

**EXPLORING THE PERCEPTIONS OF OLD AGE (HOME)
RESIDENTS REGARDING THE GENERAL CARE
RECEIVED (BY THE ELDERLY) IN THE O.R. TAMBO
DISTRICT EASTERN CAPE**

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DECLARATION

I, FEZEKA MAY, declare that the dissertation entitled *Exploring the Perceptions of Old Age Residents regarding the General Care received in the O.R. Tambo District, Eastern Cape* is my own work, original and true. It is not copied from any book, but has been achieved through my own effort and the professional guidance of my recognized supervisors.

Signature -----

Date-----

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This dissertation has been read and approved for submission.

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Dr ZZ Nkosi

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Date-----

DEDICATION

This work is dedicated to my late parents, especially my mother who passed away at the age of 78. My mother died after a Cholecystectomy operation was performed on her. It was then that I set out to find the logic of scientific answers to questions on ageing as a phenomenon.

I wanted to have a better understanding of the social and health care problems encountered by the geriatric community. My parents' teachings of perseverance, inquiring attitude and respect for all people have made me be the person that I am today. This is the reason I chose to dedicate this work to them.

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First and foremost, I would like to acknowledge and thank God the Almighty for giving me strength, guidance and protection during my study programme which culminated in the production and presentation of this dissertation.

I would also like to register my appreciation to the following people for their contribution to this work. Dr Zethu Nkosi and Prof. Busisiwe Ncama my supervisors for the entire expert support, encouragement and direction they gave me from the beginning to the end of this research project.

Furthermore, I do recognise Mrs Nonzame Matwa as one who acted as my mentor for helping me a lot when I was developing my research proposal. I am indebted to Miss Bida the CEO of the Empilweni Old Age Home (EOAH), too, for granting me permission to conduct the study at that facility. I feel equally indebted to all the residents of EOAH who participated in this project without whom I would have not been able to complete this dissertation.

Finally, I am grateful to my two research assistants, Tandiswa Halu and Ziyanda Daniel for helping me in the way each one of them did. Tandiswa assisted with jotting down a few points here and there whenever required. Ziyanda assisted with video and audio tape recording. This list of acknowledgements cannot be complete without expressing my gratitude to Mbesi and Bonani for their support and encouragement throughout my studies too. Nor will it be, without mentioning my colleague Nhlanhla who supported me by continuously motivating me to carry on whenever she noted that I was about to give up.

In a statement, I say to all the listed, “Thank you very much. I am deeply indebted to you all.”

ABSTRACT

The study is exploring the inner world of old age home resident's perceptions and how they felt on the general care they receive. The main themes were: Basic needs, psycho-social aspects, safety environment, safety medication aspect, nutrition, institutionalisation and support system. They felt aging not only meant losing independency, dignity and loneliness but also having more experiences. Not all is well at the old age home resident.

BACKGROUND:

Increasing life expectancy should be celebrated, but with it comes the challenges of the increased likelihood of multiple health conditions. With a growing older population, aging has become an important issue for attention. Extension of services provide programmes and home resident services for senior citizens, but how much knowledge about ageing and home resident's perceptions regarding the general care they receive (Nina Chen 2001). The motivation of the study had its origin on the ever increasing ageing population in the country and the observation made during case study on Stroke Assignment as a Gerontology Master's student at the selected old age home resident. The observations made were less than satisfactory conditions of the general care received by the old age home residents made the researcher to seek on exploring their perception.

PURPOSE:

To examine old age home residents' perceptions regarding the basic physical care they receive.

To gain some more understanding on the ageing phenomenon at the Empilweni old age residence.

To provide some answers that could be used by policy makers and professionals to formulate guidelines or interventions relevant to lived experiences of the older persons and the meaning attached to ageing or being old and consequently improve the basic quality of life of older person in Eastern Cape

METHODOLOGY:

Phenomenologic design within a qualitative approach to guide the research process: Data was collected from focus groups. Open ended group discussion was used. Data was collected using group discussions, field notes and through the medium of video and audio tape; raw data was transcribed, interpreted, and translated .data was analysed manually through generated into themes codes and into categorised and subcategories.

PARTICIPANTS:

An invitation in this study was announced at one of the only registered old age home at the O.R. Tambo district Eastern Cape. Purposive quota sampling was done. Twelve elderly residents participated in this study. Characteristics of the participants were described according to the age, length of stay, any chronic disease or disability, reason to stay at the residents and any relatives or family visiting. Participants were graded according to functional disabilities –active: 60-65 years semi-frail, older elderly: 65-75 years, and frail age: 75 and over years of age ranging from independency to dependency of their limitations. Senile dementia, those with cognitive impairment and very frail elderly were excluded.Data was collected.

DATA ANALYSIS:

The Tesch's approach and elicitation method was used. Data collected and displayed from stage of entry to data analysis was analysed manually. Transcribed, translated and interpreted of raw data into meaningful concepts using data from the participants, observations field notes and confirming on video/tape records. Based on the data reduction, interpretations, decontextualisation and contextualisation to generate themes. Coding process was done after reducing repeated content and linking relevant concept getting sense of the whole, by colouring , marking , abbreviate the topics as codes and turn into themes .Codes were generated. The data was classified into categories and subcategories. The following categories immersed: Basic needs, Safety environment & medication, psychosocial aspect, Nutrition, Institutionalisation and Support system aspect.

RESULTS:

Not all residents were satisfied with the general care at the old age home residence. Loss of independency accompanied low dignity and loneliness in old age home residents.

CONCLUSION:

In examining the perception of old age residents regarding general care, gaps regarding the general care for elderly residents have been identified hence recommended for more health caregiver staff, in-service on ethics morals on the caregivers and extension of services to multidisciplinary approach.

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ABBREVIATIONS

ADL:	Activities of daily living
DLA:	Daily living activities
CGA:	Comprehensive Geriatric Assessment
IADL:	Instrumental activities of daily living
ETQA:	Education and Training for Quality Assurance
E.G.:	For example
UN:	United Nations
HIV/AIDS:	Human Immune Virus/Acquired Immune Deficiency Syndrome
LOTTO:	National Lottery of South Africa
UNECE:	United Nations Economic Commission for Europe
CEO:	Chief Executive Officer
EOAH:	Empilweni Old Age Home
CG:	Caregiver
OAH:	Old Age Home

LIST OF GLOSSARY TERMS

Xhosa

Ewe

Mama

Imfuno zakho

Iminyaka yokuzalwa

Inyanga ezintandathu

Ingcaciso

Isini

Kunjani

Ukuhlala ngaphandle komzi

Ngamanye amaxesha

Nceda

Tata

Thetha

Ukuhlamba

Ukunxiba

Ukuya ngasese

Ukutya

Xela ngokuthe gabalala

Ziyananzwa

English

Yes

Female

Your needs

Years of age

6 months

Explanation

Gender

How are you?

To stay without your family

Sometimes

Help

Male

Say something

Bathing

Dressing clothes

Going to the toilet

Feeding

Give clear description

Taken care of

CHAPTER ONE

BACKGROUND AND INTRODUCTION

1.1 INTRODUCTION

In this country and the world over the ageing population has become an important developmental issue that requires urgent attention. Age is chronological in nature and an achievement measured in terms of time. An individual's age is a numerical value that is assigned to indicate the number of years that person has lived since birth. It is not easily recognised as changes take place silently throughout a person's life, but a time comes when the effects of change resulting from ageing can no longer be concealed. How a person ages depends on a number of factors including health. People age at different rates depending on genetics, diet, culture, activity levels and environmental exposure (Fennell and Phillipson ,1991).

Ageing is a universal process and affects all living organisms starting from birth and runs on till death. It happens willy-nilly. At the moment there is no United Nations (UN) standard numerical criterion used to define old age, but it is generally noted that the UN discourse identifies people aged 60 + years as belonging to the older population. WHO (2012) define ageing in terms of the official retirement age as practised and noted in several countries. In Wahrendorf and Siegrist's view it is the retirement age in several countries that should be used as a measure to indicate the beginning of old age. As reported in Wahrendorf and Siegrist (2012) in a 2012 survey conducted in Europe on Baby Boomers born in 1946 who turned 65 in 2011, the following finding was obtained. Among those who stated that they were fully retired, the average age at retirement for those Boomers was 59.7 for men and 57.2 for women. Furthermore, the theory of stratification classifies ageing according to gender as 65 years and above for males, and 60 years and above for females.

In a study using the age stratification theoretical framework conducted by Henslin and James (2009) it was reported that ageing is affected by educational level, living arrangement, residential care and financial status of a person. Henslin and James (2009) point out that their

finding in that study is supported by studies conducted along the lines of theories of perspectives wherein functionalists have found that people with better resources stay active in other roles and adjust better to old age than do their counterparts with poor resources. When a functional perspective of ageing is taken into account, it is fairly clear that given variations in educational levels, living arrangements, residential care and financial status, people age at different chronologically time determined ages since birth.

From a social order point of view, age serves as a basis for social control. The order one is, the more social control they have over those younger than they are. Given this consideration, different age groups will have varying access to social resources. Resources such as political power, economic power and behavioural age norms dictate what members of different age cohorts may reasonably do and what they should or may not do. For example, it might be considered deviant for an elderly woman to wear a mini skirt because it violates norms defining the sexuality of older females. It is the view of this researcher that this information should not be lost sight of in a study such as this one.

In terms of physical-biological considerations, ageing consists of a complex interplay between physical and biological processes and components of a human body. Indicators of that interplay are evident in physical features such as: wrinkled skin, grey hair, decline in hearing, taste, smell and functional decline in locomotion of the person in point. Indicators of ageing are not only confined to physical-biological processes and features. They are noted at a psychological level too. Psychological ageing is evidenced in a person through mental problems such as memory loss, dementia depression and many other psychosomatic disorders that are associated with old age. Social, cultural and economic aspects such as: religion, social network and economic resource like financial bankruptcy (Zeigler and Doblhommer-Reter 2010) do impact and have implications for ageing as a phenomenon too.

While some of the changes that take place in the body with advancing years, as outlined and discussed above, may have no clinical significance; some other changes do have some clinical significance too. Most of the organs do not only show signs of decline in function but they also become smaller in size as they show signs of aging. It is assumed that the reduction in function is a result of loss of cells which such organs are composed of.

In terms of health measurement, ageing is mostly defined in terms of functional age. Functional decline can be defined as a loss of independence in self-care activities or as deterioration in self-care skills, measured on activities of daily living (ADL) scale such as: bathing, dressing, transferring from bed to chair, using the toilet and feeding. The other measure used in this instance is the instrumental activities of daily living (IADL) scale such as: shopping, housekeeping, preparing meals and other function oriented activities. Not only activities of daily living can be compromised as a result of ageing.

Functional decline may also result in physical and psychosocial problems, such as dehydration, malnutrition, falls, depression, and delirium (deVos, Strydom, Fouche, Poggenpoel and Schurlink 2000). Functional age theory which is seen to be reliable in determining old age evaluates age in terms of functional performance (Henslin and James, 2009). As presented in that theory, the functional decline is influenced by lifestyle factors such as lack of exercise, smoking, alcohol abuse and by diseases between different organ systems in an individual (Vlok, 2010).

The functional status of the elderly is divided into three levels of activities classified as follows:

- Active ageing between 60-65 years are those who can perform the independent and instrumental activities of daily living on their own.
- Semi frail are people between the age 65-75 years, who are able to do daily activities like bathing, dressing, feeding, toileting and those that may be limited to one or two dysfunction indicators.
- Frail are usually people over the age of 75 years, who are afflicted with physical or mental disabilities like falls, incontinence or dementia that may interfere with the ability to independently perform activities of daily living and depend on others (Henslin and James, 2009).

Disability and frailty have been associated with the ageing process. These concepts have often been mistaken as being one and the same. Admittedly the two can co-exist, but are not necessarily one and the same thing. They are different. There is a need to understand the normal ageing process in order to differentiate between disability and frailty. Disability is a loss of function whereas frailty is the increased vulnerability to a loss of function.

Disability may be caused by any other factors such as injury or illness like stroke, rheumatoid arthritis; which are also common causes of disability in older people as well (Wahrendorf and Siegrist, 2010). However, some people who are far from old age thresholds may have disabilities right at birth or as they grow or may develop a particular disability due to injury. This is the reason it is important to distinguish between the two: disability and frailty.

The World Health Organisation (WHO), a UN organ responsible for providing leadership on global health matters, defines health as a state of complete physical, mental and social wellbeing and not just the absence of diseases. Kim and Geistfeld (2009) suggest that the above definition of health is based on the understanding that the individual's health is influenced by several factors that are often categorised into biological, physical, social environment, personal lifestyle and health services.

WHO suggests that immediate environment in which a person lives and/or works is influential in the ageing process. This means that the social, economic and cultural conditions prevalent in a society do have an effect on general health outcomes and standards of living pertaining to the members of that society. According to Psycho-social theory of ageing, socio-economic factors for example, may influence the individual's choice of accommodation, employment, feeding and other social interactions (Kim and Geistfeld, 2009).

As pointed out already, given different factors, ageing becomes noticeable in different people at different chronological year of ages. For some such indicators may be noted earlier than it may be for others. What is certain, however, is that with the passage of time some of such indicators begin showing up in a person as they grow older. Again, as alluded to in the opening paragraph of this discourse, it must be noted that ageing comes with challenges.

Ageing is associated with age related chronic and non-communicable diseases that are often disabling and costly. These undoubtedly strain health and social care systems and services, which are already burdened with challenges of communicable diseases. It is quite common for the elderly to suffer from co-morbidity. Co-morbidity is a health condition in which more than one disease is found occurring in one individual all at once. Hence, co-morbidity being

defined as conditions or diseases that occur together with a primary condition in an individual (Kim and Geistfeld, 2009).

The increasing rate of HIV and AIDS victims in Sub-Saharan Africa are undoubtedly straining the health and social care systems which are already burdened with the challenges of communicable diseases in general. As Vlok (2010) observes, although not many elderly people may be suffering from HIV/AIDS related diseases, the scourge does have a direct impact on the lives of some of the elderly.

Because comparatively, there are more younger people dying of HIV and AIDS related diseases, more and more elderly people are becoming more increasingly burdened with the care for grandchildren left orphaned by those children's own parents. The act of looking after the sick and orphans tends to drain an elderly person physically, psychologically and worse still, financially. In some circumstances, the elderly is expected to buy food for the family from their old age pension money. They may also be forced to be spending some of their pension money on the purchases of over counter medicine and herbal medication for the sick in their care.

Overwhelmed by the demands of their caregiver role that they assume by default, some of the elderly end up defaulting on their own treatment of chronic diseases. It is in the ways described above that even though not many elderly people presently may be suffering from HIV/AIDS related diseases directly, the scourge emanating from that health condition in or among their own off springs does affect them directly in some instances. Relating this situation to the topic investigated, the researcher envisioned that there might be among the residents in some old age homes, including EOA, who could be coming from such a background as described and discussed above.

The elderly population is vulnerable in that the living conditions of the elderly people are usually unsafe and quite often the elderly are of ill-health, malnourished and poor. Many factors contribute to the increasing risk of infection in older people. Notwithstanding the suffering that is brought to bear upon the elder by HIV/AIDS as merely affected, there are cases of some elderly people suffering from the scourge as infected people themselves. Given the higher levels of the prevalence of HIV/AIDS among younger people than the elderly, older persons are often the last to come in mind when thinking or planning for sufferers of

HIV and AIDS. Yet, there are a growing number of older people who now have HIV/AIDS. They don't get tested for HIV/AIDS on a regular basis and there may be even more cases than currently known.

It is reported that older Americans know less about HIV/AIDS and STDs than younger age groups because the elderly have been neglected by those responsible for education and prevention messages, and doctors tend not to ask their older patients about sex lives or drug use largely, because of cultural considerations (Tessler, Sara, Kristina, Luindenberg and Jerome, 2006).

Finally, older people often mistake the symptoms of HIV/AIDS for the aches and pains of normal aging, so that is another reason that makes them less likely to get tested (La Fleur and Small, 2009) for HIV/AIDS. Again, here, the researcher took this point into account as she set out to conduct this study in a population of the elderly at EOAH.

The percentage and life expectancy of the older person has increased over the years both in developed and developing countries. Modernisation has brought about the science, technology, medication and healthy living styles; hence elderly population tends to live longer than the case was before. Previously, elderly population relied on untested raw herbs with no proper health education regarding their health. They largely depended on experienced herbalists with no formal education on biological cellular degeneration of the body as one grows older. With huge numbers of the elderly living so long as they are doing now, the need for improved health and social services relating to the elderly cannot be overemphasised.

In relation to this study, the researcher thought of the psychological implications that would have on the elderly that might have believed in herbal medicine and other traditional health practices when they find themselves in an old age home where such may not be available or allowed. Although a lot of people are living longer now than did those in the past, there are a number of ills that modernisation has brought about. One of the ills brought about by modernisation is the abandonment of the extended family system wherein one found the elderly living with their children and grandchildren. In such a family set up, the elderly had some form of support system around them (du Toit and van Staden, 2009).

In today's society, the elderly are left on their own as their own children live far away from them. The children have gone away from home to work in big cities and some even outside the country and in some other cases those children work overseas and rarely visit home where their aged parents are. Some of the elderly have been left to stay alone in the village home may be exposed to sexual abuse by strangers and relatives (du Toit and van Staden, 2009).

Others may suffer physical, financial and emotional abuse from their children and family friends in those villages too. Where such happens an elderly person who by choice, or through some initiative by anyone else other than themselves, ends up admitted to any of such social facilities may have a physical or psychological health condition that arises from such a historical background. An old age home resident having such a historical past may present different implications for a care giver serving at such a facility.

Furthermore, in the past communal-living was practised especially by the black ethnic groups living in multigenerational families in Africa and South Africa. The elderly people used to play an active role in socializing the grandchildren who were often left in their care. For that the elderly used to be respected, receive physical and emotional care as well as monetary incentives from their adult children or extended family members. Because of the role the elderly played in the traditional society, they were accorded a lot of respect. This is not so as they are no more playing that role.

Their adult children no longer leave their children in the care of their grandparents instead they prefer to raise those children on their own. Such a practice has created a very big gap between the elderly and their grandchildren. Because of the paradigm shift in the family setting and socialisation process of the young ones, some elderly in the modern society hardly get the financial assistance their counterparts in the traditional society did. The dwindling or total withdrawal of such responsibilities and privileges has eroded the recognition and respect the elderly could otherwise be receiving if things did not change in the family and child socialisation process of such ethnic groups. Examining and discussing modernisation theory, Vlok (2010) states that in modern societies older people have the least prestige or power accorded to them than the case was in traditional societies (Vlok, 2010).

As a result of the combination of these factors, some elderly people have to stay in a nursing home residence by choice or by circumstances. An old age home residence is a long term

care facility for the aged which can either be a permanent or temporary arrangement for elderly people. It is different from hospital in that it is classified as a social home-based service for the minimal impairment, whereas hospital care serves the needs of the severely impaired older adults.

The function an old age home plays is an important one in that it provides not only accommodation and physical care, but also psychosocial and medical services where minor ailments can be treated (Martinson, Widmer and Portillo, 2002).

This involves promoting independence, supporting early intervention and intermediate care as well as meeting the needs of those requiring specialist care services. (Park-Lee, Caffrey, Segupta, Moss Rosenolf and Harris 2011). The kind of old age home care one chooses largely depends on the physical and psychological health and the financial situation of the individual. There are private and public old age homes. The private old age homes may be for those who can afford them and the public ones for those who cannot afford the former (Liu and Wen, 2010). The different types of residential care exist such as Long Term Care, Immediate Care, Day Care, Meals on Wheels Care, Respite Care and many others.

Accessing old age home residence is by inter collaboration of the Community Health Nurse, Social Worker of that catchment area, the individual family member and the referring doctor (Longterm Care Home Act, 2007). In South Africa to be admitted to the residential old age home one should be 60 for females, but 65 and above for males. Not only that, they should also be of a sound mind to sign informed consent forms for admission or by a medical doctor prescribe to support medical disability either physically or cognitively (Older Person Act 13 of 2006).

Basic needs for the elderly are seen as the primary core in addressing the customer care where the word care is defined as life giving, enhancing growth, restoring, reforming and promoting learning and healing (SEL, 2001). As defined and described by George (1990) basic needs are the personal hygiene activities such as: bathing, dressing, grooming, toileting and feeding which may be done by the person him/herself or by being assisted by another person. Such needs include the following too: nutrition care, safe environment, health and psychological care. A person who does all the activities that are identified as activities of daily living (ADLs) is said to be functionally self-managed.

Unfortunately, as people grow old some experience functional limitations which create some complications in terms of access to ADLs and health care. Such a situation necessitates a person's reliance on care giver services. It is such services and what residents of old age homes think of such services that this study focuses on. The study deals with this topic within the context of one only registered old age home in the O R Tambo District of the Eastern Cape Province of South Africa.

South Africa is situated in the sub-Saharan region of Africa. It is divided into 9 provinces. Various types of old age home residence exist in all the provinces of South Africa. Some are registered according to the required standards laid down by the Older Person Act 13 of 2006 others are not. The Empilweni Old Age Home is a registered resident institution for elderly people situated 10 km from Mthatha town, King Sabata Dalindyebo local municipality in the O.R. Tambo District in the Northern Eastern Cape.

Established in 1983, the home accommodates about 140 residents and is subsidised by the Department of Health and Welfare. Its area of coverage operation is the whole of the former Transkei and beyond, a region with more than 4 million citizens (Department of Social Development, 2006). There is a steady growth of the elderly throughout the region which has placed a huge demand on specialised accommodation for the frail and elderly folk.

The home provides a sanctuary for the frail and homeless elderly; the poor and destitute old people as well as the elderly people who have been abandoned and neglected physically, emotionally and socially (Department of Social Development, 2006). This institution is largely occupied by Xhosa speaking ethnic group.

In the Eastern Cape, there are more black older persons than any other race group. The race group with the lowest number of elderly people is the Indian or Asian population group (S.A Statistics, 2007). It must be noted that the use of old age home residences by Black African ethnic groups is not a readily welcomed accepted concept and is interpreted as being neglected by one's family (Vlok, 2010).

Because the old age home concept is somewhat foreign to African traditional practices, there is very little documented information about the existence of such facilities in South Africa and Africa as a whole. However, available literature on this concept traces the history of old

age homes to around the 18th century. As early as then such services were known as home health care services and were performed by public nurses operating under the Visiting Nurse health care settings.

Religious orders and secular groups have also been involved in providing care to the poor who were ill (Herman, 2003). Before the nineteenth century, no age-restricted institutions existed for long-term care. Rather, elderly individuals who needed shelter because of incapacity, impoverishment, or family isolation often ended their days in an alms house. Placed alongside the insane, the inebriated, or the homeless, they were simply categorized as part of the community's most needy recipients.

The alms house was eradicated due to strict financial needs and people who were physically infirm and sick had various kinds of ailments that required personal attention of a kind that one could not get in an individual home, they required nursing or medical attention. The movement of social support programme was formed and functions to play a role in providing long-term care service beneficial for the pensioners. The formal home health care programme of the Visiting Nurse Association continues to offer services because although the availability of hospitals has increased, they have not replaced home health care facilities completely.

In 1962 there were more than 250 elderly home health care agencies certified in America, and this number increased more than 11 times by 1979. About 9.5 million Americans receive care at home or in the community, and another 1.6 million reside in old age home residents or intermediate care facilities (Hendricks and Hendricks, 1979). The need for specialist care for the elderly is important as they are a vulnerable sector of the population. The emphasis is on promoting safe physical as well as psycho-social and cultural wellbeing by focusing on the personal health functional status of the elderly person, so that such a person can function independently in terms of self-care activities and in terms of mobility (Ferreira and Aboderin, 2009).

Gerontology and Geriatric care is a form of care for the elderly that addresses the complex needs of older people and focuses on psycho- social, health promotion, prevention and treatment of disease and disabilities in the elderly. It is usually provided by a multi-

disciplinary health team, and generally continues until death occurs (Wahrendorf and Siegrist, 2010).

In this country, South Africa, the increasing trend in the population ageing, inadequate geriatric care, social welfare services and the prevailing social and economic decline in the country as described earlier pose great challenges to older people and the country.

The older people are challenged to take up new roles and adjust to the emerging demands for which they were not prepared. This situation might be stressful for an older person and the meaning they attached to being old and ageing.

A study in the United States on residential care services for older people suggested that the elderly should become firmly rooted in collective consciousness to form a forum and stand up for their rights (Hank, 2010). The subculture theory of ageing focusing on the shared community created by the society states that when they are excluded due to age, voluntarily or involuntarily from participating in other groups, the elderly should develop new patterns of interaction with peers who share common backgrounds and interests on creating social and political pressure to fix those issues. It is against this background that the researcher set to explore and interrogate the issues the topic of this study dealt with.

1.2 PROBLEM STATEMENT

The prevailing socio-economic situation in many African countries including South Africa brings great challenge in the health and social services sector. There are limited resources and increased demand for public and social services in maintaining or enhancing the quality of life for the older people which might not be seen as a priority. Given what the researcher noted about the condition of care services offered to the elderly at Empilweni Old Age Home, she sought to explore the perceptions of residents of that old age home facility as representative of old age home services in the district and the province as a whole.

1.3 PURPOSE

The purpose of this study was to explore the perceptions of old age home residents regarding the general care they receive in those homes in the Eastern Cape.

1.4 OBJECTIVES

- Explore the residents' perceptions about the general care received by them in an old age home residence.
- Describe the general care of the old age home residents receive at Empilweni

1.5 RESEARCH QUESTION

- What is the perception of the old age home residents regarding the general care they receive at Empilweni Old age home in O.R. Tambo District?
- Describe the general care the old age home residents received at Empilweni

1.6 SIGNIFICANCE

The findings and recommendations of this study in one way or another will add to the existing body of knowledge on the subject it set out to explore and interrogate. With the help of the findings and recommendations of this study, policy makers and old age home caregiver practitioners are likely to improve the quality of services the aged receive in that sector. Although the immediate relevance and applications of the findings and recommendations this study may be at Empilweni Old Age Home and any other such facilities in the Eastern Cape, other facilities of this kind in the country and beyond can benefit from those findings and recommendations.

The findings may also inform policy-makers about ways to manage geriatric patients. The findings would be utilised for curriculum development for nurses more especially those connected to old age home care giving. The information in the findings and recommendations

may help to reduce the scarcity of geriatric trained nurses thereby improving the self-care and caregiver support system for the elderly population. Beyond that, this study may form a baseline for a greater study to be utilised by nurse researchers who will be able to implement this information and identify gaps therein.

1.7 OPERATIONAL DEFINITIONS OF TERMS

Gerontology: the study of the changes associated with old age and the ageing process, includes both mind and body and involves many disciplines e.g. physiological, pathological, psychological, pharmacological and sociological care (Weller and Pratt, 2009).

Geriatric Services: a branch of medicine that focuses on health promotion and prevention and treatment of disease and disability in elderly patients (Witch, 1986).

Older Person/Elderly: 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 and older (Act no. 13 of 2006).

Older Person and Elderly are used interchangeable in this study

Old Age Home: a building or other structure used for the purpose of providing accommodation, shelter, community-based care and support services to older persons (Act no. 13 of 2006).

In this study old age home is used as the institution for the old age home residents.

Caregiver: means the same as a health care aide and nurses for the purpose of this study (Act no. 13 of 2006).

Perception: is a process of attaining awareness or understanding of the environment by organising and interpreting sensory information (Weller and Pratt, 2009)

Basic physical nursing care: refers to personal hygiene, grooming, ambulating, attending to pressure parts, toileting and feeding which are activities of daily living (ADL)(Act 13 of 2006)

Long term care: safe consistent and high quality resident-centred care in setting where a resident feel as home,are treated with respect and have the supports and services they need for their health and wellbeing (Longterm Care Home Act 2007)

1.8 DISSERTATION OUTLINE

Chapter 1 contains the introduction and the background, problem statement, purpose, objectives, significance and definition of the terms of the study.

Chapter 2 covers literature related to the elderly population. Included in this chapter are the different graphical statistics about Empilweni old age residents, ageing and age-related diseases; age and culture, age and society, age and technology, age and legislation, age and equality, old age home; the effects of institutionalisation, health assessment, physical health, comprehensive geriatric assessment, physical assessment, medical assessment psychological assessment, social assessment, care provision and staffing levels.

Chapter 3 discusses the methodology research paradigm, research design, exploratory and descriptive study, data quality assurance, transferability, validity, confirm ability, credibility; triangulation, research setting, population, sample and sampling, data collection, instrument data collecting procedure; data analysis ethical considerations, permission, self-determination, privacy, data management and data dissemination.

Chapter 4 presents the findings of the study, characteristics of the participants, sampling statistics, disease statistics, content analysis, knowledge of physical care, important aspects of basic physical care, physical environment, support systems, advantages and disadvantages of staying in an old age home; comments from the manager, staffing levels policies, administration, care delivery service, health status, food services, social services, transport facilities and review documents.

Chapter 5 focuses on the discussions, recommendations and conclusions of the study on gender, characteristics of elderly residents in old age home, common conditions in old age homes, medication dissatisfaction, support systems, recommendation, limitation and conclusion.

Finally, **References** acknowledges all the authors whose materials supported the study.

1.9 CONCLUSION

This chapter has provided the introduction and background of the study. It has covered the elderly home residents, the relevant statistics and the problem statement of the study. The aims of the study and its objectives have also been presented. The significance of the study to

the practice of nursing and a discussion on how it can be used to improve the quality of general care has also been covered. The research and operational terms have been mentioned in this chapter too.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

According to Polit and Beck (2007), a literature review is necessary for comparing the results of earlier findings in order to determine what further research may be necessary on the chosen topic. The information for this chapter was fully researched using relevant books and journals from previous studies. The researcher accessed the information from the libraries, Google scholar and UKZN E-Text.

The literature reviewed focused on the demographic trends, normal ageing, technology and ageing, culture and society in ageing. It also touched on laws pertaining to old age residences, characteristics of old age home residents and the effects of institutionalisation. Some literature reviewed highlighted health and ageing, health assessment, the provision of old age care and staffing levels in old age homes. The key words guiding or gathered from the literature reviewed were: elderly care, old age home residents, physical care, functional care, disability, Health of the elder, Geriatrics and gerontology.

2.2 THE ELDERLY POPULATION

Based on statistics supplied in World Health Organisation (WHO) literature, globally the number of those who are aged 60-plus has risen from only 8% of the world populations (200 million people) in 1950 to about 11% (760 million) in 2011. There is a dramatic increase still anticipated ahead as those aged 60-plus are expected to reach 22% (2 billion) by 2050. The global population is projected to increase 3.7 times from 1950 to 2050, but the number of those aged 60-plus will increase by a factor of nearly 10, and those aged 80-plus by a factor of 26.2 by that year. Between 2010 and 2050, the total population is anticipated to increase by 2 billion, while the older population is expected to increase by 1.3 billion (WHO, 2012). Compared to Latin American countries, South Africa's health status indicators are poor due to considerably fewer resources being allocated to the health care (Ageing –related statistics :Older America 2000).

As revealed in literature reviewed there are over 3, 5 million older adults in South Africa, and it is projected that the elderly population will reach 4,858 million by 2030 with many of those being over 80 years of age (SA Statistics , 2007). Demographic studies reveal that South Africa will witness an unprecedented growth in the absolute number of elderly people between 2010 and 2030, and that the numbers of elderly people of 65 years of age and over will increase by 80 million worldwide. The fastest growing group is that of those people over 85 years of age.

The elderly population is unevenly distributed in Africa, with the highest percentage being in South Africa. Although a variety of old age homes exist in South Africa, the number of elderly old age homes is not sufficient to accommodate the number of older people in the community (SA Statistics , 2007).

Based on the SA statistics (2007), the number of people requiring home care will increase with the dramatic growth of the elder population, even though the percentage of the institutionalised older people may not increase because of a lack of facilities available. The implications for such a state of affairs are that more old age homes (OAHs) are needed if the projected increase in the elderly population in this country has to be serviced by OAHs.

In an Audit study for the residential facilities of old age population overall distribution of older person in South Africa it was noted that the distribution of old age home residential facilities is highly disproportionate. The finding in that study was that the more of such facilities were in the wealthier provinces of Gauteng and Western Cape. Yet a lack of such facilities in poorer provinces such as Limpopo, Eastern Cape and Free State was and still is remarkably alarming. Owing to out-migration and urbanisation amongst younger persons, older persons are predominantly represented in the most rural and poorest provinces in the country.

At the same time the Audit found that the majority of the facilities (79%) are concentrated in the metropolitan formal areas. Only 5% are in the informal or squatter areas while only 16% are in the rural areas (Department of Social Development, Residential Facility Audit, 2010) Surprisingly enough statistics of the elderly population shows that the highest number of old age population in all the provinces is in the Eastern Cape. Furthermore within the Eastern

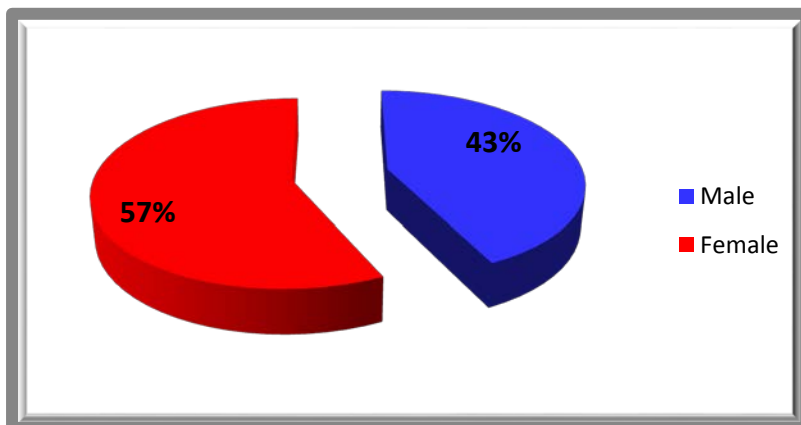
Cape group the highest number of old age people is in the black ethnic groups while the lowest number of the elderly is found in the Asian and Indian groups.

Another startling revelation coming from the literature reviewed is that more than six out of ten older persons in South Africa are females. This suggests that women tend to live longer than men and are more likely to be widows, living alone.

The female proportion of older persons among the population 85 years and over is also higher than that of males. In terms of gender, across all age bands, older persons of the Eastern Cape are dominated by females (Department of Social Development Residential Facility Audit , 2010).

As revealed in the institutional records of EOAH females make up 57.1% of the home's population while the male component of the home's population is only 42.9%. The pie chart in figure 2.1 following provides that picture of the population distribution of EOAH by gender in diagram form.

1.1 The gender population of the elderly people living in old age home at Empilweni Old Age Home in the Eastern Cape



While the preceding pie chart presents the population distribution by gender at EOAH (Empilweni old age home 2012 register of daily) . The Nelson Mandela Metro pole districts have the highest number of registered old age homes whereas O.R.Tambo has the lowest number of such facilities. (Department of Social Development Residential Facility Audit 2010 ; Department of Social Development, 2006).

From these figures one can draw a quick conclusion that there is a need for more such facilities in the O R Tambo Municipality. While the researcher acknowledges that there is a second OAH in Mthatha, she is quick to point out that it is not officially registered in government records on OAHs in the country. This is the reason; this study might appear silent about OAH.

Table 1. Older Persons in Residential Care in the Eastern Cape (2006)

Registered Old Age Homes Per District Municipality In The Eastern Cape	
District	Number of Register Old Age Homes
Amatole	11
Alfred Nzo	10
Cacadu	12
Chris Hani	9
OR Tambo	1
Nelson Mandela Metro pole	18
UKhahlamba	3
Total:	54

2.3 OLD AGE AND AGEING

There are a number of theories that attempt to explain ageing as a phenomenon. Each one of these theories attempts to provide a framework to help one understand ageing from a different perspective. For instance, a biological scientist examines ageing at a biological and cellular level whilst social scientists and psychologists examine the ageing process in terms of development and to do that effectively, they have developed developmental models (Bengtson, Silverstein, Putney and Gans, 2009). Whatever the theories on ageing may say, ageing is a normal human phenomenon which is characterised by slowing down of body processes such as energy levels, and a decline in inefficiency due to certain physiological changes that come with ageing as a process. Some of the examples of indicators of ageing include wrinkled skin, grey hair, a decline in hearing, taste, smell, locomotion, behavioural and mental problems (Finch ,1990).

Although ageing is a natural phenomenon that affects every person, the degree and rate of change that come with it vary from one individual to another. Some people age faster than others. Normal ageing does not necessarily mean a loss of health; although, generally, people do face multiple changes in health as they grow older. This claim is evidenced in the fact that a large percentage of older people are capable of looking after themselves and require only a limited form of assistance from family and friends to maintain their independence. Coping with ageing depends on a number of factors including the health status, life experiences, finances and educational levels of the individual as well as the social support system available in the society the individual lives.

Social theorists talk about functional status of the elderly. To determine an elderly person's functional status, social theorists divide and classify the elderly into three groups. As captured and presented in Activity theory the first group is classified as young old. These are the elderly who are between 60 and 65 years of age. The second one is labelled old age. This group comprises the elderly whose ages range from 65 up to 74 years of age. Finally, the third group is classified as very old or frail. In this category one finds those who are 75 years of age and over. It is important to take note of the three classes of the elderly, and this study takes cognisance of this classification of old age (Phillipson, 1998).

2.4 AGE-RELATED DISEASES

According to the mechanism theory of ageing, natural ageing is a process which is distinctly different from the onset of age-related diseases. The changes that occur in the skin, muscle or hair are not pathological. Nevertheless, the process of degeneration related with ageing affects the essential organs. It is only when this happens that the degeneration is labelled as a disease (Wade and Halligan, 2004).

There is a relationship between cells or tissue maintenance and some major human age associated diseases such as musculoskeletal where there is height loss and joint pains, in respiratory system this may be evidenced in breathlessness and difficult in coughing up secretions such as sputum (Hoogerduijn, Schuurman, Karevaan, Buurman and Rooi (2010) argues that failure to maintain healthy major organs may result in pathologies such as degenerated neurons in the brain which may cause dementia, confusion and depression; retina

and lens damage which may cause blindness. It may also cause defects in insulin metabolism which may cause Type II diabetes while defects in blood vessels and the heart may cause cardiovascular and cerebra-vascular diseases (Sondika and Madans, 2010).

If the glomerular functioning is affected, it may cause renal failure and epigenetic controls which may cause cancer. This is noticeable in dental problems such as tooth loss or decay. There are also skeletal problems like arthritis which may cause a decline in the walking pace and affected gait, and ailments like Parkinson’s disease which all serve to limit the functional status of the elderly. Minor ailments and complaints such as sleeplessness, feelings of tiredness, irritation as a result of noise, loss of appetite and forgetfulness also often affect the elderly (Kim Konvran, Harrington and Mezey ,2009). Given that this section focuses on age-related diseases, it is worth mentioning that the preparatory literature review of the existing records at EOAHS provided some insights relating to chronic diseases the residents at that facility presented. The following figure presents the picture of chronic diseases prevalent at that facility in graph form.

Table 2. Residents at Empilweni Home Suffering from Chronic Diseases

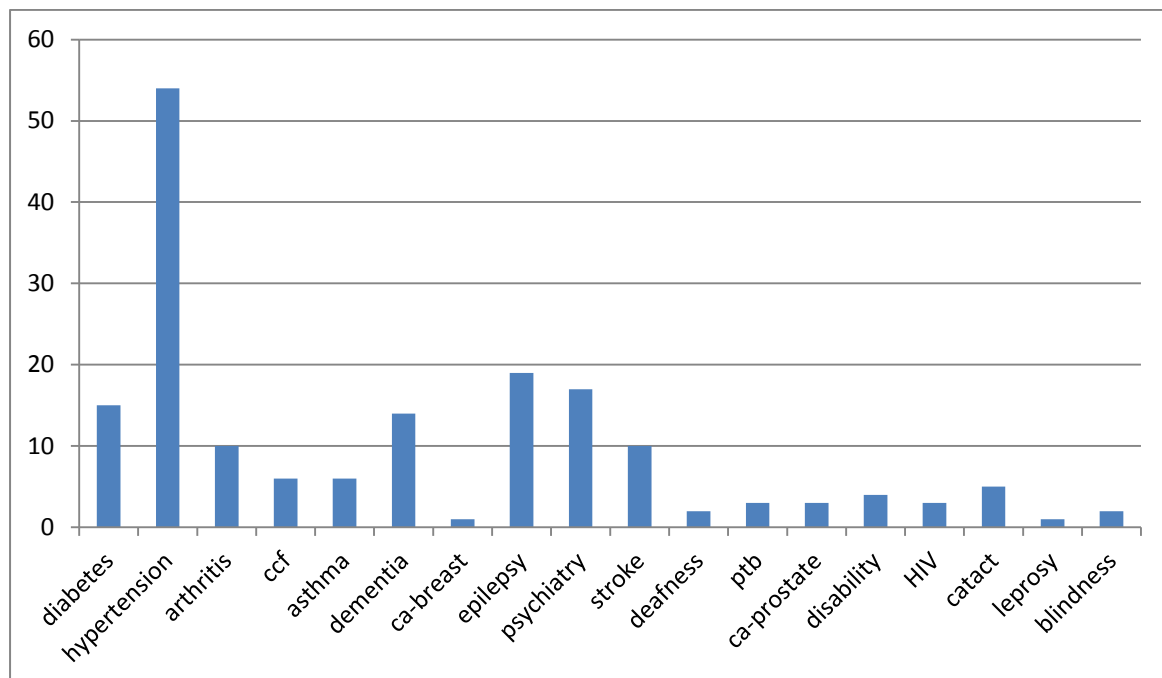


Figure 2.4.1. Number of Empilweni old age home residents experiencing different chronic diseases, 2012.

From the figures in the graph above the chronic diseases with the highest incidence among the elderly at EOAH are hypertension, diabetes, dementia, epilepsy and psychiatric disorders (Empilweni Old Age Home, 2012).

2.5 AGE AND CULTURE

According to Ferreira and Aboderin (2009), perceptions about ageing differ among cultures, depending on the basic values, world view, environment, societal circumstances and opportunities in that society. For instance, in the Eskimo traditional culture, the elderly were removed from the village at the age of 80 years and taken to the highest, coldest ice field or mountain where they were left to die because they were believed to have completed their lifecycle. This is in sharp contrast with the Western and Eastern world views, where ageing is a cultural and spiritual process rather than a biological one.

In both the Western and Eastern cultures ageing is seen as a maturational phenomenon, as a measure of acquired experience or knowledge and wisdom. This could be said true about most, if not all, African indigenous cultures too (Crowther, Paker, Acheubaum, Larimore and Koenig, 2002).

In the past when traditional influence was dominant and held sway in most societies except among the Eskimos, probably, an aged person was respected, obeyed, consulted and envied. Because then, they were in most cases respected for a number of roles they played in society which among many included socialisation of their grandchildren; especially in Africa. However, in modern society, the elderly people have been reduced to playing only a minority role because they are an economically 'non-active' group (Ferreira and Aboderin ,2009).

This is so because in modern society it is the economically powerful that controls the rest. Ferreira and Aboderin (2009) state that elderly people form a minority group in any population and they, therefore, suffer disadvantages in respect of illnesses and service provision. Often their health is affected by long years of employment in hazardous occupations or surroundings, low incomes, poor housing and restricted access to quality life. South Africa is characterised by many inequalities and disparities fundamentally inherited from the old apartheid era (Ferreira and Aboderin, 2009).

Blacks are by far the minority group in old age homes. This is because the Black population group has a negative attitude towards old age homes, and the elderly black person would rather die at their home than in an old age home. They also believe that when an elderly person is sent to an old age home, this is done because his/her family does not care enough to take care of them at home. Old age homes are associated with the white ethnic groups and chronic illness in blacks is ascribed to bewitchment (Ferreira and Aboderin 2009; de Haan 2005).

In addition to this, black people seldom prepare adequately for their retirement. Most of the black elderly reside in rural areas, are illiterate, dependent on their families, unskilled, and are often used as child-minders in their communities. They, therefore, struggle to meet the financial demands of old age Haan,Dennil and Vasuthevans, 2005). Hence, their having no choice, but to go to a public OAH instead of a private one if they require OAH services.

Without reference to race, Zeigler and Doblhammer (2010) discussing determinants of cognitive impairments state that basic physical care and personal hygiene vary widely among individual elderly people. Sometimes this is related to socio-economic differences, class, religion, developmental levels, health status and personal preferences which all affect the elderly person's culture.

Many people place a high value on physical care and personal cleanliness, and feel unclean unless they shower or bath at least once a day, while others may bath weekly and feel no need to mask their normal body odour. Some cultures may also dictate whether bathing is a private or a communal activity. In most cultures, society expects women rather than men to be the caregivers especially to the old and sick (Evans, 2004).

Given all these observations about people and culture, the researcher in this study anticipated to find differences in the way the elderly she was to study would relate to one another and the fact that they are in an old age home. In view of black people's perceptions of ageing and being placed in an old age home as opposed to being with one's own family members, the researcher sought to explore the perceptions of the elderly resident at that old age home. Her exploration of the topic, in chief focused on the residents' perception of the care the home provides to them (Vlok, 2010).

However, subsumed in that undertaking were the residents' views or assessment of the quality of familial and community relationships they once formed an active part of. The findings of the study in this respect and implications thereof are discussed in chapters 4 and 5 of this dissertation.

2.6 AGEING AND SOCIETY

Sociologic theories include the Activity Theory which proposes life satisfaction as one of the key factors to consider when dealing with ageing as a concept and reality of life. The activity theory suggests that for individuals to enjoy old age and feel satisfied, they must maintain activities and find a replacement for the statuses and associated roles they leave behind as they age (Phillipson, 1998).

In normal ageing, the maintenance of an active lifestyle, connection to and continuity with well-established habits, values and interests is integral to an elderly person's life. The rights of the elderly, such as senior citizens schemes, senior citizens' cards and reservation of seats in buses and trains, as well as separate queues in banks and post offices exist in recognition of the value of the elderly in the population.

There is a relationship between an elderly person and the environment. The emphasis in this regard is largely on psychosocial factors that keep such an environment safe and free from hazards. Sociologists view an old age home as the basic physical setting which is specifically designed to accommodate the elderly as a vulnerable population with diminished capacity in areas such as hearing, vision, mobility and memory. These factors require environmental designers to consider these factors and carefully adjust the built environment to support disability and prevent injury and hazards which could result in death. The design of a homely environment encourages active aged and semi-frail elderly residents to engage in activities such as bed-making, table-setting and laundry (Miller, 2004).

The strengths and abilities of older people are identified by creating a good relationship with their families, friends and church members, and acknowledging that they still have the ability to cope with life problems. Participating in activities that require or display wisdom and skills and participating in hobbies such as knitting and other low impact activities (Hank, 2010) will make the elderly people feel still valued by their families and community members.

According to Smeltzer, Bare, Hunkle and Cheever (2008), elderly people face disengagement from society, and this is defined as when there is a loss of roles, a contraction of contact and a decline in the commitment to norms and values. The opportunity to continue being an active member of the community is sometimes limited by retirement, the loss of a partner, physical disabilities and institutionalisation. Support from family and friends assists in preserving this vital interaction for as long as possible. Somehow, the elderly seem to be discriminated against on account of age. This type of discrimination is known as ageism.

Modern society has a negative attitude towards elderly people, using pitying terms like 'shame', 'non-productive' and 'lazy' people. This notion is supported by the Modernisation Theory (Smeltzer et al , 2008) According to the UN Declaration on the Rights of the Elderly, older persons should remain integrated in society, and should participate actively in the formulation and implementation of policies that directly affect their wellbeing (United Nations Organization, 2002; United Nations Organization, 1991).

Elderly people should also be encouraged to share their knowledge and skills with younger generations. This principle is evident in nursing homes for the elderly where active elderly persons attend to self-care activities like bathing and brushing their teeth without assistance, or with minimal assistance from the care givers, and share their knowledge with the health workers and amongst themselves. The claim that the elderly should be given an opportunity to continue participating in society and family activities is supported by what Nelson Mandela at the advanced age of 76 did. It was at that age that he was voted into the office of the President of South Africa.

He participated actively in society and was involved in policy-making decisions (United Nations Organization, 1991). While this happened to Mandela, not many elderly at that age are afforded such opportunities. Many of them are side-lined on account of old age.

In this country, South Africa, at least at government level there has been some positive movement in this regard. For instance the Department of Health in this country employs professional pensioners who are still active such as professional nurses, medical doctors and professors to assist in health care services. Financial support for the elderly differs from

country to country. In South Africa, a pension fund and food parcels are provided for elderly persons in need of basic physical care.

Non-governmental organisations like the LOTTO organisation also make a great contribution towards assisting the elderly population financially and in other spheres. The old age home under study does receive funding from LOTTO (Department of Social Development, 2006).

In the light of what is discussed above, one would say although more could be done, it looks like South Africa as a country does utilise some of the elderly.

Those who are professionals are given an opportunity to directly participate in the labour market of the country where possible and necessary. Those who may not be utilised in work place are supported by social grants. This is not the case in many other African countries.

2.7 AGEING AND TECHNOLOGY

Informal care givers (family) in home settings are exposed to high risk conditions and have minimal nursing/caring equipment. The average home is an unsafe environment for an elderly person when compared to a safe environment designed specifically for elderly home care. Current advances in medical technology where utilised are making a positive contribution to the care for the elderly in OAHs. For example where sensory thermometers instead of manual thermometers, creams applied to minimise pressure sores, the use of assistive devices, transport facilities, media and communication and computer technology are used to assist in quality care for the elderly (Tacken ,Marcellin,Mollenkopt,Ruoppila and Szeman, 2005) the quality of care improves.

Nevertheless, modern technology such as cell phones and computers which often are not accessible to the elderly because of eyesight problems, hearing problems and illiteracy, has resulted in a weakening of the traditional norms and values of the society. There is a communication gap in the younger generation where history telling is replaced by television and movie watching.

The lower economic status and perceived diminished authority of the elderly have led to a decline in support and respect from the younger generation (Tacken, Marcellin, Mollenkopt, Ruoppila and Szeman, 2005). This is one of the ways in which the important role the elderly played in the socialisation of grandchildren has been taken away from them. Consequently, the influence the elderly had in traditional society has been eroded away from them by modernisation.

One distinct advantage of modernisation, however, is that it has extended the life of the elderly population. Advanced medical procedures and treatments prolong the lives of elderly people. Chronic medication treats life-threatening illnesses and palliative treatment (hospices) comforts them when they are in pain.

Advances in surgery like plastic surgery, correction of coronary disease conditions and the use of prostheses all contribute towards extending their lives and making them more comfortable. The use of dentures to replace lost teeth helps them to continue eating healthily, thereby prolonging their lives in relative good health (Tacken, Marcellin, Mollenkopt, Ruoppila and Szeman, 2005).

2.8 OLD AGE AND LEGISLATION

On a worldwide scale, old age homes are regulated by state laws. In South Africa, the relevant legislation is contained in Act 1984 of Registered Homes (Longterm Care Home Act, 2007). The International Council of Nurses recognises the role played by the elderly so they have declared the need for nursing training to assure the availability of care for older adults (Wicht, 1986). The nursing home and its residents in South Africa are protected by the Constitution of the Republic of South Africa where basic physical care is a health care right for all. The Constitution, as embodied in Act 108 of 1996, declares the right to life, citizenship, human dignity, privacy, freedom of movement, and a safe environment (Constitution of the Republic of South Africa, 1996) for the elderly.

The Older Persons Act, Act 13 of 2006 is responsible for all matters related to the elderly population. The South African National Council for the Aged which was established in 1956 assists and supports surveys to determine the needs of the elderly, to bridge problems and

suggests co-operation with national and international organisations that have similar aims and objectives and, where necessary, to propose legislation protecting and promoting the interests and the welfare of the elderly (Wicht, 1986).

Currently Social Welfare and Health Department are responsible for the comprehensive care of the elderly population. Before 1994, Geriatrics Services fell under the Health Department and it was compulsory that all old age health workers undergo an induction course (Department of Social Development, 2006). That course equipped care givers in those institutions with necessary skills to take care of the elderly.

2.9 OLD AGE AND EQUALITY

Ageing and gender mainstreaming are interlinked. Gender inequalities in older age groups are a direct result of the accumulated gender disadvantages that they experience during their lives, and which exists in the communities. The socio-economic position, roles and relationships in later life are linked to the earlier experiences of men and women. Elderly women outnumber elderly men in all countries of the UNECEF region. They are more likely to live in poverty, be affected by disability and mobility restrictions. They are represented mainly among those living in residential care, and are at greater risk of elderly abuse (UNECEF, 2009, Ferreira and Aboderin 2009).

According to UNECEF (2009), in most countries, women's wages remain lower than those of men. This creates a gender differential in the contributions they are able to make to personal pension accounts, and leads to lower annuities being paid to retired women than to men. However, the lower wages of women are often related to their more frequent career breaks in their lifetime than their career profile. These breaks often occur during their child-bearing years, or are made to accommodate the demands of raising their children.

Laws and regulations promoting equal pay help reduce inequality in this aspect. Government pension schemes vary between countries. In South Africa, men and women get their pension fund at the age of 60 years and receive an equal monthly grant of R1040 with small annual increments (UNECEF, 2009 & Department of Social Development, 2006).

2.10 OLD AGE HOME RESIDENCES

Ideally, the staff of old age homes should consist of administration staff, a matron or manager, geriatric and general nursing staff, both skilled and unskilled, a psychologist, a social worker, a physiotherapist, visiting doctor, pharmacist, a dietician, general assistance staff, a gardener and kitchen staff. This is the ideal, but very little old age home is equipped with all these specialist staff (Carnevali and Maxine, 1990)

A well-designed homely environment that is conducive to the elderly and safety measures checked against approved standards of care are both important. A safe, homely environment, free from hazards and death cannot be over emphasised.

The needs of the elderly should be met by providing a healthy environment with no slippery floors, rails for support, and open grounds where they can walk. In studies on residential institutions, the most characteristics of old age homes were identified as: all aspects of life occur in the same place; living occurs with a large number of people; activities are tightly scheduled and occur in an orderly sequence. All the enforced activities are designed to meet the aims of the institution in the provision of services, education, setting for the purpose of maintaining or restoring a resident's maximum level of health, function and comfort mentally. The key in achieving these goals is to integrate all the services available in the health care and community system to create a living environment which is functional and stimulating (Holiday, 2000)

There are various ways in which old age services can be given to those who need them. For example, there is a special care like hospice care, or hotel care in situations which specialise in old age residents. Those who can afford it may make use of services like hiring their own caregiver. Assisted living allows the elderly to maintain some level of independence with assistance for daily living activities like cooking and cleaning. Intermediate care is for those who do not have significant nursing requirements, and day care centres cater for active independents who attend the centre to acquire skills like gardening (Thang & Lindholm, 2011).

2.11 EFFECTS OF INSTITUTIONALISATION

There are certain positive results that come from living in an old age home for the elderly. For instance, living together in a specialised old age facility promotes social cohesion and the feeling of belonging to one family among the elderly.

Residents perceive the environment differently depending to their cultural background and want different things from it. The condition and health of some elderly persons with functional disabilities due to injuries and chronic diseases improve as a result of the restorative and rehabilitation programmes which are offered at old age homes (Zlobicki and Kumarasuriyar, 1997).

On the negative side, some elderly people have fears and concerns about nursing homes. Residents may feel abandoned by their family and friends and may fear depending on strangers (caregivers). Anger is a common response from those who need nursing care. Their unmet needs may result in apathy, submissiveness and boredom. Old age dimensions vary from one institution to another. Depersonalisation, in the form of allowing a resident to have only a few personal possessions and limited privacy, may result in depression. The lack of free choice and lack of variation in the daily routine may result in boredom and resultant psychological problems (Eliopoulos, 1993).

2.12 HEALTH ASSESSMENT

Ferreira and Aboderin and Ferreira (2009) state that specific illnesses in elderly do not present or respond to treatment the same way, nor do they experience illness the same way as younger folk do. For example, old people do not experience high fever with pneumonia as do younger people, and, therefore, the presence of multiple pathological problems complicates the assessment process. Therefore, extra care should be taken for elderly people. Assessment of health includes listing of problems, co-morbid conditions, disease severity, medication review and nutritional status (Wahrendrof and Siegrist , 2010).

Poor vision and deafness are common among the elderly population and this disadvantages them in communicating and attending to basic physical care. An efficient functional assessment tool is very important in basic physical care for elderly people. Physical functional status measures reflect the physical ability of the individual to perform expected

roles and activities of daily living (ADL (Karts ,1983: Weening-Duksterhuis, Kamsma and Heuvelen , 2012)).

In a study on nutrition, health and physical impairments in the elderly population, the highest percentage of poor health, resulting in physical impairment like chronic diseases was identified (Buurman,Parlevleit,Deelen and de Rooi , 2010)).

2.13 PHYSICAL HEALTH CARE

Elderly people are a vulnerable group exposed to perturbation, physical, sexual, financial and emotional abuse and, therefore, are in need of care. Some have experienced loss of possessions such as homes or household items, loss of identity as an active member of a family and community decline in functional independence. These losses may cause the person to feel useless, powerless and hopeless. Some elderly people are ill, injured, or disabled with multiple chronic conditions. Psychosocial factors and stress play an important role in the aetiology of physical diseases called psychosomatic diseases, such as angina and migraine (Hoffman , 2009).

A study on old age perceptions of health showed that older people had a tendency to rate their health as good or satisfactory, in spite of the presence of multiple chronic conditions which they experienced. Geriatric care is a branch of medicine or social sciences that deals with health and care of elderly people. The aim of geriatric care is to promote functional independence to improve elderly people's capacity to adapt to new challenges presented by diseases and social environmental factors (Hoffman, 2009). Research has shown that elderly people want to be seen and treated as whole beings, which implies having physical, emotional, social and spiritual dimensions and that ignoring any of these aspects of humanity may leave patients feeling incomplete, and may even interfere with their ability to function (Hooyman and Kiryak , 2011).

There is a relationship between health and personal hygiene in that good personal hygiene boosts the elderly person's self-esteem while a clean environment is vital for organs and system to function properly (Rader, Barrick, Heffer, Sloane and Mckenzie, 2006). Successful ageing is attained through a healthy lifestyle, exercise, a well-balanced diet and full social support.

2.14 COMPREHENSIVE GERIATRIC ASSESSMENT (CGA)

The care in nursing homes is complex. It requires a multi-dimensional, inter-disciplinary team approach. Comprehensive geriatric assessment is a screening tool for elderly health problems. The benefits include an improvement in diagnostic accuracy, the optimisation of medical treatment, an improvement in diagnosis, the restoration of the maintenance function, and support for loss of choice and autonomy together with an improved quality of life (Buurman ,Partenvleit ,Deelen and deRooi , 2010).

Components of comprehensive geriatric assessment include medical, functional, psychological, social and environmental assessments through quality history-taking; concentrating on the key data during the interview by using a biographical approach to shorten the duration since elderly people may not have the energy to sit through a lengthy interview. Objective data on what is being observed and measured by the caregiver, e.g. blood pressure monitoring and regular reviews are essential (Buurman *et al.* 2010).

2.15 PHYSICAL ASSESSMENT AND ACTIVITIES OF DAILY LIVING

The use of all senses such as touch, smell, listening and observing will aid in identifying deficits such as malnutrition, low weight, oral health problems, use of a hearing aid, use of spectacles and assistive devices to facilitate the care and evaluation of treatment (Hank 2010). Anderson and Krutch (2006) studied the functional status of the older elderly and their findings indicate that many of the oldest elderly, particularly those with adequate social support, are content well into their last years of life.

The functional assessment tool is very important in physical care for elderly people to observe limb functioning, lifting of objects, limping and gait. The loss of independence in the performance of an ADL may be a sign of a chronic illness such as dementia, depression or heart failure. The loss of continence is a predictor for placement in long term care facilities.

Physical functional status measures reflect the physical ability of the individual to perform expected roles and activities of daily living (ADL). The Karts Index of Independence in

Activities of Daily Living (ADL) is the most used scale to screen for basic functional activities of older patients (Kartz , 1983).

Data can be collected by trained office staff from the patient, family member or other caregivers . Patients who are not able to perform one basic ADL will need daily assistance in their homes, for example, a family member or nurse aide may need to assist with bathing or dressing and feeding, transferring or cognitive deterioration or decreased outside mobility (George, 1990).

Frailty is more common in elderly persons of 75 years old and over who have cognitive or physical impairments that interfere with the performance of their activities of daily living. Physical frailty is defined as dependence in at least one activity of daily living, cognitive deterioration or decreased outside mobility. The Lawton-Brody Instrumental Activities of Daily Living (IADL) Scale (Weening-Dijksterhuis, Kamsma and Huevelen, 2011) can also be administered by trained office staff. If a patient is not able to perform one or more IADLs, assistance from caregivers will be needed for activities such as shopping, meal preparation, housework, medicine organisation and paying bills (Anderson and Krutch-Sorensen , 2006).

2.16 NUTRITIONAL ASSESSMENT

A study in U.K implementing nutritional guidelines for older people in residential care homes revealed that older people in residential homes remain vulnerable to malnutrition. Malnutrition: is any disorder of nutritional status, including disorders resulting from a deficiency of nutrient intake, impaired nutrient metabolism, or over-nutrition. It has significant negative impacts on the physical and emotional well-being of older people, including increased mortality and vulnerability to infections, clinical complications, depression, anxiety, and decreased quality of life (Gwozdz and Sousa- Poza , 2010). In a study on nutritional and functional status of elderly residents in Netherlands it was not clear whether the cognitive impairment causes malnutrition or the malnutrition causes cognitive impairment (Grieger, Nauson and Ackland , 2009) .

It is important for an elderly to eat a healthy balanced diet. The ideal diet for elderly people is fibre rich food which is good for digestion to prevent constipation, calcium and vitamin D to

prevent osteoporosis this involves low salt and less fat to maintain normal blood pressure, keep watching weight as well as overweight that may contribute to immobility.

The increase drinking 1, 2 -1, 5 litres a day to prevent dehydration in keeping the body hydrated. Older adults can learn how to make wise food choices and can find information about food labels, food safety, meal planning, food shopping, and ways to enhance the enjoyment of eating (Kaiser Bauer, Ramsch, Uter and Gurgoz, 2010).

The human body changes as one gets older, as a result ability of older adults to accurately regulate energy intake is impaired, with a number of possible explanations including delayed rate of absorption of macronutrients secondary to reductions in taste, smell, acuity, numerous hormonal and metabolic mediators of energy regulation that change with aging.

Accompanied by other physiological changes like decrease in lean body mass and redistribution of fat around the internal organs which leads to calorie decrease. There are also changes in patterns of dietary intake and a reduction in the variety of foods consumed in old age that are thought to further reduce energy intake (Roberts and Rosenberg 2006) .The common causes of malnutrition in elderly are little or no appetite, problems with eating or dentures or swallowing and eating fewer than two meals a day. These may be influenced by economic and psychosocial factors like loneliness, no transport and bankruptcy. Chronic and cognitive illnesses, disability such as visual acuity, and some medication that changes the taste of food are some of the challenges facing the elderly population.

According to multinational perspective using the mini nutritional assessment in frequency of malnutrition in older adults the following were assessed: subjective assessment, including past and present history, assessment of symptoms of malnutrition, past medical or chronic disease with long-term drug treatment, restrictive diets and surgical history, and co-morbidities. Functional limitation and assessment of physical examination emphasises the importance of oral examination. Social history present or past history of weight gain or loss and any psychological stress associated condition is also of importance in assessing the elderly nutritional state (Bareford, Heaven, May and Mayniham, 2012).

2.17 MEDICAL ASSESSMENT

History-taking on family background, past and current medical status is taken as the baseline in medical assessment. Multiple chronic conditions may require a combination of several medical regimens. Adverse drug events have been linked to preventable problems in elderly patients such as depression, constipation, falls and immobility, confusion and hip fractures (Molony, 2002).

The visit of a physician is of importance in establishing what medication is necessary, and for withdrawal of medication which has no valid clinical purpose. An objective measuring tool like the blood pressure measure and laboratory findings are of importance for correlation of drug maintenance and the resident's condition to those chronic condition.

All assessment scales recommended for CGA require a medical doctor's intervention although the nursing staff can learn to assess the elderly as well. Inappropriate medication use in older adults should be avoided because of adverse effects and the compromising of the functional status so that there is inadequacy of basic physical care among the elderly population (Donna, Fick, Cooper, William and Jennifer, 2003).

2.18 PSYCHOLOGICAL ASSESSMENT

Simple touch brings a positive feeling to older adults, shows companionship and satisfaction for social support. A study on sense of belongingness among Filipino old age home indicates that religion is seen as bringing elderly people together, lowering depression levels and the feeling of loneliness, giving a positive feeling of light and hope of new life and a connection to God (de Guzman, Dalay, Luigi ,de Guzman , de Jesus, and Flores. 2009).The psychometric properties of PAT assessing cognitive and activity of daily living is of importance to improve the health of the elderly in relieving boredom (Weening-Dijksterhuis et al. 2011) . A study on Alzheimer patients' behaviour reports on positive changes in residents' social behaviour and it is believed that keeping these residents active can help slow their decline, and certainly activity can help in maintaining their physical wellbeing, and may help prevent other illnesses and infections (Kurlowicz and Niche 1997).

In a study examining the perceptions of social determinants of depressive symptoms as well as their impact on the health and wellbeing in a community dwelling US Chinese aging population in Chicago. The findings suggest that depressive symptoms were common among older adults. It was frequently identified through feeling of helplessness, feeling of dissatisfaction with life, feeling of getting bored, loss of interest in activities, suicidal ideation, and feeling of worthlessness. Social conflicts, family conflict, financial constraints, personality and worsening physical health associated with physical depressive symptoms which may be detrimental to the overall health and the wellbeing of the elderly (XinQiDong, Chang, Wong and Simon 2012).

Other studies of associated behaviours in elderly persons with dementia suggest that the focus should be on the elderly people, rather than on the disease, because people differ in behaviours and thus small adjustments in routine and interaction skills can be made, especially with regard to elderly people suffering from dementia. Use of colour codes and preferences is suggested to individual patients with dementia as per their needs. Displaying wall clocks which indicate the date, time and day may assist in mental activity to meet the needs of the elderly (Birrer, Richard and Vemuri, 2004).

History-taking assesses the mental state (mini mental scale) in regard to general appearance, orientation, judgment, thinking processes, insight and behaviour. It is vital to know about the drugs taken and their effects, as some drugs may affect the mental system, like psychotic drugs, and may cause depression. The Cornell Depression Scale is used to assess the mood and behavioural levels scoring from 0-2, based on signs and symptoms (Ziegler and Doblhammer-Reiter, 2010).

2.19 SOCIALLY

In a residential old age home, environmental safety checks have become compulsory. Caregivers and staff members should undergo a series of background checks with regard to criminal records for the safety of the elderly residents. On entrance, camera monitors should check for firearms and other dangerous weapons which should be left at the gate. Any neglect and abuse of residents should be investigated and dealt with (Wahrendorf and Siegris, 2010).

Erickson (1982) argues that any social support from the family and relatives such as the number of people staying with the elderly person, their involvement, or visits by friends should be encouraged.

Government involvement in the care of the elderly, e.g. supply of food, clothing and physical environment (old age homes) should be assessed (Government Accountability Office, 2011).

Financial assessment is important, especially for those with no one to care for them, particularly in terms of retirement funds, or pension funds or financial support from the family. Some active elderly people are good at crafts, sewing and knitting, and the use of their knowledge and wisdom is encouraged (Act 13 of 2006).

The elderly residents should be encouraged to engage in such activities as making their beds, setting the table, doing laundry, and they should benefit from the presence of a reliable caregiver, having medical insurance, being affiliated to the religion of their choice, involvement in social activities like choir, music or in games like soccer. Social workers are usually best equipped to help old age residents (Wahrendorf and Siegris , 2010).

2.20 CARE PROVISION

Old age care is a positive intervention for strengthening the family and social support systems for the older persons. The field of nursing that specialises in the care of elderly is called Geriatrics (National institute on ageing, 2012). Bringing the elderly residents and their families to the centre and involving them in the care giving, and listening to the problems presented is of importance for the co-ordination of care for elderly people. Because ageing is a normal occurrence, care for the elderly cannot be limited to one discipline but should be provided through a co-operative effort (Smeltzer et al, 2008).

The primary health care approach and use of quality assurance standards through comprehensive geriatric assessment is the key to quality care for the elderly. A comprehensive care plan, the use of Orem's nursing theory of self-care deficit to compensate for the residents' lack of self-care abilities, and total care for the elderly provides a theoretical framework to guide the assistance of elderly residents, all these are necessary (Goerge, 1990). The caregivers should focus on the basic restorative care in its physical

aspect, prevention of complications; prolong illness and injuries through health promotion, health prevention and medication. (Hughes, Weaver, Goibbie, Hurder and Manheim, 2000).

2.21 STAFFING LEVELS

It is believed that many nursing homes are understaffed. A US federal study on nursing homes showed a severe shortage of nurses and assistant nurses to provide high quality care to elderly residents. In another US research study it was reported that staffing shortage causes neglect and creates stressful working conditions in which abuse is more likely to occur (Hirschfield, 2009).

Nurses from developing countries like South Africa and other African countries leave their countries of origin and flock overseas for the purpose of working in nursing homes mainly as a result of the economic state of their countries' economies.

In most nursing homes, the nurse works independently, yet there is a great deal of nurses to collaborate with other multidisciplinary team members for referral and advice when there is a need. Caregivers (nurse aides) and nurses are pillars also seen as part of the stakeholder's group responsible for personal health care at a low cost and sometimes are traditional health care of elderly people, depending on the institution (Smith and Buckwalter, 2005).

The minimum training level is 6 months in order to be called formal caregivers (nurse aides) and get a certificate. They differ from institutions; some perform many direct care activities, and assist in some nursing skills actions like monitoring intravenous infusion and counselling so as to provide emotional support to elderly people. People who take part in supporting elderly people at the community level are family friends and relatives (informal caregivers) (Kim, Konron, Harrington and Mezey , 2009).

The multi-disciplinary team as a whole, the doctor, the physiotherapist, the psychologist, the social worker, the dietician, the speech therapist, the specialist physician, the general doctor, professional nurses, sub-professional nurses, from the certified nurse aid to the unskilled caregiver all belong to the caregiver group. The partnership of caregivers and the family or relatives is of great importance too. Caregivers take an advocate's role in supporting,

information-sharing and working through political channels for the benefit of the elderly people (Hooyman & Kiyak , 2011).

In a variety of settings, nurses become increasingly involved with complex geriatric care, since the majority of health problems experienced by older adults come under the domain of nursing (Eliopoulos , 1993).

It is stated that nurses are a professional group which has been largely involved in elderly care, primarily because no other discipline has been keen on caring for elderly people. Gerontology is a new qualification in elderly care where all aspects and problems of ageing including physiologic, pathologic, psychological, economic and sociologic are viewed and studied.

2.22 CONCLUSION

This chapter covered the literature review that focused on the demographic picture in relation to older people, reviewing the normality and dimension of elderly clients from different perspectives, trying to unpack the world of old age generally, and more specifically, that of the old age home. The healthcare workers in old age homes will have a greater understanding of the paradigm of old age so as to give good customer care to elderly people. The increasing elderly population needs a surety that competent staff is available to execute caring duties such as assessing and screening elderly people.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

In this chapter the researcher presents the methodology she adopted when collecting information she needed in this study. A discussion on methodology is incomplete if nothing is said about research paradigm and research design. Therefore in this chapter, the researcher presents the research methodology, paradigm and design that she employed in this academic exercise.

3.2. RESEARCH METHODOLOGY

As defined by Burns and Grove (2007), research methodology relates to steps, strategies and procedures a researcher employs to gather and analyse data in a research investigation. This study adopted the qualitative methodological framework because in intent the focus of the study was on exploring perceptions of the elderly residents of an old age home, Empilweni Old Age Home (EOAH) in Mthatha.

As described by Brink ,van Rensberg and van der Walt (2012) the focus of qualitative research is on understanding, explaining, exploring, discovering and clarifying situations, feelings, perceptions, attitudes, beliefs and experiences of a group of people. The researcher adopted this research methodology because she set out to explore the perceptions in a group of people about a life experience. The group of people whose perceptions she sought to investigate was that of the old aged people institutionalised at EOAH and the experience under study was the care received at that institution.

3.3. RESEARCH PARADIGM

The research paradigm that informed the design of this study was the phenomenological approach. This paradigm which is also known as interpretative approach aims at understanding (de Vos, Strydom, Founche and Delport 2011: and Mouton 1996). As

explained by de Vos et.al (2011) in this paradigm the researcher spends hours and days in direct contact with participants observing them and making field notes relevant to the study. Central to this approach is the researcher's detailed study of transcripts, conversations and video tapes in order to make sense of subtle non-verbal communication or to understand the interaction in its real context (de Vos et al, 2011). In this study the transcripts the researcher studied and analyse were based on focus group conversations that were captured both on audio and video tapes. The researcher facilitated the conversations in person.

Through these stories the participants are able to describe their views of reality and this enables the researcher to better understand the participants' actions (Baxter and Jack, 2008)

3.4. RESEARCH DESIGN

A research design as defined by Sellitz *et al.* (1965) cited in Terre Blanche, Durrheim and Painter (2007), a research design is a strategic framework for action. That plan of action serves as a bridge between research question and the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in the procedure. Given that in her literature review the researcher did not find any documented study on the topic and context of this study, she adopted an exploratory-descriptive design. The purpose of an exploratory study is to explore the dimension of a phenomenon, the manner in which it is manifested and the other factors to which it is related.

In other words, such a study provides more insight about the nature of a phenomenon (Brink, 2001). The purpose of descriptive research is to describe a phenomenon in a real life situation. The researchers observe, count, delineate and classify in qualitative research using in-depth methods to describe the dimensions (Polit and Beck, 2003). Through the data collected by means of focus group conversations, the researcher in this study, drawing the conversations the researcher was able to come up with a description of the perceptions of old age residents regarding their basic physical care. That description would contain among much other things normality, abnormalities and the dimensions of the old age population as viewed and interpreted by the residents of EOA.H.

3.5 GAINING ENTRY AND ACCESS

The researcher approached the authorities for permission to conduct the study, explaining the nature, purpose and the significance of the study in personal face to face discussions and also in form of a written letter (see appendix E). The researcher also provided an abridged research proposal, including information to be given to the participants in order to secure their consent and how ethical principles were to be observed.

The researcher was familiar with the CEO/manager and other health workers as she was a Master's student doing Stroke case study assignment project as theory module at the residence. Given the purpose of the study the CEO/Manager gave the researcher an overview of the layout and a round on the residence area, the history and how it operated.

3.6 RESEARCH SETTING

The study was conducted in an Old age home at about 10 kilometres away from Mthatha, King Sabatha Dalindyebo municipality in the O.R Tambo District of the Eastern Cape Province. The old age home was built by the DG Murray Trust Construction as a token to the Transkeians, who were recruited to work for the construction. It was their wish to build an old age home for these loyal labourers, now retiring to Transkei for their retirement in 1983. The Holy Cross Sisters took the administration for the supervision of the home and left in 2009. Amongst other Stakeholders were the Department of Welfare and the Medical Scholarship Doctors to render free medical services.

Financial support:

The Department of Welfare subsidises the home up to 80% and the remaining 20% is paid by the old age residents through their Old age pension fund, $\frac{3}{4}$ of the Old age pension is payable monthly to supplement the government subsidy. Other sources of funding include non-governmental organisations like LOTTO. In addition, there are voluntary individuals and groups who occasionally support the home financially, socially and spiritually.

Medical support:

Fourth year Medical students from the Medical School of nearby University (Walter Sisulu University) render free medical services as their practical placement requirement as prescribed by the Medical Council. The university teaching hospital is only 9 km away from the old age home facility.

Physical infrastructure

The home consists of six cottage-type houses and two block-houses. Residents are separated according to their level of functional limitations and state of chronic condition. There are, therefore, sections catering for the active aged, the semi-frail, and the frail.

The sections are further divided along gender lines. The study included all old age residents who had been at the home for 6 months or more but excluded those with senile dementia, severe mental illness and the very frail residents.

3.7 POPULATION

A population is a complete set of persons or objects which possesses some common characteristics that are of interest to the researcher (Brink, 2001). The population of this study consisted of Empilweni old age home residents. All residents at EOAH are Xhosa speaking, thus EOAH may be described as a Xhosa speaking community. The home accommodates both male and female elderly people aged between and including 60 and 90 years of age.

All in all, there is a total of 140 residents at that residence; 57.1% (n = 80) of whom are females and males only constitute 42.9% (n = 60). About 40% of the elderly people have intact cognitive and functional disabilities ranging from total dependency to needing help with the activities of daily living and 60% of independence as measured PAT test by Weening- Dijksterhuis et al. (2010).

3.8 SAMPLE AND SAMPLING

A sample is a sub-set of the population that is selected to represent the population (Brink, 2001). According to Burns and Grove (2007) the sample defines the selected group of people (or elements). Generalisations extend the findings from the sample under study to the larger population. The quality of the study and the consistency of the study's findings with the findings from previous research in this area influence the extent of the generalisation. Sampling is defined as the process of selecting a portion of the population to represent the entire population so that inferences about the population can be made (Polit and Beck, 2008).

The advantages of sampling rather than dealing with the entire population are that the cost is lower, data is collected faster, and there is an improvement in accuracy in data quality, and homogeneity is ensured. Sampling criteria include the list of characteristics essential for eligibility or membership in the target population. This study addresses subjects from three social old age sub-groups namely: active ageing, semi-frail and frail to represent all the people at the old age home residents.

In this study, quota sampling was used to decide on who would participate in the study. The researcher aware of some of the variables in the population that was critical for achieving representativeness (Burns and Groves , 2007). Participants were non-random selected with the assistance of the CEO/Manager and the nursing staff. This study addresses subjects from three social subgroups namely with sound intact mind: active ageing, semi-frail and frail. The sample consisted of selected elderly people who were residents at Empilweni home. In order to be included in the study, the participants had to be:

- Old age residents of Empilweni home
- Aged between 60 and 90 years
- Admission from 6 months and over
- Equal representation of gender
- Equal representation of subgroups

Exclusion - very frail, senile dementia and severely mental illness elderly residents.

A purposive and quota sampling strategy was conveniently selected to ensure representativeness of all elderly, age strata and gender population to minimise distortion and bias (Polit and Beck, 2008).

TABLE 3.1

GENDER	AGE	LENGTH OF STAY	CHRONIC MEDICAL CONDITION	REASON FOR INSTITULIZATION
Female	62	Two Years	Epilepsy & burns affecting right hand	Children, all died no one visits
Male	75	One Year	Diabetes, Partial Blindness (Using a stick)	Daughter Married, Frequent Visits
Male	68	8 Months	Hypertension & Diabetes	Wife Died, Children Left Long Ago
Female	65	3YEARS	Arthritis Affecting The Hip (Using Wheel Chair)	Children Working Abroad Visit When Around South Africa
Female	70	ONE YEAR	Cataract & Diabetes Use Stick	Never Had Children Had Children Family Visits
Female	67	One Year	No Known Chronic Disease	Son, Married, Rarely Visits
Male	64	Two Years	Hypertension Limping (Polio)	Wife Dead, Children Left For Work Cape Town Visit Once a Year
Male	78	Four Years	Hypertension & Diabetes	Never Had Children Family Visit
Female	76	Two Years	Stroke Affecting Left Arm Only (Using	Children Left Long Ago No Visit

			Stick)	
Female	77	Three Years	Cancer Of The Cervix Attending Radiotherapy	DIED Children all Dead, Relatives Visit
Male	63	Two Years	Diabetes, Hypertension & Mild Stroke Affecting the Mouth	Children Come and Visit
Male	70	Three Years	Normal Ageing	Children Visiting

3.9 SAMPLE CHARACTERISTICS.

The researcher felt it was necessary to describe the participants in terms of age, gender, chronic medical disease, length of stay at the residence and the reason for staying to give a clear picture of the sample participating in the old study. Chronic related diseases some co-morbidity was common in this sample and as evidenced in the literature and statistics of the Empilweni old age home residence. Shown was the level of assistive device used for the physical limitations.

3.10 DATA COLLECTING PROCEDURE

The data collecting procedure adopted in this study was focus group discussion. The description of this procedure is given below.

3.10.1 Focus group

A focus group is a semi structured group session moderated by a researcher, held in an informal setting with the purpose of collecting information on exploring perceptions of the old age residents regarding the general care they receive. Focus groups are particularly suited

to the collection of qualitative data because they have the advantage of being inexpensive, flexible, stimulating, cumulative, elaborative, assertive in information recall and capable of producing rich data (Streubert and Carpenter, 2007).

It is a means of better understanding how people feel or think about the general care of the old age residents. Focus groups can be used for sharing experiences, investigation perceptions, validating concepts, instrument development, sensitisation or conceptualisation. Participants have common characteristics that relate to the planned topic of the focus group. The number depends on the research aim and purpose. Groups from six to ten members are accepted. An understanding of group process is important to facilitate focus group that is introducing the group, conducting the group and closing the group. The researcher understands handling of a group as she is a facilitator in a local nursing school. The goal is to have as many groups to provide a trustworthy answer. The advantage is for people who feel more confident in a group than to speak alone. The disadvantage is that in a large group size some people might be uncomfortable to express their view in front of the group or may preclude everyone from having a chance to speak. In small groups size may make group members feel as though they cannot speak freely or have to speak when they have nothing to offer (Botma ,Greeff, Mulaudzi and Wright , 2010).

Group of 12 participants was used. Language used was Xhosa. There was an equal representation of gender. Lounge/living room was arranged in the same area for the convenience of the elderly. The researcher felt it is important to emphasise that the participants are free to withdraw at any stage and reminder of the verbal consent as the signed consents were already signed the previous day before starting the focus group discussions.

Participants were informed of the use of audio and video tapes that is for the purpose of validating the study. An audiotape and videotape were used to record the focus to allow the researcher to pay full attention to what the participants had to say and to clarify some of the missed information during the focus group.

For good quality recording of the group session, at least two tape-recorders (with new batteries per session) were used simultaneously to guard against data loss due to inaudibility of recordings. Two assistants were hired to take care of the recording equipment during the

sessions, and they assisted in jotting down important notes so that there were no missed statements.

3.10.2 Field Notes

Field notes are a written account of the things the researcher hears, sees, feels, experiences and thinks about in the course of the focus group and much broader more analytic and more interpretive than a listing of occurrence activities. In addition to field notes, a researcher may use reflective notes as well.

Reflective notes are the researcher's personal thoughts such as speculations, feelings, problems, ideas, hunches, impressions and prejudices she/he may have about the subject matter under investigation or on how the process unfolds.

The researcher observed torn linen on some of the beds and a smell of urine in the rooms /units of the elderly with limited functional status.

Demographic information about time, place and date of the field setting as well as the demographic notes about the participants (Botma, Greeff, Mulaudzi and Wright, 2010) also forms a part of the field notes. As required by ethical considerations, the researcher informs participants about all this. In this study such notes were not made by the researcher alone, but by her assistants too. Such unstructured observations or comments provide some additional information about human behaviour and events during which such behaviour is captured as the process unfolds. In keeping with Brink, de Walt & van Rensburg (2012), the degree of researcher's involvement in observations of this nature was moderate.

The importance of taking field notes as accurately as possible cannot be overemphasised. Some guidelines a researcher needs to take note of in the process include the following:

Jotting down observations as one watches and/or directs the event/process. That is, putting down on paper such observations before one forgets. The events must be, as much as possible, sequenced in the order they occur in the process. After taking down such notes, the researcher must set aside some time to complete such notes. To do that the researcher must find the most suitable place to do so as well. In this study the researcher did so. She made time to look at her own notes as well as those captured by her assistants.

Field notes gathers data in three sections namely descriptive, reflective and demographic information. In this study the details relating to descriptive, reflective and demographic information are presented in the preceding paragraphs of this section as well as the details provided in table 3.1 above. There are only two details, in this regard, that have not been covered so far. These are the specific date and time when the focus group met. It was on May 16, 2012 around 11am.

These notes were an important addition during data analysis because they became very handy in locating important quotations from the tape itself. They became a very helpful tool in the validation of important points made by the participants and facilitated appropriate emphasis on emerging themes. This is in keeping with observations made by Streubert and Carpenter (2007) on the importance of such notes in this kind of research work.

3.11 DATA COLLECTION

Data collection as described by Brink (2001) refers to pieces of information gathered during a research study. Polit and Beck (2008), discussing data gathering claim that this is the precise, systematic gathering of information relevant to the research purpose, or specific objectives, questions or hypotheses of a study. In this study the focus group interviews were used as a tool for gathering such information as required in this project. The advantages of this technique are first and foremost, that it does not discriminate against people who cannot read or write.

Secondly, it is inexpensive and encourages participation from people reluctant to be interviewed individually. Lastly, it is very effective in exploring people's attitudes. The researcher had an assistant who was a colleague who was on leave to assist in data collection. That colleague did really help in collecting field notes at no cost.

As reflected in the topic of the study, the central focus of this study was on the perceptions of old age home residents of the care they so receive from such facilities in the Eastern Cape. The focus group technique of gathering information was aptly suitable for this study (Polit and Beck, 2010). The aim of the study was to obtain perception of participants. The focus

group technique allows broad questioning which may the researcher get useful data relating to people's perceptions of a subject or person under investigation. In this study the researcher listened while recording and she was busy bracketing her own views as the discussion progressed.

Being fully aware of culture and its implications for focus group technique, the researcher made every participant at ease when she announced that the medium of the discussion would be in Xhosa.

The majority, if not all of them, of residents at Empilweni Old Age Home are Xhosa first language users and elderly. Since the researcher herself is Xhosa speaking, herself, no one needed the mediation of an interpreter. That made the discussion flow a lot more naturally than it might have probably been if English was used as medium of communication in that task. Other factors considered when selecting the interview group and medium of communication included a sound understanding of the purpose of the study, research objectives, literature reviewed and the research paradigm.

The researcher was careful as she interacted with participants as well as the information coming from them. She had to put aside all her pre-judgments, as she bracketed her own experiences as advised by Creswell (2008). She relied on her intuition, imagination, and universal structures to obtain a picture of the experience, again as advised by Creswell (2008).

For data collection process to occur effectively 10-15 minutes of the focus group discussions was used to build a relationship between the researcher and the participants. During that time the researcher oriented the group to relevant features of a focus group. Such features include: an introduction, welcome, overview orientation and expectation roles and attitudes in terms of participant's answers.

All possible questions from participants were addressed and cleared as needed. An overview of the topic was given by the researcher. Ground rules were also presented and agreed upon such rules. Participants were assured of confidentiality (Streubert & Carpenter , 2007). They were also reminded of the duration of the session and their commitment to the project as well as their liberty to pull out of the project if they so felt. Reference was made to the consent

form they already signed. In terms of easier identification every participant had their name tag pinned on them. Name tags would help the members to remember one another's name as part of promoting group cohesion. The researcher explained the role of the assistant researcher that is to take field notes to document non-verbal cues and other observations without participating in the discussions as explained by Bonito and Sanders (2009). All participants were invited to refreshments after discussions as a token of appreciation.

The researcher started the exercise with a broad opening statement so as to provide participants with opportunity to describe fully their experience and for her to gain in-depth information on the subject; additional probing questions were allowed and were even encouraged. Knowing the nature of her project participants' characteristics such as memory decay, the researcher accommodated that aspect very well. She had to accept that there is a natural decay in ability to remember events that have positive correlation for example with the irregular occurrence of events, especially for folks like the elderly.

Omniscience syndrome was noted in one of the participants who believed that she could answer all the questions asked. At times that participant was ignored by the researcher to give chance to other participants. This is in line with Mouton's views (1996) regarding such a challenge. Although interviews time scheduled to last 30-45 minutes, it took longer and last a full hour. That was understood given the participants in the exercises. Being elderly, people took their time sharing their views and that was well worth the richness of data collected. Saturation point was reached where the participants were repeating the same statements and some became less active which signifies completion of data collection from the discussion pertaining to the general care of the elderly in an old age home. The interview was pre-coded. In this study, the qualitative data collected from the open-ended questions were edited, coded, categorised.

3.11.1 Broad Question

The one similar question was asked to the group the goal was to make comparison across individuals in group participants. Open-ended questions were asked so that the participants

could express their feelings, and probing questions were posed so as to achieve greater explanation on the subject.

“What are your views with regard to the general care of the old age residents at Empilweni The researcher encouraged the participants to describe their experiences and views as fully as possible. She sought to get their perspective and experiences regarding the general care they receive at that old age residence. The researcher encouraged consultative interaction within the group wherever and whenever need arose to stimulate in-depth discussion on the topic.

The researcher listened; friendly and employed a sense of humour when and where in the course of the discussion was needed but remained respectful. When facilitating a group, the researcher needs to know the background of the general care in an old age home. The researcher did qualify in that respect because she was gerontology student.

During the group discussion process the researcher encouraged all types of comments - positive and negative ones. The researcher was careful not to make judgement about the responses and control any body language that might communicate approval or disapproval. The researcher explained to the participants that there were no right or wrong answers, only different points of view. The researcher’s function during the focus group interview was to moderate, listen, observe and eventually analyse, using the inductive process as advocated by Bonito and Sanders (2009).

What the participants said, how they felt, what they had done and what they knew about the general care regarding the old age residents would be the things the researcher would learn from; to do that she had to talk to and discuss matters with the participants as advised by Andrew and Wong (2008). The researcher helped the participants to explain things in more detail by asking questions. This is what Streubert and Carpenter (1995) suggest.

The researcher probed for further explanation or clarification of statements that were not clear to her. She attended to the interviews in a manner that communicated to participants that indeed she was listening. Again, this is what Andrew and Wong (2008) state should be done in an interview of this kind.

The mode of understanding in this qualitative research using focus group interview included among many other things the following main aspects in structure.

- Centred on the participant's life-world
- seeking to understand the phenomenon perception of the old age home residents regarding the general care to them as a resource person to their life world
- being qualitative and descriptive
- being specific
- being without presupposition
- being focused on categories related to old age general care
- being open for ambiguity
- depending on the sensitivity of the facilitator, the researcher
- taking place in an interpersonal interaction

Data were gathered from the sample of old age home residents. During the focus group discussion it was also possible to elicit the opinions of the old age residents regarding the general care they received in an old age home residence. Data collection continued until the researcher believed that saturation had been achieved as advised by Streubert and Carpenter (2007). The total number of focus groups conducted depended on the saturation of data. Data saturation is said to be achieved when no new themes or essences emerge from the participants and the data become repetitive (Streubert and Carpenter, 2007). Data became repetitive on the eight participants but the researcher continued to probe on the perceptions on general care they received until the interview came to an end.

3.12 DATA MANAGEMENT

The raw tape recorded data were transcribed and translated verbatim immediately from the participants' language (Xhosa) into English after the focus group discussion in order not to lose any meaning, and to begin data analysis as a process itself (Andrew and Wong, 2008; Bonito and Sanders, 2009). The researcher then went over the discussion to make certain that what had been written made sense. Immediately after the interview, the researcher wrote down her observations on the group discussion itself, and any information that would help to

establish a context for interpreting and making sense of the interview (Andrew and Wong, 2008).

The researcher made sure that the information gathered through the medium of Xhosa was not compromised or distorted when translated from the source language into English, the language in which the presentation and compiling of this dissertation would be. To do that, the services of a university graduate with qualifications in English and conversant with both languages were sought. A High School teacher of English, a Xhosa first language user was hired to check the information so captured and interpretation after the researcher has transcribed and translated the raw data.

3.13 DATA ANALYSIS

According to Polit and Hungler (1995), analysis of data is the method of organizing data in order to answer research questions. In qualitative research, data collection and data analysis occur simultaneously with redirection of the research as new insights emerge from the analysis. All data collected are displayed starting from gaining the entry and the researchers observations and a reflection on the data is made (Creswell, 2003).

Qualitative data consists of logs from personal observation, field notes, recorded group discussions, focus group discussion transcriptions, written documents and personal journals. All those modes of information gathering used in the study had to be examined and scrutinized as part of the analysis process.

A phenomenological study describes the meaning of the lived experiences for several individuals about a concept or the phenomenon, Creswell (2003), states. To deal with the information so collected in this manner, phenomenological data analysis proceeds through the methodology of reduction, the analysis of specific statements and themes, and a search for all possible meanings. The researcher also sets and analyses the data manually.

During the interview, information was recorded on an audio tape as well as on a video tape for the purposes of data analysis. That information was gathered and sorted according to the group

discussion. The contents on the tape which were in the Xhosa language was sorted and transcribed. Field notes were taken down on paper, and observations were made. Raw material from the tapes in the form of words and phrases was extracted to generate codes

The broad question asked and from that probing question followed to get a full picture of the residents' perceptions of the general care they received at that old age home facility and from that the following categories emanated: basic needs, psychosocial, unsafe environment and medication, institutionalisation, nutrition and support system. The observations made about the general living conditions there such as the smell of urine torn linen on some of the beds and the broken down toilet and the state of the bathroom door formed part of the data to be analysed.

The contents of the data in Xhosa were translated into English, transcribed and then the information was coded. The discussions were typed and re-checked against the tapes to confirm the information typed the coded information was categorised correctly and adequately.

3.14 DATA QUALITY ASSURANCES

Data quality assurance or trustworthiness in qualitative research indicates the rigor and quality of the qualitative research data, say Polit and Beck (2010) There are various criteria to evaluate the quality of data. According to Lincoln and Guba (1985) framework cited in Polit & Beck, (2010), that framework is made up of the following: credibility, transferability, dependability, conformability and authenticity. These criteria are considered the right determinants of validity and reliability in quantitative research.

3.14.1 Transferability

Transferability refers to the potential of applicability of the findings to other settings or contexts (Polit and Beck, 2010). In this study, the researcher described sufficiently the perceptions of old age residents regarding the general care in the O.R. Tambo District of the Eastern Cape, in order to provide enough information to the reader.

Given the explanations provided in this account, the researcher came to a conclusion regarding the applicability of her findings in this study to other old age home facilities in the province and beyond.in this respect, the findings fulfill this criterion.

3.14.2 Confirm ability

Confirm ability refers to the objectivity of the data and congruence of data's meaning, accuracy and relevance between different independent people. This confirmed ability indicates that the data interpretation represent the information provided by the participants, not invented by the researcher according to his will or his own bias (Polit & Beck, 2010).

To achieve the confirm ability in this study, the searcher invited one person to read the transcripts independently and asked them to provide their interpretation regarding the data to find out whether what the researcher interpreted was really the same as what other people made of the information made available to them based on the data in point.

That would confirm that the researcher interpreted the data without any bias of her own towards the intended goal of the study.

Apart from that, the researcher went back to the participants to tell them whatever she recorded down in this regard and asked them if what she written down really represented what they meant to say and would mean. There is internal agreement between the investigators' interpretations and the actual evidence. The manager with the researcher took some rounds in and around the infrastructure of the facility together. The former was showing the latter the residence area and how the facility functioned. The information gathered about the facility was shown both to the manager and the participants for accuracy and confirmation that it be part of the study.

3.14.3 Credibility

Credibility refers to the confidence of truth the researcher and anyone who reads the report has in collected data and their interpretation. It is also the truth of the data-objectivity and triangulation indicating that more than one technique was used in data gathering by means of field notes , focus group and complement by video and audio tape (Polit and Beck, 2010).

In this study, the credibility was ensured by collecting data from the participants in private room in order to make them safe and tell the researcher their perceptions of old age residents regarding the general care in the O.R. Tambo District of the Eastern Cape. It was also

ensured by the use of more than one technique in data gathering was made. The techniques used included field notes, discussions and tape and video recording.

3.14.4 Triangulation

A convergence of multiple perspectives for mutual confirmation strengthens the credibility of the findings of this study. It contributes to the completeness and confirmation of the findings necessary in qualitative research investigations. Streubert and Carpenter (2007) describe three types of triangulation in data collection namely time, space and person. In this study the researcher used the 'person' triangulation type where more than one level of person is used, that is, a set of individuals or groups or collectives is used.

The old age residents have been stratified into subgroups of active, semi frail and frail people to gain more meaning about different types of group within the same population group aiming at gaining more meaning on the phenomena as manifested in the psyche of different categories of people. The CEO/Manager gave the overview report of the residence and took rounds with the researcher around showing her how the area operates.

In this study two forms of this strategy were applied, namely, data triangulation involving focuses group discussions, field notes and video tape to complement the understanding while collecting data in focus group notes were taken. In the data analysis triangulation there was one person besides the researcher to transcribe and interpret for independent analysis of all the collected data as prescribed by Lincoln and Guba (1985).

3.14.5. Authenticity

Authenticity refers to the extent to which a range of realities is fairly and faithfully shown (Polit and Beck, 2010). To achieve this in this study, the researcher used participants' feelings, words, and tone of the words, language, emotions such as crying, silence, and any other kind of emotion in the text when the researcher wrote a report. The researcher tried to write different realities she would find in the research without getting fixed onto one particular reality.

3.14.6. Dependability

Dependability refers to the stability of data over time and conditions (Polit and Beck, 2010). This stability is like reliability in quantitative study. To ensure dependability in this study, the researcher went to the facility earlier before for biographical data of those that would be participating in the-would be focus group and bracketing. Besides that, before the researcher took final data she came back to the participants to ask them whether the information the researcher would write was the same as the information they had given off or not.

Before continuing with focus interview, the researcher reminded the participants that they would tell the researcher about their perceptions regarding general care in the old age residencies, Empilweni being of such residences in order to ensure that each of the participants does not change his or her story. This assured the researcher that the data the research would get from the participants in one context would be the same that same participant would give in other contexts, all things being equal.

3.14.7 Bracketing

The process of “bracketing is used to retain an element of objectivity and involves researcher’s deliberate examination of their own beliefs about the phenomenon and their temporary suspension of those beliefs (Koch and Harrington, 1998). Researchers engage in this process by attempting, as far as possible, to be free from bias, working to recognize bias and ‘control’ it. The use of bracketing defends the validity and objectivity of interpretation against the researcher’s self-interest, and that bracketing is achieved through the process of phenomenological reduction Kader Parahoo (2006) are of the opinion that bracketing attempts to make researcher’s bias explicit, rather than eliminate it .They add that it is realistic to recognize that researchers can only write about their bias as honestly as possible, clearly identifying their presuppositions so that consumers of research can make their own judgment about how the researcher has been influenced by their bias (Kader Parahoo, 2006). To see the live experiences of others, one must suspend and lay aside what one thinks and already know about what is being described or discussed.

3.15 ETHICAL CONSIDERATIONS

The researcher was sensitive to the integrity of the elderly she was working with as informants in the study. She ensured that those elderly people she was working with and many others they represented were protected from harm and ensured that they were accorded the respect and rights they deserved as human beings. Care was taken in that the study involves human beings as subjects and as such should be conducted in an ethical manner to protect the participants rights to self-determination, privacy, anonymity, confidentiality, fair treatment and protection from harm and discomfort (Buzgova and Ivanova , 2011).

The researcher emphasised the fact that participation in the project was voluntary and that participants could withdraw from the project at any time if they need to do so. She undertook the study taking into account the fact that limitations of the elderly significantly restrict or change their functions and opportunities in the market place such as visual problems may display diminished functional capabilities and that older adults experience some hearing loss and imbalance in locomotion.

She was equally aware of the fact some of the participants may be suffering from, chronic illnesses, including HIV/AIDS, and that injury and nutrition related challenges might be among the challenges the elderly at that old home facility might be facing. She resolved and ensured that people were recognised and treated as people though they were to be used in the experiment. As far as she knew, the researcher avoided anything that could be deemed unethical in her dealings with the institution where the study was conducted and the people who lived or worked there. Participants in the project were treated with the respect they deserved as human beings at all levels of interpersonal interaction with the researcher and amongst themselves.

The study received ethical approval from the University of KwaZulu-Natal. Permission to undertake the study was obtained from the CEO and the nursing staff, as well as the residents of the old age home. Informed consent was signed by the participants to confirm that this requirement was adhered to.

3.15.1 Self-determination

The right to self-determination is based on the ethical principle of respect for persons, and indicates that people are capable of controlling their own destiny (Burns and Grove, 2003). The participants' rights were ensured by explaining the purpose and significance of the research to them, obtaining their informed consent, emphasising that participation was free and voluntary, and that participants had the right to withdraw from the study at any time without any negative consequence. The participants were informed about the non-monetary associated benefits linked to their participation and that to know their perception might assist in policy formulating for that sector of health and social services.

3.15.2 Privacy, Confidentiality and Anonymity

Privacy is the freedom an individual has to determine the time, extent and general circumstances under which the private information will be shared with or withheld from others (Burns and Grove, 2003). It is understood that elderly people are sensitive to exposing their private personality through conversation in public; the respondents' anonymity was assured by using codes instead of their names so that no information could be linked to specific participants. Furthermore, confidentiality was guaranteed through storage of the completed data collection tools in a safe, locked place and by ensuring that only the researcher and research supervisor had access to the data collected.

3.15.3 Data Dissemination

Data will be disseminated to various stakeholders and will be published in a journal accredited by the South Africa Department of Health.

3.15.4 Conclusion

This chapter covered the research methodology employed in the study and the following were explained. The research paradigm, research design, quality assurance of the research,

research setting population, sampling and sample size, data collection instruments and procedure, data management and analysis process as well as ethical considerations.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE MAIN FINDINGS

4.1 INTRODUCTION

In this chapter the researcher presents and discusses the analysis of the data collected. Data analysis in qualitative research begins during the data collection phase. The researcher engages with, or become immersed in the data by: describing, probing, seeking the essence,

discerning the patterns of relationships shared and listening to participants' verbal descriptions; this leads to the emergence of common themes or an essence based on the purpose of the study (Brink ,van der Walt and van Rensberg, 2012).The aim of the study was to explore the perceptions of residents of Empilweni Old Age Home in Mthatha regarding the general care they receive from their care givers there. After the data had been collected, it was analysed manually.

4.2. DATA ANALYSIS

According to Creswell (2008), data analysis refers to the categorisation and ordering of information so as to make sense of the data, so that the writing of the final report is true and accurate to answer set research questions. In qualitative research, data collection and data analysis occur simultaneously with redirection of the research as new insights emerge from the analysis. Qualitative data consists of logs from personal observations, field notes, recorded focus group discussions or interviews, discussion or interview transcriptions, written documents and personal journals. In this study which was underpinned by phenomenological principles of research, the data collected and analyzed comprised field notes, personal observations and audio tape as well as video tape recordings of a focus group discussion.

A phenomenological study describes the meaning of the lived experiences for several individuals about a concept or the phenomenon (Creswell, 2003). Phenomenological data analysis proceeds through the methodology of reduction, the analysis of specific statements and themes, and a search for all possible meanings. The researcher also sets aside all pre-judgments by bracketing his or her experiences and simply relies on intuition, imagination, and universal structures to obtain a picture of the experience (Creswell, 2008) imaging from the data so collected and analyzed.

In this study, the focus group transcripts and field notes (observational, theoretical and methodological notes) were analyzed; this included the situational analysis of the venues of the old age home. According to Andrew and Wong (2008), in data analysis the researcher synthesizes the descriptions of the participants and reduces the data into smaller and smaller numbers of categories to arrive at a consistent description of the meaning of the lived experience for all participants in the study.

In this study, the qualitative data collected from the open-ended questions were edited, coded, categorised and analysed manually. During the focus group discussion, two recording pieces of equipment were used to capture and store the information gathered from there. The discussion was both audio and video taped. All the information gathered was sorted accordingly. The contents on the tape which were in Xhosa language were sorted and transcribed. Field notes taken down on paper, and observations made were also sorted accordingly. The researcher organised the raw data, and transcribed and translated the data into English.

The focus group discussion was typed and re-checked against the tapes to confirm the accuracy of the information typed. Raw material from the tapes in the form of words and phrases was extracted by two independent ratters* to generate codes.

The content of the discussion included demographic information of the elderly people in the old age home such as the age group, gender (sex). It also included information on chronic diseases commonly found in that old age home, length of stay in the residence, the attitude of the staff regarding physical care, and support received from the caregivers. It was through those details that the researcher would capture the perceptions of old age residents of the basic physical care they receive at that institution.

The contents were transcribed and translated into English. A Xhosa first language user High School teacher of English holding a university degree qualification was hired for translating the data from Xhosa into English and editing the language of the texts so produced.

4.3 CODING

The data was analysed through a process of coding. Coding represents the operations by which data are broken down, conceptualized and put back together in new ways. Data analysis, in this study, focused on exploring perceptions of the old age home residents of the general care they receive. Wilkinson (2004) in (Botma et. al, 2010)) distinguishes between two different approaches to the analysis of focus group data. In Wilkinson's view there is content analysis which produces a relatively systematic and comprehensive summary or overview of data set as a whole. The other one according to this view is ethnographic which is more selective and typically addresses the issue of 'what is going on between participants'. In this study it was content analysis approach that was used.

The researcher got the coding from evaluating questions she was addressing. Marking and colour coding was used. Each set impressions drawn from the information collected was assigned group and a specific code. The aspects of the phenomenon under investigation highlighted in the coding and analysis of the discussion were: behaviour, events, meanings, consequences, context, and statements.

The researcher looked for the trends and patterns that reappeared within a group. She also looked at words, the context, and internal consistency, frequency of comments as well as the extent and specificity of comments made by participants in their discussion. She also, in the light of whatever was said, looked at what was not said. Not only that, but the interplay between and among the individuals in the group and the dynamics of the group as a whole also formed a part of the analysis.

This study employed **axial coding**. This type of coding involves the process of asking questions and making comparisons between identified groups of identified impressions in order to establish and identify the nature of the relationship between categories and subcategories (Strauss and Corbin 1990) emerging from the data. At this stage the focus was on specifying a category in terms of the causal condition that gives rise to it; the context in which it is embedded, the action and the consequences of those strategies in relation to the phenomenon.

The general phenomenon in the study was the general care for the elderly and the residents' perceptions of the care they so receive at that old age home facility. At this level of analysis the specifying features of the nature of a relationship identified as a subcategory gives precision to that category and qualify such a category to be referred to as a subcategory.

A subcategory in some ways contrasts with another identified as a category on its own and the relationship between the two is that the latter subsumes or contains the former.

The features of a category are defined and described as follows:

Phenomenon is the central idea, event or happening. In this research the phenomenon which is the central idea or event is the general care in an old age home residence, Empilweni Old Age Home in Mthatha.

Causal conditions or antecedent conditions are events or incidents that lead to the occurrence or development of the phenomenon in focus. Such conditions in the data under analysis are identified through linguistic semantic markers or forms such as: when, while, since, because, due to or on account of.

Context refers to the specific set of properties that pertain to the phenomenon under study; in this case it is the general care in an old age home residence as the location of events.

Action/interaction relates to managing, handling, carrying out or responding to the phenomenon general care as it exist in the context or under specific set of perceived conditions. This feature is purposeful and goal oriented, and in this research action/interaction relates to what the elderly, themselves, do or what those in charge do to respond to or manage perceptions of old age residents regarding the general care given to the former. The researcher, at this level, also identifies and highlights contravening conditions and, then she asks the question: why

Intervening conditions– are conditions that come or are brought into a situation or context that prevent something from happening or attempt to change the prevailing situation.

Consequences might not be predictable. The continued comparison of each identified category with its sub categories helps the researcher to discover different patterns of relationships that exist or emerge in the study.

Verification of statements against the data helps a researcher to look for the evidence, incidents and events that support or refute the researchers question and may change a question to a statement of relationship (Creswell, 2008).

Linking categories at the dimensional level

After answering this question on the similarities and differences, the researcher specifically analyses those words, phrases or sentences that struck him or her as significant, important or of interest with regards to the phenomenon under investigation. In this case, the researcher looked at perception residents of Empilweni old age home have of the general care they receive from their care givers there. The researcher then listed all of possible meanings from the most probable to the most improbable. The categories were identified and put together in new ways by making connections between them through their properties, dimensions and characteristics as identified in the data (Andrew and Wong, 2008). The coded information was categorised and subcategories accordingly.

4.4. IDENTIFIED CATEGORIES

As prescribed in Tesch's approach (Ryan and Bernard, 2000) elicitation technique was used as a semi structure within the principal method of data collection identified as focus group discussion. One open ended question was asked in the focus group discussion task. In identifying the categories the researcher went through focus group transcripts, field's notes and observations. These were read through carefully and the researcher and her assistants took note of some important ideas, read through them and identified the underlying meanings in the information checked; notes were made in the margin by the researcher and her assistants on each script read through. All identified themes were listed and arranged in terms of major themes, unique themes and leftovers.

Each theme was assigned a code that was written next to the appropriate group of ideas or thoughts identified on each of the piece of transcribed texts. Categories were created by describing themes more clearly; the total list was reduced as much as possible by grouping similar categories together. Then a final decision on the abbreviation for each category was made and numbered, and subcategories were alphabetized. The data material for each category was assembled; a preliminary analysis of the information and comparison between the different focus discussion documents was done. Consensus discussions regarding the identified themes and categories were held between the researcher, her assistants and the independent coders .

It emerged that the perception of the old age home residents comprises the following aspects: Basic needs (personal hygiene toileting, dressing and grooming), Safety: environment and Safety: medical aspect; Psycho-social aspect, Nutritional aspect, Institutionalization and Support from the care givers.

TABLE 4. Categories and subcategories

CATEGORIES	SUBCATEGORIES
General personal care -independence	Positive interpersonal relationship of perception of general care they receive: importance of personal care, boastful, independence in activities of living, choice in bathing – shower, basin or big bath
Loss of independence	Negative interpersonal – disability; limitation on activities of daily living, needs assistance, use stick, limping and the hand is deformed difficult in bathing negative attitude: one nurse
Safety: environment	Negative - no rails on the passage way to support, toilet doors not closing well, need assistance in walking Positive - big high windows, floors not slippery, open wards
Safety medication	Negative - no medication review by doctor, same medication no check on Epanutin blood levels, no screen before giving anti diabetic & anti-hypertensive treatment Positive - chronic disease treatment given
Psychosocial cultural aspect	Negative - attitude of one nurse; loneliness, sobbing stories, open wards no privacy Positive – ask for knitting, permission to visit home, support when

	bereaved
Nutritional	Positive - six meals a day, fluid and fibre diet, cultural consideration Food negative - cold coffee, too much fluid affects bladder, frequent urination problem of disability
Institutionalization	Positive- treated as one family, socialising, Negative - routine, strict rules, forced to bath even in cold weather
Support systems	Positive - family, relatives free to visits, bereavement, support by professionals

The themes emerging from the codes were categorised as follows:

- Category 1: Basic needs aspect
- Category 2: Psycho-social aspect
- Category 3: Physical safety environment aspect
- Category 4 Medical safety aspect.
- Category 5: Nutritional aspect
- Category 6: Institutionalisation
- Category 7: Support from caregivers aspect

4.5 CONTENT PRESENTATION AND DISCUSSION

Interpretation language - Xhosa

Participant-P

The purpose of the study was to find out how elderly persons of the selected old age home residence perceive the general care they receive in their daily lives. Through elicitation and self-reporting participants narrated their needs. It is interesting to note that these needs were so prevalent in the transcripts and it is likely that they speak to the fact that there is need to attend to such needs urgently. These were referred to as basic care needs.

4.5.1 Category 1: Personal care (bathing, toileting, dressing, grooming)

The majority of the elderly knew about basic physical care and were capable of taking care of their personal hygiene which is an instrumental activity of daily living (IADL). Such activities include the following: managing their own personal finances, shopping; answering telephones; doing their laundry and taking care of their personal hygiene. Some elderly residents had functional disabilities that limited their activities of daily living (ADL).

Following below are the responses to specific question they were asked.

P1: 62 female “*Ewe, siyazi sigugile kodwa siyazinceda*”

(*Oh! Yes we know that we are old, but we do help ourselves*). – Confidence shown, (Epilepsy and burns affecting right hand). active elder.

P2: 75 male “*Ndiyakwazi ukondlula, ndihlambe, ndixukuxe ndinxibe kakuhle.*”

(I can make my bed, go to the bathroom and brush my teeth; and wear my nice Jacket) . - (Diabetes, partial blindness –using stick).

P3: 68 male “*Ukuzihoya unxibe kakuhle*” (Taking good care of you (means), wearing clean clothes) .- smile (diabetes and hypertension -active elder .

P4: 65 female “*Andifuni kuphathwa ebusweni xa sendichonchile ngento zokuthambisa kaloku zifihla ubuso obushwabenyoy*” – smile on face.

(I don’t like somebody touching my face; after putting on my make-up at least the wrinkles are concealed). - Active dependant (wheel chair bound).

P5: 70 female “*Ukuvuka nje kwam ndiqale ndichame khonukuze ndikhululeke ngexesha lokuhlamba nelokutya*” - Cataract and Diabetes (uses stick).

(Caregiver should assist me, first thing is to visit the toilet to avoid disturbance during bathing and taking my breakfast).

P6: 67 female “*Uyazikhetha apha, ukuhlamba ebhafini okanye eshowereni; phofu mna*

Andiziqhelanga kaloku.” - showing appreciation”

(Here they give us a choice either to use a bath or a shower or a basin. I am not used to a shower or a bath so I use the basin for bathing). – Normal ageing.

P7: 64 male “*Ndim kuphela osonga kakuhle impahla, jonga ezabo.*” - bragging

(I am the only one in this room who can neatly pack my clothes, look at theirs) - **active elder-** limping polio

P8: 78 male (*Ndixukuxa emva kokutya ndonqena umlomo ombi xa ndiqale ndaxukuxa*)

(I like brushing my teeth after breakfast to avoid the bad taste of toothpaste” –

***active elder (diabetic and hypertension.)**

P9: 76 female “*ave ndingafuni ukudibaniselana nge-bathroom ngoba abanye ngamaxelegu*

” -sarcastic face – stroke affecting left arm (using stick).

(I hate sharing the bathroom some leave the area unhygienic). – **active/dependent?**

P10: 77 female “*Ilaphu lona makondlulwe ngalo likhusela izibi zangaphantsi*” - cancer of the cervix on radiotherapy

(I always remind the nurse of putting a linen saver or cloth (should) be put on top of the bed to take care of the discharge) .- Assisted – dependant.

P11: 63 female “*Ngase xa endincedisa tana angagubhuzelisi ngesepha apha kusisi akumnandanga ndiyatyabuka* ” – frowning - stroke affecting the mouth –diabetes and hypertension (I so wish the nurse could be careful by not putting too much soap on my private part because this makes me uncomfortable and itchy).

P12 70 male- was not active keep on nodding whenever somebody raising a statement (normal ageing).

It is clear from the above statements that the comments were from the active independent old age home residents. Regarding the toiletry paraphernalia used at that institution, some of the elderly resident there showed that they were not familiar with some the items included therein. The toiletry wares used at that institution include the following: basins, towels, soaps, deodorant and make-up kit, and clean, ironed clothing. Those are the items which generally

constitute a personal hygiene kit for residents in such facilities. This is evidenced in the comments made by some of them regarding personal hygiene kit so provided at that old age home facility. Following are some of the statements so uttered.

A 78 year old male said, “*ndisebenzisa nokuba leliphi ilaphu, zona zincinci izitya zokuhlambela kwaye ndoyika lebhafu inkulu kakhulu neshowara itsho ngemvula yamanzi*”

“I just use any cloth to bath with. I don’t care, as long it is a material cloth. The

Basins are small and I am scared to use the bath, it is too big, and the shower water runs too fast on my face.”

The dependant elderly people commented on the loss of independence pertaining to their personal hygiene and belongings. Their comments highly suggested that in their view dependence limits personal physical care for most of them. Some participants, especially male elderly ones, are uncomfortable to be dependant due to their cultural background. This was noted in comments such as the following.

One 65 year old female said, “*Ndibanentloni ukuhlanjwa ibe isinqe iqinile ayoluki.*” When translated into English, what she said means, (It’s difficult and embarrassing to be cared for in terms of one’s personal hygiene, yet my hip is stiff because of arthritis).

Another, a 76 year old female observed, “*Ngoba andikwazi ukuzenzela kuba ndilinxele xa ndihlanjwa bade bahlambe nobusisi bam zintloni ke ezo.*” She said this a sad face. What she said in English means,

(Assisted bathing makes me feel so embarrassed that I am so disabled that a caregiver is intruding on my privacy by touching my private parts).

From these few utterances, one can see that many of the elderly in the old age nursing homes feel that disability in a way robs them of their dignity. Some of the services care givers render to them they would not accept if they had the ability to take care of their own needs in those respects.

However, it is not all regrettable living in an old age nursing home. A study of the quality of life after a stroke provided a comparison between those people living in a nursing home and

the community revealed that quality of life of the elderly in a nursing home was significantly higher than that of their peers living in their homes (Wade and Halligan, 2004). What some participants in this study said about the care they receive in that nursing home affirms this finding.

One 62 year old female commented, “*Apha siyancedwa. Mna izandla zam zatsha ngexesha ndandixhuzula, andifikeleli kwezifihlekeleyo indawo.*” The English equivalent of this statement would be, (I appreciate being looked after because my hands are deformed as a result of burns. It is difficult to bath myself, I need assistance.

The staff do take good care of us. I cannot reach my back and private parts so the care givers assist.) While some of the elderly in those social care facilities may feel that way, there are others who feel otherwise. Two of the participants had this to say about bathing and their attitude towards that aspect of care they receive there.

A 78 year old male said, “*Akwaba bangayeka ukusinyanzela ukuhlamba,*” meaning (I wish I can tell them not to force us to bath).

Another male aged 70 agreed and said, “*Ewe, ngamanye amaxesha kusebusika kuyabanda sakungenwa yingqele.*” This statement translated into English would mean, (Oh yes, sometimes it is cold in the winter and we can catch a cold).

Another one, a 65 year old female added, “*Ikhona inures engenambeko; endigxagxamise ndinganxibanga kuvulwe umnyango.*” The English language equivalent would be, (One of the nurse was so inconsiderate and rude forcing me to bath that she ended up exposing me naked in an open bathroom).

These three preceding utterances from the elderly in an old age nursing home provide some revelation of how some of the elderly perceive the care they get at a nursing home where they reside. These seem not to appreciate the care they receive in the area of bathing. Some feel the care givers are inconsiderate. They do take the atmospheric conditions when demanding that the elderly bath. In such residents ‘view some of those care givers have no sense of respect or they fail to demonstrate to the elderly entrusted to their care in the matter of bathing. Notwithstanding what has been expressed above in terms of bathing, there were other

elderly people who sounded appreciative that they had access to baths and bathing facilities at that home. Here is a connection between physical care and health. Most of the elderly participants mentioned important aspects that relate to bathing.

A 68 year old male asserted, "*Ewe ,uyadlamka kuphele nezigulo emva kokuhlamba umzimba, meaning,* (Yes, after bathing the body becomes revived and one has the feeling of being young again as some of the minor ailments are gone).

The last one on this aspect, a 62 year old female shares the view that bathing is essential to one's health, but quickly points out her own fears about the physical environment bathing in that nursing home take place.

She submitted, "*Ndiyazi funeka ndicocekile kodwa ndoyika ukungena emanzin shower nebhafu ngoba ndingase ndivukwe sisigulo sokuxhuzula.*" The English language equivalent of what she said here would be, (I know that one needs to be clean, but I am scared to use the big bath basin for bathing in case I have an attack of Epilepsy. I want to be fully immersed in water but am scared to use the shower).

In a study on adapted towel bath-Tot man technique, bathing disability on community living, an older person complained of the routine, and suggested that there should be an adjustment by switching bathing time so as to separate hair washing from body washing.

In a study on the bathing of older adults with dementia, it was revealed that older adults who need assistance with bathing often find the activity to be both physically and emotionally demanding, as do their care givers, due to several factors like confusion, pain, weakness and being in an unfamiliar place. For these reasons, forced bathing is discouraged (Rader *et al.*, 2006).

Emerging from the comment that said 'seated the whole day 'it seems as if the elderly are bored seated the whole day some hobbies and their talents need to be revived.

4.5.2 Category 2: Psycho-social aspect

P1: 62, female, "*Ndikhe ndicinge indlela abambulala ngayo unyana wam* -silence (I sometimes think of the way they kill my only son at my home).

P2: 77, female “*Ngeba ndihleli nentombi nonyana bam ndinabazukulwana ngoku*” – shaking her head in deep sorrow.

(I could have been staying with my family and grandchildren in my home)

P3: 78, male “...*er (sobbing), ndiziva ndindodwa kungabikho noyedwa umntwana*” - the researcher gave him some tissue paper to wipe tears in his eyes.

(I feel very lonely not even one child is around?).

P4: 65, female “...*eish (shaking her head) oko ndabanje amalungu aqinile ngunyaka wesithathu*”

(...my legs are stiff I have been like this for three years).

P5: 63, male “*Ngase libekhona ichiza lokulungisa lomlomo, seyingunyaka ninje. Sihlala imini yonke sakuphunyuzwa kuyokutya asivumelekanga silale emini ngaphandle kogulayo*”

(I so wish there is a quick remedy for my twisted mouth, its been a year now (mumbling word wed to lie on the bed unless not well . We sit the whole day (because) we are not allowed to sleep during the day unless one is sick).

P6: 67, female “*Akukhomdla apha uyatya, uhlale ulale*”

(The only thing you do here is eat and seat or sleep, it’s boring no family visits)

P7: 68, male “*Kusisithukuthezi apha, Sijikelezwe sabiyelwa lucingo okwezilwanyana sisethangweni apha sivalelekile*” (Surrounded by electric fenced wire like an animal in a kraal not free Nothing is stimulating here) .

P8: 78, male “*Yhee wethu akukho ntlonipho apha nididiyelwe endlini nonke amadoda namaxhego okwamakhwenkwe*”

(There is no privacy here you grouped in one room like young boys) (shaking his head).

P9: 76, female *andazi kwathini ‘Akhomntu undindwendwelayo ‘*

(I sometimes miss my family they don’t visit me, I wonder why!) (shouting voice).

P10: 70, male''*Kukho lentokazi eyithandayo , lonto ndiyazigilisa kuyo ndizama ukuyincokolisa ayindihoyi,nantsiya singasbonwa ''*

(There is a lady that catches my attention, try and show how I care for her, but she seems not to understand) trying to show one of the elderly ladies whispering –don't tell others.

Another female aged 70 added, "*Uhlala nabantu ongabakhethanga ngokwakho* "(You don't live with people you chose on your own) Adding to that she said, "*Kuleqwa amaxesha ezinto zonke akuthandiswa wena* "(Rushing to be on time everything is routine here) Just then a male aged 68 commented '' *Sijikelezwe sabiyelwa lucingo okwezilwanyana sisethangweni apha sivalelekile* "(Surrounded by electric fenced wire like an animal in a kraal not free).

From the comments made by the residents of that home it is clear that the old people there do not feel at home at all. They feel trapped and bored. This state of affairs as some of them observed leads to more degeneration of their cells and systems in their bodies. Therefore, there is a great need for an occupational professional to stimulate and sustain meaningful mental occupation productivity of handwork of some sort. That could be achieved through guided handwork such as crafts making, knitting and weaving.

Another essential professional needed there would be a sectional physiotherapist who would actually focus on helping them with physical exercises for their limbs and all parts of the human body that require physical locomotion and stretching. In that way the elderly would feel a sense of worth and meaningful living. Their bodies might be kept in fairly sound health relative to their age.

4.5.3. Category 3: Physical safety environmental aspect

Category 5 Physical environments emerged from chronic health conditions and other health related conditions that restrict physical mobility and autonomy to perform the activity of daily living. Some respondents commented on the safety of the physical environment, like they appreciate the physical layout of the home and feel safe.

P1: 64, male “*ndiyaguqu-guquka xa ndilele ze ishiti lisongane ngathi likhuni elindoyamileyo*” (‘‘I turn sides when sleeping and then the torn linen disturbs me sometimes I think it’s a stick; the linen rolls off and irritating my skin).

(P2 70 male’’ *akasarhoni umntu ongummelwane atsho ndiphelelwe bubuthongo*’’(my neighbour is a snorer wakes me in the middle of the night).

P3:77, female ‘ *Sendiqhelene nelivumba andisaliva,kodwa bona bayalicoca yonke imihla*’’ (I am used to the bad smell of the urine in the rooms but the cleaners clean the floors every day’).

P4:75, male “*izixhasi zokubambelela ngaseludongeni xa ungena apho silala nasendleleni ephumayo ezindlini azikho*’’(There are no rails to support us when walking into our rooms and along the passages).

P5:78, male“.” *Ndoyika ukuwa ndingevazelwa yimilenze,ayiqinanga*’’ (I have some weakness in my legs, I’m scared of falling).

6:70 female“.” *azivaleki kakuhle itoilets nebathrooms* ‘ (Bathrooms and toilet doors are not properly closing; there is a lack of privacy).

P7: 68, male“.” *ndiyayithanda impepo apho kungekho vumba lomchamo* ‘(I like a tidy, clean room and fresh air with no bad odour of urine in the house).

P8:67, female‘.” *Zinkulu zithe gabalala kamnandi ke wethu ,uyabukela indalo ngoku ungqengqile ingakumbi ekuseni*’’ (Warm rooms, big windows for a good view especially in the morning while relaxing in bed).

P9: 65 female “*Noko sikhuselekile sigadiwe konqevu kubonakala yonke into ethukuzayo kumaqosha obuchwepheshe wokugada* ‘ (We are happy there are security windows and the intercom satellite to guard against robbers).

P10:75, male “ *Eyona nto ingamandla izitulo azisoneli sibandinzi kunazo*”(we are short of chairs).

P11: 77, female “ *ke lonto kuyadina ukuhlala endaweni enye nokuya endlini yokudlela ngamanye amaxesha umqolo uba buhlungu kwaye asivumelekanga ukulala ngaphandle kokuba asiziva mnandi okanye kusemva kwemini*”

(Sometimes my back is aching due to sitting and walking to dining hall and you are not allowed to sleep during the day unless not feeling well or after lunch).

4.5.4 Category 4: Medical safety aspect

Screening elderly for chronic medication and safety is not common at the residence
Participants were concerned about medication. A lack of treatment reviews and qualified visiting doctor was a concern to the elderly people.

P1: 62, female “*kunini ndinikwa lentlobo inye ndifuna ugqirha andibone ngoba andide ndiyeke ukuxhuzula*”

(I have been taking the same epilepsy treatment for two years, but no doctor has come to visit and review my treatment, there is no improvement in my illness).

P2: 68, male “*Ke lonto akhe aphele nalomayeza kufuneka siye kuwafuna esibhedlela*”(The medicines are sometimes out of stock and we are sent to the nearby hospital for repeat treatments).

P3: 64, male “*Phofu kuyemiwa xa ulinde lomayeza kweso sibhedlela’maxa wambi ungawafunani kuvalwe ze uvukele ngosuku olulandelayo*”(What I don’t like in hospital is the long queues and sometimes the dispensary closes before we get medication the care givers have to come the next day).

P4: 70, female “*Kanti nakwesosibhedlela akabikho singabinanto yokuzinyanga*”
(Some of the medications are out of stock even at the state hospital and we suffer).

P5: 65, female “Kow bethu bayasimela ngamalingelo ethu kogqirha torwana”

(We are concerned about how we are treated, but we can see our care givers are trying to advocate for us, but still there are not so many doctors as per patient or client ratio).

P6: 78, male “Sazifundiswa impawu zeswekile eyehlayo nenyukayo”

(We are taught of the signs of hypo /hyperglycemia I now notice the signs of my

diabetes my body feels tired and dryness of the mouth and then call the care giver).

P7: 78, male “Nditya ipilisi zimbini kusasa inye nasemalanga ze gazi eliphezulu”

I take two small tablets morning and night for hypertension.’

,

P8: 68, male “Nditya lepilisi imhlophe ekuseni yeyeswekile “

(I take Glucophage every morning for Diabetes).

P9: 70, female “xa ugugile ufane uve umzimba utefa ngamanye amaxesha”

(Most times when I’m not feeling right I say it is old age. Old age causes most of the ills .Old age causes sickness..I put everything down to old age)

P10: 62, female “ndiphononongwa xa ndingaziva kamnandi”(I am being checked only if there is unusual behaviour).

Epilepsy sufferers complained of not having their conditions reviewed by a doctor or not being referred to a hospital, but only being visited at the home by student doctors and some residents were scared as they had been taking the same medication for two years. It must be noted that Epilepsy is not common in old age and can be controlled and that old due to their cell degeneration, old aged people do not respond the same way as do young ones.

The researcher had visited the home when she was doing a Stroke Assignment for her Master’s theory. It was then that she observed that residents were given medication without baseline check as a result a diabetic patient showing no signs of illness before taking food had blood sugar of 24mmols. It is clear that the residents are not happy about that.

According to studies on the criteria for potentially inappropriate medication use in older adults, medication's toxic effect and drug-related problems can have profound medical and safety consequences for elderly people and may affect their health system economically (Donna ,Fick,Cooper and Williams, 2003)

4.5.5 Category 5: Nutritional aspect

Like any other elderly anywhere, the elderly people there had a problem with food chewing due to tooth decay, loose tooth general degeneration of tooth. Generally, the older one gets greater are the chances of them losing most if not all their teeth. The loss of teeth or weakening of their gums causing teeth shaking and becoming weak presents a great challenge for the aged when chewing food. For this reason, the elderly need high fluid and fibre diet since there is slow digestion due to ageing. A few of the respondents commented on nutrition and physical care. Observations relating to this aspect ranged from comments on oral hygiene to the quality of food served as well as the times the food is served. Generally speaking, proper nutrition is essential for the aged as there is degeneration of the body for the elderly.

Here are some of the comments made by the elderly there on this aspect:

P1: 62, female “*kutsho kubemnandi emlonyeni xa uxukuxile*”

(Good appetite is enhanced after brushing the teeth).

(P2: 68, male “*Ndixukuxa emva kokutya ngoba incasa yokutya ayivakali xa uqale ngokuxukuxa*” (I don't brush my teeth before eating because that alters the food taste).

P3: 70, female “*Ndiyongqena ukuvuka ebusika ingubo kaloku zishushu ndiyakuqakatha okwakutya kwanentsimbi yesithandathu ndiqale ngentsimbi yeshumi*’ (The breakfast is at 06h00, tell me, in winter you have to leave your warm blankets for breakfast? This is unfair. I skip the early breakfast meal and start at 10h00).

P4: 64, male “*Yhoo apha siphungiswa iti ebandayo nasele kubanda*’ (The tea they serve is not hot even in cold weathers).

P5: 78, male “*La suphu yabo ye peas imnandi ndiyayithanda*“(I like the thick pea soup they serve).

P6: 75, male “(*Ke tana ndinengxaki yamazinyo emboleko ayagungqa andityisa kakubi kubabuhlungu ngoba enza izilinda* “(My dentures do not fit well and giving me problems of sores on the mouth when I eat).

P7: 77, female “*umngqusho uyasiyalula isisu sam kwaye uqaqambelisa amazinyo* “(I use to take mealie- samp but, lately my tummy becomes upset following the intake and also the fact that sometimes it is hard to chew and it hurts my teeth).

P8: 67, female”(*Umfino okanye umqa, ndivele ndikhumbule ekhaya xaizintsuku zomqa nomfino* “(At least once or twice a week traditional vegetables are served this remind me of our traditional foods at home).

P9: 78, male “*Bayasixhesha ngeziiselo kakhulu kane nakahlanu ngemini kangangokuba ndiyatsibisa ngoba zindivusa sendilele ngomnchamo ndide ndifike senditsipizele umthawuzo wam*”

(we are drinking a lot of tea and soup five times a day and small amount of food I skip some of the fluid diet, they wake me up even at night and drips of urine wet my underwear).

P10: 67, female “*Kunenyama ukutya kwethu kwe mini*) (looking excited about that “(Our heavy meal is midday contains meaty nutrients daily).

P11: 68, male “’*Ngenye imini sakhe sadliswa iRussians ezimuncu zingatyeki asazi ngubani owazisa onondaba sabona befika besibuza*” (frowning)

(I don’t know who told the press that the other afternoon Russian sausages were stale, we could not eat the taste was unbearable).

P12: 76, female “’*Ndiyancediswa ekutyeni isandla sam asisebenzi*“(I am being assisted in feeding my other hand is not working).

Oral hygiene care services by a dentist and urologist are needed. The elderly needing such services could be referred to Mthatha General Hospital or Mandela Academic Hospital 9km away. A food health inspector should visit the old age home and inspect if the cold room at that institution is maintained.

4.5.6 Category 6: Institutionalisation

The majority of the participants, especially the active aged, were active in answering the questions on independence and participation in activities of daily living. Most of them indicated that they made their own beds and that they were actively involved in the resident meetings. They also mentioned that they treated one another as family.

P1: 76, male ‘‘*Eyona nto emnandi siyasebenzisana sonke singabomzomnye*’’
(The advantages are that we are like one family, we eat, sing and sleep together).

P2: 62, female ‘‘*Lonto yenza silibale sonwabe*’’(That makes us forget some of the worries)

P3: 63, male ‘‘*Kaloku siyazalana apha ngeziduko kwaye sixabisene sibambene*’’(Networking culturally by respecting and admiring those sharing the same clan name).

P4: 78, male’’*Likhaya esinalo eli lonto siyayazi*’’(We understand that this is the only home place we have for now understand one another).

P5: 64, male ‘‘*Khangelapha ndikubonise unonqwaza walapha nankuya*’’ (I will show you the fussy lady, who shows a long face most of the time).

P6:70, female ‘‘*ngemini ezinkulu sifumana amabhaso kwaye sidlaliswa nemidlalo*’’ (We receive donations from the community and the corporate world of items such as blankets, radio sets and feasts for Elderly Persons’ Day; sometimes we are taken for a tour to the coastal area by the beach and the institution also organises games like soccer and netball for us to play).

P7: 74, male ‘‘*siyakhungana owehlelwe lilifu elimnyama simhoye*’’
(We support each other in bad times like bereavement, and there is common understanding).

Residents did not seem happy about some of the residential rules and regulations like the strict routine and tight schedule especially the semi frail and disabled who partly depend on care givers for bathing or feeding.

P1: 68, male “*ndicaphukela le ntsimbi ngoba ifuna ndisukume ndiyokutya xa kanye ndifuna ukuphumla*” (I hate the bell for meals at the dining hall when one needs to rest.)

P2: 78, female “*Mhlawumbi lentsimbi isinceda ekusikhumbuzeni naxa kukho ingxaki bethu*” (Sometimes the advantage of the bell is to inform a care giver who is on the one side of the room when there is an emergency).

P3: 63, male “*eyona indigqibayo lixesha lokuhlamba ekuseni*” (What disturbs me is bathing time in the morning before breakfast, I dodge and pretend as if I’m from the bath).

4.5 7. Category 7: Support systems

Sub category A: Staff members

Most of the respondents were satisfied with the quality of support from care givers concerning the activities of Daily Living. Nevertheless, they expressed some complaint against one staff members they considered inconsiderate.

P1: 62, female “*ngede basifeze sibaninzi kunabo*” (Not all the needs for care can be met because we are so many here” another elder says).

P 2 68male “ *Ke lonto ndiyabasizela abanye bancinci ngeziqu funeka bethwale banceda umntu omkhulu kunaye*”(I sometimes pity them when they had to assist an overweight person and when they are so thin size body).

P3: 65, female Intenayo kukho *ongahloniphi yo okrwada kubasebenzi ngakumbi ngethuba lokuhlunjwa uyasigxagxamisa ,ade avalisisi necango xa esihlamba ,iyandicaphukisa ke lonto*”(The thing that upsets me is one of the staff members is rude dehumanising no privacy , and is so inconsiderate when bathing me, however that is the only staff member I don’t like other care givers support us mostly during bathing time).

P4: 70, male “*Bayasondlulela bancedise ekusityiseni torwana xa ungakwazi*”(Some of us can make our beds and the caregivers assist those who are unable.shame the caregivers assist us in feeding).

P5:78, male “*Kaloku soyiswa nakukunxiba izihlangu asikwazi kugoba ,batsho ke basincede*”(I cannot put on my shoes my feet sometimes becomes stiff the caregiver assist)

P 6: 64, male “*Bayasilungisela nefoni kanti kukungakwazi nje ukucofa*”(There was a time my phone was not working the care giver fixed it for me then I was able to communicate with my aunt).

P7: 77, female “*Siyazilibala kaloku nesuku eli lokuzalwa kwakho*”(Sometimes we forget our birthdays with the help of the caregivers they remind us).

P8: 67, female “*Sikhunjuzwa nangemini yecawa ukuba silungiselele icawe*”(Even on a Sunday when we have to prepare for church hall, the care givers keep on reminding us before the bell rings).

P9: 70, female “*bayancediswa batyiswe abangakwaziyo*”(Assist in feeding those who are unable to feed for themselves).

Subcategory B: Relatives

The elderly feel lonely and loss of identity, loss of control as at that institution they live with strangers and miss their friends, family and their homes. Visitors from families and friends are highly appreciated although sometimes such visits bring back bad memories about the past. Gifts and presents from the relatives have a good meaning to elderly people especially when such gifts come on special days like birthdays.

P1: 77, female “*Izihlobo zethu ziyasindwendwela kodwa ayingawo onke amaxesha azanendaba ezimnandi nezimbizisishiya sihluphekile emphefumleni*”(Yes, most of the relatives visit, especially on weekends, but they do not always bring good news sometimes they leave you depressed because of a bereavement).

P2: 70, female “*Siphathelwa izipho*”

(Most of the time they bring joy and presents when they visit).

P3: 70, male “*Uyakhululuhlelwe lilifu elimnyama*”

At least you are released for your relative bereavement”

P4: 78 male, “*Ngemini ezinkulu zokuzalwa ,losuku lwethu siyaculelwa siphilwe izipho*”

(When it’s one’s birthday, a surprise song and cake to celebrate on your day and make us feel cared for).

P5: 68, male “*Xa ufuna uyokroba ekhaya uyakhululwa uzanyelwe indlela yokuvela xa ungalandwanga ekhaya*”(When there are rituals or ceremonies in the family, arrangement is made for one to visit home).

Subcategory C: Social services

The respondents were happy that the state government is taking care of their needs through social services such as old age pension fund. Others include social work duties such as checking or verifying their identity document and updating them on the state of their burial fund aid.

P1: 76, female.”*Ndancedwa ngonontlalontle bandikhapha saya ekhaya kumke indlu nomoya bapatanisa babafunela abazukulwana indawo yokuxhwarha, ukutya nempahla yokunxiba*”(A social worker accompanied me to my home when the thunderstorm struck my house and organise ways of temporal houses for my grandchildren ,clothes and food parcels, at least that relieved me).

P2: 64, male “ *Phofu sinedwa ngaba nontlalontle apha bayasigcinela ngoba siyazilibala izazisi namacard okwamkela apho siwabeke khona* ”

(“I lost my identity document when I was visiting my home and the social worker helped me to get a new one Well, we are assisted by the social workers by keeping our IDs and Pension cards...because we often lose memory).

P3: 70, male “*Oh ke khona siyaziphiwa izipho ezivela kurhulumente ngonontlalo xesikweni kukhunjulwa uzwelonke lwabadala nangesuku lokuzalwa komntu into ezinjenge ngubo*

nezihlangu''(International old age day and birthdays we are given presents according to our disability like I was given a radio last Birthday and a blanket on Old age day slippers shoes from the government delivered by the social worker).

P4: 67, female "*siyazibandakanya kwimidlalo yebhola apha* '' (They are trying to make us happy at least, those active are involved in games we do play ball games here).

P5: 68, male "Siyahamba ngo September siya eMonti siyokudlala'' (In September we will be going to East London to play a match at least we meet new friends and that is good).

P6: 65 female "Abangakwaziyo ukuhamba banikwa onomathotholo'' (The bed ridden elderly are given radio sets).

P7: 78, male "Kule Krimesi idlulileyo besiphiwe izihlangu zokurhuqa ezithambileyo ezishushu'' (Last Christmas we were all given slipper shoes to wear as a Christmas present).

P8:63, male "*Qho ngomhla wokuzalwa kukaMandela kubakho ingxikela yethoko ,siye sithathwe siyokuzimasa sibukele imixhentso yakwantu*''(On each and every Mandela Birthday we are transported to Mandela Museum entertained by the cultural activities and dinner at least taken for an outing except the elderly confined to bed).

P9: 77, female "*Sinabo omabonakude ke tana kubukela kamnandi abangakwazi ukuzizulela* (At least there is a television set for those who are confined to bed).

4.6. SITUATION ANALYSIS OF THE SELECTED OLD AGE HOME IN OR TAMBO

This was an overview of the situation at the residence as presented by the CEO/Manager after granting permission to conduct the study. She, the researcher and her assistants the layout of the residence and took the team round to familiarise the researcher with the area under study. The researcher felt that it was necessary to confirm and report on the overview.

4.6.1. Structural building analysis

The home consists of six cottages and two big houses. Each cottage has 8-10 rooms depending on the structure. The rooms are warm. Each room has a window, a bedside stand, a chest of drawers and a comfortable chair. All beds are easy to reach. However, there is no provision for call buttons accessible to residents in case of need. Shower and bathrooms are conveniently located, residents share the bathrooms. Bathrooms have handgrips but no call buttons in there either. There is one lounge per cottage and the cottages are close to one another for convenience of care. Elderly people are graded according to their level of limitation or disability and classified as follows: active, semi-frail and frail elderly people. Males are separated from females. Elderly people share the rooms, two per room for the semi-frail. Residents are allowed to bring their own belongings, but not furniture. There is an open room for those who are active, per gender, and also an open room for a special care room for stroke patients and frail elderly people. There is an obvious odour, especially in that room, but chemicals are used to camouflage the smell.

4.6.2. Staffing levels

There are 28 health staff members. These consist of a Geriatric nurse who is also the CEO/Manager, two professional nurses, one enrolled/staff nurse, one social worker and 24 care givers/nurse aides (with a minimum training level of 6 months) compared to a total of 140 elderly people. The sum total of the old age home workers is 65(including kitchen staff, gardeners, laundry workers, general assistants, accountants, clerks, receptionist, cleaners and security guards).The professional nurse is responsible for scheduled drugs and the operational manager and staff nurse are responsible for medication and supervision of care, while the

care givers are responsible for the personal care of the elderly. The caregivers are visible in the elderly residents' rooms as they wear uniforms and name tags. A licensed, fulltime social worker attends to social problems like their pension fund problems and the arrangement of death registration identification documents.

4.6.3 Policies

The Government subsidises the operational costs by 80 % and 20% is paid by residents through one-third of their pension money which is deducted, upon receipt of that money, for board and lodging. The Older Person's Act, Act 13 of 2006 guides the home, focusing on health and wellbeing, a supportive environment and the development of the older person through intersectional collaboration. There is a fulltime auxiliary social worker. All elderly residents who are people over 60 years old in the home are cared for, and are on a pension fund scheme according to the Act. The home is registered under the Act 13 of 2006 (Department of Social Development, 2006).

The philosophy, mission, vision, and the organisational structure of the institution, programmes, guidelines and the demographic profile job descriptions are all displayed. There is a declaration of the rights of elderly people, which encourages independence and participation in activities to integrate residents into society displayed in every cottage. The admission criteria, policy manual, procedure files and off-duty schedules are displayed on the office drawers. Records of burial societies are filed and kept under lock and key since they involve the data of residents' finances.

4.6.4. Administration

Admission criteria for the elderly consist of the consent from the immediate family, care giver or relative, headman of the location or the councillor; proof that the elder is a pensioner, an identity document copy, the address of the elderly person's next of kin and a brief background of the family. The relative and the elderly person are informed of the conditions of the stay, and are required to pay one-third of the fee for board and lodging as a contribution towards the elderly person's stay expenses. The relative is made to sign after

reading (if literate) and following verbal information (if not) on the rules and regulations of the old age home residence.

4.6.5. Care delivery service

The CEO/Manager is a Geriatric nurse, and the two professional nurses and the staff nurse have experience in working as home care nurses. The implementation of care is through a primary health care approach and curative care is by means of referral to the nearby state hospital since there are no doctors, physiotherapists/speech therapists and pharmacists, only student doctors (Fourth year students) visit the home to provide medical doctor services there.

The caregivers are the nurse aides who take personal care of the patients and are involved in decision-making, turnings, feeding, taking care of incontinence, bathing, transferring and they also assist in observations like those for temperature, pulse, respiration and blood-pressure taking. There is a good relationship between the elderly people's families and the staff. They speak the same language, and they participate very well in conversation. Those who are still active take part in light chores like making beds and cleaning their lockers on their own.

4.6.6. Health status

Most of the elderly people suffer from chronic diseases and have disabilities. Some have more than two chronic conditions. The most common chronic condition is hypertension and some complications in stroke-related diseases. The stroke patients are grouped together for easy care. Elderly clients are referred to hospital for further management as there are no visiting doctors, only fourth year student doctors placed as per allocation for their curriculum. Clients on chronic medication are sent to hospital on referral. The caregivers take extra care when feeding stroke clients. There is no visiting physiotherapist; therefore, care givers perform passive exercise routines to assist residents and to prevent complications.

4.6.7. Food services

There is no dietician, only two nuns who are experienced chefs. The home intends to hire catering services in 2012-13. Meals are served five times a day. While the frail ones are served within their rooms, the active elderly are served in the dining hall. Food is nutritious and consists of fluid, soft and high protein diet.

Cultural meals like wild vegetables (umfino and mqa) are prepared on some days to cater for those that are still conservative to respect their culture. Frail elderly residents and stroke sufferers are fed by the care givers. The kitchen staff work shift duties to prepare the early morning tea at 06h00.

4.6.8. Social activities

There are no activities available for residents who are confined to bed except radio and television programmes. Arrangements are made for residents to participate in religious services of their choice. Special days like Christmas and Older Persons' Day are celebrated, and residents are given gifts and cakes. Active residents are involved in Golden Games such as net ball, volley-ball and soccer. The elderly are sent on tours to visit the beach and to the zoo in sunny weather. Donations of blankets, radio sets, slippers, shoes and sweets are received from the mainstream community.

4.6.9. Transport facilities

A mini-bus and a van are available for transportation in terms of the activities of the home. A mini-bus was donated by an NGO to transport the elderly during social events such as bereavement and tours on game tournaments and other administrative activities since the area is 10km away of Mthatha. Transport is available for deliveries like stationary and kitchen groceries. Sometimes once or twice a year a bus is hired for transporting the elderly to go to the zoo or sea side (beach).

4.6.10 Conclusions

Data collected were transcribed, coded by an independent researcher and converted into categories. Information collected from discussions was analysed and it was established that participants on chronic medication were not happy to be given treatment only, but felt that they needed to be examined by a doctor. One caregiver was identified as treating the elderly residents harshly, rude and inconsiderately.

The chronic disease with the highest recorded incidence was hypertension that complicate to stroke. On the researchers observations there were gaps diabetic and blood pressure check-ups. From the information gathered it became clear that not all elderly people are happy to stay in the home residence. The researcher observed that there was a critical shortage in linen supplies. This shortage came to her attention as she was assisting some of the dependant and

CHAPTER FIVE

SUMMARY OF THE FINDINGS, RECOMMENDATION AND CONCLUSION

5.1 INTRODUCTION

The aim of this chapter is to present a summary of the findings, make the necessary recommendations and briefly discuss the limitations of the study, and then offer a conclusion in line with the objectives of the study. The literature reviews as well as the findings from studies of other researchers have been used to inform this discussion. The necessary recommendations have been made.

5.2 SUMMARY/RESULTS OF THE STUDY

The results from this study demonstrated that administratively, there is a criterion for admission in the old age home and this protocol is observed by all members of the old age home. It consists of the consent from the immediate family, care giver or relative, headman of the location or the councillor; proof that the elder is a pensioner, an identity document copy, the address of the elderly person's next of kin and a brief background of the family.

All elderly residents over 60 years old receive a pension fund scheme according to the Act. The home is registered under the Act 13 of 2006 (Department of Social Development, 2006). The Government subsidises 80 % and 20% is paid by residents through one-third of their pension money which is deducted for board and lodging. The family relatives and the elderly person are informed of the conditions of the stay. The relative is made to sign after reading (if literate) or verbal information for illiterate and use of right thumb print (sign) after given information on the rules and regulations of the old age home residence.

The old age home residence is characterised by high number of females especially widows 57% than males 43% and this is in line with the literature review of old age population and Statistics South Africa.

From the finding of this study the following aspects had been identified:

Basic care needs: residents with limited disabilities are assisted with the basic physical care, but not all are happy with the care. Torn linen poses the risk of pressure sores to the wrinkled skin of the elderly.

Safety - environmental: Structural physical layout is safe with big high windows secured with bugler proofs, a satellite monitor, a security guard at the gate and locked doors.

There was an observable absence of rails on the passage to the bathrooms way to support the elderly from falls and this poses some health hazards for the elderly.

Safety - medication: Medication was not monitored as the chronic medication was given without baseline information of screening assessment prior medication especially for Diabetic and Hypertensive clients. A problem of lose dentures for some elderly was a concern. No sessional doctor visiting the home to review chronic treatments. No collaboration of multidisciplinary team comprising a sessional physiotherapy, occupational therapy and dentist was noted there.

Nutrition: Not all residents are satisfied with the food service; there was a comment on cold coffee or tea and too much fluid than solid food being served which predispose one to a condition that makes them frequent the toilet to empty the bladder more. There was a complaint of serving stale sausages as well. The kitchen is not inspected and the cold storage is not well maintained. The kitchen staffs are experienced cooks, but not qualified chefs.

Psycho-social: Some residents expressed a dislike for bathing every day. There were others who complained about bathing on cold days and a lack of privacy when bathing. Worse still there was a complaint about one inconsiderate and rude caregiver who somewhat dehumanised the vulnerable and frail elderly needing assistance when bathing. That staff member's rude and uncaring character would be noted during the time that staff member would bathe the elderly. The affected elderly were concerned about the limited functional status. They said because they could not do certain things on their own they were at the mercy of a caregiver even in very personal hygiene matters such as bathing. They pointed out that even if they did not feel like bathing a caregiver was in control of their personal care. There was also a mention of not being involved in decision making.

Not only that, they did talk about bad memories, sobbing stories and a dislike for a routine like bell ringing for breakfast and lunch. They also talked about loneliness and depression. A sense of religious and or spiritual connection was displayed by some elderly but there was no serious attraction to the opposite sex even though men's admiration for some women was noted.

Institutionalisation: Active elderly experience some amount of autonomy, but some complained about sleep disturbances arising from others who may be snoring in sleep. They also talked about the strict routine followed and the attitude of the staff towards the residents. Some of them felt there was no privacy since a number of them may be living and sleeping in one big room, no confidentiality in that the information of day to day activities is shared. Most of the elderly disliked sharing bed rooms, bathrooms and information.

Support system: Family and relatives of the residents are the key support for elderly people. Unfortunately, not all the elderly were visited by their family and friends. Those who were visited showed a higher level of self-esteem than did those who had no one visiting them.

5.3 THE RESEARCHER'S OBSERVATIONS:

There was a critical shortage of linen. The little linen available was as torn and old as were the few blankets available on the beds. It was noted that involving the elderly, the family or immediate relatives in every decision making, is one way of showing respect and understanding of the clients' cultural beliefs. This recognition of the clients' cultural beliefs boosts the self-image and human dignity for the elderly. It was also noted that the elderly also appreciate presents and gifts from whomever such gifts or presents come.

Furthermore, it was noted that at EOAH guidance support is provided to the elderly who are active and can manage their own personal budgets to be involved in their financial activities like shopping sprees. Such residents are also encouraged to do the following: using the telephone, doing laundry, making their beds and cooking. Key social support is supplied to the residents in terms of checking on the elderly people's financial matters and to assist with family and friends' visits for them. Given that the elderly anticipate death any time, one appreciates the inclusion of burial-societies matters in old age home services. It is important knowing that they will have a descent funeral when they die, generally, makes the elderly happy. The participants were happy that the state government is taking care of them.

The evidence of that care is noted in social services such as Social workers' assistance in checking or verifying their identity documents and updating the residents on the state of their burial fund aid and follow ups on their pension fund facilities. Activities such as game playing

for the physically active elderly residents and music as well as listening to radio and watching television programmes especially for the invalids are valued by the elderly. Psychological support provided through simple touch, positive statements, therapeutic use of self, listening, showing love and empathy, acting as a counsellor and always being available is equally appreciated by residents in OAHs and elderly in general.

Comments from most of the participants in the study indicated that, at EOA, residents had a positive perception of the staff positively in terms of care and support received from care givers concerning the activities of daily living. Nevertheless, dissatisfaction or complaint on the inconsiderate care of one staff member was registered by a number of the residents participating in the project.

However, this study, noted a shortage of caregivers through observation on daily care giving available at EOA. In terms of staffing the study revealed that there is a critical shortage of staff, especially in the caregiver's category. According to the criteria and guidelines for ETQA 58 of 1995, the staffing of EOA does not match the client population there. The total number of nursing staff including caregivers at EOA is 28 as matched against 140 residents. Statistically speaking, the number of staff is un-proportional to the number of the residents attended to; as the staffing ratio is 2.9 hours of time spent per resident as per quality standards (SAQA, 1995).

As revealed by this study the caregivers take personal care of the patients and are involved in decision-making relating to caring services which include the following: turning, feeding, taking care of incontinence, bathing and transferring from bed to a seat for the elder in their care. However, it was noted that they seldom take or assist observations like those for temperature, pulse, respiration and blood-pressure. Baseline observation on temperature, pulse, respiration and blood pressure are only done when the condition of the elderly is alarming. Notwithstanding that, there is a good relationship between the elderly people's families and the staff.

The elderly people speak the same language (Xhosa) as do the majority of the caregivers and other staff members there. Residents participate very well in conversations. It noted that while those who are still active take part in light chores like making their beds and cleaning their lockers, the invalids are assisted in this regard.

5.4 HEALTH STATUS OF THE ELDERLY PEOPLE AND CARE SERVICES

This study revealed that most of the elderly people from EOAHS suffer from chronic diseases and have disabilities. Some have more than two chronic conditions. The most common chronic condition is hypertension and some complications in stroke-related diseases.

The findings from this study demonstrated also that there is some care delivery service offered to old age people at EOAHS. The CEO/Manager is a Geriatric nurse, and the two professional nurses and the staff nurse have experience in working as home care nurses but there is a gross shortage of other health workers. Geriatric ethics need to be practised by all the health workers as behaviour forms such as being rude and inconsiderate to the patients are not tolerated in health practice. The implementation of care is through a primary health care approach and curative care is by means of referral to the nearby state hospital since there are no doctors, physiotherapists/speech therapists and pharmacists, only student doctors (Fourth year students) visiting the home as per their curriculum requirement.

5.5 RECOMMENDATIONS

Findings in this study indicate that elderly population at EOAHS appreciate that they have such a home but need more nurses and caregivers to care for them and nursing ethics to be observed. The home administration need to collaborate with the CEO of the state hospital in town to find a solution to the challenge relating to how to better care for the health of the elderly population with chronic diseases and minor ailments in the old age home residence.

5.5.1. Nursing practice

- The residents should undergo a comprehensive geriatric assessment on admission and periodically as per protocol.
- Multidisciplinary health team at the hospital level should be part of the Old age home.
- Policy makers should utilize these findings when compiling their health policy
- Outreach Campaigns raising awareness of the community regarding problems affecting the older persons and the availability of old age home residences are needed.

- There should be maximum cooperation and coordination between the intersectional committee on ageing which includes representatives from all departments which have contact with elderly people, namely Welfare, Health, Safety and Security, Housing and Local Government when the elderly person is discharged back into the community.
- The partnership between the family and the caregiver is an important tool for the effective care of the elderly population.

5.5.2. Nursing Education

- Residents should be aware of their rights, to report any type of abuse, be it physical or mental for example Act 13 of 2006.
- Induction on geriatric introduction workshops and courses for staff employed at the Old age home be compulsory, e.g. caregivers should attend in service training course on personal health care or activities of daily living (ADL) periodically according to quality standards.
- Geriatric nursing training schools should be established in all provinces so as to produce enough nurses in this category of health workers.

5.5.3. Nursing Research

- Studies of this nature adopting a combination of qualitative and quantitative methods be conducted in future to provide a more holistic understanding of the perceptions old age home residents have of the general care they receive in such social facilities.
- More research studies on Gerontology and Geriatrics are needed to develop further theories and models on ageing.
- Develop more theories and models that support ageing.
- This study may form a baseline for a more extensive study to be conducted within this domain of health care in this country or elsewhere.

5.6 LIMITATIONS

Like any other, this study while having attained its set objectives it has had its own limitations. The first being financial and time constraints that made the study be limited to only one old age home, namely Empilweni Old Age Home in Mthatha. This limitation imposes on the application of the findings of the study. Given this fact, the results and findings of the study may not be generalised to all old age homes in the Eastern Cape Province as a whole. Apart from this general limitation, it must be mentioned that during the time of data collection there was a two day industrial strike action, at EAOH, which disrupted the process somewhat. In addition, the researcher carried out this study whilst working full time at her regular job.

Administratively, the researcher feels that the composition of the focus group imposed some limitation on the way of capturing differences in perceptions according to age levels.

However, despite these limitations, the validity and reliability of the instrument in this study suggests that the participants participated with some consistency, and appeared to have found the contents of instrument comprehensible. It is in this light that the researcher strongly believes the limitations, cited, did not overshadow the strengths of the study. One of the strengths of this study, however, is that it provides some insights into an area which has been severely limited and neglected so far as research in this domain is concerned.

5.7 CONCLUSION

In this chapter the researcher has presented the summary of the findings of the study and the discussion thereof as well as the recommendations based on those findings.

The study has established that ageing is part and parcel of life and that all one has to do is prepare for old age in the best way possible. Those who do that may have a choice should they need old age home institutionalisation in their old age. They may choose to be admitted to a private old age home with better facilities and care and remain there as long as they wish or till death. On the other hand, those who never prepare for old age have no choice should they need old age home care, but to go to public ones where facilities and care may not be the same as what one may find at a private institution of the same nature.

With specific reference to Empilweni old age home where the study was conducted, the study has revealed that in many respects the elderly people resident there are generally happy with the care they receive. However, the study has also noted that there is at least one caregiver whose behaviour towards the elderly entrusted to the care of the institute is not good at all. The study has also revealed other problems there including: staff-client ration especially in the category of caregivers; the state of linen and toilet and bathroom doors not good. A critical lack of certain qualified professionals who would make meaningful contribution to the care the institution provides to aged residents. The study did not only identify areas of concern, but also provided some recommendations.

It is the researcher's hope that if some or all the recommendations this study advances are implemented, the quality of care given in public old age homes may be better than the case presently is.

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APPENDICES

APPENDIX A

PATIENT GROUP DISCUSSION QUESTIONS – ENGLISH

Please explain to me your perception on the general care of the old age residence under the following:

- Tell me the importance in personal care
- What is your understanding on the safety environment of the home?
- Tell me more on the aspect of giving medication
- What makes you feel good about your stay at the home?
- Tell me about serving of meals
- Are you okay with your stay at the home?
- What can you say about the caregivers?
- Say something about your relative or friends visit
- What can you say about the social services?

PATIENT GROUP DISCUSSION-XHOSA

- Khawundixelele ngokuthe gabalala uyibona njani intlalo yenu apha
- Khawunabe malunga ngobume bokuzihoya
- Ukhuseleko lobume bakho,ngokwezempilo,kwabakuncedisayo
- Engqondweni ikunika ntoni lentlalo?
- Ungaphawula ntoni ngokudla?
- Sixelele ngentlalo yonke yalapha

APPENDIX B

FOCUS GROUP DISCUSSION

Duration : 45-1hour.
Time :11-12am
Date :16 /05/2012
Venue : Empilweni old age home

Background: For data collection process to occur effectively, the 10-15 minutes of the focus group discussions was used to build a relationship between the researcher and the participants. Activities done in those 10-15 minutes included: some introduction and welcoming remarks. The researcher gave an overview orientation of what was to be done and expectation roles and attitudes in terms of participants' answers were explained and clarifications wherever needed were made. Participants were reassured of confidentiality and were reminder of how long the session would be since they had already signed consent forms. They were also reminded of the fact that they were free to drop off from the project if they so felt. After that reminder, the researcher informed the participants that if they had not changed their minds about taking part they could then put their name tags on to help the members to remember one another's name as part of promoting group cohesion. The researcher explained the role of the assistant researcher that it was to take field notes to document non-verbal cues and other observations without participating in the discussions (Bonito & Sanders 2009). All the participants were invited for refreshments after discussions as a token of appreciation.

The researcher started the exercise with a broad opening.

Codes: I: Researcher P: Participant

(Please be advised that the participants sometimes expressed themselves in second or even in third person when referring to themselves because of the sensitive nature of the topic. After the necessary red tape the discussion started).

The researcher informed each participant:

Last month I, the researcher, asked for permission to find out from you what you think of general care you receive here.

This is part of my study and it is also intended to help those who take care of you here give you the best service they can. I will read you the information sheet so that you know exactly what the study involves and what is expected of you. [I then read the informed consent (b) to the participant and thanked her for agreeing to join the study].

Q “WHAT IS YOUR PERCEPTION OF THE GENERAL CARE GIVEN TO YOU”?

(I: Tell me about the importance in personal care.

Following below are the responses to specific question asked.

P1: 62 female “*Ewe, siyazi sigugile kodwa siyazinceka*” (Oh! Yes we know that we are old, but we do help ourselves.) – confidence shown, (Epilepsy and burns affecting right hand) active elder

P2: 75 male “*Ndiyakwazi ukondlula, ndihlambe, ndixukuxe ndinxibe kakuhl* (I can make my bed, go to the bathroom and brush my teeth; and wear my nice *jacket*.) - (Diabetes, partial blindness –using stick)

P3: 68 male “*Ukuzihoya unxibe kakuhle*” (Taking good care of you (means), wearing clean clothes.) - smile (diabetes and hypertension active elder)

P4: 65 female “*Andifuni kuphathwa ebusweni xa sendichonchile ngento zokuthambisa kaloku zifihla ubuso obushwabeneyo*” – smile on face (I don’t like somebody touching my face; after putting on my make-up at least the wrinkles are concealed.) - active dependant (wheel chair bound)

P5: 70 female “*Ukuvuka nje kwam ndiqale ndichame khonukuze ndikhululeke ngexesha lokuhlamba nelokutya*” - Cataract and Diabetes (use stick)

(Caregiver should assist me, first thing is to visit the toilet to avoid disturbance during bathing and taking my breakfast)

P6: 67 female “*Uyazikhetha apha, ukuhlamba ebhafini okanye eshowereni; phofu mna Andiziqhelanga kaloku.*” - showing appreciation

(Here they give us a choice either to use a bath or a shower or a basin. I am not used to a shower or a bath so I use the basin for bathing.) – normal ageing

P7: 64 male “*Ndim kuphela osonga kakuhle impahla, jonga ezabo.*” - bragging

(I am the only one in this room who can neatly pack my clothes, look at theirs) - **active Elder-**(limping polio)

P8: 78 male (*Ndixukuxa emva kokutya ndonqena umlomo ombi xa ndiqale ndaxukuxa*)

(I like brushing my teeth after breakfast to avoid the bad taste of toothpaste” –

***active/dependent?(diabetic and hypertension)**

P9: 76 female “*ave ndingafuni ukudibaniselana nge-bathroom ngoba abanye ngamaxelegu*

” -sarcastic face – stroke affecting left arm(using stick)

(I hate sharing the bathroom some leave the area unhygienic) – **active/dependent?**

P10: 77 female “*Ilaphu lona makondlulwe ngalo likhusela izibi zangaphantsi*” -

cancer of the cervix on radiotherapy (I always remind the nurse of putting a linen saver or cloth on top of the bed to take care of the discharge) - assisted – dependant

P11: 63 female “*Ngase xa endincedisa tana angagubhuzelisi ngesepha apha kusisi akumnandanga ndiyatyabuka*”] – frowning - stroke affecting the mouth –diabetes and

hypertension (I so wish the nurse could be careful by not putting too much soap on my private part because this makes me uncomfortable and itchy)

P12 70 male- was not active keep on nodding whenever somebody raising a statement(normal ageing)

A 78 year old male said, “*ndisebenzisa nokuba leliphi ilaphu,zona zincinci izitya zokuhlambela kwaye ndoyika lebhafu inkulu kakhulu neshowara itsho ngemvula yamanzi*”

“I just use any cloth to bath with. I don’t care, as long it is a material cloth. The

basins are small and I am scared to use the bath, it is too big, and the shower water runs too fast on my face.”

One 65 year old female said, “*Ndibanentloni ukuhlanjwa ibe isinqe iqinile ayoluki.*” When translated into English, what she said means, (It’s difficult and embarrassing to be cared for in terms of one’s personal hygiene, yet my hip is stiff because of arthritis.)

Another, a 76 year old female observed, “*Ngoba andikwazi ukuzenzela kuba ndilinxele xa ndihlanjwa bade bahlambe nobusisi bam zintloni ke ezo.*” She said this a sad face. What she said in English means,

(Assisted bathing makes me feel so embarrassed that I am so disabled that a caregiver is intruding on my privacy by touching my private parts.)

. One 62 year old female commented, “*Apha siyancedwa. Mna izandla zam zatsha ngexesha ndandixhuzula, andifikeleli kwezifihlekeleyo indawo.*” The English equivalent of this statement would be, (I appreciate being looked after because my hands are deformed as a result of burns. It is difficult to bath myself, I need assistance. (The staff does take good care of us. I cannot reach my back and private parts so the care givers assist.) While some of the

elderly in those social care facilities may feel that way, there are others who feel otherwise. Two of the participants had this to say about bathing and their attitude towards that aspect of care they receive there. A 78 year old male said, “*Akwaba bangayeka ukusinyanzela ukuhlamba,*” meaning (I wish I can tell them not to force us to bath.)

Another male aged 70 agreed and said, “*Ewe, ngamanye amaxesha kusebusika kuyabanda sakungenwa yingqele.*” This statement translated into English would mean, (Oh yes, sometimes it is cold in the winter and we can catch a cold.) Another one, a 65 year old female added, “*Ikhona inures engenambeko; endigxagxamise ndinganxibanga kuvulwe umnyango.*” The English language equivalent would be, (One of the nurse was so inconsiderate and rude forcing me to bath that she ended up exposing me naked in an open bathroom.)

A 68 year old male asserted, “*Ewe ,uyadlamka kuphele nezigulo emva kokuhlamba umzimba, meaning,* (Yes, after bathing the body becomes revived and one has the feeling of being young again as some of the minor ailments are gone). The last one on this aspect, a 62 year old female shares the view that bathing is essential to one’s health, but quickly points out her own fears about the physical environment bathing in that nursing home take place.

She submitted, “*Ndiyazi funeka ndicocekile kodwa ndoyika ukungena emanzin shower nebhafu ngoba ndingase ndivukwe sisigulo sokuxhuzula.*” The English language equivalent of what she said here would be, (I know that one needs to be clean, but I am scared to use the big bath basin for bathing in case I have an attack of Epilepsy. I want to be fully immersed in water but am scared to use the shower)

R: Are you okay with your stay in the institution

P1: 62, female, “*Ndikhe ndicinge indlela abambulala ngayo unyana wam*”

-silence (*I sometimes think of the way they kill my only son at my home*)

P2: 77, female , “*Ngeba ndihleli nentombi nonyana bam ndinabazukulwana ngoku*” – shaking her head in deep sorrow.

(*I could have been staying with my family and grandchildren in my home*)

P3: 78, male, “...er (sobbing), *ndiziva ndindodwa kungabikho noyedwa umntwana*” - the researcher gave him some tissue paper to wipe tears in his eyes.

(*I feel very lonely not even one child is around?*)

P4: 65, female “...eish (shaking her head) *oko ndabanje amalungu aqinile ngunyaka wesithathu*”

(...my legs are stiff I have been like this for three years.)

P5: 63, male “Ngase libekhona ichiza lokulungisa lomlomo,seyingunyaka ninje.Sihlala imini yonke sakuphunyuzwa kuyokutya asivumelekanga silale emini ngaphandle kogulayo”

(I so wish there is a quick remedy for my twisted mouth, its been a year now (mumbling word wed to lie on the bed unless not well . We sit the whole day (because) we are not allowed to sleep during the day unless one is sick)

P6: 67, female “Akukhomdla apha uyatya,uhlale ulale”

(The only thing you do here is eat and seat or sleep, it's boring no family visits)

P7: 68, male”Kusisithukuthezi apha ,Sijikelezwe sabiyelwa lucingo okwezilwanyana sisethangweni apha sivalelekile “(Surrounded by electric fenced wire like an animal in a kraal not free Nothing is stimulating here)

P8: 78, male ‘Yhee wethu akukho ntonipho apha nididiyelwe endlini nonke amadoda namaxhego okwamakhwenkwe”

(There is no privacy here you grouped in one room like young boys) (shaking his head)

P9: 76, female andazi kwathini ‘Khomntu undindwendwelayo ‘

(I sometimes miss my family they don't visit me ,I wonder why!) (shouting voice)

P10: 70, male”Kukho lentokazi eyithandayo, lonto ndiyazigilisa kuyo ndizama ukuyincokolisa ayindihoyi,nantsiya singasbonwa ”

(There is a lady that catches my attention, try and show how I care for her, but she seems not to understand) (trying to show one of the elderly ladies whispering –don't tell others)

)Another female aged 70 added, “Uhlala nabantu ongabakhethanga ngokwakho “(You don't live with people you chose on your own) Adding to that she said, ‘Kuleqwa amaxesha ezinto zonke akuthandiswa wena “(Rushing to be on time everything is routine here) Just then a male aged 68 commented ” Sijikelezwe sabiyelwa lucingo okwezilwanyana sisethangweni apha sivalelekile “(Surrounded by electric fenced wire like an animal in a kraal not free

R: What do you understand about safe environmental .

P1: 64, male “ndiyaguqu-guquka xa ndilele ze ishiti lisongane ngathi likhuni elindoyamileyo ‘” (I turn sides when sleeping and then the torn linen disturbs me sometimes I think it's a stick; the linen rolls off and irritating my skin”

(P2 70 male” akasarhoni umntu ongummelwane utsho ndiphelelwe bubuthongo”(my neighbour is a snorer wakes me in the middle of the night)

P3:77, female ‘ Sendiqhelene nelivumba andisaliva,kodwa bona bayalicoca yonke imihla”

(I am used to the bad smell of the urine in the rooms but the cleaners clean the floors every day')

P4:75, male "*izixhasi zokubambelela ngaseludongeni xa ungena apho silala nasendleleni ephumayo ezindlini azikho*" (There are no rails to support us when walking into our rooms and along the passages)

P5:78, male ". " *Ndoyika ukuwa ndingevazelwa yimilenze, ayiqinanga* "

(I have some weakness in my legs, I'm scared of falling)

6:70 female ". " *azivaleki kakuhle itoilets nebathrooms* " (Bathrooms and toilet doors are not properly closing; there is a lack of privacy)

P7: 68, male ". *ndiyayithanda impepo apho kungekho vumba lomchamo* " (I like a tidy, clean room and fresh air with no bad odour of urine in the house)

P8:67, female ". " *Zinkulu zithe gabalala kamnandi ke wethu ,uyabukela indalo ngoku ungqengqile ingakumbi ekuseni* " (Warm rooms, big windows for a good view especially in the morning while relaxing in bed)

P9: 65 female "*We are happy there are security windows and the intercom satellite to guard against robbers*" (*Noko sikhuselekile sigadiwe konqevu kubonakala yonke into ethukuzayo kumaqosha obuchwepheshe wokugada*)

P10:75, male "*we are short of chairs*"

(*Eyona nto ingamandla izitulo azisoneli sibaninzi kunazo*)

P11: 77, female "*ke lonto kuyadina ukuhlala endaweni enye nokuya endlini yokudlela ngamanye amaxesha umqolo uba buhlungu kwaye asivumelekanga ukulala ngaphandle kokuba asiziva mnandi okanye kusemva kwemini*"

(Sometimes my back is aching due to sitting and walking to dining hall and you are not allowed to sleep during the day unless not feeling well or after lunch)

R: Tell me about the medication aspect

Screening elderly for chronic medication and safety is not common at the residence

Participants were concerned about medication. A lack of treatment reviews and qualified visiting doctor was a concern to the elderly people.

P1: 62, female "*kunini ndinikwa lentlobo inye ndifuna ugqirha andibone ngoba andide ndiyeke ukuxhuzula*"

(I have been taking the same epilepsy treatment for two years, but no doctor has come to visit and review my treatment, there is no improvement in my illness.)

P2: 68, male “*(Ke lonto akhe aphele nalomayeza kufuneke siye kuwafuna esibhedlela ‘(The medicines are sometimes out of stock and we are sent to the nearby hospital for repeat treatments.)*

P3: 64, male “*Phofu kuyemiwa xa ulinde lomayeza kweso sibhedlela’maxa wambi ungawafunani kuvalwe ze uvukele ngosuku olulandelayo’(What I don’t like in hospital is the long queues and sometimes the dispensary closes before we get medication the care givers have to come the next day)*

P4: 70, female “*Kanti nakwesosibhedlela akabikho singabinanto yokuzinyanga’*”
(Some of the medications are out of stock even at the state hospital and we suffer)

P5: 65, female “*Kow bethu bayasimela ngamalingelo ethu kogqirha torwana’*”

(We are concerned about how we are treated, but we can see our care givers are trying to advocate for us, but still there are not so many doctors as per patient or client ratio.)

P6: 78, male “*Sazifundiswa impawu zeswekile eyehlayo nenyukayo’*”

(We are taught of the signs of hypo /hyperglycemia I now notice the signs of my

Diabetes my body feels tired and dryness of the mouth and then call the care giver.)

P7: 78, male “*Nditya ipilisi zimbini kusasa inye nasemalanga ze gazi eliphezulu’*”

I take two small tablets morning and night for hypertension.”

P8: 68, male “*Nditya lepilisi imhlophe ekuseni yeyeswekile ‘*

(I take Glucophage every morning for Diabetes.)

P9: 70, female “*xa ugugile ufane uve umzimba utefa ngamanye amaxesha’*”

(Most times when I’m not feeling right I say it is old age. Old age causes most of the ills .Old age causes sickness..I put everything down to old age)

P10: 62, female “*ndiphononongwa xa ndingaziva kamnandi’*”(I am being checked only if there is unusual behaviour)

R: What can you say about the meal serving aspect?

P162, female “*kutsho kubemnandi emlonyeni xa uxukuxile*”: (Good appetite is enhanced after brushing the teeth.)

(P2: 68, male “*Ndixukuxa emva kokutya ngoba incasa yokutya ayivakali xa uqale ngokuxukuxa*” (I don’t brush my teeth before eating because that alters the food taste).

P3: 70, female “*Ndiyongqena ukuvuka ebusika ingubo kaloku zishushu ndiyakuqakatha okwakutya kwanentsimbi yesithandathu ndiqale ngentsimbi yeshumi*’ (The breakfast is at 06h00, tell me, in winter you have to leave your warm blankets for breakfast? This is unfair. I skip the early breakfast meal and start at 10h00.)

P4: 64, male “*Yhoo apha siphungiswa iti ebandayo nasele kubanda*’ (The tea they serve is not hot even in cold weathers.)

P5: 78, male “*La suphu yabo ye peas imnandi ndiyayithanda*“(I like the thick pea soup they serve.)

P6: 75, male “(*Ke tana ndinengxaki yamazinyo emboleko ayagungqa andityisa kakubi kubabuhlungu ngoba enza izilinda* ‘(My dentures do not fit well and giving me problems of sores on the mouth when I eat)

P7: 77, female ‘*umngqusho uyasiyalula isisu sam kwaye uqaqambelisa amazinyo* ‘(I use to take mealie- samp but, lately my tummy becomes upset following the intake and also the fact that sometimes it is hard to chew and it hurts my teeth)

P8: 67, female’’(*Umfino okanye umqa, ndivele ndikhumbule ekhaya xaizintsuku zomqa nomfino* “(At least once or twice a week traditional vegetables are served this remind me of our traditional foods at home)

P9: 78, male ‘*Bayasixhesha ngeziiselo kakhulu kane nakahlanu ngemini kangangokuba ndiyatsibisa ngoba zindivusa sendilele ngomnchamo ndide ndifike senditsipizele umthawuzo wam*’’

(we are drinking a lot of tea and soup five times a day and small amount of food I skip some of the fluid diet, they wake me up even at night and drips of urine wet my underwear.)

P10: 67, female ‘*Kunenyama ukutya kwethu kwe mini*) (looking excited about that “(Our heavy meal is midday contains meaty nutrients daily)

P11: 68, male ‘’*Ngenye imini sakhe sadliswa iRussians ezimuncu zingatyeke asazi ngubani owazisa onondaba sabona befika besibuza*’’ (frowning)

(I don't know who told the press that the other afternoon Russian sausages were stale, we could not eat the taste was unbearable.)

P12: 76, female "*Ndiyancediswa ekutyeni isandla sam asisebenzi*" (I am being assisted in feeding my other hand is not working)

R: How is it to be in this Institution?

P1: 76, male "*Eyona nto emnandi siyasebenzisana sonke singabomzomnye*" (The advantages are that we are like one family, we eat, sing and sleep together)

P2: 62, female "*Lonto yenza silibale sonwabe*" (That makes us forget some of the worries)

P3: 63, male "*Kaloku siyazalana apha ngeziduko kwaye sixabisene sibambene*" (Networking culturally by respecting and admiring those sharing the same clan name)

P4: 78, male "*Likhaya esinalo eli lonto siyayazi*" (We understand that this is the only home place we have for now understand one another.)

P5: 64, male "*Khangelapha ndikubonise unonqwaza walapha nankuya*" (I will show you the fussy lady, who shows a long face most of the time.)

P6:70, female "*ngemini ezinkulu sifumana amabhaso kwaye sidlaliswa nemidlalo*" (We receive donations from the community and the corporate world of item such as blankets, radio sets and feasts for Elderly Persons' Day; sometimes we are taken for a tour to the coastal area by the beach and the institution also organises games like soccer and netball for us to play)

P7: 74, male/female "*siyakhungana owehlelwe lilifu elimnyama simhoye*"

(We support each other in bad times like bereavement, and there is common understanding)

P1: 68, male "*ndicaphukela le ntsimbi ngoba ifuna ndisukume ndiyokutya xa kanye ndifuna ukuphumla*" (I hate the bell for meals at the dining hall when one needs to rest.)

P2: 78, female "*Mhlawumbi lentsimbi isinceda ekusikhumbuzeni naxa kukho ingxaki bethu*" (Sometimes the advantage of the bell is to inform a care giver who is on the one side of the room when there is an emergency)

P3: 63, male "*eyona indigqibayo lixsha lokuhlamba ekuseni*" (What disturbs me is bathing time in the morning before breakfast, I dodge and pretend as if I'm from the bath.

R: What can you say about the caregivers?

P1: 62, female “*ngede basifeze sibaninzi kunabo*” (Not all the needs for care can be met because we are so many here” another elder says.)

P 2 68 male “ *Ke lonto ndiyabasizela abanye bancinci ngeziqu funeka bethwale banceda umntu omkhulu kunaye*”(I sometimes felt pity for them when they had to assist an overweight person and they are so thin size body)

P3: 65, female Intenayo kukho *ongahloniphi yo okrwada kubasebenzi ngakumbi ngethuba lokuhlunjwa uyasigxagxamisa ,ade avalisisi necango xa esihlamba ,iyandicaphukisa ke lonto*”(The thing that upsets me is one of the staff members is rude dehumanising no privacy , and is so inconsiderate when bathing me, however that is the only staff member I don’t like other care givers support us mostly during bathing time),

P4: 70, male “*Bayasondlulela bancedise ekusityiseni torwana xa ungakwazi*”(Some of us can make our beds and the caregivers assist those who are unable.shame the caregivers assist us in feeding)

P5:78, male “*Kaloku soyiswa nakukunxiba izihlangu asikwazi kugoba ,batsho ke basincede*”(I cannot put on my shoes my feet sometimes becomes stiff the caregiver assist)

P 6: 64, male “*Bayasilungisela nefoni kanti kukungakwazi nje ukucofa*”(There was a time my phone was not working the care giver fixed it for me then I was able to communicate with my aunt)

P7: 77, female “*Siyazilibala kaloku nesuku eli lokuzalwa kwakho*”(Sometimes we forget our birthdays with the help of the caregivers they remind us)

P8: 67, female “*Sikhunjuzwa nangemini yecawa ukuba silungiselele icawe*”(Even on a Sunday when we have to prepare for church hall, the care givers keep on reminding us before the bell rings)

P9: 70, female “ *bayancediswa batyiswe abangakwaziyo*”(Assist in feeding those who are unable to feed for themselves)

R: Tell me anything about the relatives and friends visits

P1: 77, female “*Izihlobo zethu ziyasindwendwela kodwa ayingawo onke amaxesha azanendaba ezimnandi nezimbizisishiya sihluphekile emphefumleni*”(Yes, most of the relatives visit, especially on weekends, but they do not always bring good news sometimes they leave you depressed because of a bereavement.)

P2: 70, female “*Siphathelwa izipho*”

(Most of the time they bring joy and presents when they visit.)

P3: 70, male “*Uyakhululuhlelwe lilifu elimnyama*”

At least you are released for your relative bereavement”

P4: 78 male, “*Ngemini ezinkulu zokuzalwa ,losuku lwethu siyaculelwa siphawe izipho*”

(When it’s one’s birthday, a surprise song and cake to celebrate on your day and make us feel cared for)

P5: 68, male “*Xa ufuna uyokroba ekhaya uyakhululwa uzanyelwe indlela yokubela xa ungalandwanga ekhaya*”(When there are rituals or ceremonies in the family, arrangement is made for one to visit home)

R: What can you say about the social service received

P1: 76, female.’’*Ndancedwa ngonontlalontle bandikhapha saya ekhaya kumke indlu nomoya bapatanisa babafunela abazukulwana indawo yokuxharha, ukutya nempahla yokunxiba*”(A social worker accompanied me to my home when the thunderstorm struck my house and organise ways of temporal houses for my grandchildren ,clothes and food parcels, at least that relieved me).

P2: 64, male “ *Phofu sinedwa ngaba nontlalontle apha bayasigcinela ngoba siyazilibala izazisi namacard okwamkela apho siwabeke khona* ”

(“I lost my identity document when I was visiting my home and the social worker helped me to get a new one Well, we are assisted by the social workers by keeping our IDs and Pension cards...because we often lose memory).

P3: 70, male “*Oh ke khona siyaziphiwa izipho ezivela kurhulumente ngonontlalo xesikweni kukhunjulwa uzwelonke lwabadala nangesuku lokuzalwa komntu into ezinjenge ngubo nezihlangu*”(International old age day and birthdays we are given presents according to our disability like I was given a radio last Birthday and a blanket on Old age day slippers shoes from the government delivered by the social worker)

P4: 67, female “*siyazibandakanya kwimidlalo yebhola apha* ” (They are trying to make us happy at least, those active are involved in games we do play ball games here)

P5: 68, male “*Siyahamba ngo September siya eMonti siyokudlala*”(In September we will be going to East London to play a match at least we meet new friends and that is good)

P6: 65 female “ *Abangakwaziyo ukuhamba banikwa onomathotholo*”(The bed ridden elderly are given radio sets.)

P7: 78, male “Kule Krimesi idlulileyo besiphiwe izihlangu zokurhuqa ezithambileyo ezishushu”(Last Christmas we were all given slipper shoes to wear as a Christmas present.)

P8:63, male “*Qho ngomhla wokuzalwa kukaMandela kubakho ingxikela yethoko ,siye sithathwe siyokuzimasa sibukele imixhentso yakwantu*”(On each and every Mandela Birthday we are transported to Mandela Museum entertained by the cultural activities and dinner at least taken for an outing except the elderly confined to bed).

P9: 77, female “ *Sinabo omabonakude ke tana kubukela kamnandi abangakwazi ukuzizulela* ”(At least there is a television set for those who are confined to bed.)

APPENDIX C

INFORMATION DOCUMENT

STUDY TOPIC: Investigating the perceptions of old age residents regarding the general care received .

INVITATION AND CONSENT TO PARTICIPATE IN A RESEARCH

STUDY-Manager

Madam

I am a registered nurse studying towards a Master's Degree in Gerontological Nursing with the University of KwaZulu-Natal. I am conducting a research study on the perceptions of old age residents regarding the general care received at Empilweni Home near Mthatha town. The purpose of the study is to improve the standard of care of the residents. You are expected to give the overview as a manager of the residence. When signing this form you should know that you are giving consent to be interviewed for not longer than one hour. You will be asked to furnish your biographic details and these will be written down. You will be then asked about the care here and activities of daily living and what it is like working here. An audiotape will be used to record the interview. In this matter I undertake to ensure your anonymity by omitting the use of your name and address. Confidentiality will be ensured by erasure of the taped material on completion of the study; the transcription of the taped material will only be accessed by my supervisor and me. You will not be paid for participating in this study, but you will possibly be one of the beneficiaries of the envisaged guidelines. It is understood that you are under no obligation to participate in this study. You give your informed consent but still reserve the right to cancel your participation at any stage of the proceedings should you change your mind .If you are interested to know the findings of this study, they will be communicated to you as soon as they are available. Should you wish to contact me, call me at the following telephone numbers: 0789935300/0822090521(at all times) or 047-5024082(office hours).

Many thanks for considering my request

Participant's signature _____

Researcher's signature _____

Date_____

APPENDIX D

INFORMATION DOCUMENT

STUDY TOPIC: Investigating the perceptions of old age residents regarding the general care they received .

RE: INVITATION AND CONSENT TO PARTICIPATE IN A RESEARCH STUDY-Residents

Dear Sir/Madam

I am a registered nurse studying towards a Master's Degree in Gerontological Nursing with the University of KwaZulu-Natal. I am conducting a research study on the perceptions of old age residents regarding the general care they receive at Empilweni Home near Mthatha town. The purpose of the study is to improve the standard of care of the service rendered to the residents. You are invited to participate in this study because you have been a resident here for more than six months and you can speak either Xhosa or English. When signing this form you should know that you are giving consent to be interviewed for not longer than one hour. You will be asked to furnish your biographic details and these will be written down. You will then be asked about the care here and activities of daily living and what it is like living here. An audiotape will be used to record the interview. In this matter I undertake to ensure your anonymity by omitting the use of your name and address. Confidentiality will be ensured by erasure of the taped material on completion of the study. The transcription of the taped material will only be accessed by my supervisor and me. You will not be paid for participating in this study, but you possibly will be one of the beneficiaries of the envisaged guidelines. It is understood that you are under no obligation to participate in this study .You give your informed consent, but still reserve the right to cancel your participation at any stage of the proceedings should you change your mind .If you are interested in knowing the findings of this study, they will be communicated to you as soon as they are available. Should you wish to contact me, call me at the following telephone numbers: 0789935300/0822090521(at all times) or 047-5024082(office hours).

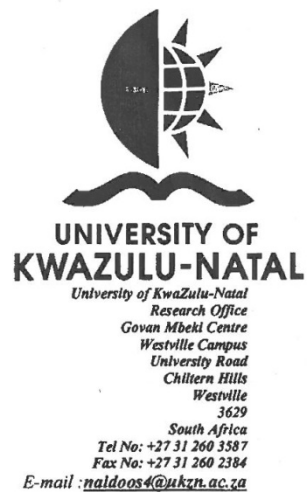
Many thanks for considering this request

Participant's signature _____Researcher's signature _____

Date _____

APPENDIX E

[Faint handwritten notes]



24 October 2010

Mrs F May
School of Nursing
HOWARD COLLEGE CAMPUS

Dear Mrs May

PROTOCOL: Exploration on the Perception of the Old Age Residents regarding Basic Physical Nursing Care in an Old Age Home in Eastern Cape
ETHICAL APPROVAL NUMBER: HSS/1231/2010 M: Faculty of Health Sciences

In response to your application dated 25 October 2010, Student Number: **202524276** the Humanities & Social Sciences Ethics Committee has considered the abovementioned application and the protocol has been given **FULL APPROVAL**.

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

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Professor Steve Collings (Chair)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

SC/sn

cc: Dr. Z Nkosi (Supervisor)
cc: Mr. S Reddy

APPENDIX F

University of KwaZulu-Natal
Nursing School Research Dept.

Durban
4000
10/07/2012
The Manager
Empilweni Nursing Home
Mthatha

Dear Sir/Madam

Re-Permission to undertake a study at your institution

I kindly request permission to undertake a study at your institution.

I am a student currently registered for a Master's Degree in Gerontology with the above mentioned University.

Hoping my request will receive your favourable consideration.

Yours truly
Fezeka May

APPENDIX G



Empilweni home
(an Incorporated Association not for gain)

P.O. BOX 728 UMTATA 5100 EASTERN CAPE SOUTH AFRICA
TEL: +27 (047) 532 4094 / 5 : fax on request : empilweni@intekom.co.za

EMPILWENI HOME CONSENT FORM

Permission is given to the under mentioned Fezeka May student to obtain information from our institution facility for the purpose of doing a observational visit as part of the compulsory community Health practical.

The reasons for the interview and the procedure have been explained to us.

Name of Student _____

Student Number _____

Name of facility _____

Signature *uBota*

Date _____

**EMPILWENI HOME
P.O. BOX 728
MTHATHA**

