 12th grade: ----, Post high school: -------, Tertiary education: ------, Bachelor's degree: -------, Master's degree: -------, Other specify: ----------
13. What is the nursing staff's level of training? --------- (Please describe their levels of training?
14. Is there an in-service training program for staff? Yes -----, No: ---- If yes, please describe----------
15. Is there a staff/orientation programme? Yes: ---; No: ---. If yes, please describe----------

PROCESS ASSESSMENT

1. What are the different methods and approaches of elder care in this nursing home?
2. Please describe the level of interpersonal relationships between the nursing staff and the elderly?
3. How well is the care and service coordinated and individualized?
4. What is the extent to which the elderly are included in the area of decision making? E.g., in planning educational or other activities?
5. How are activities plan? (time table for activities) Can you describe it? Can I please have a copy?

OUTCOME ASSESSMENT

CARE AND SERVICE DELIVERY (Care and service delivery, Coordination of Care, Individuality, Interpersonal relationship)

1. Please describe the success of the program in:
    - Caring for elderly with challenging behaviour? Please explain.
2. Have you experienced any case of elder abuse in the past? How did you handle it?
3. How do you usually handle cases of elder abuse? Please explain: ----------
4. What are the elderly perspectives on the care provided? Probe: What do they usually say to you? Do they verbalize that they are happy/pleased with the care they receive?
5. What are the nursing staff's/caregivers' perspectives of their care giving interactions?
6. What are the problem areas most frequently found among the elderly population? Probe: How have you dealt with these problems?
7. What type of problems are you usually successful in solving? What type of problem are you usually unsuccessful in solving?
8. Are the Board members pleased with the quality of work been done? Please explain.
9. What is the mortality rate of the elderly? How many elderly past away in the past one or two years? What is the burial procedure? Probe: Buried by family or the program?
10. Please describe the type of programme evaluation.

APPENDIX IV: QUESTIONNAIRE

PROCESS ASSESSMENT

QUANTITATIVE ASSESSMENT
For: Nurses and Care givers
Date: ----------
Code: ----------
Program/Facility location: ----------

DEMOGRAPHIC INFORMATION

Age:

Gender:

Marital Status:

Level of Education/Training:

- Knowledge about certain professional skills

KNOWLEDGE ABOUT ELDER CARE

1. What are the different things that you do for the elderly?
2. What strategies do you use to manage challenging behaviour such as aggression?
3. How do you usually manage those elderly suffering from confusion?
4. Do you have skills in counselling?: Yes: ---; No: ---
5. Do you have any skills in problem solving?: Yes: ---; No: ---
6. How does problem solving skill help you in the care of the elderly with challenging behaviour?

Please indicate your knowledge about the following:

7. Medication management: Yes: --; No: --
8. Infection Control: Yes: --; No: --
9. Universal precautions: Yes: ---; No: ---
10. Wound Care: Yes: ---; No: --
11. Management of incontinence: Yes: --; No: --
12. Prevention and management of pressure sores:
13. Patient Safety and protecting the elderly from hazards: Yes: ---; No: ---

14. Preventing the from falls in nursing homes: Yes: ---; No: ---
15. Nutritional need of older people: Yes: ---; No: ---
16. How to connect patients to services: Yes: ---; No: ---
17. Rehabilitation need of the elderly: Yes: ---; No: ---
18. The need for exercise for the elderly: Yes: ---; No: ---
19. Recreational need for the elderly: Yes: ---; No: ---
20. The need for respite care for the elderly care giver: Yes: ---No: ---
21. Palliative care and dying: yes: ---; No: --
22. Spiritual needs of the elderly: yes: ---; No: ---
23. How did you acquire this knowledge? A. During my professional training; B. In-service training; C. Doctors and senior nurses; D. Other: Specify: ----------
24. How does this knowledge affect your care to the elderly?

APPENDIX VI: INTERVIEW SCHEDULE

OUTCOME ASSESSMENT

For: The Elderly

Date: ----------

Code: ----------

Program/Facility location: ----------

DEMOGRAPHIC INFORMATION

Age

Gender: Male: ------ / Female: -------

Race: Black: ----------, Whites: --------, Colored: ------, Indians: _____, Others: ---

---

Marital Status: Married: --------, Single: --------, Widow: --------, Divorce: --------, Separated: ----------

ACTIVITY OF DAILY LIVING

1. Level of self care: Disability Assessment: Standard Instrument: (ADLs)

GET UP AND GO TEST

2. Mobility Assessment: Standard Instrument: (Get up and go test)

MINI MENTAL STATE EXAM

3. Mental Status (Cognition) Assessment: Standard Instrument: MMSE Instrument

EXPERIENCES OF THE ELDERLY

4. How can you describe your current heath status?
5. How do these characteristics affect the care you receive?
6. How long have you been living here? How did you come here?
7. How is it like staying in this home?
8. How can you describe the attitude of the care givers? How can you describe your attitude toward the care givers?
9. Do you have any family members? Do they visit you? How often do they visit you?
10. How is it like for you to live away from your family?
11. How can you describe your health status?
12. How can you describe your quality of life?
13. Are you satisfied with the care you receive? What aspect of the care are you satisfied with? What aspect of it you are dissatisfied with?
14. What changes would you like to see implemented here?

APPENDIX VII: CHECKLIST

For: Document Review
Code: ----------
Date: ----------
Program/Facility location: ----------

ype of Document	Available	Unavailable	Compiled by	Maintained
lission Statement				
'ision				
ioals				
)bjectives				
'olicies: Scope of practice (SANC)				
tegister				
ob description				
\ctivity Schedule				
'rocedure manuals				
\dmission				
)ischarge				
Transfer				
Referral				
Protocols/guidelines for:-Admission -Assessment -Care giving -Infection Control -Informed consent -Discharge -Death and burial -Transfer -Referral				
Communication: Ambulance services Referral to hospital				
Training Manual				
Activity Schedule				
Others (specify)				
Total				

APPENDIX VIII: CHECKLIST

For: Observation Checklist
Code: ----------
Date: ----------
Program/Facility location: ----------

Checklist for observing care giving environment and interactions between nursing staffs and the elderly

Description of the environment	Characteristics of the environment	Description of care giving interactions: nursing staffs and the elderly during activities of daily living (ADLs)	Communicating with the elderly	Other (Specify)
Single room	Tidy	Feeding	Normal tone of voice	
Dormitory	Dirty	Bathing	Shouting at the elderly	
Other (specify	Other (specify)	Dressing	Calling names	
		Other (specify)	Abusive: (verbal, physical, emotional, etc)	

ANNEXURE : F

THE DQ98 – DEPENDENCY QUESTIONNAIRE (1998) AND MANUAL

Department of Social Development
Empowering the Nation

Private Bag x 901
PRETORIA
0001
Republic of South Africa

DQ98 - DEPENDENCY QUESTIONNAIRE (1998) AND MANUAL

October 2000 edition

USER MANUAL FOR DQ98
Assessment for Admission to Homes for Frail Persons and / or Support Service Requirements for Older Persons

The DQ98 (Dependency questionnaire, release 1998) has been developed to assist with the assessment of needs for persons requiring frail care or support services. The accurate completion of the documents will enable the Department of Welfare and relevant organisations ensure that the appropriate service is provided. The DQ98 replaces all previous assessment instruments.

Because the format used for assessment differs significantly from previously used methods, this manual has been prepared. The assessment is based on the dependency needs of the client, rather than the medical and social diagnoses.

The manual is provided to enable assessors to complete the forms accurately according to the meanings and criteria, which have been researched nationally. Please read it carefully, and ensure that it is available for reference, particularly when completing the sections relating to dependency needs.

The form is divided into 5 sections:

Section 1 **Registration details** of the client and the person doing the assessment.

Section 2 **Assessment of dependency needs of the client.** Subsection 2A provides an opportunity to indicate the degree of urgency of the application. Subsection 2B is a score based needs assessment where reference to the manual is essential.

Section 3 **Key to assessment for service requirement** provides the frame for calculating the score and recording the findings.

Section 4 **Recommendation.**

Section 5 **Conclusion of assessment.**

Please ensure that <u>all</u> sections are answered by placing a tick or cross in the relevant block. Do not write in the shaded areas. Space is provided for additional information.

Annual re-evaluation

For the purposes of annual re-evaluation the information required is limited to a portion of section 2 and the confirmation of personal details.

Further information and enquiries should be directed to the Department of National Welfare or you local Social Services officers.

Contents

Philosophy of DQ98

The evaluation of persons for admission to frail care is based on the dependency needs and levels of safety of the frail person, and is not dependent on the medical diagnosis, social or health problems. These contribute to the history of the client when undertaking a holistic evaluation, but do not constitute the criteria. The evaluation therefore depends on an objective assessment of the ability of the client to carry out various functions and activities which are required to maintain a safe environment and function at a satisfactory level. The utilisation of community and social resources is also evaluated as effective referrals may enable a client to remain in the community and family setting.

Overview of scoring system:

The scores commence in SECTION 2 It will be seen that, in this and subsequent sections, the boxes that need to be marked contain numbers, each giving a certain number of 'points' if the client qualifies for that particular criterion.

For example, under pressure care the points scored go from 0 to 11 to 22 to 33. The reason that these particular scores apply here while different scores apply in other sections is that the dependency implications of each and every domain in the DQ98 has been carefully evaluated. As a result relatively more points apply to some sections than to others.

Each section needs to be completed in its own right, the sub-total for that section must be obtained by adding the scores from the subsections. These sub-totals are carried over to SECTION 3, where the sub-totals are multiplied by a weighting index. These weighted sub-totals are added to each other to give the DQ98 Index score.

Detailed description

1. Skilled Care

   It will be seen that this sub-section has 3 domains, namely Pressure Care, Specialised Care, and Night Care. Make a cross in the box in each of these domains that most accurately describes the client's need for Skilled care. Then write the number in each of the boxes that you have marked in the 'Skilled Care Total' sum, and add a+b+c to get the 'Skilled' Care subtotal. Write this subtotal in the appropriate box in SECTION 3.

2. Activities of Daily Living

   Make a cross in each of the 10 domains in this subsection, taking care to observe the definitions in the Manual. Add up the Total for all the Marked blocks and write this in the block called 'Total for ADLs'. Write this subtotal in the appropriate box in SECTION 3.

3. Mental Functioning

Make a cross in the correct box in this subsection, taking care to observe the definitions in the Manual. Write the number from the Marked block in the block called 'Score for Mental Functioning'. Write this subtotal in the appropriate box in SECTION 3.

3. Primary Needs

Make a cross in each of the 4 domains in this subsection, taking care to observe the definitions in the Manual. Add up the Total for all the Marked blocks and write this in the block called 'Primary Total'. Write this subtotal in the appropriate box in SECTION 3.

4. Community infrastructure

This section does not have a "point" allocation, but must be completed to provide admissions committees with sufficient information to prioritise admissions to homes.

5. Support Systems Available to Client

Make a cross in the correct box of this subsection, taking care to observe the definitions in the Manual. Write the number from the Marked block in the blocks called 'Section 6 Score'.

6. General Functioning of the Care-giver

Make a cross in the correct box of this subsection, taking care to observe the definitions in the Manual. Write the number from the marked block in the blocks called 'Sections 6 Score'.

The Scores for Sections 6 & 7 are added together (i.e. Support Systems Available to Client + General Functioning of Care-giver). Write this in the block called 'Total Section 6 + 7 "Carer"' and also carry over to the appropriate block in SECTION 3.

In section 3 the scores are multiplied by the weighting factor and added together to obtain the Index score.

SECTION 1: REGISTRATION DETAILS

A. Organisation:

Refers to the organisation to which application is being made, or the frail care in which the client is resident. A space is provided for a registration number where applicable.

Type of assessment:

Please indicate the purpose of the application according to the categories provided.

Urgency:

This refers to the urgency with which the client needs to be provided with the required support or admission to a frail care facility.

Place of assessment

Please indicate where the assessment is being done, e.g. sheltered accommodation or community centre (club) or client's own home (the home in which the client lives).

Reasons for referral:

Why is the client in need of the assessment? Is it for increased support (e.g. meals on wheels or home help), or for a request for admission to a frail care facility or residential care?

Assessor: Please write your name here.

Occupation of assessor: write your trained profession (if appropriate) e.g. professional nurse, Occupational Therapist, physiotherapist, social worker, medical practitioner, etc.; if you do not have formal training, write "LAY".

Reference source: indicate the source from which the referral was received.

B. Client's personal details : Complete as indicated
Note: "Race" is included for statistical purposes only.

Source of income: Please indicate client's source of income, e.g. Disability grant, 'Old Age Grant or private pension, civil service pension, (SAPS, SANDFN) etc. More than one block may be ticked.

Gross income per month: refers to the total monthly income before tax, medical aid, insurance and other deductions, either for the client if he/she is single, or the couple if married.

Accommodation: This refers to where the client normally lives permanently.

"Retirement complex" refers to housing where individuals live independently but have access to social and support services.

"Housing scheme" refers to an owner of a house which forms part of a subsidised housing scheme, without any support system.

"Tribal" refers to rural, traditional housing arrangements.

Other: If the client's accommodation is not listed, please specify in writing.

Family composition: This relates to the number of people living in the same dwelling, house or flat as the client. More than one category may be ticked.

"Other elderly" refers to a non-family member who is of the client's age group, such as group housing.

"Extended family" refers to different generations of the same family living in the same dwelling or groups of dwellings.

"Rural extended family" refers to living arrangements where support is derived from family members more distant than first degree relatives (brothers, sisters, parents or children).

Please state the number of persons living in the household.

C. Needs identified by client:

Write details identified by the client or immediate carer, e.g. "a secure place to live" or "regular meals" or "someone to help me bath" (Note that several needs may be listed here)

Source of information

It is essential to have the most accurate possible assessment of the client. If you feel it is necessary to speak to people (e.g. care-givers) other than the client to fully assess his/her dependency, please do so. Indicate the additional sources of information.

D. Details regarding next of kin / caregiver: Please provide the relevant information concerning the person responsible for the client's welfare. This information is required for following up assessed clients or if there is an appeal against the findings of the assessment.

SECTION 2 : ASSESSMENT

A. Urgent evaluation criteria

This section does not contribute to the admission criteria score, but it indicates a particular degree of severity or urgency.

Bedbound: A client who is bed bound due to severe physical illness or frailty.

Mentally disabled with total incontinence: A severely mentally disturbed client with total incontinence of bladder and bowels.

Chronic high risk medical condition requiring continuous nursing: A client with one or more chronic high risk conditions requiring continuous nursing care. Examples such as end stage lung disease requiring continuous oxygen, a brittle diabetic requiring insulin or a poorly controlled epileptic or cardiac.

Other Medical Conditions : List the medical conditions (diagnoses) from which the client suffers as the basis of the medical history required on admission.

B. Criteria for admission

This section deals with specific needs which may justify admission into a frail care facility. It is divided into various categories. Each category is scored differently according to a predetermined weighting which is the number reflected in the block next to the description of the level of assistance or need. They are not necessarily progressive.

Please note:

(i) The descriptors used in the form are insufficient to assess the client needs, the manual provides more specific guidance.

(ii) Certain descriptors may not be relevant in an activity being assessed, such as " "eating" – needs help of two persons". These are indicated "N/A" and should not be used.

Note regarding Descriptions - the definition of the categories given in this Manual is the one to learn and use; those that appear in the questionnaire itself are over-simplified and serve only as memory aids for the interviewer.

The DQ98 does not attempt to measure impairment or to categorise impairments. Considerable effort is made to gather information on disability and care-giver needs (dependency). Therefore, the effect of any specific physical impairment is expressed as its consequent disability/dependency.

(For example, if one considers visual impairment, it is possible to measure the severity of impaired vision accurately; but what is relevant here is whether the client's visual impairment renders him dependent on others for care and, if so, the amount of care that is required. It will be seen, therefore, that apart from the relevance of vision with respect to communication, there is no specific section dealing with the effects of loss of eyesight. The reason for this is that the implications of blindness would automatically be incorporated in the need for assistance with dressing, mobility, eating etc. Similarly, there is no specific item dealing for example with arthritis, or the loss of one arm, etc. We know that in older persons there are often several causes of dependency with respect to certain activities of daily living - again, the specific cause of impairment is not important here, but rather the degree of disability/dependency.)

1. Skilled Care:

This relates to the need for skilled care or a heavy burden of care, and aims to focus on the 24 hour dependency requirements The care demands resulting from these conditions is such that the care giver is unlikely to manage the client even with support from community services (e.g. community sister, trained care giver).

a. **Pressure care**:

Nil The client requires no pressure care as they are fully mobile and have no pressure sores.

1 - 3 x per day : requires attention to pressure areas 1 – 3 x daily to prevent abrasions or sores.

Every 4 hours: requires 4 hourly pressure care / turning

Every 2 hours: requires 2 hourly pressure care / turning

b. **Specialised care**:

The client is on a regular treatment such as insulin injections based on blood sugar levels or dressing of wounds on an ongoing basis. These are self explanatory. Routine blood pressures and blood sugars are not included.

Requires no care / dressings: No dressings or special care required.

Simple daily treatment or dressings: Treatment or dressings which the client cannot do for themselves, either once or twice daily.

Requires complicated treatment **or** dressings 3 or more times per day: The client requires a treatment which can only be provided by a professional person, **or** requires wound care 3 or more times a day.

c. **Night-care:**

This relates to the need for any form of care, attention and supervision which results in the client needing the carer to get up to attend to the client during the night on a regular basis.

Nil or infrequent night care required: Seldom requires the attention of the carer once the client has been settled for the night.

Regular, 1 x per night care required: Client must be attended to at least once during the night.

Regularly requires attention 3 x per night: Client requires regular attention during the night.

Usually awake, restless, disturbing others: This is self explanatory.

A space is provided to list the medical conditions from which the client is suffering, make additional comments and list the medications currently being used.

2. Activities of daily living (A.D.L.S)

Definitions A few terms are used quite specifically in the DQ98, and are defined accordingly. These are very important; bear them constantly in mind!

'supervision' means 'keeping an eye on' the client to ensure that a task is being done, and may include prompting or coaxing the client verbally - it does not include physically assisting the client. For example, reminding a demanding client to dress or eat.

'helping' means that physical contact with the client is required or help in using an aid that the client normally uses is required.

Due to the nature of the activities, only "toileting" and mobility qualify for a score in either "needs help of two persons" or "needs continuous care". The remaining activities are only scored on one of these levels.

a. **Eating**

Includes the use of suitable utensils to bring food to the mouth, chewing and swallowing once the meal is presented in the customary manner.

Fully independent: The client can eat a plate of food or drink without any help.

Independent with aid devices: The client eats and drinks independently but requires use of specially adapted cutlery to cut the food, or spread butter etc.

Needs supervision but manages on his own: The client manages to feed or drink by him/herself (with or without an assistive device) but needs constant prompting throughout the meal otherwise the meal is not fully eaten.

Needs regular supervision and help with certain tasks: The client needs assistance with associated tasks such as cutting up food, adding salt or pepper to food, opening cartons of milk, adding sugar or milk to tea and pouring liquids, but the client does contribute to the task.
(**Note** that any help needed in getting to his/her food or bringing food to the client is a feature of mobility; this section simply determines whether the client is independent with respect to feeding him/herself.)

Needs help of one person: Client needs to be fed.

Needs help of two persons: Does not apply to feeding.

Needs continuous care. Client not able to eat or drink normally and relies on other means of feeding such as gastrostomy or nasogastric feeding and does not administer the feeds him/herself.

b & c. **Dressing**

This is divided into **upper body** (shirt, bra, dress, etc.)and **lower body** (sock, pants and underpants), as they result in different dependency levels. The descriptions refer to both the 'upper body' and 'lower body' sections of the questionnaire which are to be filled in separately.

This includes dressing and undressing as well as applying and removing prosthesis or orthosis, where applicable. An orthosis is a device applied to or around the body in the case of physical impairment or disability, such as an artificial limb.

Fully independent: Client dresses and undresses independently including getting clothing from drawers, wardrobes, etc. and manages to put on all garments, manages zips, buttons, press studs and can tie shoe laces and is able to apply or remove prosthesis or orthosis when applicable.

Independent with aid devices: Client requires special adaptive fastenings such as velcro or an assistive device to dress or takes more than reasonable amount of time to get dressed or undressed.

Needs supervision but manages on own: Client requires supervision e.g. watching and prompting, or setting out clothes or dressing equipment.
(**Note** that any help needed in getting to clothes or bringing clothes to the client is a feature of mobility; this section simply determines whether the client is independent with respect to dressing).

Needs regular supervision and help with certain tasks: Client requires demanding supervision and help in dressing and undressing, but client does co-operate and tries to assist with dressing and undressing. Requires assistance with fastening clothing such as zips, buttons, bra, shoes, etc.

Needs help of one person: Client needs physical assistance for most aspects of dressing and undressing, but is able to participate to some degree with putting on and/or removing clothing.

Needs help of two people: Client is dependent in all aspects of dressing and is unable to participate in the activity.

Needs continuous care: Does not apply to dressing.

d. **Personal Hygiene**

This includes mouth care and denture care, washing of hands and face, shaving, combing or brushing hair.

Fully independent: Client performs the above tasks independently and performs them safely.

Independent with aids or devices: Client needs aid devices (e.g. an adapted comb) for personal hygiene.

Needs supervision but manages on his/her own or with minimal assistance: Client requires supervision e.g. watching or prompting, otherwise the tasks are not completed.
(**Note** that any help needed in getting to items needed for hygiene or bringing such items to the client is a feature of mobility; this section simply determines whether the is independent with respect to performing their own tasks of hygiene.)

Needs regular supervision and help with certain tasks: Client needs supervision and assistance with some tasks, e.g. setting out equipment, opening a tap, applying toothpaste to a tooth brush, or opening containers.

Needs help of one person: Client needs assistance with almost all aspects of hygiene, but is able to participate to some degree with personal hygiene.

Needs help of two persons: Does not apply to hygiene

Needs continuous care: Requires constant attention due to continuous soiling. Client is dependent in all aspects of personal hygiene and is unable to participate in the activity. This category only applies in exceptional circumstances.

e. **Bathing**

This includes washing, rinsing and drying the body from the neck down *excluding the back*; may be either in a bath, a shower, a basin or sponge/bed bath.

Fully independent: Client is fully independent with bathing. Can get in and out of the bath or shower, can sit down in the bath and stand up from sitting; he/she can reach the taps and turn taps on and off and is able to wash and dry him/herself. Does not require a second person in the bathroom.

Independent with aids or devices: Client can perform the above task but needs an aid device, e.g. long handled sponge, special board to sit on or aid devices to open and close taps.

Needs supervision but manages on his/her own: Client baths/showers independently but needs prompting to enable him/her to complete the task.
(**Note** that any help needed in getting to the bath or bringing a basin to the patient is a feature of mobility; this section simply determines whether the is independent with respect to using the bath/basin.)

Needs regular supervision and help with certain tasks: Client needs some help with certain tasks, e.g. with getting in and out of the bath or supervision is required for safety, e.g. adjusting water temperature or setting out equipment for bathing.

Needs help of one person: Client is dependent on the help of one person in all aspects (e.g. transfer to a bath tub or shower and needs help with washing and drying, but is able to participate to a minimal degree.

Needs help of two persons: Client dependent on 2 persons for some (or all) aspects of bathing.

Needs continuous care: does not apply to bathing.

f. **Toileting**

Includes getting on and off the toilet, maintaining hygiene of private parts and adjusting clothing before and after using the toilet. It also includes the ability to manage a stoma or catheter independently.

Fully Independent: Client is able to perform all tasks of toileting safely.

Independent with aids or devices: A client is independent in toileting with some aid devices and, in addition, the client is able to empty and clean the aids where applicable.
[Bed pans, commodes, urinals, pads, a raised toilet seat or bars fitted on sides of the toilet or catheters are aids or devices.]

Needs supervision but manages on his own: Client manages on his own, but needs some prompting to carry out the task.
(**Note** that any help needed in getting to the toilet or bringing a commode to the patient is a feature of mobility; this section simply determines whether he/she is independent with respect to using the toilet / bedpan / commode.)

Needs regular supervision and help with certain tasks: Client needs supervision for safety and needs assistance in getting on and off the toilet and emptying or cleaning the toilet, commode or bed pan where applicable.

Needs help of one person: Client needs assistance of one person in all aspects of toileting, i.e. with getting on and off the toilet, adjusting clothing, and cleaning of the private parts as well as emptying and cleaning the bed pan where applicable. Requires regular assistance to empty urine bag or care for stoma. Needs to be taken to the toilet regularly to prevent incidents of incontinence.

Needs support of two people: Client needs assistance of two people in all aspects of toileting, e.g. due to a client with stroke and obesity or severe joint deformities with stiffness.

Needs continuous care: Client needs assistance in all aspects of toileting as he/she is incontinent of **both** urine and stool which is not controlled by regular toileting.

g. **Medications**

Includes opening containers, counting the tablets according to prescribed dosage, taking the medication, tablets or nebuliser in correct amounts or administering injectable medications where applicable.

Fully independent: Client can safely administer his/her own medication and control it independently, that is, he/she remembers when to take his medicines and when to request renewal of his/her stock.

Independent with aids or devices: Client uses special devices to open pill boxes, or uses a pill dispenser of other aid device.

Needs supervision but manages on his/her own: Client needs to be reminded when the administration of medication is due and dosage needs to be checked for safety. (Client swallows medicines without requiring any assistance.)

Needs regular supervision and help with certain tasks: Client needs help with opening containers and drawing up injectable medication.

Needs help of one person: Client needs help of another person for all aspects of administering medication, including placing it in the client's mouth or injecting the medication (e.g. insulin), but is able to participate to some degree.

Needs help of two people: Not applicable to medications.

Needs continuous care: Client is not able to swallow and medication is administered via a nasogastric tube **or** by injection and client is unable to participate in the process, and is prone to severe crises if not taken accurately eg: Brittle diabetic, Epileptic.

h. **Mobility**

This includes walking, climbing stairs, walking up a slope, getting in and out of a car or bus, walking in the street including kerbs.
If he / she is wheelchair bound, the ability to move about in the chair independently or with help needs to be assessed.

Fully independent: Client is independent and safe in all aspects of mobility.

Independent with aids or devices: Client is able to mobilise independently but requires assistive devices e.g. walking stick, crutches, prosthesis or wheel chair.

Needs supervision, but manages on his/her own: Supervision is required in some aspects of mobility for safety or as a confidence measure.

Needs regular supervision and help with certain tasks: Client needs to be watched for safety and needs physical help for certain tasks, e.g. going up stairs, going into public places or walking long distances.

Needs help of one person: Needs constant help by one person for all aspects of mobility, but is able to contribute. This includes the demented person who wanders off and required constant supervision.

Needs help of two persons: Needs help by two persons for all aspects of mobility.

Needs continuous care: Due to mental impairment, client is constantly active and at risk of falling.

i. **Communication**

This includes intelligible/sensible communication through speech, hearing and vision (sign language or some other visual method of communication).

Fully independent: Independent in communication.

Independent with aids or devices: Independent when using hearing aids, speaking devices.

Needs supervision, but can manage on own: Does not apply to communication

Needs regular supervision and help with certain tasks: Client requires assistance with communications or guidance/directions in public places.

Needs help of one person: Client needs one person to assist in communication in public places because of speech or hearing disorder.

Needs help of two persons: Does not apply to communication

Needs continuous care: May apply to clients with two or more communication deficits (e.g. blind and deaf etc.) or where client's attempts at communication are wholly ineffective.

j. **Transfers**

Includes transferring from bed to a chair or wheelchair and back with safety.

Fully independent: Needs no help or assistive devices.

Independent with aids or devices: Devices (bed hoist, special handles etc.) are necessary, but can be handled by client without any help.

Needs supervision but manages on own: The client needs prompting, coaxing etc., without the supervisor physically having to help the client.

Needs regular supervision and help with certain tasks: Client needs supervision for safety **and** needs physical assistance e.g. to steady a chair, etc.

Needs help of one person: Client always needs assistance of one person for transfers, but is able to contribute to some extent.

Needs help of two persons: Client needs two persons to transfer him/her safely.

Needs continuous care: Does not apply to transfers.

3 Mental functioning

NB. This is not based on medical diagnosis. Where a mental illness has been diagnosed, this should be provided in section 2A "Medical conditions and diagnoses".

This section deals relates to the client's behaviour resulting from an impairment of their mental function.
These categories are not necessarily incremental by nature, and should be assessed according to the actual behaviours exhibited.

No support required: Client has normal memory and mood and requires no support.

Observes accepted social standards with support: Client has poor memory or is known to have a mental illness such as depression, but behaviour is normal except that he/she requires regular reminders of certain tasks or needs regular counselling.

Behaviour is unusual but does not offend others or endanger self: Self explanatory.

Behaviour disturbing to others at times but not a danger to self or others: Client has loss of memory associated with the repetitive questions and restlessness; or disturbs others regularly due to other underlying mental disability.

Continuous, uncontrollable, demanding behaviour: Client is constantly seeking attention, shouting in an uncontrollable manner, but is not a danger to self or others.

Behaviour dangerous / risk to him/herself or to other people: Client's life is endangered by forgetfulness, confusion, paranoia and mental illness or he/she is a threat to the safety of others.

Would a formal psychiatric assessment be beneficial?
State if you think that a formal assessment would assist with the management of the client or improve their psychiatric illness management. This is your opinion, based on the interview. (Input from professionals may be included if necessary).

4 Primary Needs

This section applies only to community dwelling clients and it records information regarding the accessibility of water, food, toilet and safe shelter for the client. Make a cross in the 'Not applicable' box if the client is currently institutionalised.

a. Water

This deals with the accessibility of a running water supply to the client.

Available: The source of water supply is readily available to the client, i.e. tap water within the house and there are no physical obstructions.

Limited: The source of client's water supply is outside the house; or inside the house, but up or down one or more flights of stairs.

Inaccessible/dangerous: Client has to walk more than 50 metres to get to the nearest tap; or is subject to potential harm in getting to the water supply.

Not available: Client has to rely on a water supply from a river or well which involves walking a long distance.

b. **Food**

Available: Shops and other sources of food are easily accessible, i.e. within easy walking distance; and the client is able to prepare / access food from its point of storage.

Limited: Shops and other sources of food are accessible but can only be reached with difficulty; or is available, but the client is unable to access it due to disability.

Inaccessible / dangerous: Shops and other sources of food are at a distance and client or care giver requires to use public transport to get basic food requirements.

c. **Toilet**

Available: Toilet facilities are within easy reach for client i.e. within the house.

Limited: A toilet is nearby the dwelling, but the client can get to it without difficulty.

Inaccessible / dangerous: Toilet facilities are available but are not readily accessible to the client.

Not Available: No formal toilet structure within 100 metres of the patient's dwelling.

d. **Safety**

This includes security, fire safety and structural safety of dwelling as determined by the interviewer.

Available: Client's dwelling is secure with adequate door and window locks. His/her cooking facilities do not represent a fire hazard. The client's dwelling (including stairs) appears to be structurally sound.

Limited: Client's dwelling is secure but there is a fire hazard (e.g. loose wiring, use of candles or other open fires) or the dwelling structure may be unsafe.

Inaccessible / dangerous: Client's home has inadequate security and does not offer reasonable protection against intruders.

Not Available: No security or safety measurement apparent.

5. Community infrastructure

These are facilities that are necessary to the elderly person for him/her to cope in the community. These do not have a "score" but should be completed. Make a cross in the 'Not applicable' box if the client is currently institutionalised.

a. **Transport** (public or private)

Available: The client has ready access to private or public transport.

Limited: Transport is available in the vicinity, but some distance from the dwelling.

Inaccessible/dangerous: Client relies on public or other transport but it is relatively inaccessible or in a dangerous area.

Not available: No transport available.

b. **Telephone**

Available: Client has a telephone available in his/her own dwelling.

Limited: Telephone not available in the client's dwelling but readily accessible in the vicinity.

Inaccessible / dangerous: Not within walking distance or only available in a dangerous area.

Not available: No telephone service in the area.

c. **Post Office or pension pay-out point**

Available: Easily accessible.

Limited: Not readily accessible in the vicinity.

Inaccessible/dangerous: Not within walking distance or in a dangerous area.

Not available: Not available in the community where the client lives.

6. Support systems available to client

This represents a social network system that helps the client meet his/her needs. In some instances the support systems are available but the client is unaware or unwilling to use the services. By implementing such services it may be possible to maintain the client in the community.

Make a cross in the 'Not applicable' box if the client is currently institutionalised.

Support systems functioning well: Client lives with spouse who is in good health; or lives with a member of the family who is very supportive, or is actively supported by the immediate community.

Support system available but not functioning well: A spouse, family member or friend is available but is not very supportive to the client; or unable to support the client effectively. The support may be available but the client refuses to use the resources.

Living alone with access to other support systems: Client lives alone but has support from family, friends or neighbours who are easily accessible and supportive.

Only formal support system: Client's only support system is from professional organisations, e.g. social worker, district nurse or from clubs or the church.

Support system available but exploitation / abuse / neglect suspected: This is the interviewer's opinion, based on the interview and information available. (Input from other professionals may be necessary).

No support system available: Client lives alone and has no support from family, friends, social welfare, clubs or church etc.

7. General functioning of care giver **NB. This refers to the caregiver, not client.**

Many clients would be at great risk if the primary carer becomes unavailable or can no longer cope. This evaluation assists with decision making in the community setting, and also alerts the welfare and health agencies as to potential risk. Make a cross in the 'Not applicable' box if the client is currently institutionalised.

Care-giver fully in control of the situation: The care-giver is providing adequate care to the client and him/herself.

Care-giver requires some support: The care-giver is managing well but needs some support for caregiving (e.g. counselling, home-help, etc).

Not healthy / aged / disabled / emotionally frail: Care-giver is frail or other factors are present which may lead to an inability to provide care at any given time.

Requires continuous support / help: Care-giver needs to employ a carer to provide the necessary support and care to enable the client to remain in the community.

Total incapacity to provide care: Caregiver is unable to provide care due to personal, physical or mental infirmity. e.g. care-giver who is her/himself developing a dementing illness and is not capable of rendering the necessary support.

Total burn out: Care-giver is physically and emotionally exhausted, placing the client at risk .

7. Other persons involved in assessment

Please indicate which health professionals assisted you in the evaluation of this client.

SECTION 3: KEY TO ASSESSMENT FOR SERVICE REQUIREMENT

a. Calculation of Index Score

This section provides for the calculation of the DQ98 Index Score.

To calculate the DQ98 Index Score, follow the formula in SECTION 3.

Scores are added together in each sub-section and transferred to the first open column in Section 3. Now multiply each of the individual subtotals by the weighting number shown on the shaded column in SECTION 3, using the attached tables. For example, "skilled care" total is x 0.2, "ADL" x 0.25, etc The results are written in the second open column, are then added to obtain the final total. This is the DQ98 Index score.

If a score of, for example 27 was brought over from Section B1 (Skilled Care), this number should be multiplied by 0.2, thus 27 X 0.2 = 5.4 For your convenience, a table with all the possible calculations is supplied on the following pages.

Section B1 (Skilled care) multiply by 0.2;
Section B2 (ADL's) multiply by 0.25;
Section B3 (Mental functioning) no multiplication as it has a weight of 1;
Section B4 (Primary needs) multiply by 0.15;
Section B5 (Community infrastructure) not scored;

Section B6 (Support systems available to client) add to section 7;
Section B7 (General functioning of care-giver) with section 6. multiply by 0.15

Having done the above multiplications and having written each answer in the appropriate box on the right, add the numbers in the 5 boxes together and the resulting Total will be the DQ98 INDEX SCORE.

The Index Score will provide an indicator to establish the need for admission to a frail care facility according to the guidelines set by the Dept of Welfare.

b. **Findings**

Please state your opinion based on you interview and assessment what type of care or support is required by ticking the appropriate box.

SECTION 4. RECOMMENDATION

In this Section the interviewer is required to make several recommendations, based on the information gathered using the DQ98.

- **The columns relating to community services "in use" should be completed even where an admission is recommended.**

  First, it should be decided whether Admission to a frail care facility or residential care is recommended.

- If the answer to this question is 'Yes', then it should be decided whether the client's condition and circumstances warrant 'urgent' admission or whether the client may be placed on a waiting list.

- If the client does not warrant admission or if the client is to be placed on a waiting list, the assessor should recommend:

  - whether community services are required,
  - the input of required from medical specialists (a psychiatrist, medical physician or geriatrician). If any of the latter specialists are to be consulted, a specific doctor should be identified and an appointment made on behalf of the client, and noted in the document.

- If Community services are advisable, then the Subsection headed '**Support services recommendation**' should be completed and the necessary services arranged.

- **Note** This Section requires that you indicate:

  - which Services are currently being used;
  - whether in your opinion the services being used are ineffective and could be stopped;
  - whether additional Services are needed - indicate this by making a cross in the 'Needed' blocks.

SECTION 5. CONCLUSION OF ASSESSMENT

The assessor is required to discuss the findings of the assessment with the applicant – either the client or the person who has made the application. It is important to ensure that the process of the assessment has been transparent and that the client (applicant or care-giver) has been party to the assessment.

The applicant (for support services or admission to a frail care) is required to indicate that he/she

- agrees or disagrees with the assessor's recommendation; and
- to grant permission for the information contained in the document to be passed on to the Management of the relevant Home for the aged or other Organisation.

Where the applicant does not agree with the assessment, recommendations, or referral, they are provided with a space in which to motivate for a re-evaluation by another assessor.

The final line in this Section indicates who the next person or body will be that will be responsible for helping the client reach a satisfactory conclusion of his/her application.

Annual Reassessment of Residents currently in Frail Care Facilities.

Assessment for persons in frail care facilities requiring re-assessment requires the completion of the following:
Section 1. Check that the personal, family and financial details remain accurate;
Section 2, subsections B1 (criteria for admission), B2 (activities of daily living) & 3 (mental functioning) only.

The scores are transferred to Section 3 as is done in the pre-admission assessment, multiplied by the relevant factor, and added together to obtain the Index score.

The Index Score for reassessment will be established by the Dept. of Welfare.

Manual written by: Dr S Kalula, Prof. S Louw, Mrs D Regensberg, Mrs K Brodrick
Revised: D Regensberg, October, 1998.

Calculation Tables for Section 3

"Primary" "Carer"	x 0.15	"Skilled"	x 0.2	"ADLs"	x 0.25
0	0	0	0	0	0
1	0.15	1	0.2	1	0.25
2	0.3	2	0.4	2	0.5
3	0.45	3	0.6	3	0.75
4	0.6	4	0.8	4	1
5	0.75	5	1	5	1.25
6	0.9	6	1.2	6	1.5
7	1.05	7	1.4	7	1.75
8	1.2	8	1.6	8	2
9	1.35	9	1.8	9	2.25
10	1.5	10	2	10	2.5
11	1.65	11	2.2	11	2.75
12	1.8	12	2.4	12	3
13	1.95	13	2.6	13	3.25
14	2.1	14	2.8	14	3.5
15	2.25	15	3	15	3.75
16	2.4	16	3.2	16	4
17	2.55	17	3.4	17	4.25
18	2.7	18	3.6	18	4.5
19	2.85	19	3.8	19	4.75
20	3	20	4	20	5
21	3.15	21	4.2	21	5.25
22	3.3	22	4.4	22	5.5
23	3.45	23	4.6	23	5.75
24	3.6	24	4.8	24	6
25	3.75	25	5	25	6.25
26	3.9	26	5.2	26	6.5
27	4.05	27	5.4	27	6.75
28	4.2	28	5.6	28	7
29	4.35	29	5.8	29	7.25
30	4.5	30	6	30	7.5
31	4.65	31	6.2	31	7.75
32	4.8	32	6.4	32	8
33	4.95	33	6.6	33	8.25
34	5.1	34	6.8	34	8.5
35	5.25	35	7	35	8.75
36	5.4	36	7.2	36	9
37	5.55	37	7.4	37	9.25
38	5.7	38	7.6	38	9.5
39	5.85	39	7.8	39	9.75
40	6	40	8	40	10
41	6.15	41	8.2	41	10.25
42	6.3	42	8.4	42	10.5
43	6.45	43	8.6	43	10.75
44	6.6	44	8.8	44	11
45	6.75	45	9	45	11.25
46	6.9	46	9.2	46	11.5
47	7.05	47	9.4	47	11.75
48	7.2	48	9.6	48	12
49	7.35	49	9.8	49	12.25

"Primary" "Carer"	x 0.15	"Skilled"	x 0.2	"ADLs"	x 0.25
50	7.5	50	10	50	12.5
51	7.65	51	10.2	51	12.75
52	7.8	52	10.4	52	13
53	7.95	53	10.6	53	13.25
54	8.1	54	10.8	54	13.5
55	8.25	55	11	55	13.75
56	8.4	56	11.2	56	14
57	8.55	57	11.4	57	14.25
58	8.7	58	11.6	58	14.5
59	8.85	59	11.8	59	14.75
60	9	60	12	60	15
61	9.15	61	12.2	61	15.25
62	9.3	62	12.4	62	15.5
63	9.45	63	12.6	63	15.75
64	9.6	64	12.8	64	16
65	9.75	65	13	65	16.25
66	9.9	66	13.2	66	16.5
67	10.05	67	13.4	67	16.75
68	10.2	68	13.6	68	17
69	10.35	69	13.8	69	17.25
70	10.5	70	14	70	17.5
71	10.65	71	14.2	71	17.75
72	10.8	72	14.4	72	18
73	10.95	73	14.6	73	18.25
74	11.1	74	14.8	74	18.5
75	11.25	75	15	75	18.75
76	11.4	76	15.2	76	19
77	11.55	77	15.4	77	19.25
78	11.7	78	15.6	78	19.5
79	11.85	79	15.8	79	19.75
80	12	80	16	80	20
81	12.15	81	16.2	81	20.25
82	12.3	82	16.4	82	20.5
83	12.45	83	16.6	83	20.75
84	12.6	84	16.8	84	21
85	12.75	85	17	85	21.25
86	12.9	86	17.2	86	21.5
87	13.05	87	17.4	87	21.75
88	13.2	88	17.6	88	22
89	13.35	89	17.8	89	22.25
90	13.5	90	18	90	22.5
91	13.65	91	18.2	91	22.75
92	13.8	92	18.4	92	23
93	13.95	93	18.6	93	23.25
94	14.1	94	18.8	94	23.5
95	14.25	95	19	95	23.75
96	14.4	96	19.2	96	24
97	14.55	97	19.4	97	24.25
98	14.7	98	19.6	98	24.5
99	14.85	99	19.8	99	24.75
100	15	100	20	100	25