

**AN EDUCATIONAL, PRACTICE- ORIENTATED  
PROGRAMME FOR CAREGIVERS OF THE  
ELDERLY IN OLD AGE HOMES IN  
WINDHOEK AND REHOBOTH.**

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**DEDICATION**

This thesis represents the peak accomplishment of my 41-year journey in the health care profession. My engagement in my profession has contributed to who I am and has had an impact on numerous individuals and communities, on a personal and professional level. I therefore dedicate this thesis to the many who accompanied me on my journey.

Our heavenly Father who inspired me with the wisdom, knowledge and understanding to make this study possible. Praise be to the Lord, the God of Israel, from everlasting to everlasting. Amen and Amen (Psalm 41:13)

My husband, Vincent, for his love, support and encouragement and the example he has given me of his own determination to always strive for greater heights

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My parents and parents-in-law for their love and support and their example of faith in Christ and a passion for education

The members of the Windhoek Khomasdal Community, who instilled in me a sense of belonging and appreciation for my work amongst them

**DECLARATION**

I, Joan Magdalene Kloppers, declare that the study on “An educational programme practice oriented programme for caregivers of the elderly in old-age homes in Windhoek.” is a true reflection of my own research and that this work, or part thereof, has not been submitted for any degree in any other institution of higher education.

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J M Kloppers

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Date

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**ABSTRACT**

Although normal ageing does not imply disease, the incidence of chronic disease increases with age. Chronic diseases refer to those illnesses that last three to six months or more and are usually treatable but not curable, such as arthritis. Another major problem for elderly people is the prevalence of co-morbidity (several chronic diseases in one person) which makes treatment and quality of care and life more difficult. Therefore, caregivers have a major role in coordinating comprehensive long-term care.

In many instances care for the frail elderly, especially in long-term care institutions, is provided under minimal supervision by caregivers who are lay people. This can lead to poor quality care or neglect of the frail elderly. The research questions were: “How competent the appointed lay people, who are carers for the elderly in old age homes, but lack the opportunity for training and improving their knowledge and skills, in delivering care to the elderly.”

The purpose of this study was to develop, implement and evaluate a supportive educational programme for caregivers of the elderly in old age homes in Windhoek.

The objectives of the study were identified as the following:

To explore and describe the experiences of the elderly and the caregivers in respect of nursing care they receive.

To explore and describe the experiences of the caregivers in respect of caring for the elderly

To determine the learning needs and support of caregivers in the provision of health care for the elderly

To develop an conceptual framework and an educational programme for the caregivers

To implement and evaluate the educational programme for caregivers in old age homes in Windhoek

In terms of the research design, a qualitative, explorative, descriptive, contextual and phenomenology design was used to perform this study.

The study was conducted in three phases. Firstly a situational analysis was carried out to explore and describe the experiences and needs of the caregivers and the elderly. The situation analysis revealed themes in terms of interpersonal relationships that could be positive or negative regarding the elderly, with the sub-themes like communication, support and caring for elderly people. These themes and sub-themes include the following: Interpersonal relationships were viewed as an important aspect of the caring process. Lack of regular in-service training sessions for caregivers, with a subtheme of a lack of adequate knowledge of procedures. Lack of human resources, equipment and policies

In the second phase, a conceptual framework was derived from the results of phase 1, using the activities prescribed by Dickoff, James and Wiedenbach (1968). In the third phase, a programme was developed from of the findings of the previous phase. Finally, the educational programme was implemented and evaluated in old age homes in Windhoek.

Subsequently, an educational programme was developed from the themes and categories identified by the research. The educational programme consists of three sessions comprising the following learning content:

**Session 1:** Discover the value of good interpersonal relationships

**Session 2:** Improve knowledge and skills of practical procedures in order to improve physical care and proper nutrition

**Session 3:** Guidance given on specific managerial aspects

The programme was implemented, evaluated and adjusted according to the recommendations and findings. Focus group discussions were carried out for the evaluation of the programme. The feedback session with participants would indicate that their responses to the programme were positive and they mentioned that the programme was indeed needed. The intention and hope is that the educational programme will help caregivers of the elderly to be competent and provide quality care.

Recommendations were made as a result of the research study: It is recommended that an environment that is conducive to quality care for the elderly be established. The following strategies can be used: Human resources, supervision and support and provision of the necessary equipment.

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## **CHAPTER 1**

### **1. INTRODUCTION TO THE STUDY**

#### **1.1 OVERVIEW AND RATIONALE**

The number of Elderly people has increased tremendously and with all their chronic diseases, and biological changes in their body, they need competent caregivers' to care for them. According to Brown, 2006; Tanner, (2004) competency means having suitable and sufficient knowledge, qualifications and experience in the fields that caregivers work in. This enables them to understand the hazards and risks involved with the work, the operating environment, and the type of people they need to work with. They would have sufficient training to be able to communicate the results of their assessment to all necessary persons (in writing if necessary) in a clear, understandable and comprehensive manner. Improvement in competencies of the caregiver can be obtained through communication and support, in order to strengthen their competencies and teach them new skills that will enhance patient safety.

Certain interventions need to be applied. Firstly, an intervention programme can support the caregiver and client thereby directly reducing caregiver distress and the overall impact on their health and well-being. In this intervention approach, the caregiver is the recipient of the direct benefit and the patient can benefit from it. Secondly, intervention programme can be aimed towards assisting the caregiver to become more competent and confident, thereby providing safe and effective care to

the patient, which can indirectly reduce caregiver distress by reducing their load or increasing their sense of certainty and control (Sorensen, Pinquart, Duberstein, 2002). According to Reinhard, Given, Peplic & Bemis, (2008) caregivers often feel unprepared to provide care owing to the fact that they have inadequate knowledge to deliver proper care, and receive little guidance from the formal health care providers.

Biological aging begins at least as early as puberty and is a continuous process throughout adult life. Economically, the elderly are sometimes defined in terms of retirement from the workforce and, chronologically, age has long been used as an indicator of expected residual life span. In 1980, the United Nations defined 60 years as the age of transition of the 'elderly' phase (World Health Organization, 2004). Ageing is a normal human phenomenon surrounded by myths, including the beliefs that ageing is a time of tranquillity, is synonymous with senility, and is marked by reduced productivity and resistance to change.

The structural and functional changes with advancing years are termed the 'ageing processes'. The theories of ageing according to gerontologists include the loss of irreplaceable cells, the production of unsound cells, and limited capacity for division and accumulation of waste products. Owing to structural changes, many of the organs become smaller, with only the prostate increasing in size. The ageing process also sets in faster in the lungs of a chronic smoker (Clarke, 2008).

The ageing process creates many challenges for society and the number of elderly persons is increasing. The problem of an increasing aged population is highlighted by the World Health Organization, which estimates that today worldwide there are around 600 million persons aged 60 years and over, by the year 2025, this total will

double and will reach virtually two billion by 2050- the vast majority of them in the developing world. (World Health Organization, 2002).

Some authors predict that, by 2030, the elderly population throughout the world will increase to 973 million, and the number of older adults will be more than triple in developing countries, which will account for 71% of the world's elderly population. According to You, Deans, Lui, Zhang and Zhang, (2004), China has the largest elderly population in the world. The number of centenarians (people over 100 years of age) is expected to increase fifteen fold by 2050 to 2.2 million persons worldwide; in 2005 there were already 300 to 450 'super centenarians'.

Since 1970, the median age of the United States population has been rising and is expected to rise into the mid 21st century. A recent trend is "counter migration", which supports the importance of family caregivers. Some elderly people, who moved to old age homes, have moved back into their children's homes again Cicirelli, (1983) (in Elliott and Rivera, 2003).

Statistics in Namibia show that in 2001 there were 122,195 elderly people. The Khomas Region, incorporating Windhoek as the capital city, included 8858 elderly people, which represented 7.2% of all elderly people in Namibia, according to the National Planning Commission (2001).

According to Gorman (2006), increased ageing of the developed population constitutes a difficult situation because the ageing process is a biological reality. Accordingly, more people are reaching old age and more are suffering from chronic diseases, are becoming seriously handicapped and disabled, and are no longer

productive and, hence, become a mounting burden on the community and the younger generation who already live in very stressful times. Dima, (2001) find that Windhoek have five (5) old age homes that are either privately owned or owned by church organizations. To care for the dependent aged proper resources are needed in the form of caregivers as well as proper equipment and special materials.

Apart from disability there are also physiological changes, which include deterioration of the ability to sense external stimuli. Consequently, sight, hearing, taste and feeling are often affected and can lead to fatal accidents like overdosing on tablets, falling and burning. The presence of caregivers is therefore essential in order to avoid this. Hogstel & Curry, (2001) (in Rakel, 2007) suggest that caregivers in old age homes should note whether signs of neglect, physical and psychological abuse are present, when doing assessments or providing care to the aged. It is estimated that 2 million older Americans are abused annually. In this country as elsewhere this problem still remains hidden to public, as well as professionals Murray & Zentner, (1997) (in White, 2000).

Ageing also affects the kidneys and heart and results in chronic diseases like hypertension, diabetes mellitus, arthritis and osteoporosis Tanner, (2004). These diseases require regular follow up and prolonged treatment, as well as skilful caregivers to look out for signs of side-effects or toxicity (Clarke, 2008). A study done in 2004 among elderly people in an Irish community revealed that 86% of the elderly received at least three or more drugs for at least one of the nine chronic conditions. These include cardiovascular diseases (72%); central nervous system for example dementia (37%); musculo-skeletal conditions (28%); upper gastrointestinal

diseases (24%); respiratory diseases (14%); diabetes, thyroid and glaucoma (5–8%); and cancer therapy (4%) (Naughton, Bennett & Feely, 2006). Chronic diseases can have an intense impact on the health and quality of life of the elderly (Common chronic conditions in ageing at home, 2010).

The elderly are also prone to bladder cancer and incontinence. Subsequently, the intake and output of fluids need to be measured and compared daily to prevent kidney failure. According to Clark (2008), fecal impaction or severe constipation can also be one of the problems of the elderly.

Furthermore, the elderly often experience limitations in mobility. Factors affecting mobility include deterioration of cognitive, sensory, cardio-vascular, neurological and muscular-skeletal systems. This leads to lowered self-esteem, mood changes, and depression (Clark, 2008).

Apart from the physiological changes, there are also mental health problems. Mental health is as important as physical health in old age. Owing to the progressive loss of neurons in the brain, the brain of a 70-year-old person weighs only 56% of its original weight. One result of this is depression. Elderly people suffering from depression are faced with feelings of apathy, loss of interest in life, worry and agitation, as well as anxiety. Moreover, appetite loss, loss of weight, sleeplessness, constipation, memory loss and loneliness are also encountered. These clients may have had a negative attitude throughout life with the result that caring offered by the caregiver is made very difficult. Elderly people are also prone to suicidal thoughts and needs counselling and antidepressant medication (Common ailments in the elderly, 2008). These clients need to be kept under observation, which add to the

caregiver's burden.

Memory loss owing to the deterioration of the brain cells, as mentioned above, is another psychological problem stated by Hattingh, Van der Merwe, Van Rensburg, & Dreyer, (1996) (in Videbeck, 2010). The consequences of memory loss may be serious, for example, adding too much salt in the preparation of food, forgetting appointments and not being able to remember family members. Memory loss can be indicative of a condition known as Alzheimer's disease, as well as Dementia which manifests itself in memory loss and lack of orientation, leading to confusion and wandering aimlessly, and difficulties with mental functions, such as calculations (Dementia behaviour health advisor 2007). This disease has four stages and, during the final stage, the elderly will be bedridden and will require complete care (Define Alzheimer disease, 2007).

Dementia can be the result of Alzheimer's disease. The loss of cognitive function, as mentioned above, is primarily as a result of dementia. Subsequently, the elderly lose their intellectual functioning including memory, problem-solving ability and judgement Garand, Buckwalter & Hall, (2000) (in Fitzpatrick, 2006). In a study conducted by (Hortiana, Fahlström & Ahlstrom , 2010) titled "Experiences of relocation in dementia care from the perspectives of six caregivers", it was concluded that, from a caregiving perspective, relocation is a complex process with conflicting values and practical issues that hinder the provision of good care and security.

Furthermore, the elderly usually experience social problems as well. The main problems are classified as financial, transport and adequate housing. These factors affect the ego of the aged. Dube, (2010) find that more than 15 elderly from

Mpumalange, who left their homes for home-based care, hoping for a better life, are now living in poverty. Financial problems usually result in a lack of food, among other things, with the result that the nutritional needs of the elderly person cannot be met. In a study conducted by Söderhamm, Christenson, Idvall, Johansson and Lindström (2010) on factors associated with nutritional risk in the 75-year olds in the community, it was found that 1% of participants had a high risk of malnutrition, 21.3% a medium risk and 77.7% a low risk. Medium or high risk was predicted by living alone – this impaired perceived health. It was also indicated that malnutrition in the elderly is known to contribute to poor health.

In another study conducted by De Oliveira and Leandro-Merhi (2010) on the food intake and nutritional status of hospitalised older people, it was concluded that deterioration of the nutritional status of older people is accompanied by a reduction in energy and nutrient intake. The investigation of food intake in older people could provide important information about nutritional risk.

According to Watson (2004), caring for the elderly and listening attentively to what they say about themselves and their varied health situations, especially in relation to quality of life and peace of mind, body and soul, are important matters to persons aligned with caring for the elderly.

As a result of all these factors influencing the elderly, great demands are made on health care resources, services and personnel. Specially trained caregivers are a necessity in the care for the elderly, since ageing is accompanied by many changes on a physiological, social and psychological level (Clarke, 2008).

This is also emphasised by Gorman (2006), who indicates that, in the future, more people will need to be trained and educated to care for the elderly. They will have to be flexible and adaptable, because not all elderly people are fortunate enough to be accommodated in old age homes or similar institutions. Many stay with families, surrounded by their communities. In addition, many elderly people live in intolerable conditions, as they have no one to look after them. As stated previously, the elderly become a mounting burden to the community and the younger generation who already live in very stressful times (Gorman, 2006).

Owing to the physiological, psychological and social problems experienced by the elderly they become a burden to their families in the sense that family members are not able to cope with caring for them. The next step then, is that the family opts for home-based care or institutionalisation. Although these options may relieve much of the burden on families, there are challenges.

## **1.2 PROBLEM STATEMENT**

Caring for the elderly has a long history both in developing and developed countries. Over the past decade the phenomenon of the ageing process and caring for the elderly has been developed and extended to include a range of activities that could be executed in this regard.

Usually the elderly are cared for by family members and friends or are admitted to institutions where they are cared for. However, the literature mentions that elderly people are in some instances seriously neglected and abused all over the world and

Namibia is no exception (Murray & Zentner, (1997) (in Pederson, 2010).

Furthermore, there is the perception that when the elderly are admitted to institutions such as old age homes they are well cared for. In Namibia an article was published in a local newspaper which reflects the concerns and doubts of the skills and knowledge of caregivers of the family of an elderly person cared for in an old age home. The article draws attention to caregivers who, it is said, were unable to diagnose or identify a fractured leg (femur), which resulted in an elderly person's death. This incident and similar occurrences justify an investigation, evaluation and study of this issue (*Die Republikein*, July 2002).

What is cited in the literature is a narrow vision of caring for the elderly, which emphasises caring by well-informed family members or institutions by well-trained and educated nurses.

An extended view should have included many factors that influence the quality of caring for the elderly, such as lay and untrained people who must care for such people in old age homes, and the circumstances under which they must do it.

In Namibia, Bösl & Diescho, (2009) and Ministry of Health and social Services Patient charter, (1998) emphasized that care for the elderly is posited in the Namibian Constitution as one way of alleviating negligence, abuse and socioeconomic factors. The section on fundamental rights in the Constitution includes the following, which are relevant to the elderly–caregiver relationship:

The protection of life – providing safe quality care

The protection of liberty

Respect for human dignity, equality and freedom from discrimination

The right to privacy (Government Notice of 1999. No. 2040 the Republic of Namibia).

Once moved into an institution for the elderly, the issue of caring for the elderly with all their problems frequently becomes a challenge. Financial constraints often result in old age homes experiencing difficulties in the appointment of well-trained geriatric nurses. It should be stated here that caring for the elderly is a specialised field. However, many of the people who are appointed to such positions have little or no training. Furthermore, as a result of staff shortages, they are unable to attend in-service education or training opportunities to improve their knowledge and skills (Clarke, 2008).

A possible solution to this problem is to provide formal training and education for these caregivers. Caring for the elderly is risk-laden therefore this type of work should be done by persons who have the insight, knowledge, skill and integrity to act responsibly and humanely so that the elderly person is safe in their care at all times (Clarke, 2008). Ageing is a time of increased problems and decreased resources for dealing with them.

Windhoek has five old age homes, including Rehoboth, where this study was conducted. These institutions are either privately owned or owned by church organisations. Together these old age homes cater for 341 elderly people, some of whom need more care than others, in the sense that they are unable to meet all their

basic needs independently. The staff complement of these old age homes is 64 (July 2006), which, by implication, means that there are sometimes one to three registered nurses in charge, but the real caring is done by lay workers. Although the lay workers are given some orientation to the work, there is no formal education programme according to which they can obtain in-service education. The question that should be asked here is: “How competent the appointed lay people, who are carers for the elderly in old age homes, but lack the opportunity for training and improving their knowledge and skills, in delivering care to the elderly.”

Elderly people need special care. The problem is that, in old age homes in Namibia, it is not clear how effective the care given to the elderly is. Furthermore, it is not known what knowledge and skills the caregivers have with regard to caring for the elderly. This prompted the researcher to conduct a study in this regard.

### **1.3 THE PURPOSE OF THE STUDY**

The purpose of the study was to develop, implement and evaluate a practice - oriented training programme for caregivers of the elderly in old age homes in Windhoek and Rehoboth.

### **1.4 OBJECTIVES OF THE STUDY**

The objectives’ of the study include the following:

- to explore and describe the experiences of the elderly in respect of the daily care they receive

- to explore and describe the experiences of the caregivers in respect of caring for the elderly
- to assess the learning needs and support of caregivers in the provision of health care to the elderly
- to develop a conceptual framework and an educational programme for caregivers of the elderly
- to implement and evaluate an educational programme for caregivers in old age homes in Windhoek

### **1.5 SIGNIFICANCE OF THE STUDY**

The researcher envisaged that the study would make a useful and important contribution to existing knowledge and practice in the following areas:

- Managers in old age homes will become more competitive within their field, as they will have more confidence in their caregivers, trusting that the right procedures will be followed in the care of the elderly.
- Caregivers caring for the elderly in old age homes will feel more self-confident, motivated, organised and responsible in terms of taking care of the elderly.
- The elderly people in old age homes will have more faith in their caregivers and the managers, in view of the fact that caregivers are following a

programme that is designed to take care of their needs.

- In terms of future research, the development of measuring instruments to determine the competence of caregivers is important.

All human beings grow older; accordingly it is a fundamental human right that the quality of life of the elderly should be sustained through (among other things), respect for human dignity, equality and freedom from discrimination, as well as the right to privacy and the protection of life.

This can only be made possible if a culture of awareness and sensitivity towards the needs of the elderly, as well as their caregivers, is cultivated at an early stage to prevent deviations early. Caregivers need to be equipped and trained in order to realise the objective of ensuring the quality of life of the elderly. The needs of caregivers seem to have been neglected for far too long, mainly in the form of clear guidelines and adequate training.

This study will assess the precise nature of the problems experienced by the elderly, as well as the problems relating to the health care rendered to the elderly in old age homes. The results of this assessment will enable the researcher to draft and develop an educational programme for the caregivers of the elderly.

The educational programme could contribute to the improvement of health care in general for all elderly persons in Namibia and specifically at institutions (old age homes) where the elderly are cared for. According to the findings of Ipinge and Le Beau (1997) (in Dima, 2001), there is a shortage of information and research on the elderly in Namibia. Accordingly, it is expected that this study will make a valuable

contribution to caregivers in general and, more importantly, to the elderly of Namibia.

For new and experienced caregivers of the elderly in old age homes, the implementation of this programme will involve in-service training aimed at providing knowledge and skills. This will provide them with a sense of empowerment and a sense of pride in their work, as their status as caregivers will be improved. Subsequently, a change in attitude towards caring for the elderly and increased motivation to provide high quality care should be evident. For the elderly, an obvious improvement in their health needs, which is a basic human need, will be the result. This will provide a sound basis for the fulfilment of other needs of the elderly as well.

## **1.6 PARADIGMATIC PERSPECTIVE OF THE STUDY**

A paradigm can be described as a worldview; a worldview is a particular way of thinking about the world as one experience it or the belief system that an individual habitually applies to make sense of the complexities of the real world (Polit & Hungler, 2006).

Neuman (2000) (in Picard, Jones, 2005) describes a paradigm as a general framework that includes basic assumptions, major questions to be answered, models of good research practice and theory, and finding answers to these questions.

Furthermore, paradigms are essential for making sense of epistemology, ontology

and the philosophy of science, because they are theoretically explanatory constructs that illuminate our fundamental assumptions about the nature of reality Patton, (2002) (in Bringle, Hatcher & Jones 2010).

### **1.6.1 Theoretical-conceptual assumptions**

Theoretical-conceptual assumptions denote commitments to or belief in the truth of the theories and laws in terms of which a particular paradigm is constructed (Mouton & Marais, (1990) (in Mashele, 2009). Also, qualitative researchers are particularly interested in understanding the meanings inherent in the phenomena that are investigated, which, in this study, is caring for the elderly by caregivers. Participants can explain how they arrive at their meanings and how these meanings influence their daily lives (Mirriam, 2002; Polit & Beck, 2004). The assumption made is that although people are old and have been admitted to institutions they have the right to quality care in the sense that they are still worthy human beings.

#### **1.6.1.1 Methodological technical assumptions**

According to Mouton (1996) (in Mamabolo, 2009), methodological technical assumptions describe the nature of the research process and the most appropriate methods for carrying out the research project. It can be assumed that the phenomenological interpretive method is eminently suitable for shedding light on the meaning of the experiences of the caregivers and the elderly in caring for the elderly. This method includes individual dialogical engagement between the participants and

the researcher. Uys and Basson, (2000); Stacks & Salwen, (2008) stated that research includes all the decisions in respect of the formulation of the problem, the research design, strategies and techniques.

#### **1.6.1.2 Ontological assumptions**

Ontological assumptions are implicit in our understanding of human nature, society, the status of mental entities, the meaning of obstacles, causality and intentionality in human behaviour Mouton, (1996) (in Mamabolo, 2009). By implication this means reality in life. Polit and Hungler (2006) describe reality as multiple, subjective and mentally constructed by individuals; thus reality arises out of each individual's perceptions of their experiences. In this study it applied to the elderly in terms of how they experienced the care given to them, and the caregivers in terms of how they experienced caring for the elderly.

According to Watson (1985) (in Fitzpatrick & Whall, 2005), caring has existed in every society. There are always people to care for. A caring attitude is not transmitted from generation to generation by genes: it is transmitted by culture or as a unique way of coping with a situation.

#### **1.6.1.3 Axiological assumption**

Axiology is the study of being and influences the way people view themselves in their relationships with others. In this regard values play an important role (Polit & Beck, 2004). A value is an idea shared by people in society about what is good and

bad, right and wrong, desirable and undesirable. Accordingly, values shape the ideas and goals of a society.

Caregivers and the elderly possess their own unique values and these values are the fundamental core around which interpersonal relationships develop. It is therefore important that this be taken into consideration in efforts to develop sound relationships.

When the elderly are admitted to an institution it makes them more vulnerable because they are now in a new environment which can confuse them and make them very unhappy. Therefore, there should be an understanding and commitment from caregivers to assist the elderly in this regard as far as possible Popenoe, Cunningham, & Boulton, (1998) (in Anderson, 2006).

In traditional African culture, an important value is respect for the elderly, which is reflected in various customs, such as taking care of the elderly and addressing them in a specific manner. The African value of *ubuntu*, a sense of oneness with those around one, and the value of community involvement, rather than individuality, are also relevant and would be expected to guide the behaviour of caregivers.

However, factors that prevent family members from taking care of their elders include the phenomenon of an increase in the number of widows and widowers and the fact that the elderly often no longer belong to a family. In addition, the high cost of living that makes it necessary for both husbands and wives to work, which also reduces the availability of caregivers for the elderly of a family.

#### **1.6.1.5 Epistemological assumption**

According to Polit and Beck (2004), an epistemological assumption questions the relationship between the enquirer and what is being studied. Hence, epistemological claims are philosophies or theories about how and what phenomena may be known.

In this study, the researcher does not have knowledge of the experiences of the elderly or how they are cared for by caregivers. Therefore, in-depth interviews were conducted with the elderly and the caregivers in order to obtain answers. The truth lies in the constructed reality, and can thus be generated from the elderly and the caregivers (McNiff & Whitehead, 2009).

During the research process, the researcher kept a distance between herself and the research participants (the elderly and the caregivers) so as to obtain their real experiences in this regard. The voices and interpretations of the participants are, therefore, key to understanding the phenomena in this study, namely the experiences of the elderly and caregivers.

#### **1.6.1.6 Philosophical basis of the study**

For this study, a phenomenological interpretive method was used together with a naturalistic inquiry approach. The phenomenological interpretive method describes the meaning of the caring relationship between the elderly and their caregiver (Berg Skott & Danielson, 2006). For the naturalistic inquirer, reality exists within a context and many constructs are possible (Polit & Hungler, 2006). For the naturalistic inquirer, reality is not a fixed entity, but rather a construction of the individual's

participation in the research. This is called constructivism. Constructivists therefore pay careful attention to the multiple realities that are constructed by individual people and to the consequences of such construction (Patton, 2002) (in McMahon & Patton, 2006).

This philosophy was appropriate to serve as a basis for this study and entails the following assumptions: Both the elderly person and the caregiver exist in society and are exposed to many processes, which influence their behaviour. The elderly and the caregivers have the freedom to make choices about their lives and the care they want and will give.

The events in caring experienced by the elderly and the caregivers can be regarded as a personal reality which they construct themselves. The method that the researcher adopted for this study was dialogical engagement (interviews) with the elderly and the caregivers. This placed the researcher in a position from which she could report truthfully on the information that was obtained.

## **1.7 THEORIES**

### **1.7.1 Watson's philosophy and theory of human caring**

This study is based on certain aspects of Watson's Theory of Carative Factors. This theory was selected because, according to Watson, human caring is related to inter-subjective human responses to health, illness, environment, personal interaction, self-knowledge and knowledge of one's power and limitations (Watson, 1985) (in Fitzpatrick & Whall, 2005). In caring for the elderly these aspects are of the utmost

importance.

Furthermore, Watson's portrait of caring reflects aspects of existential phenomenology, spiritual influences and value systems. These can be summarised as

- a spiritual dimension of life
- capacity for growth and change
- a deep respect for the person and human life
- The importance of an effective interpersonal relationship between patient and caregiver Watson, (1985) (in Fitzpatrick & Whall, 2005).

The human caring process consists of ten carative factors which give meaning to the structure. These are discussed on page 179 - 183 of chapter 5.

### **1.7.2 Conceptual framework**

According to Burns and Grove (2005), a conceptual model can be defined as a set of highly abstract logical structures that broadly explains phenomena of interest, expresses assumptions and reflects a philosophical stance, to link findings to the body of knowledge of nursing. According to Fawcett (1991) (in Burns & Grove, (2005) an organised programme of research is important for building a body of knowledge related to the phenomena. Moreover, Woodgate (1999) (in Norlyk, 2010) maintains that developing a framework for qualitative studies is more philosophical than theoretical.

For this study, Dickoff, James and Wiedenbach's (1968) practice-orientated theory

was applied to conceptualise the findings. The aspects of the activity correspond to the six questions or six ways of looking at one thing. The reasoning map of practice-orientated theory asks the following questions:

- Who or what performs the activity?
- Who or what is the recipient of the activity?
- In what context is the activity performed?
- What is the end point of the activity?
- What is the guiding procedure, technique or protocol of the activity?
- What is the energy source for the activity whether chemical, physical, biological, mechanical, psychology? (See chapter 4.)

### **1.7.3 Knowles' informal adult education**

Knowles' notions of informal adult education, self-direction and andragogy were applied in order to develop a support programme for caregivers of the elderly (see page 186). Caregivers of the elderly are adults. The word adult is defined as a person who is fully grown and developed (Hornby, 2006), while education refers to the process by which a person learns at school or a similar institution. This is discussed on page 186 in chapter 5.

## 1.8 OPERATIONAL DEFINITIONS

### *Caring*

The elderly population is growing, and these people need assistance and care in a healthy and safe environment. The elderly face a broad range of medical and physical needs that require assistance and supervision on a temporary or full-time basis, depending on their circumstances.

There are many reasons why the elderly may be in need of care, for example, if an elderly person suffers a medical illness, such as a stroke or a diagnosis of dementia or Alzheimer's disease, he/she may need assistance and care. This could take the form of a combination of in-patient or physician care and home or institutional-based care. The elderly person may be treated in a hospital or at a clinic, then sent home or back to old age homes to be assisted by caregivers. As an example, elderly people who are prone to skin breakdown may require wound care, consequently, caregivers would need to observe the integrity of the elderly person's skin and monitor the way in which the wounds are healing. Some elderly people need round-the-clock care because they can no longer care for themselves (Boehlke, 2001).

The concept of "caring" is the rubric or the frame within which all caring activities occur. These activities should be moral and centred on the wellbeing of humans Bandman & Bandman, (1995) (in Khosravani, Manoochehri, Memarian, 2005).

Roach (in Smith & Godfrey, 2002) describes 5c's of caring as the following: compassion, competence, confidence, conscience and commitment which are needed for every carer. Pusari, (1998) added another 3c's for caring as courage, culture and

communication. This is to render a holistic care which encompasses physical, psychological, emotional, spiritual and cultural aspects. A study was done on 77 Hong Kong student nurses. A study done by Auther, Pang, & Wong, (2011) highlighted compassion and competence as their major features and it suggested that methodological problems may have inhibited a deeper analysis of their caring attributes and behaviour.

Benner and Wrubel (cited in Clark, 2008) indicate that the term “caring” refers to and means persons, events, projects and all the things that matter to people. Caring covers a range of involvements, from romantic love to parental love, to friendships, to caring for one’s patients. Caring entails assertive, supportive or facilitative actions towards another person or group with evident or anticipated needs, in order to ameliorate a human condition or way of life (Clark, 2008).

Although caregivers are not always nurses, it is worth mentioning that nursing is a moral activity that constitutes the act of doing well to patients and avoiding harm Bandman & Bandman, (1995) (in Khosravani, Manoochehri, Memarian, 2005). This can be extrapolated to all caregivers as a guideline for their activities.

### *Caregiver*

The Encarta dictionary (nd 2009) defines a caregiver as somebody who has the principal responsibility of caring for a person. Accordingly, a caregiver or carer is someone who provides assistance to another person who cannot live fully independently owing to physical, psychological or mental disability. Caregivers may have duties which are fairly light, such as stopping by someone's house every few

days to tidy up, or the duties may be more involved, such as living with someone to provide constant assistance with a variety of tasks. Both volunteer and paid caregivers work all over the world (Goodheart, 2010).

A caregiver is somebody who is either employed or who voluntarily cares for elderly people. Clarke (2008) stated that the role of the caregiver involves the application of the principles of caring at any level of care. It includes the family, group or community and includes assessing needs, planning appropriate caring interventions, implementing a plan for care and evaluating care. Videbeck, (2010) stated that caregivers can be family members, friends, social workers or nurses. These authors also state that caregivers can be of three types:

Trained caregivers who are compensated to take care of the elderly.

Caregivers who voluntarily offer their services and belongs to an organisation.

Family members who takes on the role of caregivers.

Carter, (2010) stipulates that caregivers need to perform the following functions: shopping, housecleaning, cooking, paying bills, giving medication, toileting, bathing, dressing and helping with eating.

The caregivers in this study worked in the five old age homes in Windhoek and Rehoboth. Rehoboth had two old age homes of which one was used for pilot study. All but one of the caregivers was women. The age group of the caregivers ranged from 21 (1 caregiver) to 63. All the caregivers in the study earn a salary.

### ***Competency***

The National Training Organisation describes competence as: ‘a combination of knowledge, skills and practical experience which a person has to have to be able to do a particular task properly. This includes not only the routine task, but also covers unexpected situations and changes’ (Healthy hand Safety, 2011)

### ***Quality care***

According to Aspden, Corrigan & Wollcott, (2004) many view quality health care as an overarching umbrella under which patient safety resides. The institute of medicine define quality as “The degree to which health services for individuals and population increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Pratt, 2007). Quality health focused on the following positive indicators: achievement of appropriate self- care, demonstration of health-promoting behaviours, health-related quality life, perception of being well cared for, and symptom management (Mitchell & Lang, 2004). The Committee of the Quality of Health Care in America, (2001) identify the components of quality care which is the foundation upon which all other aspects of quality care are build as follows: quality care is safe, effective, patient centered, timely, efficient, and equitable.

### ***Elderly***

The ageing process is of course a biological reality, which has its own dynamics, largely beyond human control. However, it is also subject to the constructions by

which each society makes sense of old age. In the developed world, chronological time plays a paramount role. The age of 60 or 65, roughly equivalent to retirement age, in most developed countries is said to be the beginning of old age. In many parts of the developing world, chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant such as the roles assigned to older people. In some cases it is the loss of roles accompanying physical changes, which is significant in defining old age. Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active contribution is no longer possible (Gorman, 2006).

The more traditional African definitions of an elder or “elderly” person correlate with the chronological ages of 50 to 65 years, depending on the setting, the region and the country. Adding to the difficulty of establishing a definition, actual birthdates are quite often unknown because many individuals in Africa do not have an official record of their birthdates (Gorman, 2006).

The Older Persons Act No.13 of 2006 of South Africa states that a male is an aged person at 65 years of age and a female at 60 years. The *Encarta Dictionary* (2009) explains an elderly person as someone past middle age and approaching the later stages of life.

“Elderly” is a term that is used for old – old, elderly, or very old. Burbank, (2006) defines “frail” as a state that occurs in people who are not strong; not robust/strong; needing assistance, and who are morally weak. The Vicon project (2010) explains old as somebody in a physically weakened state and vulnerable to injury. Similarly to

other periods in life; childhood and adolescence for example, it is impossible to have an absolute chronological definition

### ***Programme***

Thompson (1998) (in Kraska, 2008) defines a programme as a list of events. Hornby (2006), on the other hand, defines a programme as a plan of things that will be done that is organised into a set of instructions that control the operation or functions. The Vicon project (2010) explains a programme as a plan of action for achieving something. In this study, a programme will be developed to assist caregivers in rendering improved service to elderly persons.

### ***Old age home***

An old age home is an institution where 24-hour care for residents is provided by church organisations, social services, voluntary organisations and private individuals. The elderly may have their own rooms or they may share, and they might require help with bathing, washing, toileting and eating Stoye, (1992) (in Dolon & Holt, 2000).

## **1.9 DIVISION OF CHAPTERS**

- Chapter 1: Overview and rationale
- Chapter 2: Research design and method
- Chapter 3: Results of interviews
- Chapter 4: Conceptual framework
- Chapter 5: Development of an educational programme
- Chapter 6: Implementation and evaluation of the educational programme
- Chapter 7: Conclusion, recommendations and limitations

## **1.10 SUMMARY**

This chapter gave the background of and the rationale for the study. This was followed by an explanation of the problem statement, the purpose of the study, the objectives and the significance of the study. Chapter 1 of the study also contained the paradigmatic perspectives on the meta-theoretical assumptions and the operational definitions that are used in this study. In the following chapter the research methodology will be discussed.

## **CHAPTER 2**

### **RESEARCH DESIGN AND METHODS**

#### **2.1 INTRODUCTION**

In the first chapter, an overview of the research was given and the research problem that led to this study was discussed. In chapter 2 the research design and method that will be applied in order to address the research problem will be discussed. In addition, ethical consideration and aspects of trustworthiness as applied to the current study will be explained.

##### **2.1.1 Purpose of the study**

The overall purpose of the study was to develop, implement and evaluate an educational practice- orientated training programme for caregivers of the elderly in old age homes in Windhoek and Rehoboth.

#### **2.2 RESEARCH DESIGN**

The research design forms a broad overall approach in the execution of the research so as to accomplish the objectives (Saks & Allsop, 2008). Therefore, the research design is defined as a set of guidelines and instructions to be followed when addressing a research problem. Thus, the main function of the research design is to enable the researcher to anticipate what the appropriate decisions should be in order

to maximise the trustworthiness of the eventual results (Burns & Grove, 2005). The research design that was selected for this study was qualitative, exploratory, descriptive, contextual and phenomenological in nature.

The research design of this study is aligned to the processes of programme development, including situational analysis, programme implementation and programme evaluation (Cresswell, 2005).

### **2.2.1 Phenomenology**

A phenomenological approach focuses on exploring the way that human beings make sense of experiences and transform experiences into consciousness. Consciousness is the only access human beings have to the world. Thus, phenomenology aims at gaining a deeper understanding of the nature or meaning of the everyday experiences of people. In this study, the experiences of the caregivers in terms of caring for the elderly, and how the elderly experience the caring that caregivers provide to them (Byrne, 2001) (in Taylor & Kermode, 2006) are explored.

The researcher agrees with the notion that phenomenological theory attempts to understand human beings in their everyday life, living in a world of relationships with other people, as well as living in their own world (Handbook of Phenomenological Aesthetics, 2010).

### **2.2.2 Qualitative research design**

A qualitative research approach was selected for this study, as this is a means of exploring the depth, richness and complexity inherent in a phenomenon. According to Jackson *et al.* (cited in Schneider, Elliott, Wood & Haber, 2003), qualitative research is a broad term used to describe research that is focused on human experience and it involves close contact between the researcher and the participants.

Qualitative methods are particularly useful when describing a phenomenon from the “emic” perspective, that is, the perspective or point of view of the participants (De Vos, 2002) (in Gibson, 2010). This perspective will enable the researcher to explore, describe and understand the phenomenon as a whole (Burns & Grove, 2005). In this study caring for the elderly by caregivers was explored in selected institutions. For this study qualitative design was chosen instead of quantitative design in order to obtain caring experiences from the caregivers and receivers. To understand the phenomenon about which little is known; and to gain more indepth information that may be difficult to convey quantitatively (Silverman, 2009).

### **2.2.3 Exploratory research design**

During exploratory studies, new data were collected and new hypotheses are developed to explain these data in a field where previously not much research has been done (Stebbins, 2001) (in Jupp, 2006). In the research field addressed by the current study, very little research has been done on caring for the elderly by caregivers in selected institutions in Namibia, specifically the experiences of the

elderly in this regard, as well as the needs of caregivers in these situations. According to Neuman (2000) (in Sibula, 2009) an exploratory design may be the first stage in a sequence of studies on a specific problem.

An exploratory design for this study was appropriate because it gave the researcher the opportunity to investigate the relationship between phenomena (experiences of the elderly and the caregivers) and to present the results in the form of an educational programme Mouton, (2001) (in Mabuda, 2009) In exploratory research it is critical that the researcher describe “how” and “where” research will be conducted Terre Blanche & Durrheim, (1999) (in Maluleke, 2008).

#### **2.2.4 Descriptive research design**

A descriptive design aims at obtaining more information about a specific field in order to provide insight into a situation as it naturally happens and it can be applied very effectively in programme development (Burns & Grove, 2005). The aim is to accurately and cautiously describe a phenomenon (Bless & Higson-Smith, 2000) (in Models in Research Process, 2007) primarily describing the phenomenon rather than explaining it (During this study the following phenomena will be described:

- The experiences of the elderly concerning the care they received from caregivers.
- The experiences and needs of caregivers while caring for the elderly.
- An educational programme to strengthen aspects of caring for the elderly.

### **2.2.5 Contextual research design**

In a contextual study design, phenomena are studied and described in relation to their specific contextual meaning Mouton, (2001) (in Notshe, 2007). The researcher acknowledges the context in which the research takes place in order to understand the surrounding dynamics and systems (Holtzblatt, Wendell, & Wood, (2005); Terre Blanche & Durrheim, (1999) (in Timm, 2009). In order for this study to be relevant and applicable in practice, the research was conducted in the context of selected old age homes in Windhoek.

### **2.3 LOGIC OF RESEARCH AND REASONING STRATEGIES**

Logic can be defined as the study of the methods and principles used to distinguish well from bad reasoning. Johnson and Weber (2001) (in Wasieleski, 2009) explain that reasoning enables a person to use knowledge to answer questions, solve problems and describe and explain phenomena by identifying and relating concepts, as well as by understanding, explaining, influencing and controlling propositions, variables and assumptions.

In order to derive at logical assumptions during a study it is important to make use of good and correct reasoning to validate the research findings. Therefore, the following established reasoning strategies were used during the research.

### **2.3.1 Deductive reasoning**

Burns and Grove, (2005) and Babbie, (2001) (in Botha, 2008) explain deductive reasoning as moving from a general premise to a particular situation or conclusion. Accordingly, deductive reasoning starts from the information that the researcher collects from themes and extractions from the inter experience.

According to Johnson and Weber (2001) (in CH YU, 2005) deductive reasoning enables a person to apply theories, laws, principles and known facts in order to explain other related phenomena therefore moving from general knowledge to specific knowledge. Botes, (2001) (in Nursing theories a companion to nursing theories and models, 2011) explains that deductive reasoning is used to identify and link concepts through a literature review. In this study a literature control was conducted in order to explore all phenomena with regard to aspects concerning caring for the elderly and the experiences and needs of caregivers.

### **2.3.2 Inductive reasoning**

Inductive reasoning can be defined as moving from specific observation to broader or general concepts, whereby particular instances are observed and then combined into a larger whole (Burns & Grove, 2005: Shank, 2004). It is also defined as a set of specific observations used to discover patterns that give some degree of order among events Babbie, (2001) (in Botha, 2008).

Inductive logic was used to find out the experiences, ideas and feelings of the elderly and their caregivers regarding caring for elderly people (Chinn & Kramer, 2004).

Thus, inductive reasoning draws conclusions about objects or events. In this study, inductive reasoning helped to apply the information gathered from interviews and focus groups discussions in identifying the themes for the development of the educational programme, Wheeldon & Ahlberg (2011).

### **2.3.3 Analysis**

According to, Denzin & Lincoln, (2005) analysis includes both a qualitative component such as thematically and content analysis as well as quantitative or statistical analysis. In this study a thematic and a content analysis were carried out during the literature control as well as during the development of the educational programme.

### **2.3.4 Synthesis**

Thomas & Harden, (2008) describes synthesis as the interpretation or explanation of data. It is the process of dividing concepts into categories or units that describe a phenomenon (Walker & Advant, 2005).

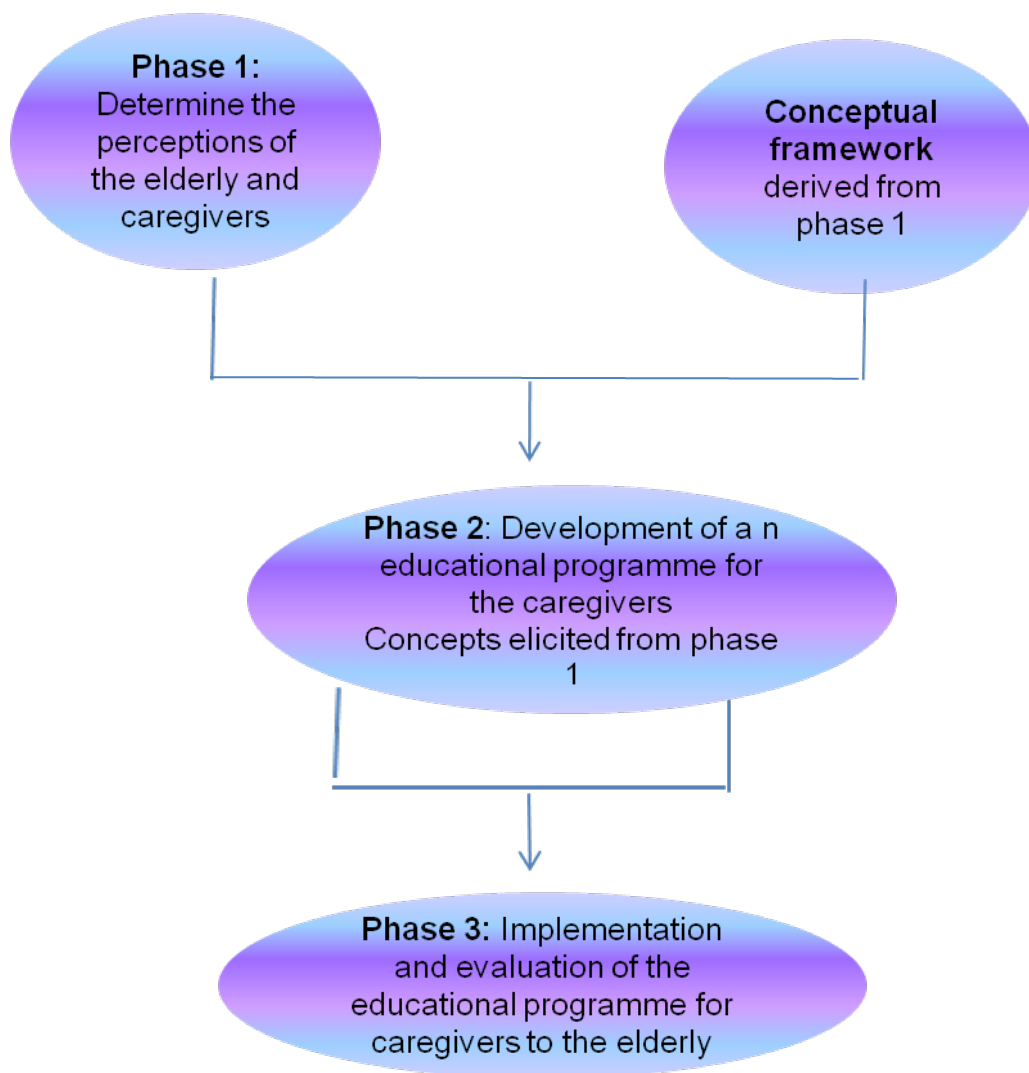
During the evaluation of the educational programme that followed its implementation, a focus group discussion was used to gather the ideas and feelings of the participants. Accordingly, new concepts were formed (Walker & Advant, 2005) and these were used to make recommendations.

## **2.4 RESEARCH METHOD**

A research method can be defined as a systematic set of techniques and procedures followed by the researcher when collecting and analysing data. Effective research

methods ensure that a research question is answered as reliably as possible, so that the objectives of the study may be achieved (Richards & Schwartz, 2002). The research method for this study was programme development and the study was conducted in three phases.

A graphical representation of the development of the phases appears of the study figure 2.1.



**Figure 2.1:** A graphical representation of the developmental phases of the study

**Phase 1**

This phase involved a situational analysis and development of a conceptual framework

**Phase 2**

This phase involved the development of an educational programme.

**Phase 3**

This phase involved the implementation and evaluation of the educational programme.

These three phases will now be explained.

**2.4.1 Phase 1: Situational analysis**

Phase 1 involved an analysis that explored and described the experiences of the elderly concerning the caring they received from caregivers, as well as how caregivers experienced caring for the elderly.

**Purpose**

The purpose of phase 1 was to determine the type of care that is provided for the elderly by caregivers in old age homes.

## **Objectives**

The objectives of this phase were to explore and describe elderly persons' experiences of the care received from caregivers to explore and describe the caregivers' experiences of caring for the elderly to determine the knowledge and skills of caregivers in the provision of care for the elderly.

### **2.4.2 Target population**

The target population for phase 1 consisted of two groups. The first group was the Elderly who are being cared for in for in the five old age homes in Windhoek and Rehoboth has two old age homes. One old age home in Rehoboth was used for the (pilot testing), which amounts to 341 elderly people. The second group consists of 64 caregivers caring for the elderly in the various old age homes.

### **2.4.3 Sampling and the sample**

Polit and Beck (2006) define sampling as the process used to select a portion of the population to represent the entire population. For this study purposive sampling was used to select the participants. Purposive sampling was appropriate because the researcher could select the most eligible participants, those with an abundance of pertinent information (Welman, Kruger & Mitchell, 2007). Furthermore, participants should have similar characteristics in order to increase the theoretical understanding of the phenomenon being studied (Burns & Grove, 2005).

Purposive sampling was also done according to the sampling criteria (see section 2.4.1.3).

**Population: 1**

The elderly who met the criteria were interviewed until the data were saturated; Data saturation was reached, after 29 elderly persons had been interviewed. Accordingly, the sample numbered 29. The reason why only twenty- nine (29) elderly people were interviewed was because the researcher collected sufficient information in terms of the five old age homes.

**Population: 2**

Twenty-six (26) caregivers were identified for the sample out of a total of 64 who were available. Data saturation was reached, after 26 caregivers had been interviewed.

Table 2.2, which follows tabulates the sample size.

**Table 2.1:** Sample size

<b>Participants</b>	<b>Population</b>	<b>Sample</b>	<b>Percentage of the population</b>
Elderly	341	29	9
Caregivers	64	26	41

### **2.4.3.1 Sampling criteria**

#### **Sampling criteria (elderly)**

The participants were selected purposively according to the following criteria:

- Participants who could speak English or Afrikaans so that the researcher could communicate effectively
- Participants who could remember past and current events and who were not suffering from severe dementia
- Participants who were willing to participate in the study

#### **Sampling criteria (caregivers)**

- Participants who could speak English or Afrikaans
- Participants who were willing to participate in the study

### **Sample**

#### **Elderly**

Purposive sampling was appropriate for this study because the elderly selected had from two months' to 20 years' experience of living in an old age home. The participants were chosen according to specific criteria (language capabilities,

integrity of mental functions as memory and willingness to participate). Initially, the sampling was conducted by requesting that managers give an indication of which participants fitted the criteria. Subsequently, informal discussions were conducted with the chosen elderly people in order to assess their ability to participate. Certain identified elderly people were unable to answer questions appropriately, thus the researcher attempted to interview additional subjects, who had not been identified by the managers, in order to attain sufficient numbers of participants to ensure data saturation. Data saturation is a state during data collection when repetition of already discovered information occurs Streubert & Carpenter, (1995) (in Bowen & Glenn 2008).

### **Caregivers**

Sampling means selecting a part of the population as representatives of that population to participate in a research project (Burns & Grove, 2005) and the caregivers for this study were selected according to specific criteria. Purposive sampling was appropriate for this study, with the participants selected having experience ranging from one to 23 years. All caregivers in the respective old age homes were selected as part of the sample, as their numbers were few. Devers and Frankil, (2000) (in Ramsey, 2010) regard purposive sampling strategies as being conducive to enhancing the understanding of selected individual's experiences, or for developing concepts.

#### **2.4.4 Pilot testing**

Pilot testing was done with elderly people and their caregivers in Rehoboth, which

has two old age homes. The other old age home in Rehoboth was used in the study. The elderly and the caregivers were selected after explaining the purpose of the research. Those who could speak English or Afrikaans as a medium of communication and who were willing to participate and, in addition, were not suffering from severe dementia were chosen. Sarantakos (2000) (in De Vos, 2011) maintains that researchers should never start the main inquiry unless confident that it will be reliable, effective and free from errors. According to Koniak-Griffen, Verzemnieks, Anderson, Brecht, Lesser and Kim (2003), a pilot study can be used to improve the quality of the research conducted and the findings need to be shared through presentation and publication.

The results of the pilot testing were positive and no problems were experienced with the elderly and the caregivers concerning the interviews conducted. After considering the questions and uncertainties, from the pilot testing the researcher went into the field.

#### **2.4.5 Data collection**

Data were collected by using in-depth interviews for both groups of participants. Data collection involves selecting subjects and gathering information from the participants in order to achieve the research objectives. In this study, the researcher was actively involved in the process of collecting data (Burns & Grove, 2005). The data collection process consists of preparing the field, conducting the interviews intended to explore the experiences of the elderly and the caregivers and taking field

notes.

#### **2.4.5.1 Preparing the field**

The researcher went to the old age homes beforehand to identify her as a researcher, arrange for specific dates and times when the interviews could be conducted, as well as to obtain the permission of the managers and the participants (elderly and caregivers) in this regard and to explain the purpose of the study (Rubin & Babbie, 2010). As some of the participants were immobile, it was arranged to interview them in their rooms. A suitable or conducive room in each old age home was arranged for interviewing the participants. The suitability would be characterised by an available, non-essential room (not required for use for alternative activities at the scheduled time of interviewing), in order to avoid interruptions and movement and ensure privacy. Other noise and visual distractions would also need to be limited as well as a preference for adequate lighting, ventilation and seating, for comfort.

Data were collected at the five old age homes in Windhoek and Rehoboth (pilot testing) in the natural setting of the participants. Participants were kept informed throughout on the purpose and objectives of the study and the applicable procedures, while signed permission was sought from the participants for the use of an audio tape recorder.

Anonymity refers to the assurance that participants would be interviewed in privacy, that their identity would be protected and of the condition that the participants could withdraw at any time during the interview, if they so desired (Brink, Van Der Walt & Van Rensburg, 2006).

### 2.4.5.2 Conducting interviews

Data for phase 1 was collected from in-depth interviews held at the four old age homes in Windhoek, in the natural setting of the participants. In-depth interviews are held in order to understand the “emic” or insider view of a phenomenon, culture, social world or issue (Polit & Beck, 2008)

The following steps were taken to ensure that the interviews proceeded successfully:

- The purpose of the research was explained to the participants.
- Written consent for participation was obtained from both the elderly and the caregivers.
- Participants can benefit from the study in the following ways: improvement in healthcare delivery to the elderly, improved assessment of the health needs of the elderly and enhancement of their self esteem as a result of special attention for both elderly and their caregivers.
- The elderly participants were interviewed in their rooms and the caregivers were interviewed in their staff tearoom or office. Prior to initiating the interviews, the researcher put them at ease.

The use of the audio tape was explained to the elderly and the caregivers, where after both parties refused to be audio taped. According to De Vos, Strydom, Fouché and Delpont (2007), the use of a tape recorder can make the respondents feel vulnerable like, for example, stage fright. The researcher decided to do the interviews without the audio tape recorder so that the participants would feel free to express themselves

fully. According to Ritchie and Lewis (2003) the measuring instrument should not constrain respondents from saying what they want to say.

During the interview, the researcher simultaneously observed verbal and nonverbal behaviour and took written notes. The atmosphere was relaxed and enough time was allowed to facilitate for each participant to answer questions in detail. Dzija, Hernandez, Nardi, Theriault, & Wynne, (2005) states that if people are allowed to chat freely in a non-threatening environment, they tend to be more cooperative. Elderly and caregivers in the five old age homes were also interviewed in 2009.

Interviews were started by posing the following question to the elderly:

“Tell me about your experience of the caring that you receive from the caregivers.”

Caregivers and the elderly in the five old age homes were also interviewed in 2009, at a time that suited them, some even during their lunch hour. Interviews were conducted and the question posed to them was:

“Tell me about your experience of caring for the elderly in old age homes.”

Notes taken were read to the participants to verify that they truly reflected what was said and to find out whether any additional information existed. Burns and Grove (2005) maintain that, in such a process, the interviewer becomes a detective in search of important information.

Probing for more responses was also done. According to Minichiello, Sullivan, Greenwood and Axford (1999) (in Paterson, 2005) probing is an art and suggests three techniques:

- Probing – eliciting further details or seeking clarification
- Story telling – stories can be elicited by asking questions
- Funnelling – beginning the interview with general and broad opening questions and narrowing the questions down to acquire more detailed information.

Interviews were conducted until the data were saturated. For the elderly it was saturated after the twenty ninth participant in five old age homes and for the caregivers after the twenty sixth participant in five old age homes. Marshall and Rossman (1999) (in Mamabolo, 2009) indicate that reading and rereading notes again and again to become familiar with the data is essential in order to determine saturation of data. Although there is some uncertainty as to whether it is possible to achieve true saturation, its accepted meaning is repetition of data obtained during the course of the study Streubert & Carpenter, (1995) (in Bowen & Glenn 2008).

#### **2.4.5.3 Field notes**

In this study the researcher made use of field notes. Field notes involve detailed descriptions of social situations and interactions that occur in the field of research. Such notes are important for field research (field notes and inter experiences should be treated as valuable material), and are just as much about impressions of one's observations as they are records on who says what and can capture words but not thoughts (Streubert Speziale, Streubert & Rinaldi, 2010 ; Wolfinger, 2010; Patton, 2002; Shank, 2006).

Field notes are used to refer to critical points and are made to avoid losing critical data. Furthermore; it is desirable to use standardised procedures in participant observation Denzin & Lincoln, 2011; Silverman, (2000) (in Thorpe & Holt, 2008).

There are different types of field notes; however. Wilson (1989) (in Munhall, 2011) refers to personal notes, which were also used by the researcher to reflect her own feelings, reflections and experiences. These types of field note will therefore be similar to a diary. According to Neuman (2000) (in McNabb, 2008) personal notes have a three-pronged purpose: they allow the researcher to debrief, they record personal reactions and they serve as references for future data analysis. Besides personal notes, theoretical and methodological notes can also be used.

Theoretical notes are notes that give meaning to the observational notes (Groenewald, 2010). The researcher used theoretical notes for interpretations, assumptions, inferences and the observations.

Methodological notes are meant for the researcher him/herself and consist of important aspects and critical notes that the researcher seeks to remember or take note of Van Schalkwyk, (1997) (in Basson, 2009). Field notes were recorded in a notebook, as participants recounted their experiences. These notes were analysed to give the meaning to feelings and behaviors' and were grouped as sub themes. The researcher also used methodological notes to reflect on achievements and failures, as well as suggested corrective measures that might be implemented.

## **2.5 ETHICAL MEASURES**

Ethical considerations should encompass the concepts of respect for autonomy (self-determination, confidentiality, privacy and anonymity), non-malificence, beneficence and justice Beauchamp & Childress, (2001) (in Earle, Lloyd, Sidell & Spurr, 2007). These principles are based on the human rights that need to be protected. Protection of human rights is an ethical responsibility of the researcher, executed by protecting participants 'rights. The participants have the right to self-respect, dignity and health. The human rights that require protection in research are (1) self-determination; (2) the right to anonymity and confidentiality; (3) the right to fair treatment; and (4) the right to protection from discomfort and harm (Burns & Grove, 2005).

### **Respect for autonomy**

The right of self-determination is based on the ethical principle of respect for autonomy. Humans are capable of controlling their own destiny and have the freedom to conduct their own lives (Burns & Grove, 2005). The elderly developmental group represents a group of people who are vulnerable to diminished autonomy. The researcher ensured the protection of autonomy by inquiring from the participants and caregivers whether they were willing to participate in the research (Brink, Van Der Walt & van Rensburg, 2006). Consent in this context entails agreement to participate in the research as a participant. Free consent can be defined as the voluntary consent of human subjects. Accordingly, the person involved should have the legal capacity to give consent and should be able to exercise free power of choice without any element of force (Burns & Grove, 2005). The researcher explained to the participants that they could withdraw at any time from the research

without penalty Cormack, (1997) (in Kgomotso, 2009). Self-determination was also taken into account by allowing freedom of choice concerning exposure to audio-tape recordings. The elderly and the caregivers were confined to an institution, that is, old age homes, where they stay and worked respectively. In this regard, the researcher was given permission verbally by the various old age homes to conduct the interviews with the elderly and their caregivers.

Furthermore, the caregivers and the elderly gave permission in writing. On initiating phase 1 of the research, the objectives and purpose of the study were explained to the elderly and their caregivers, and this was personalised by conveying how participants might benefit from the outcome of the study. Participants can benefit from the study by the improvement in health care delivery to the elderly as well as improved assessment of their health needs and enhanced their self esteem as a result of special attention (Brink, *et al.* 2006). Procedures to be followed to obtain information from these participants were also discussed (Burns & Grove, 2005). It is essential to obtain informed consent from the participants in order to conduct the research.

The anonymity of participants was considered at all time. Concealment of individual identity was assured by concealing the names of participants (i.e. referring to them as participant 1, 2, 3, etc) and informing participants of the anonymity of their responses. Obtaining permission from participants to use acronyms or changing their names also ensures anonymity.

Anonymity and confidentiality were assured. According to Gorman and Clayton (2005) confidentiality is of greater concern than anonymity. The researcher assured confidentiality by making sure that the raw data remained inaccessible to

unauthorised persons. The researcher also informed participants, management staff and family members that raw data would not be shared. Confidentiality in terms of content disclosure was not possible; however, it was possible to ensure anonymity.

The researcher assured the right of privacy by interviewing the elderly alone in their rooms because personal information was shared. This information consisted of the beliefs, behaviours and opinions of participants (Leedy & Ormond, 2001).

The researcher always had the responsibility to respect the participants' right to privacy. The private information that was shared by participants had to be withheld from others (Brink, *et al.* 2006).

### **The principle of non-maleficence**

This principle encompasses the importance of avoiding harm, or ensuring that as little harm as possible is done (Dhai & McQuoid-Mason, 2010). Consequently, participants have a right to protection from discomfort and harm. The researcher conducted the research in such a manner that the participants were protected from discomfort and harm and their wellbeing was protected. This applies to physical, spiritual, emotional, social and legal protection (Brink, *et al.* 2006). Leedy and Ormond, (2001) also describe possible sources of discomfort and harm as being physiological, emotional, social and economical. For example, the elderly sometimes tired easily during the interviews and time was allowed to restore their energy (Leedy & Ormond, 2001). Providing information on the purpose and objectives of the study and the procedures of interviewing provided reassurance and comfort. A safe environment which created an open atmosphere in which to communicate freely,

experiences also contributed to comfort.

### **The principle of beneficence**

Beneficence refers to ensuring that the wellbeing and interests of others are promoted, implying that health care providers act in the best interests of their clients to promote their welfare (Dhai & McQuoid-Mason, 2010). Beneficence was ensured by asking participants the right questions, that is, those which would translate into the inclusion of the issues discussed in the formulation of the educational programme. This would then have the potential to bring about positive changes in caregiving.

### **The principle of justice**

Justice refers to the fair distribution of limited healthcare resources –the benefits and burdens of society should be fairly distributed Justice is not necessarily reflected by how individuals are treated, but how individuals are treated in the larger context (Dhai & McQuoid-Mason, 2010). The participants (the elderly and the caregivers) need fair treatment that is based on the ethical principle of justice. In the past, injustice in subject selection resulted from social, cultural and racial biases in society. While conducting the research, it is expected that the researcher will treat the participants fairly and respect the agreement established between them and the researcher (Burns & Grove, 2005). Justice was assured by accepting responses without judging the content, providing a safe environment which created an open atmosphere, to communicate experiences. This principle includes that the participants had the right to fair selection and treatment. A vulnerable population group is a sub-group of the population that is more likely to develop health problems as a result of

exposure to risk factors, or has worse outcomes from these health problems (Stanhope & Lancaster, 2006). Elderly people are one of the vulnerable groups that need protection from exploitation. Protection from exploitation also encompasses consent that needs to be obtained – personal consent from participants should be sought and formal consent from guardians or relatives is also required (Gillham, 2005). Purposive sampling ensured that all participants possessed the legal capacity to provide consent and representative insight on caregiving.

## **2.5. Permission**

Institutional permission was obtained from the Postgraduate Research Committee of the University of Namibia. Approval for the study was given telephonically and verbally by the five old age homes in order that the researcher would not be delayed. Written consent was given by both the elderly and their caregivers.

### **2.5.2 Trustworthiness**

Lincoln and Guba, (2000) state that trustworthiness is simply the degree to which we can depend on and trust the information given in research findings. According to Moss (2004), trust is not really established, but built up and nurtured. During data collection the researcher adhered to criteria for ensuring trustworthiness. The trustworthiness of the data was ensured by using Guba's model (Lincoln & Guba, 1985). Criteria such as credibility, transferability, dependability and confirmability were used. Guba's strategies of applicability, consistency, truth value and neutrality were applied to attain the criteria for trustworthiness (Terra Blanche & Durrheim, (1999) (in Mayburg, 2007). Criteria and strategies for establishing trustworthiness are given in table 2.2.

**Table 2.2: Criteria and strategies for establishing the trustworthiness**

<b>Criteria 1 Truth value</b>
<b>Strategy: Credibility/ internal validity</b>
<p><b><u>Definition:</u></b></p> <p>According to Shank (2006), credibility deals with the degree of believability of the research findings; ensuring that data is consistent and interrelated, rather than scattered and contradictory.</p> <p>Brink <i>et al.</i> 2006) refers to credibility as internal validity; the researcher asks if the findings are credible to the people studied as well as the readers.</p> <p><b><u>Application:</u></b></p> <p>Prolonged and varied engagement in the field: varied engagement, with two groups of participants, being a total of 55 persons, in all old age homes in Windhoek and Rehoboth, using different data gathering methods: first, the situational analysis and, secondly, the focus group discussion for the evaluation of the programme, until data were saturated. Each interview lasted 30 to 45 minutes, enabling in-depth discussions. This varied engagement increased the possibility of providing clarity on the research question from various perspectives and provided adequate variation of the phenomena under investigation (Graneheim &amp; Lundman, 2003).</p> <p>The experience of the researcher includes 16 years as a professional nurse and twenty years' in community health education training, including geriatric care.</p> <p>Peer group debriefing/examination: A professional nurse, with valuable experience in community health nursing, was asked to be the co-coder during data collection. Data were also written, analysed and reconstructed according to key themes and subthemes and presented to the study supervisor, who has extensive experience in nursing and research. Notes were compared to ensure completeness and uniformity. Two experts, as well as the managers of the old age homes, also evaluated the educational programme.</p> <p>Member checking/respondent validation was done by discussing and clarifying the specific content of interviews with the specific caregiver, from whom the information was obtained. Accordingly, it was determined whether they agreed with notes – returning to participants regularly to see whether they recognised the findings as true (Leedy &amp; Ormond, 2001). Data collected were also categorised into themes and presented to participants. Lincoln and Guba (1985) refer to this activity as “member check”.</p> <p>Referential adequacy: Although all participants refused to be audio taped, field notes</p>

(see dependability) were used to record data. Verbatim transcripts were typed, which resulted in adequate data that could be referred to when necessary (Babbie & Mouton, 2001).

Limitation of subjectivity: Qualitative research entails that the researcher is subjectively involved in data collection and analysis. It is therefore important to ensure the impartiality and trustworthiness of data. Subjectivity was limited by using Tesch's open coding system for data analysis, which allowed movement from subjectivity to intersubjectivity, an important basis for qualitative research. Data belonging to a particular individual is subjective, thus member-checking (see credibility) and peer group debriefing (see credibility) allowed for the creation of data by group consensus, which represents intersubjectivity.

See also reflexivity (confirmability)

## **Criteria 2: Applicability**

### **Strategy: Transferability/ external validity/ generalisability**

#### **Discussion of strategies definition and application**

##### **Definition:**

According to Lincoln and Guba, transferability is an alternative to external validity or generalisability, and refers to the ability to demonstrate the applicability of one set of findings to another context (De Vos *et al.*, 2007).

##### **Application:**

Data collection and analysis are guided by concepts and models. Reference to the theoretical framework of data analysis can be used to facilitate transferability of data. The transferability of a qualitative research to another setting is often problematic and a weakness in qualitative approaches (De Vos *et al.*, 2007). Tesch's open coding assisted in structuring raw data and aided in the creation of topics, themes and sub-themes within the data, which could be viewed as the parameters of the study.

Purposive sampling allowed the researcher to select participants on the basis of knowledge of the phenomenon being studied (Brink *et al.*, 2006). Participants were selected according to the following criteria: Afrikaans or English speaking, ability to remember past and current encounters and willingness to participate.

Dense/thick description of the research results including literature control and direct

quotations from the individual interviews during phase 1, and focus group discussions during the evaluation session, could aid in establishing the framework for the educational programme.

The literature control – international and national literature

The use of multiple cases and informants to produce interview transcripts. This involved collection of data with a central question posed to the elderly and the caregivers during in-depth interviews for phase 1 and phase 3 (focus group discussions).

The researcher and peer group's experience (see credibility)

Field notes

### **Criteria 3. Consistency**

#### **Strategy: Dependability/ reliability**

#### **Discussion of strategies definition and application**

##### **Definition:**

Dependability is an alternative to reliability (De Vos *et al.*, 2007). Lincoln and Guba (1985) also regard dependability as the qualitative correlate of the traditional notion of reliability. Dependability refers to the consistency, stability and repeatability of the informant's accounts (participants' experiences), as well as the researcher's ability to collect and take record of information precisely (Selltiz, Wrightsman & Cook 1976, in Brink *et al.*, 2006).

De Vos (1998) states that dependability refers to the extent to which research findings can be confirmed in respect of research within the same context and with the same participants. Generally, a peer that follows the same process and procedures used by the researcher in the study should have the same findings (Brink *et al.*, 2006).

##### **Application:**

The dependability of the study was ensured by thick description (see transferability), or describing research methods in detail, so that the results of the research would be consistent under exactly the same conditions (same participants, same question and same context).

Dependability was also ensured by using a co-coder (see peer group debriefing at credibility), using open coding (raw data colour coded to distinguish topics, themes and subthemes, according to Tesch's open coding) as the data analysis method, as well as member checking (see credibility) (Polit & Hungler, 2006).

An audit trail/investigative audit was performed by writing, analysing (colour-coding) and reconstructing data in key themes and subthemes and presented to co-coder according to Tesch's open coding (Lincoln & Guba, 1985; Polit & Hungler, 2006).

The researcher's experience (see credibility) also contributes to dependability.

Field notes: During each interview the researcher produced field notes, which included observations of nonverbal communication, such as lack of interest, uncertainty and certain gestures. This also aided in the reliable interpretation of data. According to De Vos *et al.* (2007), field notes should include observations, interpretations, the researcher's emotions, preconceptions, expectations and prejudices in order to develop the final product.

#### **Criteria 4. Neutrality**

#### **Strategy: Confirmability/objectivity**

#### **Discussion of strategies definition and application**

##### **Definition:**

Confirmability reflects the traditional concept of objectivity. In a qualitative study design, the data's ability to confirm the general findings (themes) and lead to the implications (educational programme) is the criterion for confirmability (De Vos *et al.*, 2007).

Confirmability guarantees that the findings, conclusion and recommendations are supported by data and that there is internal agreement between the investigator's interpretation and the actual evidence (Brink *et al.*, 2006).

According to Shank (2006), confirmability deals with the details of the methodologies used; how the data were analysed and how categories and themes were formed. This was done by describing the research process.

##### **Application:**

Reflexivity: The researcher needed to be cautious that personal values and assumptions did not influence participants' responses (Leedy & Ormond, 2001). The researcher constantly reflected on her values, behaviour and position with the participants, in order to avoid influencing their responses. Reflexivity was also

assured by presenting data collected in phase 1 to the participants for elucidation. (See member checking/respondent validation in credibility.)

To confirm that the information that was collected from respondents was trustworthy, the researcher and the co-coder compared notes (Streubert & Carpenter, 1995; Polit & Hungler, 2006) (see peer group debriefing in credibility).

An audit trail (see dependability) also contributes to confirmability (Polit & Hungler, 2006).

## 2.6 DATA ANALYSIS

As part of data collection, data were first written down. All inter experiences were recorded by means of note-taking, rather than being typed. Pauses were denoted in the notes with dashes and all exclamations and interjections, including laughter, were included. The spoken words were written down by the researcher, entered in the computer software programme and printed. Data analysis commenced as soon as the researcher had listened to the opinions of participants. The data collected were unstructured, thus the eight steps of Tesch's approach of open coding (Tesch, 1995), was used to develop an organised system of data.

**Step 1** *Reading to make sense of the whole*: The first documents were read (as well as later documents) and notes were made by the researcher as ideas came to mind. This was done not with the purpose of memorising the information, but rather to create a framework within which individual pieces of data could be understood (to get a sense of their scope) (Burns & Grove, 2001). Step 2 was undertaken when a

number of transcripts had been read

**Step 2 *identifying topics***: Pieces of data of a few initial data documents become topics and are labelled. The first data document on top of the pile was selected to find the underlying meaning or topic, that is, what the piece of data was about. Topics noted were written in the margin.

**Step 3 *Clustering and labelling similar topics, creating major topics, unique topics and leftover topics***: The procedure described above was followed for a number of documents and a list of all the topics that arose was compiled. The researcher used highlighter pens of different colours to simplify the analysis process. Words and phrases that could be used to give meaning to feelings or concepts were highlighted in colour and code

**Table 2.3:** Examples how pieces of data were colour-coded as topics

<b>Data document 1</b>	<b>Data document2</b>	<b>Data document 3</b>	<b>Data document 4</b>	<b>Data document 5</b>
<b>Topic</b>	<b>Topic</b>	<b>Topic</b>	<b>Topic</b>	<b>Topic</b>
<b>Topic</b>	<b>Topic</b>	<b>Topic</b>	<b>Topic</b>	<b>Topic</b>
<b>Topic</b>	<b>Topic</b>	<b>Topic</b>	<b>Topic</b>	<b>Topic</b>
<b>Topic</b>	<b>Topic</b>	<b>Topic</b>	<b>Topic</b>	<b>Topic</b>
<b>Topic</b>	<b>Topic</b>	<b>Topic</b>	<b>Topic</b>	<b>Topic</b>

Similar topics were clustered together manually and thereafter the researcher arranged the topics in columns headed “major topics”, “unique topics” and “leftovers”.

**Table 2.4:** Examples of major, unique and leftover topics derived during data

analysis

Major topics	Unique topics	Leftovers
Intra-personal functioning and inter-personal relationships	Feelings of inadequacy and being a hindrance	E.g. establishment of a quality assurance board/body
Procedures	Difficulty in accepting developmental stage of elderly and associated crises	E.g. staff shortages
Nutrition		E.g. limited and minimal salaries
Lack of support		

**Step 4** *A preliminary organising system* (comprised of major and unique topics which are abbreviated with codes) was used on initial and additional documents. All data material belonging to a topic was grouped together, and a preliminary analysis was performed. Field & Morse, (1985) (in Mamabolo, 2009); Creswell, 2005, Roberts, (2004) suggest that during coding one would note the occurrences, the form a phenomenon takes, and any variation within the phenomenon.

**Step 5** *Refining the organising system*: Topics become categories/themes or subcategories/subthemes and relationships between topics are mapped. Burns and Grove (2001) describe cross-checking each bit of data with all the other bits of data on pieces of paper.

**Step 6** *Collected data were clustered*, which entailed grouping data by finding

relationships. According to Miles and Huberman (1994) (in Gibbs & Taylor, 2005) the researcher should identify names for categories/themes for sorting and organising data into meaningful phenomena. Names of categories were simply generated by the researcher herself according to Strauss and Corbin (1990) (in Merrill & West, 2009).

**Step 7** *Final abbreviation of category / theme names and alphabetising of codes and application to all data available (code all relevant text in sensible way, to recode later).* Figure 3.2, in chapter 3, gives the names of the categories and themes.

Assemble data for each category and analyse one category at a time in terms of content (taking stock), and relative to research purpose or question.

**Step 8** *Categories or themes are crystallised into concepts.* To develop an educational programme for the caregivers of the elderly the researcher grouped the experiences, ideas and feelings into clusters of phenomena to form themes and subthemes (Walker & Avant, 2005). These themes were used to develop the programme.

## **Phase 2**

The conceptual framework is described in chapter 4. The educational programme for caregivers was developed from the themes derived, as explained above, by extracting the experiences of the caregivers and the elderly. These experiences are discussed in Chapter 5.

## **Phase 3**

Implementation of the programme is discussed in Chapter 6 and its evaluation is presented in chapter 7.

Table 2.7 below gives an exposition of the methods proposed for phases 1 to 3.

**Table 2.5:** An exposition of the methods proposed for phases 1 to 3

Phase	Design	Population/unit of analysis	Data collection	Data analysis	Result
1	Needs analysis  Design method Qualitative, exploratory and descriptive	Elderly  Caregivers	Inter experiences	Qualitative  Analysis of open coding using Tesch's methods	Experiences regarding health care provision
2	Programme development	1. Viewpoints of the elderly and the caregivers  2. Literature  3. Conceptualisation concepts of the study	Results derived from the phase 1 inductive process	None	Draft programme
3	Programme implementation and programme evaluation – qualitative	Caregivers working in old age homes  Results of the study	Practical implementation  Inter experiences	None  Qualitative analysis of open coding use of Tesch	Validated programme; operational guidelines

The following section summarises this chapter.

## **2.7 SUMMARY**

Chapter 2 focused on the research design and methodology used for the study. These included the use of a phenomenological approach and a qualitative, exploratory, descriptive and contextual research design. Reasoning strategies (deductive and inductive reasoning), as well as the analysis and synthesis of data were described. The research methods were then discussed, as well as ethical measures and trustworthiness. Strategies for ensuring trustworthiness in the qualitative approach were explained and obtained by applying the criteria of credibility, transferability, dependability and confirmability. Data analysis using Tesch's (1995) method was also discussed.

In Chapter 3 the results of the inter experiences of caregivers and the elderly will be discussed, as well as the associated literature control.

## **CHAPTER 3**

## **RESULTS OF INTERVIEWS AND LITERATURE CONTROL**

### **3.1 INTRODUCTION**

In chapter 2 the research methodology was focused on describing the research design, the reasoning strategies and measures to ensure the trustworthiness of the qualitative approach applied to this study. A qualitative approach was used because it was relevant for eliciting the experiences of the elderly and their caregivers. The data were collected from sample size that comprised 9% of the elderly population and 41% of the caregivers

In this chapter lived experiences (the experiences of caregivers and elderly people) and the literature control are discussed.

#### **3.1.1 Main themes categorised:**

- Interpersonal relationships, with sub-themes of character of the participants and communication and language as important entities in the caring process.
- Basic physical care, with sub-themes of personal hygiene, wound care, taking of medication, adequate nutrition and exercise, which were viewed as the supporting activities of the caring process.
- Support of management and family, with sub-themes of equipment, transport, in-service education, and career structure and staff shortages.

The main themes and the sub-themes are presented in table 3.1 and discussed in the

accompanying text.

### **3.2 RESULTS OF INTERVIEWS**

#### **Central story line of the elderly and the caregivers**

The elderly experience poor interpersonal relations and inadequate attendance to their basic human needs. Caregivers also experience challenges in terms of interpersonal relationships with the elderly, as well as a lack of support from their management in rendering proper care to the elderly. Accordingly, this is the central story line that emerges from the data analysis, and it will be discussed next. Themes and sub-themes obtained from the perceptions of the elderly and caregivers during the data gathering process are reflected in table 3.1. These themes are elicited from concept analyses of the perceptions of the elderly people and their caregivers regarding their experiences of caring.

**Table 3.1:** Identified themes and sub-themes on the elderly and caregiver

MAIN THEMES	SUB-THEMES
<p>1. Interpersonal relationships were viewed as an important part of the caring process.</p>	<p>Positive and negative experiences by elderly and caregivers concerning the following:</p> <ul style="list-style-type: none"> <li>❖ Perseverance, patience and respect were viewed by participants as positive characteristics of interpersonal relationships, while stressful behaviour eg, poor temperament and confusion were regarded as negative behaviour.</li> <li>❖ Communication and languages are important aspects of quality caring, for example: shyness, disrespect and aggression were all viewed as negative.</li> </ul>
<p>2. The activities involved in basic physical care were viewed as important support for the caring process.</p>	<p>Positive and negative experiences concerning physical care included issues such as</p> <ul style="list-style-type: none"> <li>❖ personal hygiene</li> <li>❖ wound care</li> <li>❖ taking medication</li> <li>❖ exercise</li> <li>❖ adequate nutrition</li> </ul>
<p>3. A support system in a conducive environment is needed for the caring process.</p>	<p>It was felt that the elderly and the caregivers needed management and family support if the caring process is to be executed optimally.</p> <ul style="list-style-type: none"> <li>➤ managerial</li> <li>❖ equipment</li> <li>❖ transport</li> <li>❖ in-service education</li> <li>❖ career structure</li> </ul>

	<ul style="list-style-type: none"> <li>❖ staff shortage</li> <li>• Family support</li> </ul>
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### 3.2.1 Main themes and sub-themes

A discussion of main themes and sub-themes follows.

#### 3.2.1.1 Main theme 1: *Interpersonal relationships*

Interpersonal relationship refers to the interaction between two or more people; this relationship may be professional or personal (Taylor, 2010). In an interpersonal relationship, people may interact overtly, covertly, face-to-face or even anonymously. Interpersonal relationships occur between people who fulfil each other's explicit or implicit physical or emotional needs in some way (Cavazos, 2010). An intimate relationship is a particularly close interpersonal relationship and can be defined by the following characteristics: enduring behavioural interdependence, repeated interactions, emotional attachment, and need fulfilment (Miller, Perlman & Brehm, 2007). Interpersonal relationships are dynamic systems that change continuously during their existence. They are complex for both the elderly and the caregiver, thus a natural development of the relationship should follow (Hornby, 2006). During the caring process the interaction between the caregiver and the elderly should be physically and emotionally stable for the benefit of both parties. In this study, the people that were involved in this relationship are the elderly people and the caregivers.

Interpersonal relationships are formed in the context of social, cultural and other

influences and are connected with relationships between people having interpersonal skills (Hornby, 2006). In this study; interpersonal relationships are applicable to the work place where people with different cultural backgrounds and social status form part of the caring process.

Social relations can refer to a multitude of social interactions, regulated by social norms, between two or more people, with each having a social position and performing a social role. Within the caring process it is a reality that both the elderly and the caregiver have social obligations within society and during the process of caring.

Culture and ethnic history are important components of social assessment. Therefore, it is important for the caregiver to enquire about the place of birth, language or cultural group, medicines and other practices. Caregivers need to be sensitive to cultural issues Hogstel, (2001) (in Evans, 2007).

In this study, positive and negative experiences concerning interpersonal relationships emerged. A discussion of this will follow in the following sections.

#### ***3.2.1.1.1 Sub-themes of interpersonal relationships***

Perseverance, patience and respect were viewed by participants as positive characteristics of interpersonal relationships, while stressful behaviour, temperament and confusion as negative behaviour.

Perseverance is defined as steady persistence in a course of action, a purpose, a state,

in spite of difficulties, obstacles, or discouragement (Dictionary.com, 2010).

Caregivers also gave an indication that their role as caregivers is affected by a lack of perseverance.

Caregivers stated the following:

*“Ou mense nodig baie aandag. ‘n Mens moet geduld en lankmoedig wees.”*

[The elderly need a lot of attention. You need patience and perseverance.]

*“Borde sal afgedra word kamer toe en môre kry jy dit daar. ‘n Mens moet lankmoedig wees. Een ouma baie moeilik, sy sê ons steel ons word beledig.”*

[You will tell them not to put plates in the room but you will find the plates in rooms. One needs to have perseverance. One very difficult grandma insults us and accuses us of stealing her things.]

The elderly stated the following:

*“Die Here is belangrik in my lewe. Hy gee my krag en uithou vermoë.”*

[The Lord is important in my life. He gives me strength and perseverance.]

*“Is net gebed wat ons dra en uithou vermoë gee.”*

[It is only prayer that keeps us going and gives us perseverance.]

Webster (2010) defines perseverance as a continued effort to do or achieve something despite difficulties, failure, or opposition: It is also indicated as being the action or condition or an instance of persevering, as well as steadfastness.

In caring for elderly people, caregivers need to have perseverance. Horton (2010) indicates that significant problems should be approached with patience and perseverance, as we live in a world where we expect instant results. He indicates that if people are hungry, they seek fast foods. If they are feeling down, instant gratification is desired.

Perseverance must permeate one's life – in particular in one's ongoing efforts to develop the clear and persistent mindset that creates a foundation for effortless succession the other hand, what if one fails or the feeling of failure is prominent? Horton describes failure as just another opportunity to persevere (Horton, 2010).

It was found that positive and negative remarks were made by both groups of participants concerning the interpersonal relationships.

Within the caring process caregivers need to have perseverance because caring for the elderly is time consuming and hard work; however, patience is also part of the caring process.

Ageing is inevitable for everyone. When caring for the elderly, it is worthwhile taking cognisance of the cliché “do unto others as you would have them do unto you”. This is enabled through patience, perseverance and respect.

Caregivers specifically mentioned patience as an aspect that they sometimes fail at.

This is shown in the following quotes:

*“Oumense is moeilik ‘n mens moet baie geduld hê. Hulle is soos klein kinders en soms deurmekaar. Hulle moet baie aandag kry en hulle beskerm van gevaar.”*

[Old people are difficult, you need patience. They are like small children and sometimes confused. They need a lot of attention and protection from danger.]

*“Ou mense nodig baie aandag. ‘n Mens moet geduldig lankmoedig wees.”*

[The elderly need a lot of attention. You need patience and perseverance.]

*“Ou mense is lieflike mense. Ek het geen probleem met hulle nie. Ek werk saam met hulle. My werk is baie wonderlik ‘n mens moet geduld hê.*

[Old people are really lovely. I don’t have any problem with them. I work with them and my work is wonderful however you must have patience.]

Patience means the capacity to endure delay or provocation without becoming angry or upset (Thesaurus, n.d.). Caregivers are obliged to exercise patience when they care for the elderly. According to Christian beliefs, patience is described as a gift or a fruit of the Spirit, and is also one of the most important virtues that are needed in the care of the elderly.

When showing patience, one experiences a sense of calm, love and peace. It prevents one from being angry, distances one and results in feelings of happiness (Dhammacaro, 2008). Brown (2010) states that while a person exercises patience it

orders the brain to think strategically and to plan correctly.

Patience allows a person time for strategic thinking and to evaluate a situation completely. Consequently, all things fall into place at the right time, presenting a clearer strategic view of what is taking place and thus a clearer strategic view can be presented. While one waits for a calmer atmosphere, one is placed in a better position to make strategic decisions. It is also likely that one display empathy to the challenges that others face, even if these challenges are not shared (Brown, 2010).

In many instances when people get angry their level of patience can be affected so that they become impatient. In terms of interpersonal relations between elderly and caregivers, both parties have the potential to become impatient with each other.

One caregiver stated:

Nie een mens is volmaak nie. Soms word ek kwaad, byvoorbeeld as hulle vuil gemaak het dan stry hulle af.”

[No one is perfect. Sometimes I become angry, for example when they wet/soil themselves and then deny it.]

Another caregiver says:

“Soms word jy kwaad vir die oumense, maar jy kan nie heeldag kwaad wees vir hulle nie.”

[Sometimes you become angry with the old people but you can't stay angry with them for the entire day.]

It was found that although caregivers sometimes lack patience they overcome it.

Remarks of elderly, displaying negative occurrences, but a positive outcome:

*“As ek met die werkers ‘n stryjtjie gehad het, praat ons weer môre.”*

[If I have a difference of opinion with the workers, we speak again the following day.]

During inter-experiences caregivers have negative perceptions of the elderly. The following statement is evidence of this:

*“Soms is die oumense hardkoppig.”*

[Sometimes the old people are stubborn.]

Negative response from the elderly:

*“Ek kan nie so lekker asemhaal nie dan word ek ongeduldig en verloor my humeur.”*

[I can't breathe properly then I become impatient and lose my temper.]

*“Ek lei aan mental disability, wat my soms ongeduldig maak.”*

[I suffer from a mental disease which makes me impatient sometimes.]

Trivial or insignificant problems can arise from a lack of patience, which in extreme

cases can result in fighting, war and loss of life. Violence is evident, owing to a lack of patience. Impatience seems to be the cause of these miserable events (Dhammacaro, 2008).

According to Brown (2010), the disadvantage of being impatient is that one misses important opportunities to act while one waits for everything to be in place, even things not absolutely necessary. It is also likely for one to present information that simply confuses or does not add any real strategic value in clarifying a situation. One can also ignore the innovative wisdom that comes from going with one's instincts and initial perspectives. In addition, in teamwork, one may too easily make allowances for team member's correctable challenges, thus compromising overall team performances.

Within the caring process, patience is important for caregivers working with the elderly and it goes hand in hand with respect.

According to Thesaurus (n.d.), respect denotes both a positive feeling of esteem for a person or other entity (such as a nation or a religion), and also specific actions and conduct representative of that esteem. Respect is one of the basic principles of satisfactory interpersonal relationships between caregivers and elderly people.

This is what a caregiver had to say about the elderly in terms of respect:

*“Jy moet baie geduld en respek het. Volwas is moeilik in die winter. Dit is te koud. Ander sê ek word nie deur n klein kind gewas nie.”*

[You must have patience and respect. To do a full wash is difficult during

wintertime, because it is too cold. Others will say I will not be washed by a small child.]

*“You need to respect old people they are like children”.*

The elderly stated the following in terms of respect:

*“Daar is een meisie wat nie weet hoe om met grootmense te praat nie.”*

[There is one girl who does not know how to speak to old people.]

*“Die werkers behandel ons nie so goed nie soos ou mense nie. Soms skree van hulle op ons.”*

[The workers do not treat us with the respect due to old people. Sometimes they shout at us.]

Caregivers need to show respect for the elderly they care for and, despite complete dependence on others for their self-care, these persons need to be treated with dignity. This will ensure good interpersonal relationships when caring for the needy and weak. Respect is also part of the socialisation process, implying that it is often learned from parental values.

In humans, physiological and psychological changes occur with ageing. When caring for the elderly, these changes should be appropriately dealt with and the basic principles of caring for the elderly should be considered. The terms “grandpa” or “grandma” are often used to address the elderly. Before providing health care, respect should be demonstrated by enquiring about the elderly person’s preference for being addressed. “Mr”, “Mrs” or “Madam” are often neutral and are a respectful way of addressing people, unless otherwise preferred. What is more, no matter how old and of what gender persons are, their privacy should be adequately protected and respected (Basic principles in caring for the elderly, 2002) no author.

Self-respect in the elderly should be maintained for as long as possible through involvement in activities and decision making concerning their affairs, as well as respecting their privacy (Kleynhans, 2005).

Establishing a routine has certain advantages that will make life more predictable and less stressful for both the caregiver and the person in their care. There are numerous things to remember and do, such as administering medication, attending to personal hygiene and preparing meals, thus a good routine will aid in remembering what needs to be done and when it should be done. Seniors desire routine and detest unexpected events, as well as chaos (Elderly care tips, 2010) no author.

Respect for routine and habits, as described above is very important, but it is also important not to be completely constricted by routine. Although for the elderly person routine can increase feelings of control and safety, it can also become stifling and restrictive. Some experts now think that routine can be “boring” and elderly

people can become anxious, depressed and forgetful if forced into a restrictive routine that they are not comfortable with (Elderly care tips, 2010).

A solid relationship based on trust and mutual respect can be established. This type of relationship is essential – one based on any other alternative is destined to failure (Elderly care tips, 2010).

Virtues or desirable qualities for building sound interpersonal relationships have been discussed above; however, various obstacles to the development of interpersonal relations were evident from the experiences of caregivers and elderly, including issues like stress. Stress is one of the contributing factors that influence interpersonal relationships between the caregiver and the elderly.

Some caregivers experienced their relationship with the elderly as stressful and difficult, because caring for the elderly is demanding and they require a lot of attention. The elderly become comfortable with their rooms and situation and resist any change. Accordingly, caregivers experience the elderly as being obstinate. Additionally, the elderly can also become aggressive or reserved if their comfort zone is disturbed, or when they feel they are not being treated well by caregivers. Elderly people can also become aggressive, as was stated by one of the caregivers, and this makes it difficult to build a relationship. According to Heck (2010), aggression in the elderly is a common problem. Physical and emotional aggression is widely recognised as the most common precipitate behaviour in the elderly (Thesaurus n.d. 2010)

Caregivers stated the following in this regard:

*Ou mense is baie stressvol. Soms is hulle olik dan moet jy weet hoe om hulle te hanteer, dan sê jy “kom ek maak ouma mooi vandag.”*

The elderly are very stressful. Sometimes they are unwell then you must know how to handle them, then you say, “come let me make you beautiful”.]

*“Ou mense is moeilik en stressvolle mense veral as hulle nuut is dis moeilik om aan te pas.*

[Old people are difficult and stressful; when they are new it is difficult to adapt].

The elderly stated the following:

*“Dit maak my soms stressvol om nie te kan doen wat ek wil doen nie.”*

[It sometimes stresses me that I cannot do what I want to do.]

*“Die werkers steel ook ons se goed en dra dit huis toe. Ek wil nie oor sulke goed praat nie dan word ek somer stressvol.”*

[The workers also steal our things and take them home. I don’t want to speak about such things then I become stressed.]

The elderly and their caregivers all experience stress. Caregivers should be able to recognise stress and talk about it. Often the elderly become upset if their family members do not visit, or if they are unable to do much for themselves. Another source of stress is the presence and effects of chronic disabilities in the elderly. Some authors state that the degree of adverse response to disability may be a function of

one's perceptions of control Schulz, Heckhausen & O'Brien, ( 2000) ( Clarke, 2003)

Negative emotions like bad temperament have an effect on the caring process.

Temperament has an influence on the interpersonal relationships between the caregiver and the elderly. Temperament is related to the amygdalae, the part of the brain related to emotions and new situations. The amygdala evaluates new situations based on memories of past experiences. If the new situation appears threatening, the amygdala sends out a warning signal. In a shy person the amygdala is extremely sensitive and much more active than that of an outgoing person. Thus, the increased activity causes the person to withdraw either physically or emotionally. This withdrawal is known as inhibition (Henderson & Zimbardo, 2008).

Caregivers stated:

*“My ervaring is dat oumense soms moeilik is. Hang af van watter geaardheid jy het. Dit kan ook bedaring bring. Jy kan probeer goed wees met hulle maar hulle is sleg met jou.”*

[My experience is that the elderly are sometimes difficult. Depending on your temperament, it could also bring a sense of calm. You can try to do well to them, but they are unpleasant towards you.]

*“Some old people are happy some difficult it depends on what kind of temperament he/she has.”*

[Sommige ou mense is gelukkig en ander is moeilik hang af watter soort temperament die hy/sy het.]

The elderly stated in this regard:

*“Ek was gedwing om hier na toe te kom deur my seun. Ek het nie geweet nie. Ek het baie gehuil en was humeurig.”*

[I was forced by my son to live in the Old Age Home. I did not know. I cried a lot and lost my temper.]

Psychologists Buss and Plomin have proposed the existence of four basic temperamental dimensions present in human beings (McAdams, 1989).

*Emotionality* is the tendency to express negative emotions such as anger and fear frequently and vigorously.

*Activity* is the degree of physical movement that a person characteristically shows.

*Impulsivity* is the degree to which a person acts quickly without deliberation, moves from one activity to the next, and finds it difficult to practise self-control.

*Sociability* is the tendency to be outgoing and friendly and to enjoy the company of others (McAdams, 1989). These dimensions are present in infancy and continue to grow throughout childhood and adulthood. Such modifications are the results of interpersonal relationships that begin to form during early life. The development of a unique interpersonal style is a function of temperament (McAdams, 1989).

As a result of sensitivity and responsiveness on the part of the caregiver, an elderly person may develop a "secure" attachment style (Rothbard & Shaver, 1994 in Fraley, (2010). Caregivers who develop "secure" personality types feel confident and at ease when relating to others (McAdams, 1989). Watson (2005) indicates that to be human is to feel. People allow themselves to think their thoughts, but not to feel their

feelings. The only way to develop sensitivity to oneself and to others is to recognise and feel one's feelings.

The elderly seek to develop autonomy while maintaining the ability to retreat to their caregiver for support. Taking responsibility for aspects of their own character requires distancing from authoritative figures (Graham & Lafollette, 1989 in Cardillo, 2002). The concern about the adaptation to the self and one's ability cause people to seek identity through intimacy. Accordingly, the elderly are concerned with developing individuation while still seeking the acceptance of those around them. For the first time, one does not search for oneself in others, but rather confronts the other as a separate person with whom one longs to connect (Maniaci & Reis, 2010). The ability of an individual to combine his or her multiple selves and to create a well-articulated life story results in the ability to guide one's actions, emotions and personality traits (Savin-Williams & Berndt, (1990) (in Cardillo, 2001)

In many instances caregivers and the elderly can be volatile, if they have an oversensitive temperament or experience severe abuse. This can lead to loss of self-control (Millon, (1996) (in Groopman & Cooper, 2006). Owing to the different temperaments that elderly people have they also suffer from confusion, which can influence the caring process negatively.

Caregivers stated that it is sometimes difficult to care for the elderly when they are confused, as it can result in them refusing to eat or wash.

*“Ek is gelukkig met my werk. Soms is dit moeilik as hulle koppe nie reg is nie. Hulle is deurmekaar. Ons wat jare werk weet hoe om hulle te hanteer.”*

[I am happy with my job. Sometimes it is difficult if their minds are not right. They are confused. We, who have worked for a long time, know how to handle them.]

*“Sommige oumense is moeilik, veral die Alzheimer. Ons moet hulle voer. Hulle vergeet alles.”*

[Some of the elderly are difficult especially those with Alzheimer’s. We have to feed them. They forget everything.]

The elderly stated:

*“Die meisies is nie soms so goed nie behandel my soos ‘n st. 1. Dit is waarvan ek nie hou nie. Hulle dink tog ek is mal.”*

[The girls is sometimes not so good, they treat me as a Grade 3. I don’t like it. They think I am mad.]

*“Die mense hier se koppe is nie meer so mooi nie.”*

[The people here their heads are not so right.]

*Ek verloor die woorde dan stop dit skielik in my mind dan weet ek nie wat ek wou sê nie.*

[I lose words then my mind suddenly stops. I don’t know what I wanted to say.]

Confusion may occur when the elderly are moved from their familiar surroundings to

an old age home; this is called relocation trauma. If confusion is chronic it can be associated with dementia, but it can also be a side-effect of medication. Confusion can also be a symptom of Alzheimer's disease. Treatment with oestrogen and NSAIDs may delay the onset of this disease Garand, Buckwalter, & Hall, (2000) (in Fitzpatrick, 2006).

Interpersonal relationships usually involve some level of dependence; because of this interdependence, most things that change or impact on one member has some level of impact on another. If the elderly person suffers from Alzheimer's and is not able to remember, this will influence his/her relationships (Snyders & Lopez, 2007). Elderly persons may also forget the factors which aid in building a relationship. One author notes:

Alzheimer is a disease of the brain, resulting in a loss of brain cells, causing progressive memory loss and dementia. It is one of many neurological disorders currently targeted by (Amgen Science, 2011). It is also defined as a group of disorders causing deterioration of the brain, which affects one's memory and reasoning capabilities and affects the parts of the brain that control thought, memory, and language (Define Alzheimer Disease, 2007).

Dementia in the elderly can also affect the interpersonal relationships between the elderly and the caregivers that influence caring; dementia is caused by damaged brain cells (*Caring for people with progressive dementia*, 2006). A stroke, brain tumour, head injury or diseases such as Alzheimer's or Huntington's, can also destroy brain cells (Dementia Alzheimer disease, 2007). These complaints are more common in

older adults and often include emotional and personality changes. Dementia is also defined as a gradual loss of mental functions such as the ability to think, remember, reason and plan. However, dementia is not a disease, but a group of symptoms and it is not a normal part of ageing (Dementia Behavioural Health Advisor, 2007).

In normal ageing, memory loss is slow, not sudden. As they age, people may forget names or phone numbers, or where objects were placed (Dementia Behavioural Health Advisor, 2007). According to Stanhope and Lancaster (2006), elderly people can suffer from memory impairment. Benign senescent forgetfulness often exacerbates the problem of mild memory impairments. Elderly people, for instance, forget easily that they were angry, as some of them suffer from memory loss. Reassurance is important for the elderly since memory loss can lead to anxiety.

One caregiver commented:

*“Oumense vergeet maklik dat hulle kwaad is.”*

[Elderly people forget easily that they were angry.]

Researchers are finding more and more evidence that the age-related loss of mental ability associated with the disease called vascular dementia can also affect communication. The elderly also indicated that healthy relationships regarding vascular dementia do not exist. The following problems are evidence of this:

- putting thoughts into words, or responding to others
- understanding complex information
- reading and writing

- learning new information and new skills
- remembering things (Caring for People with Progressive Dementia, 2006)

Although a person with Alzheimer or dementia is confused they need to feel secure and safe. As mentioned previously, according to Norrgard, Matheis-Kraft, & Rigler (2007), reassurance is important for the elderly since such conditions can lead to anxiety. Within the context of safe, secure attachment, people cannot pursue optimal human functioning and flourishing (Gable & Reis, 2010). In conclusion, negative attitudes also have an impact on the integrity of interpersonal relationships. According to Wright (1998) (in Clark, 2008) negative attitudes toward older people are one of the reasons contributing to poor nursing care. Bradley (2005) states with regard to combating negative attitudes, that such attitudes lead to doubt and low esteem. Rogers and McWilliams, in the same article, describe the prominent degree of danger associated with having negative thoughts, which can affect the mental and physical health of the terminally ill client. According to Young (2007), a positive attitude is associated with confidence, excellent job performance, high self-esteem and success. Applying to the caregiver.

A discussion on communication follows.

Communication and language are important aspects for quality caring. The following sub- themes of communication are describe below for example shyness, disrespect and aggression According to Hornby (2006), communication is the activity or process of expressing ideas and feelings or of giving people information; it is the act of talking to others, particularly in terms of imparting news or information.

Communication is described as the matrix of thought and relationships between people (Jooste, 2003). Thus, it can be said that communication forms the basis of an interpersonal relationship. In establishing a caring relationship with the elderly, the mode of communication establishes rapport and caring (Watson, 2005). The following statement is evidence of this.

An elderly person stated:

*“Daar is ’n meisie wat nie weet hoe om met grootmense te praat nie.”*

[There is a girl who does not know how to speak to adults.]

The elderly also indicated that caregivers are ignorant, since they seem not to know how to talk to them; on the other hand, caregivers convey the feeling that the elderly are mad.

*“Die werkers behandel ons nie so goed soos ou mense nie. Soms skree van hulle op ons.”*

[The workers do not treat us well, as the elderly should be treated. Sometimes some of them shout at us.]

Experiences reflected by the elderly and the caregivers indicate that communication and language contribute to the effectiveness of the caregiving process.

One elderly person made the following remark:

*“Die werkers behandel ons nie so goed nie soos oumense nie. Mens voel of jy die mense aankla- mens moet die waarheid praat”*

[The workers don't treat us as old people should be treated. One feels as though one files complaints against them – the truth needs to be spoken.]

The caregivers stated:

*“Eendag praat die ou mense sleg en is hulle kwaad en ‘n ander dag is hulle gelukkig.”*

[One day the old people talk bad and they are angry. On another day they are happy.]

*“Ek moet die oumense aanvaar met hulle swakhede. Ek moet geduldig wees en liefwees vir die oumense. My gesig moet nie suur wees as ek met die oumense werk nie.”*

[I must accept the old people with their weaknesses. I must be patient and loving with them. My facial expression must not be disagreeable when I work with the old people.]

The status of any relationship is revealed by the communication and is a dynamic process (Gable & Reis, 2010). If we are to maintain a balance in and with the elderly we must have open communication channels. Communication is the process during which information is conveyed by a sender, who in this case is the caregiver, to a receiver, in this case, the elderly. Communication gaps show up between parents and their children, couple's divorce, lovers split, close friends snub each other, and animosity is created at the workplace (Shoshanna, 2005).

Every individual has the inherent capacity to deal constructively and successfully with his or her problems, and will do so given the right emotional environment. The

caring relationship can move to a deeper, more honest and authentic level if the caregiver allows it. Listening to and honouring another person's feelings and story holds meaning and importance for them and their healing (Watson, 2005).

According to the Shah, (2010), individuals with cognitive impairment may experience behaviour problems including communication problems such as perseveration (fixation on repetition of an idea or activity), aggressive memory problems and poor judgement. Managing these problems includes keeping language simple (using simple commands such as "let's walk"), asking one question at a time and breaking down a task into simpler manageable steps.

In a study conducted by McGilton, Soren-Peters, Sidane, Rochon, Boscart and Fox (2010) on communication, it was indicated that more than 50% of stroke survivors had speech and language impairments and that caregivers lacked the skills to communicate effectively with patients. It was recommended that tailored approaches to communication-enhancement education may be necessary Brown & Levison, (1987) (in Mills, 2003).

Numerous factors can contribute to the quality of communication, which was described as the basis of interpersonal relationships. The factors indicated by the study participants made reference to shyness and disrespect or cheekiness.

### **Shyness**

Shyness results in a lack of communication between the elderly and the caregiver. The elderly fail to communicate their needs; for example informing the caregivers when they are ill.

Shyness is a personality trait that produces behaviours ranging from feeling uncomfortable at a party to an extreme fear of being watched by others (Carducci, 2000). Shyness may be defined experientially as discomfort and/or inhibition in interpersonal situations that interferes with a person's performance. The elderly, as they are taken from their known environment to a new environment, feel shy, heartbroken and reserved.

A caregiver has this to say:

*“My ervaring is dat die eerste dag wanneer die ou mense deur kinders gebring word voel hulle skaam, harseer en teruggetrokke. As jy jou werk lief het kan jy respek en geduld hê.”*

[My experience is that the first day when the old people are brought to the old age home they feel shy, heartbroken and reserved. If you have a love for your work you will have respect and patience.]

The elderly stated:

*“Die eerste tyd toe ek my huis verlaat het was ek nie gelukkig nie, want ek verlang terug en ek was skaam om in ‘n oue tehuis te bly.”*

[The first time I left my home I was unhappy because I longed for my home and I was shy to be in an old age home.]

*“My pastoor het vir my plek hier gekry toe ek my huis verloor het. In die begin het ek hopeloos en skaam gevoel.”*

[My pastor got me this place here, when I lost my house. In the beginning I felt hopeless and shy.]

Shyness affects people of all ages and is linked to brain activity, how a person was raised and other experiences, and the person's reaction to those experiences. Extreme shyness is sometimes referred to as a social phobia. Also known as social anxiety disorder, a social phobia is a psychiatric condition defined as a "marked and persistent fear" of some situations, hindering one's interpersonal or professional goals (Henderson & Zimbardo, 2008). Retirement may also bring out feelings of lower self-esteem.

Shyness treatment concentrates on changing behaviour so the person feels more at ease in shyness-provoking situations. The person may be guided by a self-help book or participate in individual therapy. Relaxation tapes and CDs guide the listener through a series of actions to relieve tension. The activity starts with deep breathing and then the person progressively focuses on different parts of the body (Carducci, 2000).

### **Disrespect or cheekiness**

The American Heritage Dictionary (2009) defines "cheeky" as being disrespectful in speech or behaviour, or impudent, which means ill-mannered. Even in the literature that does not pertain specifically to old age homes, it is clear that most authors are aware of many kinds of humour in speech and that these can have different functions. Both the elderly and caregivers can be cheeky. If differences of opinion exist, this can lead to arguments.

Negative remarks from caregiver are evident from the following statement:

*“Hulle is ‘n bietjie ‘cheeky’. As hulle gepay het, dink hulle jy wil hulle onderdruk.”*

[They are a little cheeky. If they have received their allowance, they think you want to undermine them.]

Norrick (1993), Kotthoff (1996), Bower and Cortes-Conde (1997), Astedt-Kurki and Liukkonen (1994) and Robinson (1983) ( in Parreira, Thorson, Allwardt, 2007) make a basic distinction between “joke-telling” and “conversational humour”; the former being a delineated speech event with its own internal organisation/specific generic qualities (e.g. a punch line), and the latter being a catch-all term for various kinds of verbal “playing”. Conversational humour can be further broken down into various other categorisations: Bower and Cortes-Conde (1997) (in Grainger, 2002) identify teasing (i.e. where someone present is the object of fun), joking about absent others and self-denigration. Norrick (1993) (in Grainger, 2002), on the other hand, identifies anecdotes, joint narratives, word play, mocking, sarcasm and teasing.

### **Aggressiveness**

Aggressiveness can also be evidenced as disrespect. Thesaurus (n.d.) defines aggressive as the readiness, or having a tendency, to attack or to do harm to others. According to Soanes, Hawker and Elliot, (2005), emotion can be defined as a mental and physiological state associated with feelings, thoughts and behaviour. Emotions are associated with mood, temperament, personality and disposition. The word “emotion” includes a wide range of observable behaviours, expressed feelings and

changes in the body.

Caring for the elderly is not easy; sometimes they are unwell and do not want to cooperate and say nasty things to the caregivers.

*Ons het ons goeie dae en ons slegte dae met die ou mense. Ek het ook al met n klap deur gestap. Dit was oor 'n kledingstuk. Sy wou blou slaapklere hê. Toe het ek die hele klere uit gehaal en gewys want daar was nie blou klere nie. Ek moes maar net sluk en voortgaan.*

[We have good and bad days. I also received a smack from an elderly woman. It was about a blue nighty that she wanted to put on but there was no blue nighty. So I took all her clothes out to show her. After the smack I just had to swallow and go on working.]

*“Soms is hulle aggressief grappig en praat hard dan stuur hulle jou weer.”*

[Sometimes they are aggressive and make jokes and speak loudly, and then they send you again.]

Physiological changes occur in all body systems with the passing of time, for instance a loss of auditory neurons occurs, which can lead to hearing loss and can be the reason why elderly people speak too loudly (Stanhope & Lancaster, 2006).

## **Language**

Webster (n.d.) provides numerous definitions for the term “language”, of which three

clarify language as being part of communication. Language is defined as a systematic means of communicating ideas, by the use of conventionalised signs, sounds, gestures or marks having understood meanings. It is also viewed as a form or manner of verbal expression. It is further defined as the words, their pronunciation and the methods of combining them that is used and understood by a community.

The use of language can also pose a problem in communicating with the elderly. The concept of society as an extension of the family is evident in the transposition into social usage of a language originally intended for domestic life (Hornby, 2006).

Elderly people indicate that caregivers are discourteous and do not show respect. As an example, the use of the word “you” in English is an acceptable form of addressing people, while in Afrikaans when speaking to the elderly one would use the word “u” and not “jy”, which is the equivalent of the word “you” in English. Use of “u” in Afrikaans implies respect for the elderly. In American and Vietnamese society the same problem arises. In American society, emphasis is placed on friendliness in interpersonal relationships, while in Vietnamese society the emphasis is more on respect Brown & Levison, (1987) ( in Mills, 2003).

This sense of respect is also reflected in the language differences between the Vietnamese and Americans, in their daily lives. American people use only one word, the word “yes”, to express agreement. This word is neutral as to respect or disrespect. Of course, an answer with the mere word yes, lacks the courtesy conveyed by a longer answer, such as "Yes, I am"; "Yes, he did"; or "Yes, Mr. Black. These

intricacies are described as complex (Shoshanna, 2005). These examples imply sensitivity to cultural use of language to ensure respect.

As referred to in the discussion on respect, the terms “Grandpa” or “Grandma” are often used to address the elderly. Before providing health care, respect should be demonstrated by enquiring the elderly person’s preference in addressing them. “Mr”, “Mrs” or “Madam” is neutral and respectful ways of addressing persons, unless otherwise preferred (Basic principles in caring for the elderly, 2002).

Negative remarks concerning the interpersonal relationships of caregivers can be summarised as follows:

Caregivers experienced various emotions in their caring role, which has an effect on their interpersonal relationships with the elderly. The display of these emotions resulted in the presence or absence of various desirable qualities or virtues in the caregiving process or in interpersonal relationships in general. As stated previously, according to Wall (2008) (in Rankin, 2010), an emotionally intelligent person is described as “having the ability to identify, manage, and control their emotions – that of a group or self”. An emotionally intelligent person (i.e. the caregiver) will assess a situation first; whereas an individual who is not emotionally intelligent will fail to do so and hence make wrong decisions (Schultz, (1958) (in Hill, 2006).

#### ***3.2.1.2.2 Concluding remarks of interpersonal relationships***

Interpersonal relationships were viewed as being an important part of the caring process. Perseverance, patience and respect were viewed as positive characteristics of interpersonal relationships as these qualities can positively influence the type of care

rendered. On the other hand, negative behaviour, such as aggression, bad temper and confusion can negatively influence quality care. Lack of good communication skills and language can be hindrances to quality care.

### ***3.2.1.2 Main theme 2: Basic physical care***

Stoyle, (1992) (in Dolon & Holt 2000) defines “caring” as a combination of putting feelings into practice and the knowledge and skills to allow someone else to live as independently as possible. Care can be either good or bad care. Good caring requires an imaginative approach; it also entails looking after somebody, such as assisting with toilet and other essential hygiene activities, as well as listening to someone’s troubles.

Some of the elderly indicated that carers sometimes neglected to attend to their basic physical needs:

*“Die versorging is nie so perfek nie.”*

[The caring is not perfect.]

*“Ons het nie n verpleegster wat vir ons kyk nie. As ons siek is moet ons self hospitaal toe.”*

[We do not have a nurse who cares for us. If we become sick we have to go to the hospital ourselves.]

Caregiving is so hard because the elderly you are caring for may not know you

anymore. He/she may be too ill to talk or follow instructions. This may be true if the person suffers from dementia. The person's behaviour could change, including having outbursts like yelling, hitting and wandering away from home. This type of behaviour may make you feel angry (Family doctor, 2007).

#### ***3.2.1.2.1 Sub - themes of basic physical care***

##### **Personal hygiene**

The results revealed that elderly people often experience that carers neglect to care for their basic human needs. Maintaining good personal hygiene is an essential part of caring for an elderly person and it enhances a person's physical and mental wellbeing Serafin, (2010). However, if you are a carer, you should be aware that when a person becomes dependent on another person for personal hygiene, they can experience a deep loss of independence and self-esteem, which can lead to agitation and depression. In most cases, it is best to help the person with personal hygiene rather than do everything for them Guinn, (2004). For example, if a person can still move their arms, they can brush their own teeth and wash their own face – albeit slowly. The advantage of this is that it keeps them from becoming completely dependent on you, relieves your workload as the carer and helps maintain mobility (Expert information, 2010).

On the other hand, caregivers indicated the challenges they face in rendering basic care to the elderly. Abott, Carman, Carman, & Scarfo, (2009) states that, in nursing homes, all residents should be clean dressed and well groomed. Elderly people can state their own preference if they want to be washed. This is evident from the

following statements.

The elderly stated:

*“Kry mense hier wat jou was, wat nie so goed is nie so 80%....!”*

[There are people here that wash you, that are not so good so for 80% ...!].

*“Die versoring is nie so perfek nie soms wil ek nie was nie, as ek nie lekker voel nie.”*

[The care is not so perfect; sometimes I don't want to wash because I am not feeling well.]

Caregivers stated:

*“Ou mense moet in die oggend gebad word naels, voete, ore moet gekyk word, onderklere moet gekyk word of dit skoon is. Kyk na die beddegoed. Die versorging is nie so goed nie. Hulle sê dit is nie my afdeling nie. Gee nie vir die oumense oefening nie. Kry oumense swaar uit die kamers, om na die saal te kom.”*

[Elderly people must be bathed in the morning. Their nails, feet and ears need to be checked. Underwear must be checked to see if it is clean. Check the bedding. The care is not so good. Other caregivers say this is not in my job description. They don't help the elderly to exercise. Simply get them out of the rooms to come to the dining hall.]

Another caregiver said:

*“As ek hom moet was sê hy ek is te jonk om te was. Die bedlêendes word elke dag*

*gewas.”*

[When I have to wash him he says that I'm too young. The bedridden are washed every day.]

One of the caregivers indicated:

*“Oumense is net soos kinders. Jy moet mooi met die persoon praat en vra of hy/sy belangstel om te was ...? As jy vra of werk vir u kan bad en sy sê nee dit is te koud, dan se jy O! ...ons sal maar môre bad.”*

[Old people are just like children. You have to speak them politely and ask them if they are interested in bathing. If he/she says it is too cold then you answer Oh! we will bath tomorrow.]

*“Party wil nie was nie. Dan word hulle kwaad. Ons fors hulle nie. As hulle se nee dan los ek”*

[Some of the elderly do not want to wash. They become angry. We don't force them. If they say no, I leave them.]

The caregivers maintain that the elderly people do not want to be washed and refuse to do exercise. The causes for this could be changes in the sensory system that cause a loss of neurons/nerve fibres, thus causing pain in the elderly, which makes them angry and unwilling to be washed. According to Stanhope and Lancaster (2006), a decrease in bone mass can also lead to osteoporosis that could lead to the increased risk of fractures. Some elderly people have a fear of water or showers and will fight against attempts to wash or bathe them. The solution here is to look for the root cause

of the fear (Expert information, 2010).

Another caregiver commented on personal hygiene:

*“Party wil nie was nie dan word hulle kwaad.”*

[Some don't want to be washed and become angry.]

The reason people need to bath mostly has to do with odour, and preventing it. The under arms (axilla) and groin (peri) areas of the body contain apocrine glands, which secrete thicker sweat than other sweat glands. This increased sweat mixes with bacteria on the skin surface, causing a strong odour, which some people find offensive (Expert information, 2010). One author says that elderly people start to economise by skipping showers and re-wearing clothes. They also lose their sense of smell and forget that they can still be smelled by others (Breath, 2008). The skin of the elderly becomes thin and needs special care, which will prevent pressure sores.

When taking care of elderly patients' bathing and cleansing needs, the following is recommended: Daily cleansing should include the face, peri area (groin), under the breasts, under skin folds, and the arm pits. Peri care or washing the privates may have to be done more frequently if patients are incontinent and using diapers. Full body bathing can be done less often, as skin tends to become drier and more fragile as we age. Frequent bathing can cause dry, itchy skin and irritation. When bathing an older adult, gentle soaps are recommended that won't sting the eyes and can double as shampoo. Lotions can be helpful after bathing to prevent dry skin (Serafin, 2010).

Another reason why the elderly don't want to wash can be due to pain, which affects their emotions and causes depression (Loughlin, 2004).

### **Pain management**

According to Anthony and Aboraya (1992) (in Clark, 2003), incidents of pain also influences emotion which may cause depression. It may also be confounded by factors such as sleep abnormalities and functional limitations. Pain and depression can result in mood swings in the elderly.

New information on pain reported by Gordon (2010) reveals that almost half of elderly people report pain in the final months of life. A quarter of people surveyed reported being troubled by moderate to severe pain two years before they died. This study shows that there is substantial burden of pain at the end of life.

### **Wound care/dressings**

A wound is a disruption in the continuity of tissue and wound healing is the restoration of that continuity.

The elderly indicated the following:

*“My regter been was af gesit. Verband was nie gereeld gedoen nie.”*

[My right leg was amputated. The dressing was not done regularly.]

*“Ek het ‘n vleis wond, kanker aan my (R) been. Dit is nou al ses jaar daar. Ek maak my wond self skoon.”*

[I have had a flesh wound, cancer on my right leg, for six years. I clean the wound myself.]

The caregivers stated as follows:

*“Ek het nog nie training ontvang nie. Wil graag training hê om wonde skoon te maak asook bedseere. In noodhulp spuite en mond versorging.”*

[I did not receive any training. I would like to be trained in wound care, treatment of bedsores, emergency care, injections and mouth care.]

*“Die moeilikste vir my is die wonde, veral as die hele lyf deur trek is met wonde, moet iemand jou tou wys.”*

[My experience is that the difficult part is the wounds that are all over the body. You need someone to teach to you.]

Caregivers need training in wound care, bed sore emergency care, injections and mouth care. Administering injections does not fall in the scope for caregivers. All these procedures are discussed in the educational programme.

If dressings were not done regularly it can lead to infection and tissue death. This can cause gangrene to set in and the person’s leg then has to be amputated (Cawthorne, 2008).

The following are some of the causes of wounds:

- Pressure, friction, which result in pressure sores
- Injuries, such as cuts
- Thermal wounds caused by extreme cold or heat

- Chemical wounds – acid on skin
- Operation wounds
- Closure of arteries resulting from blood clots, which can cause gangrene

(Mogotlane, Manaka-Mkwananzi, Makoena, Chauke, & Young, 2004)

The following section will contain a discussion on the taking of medication.

### **Taking of medication**

Some elderly find it difficult to drink their pills. They say they are healthy and do not have to drink any medication. Medicine is chemical and biological substances are administered to a person in order to prevent and treat diseases. Medicine has the ability to cure, prevent and/or manage symptoms of certain diseases but can also have side-effects. Studies have shown that the elderly may respond differently to younger people. In addition, there is a direct correlation between age and the number of drugs prescribed Chutka, Evans, Flemming & Mikkelson, (1995) (in Chang, 2005). Medication should be revised regularly, because, in the elderly, the metabolism is slower and toxicity can build up and side-effects can occur.

Caregivers stated the following in this regard:

*“Party is moeilik om hulle pille te drink. Party sê ons is gesond, ek kan nie pille drink nie.*

[Some elderly people find it difficult to drink their pills. Some say that they are healthy and do not have to drink pills.]

*“As hulle siek is, moet ek hulle behandel vir verkoue, ek moet die medisyne gaan haal. As iemand siek is raadpleeg ons die dokter.”*

[If they are ill I treat them for a cold. If someone is sick we consult the doctor.]

The elderly stated:

*“As ek siek is gee hulle vir my pilletjies.*

[When I am ill they give me pills.]

*“My suiker was baie hoog. Ek kom by Dr. Solomons, en is nou op die insulien spuit:- 45 units in die oggend en 20 units in die aand. Ek spuit myself of soms een van die hulpe.”*

[My sugar level was high. Dr Solomons treat me with 45 units of insulin in the morning and 20 units at night. I inject myself and sometimes one of the caregivers helps me.]

Caregivers were tasked with giving basic care to the elderly with chronic medical conditions. A chronic condition is an illness that lasts for a long period of time. Chronic conditions include cancer, stroke, multiple sclerosis, dementia, diabetes and Alzheimer’s disease Cesta, & Tahan, (2002) (in Fitzpatric, 2006).

Caregivers stated that they had to do everything for the elderly. As a caregiver one may be doing the following things for another person, including lifting, turning him or her in bed, bathing, dressing, feeding, cooking, shopping, paying bills, running errands, giving medicine, keeping him or her company and providing emotional

support (Family doctor, 2007).

(See further discussion on routines of administration, instructions on labels, safety measures and the administration of medication in the educational programme provided in Addendum B.)

Exercise will be discussed in the following section.

### **Exercise**

The caregivers complained that the elderly did not want to do exercise. However, elderly people are prone to falling and disease, a weak posture, balancing problems and rheumatoid problems and medication play a big role. Regular exercise programmes can be of great help. Safety hand rails along the wall can be installed to allow for support. Exercise should be done in places where the floor is not polished or wet.

One caregiver stated:

*“Ou mense is hardkoppig wil nie oefeninge doen nie.”*

[The elderly are stubborn and do not want to do exercise.]

Another caregiver said:

*“Ek gee nie die ou mense oefening nie. Dit is moeilik om die ou mense uit die kamers te kry, om na die saal te kom.”*

I don't give elderly people exercise. It is difficult to get them out of their rooms to the hall.]

Another caregiver indicated:

*“Ons nodig ‘n kursus in hoe om oefeninge te doen.”*

[We need training in how to give exercise.]

The elderly indicated:

*“Ek is in die rolstoel vir twee jaar. My bene is nie so lekker nie doen ook nie oefeninge nie.” “Ek is gelukkig, versorging is goed.”*

[I have been in a wheelchair for two years now. My legs are not very good and I don't do exercise. I am happy, the caring is good.]

*“Ek is bedlêend vir drie jaar. Ek het gegly in die toilet en my been gebreek . Ek kry nie oefeninge nie.”*

[I have been bedridden for three years. I slipped in the toilet and fractured my leg. I don't get exercise.]

Physical activities are important for people's physiological and psychological welfare. Exercise for those older than 60 is beneficial in building muscle, which helps with posture and balance. Flexibility, strength and cardiovascular endurance are all enhanced with regular physical activity. Bodies weaken with age, but with specific exercise for the elderly one can relieve joint aches and help them feel stronger (Hurd, 2007). Exercise normalises glucose tolerance, improves gait and balance, increases energy, and promotes bone mineral density, improves mobility,

decreases the effect of arthritis, promotes weight loss, reduces blood pressure, lowers cholesterol, promotes rest and relaxation, and improves sleep.

Hogstel (2001) (in D'Adamo & Miller, 2011) stated that there are myths about ageing and exercise:

- Older adults do not have the energy or strength to exercise.
- Exercise cannot help after the age 65 or 70.
- Exercise is dangerous for older adults.
- Older adults do not like to exercise.

Exercise is beneficial for many reasons, but especially for the musculoskeletal and cardiovascular systems. Exercise programmes may play a role in reducing loneliness and depression. In addition, they reduce heart disease and obesity, and other health problems, as well as helping to reduce sleeping disturbances and stress levels (Lee, 2007).

Regular exercise is beneficial for the body as well as the mind. Some of the benefits of exercise include less chances of coronary heart disease, reduced risk of high blood pressure and hypertension, decreased resting heart rate so that the heart need not work as hard to pump the same amount of blood (resting heart rate is the number of heart beats per minute when you first wake up and before you get up), an increase in bone density and reduced risk of osteoporosis. Besides, regular exercise improves the strength and stamina of the individual, improves blood circulation, reduces excessive weight, and even helps in reducing stress. Older people can benefit from exercise through an improvement in the level of coordination and balance, relieving

constipation, controlling weight and improving the sense of general wellbeing (Lee, 2007).

Exercise programmes should start slowly and increase according to individual tolerance levels. Most programmes begin with five minutes of exercise or until the individual reaches a tolerance level.

Suggested exercises for the elderly are walking, dancing, gardening and yard work, swimming and weight lifting. The best exercises are those that strengthen large muscles. Simple walking is the best and safest exercise – walking around the house and yard is all helpful. Exercise can prevent or reverse up to half the physical decline problems associated with ageing, as lack of muscle use leads to atrophy (D'Adamo & Miller, 2011).

There are a wide variety of elderly exercises to try. The best one to increase heart rate is aerobic. Another part to fitness is through yoga which is a fantastic form of elderly exercise. Yoga consists of a series of gentle stretches, poses and breathing techniques. Yoga exercises will make the elderly feel more flexible and relaxed (Hurd, 2007).

It is always great idea to let the elderly do warm up walks for up to 10 minutes before you start to work out. Then begin with small weights for the biceps muscles (Hurd, 2007).

The best option for an elderly exercise programme is to visit a gym or fitness centre in the area. It is also good for the elderly to state that they are beginners (Hurd, 2007).

**Phase 3: Implementation  
and evaluation of the  
educational programme for  
caregivers to the elderly**

The following section will contain a discussion on addressing the challenges experienced in providing and receiving adequate nutrition.

**Nutrition**

Nutrition is a very important aspect in everybody's daily lives and for the elderly in particular. Nutrition means the process by which living organisms obtain food and use it for growth, metabolism and repair. The stages of nutrition include ingestion, digestion, absorption, transport, assimilation, and excretion Whitney, Cataldo, DeBruyne, & Rolfes (2001) (in Simmers, 2004).

Nutrition is defined as a scientific study of food and nourishment, including food composition, dietary guidelines and the roles that various nutrients have in maintaining health (Online Free Dictionary Free Dictionary, n.d.).

The classification of nutrition will be discussed. A lot of research has been conducted on the role of dietary factors in various non-communicable diseases, such as diabetes, cancer and heart disease (Lindeberg, 2010). Caregivers should have knowledge of the types of foods that are good for the elderly.

Foods are classified in various categories.

Origin: animal, vegetable

Chemical composition: proteins, fats, carbohydrates, vitamins

Predominant functions:

Body-building food – milk, meat, poultry, fish, eggs, pulses, groundnuts

Energy giving foods –cereals roots, tubers, fat

Protective foods – vegetables, fruit, milk

Nutritional value – cereals, pulses, vegetables, nuts, oil, seed, fruit, animal food fats, sugar, spices. For maintaining good health we require energy-providing nutrients (Diet and Nutrition for Good Health, 2010).

In the process of becoming old the chances of developing chronic diseases like diabetes mellitus and hypertension are greatly increased. Caregivers need to have knowledge of these diseases, as well as of special diets.

- **Special diets**

The results indicated that the elderly participants were provided with insufficient nutrition, while caregivers also experienced some challenges in feeding the elderly. Some of the elderly suffer from diabetes mellitus, which requires a special diet.

This is evident from the following statements of the elderly:

*“Ons is vier oumense wat suikersiekte het. Ons kry nie ons spesiale diët nie. Ons eet maar wat hulle voorsit.”*

[We are four elderly people suffering from diabetes. We do not get our special diets. We eat what they serve us.]

The caregivers indicated:

“The elderly usually complain that they eat too early. I have brought this concern under the new pastor’s attention. To change the time to 7 and 10 o’clock to give a

snack for the Diabetic patients.”

“Kos is nooit goed nie of dit is te sout. Ons probeer ons bes om dit eetbaar te maak.”

[Food is not good or it is too salty. We try our best to make it edible.]

“Ek moet weet watter mense moet sagte kos eet en nie sout eet nie.”

[I need to know who must eat soft food and a salt-free diet.]

It is important for caregivers to be informed about diabetes mellitus and hypertension, as these two diseases need special diets. The manager of one of the old age homes indicated that one of the first things the caregiver needs to do when an old person feels weak and ill is a glucose test.

Diabetes mellitus is a group of metabolic diseases affecting the ability of the pancreas to produce or use the hormone insulin, affecting insulin secretion, insulin action, or both. Diabetes mellitus is characterised by variable and chronic hyperglycaemia and other disturbances of carbohydrate, lipid, and protein metabolism (Fain, 2009).

Those suffering from diabetes mellitus are referred to as diabetics. There are some things that they may need to change about their eating habits in order to help them maintain their blood sugar at a healthy level Bader, (2008-2010). Their doctor or a dietician can help them to plan for a particular diabetic diet plan, meaning that they will have a basic plan to follow to help make food choices for each meal and snack throughout the day. There is no hard-and-fast rule about certain foods a diabetic can

eat or cannot eat. They can eat a little of everything in moderate amounts (Lindeberg, 2010).

A diabetic person needs special care because he/she can no longer handle drastic changes in eating. Someone without diabetes may be able to skip breakfast and lunch, and then eat a huge dinner late at night, and this person's body will be able to compensate. If you are diabetic, this type of irregular eating can be dangerous because your body cannot deal with the lack and then overwhelming intake of food. Diabetic diets were created to help diabetics feed their bodies in a very controlled, regular way. Diabetics cannot skip meals or overeat at meals. Moreover, the elderly need to eat certain amounts of food at regular intervals. A dietician could help to create a daily plan specifying the number of servings of each food group to be eaten at each meal or snack (Lindeberg, 2010).

Persons suffering from high blood pressure also require special lifestyle changes, including dietary changes. This will be discussed in the following section.

Hypertension (high blood pressure) is a highly prevalent and largely symptomless chronic medical condition that affects almost one in three adults living in industrialised nations. Hypertension is more prevalent among blacks than whites, with the prevalence rates of black Americans being among the highest in the world. Among whites, hypertension is more prevalent among males than females until the age of 65, when females with hypertension begin to out number males Naughton, Bennet, K., & Feely, (2006). There are two forms of hypertension: primary (or essential) hypertension and secondary hypertension. Essentially, hypertension

represents the vast majority of cases and is characterised by chronically elevated blood pressure of unknown origin. In contrast, secondary hypertension is characterised by elevated blood pressure caused by another physiological abnormality, such as kidney disease, endocrine disturbances, or blockage of blood circulation (Chin & Rubin, 2008).

Diet is extremely important for elderly people with high blood pressure, because eating unrecompensed food can lead to kidney failure or heart-attacks. Elderly who have high blood pressure must have a healthy diet if they want to improve their condition (Groshan, 2005).

To lower blood pressure it is quite important not to eat salt or products that contain fats. It has been shown that a salt-free natural diet greatly reduces the blood pressure and the risks of having a stroke, because natural food such as fruit has a high concentration of electrolytes, which play an important part in lowering blood pressure. Two highly dangerous factors that seriously increase blood pressure and the risks of being struck by a heart-attack are alcohol and tobacco (International Encyclopaedia of the Social Science, (2008).

One elderly person commented:

*“Die kos in die tehuis is nie so goed nie. Moet meer Duits kook. Hulle dra meer kos weg as wat ons eet.”*

(The food in the home is not so good. They must cook more German. They carry more food away than we eat.)

Most people prefer to eat their traditional staple food; accordingly, old age homes need to make provision for this even if it is only once a month. For instance, Africans like porridge, Chinese rice, and white people bread.

Abott, Carman, Carman & Scarfo, (2009) stated that elderly people should be allowed to express their preferences about food and sleeping and waking times and elderly people should be treated with respect and dignity. The Human Resource Code in the (Government Gazette Republic of Namibia, No 3360 of 2004) states that elderly people have the right to make their own choices regarding care, benefits and personal affairs.

One elderly person commented:

*“Elke aand dieselde brood en wors ‘n koppie sop en vla. Vleis is te klein.”*

[Every night the same bread and sausage, a cup of soup and custard. Meat too little.]

The elderly need to eat a balanced diet.

The caregivers stated:

*“Die bejaardes kry oggend en middag ete. Aand ete moet hulle self sorg”*

[The elderly are provided with breakfast and lunch, supper they had to provide for themselves.]

Further discussion on staple food, contamination of food, diseases that can be contracted through milk, preventive measures, and the caregiver’s function of serving a meal as well as special diets appears in the educational programme (Bader, 2008–2010; Rolfes, Pinna & Whitney, 2009).

### ***3.2.1.2.2 Concluding remarks on basic physical care***

Basic physical care was viewed as important supportive activities for the caring process. Some of caregivers had not received any formal training in the basic caring needs of the elderly. These needs were identified as follows: personal hygiene, wound care, taking of medication, exercise and nutrition. Accordingly, it is important to develop an educational programme for caregivers to ensure quality care (see figure 4.1 – Reasoning map; figure 4.5 – Dynamics interactive facilitation and chapter 5 – Development of an educational programme).

The following theme focuses on the managerial support needed for the caring process.

### ***3.2.1.3 Main theme 3: Managerial support is needed***

For Hornby (2006), support means to help and encourage, providing for or maintaining by supplying. It can be moral, psychological, financial or material and, by showing or saying that you agree, it also meant to give or be ready to give.

According to the American Heritage Dictionary (n.d.), support means to bear the weight of a person. The Dictionary Com and Thesaurus, (nd. 2010) defines support as to give moral or psychological support, aid and courage as an activity providing for or maintaining by supplying.

### **Caregivers need managerial support**

Managerial support is important so that the old age home can function effectively and smoothly. The work cannot be done if there is not enough staff, finance or equipment. Around-the-clock care or supervision is needed, which means that the financial implications for maintaining old age homes are high. The salaries of caregivers are also low and do not inspire people to become interested in taking care of elderly people. Some of the old age homes do not have professional nurses for taking care of the sick.

A caregiver stated:

*“Net die tyd as jy werk is dit goed. As jy iets verkeerd doen moet jy uit....?  
Byvoorbeeld het ek n privaat werkie gedoen en die oumense het my vergoed. Toe is dit ‘n dissiplinêre verhoor”.*

[The time you work is good. If you do something wrong you must go. I have done a private job for some elderly and they rewarded me but it resulted in a disciplinary hearing.]

The following sub-themes were derived:

#### ***3.2.1.3.1 Sub - theme of managerial support***

##### **Equipment**

Caregivers complain that there is always a shortage of bandages, medicines, ointment and antiseptics and this prevents them from doing their work correctly.

Most of the old age homes in Windhoek are not sponsored by the government but by

church organisations and public donations. Others are private.

The elderly people in the private old age homes have to pay three to four thousand Namibian dollars per month. This pays for caring; food and washing and also been accompanied on visits to the doctor. Some of the elderly people have their own medical funds and this makes it easy to visit the doctor. Those with no medical fund need to visit state hospitals and clinics.

Elderly people in old age homes in Katutura, Khomasdal and Rehoboth have to pay from their pension money. On 11 August 2008, in a radio news broadcast, the matron at the Katutura old age home requested the public to provide for the needs of the elderly seeing that they only pay N\$20 of their pension money towards their keep and they have to eat three meals day.

Elderly people need constant caring and medication, as, owing to a deteriorating immune system, they are at risk of illness. They usually don't say that they are ill which is why one needs caregivers who are observant and recognise any signs of illness in the elderly.

The following statement is evidence to it.

*“We need during winter equipment like dressings, bandages wintergreen ointments disinfectant like dettol, savlon.*

*“In die winter nodig ons verkoue medisyne soos hoestroop, maagwerk en stink salf.”*

[During winter they need medicine for coughs, diarrhoea, and wintergreen ointment.]

As a caregiver it is important to learn to use home remedies to solve common problems of caring. In the place of disinfectant, salt water can be used to clean wounds. A sore throat can be treated with lemon and water. Diarrhoea can be treated with custard mixed with water.

### **Transport**

The elderly also experience transport problems, especially in the case of emergencies.

Elderly people had this to say:

*“Ervaar probleme in die aand. Selfone het nie krediet nie, om die ambulans te bel as daar nood is.”*

[Experience problems at night. No credit for cell phones to make an emergency call.]

Another elderly person said:

*“Vervoer is wel hier, maar word nie vir ons gebruik nie.”*

[Transport is here, but not for our use.]

The elderly need someone to be in charge of the old age home at all times, as emergencies may occur during the night. Transport is a problem in some of the old age homes; when there is an emergency an ambulance is generally called. In some of the old age homes a caregiver sleeps on the premises.

Social relationships and activities are important elements in the quality of life of older people. With advancing age, they are made more difficult through the possible loss of physical functions, through societal processes of differentiation, and through unfavourable environmental and technological conditions. Therefore, mobility becomes a fundamental prerequisite for participation in social relations and activities (Mollenkopf & Marcellino, 2005).

Should old people be allowed to drive? Mollenkopf & Marcellino, (2005); Doyle & Pamplona, (2006) is passionately against old people driving. He claims that at the age 74 or older the crash rates are too high. But he also points out that the crash rates are just as high as anyone under 24. Therefore, if people over the age of 74 are not allowed to drive then neither should 24 year olds (New Media Writers, 2010).

Most elderly persons experience financial problems. Many elderly people live on social security alone or social security with a small pension. Elderly people experience transportation issues since not all elderly people are able to retain their vehicles due to the expense of upkeep and fuel, as well as possible vision problems. Not all senior citizens are located on a bus-line. Some must walk or depend upon family or friends. Health concerns (such as limited mobility, arthritis, vision and/or hearing problems) may hinder the everyday tasks which many of us take for granted. Elderly people need transport for everyday activities or tasks include grocery shopping, bathing, grooming and housekeeping, cooking and budgeting (The problems elderly people face, 2010).

American elderlies of colour also experience transport problems. Only one half of

Americans of 65 or older have access to public transportation to meet their daily needs. Yet research shows the elderly use public transportation when it is available, and that access to goods and services reduces their isolation and increases their mobility. The elderly who do not drive take an estimated 310 million trips per year on public transport.

### **In-service education**

In-service training is defined as education to help individuals to develop their skills in a specific area of employment after they have started work.

In-service education and training in basic hygiene is needed to care properly for the elderly.

In this study, “procedures” refer to processes for taking care of the elderly properly. Caregivers need training on how to do a full wash, back and pressure parts. Some have training and others not.

The *US Department of Defence* (2005) and the *Online Free Dictionary* (n.d.) state that a procedure entails standard, detailed steps that prescribe how to perform specific tasks.

Procedures are defined as a course of action intended to achieve a result in the care of elderly patients that is used by all caregivers and health workers. A procedure’s intention is measure a patient’s condition with the intention of treating, curing or restoring. Rehabilitation procedures are included in this group. If caregivers are not trained and have no knowledge to do procedures correctly, it may lead to serious

consequences like physical harm, abuse and death. To control any dangerous practices within the work environment to prevent harm to the employees in accordance to the (Department of Labour Occupational Safety Health Administration)

The elderly have the right to be free from abuse, neglect and exploitation and have the right to designate a guardian to ensure the right to quality stewardship.

There are two types of caregivers: those who have received training and those without training. Caregivers stated that there is a need to receive training on the care of fractures.

The following section includes a discussion on fractures, which was identified as one of the in-service training needs.

### **Fractures**

Many elderly in old age homes fall and fracture their hips or legs.

According to Kane, Ouslander and Abrass (1994) and Tierney, McPhee and Papadakis (1994) ( in Common syndromes in older adults related to primary and secondary, 2011) 30% of the elderly fall each year and one out of four of those who fall sustain serious injuries, including fractures. Falls are a leading cause of death and are a contributing factor in 40% of admissions in nursing homes. Morbidity and mortality resulting from injuries and falls are also serious among the elderly. In 1997, 17.2 of every 100 people over the age of 65 were injured (US Census Bureau, 2005).

This was evident from the following statements by the caregivers:

“As ons kan verder opleiding kan kry oor frakture en by die raad geregistreer kan word.”

[If we can receive training on fractures, and also be registered at the council.]

*“2002 het ek en ‘n paar meisies ‘n kursus ondergaan oor frakture deur ‘n dame van uit die Kaap. As ons kan verder opleiding kry oor frakture en by die raad geregistreer kan word.”*

[In 2002 a few of the girls and I attended a course on fractures offered by a lady from Cape Town. If we could have further training on fractures and be registered at the council.]

The elderly stated in this regard:

*“Ek het gegly in die toilet en my been gebreek.”*

[I slipped in the toilet and fractured my leg.]

*“Ek het op my linker been geval en gebreek hier buite kant die oue tehuis.”*

[I fell on my left leg and broke it outside of the old age home.]

Caregivers need training in handling fractures, as the elderly’s surroundings contain many potentially dangerous places. Added to these are the physiological causes, resulting from the natural ageing process, and pathological causes.

Some of the environmental factors affecting risk of falling in the home are the following: absence of switches at room entrance and night lights; loose carpets, rugs,

and wax on the floor, small objects on the floor like cords, shoes and so on.

To prevent falls, caregivers need to see that stairs have good lighting and bilateral handrails should be fastened to the wall; bathrooms should have grab bars for tub, shower and toilet and a rubber mat in tub or shower. Shoes should be firm, non-skid with low heels; avoid walking in socks or loose slippers.

The following section will contain a discussion on the care of patients with epilepsy, which is one of the in-service training needs of caregivers.

### **Epilepsy**

Caregivers also need training in handling fits and emergencies.

A caregiver indicated:

*“Mense wat aanvalle kry wil ek weet hoe om hulle te behartig.”*

[People who get fits, I want to know how to handle them.]

Caregivers want to know how to handle epilepsy and that is why the researcher found it necessary to teach the caregivers about epilepsy. Epilepsy is one of the most common neurological diseases and, although few primary-care practitioners realise it, the prevalence of epilepsy is highest among older adults, especially after the age of 65 (1–3). In those older than 70, the incidence of epilepsy is nearly twice that of children (3) and in those aged 80 years and older, the disorder occurs three times more often than it does in the paediatric population (Riban, 2008).

Among patients older than 75, 10% will experience a seizure and 3% will be

diagnosed with epilepsy. Until recently, however, there has been very little information about epilepsy or seizures in older adults, the focus being on infants, children and young adults (Epileptic seizures in older adults, 2009).

### **Career structure**

Most caregivers want to climb the career ladder; they want promotion and an increase in salary, benefits such as a housing allowance, a medical fund and a bonus. Some elderly homes have these benefits, others not. Most caregivers are married with a family to support. Moreover, most care for the elderly as it were a calling. The following statements are evidence of this:

*“Verdere studies is belangrik. Ons lewer ‘n belangrike werk dat ons kan strewe na ‘n diploma nie net ‘n sertifikaat nie. Ons werk al so lank kan upgrade word.”*

[Further study is important. We deliver very important work to strive for a diploma and not only a certificate. We work for so long and need to be upgraded.]

A study conducted by McGarry (2009) focused on the quality and nature of boundaries of care in the relationship between caregivers and the elderly within the home context. It was found that the location of care and the concept of the home in terms of geographical and metaphorical meanings was also a crucial factor in caring. What is crucial is that the implicit qualities that are valued within the caregiver–elderly relationship within this context of care and which contributes to the quality of care are recognised and made more explicit at the organisational and policy level. It is recommended that managers should clearly define and articulate the role and function of the caregiver, the nature of their relationships and issues concerning

construction in the specified caring environment.

### **Staff shortages**

Most of the caregivers indicated that they had to work long shifts owing to a shortage of staff. Accordingly, their family life is also affected. If there is a family gathering they have to work. Baldwin and Peters (2001) (in Baldwin & Hanel, 2003) maintain that when demands are high, overtime has to be worked in an attempt to make the system work. One is therefore always in a dilemma and end up sacrificing one's family life.

A study conducted by Stevans, Hasbrouck, Durant & Dellinger, (2004) investigated the cost of high staff turnover in long-term care facilities. The report includes direct and indirect cost. Direct cost can be a total of about \$2,500 per loss for each worker, including hiring temporary staff or paying overtime wages to the current staff, advertising, interviewing and background checks and training of new staff. Additional costs of \$1,000 can be added for replacing an employee.

One caregiver indicated:

*“Jy moet almal na se probleme luister. Jou werk beïnvloed familie sake wat jy nie kan bywoon nie. Daar is nie genoeg geld om meer personeel aan te stel nie.”*

[You have to listen to every one's problems. Your work influences family life. There is not enough money to appoint more personnel.]

Another care giver stated:

*“Finansiële sake is moeilik, daar is 'n tekort aan staff. Moet instaan voer of vas hou,*

*nie kans vir omdraai nie.”*

[Finance is difficult; there is a shortage of staff. You have to stand in, no chance to turn around.]

One elderly stated.

*“Ek dink hulle het te min personeel vir die aantal mense wat hier bly.”*

[I think they have too few staff for the total number of people living here.]

Staff shortages are not only a problem in Namibia but also in South Africa and worldwide. A spokesperson for Manto Tshabala-Msimang, a former South African Minister of Health, Sibani Mngudi, Stiftung, (2010) states that the government is renewing efforts to develop skills by attracting health workers home, as crime and affirmative action are driving health workers abroad.

Owing to staff shortages, caregivers experience no relief or given time off. According to Stanhope and Lancaster (2006), this can lead to frustration and bad temper and rough handling, which can lead to bruising and bleeding. Stress and burnout in caregivers lead to frustration owing to long working hours and there are no counselling sessions available to relieve stress. Discrimination and favouritism against the dependent elderly prevail because of their rudeness or untidiness, to mention but a few reasons.

Kibler (2010) states that, in West Germany, there is also a scarcity of doctors, nurses and domestic staff. Again and again whole or half departments have to be closed because of lack of staff.

Mc Gann and Lyytinen (2008) stated that, in Helsinki, the reasons for a shortage of nurses in old age welfare include small salaries and difficult working conditions. A dozen vacancies out of 1,600 are open.

Bethesda, (2008) predicts that by the year 2015, 31 sub-Saharan countries will face a cumulative shortfall of 800,000 health care professionals.

Participants complain that there is a shortage of staff so family days are neglected; they have to work long shifts and also over weekends. Caregivers stated as follows:

*“Jou werk beïnvloed familie sake wat jy nie kan bywoon nie. Daar is nie genoeg geld om meer personeel aan te stel nie.”*

[Your work interferes with family matters; one cannot attend family gatherings; and there is not enough money to appoint more staff.]

Most of the caregivers complained that there is no formal association or quality assurance body overseeing the caregivers. The responsibilities of the association should be to do inspections and also to uplift caregivers as a group. Participants had the following to say.

*“Stappe kan gedoen word dat ons ‘n organisasie kry.”*

[Steps need to be taken to form an organisation.]

### **Elderly and caregivers experience lack of family support**

The elderly indicated that they needed the support of their families.

This is evident from the following statement:

“Die kinders kan nie na my kyk nie. Ek kom van Maltahöhe.”

[The children cannot look after us. I am from Maltahöhe.]

“*Ek het geen familie hier nie wat my kom besoek nie.*”

[I don't have family here that will visit me.]

The participants complained that once the elderly are admitted to the old age home the family forget about them. Burress (2008) suggested that the care of elderly parents should be discussed by everyone in the family, with the entire family being involved in making caregiving decisions that are in the best interests of the elderly parent as well as all caregivers. It is important to have respectful and open conversations, gently discussing a parent's wishes, needs and abilities based upon their mental, emotional and physical condition.

Elderly people need support from family members and friends. Caregivers need support from employers and colleagues, friends and family members, and the elderly. Public support is also important because it is tiring and exhaustion to take care of the elderly.

An elderly person can be rejected on an individual basis or by an entire group of people or by family members. Furthermore, rejection can be either *active*, by bullying, teasing, or ridiculing, or *passive*, by ignoring a person, or giving the "silent treatment". The experience of being rejected is subjective for the recipient, and it can

be perceived when it is not actually present. Although humans are social beings and some level of rejection is an inevitable part of life. Nevertheless, rejection can become a problem when it is prolonged or consistent, when the relationship is important, or when the individual is highly sensitive to rejection. Rejection by an entire group of people can have especially negative effects, particularly when it results in social isolation (Williams, Kipling, Joseph, Forgas & Von Hippel, 2005)

The experience of rejection can lead to a number of adverse psychological consequences such as loneliness, low self-esteem, aggression and depression. It can also lead to feelings of insecurity and a heightened sensitivity to future rejection McDougall, Hymel, Vaillancourt & Mercer, (2001) (in Levy & Killen, 2010).

To be rejected is emotionally painful because of the social nature of human beings and our basic need to be accepted in groups. Abraham Maslow and other theorists have suggested that the need for love and belonging is a fundamental human motivation (Maslow, 1954).

Positive comments were also made by elderly participants:

*“Ek het twee kinders wat ek waardeer. My dogter besoek my om vyfuur.”*

[I have two children whom I appreciate. My daughter visits me at five.]

James cited in (Samchar, Ahmedabad & Gandhingar, 2010) says “caregivers need care” to share their task with family members and friends. His further states that caregivers need to ask friends, neighbours and others to help them take a break from the strains of caring for the elderly.

*“My dogter kom besoek my elke dag.”*

[My daughter visits me every day.]

Negative remarks from caregiver’s participants regarding family support:

*“As die kinders nie kom besoek nie begin hulle hul goed te pak om huis toe te gaan. Dis belangrik dat kinders kom besoek. Dan moet ons hulle troos totdat hulle afkoel.”*

[If children do not visit they start packing their things and they want to go home. It is very important for children to visit. Then we have to comfort them until they cool down.]

Two caregivers stated:

*“Soms voel die ou mense baie ongelukkig as die kinders nie kom kuier nie. Ons hang die foto’s van kinders op die mure as troos.”*

[Some old people are unhappy if the children do not visit. We place the photos of the children against the wall.]

Another caregiver indicated:

*“Sommige oumense het familie maar hulle kom kuier nie dan word hulle gefrustreed.”*

[Some old people have family but they don’t visit and this makes the old people frustrated.]

Various types of support concerns were noted by the elderly and caregivers, which could facilitate improved functioning (Reinhardt, Given, Peplic & Bemis, (2008).

According to James cited in ( Samchar, Ahmedabad & Gandhingar, 2010) in caring for the elderly there are many emotional demands, especially when dealing with an elderly person with a chronic disease like Alzheimer's.

Worldwide, the elderly are neglected by family members. The United Nations declared 1999 as the International Year of Older Persons and requested the nations of the world to look after their older people (*Common chronic conditions in ageing at home 2010*). If families don't have an elderly person, they can adopt one. Remember, we will all grow old one day. The responsibility to sustain the elderly with an allowance should be realised. In other words, this should be viewed as a responsibility and not an act of charity. This will enable the elderly to live in pride and dignity (Samchar, Ahmedabad & Gandhingar, 2010),

#### ***3.2.1.3.2 Concluding remarks on managerial support***

Caregivers need support from management to render quality care. Management is important in order for the following areas of the caring process to be executed optimally: equipment, transport, in-service education, career structure and staff provision, which can all be barriers to the provision of quality care.

A summary will follow.

### **3.3 SUMMARY**

This chapter described the results of the survey interviews and the literature control.

This phase of the research helped the researcher to come to an understanding of the

phenomenon as an insider.

Data analysis was done using Tesch's open coding and the concepts elicited were categorised into three main themes with subthemes. This information was derived from the perceptions of the caregivers who care for the elderly in old age homes. The following sub-themes were identified:

*Theme 1: Interpersonal relationships.* These were viewed as an important entity in the caring process and present a challenge to caregivers in terms of their negative and positive aspects. The sub-themes for this theme were identified as perseverance, patience and respect, which were viewed as positive; while stressful behaviour, aggression and confusion were viewed as negative. Communication and language with negative aspects such as shyness, disrespect and aggression are important aspects that can be obstacles in the interpersonal relationships needed to render quality care.

*Theme 2: Basic physical care.* This was viewed as involving important supportive activities for the caring process. Positive and negative aspects of physical care were identified as sub-themes, which include personal hygiene, wound care, taking of medication, exercise and nutrition.

*Theme 3: Managerial and family support.* This is needed for the implementation of the caring process. The following sub-themes were identified are being needed for the caring process to be executed optimally: equipment, transport and in-service education, career structure and staff shortages.

In essence, a need was identified for in-service education programmes for caregivers

in old age homes in order to improve the quality of care.

Chapter 4 will focus on the conceptualisation framework of the concepts elicited from the inter-experiences in phase 1.

## **CHAPTER 4**

### **CONCEPTUALISATION AND FRAMEWORK**

#### **4.1 INTRODUCTION**

The development of the conceptual framework will be discussed in this chapter. Conceptualisation makes up phase 2 of the programme development process. According to Mouton, (1996) (in Masunga 2007) conceptualisation refers to both the clarification and the analysis of the key concepts in a study and to the way in which one's research is integrated into the body of existing theory and research. According to Mouton, (1996) in Masunga 2007) it also refers to the underlying theoretical framework that guides and directs this study.

From the results obtained by relating of experiences of the elderly and caregivers concerning the care that is provided to them, the main themes and sub-themes were identified. A schematic representation of the elements of a practice theory, as described by Dickoff, James and Wiedenbach (1968), within which main concepts will be classified and organised systematically is indicated in figure 4.1: Reasoning map.

## **4.2 CONCEPTUAL FRAMEWORK**

A conceptual model can be defined as a set of highly abstract terms related to constructs that broadly explain phenomena of interest, express assumptions and reflect a philosophical framework (Burns & Grove, 2005). This enables the researcher to link findings to the nursing body of knowledge.

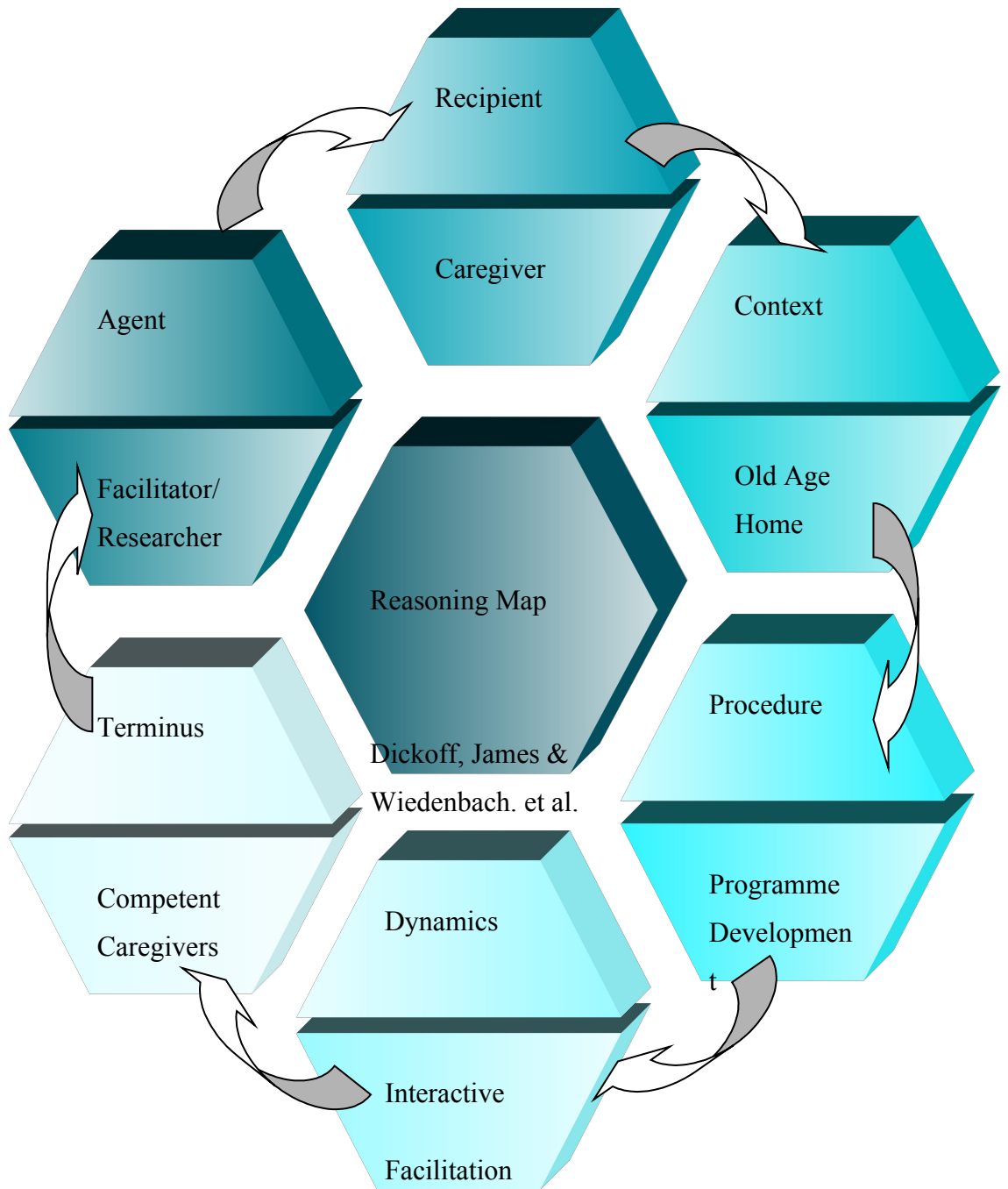
According to Fawcett (1991) (in Burns & Grove, 2005), an organised programme of research is important for building a body of knowledge related to the phenomena. While according to Woodgate (1999) (in Norlyk, 2010), the basis for the

development of qualitative studies is more philosophical than theoretical.

The framework is derived deductively from the theory. For this study the conceptual framework of Dickoff *et al.* (1968) was chosen. The reasoning map will be discussed below.

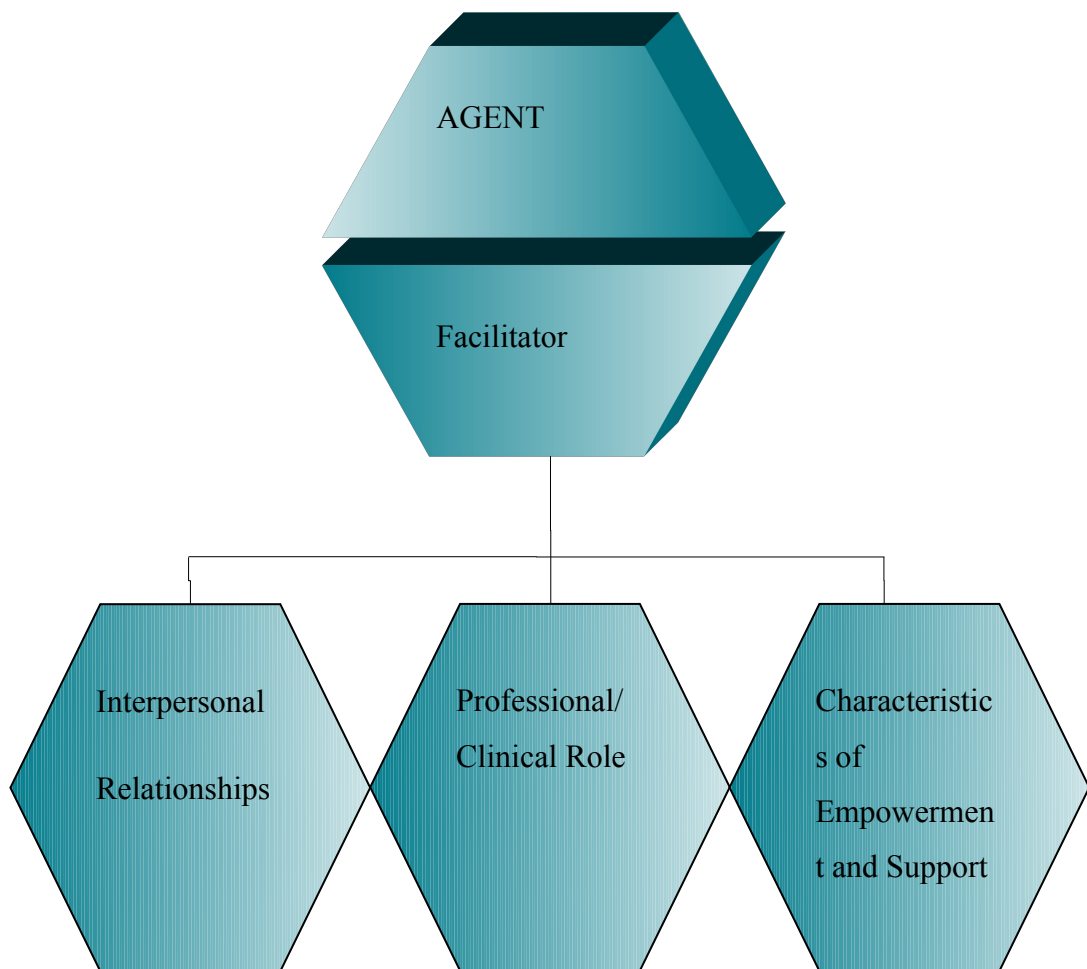
### **4.3 REASONING MAP**

In terms of the reasoning map (see figure 4.1 below), the “agent “refers to the researcher with her scientific knowledge and skills who performs the activity. The “recipient” is the caregiver who needs to be empowered to give quality care to the elderly people. The “framework” is the context in which the activity is performed in the old age homes. “Terminus “refers to the end point of the activity. The end point is to have a competent caregiver with knowledge about the elderly and skills to perform activities. The “procedure” is the guiding processes, technique or protocol of the activity. The “dynamics “refers to the energy source that is needed for the activity, which is the relevant dimensions, realities and theories (Dickoff *et al.*, 1968).



**Figure 4.1:** Reasoning map

**Source:** Dickoff *et al.*, 1968



**Figure 4.2:** The Agent: Facilitator (researcher)

#### **4.3.1 Agent:** Facilitator (researcher)

The agent is a researcher, lecturer, facilitator and community health nurse who lectures third-year students of the Comprehensive Diploma in Clinical Practice. Students are often assessed in old age homes, where they conduct physical

assessments of the elderly.

According to Stanhope and Lancaster (2006), the community health nurse is equipped with leadership roles through applying the nursing process, as well as public health science, to the population at risk, for example the elderly in old age homes.

The agent must have the following characteristics:

### **Educational aptitude (particular skill)**

Educational preparation for the community health nurse is based on a synthesis of current knowledge, nursing research, public health and other scientific disciplines. Additionally, the agent is required to perform the functions of a generalist and specialist and should possess clinical experience in interdisciplinary planning, organising, delivering and evaluation of services. Community empowerment and political and legislative activities should also be performed. The functions of professional nursing should also be performed and include assessing, diagnosing, conducting physical examinations, developing and implementing treatment plans for acute and chronic illnesses.

### **Clinical skills as a clinician**

Community health nursing practice includes nursing directed at individuals, families, and groups. The primary responsibility is to acquire a leadership role in the overall assessment, coordination and evaluation of innovative development programmes to meet the needs of the elderly and the community (Stanhope & Lancaster, 2006).

**Administrative skills as an administrator**

As a health administrator the community health nurse may be responsible for the client and have direct and indirect authority and supervision over the organising staff and client care. They serve as decision makers and problem solvers.

**Consulting skills as a consultant**

The researcher acts as a consultant who involves problem solving with an individual, family or community to improve health care delivery. Fenton (1992) (in Hutti, 2005) identify the steps of the consultation process as: assessment of the problem, determining the availability and feasibility of resources, proposing solutions and assisting with implementation.

**Researcher**

The researcher can act as agent by conducting his/ her own investigations and answering questions relevant to nursing practice and primary health care (Polit & Beck, 2008). Research in nursing practice can also improve nursing practice by the addition of new information to the existing body of scientific nursing knowledge. The researcher served as a change agent, working with individuals, groups, families and communities.

***4.3.1.1 Interpersonal relationships of the agent***

Developing a helping trusting relationship is the mode of communication that establishes a rapport of caring; the characteristics of caring are empathy and warmth.

Warmth means to accept the caregiver (Watson, 2005). Congruence means that the agent is genuine, honest and open in her/ his interaction with the caregiver. The agent requires patience, as recipients may process information at a slower rate than others. The agent needs to be helpful and supportive. Negative behaviour will prove to be futile. The researcher as a facilitator requires a high level of integrity to provide feedback on the results of the research and follow-through on promises.

She needs to have respect for the privacy and dignity of others, implying that if participants decide to withdraw from participating in the research, the researcher should respect this decision and not coerce or force participation. The agent needs to be non-judgemental in order to work with persons of different creed, colour, race, ethnicity, sex, socioeconomic status or health status. The agent should allow freedom of expression without interference, as the lived experiences are unknown to her.

The researcher, as a facilitator must have good interpersonal relationships and good communication skills, including good listening and probing skills. She should also possess excellent oral and writing skills so as to communicate easily, effectively and persuasively on the phone and in writing.

#### ***4.3.1.2 Qualities of the agent (researcher)***

The three vital characteristics of a researcher are enthusiasm, perseverance and staying informed (Salloum, 2007). Caregivers and health workers are always surrounded by negative energy, as caring for the sick and the dying can influence enthusiasm. One deadly enemy is failing to demand all facts before committing

ourselves to the venture is to sit, do nothing and lose it all (Michael, 2001). Hawker (2006) maintains that enthusiasm means excited interest in and enjoyment of something. Enthusiasm, according to Hornby (2006), means an excited or passionate interest or eagerness to do something. Michael (2001) says that an enthusiastic person exudes confidence in the working situation which is contagious. People with positive attitudes are always surrounded by positive energy. Positive people are always motivated and will find a solution for each difficulty (Weinstein, 2001). Michael (2001) states that enthusiasm in the way you smile, the way you walk and the way you act to attract others. According to Hill (2006), enthusiasm is fuelled by inspiration and perseverance, it travels with passion and its destination is excellence; powerful transformation takes place when we are surrounded by enthusiastic people.

In academic circles, rejection is rife, and part of this line of work; the key would be to regard this rejection as a learning opportunity and persevere against all odds. Perseverance, according to Hornby, (2006), means the quality of continuing to try to achieve a particular aim despite difficulties; to be steady and continue to act, usually over a long period, doing something in spite of difficulty or lack of success. According to Barrett, (2008) “perseverance” is to be committed and hardworking, to have patience and endurance, and be able to bear difficulties calmly and without complaint and to try again and again. People have the ability to display perseverance even though they come from a home where fighting and unhappiness is prevalent. Perseverance is to study and to work hard to give it try one’s best, to obtain your ideals and never be a quitter.

The researcher should be creative and highly motivated; a good problem solver who

sees problems as challenges that can be overcome. Hawker, (2006) explains “creative” as an adjective involving the use of imagination in order to create something. Motivation is explained in Hawker, (2006) as providing someone with a motive for doing something, i.e. making someone do something.

The researcher also needs to have a good appearance and be a good role model since they will represent their work place outside. They should be able to work as a member of a team and take direction.

### **Leadership**

According to Clark (2003), leadership is the ability to influence the behaviour of others. According to Podolmy, Khurana and Hill – Popper (2005), leadership means the ability to lead, guide, direct or influence people. The researcher as a leader must be able to adapt her leadership style to fit the needs of the moment. As a leader, the researcher also has the function of identifying the need for action and leadership and assessing the needs of followers. According to Rick (2000), the point could be made that management and leadership are not the same, since persons who function like managers are not necessarily effective leaders. Today, strong leadership skills are more sought after than effective management skills. According to Milligan, (2006) a leader can be a motivator and cheer leader, setting the tone and nurturing morale, commitment and motivation.

A leader should be positive. A leader can also be the promoter and makes plans to increase success in each role of the followers (*Leadership and dealing with conflict* 2010).

There are seven good leadership principles that will produce the desired respect and trust in followers (*Leadership and dealing with conflict*, 2010).

1. *Leaders should be competent in their job.* It is the duty of a leader to ensure continued professional development. The agent has the responsibility of being knowledgeable about principles of caregiving and to discern the level of knowledge to be disseminated to caregivers, who are often unqualified. Latest best available evidence should be employed to ensure evidence-based practice, even at the level of caregivers.
2. *Leaders should know their people and know themselves.* Leaders cannot lead if their followers do not know them. Interaction with those under the agent's leadership is essential. Being involved as a cheer leader and motivator best describes a leader, as stated by Milligan (2006). The agent should know the strengths and weaknesses of those he/she works with. Accordingly, a situational analysis made it possible to investigate the strengths and weaknesses of caregivers. The agent as a professional nurse and lecturer with extensive involvement in community work attained credibility as a leader.
3. *Leaders should be frank and keep subordinates well informed.* The agent should be honest and disclose the strengths and weaknesses of the caregivers. Work done well should be praised. Accordingly, after the completion of phase one, when the data had been analysed, the caregivers were informed of the outcome of the data analysis, especially with regard to the general experiences of the elderly. As the elderly receive services from the caregivers, the input of the elderly gave an indication of the quality of care given.

4. *Leaders should aim to be good coaches, set realistic standards and give an indication of reasons for standards of practice.* As mentioned previously, the agent had to be able to discern the level of the knowledge to be disseminated to the caregivers, as this would ensure the establishment of realistic standards. The agent had to be a good instructor and explain and demonstrate procedures step by step. Caregivers were given the opportunity to practise or demonstrate what they learnt so that uncertainties could be clarified. An important reason for maintaining standards of caregiving is the safety of the elderly and to prevent medico-legal hazards.
5. *Leaders need to be impartial and avoid favouritism.* (Nobody likes everybody in this world). An essential part of the educational programme was to inform caregivers of the characteristics of ageing, as well as the dynamics of intra- personal functioning, which established a basis for caregivers to understand and accept the physical, psychological and social changes in the elderly. In this way, the caregivers would be able to cope with the change in behaviour of the elderly, which often leads to conflict, and would know how to handle it. The agent also needed to be objective and to understand the differing views of the caregivers.
6. *Leaders need to be sensitive.* Sensitivity allows one to detect the subtle changes in individuals that indicate problems. The agent experienced very few difficulties with the caregivers, but sometimes willingness to participate was seen as an obstacle (McNamara, 2010). The agent needed to be sensitive and observant and to respond quickly to problems with the caregivers. The *humanistic value of sensitivity to one's self and to others* is synonymous with recognising and sensing or feeling one's own feelings. The development of the self and the nurturing of judgement, taste, values

and sensitivity in human relationships evolve from emotional states (Watson, 2006). In terms of this study, it was necessary to politely guide caregivers in the right direction. It was also very important to allow time between the sessions to discuss uncertainties and problems.

7. *Leaders need to be firm and be well rooted in what he/ she believes is right.* A good leader will use all the information at his/ her disposal to make a decision. The agent, as a leader, must stand firm on his belief in what is right. Leaders often have this title, as they have relevant knowledge, skills and experience, which form a foundation on which to make relevant decisions, without being influenced by factors such as favouritism, friendships or a desire to avoid conflict. In this study, it was found that some caregivers with many years of experience in caregiving were reluctant to accept new information, but after being given reasons for the prescribed methods, they were able to concede that methods could change.

#### ***4.3.1.3 Concluding remarks regarding the agent (facilitator)***

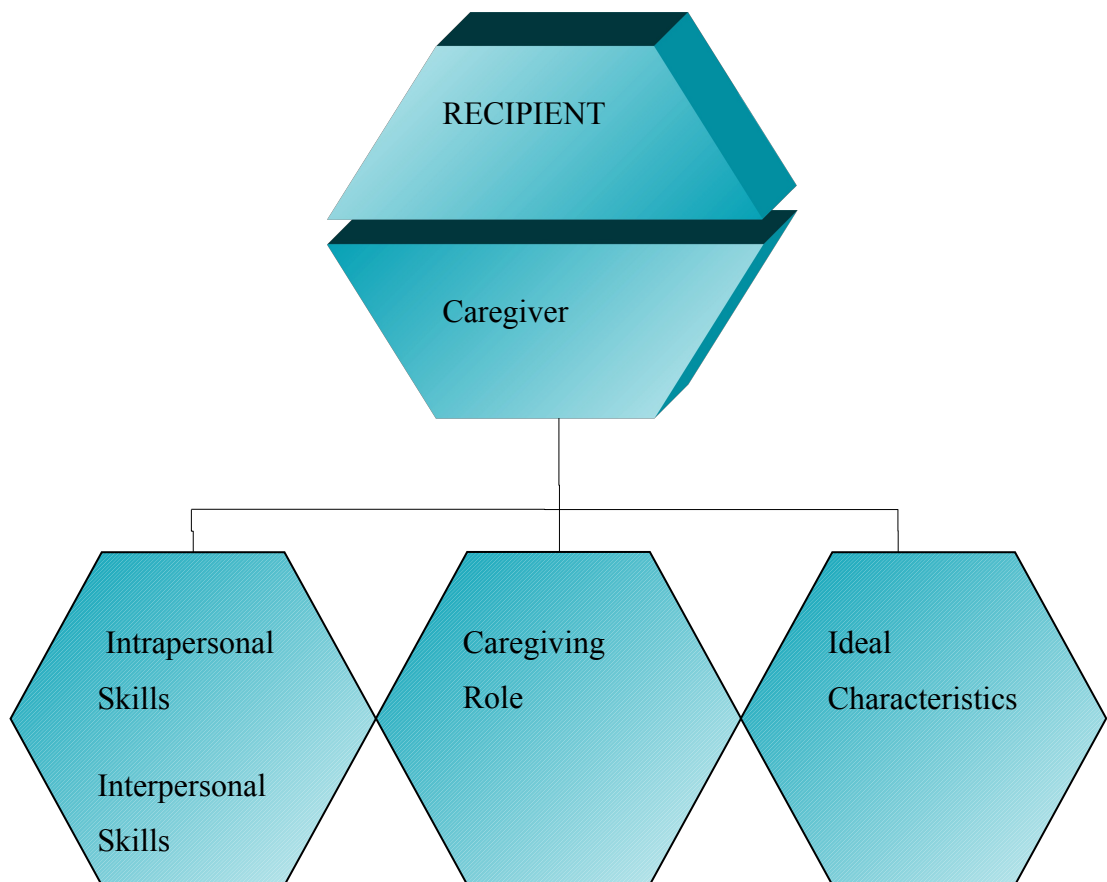
It is concluded that the agent as facilitator should possess the qualities, interpersonal relationship styles and leadership styles needed to successfully facilitate the participation of the recipients or caregivers of the elderly. Good leadership styles will produce the desired respect and trust between the facilitator and the recipient and ensure the development of competencies.

As described by Dickoff *et al.* (1968), the second aspect of activity in practice-oriented theory is the recipient. For this study the recipients are the caregivers at the

five old age homes. Figure 4.3 illustrates the caregiver as the recipient.

Following will be a discussion on the recipient.

#### 4.3.2 Recipient: caregivers in old age homes



**Figure 4.3:** Recipient: caregiver in old age homes

According to the Hawker, (2006), the recipient (a common noun) is a person who receives something. In the study, the recipient was the caregiver who had the duty of caring for the elderly.

#### ***4.3.2.1 Interpersonal skills***

Interpersonal skills are the skills that a person uses to interact with other people. These are sometimes referred to as “people skills” or “communication skills”. Interpersonal skills involve using skills such as active listening and tone of voice, and also include delegation and leadership. They are about how well you communicate with someone or how well you carry yourself (Vincent, 2009). The ideal caregiver should have good interpersonal relationships and effective communication skills, should strive to be pleasant and be a good listener, owing to the fact that the elderly can be challenging to work with. The caregiver needs to be patient, as elderly people often suffer from hearing problems and instructions or messages often need to be repeated several times. Patience as quality for caregiving was mentioned by most of the caregivers, because they felt that the elderly are like children: you had to think for them; you had to remind them to wash, to dress and to eat. Consequently, short sentences should be used seeing that the elderly have memory problems. The caregiver needs to be motivated so that learning can take place.

Vincent (2009) states that the productivity of an organisation increases if positive skills are present. Some ways to improve interpersonal skills are the following:

- Think positively and enter a mindset to work well with others.
- Do not criticise others or yourself.
- Be patient.

- Learn to listen – experts recommend listening 80% of the time and only talking 20%.
- Be sensitive to others.
- Treat others and their experiences with respect Mercury, (2006).
- Praise and compliment people when they deserve it.
- Look for solutions.
- Do not complain.

### **Caregiving role**

According to Hornby (2006), the term “clinical” is based on medical treatment or observation, practice or diagnosis. Hawker (2006) explains that clinical is related to the observation and treatment of patients.

The caregiver needs to know all the practical procedures needed to render a good service to the elderly. If these procedures are implemented, they will feel secure, their self-esteem will be high and every situation they face will be handled effective and with confidence (*Dictionary.com Unabridged*. (n.d.). 2011). The elderly need to be washed, dressed and groomed and require adequate mouth care, bed-making and intake and output. In some cases, caregivers are expected to wash used linen and clothes and also to clean rooms.

Watson’s theory of carative factors provides a basis for a supportive, protective and corrective environment, as well as a sound mental, physical, socio-cultural and spiritual environment. For example, when the caregiver is dealing with a daily full

wash or perineal care, he/she does it for restoring health Watson, (1979) (in Black & Hawks, 2005). The carative factor teaches the caregiver that every human being has basic needs, that needs that are similar to Maslow's Hierarchy of Human Needs (1954). If caregivers deal with the daily routines, like full-wash and other procedures, a comfortable and safe environment is assured (Watson, 2005).

#### ***4.3.2.2 Ideal caregiver characteristics***

Caregivers need to be innovative. The presence of competent caregiver's at old age homes must bring a change in the caring of the elderly. Hawker, (2006) states that "innovative" means to introduce and use new ideas or ways of doing things.

Caregivers need to be committed to their work. Committed means the caregiver must be willing to work hard and give her time and energy to her work (Hornby, 2006). During the inter-experiences, caregivers complained that there is no time for family life. If they are off duty they wonder whether the elderly people are ok. The elderly become like their children.

Caregivers need to be competent to do their work. Competence, according to Eksteen (1986) (in Muthuveloo, Rajendran, Rose, Raduan and Che, 2005) means to be qualified and able to execute patient care safely, without any medical hazards. According to the Hornby (2006), competence means having enough skills or knowledge to do well and to the necessary standard. This quality is important seeing that elderly people are a vulnerable group.

Caregivers need to be gentle. According to the Hornby, (2005), gentleness means to be calm and kind, doing things in a quiet and careful way using a gentle

voice/laugh/touch. Elderly people want to be treated with respect and to be talked to in a gentle way. If one is harsh they may not like you and will say that you have no manners. During the inter-experiences many of the elderly people complained that caregivers did not know how to talk to them. Respect is another quality that caregivers need with regard to the elderly. Everyone has the right to be treated with respect Gorman, (2006). The elderly need to be respected in terms of their privacy and their possessions. Hornby (2006) maintains that respect means a feeling of admiration for someone because of their good qualities. Respect is a feeling or attitude of admiration and deference towards somebody or something.

Watson, (2006) investigated the issue of respect in five generations across Wales. The responses attained from the study distinguished respect as being a two-way process. Accordingly, respect given deserves respect in return. We live in a time where respect for one another is sadly lacking; self-interest with no consideration for others characterises our society.

According to the *accurate and Reliable Dictionary* (n.d.), punctuality means arriving or taking place at the arranged time, or the need to be punctual on duty. The dependent elderly need to receive their medicines, food and caring on time. According to an article in the *Manila Bulletin* (2006), punctuality is the trait of being on time in a meeting, in attending occasions, in doing one's work.

Punctuality connotes cooperation, considered tolerance, promptness, readiness, responsibility in attending to ones duties and obligations to others. Punctuality is a very important value that our caregivers must possess. In an article by Antonuk, (2007) quoting Dudycha (1937), it is maintained that men tend to be more punctual

than women, but more women than men mentioned consideration for others as an important context of punctuality.

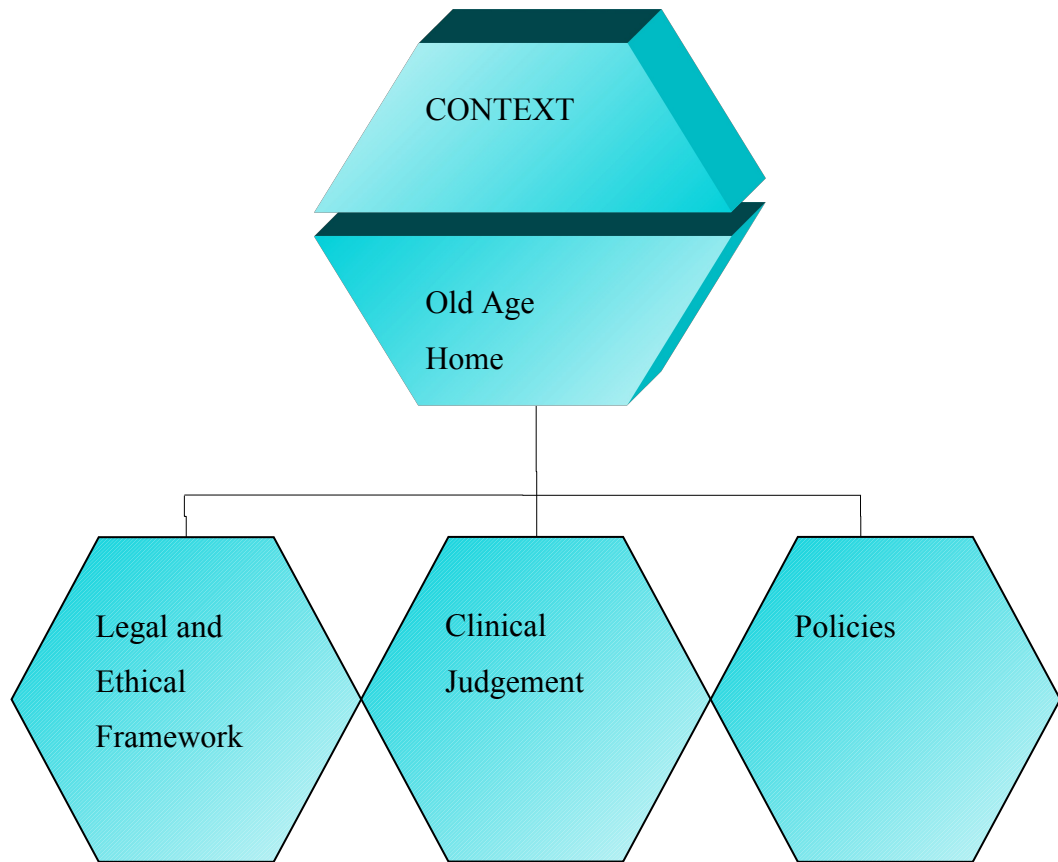
#### ***4.3.2.3 Concluding remarks regarding the recipient***

The caregiver needs to have good interpersonal relationships in order to communicate effectively with the elderly, as well as with the facilitator. The ideal caregiver should be innovative, committed, competent, gentle and respectful, as well as punctual and responsible. To integrate these values the person must be at peace with him/herself.

The third activity in the practice-oriented theory described by Dickoff *et al.* (1968) is the context. In this study, the context is the old age homes where the caregivers work.

Figure 4.4 illustrates the context, that is, the old age homes

### **4.3.3 Context: old age homes**



**Figure 4.4: Context: old age homes**

Hawker (2006) explains context as the circumstances surrounding an event, statement, or idea. In this case the old age homes are the context where the caring of the elderly took place. Old age homes have internal rules according to which they function. These concern the following: criteria for admitting an elderly person to the home; what the elderly have to pay for their board; visiting times for family and friends; what to do when elderly people are ill; safety aspect that have to be

addressed when planning old age homes; elimination of environmental hazards; home and neighbourhood security; and prevention of elder abuse (Clarke, 2003).

Watson (2009) divides the environment into physical safety and environmental factors. The aim of the caritas process is to create a healing environment on all levels, namely, physical, psychological, spiritual and social, to ensure comfort, peace and dignity.

#### ***4.3.3.1 Legal and ethical framework***

##### **Disciplinary code**

Old age homes function according to a disciplinary code. On appointment, caregivers are given a copy of this code. On transgressing the code, the transgressor receives three written warnings. There after a labour consultant looks at the case and the defendant has the right to appeal any decision.

#### ***4.3.3.2 Policies***

**4.3.3.2 (a) Health and Safety Act** (No 15 of 2004 in the Labour Act 1992 of 13 March 1992) cited in the *Government Gazette* (2004) to consolidate and amend the Labour Law, to establish a comprehensive labour law for employers and employees; to entrench fundamental labour rights and protection; to regulate basic terms and conditions of employment; to ensure the health, safety and welfare of employees; to protect employees from unfair labour practices; to regulate the registration of trade

unions and employers' organisation to regulate collective labour regulations; to provide for the systematic prevention and resolution of labour disputes; to establish a labour advisory council, a labour court, a wages commission and a labour inspectorate.

Regulations relating to the health and safety of employees at work (Government Notice No. 156 of 1997) are cited in the *Government Gazette*. This is just an overview of the different chapters protecting employers and employees:

Chapter 1: Rights and duties of employers. Employers need to know their rights and duties.

Chapter 2: Administration

Chapter 3: Welfare and facilities at workplaces

Chapter 4: Safety of machinery

Chapter 5: Hazardous substances

Chapter 6: Physical hazards and general provisions

Chapter 7: Medical examinations and emergency arrangements. Caregivers need to go for medical checkups annually. They also need to attend their follow-ups for chronic diseases monthly Tanner, (2004).

Chapter 8: Construction safety

Chapter 9: Electrical safety

#### **4.3.3.2 (b) Private Health Facility Act 1999.2 Commencement**

This Act is to amend The Hospitals and Health Facilities Act of 1994, so as to further regulate the Minister's powers with respect to the classification of state hospitals and state health facilities in terms of authorising the letting out of available rooms or space in a state hospital or state health facility for use for certain private purposes; to require that patients admitted for treatment at a state hospital or state health facility must elect to be classified as a state patient or as a private patient to further regulate the power of the Minister.

The Hospital and Health Facility Amendment Act, 1998 complies with a condition stipulated in the licence issued under subsection (3d) the owner of such a private health facility is convicted of an offence under this act by false information. The Minister can withdraw the licence. It is in the public interest to do so (*Government Gazette of the Republic of Namibia* 5 March 1998, Act no. 1804 of 1998).

#### **4.3.3.2 (c) Aged Persons Act (Act No. 81 of 1967) Aged Persons Amendment Act No. 14 of 1971**

To provide for the protection and welfare of certain aged and debilitated persons, for the care of their interests, and for the establishment and registration of certain institutions, for the accommodations and care of such persons in such institutions, for the payment of old age pensions and certain allowances to or in respect of certain aged persons (Statutes of the Republic of South Africa – Salaries and Pensions 1967).

Namibia is still using the Aged Persons Act (Act No. 81 of 1967) of South Africa.

Repeal of Ordinance 2 of 1965 of the territory of South West Africa in certain respects. (1) Subject to subsection (2), the Social Pensions Ordinance No. 2 of 1965, of the territory of Southwest Africa is hereby repealed in so far as it relates to old age pensions and matters incidental there to.

#### **4.3.3.2 (d) Living will**

Owing to advances in science and technology to extend life and because of legal ethical issues related to dying, more people provide their families with documents called advanced directives. Watson's factor on allowance for the existential-phenomenological spiritual dimension makes provision for life-death experiences and attending to the spiritual needs of the elderly (Watson, 2004).

Living wills are a legal document that specifies exactly what a person wishes at death. It generally states that no measures are to be taken to prolong life. A living will includes the following:

- Do not resuscitate in the case of cardiac or respiratory arrest.
- Do not hospitalise. Residents may choose to stay in old age homes although some procedures cannot be performed in nursing homes.
- Feeding restrictions – do not feed artificially.
- Medication restrictions – nonlife-sustaining medication, antibiotics, chemotherapy, blood transfusions, surgery or tracheotomy.

All these instructions must be documented and witnessed by a lawyer (Hegner &

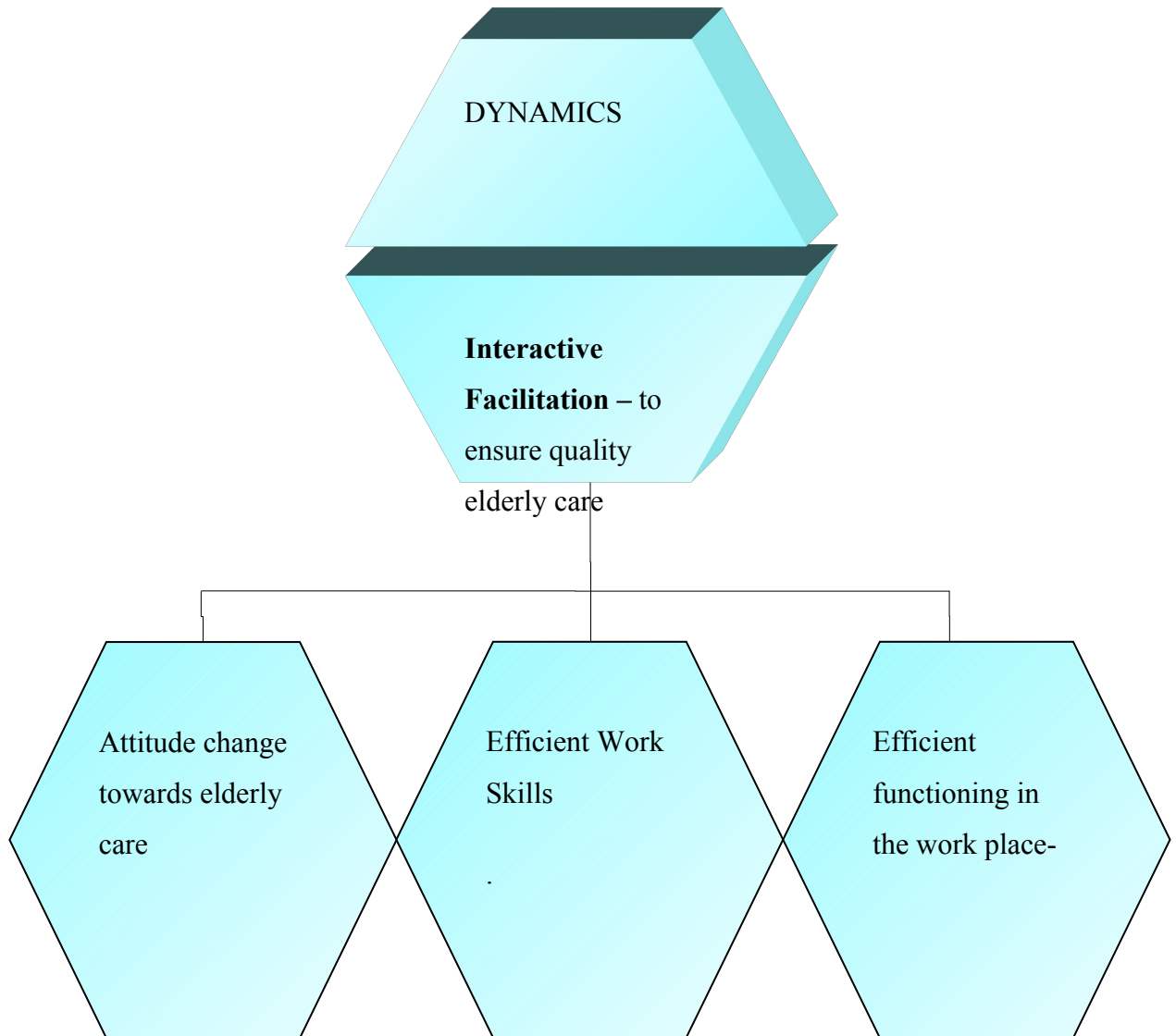
Acello & Caldwell, 2009).

#### ***4.3.3.3 Concluding remarks regarding the context***

The context in this study is the old age homes where caregivers are employed to render service to the elderly. To function properly they need to comply to certain conditions like health legislation in order to be issued with a licence to function, to provide a safe physical environment and to prevent medico-legal hazards to the elderly. It is also important for the management team to provide support and in-service training for the caregivers of the elderly.

The fourth activity of the practice-oriented theory described by Dickoff *et al.* (1968) is the dynamics. For this study “dynamics” refers to the themes and sub-themes that were derived from the situational analyses of the interviews held with the elderly and the caregivers.

#### 4.3.4 Dynamics: interactive facilitation



**Figure 4.5:** Dynamics Interactive facilitation

##### ***4.3.4.1 Attitude change towards elderly care is required***

According to the Hornby, (2006), “dynamics” means the forces involved in movement; forces which stimulate change, constantly changing and developing; the

forces that produce motion. It also means being full of energy, enthusiasm, and new ideas. Interactive means to influence each other and allowing a two-way flow of information between the caregiver and the user (Hornby, 2006). “Facilitation”, on the other hand, means to make something possible and easier.

“Quality” means the standard of something as measured against other similar things. How good or how bad is the care given to the elderly? Excellence could be the highest or finest standard (Hawker, 2006). The focus of quality assurance is on making sure that the process by which care is provided meets certain established standards. If the standard is met, no action is warranted and programme operation moves and continue. Quality improvement focuses on the continuing improvement of educational programmes. The client’s needs and expectations change over time, for example an elderly person’s condition can change from independent functioning to total dependence. The programme needs to be adjusted to the circumstances in order to improve the care (Aday, Begley, Lairson & Balkrishnan, 2004).

The researcher or manager might also contact clients or family members to obtain their perceptions of the quality of care provided to the elderly Cesta & Tahan, (2002) (in Fitzpatric, 2006).

#### ***4.3.4.2 Efficient work skills***

Hawker, (2006) states that the term “efficient” refers to working well, with no waste of money or effort.

The process of evaluation integrates efficiency, cost, equity, adequacy, quality,

timelessness and satisfaction with the care receiver. Efficiency evaluation addresses the use of resources in relation to the outcome achieved by the programme. Programmes may be highly effective but may be delivered at a high cost (Linnan & Steckler, 2002). What is the cost of the programme? Are resources (time, personnel, equipment and supplies, funding) being used as efficiently as possible.

#### ***4.3.4.3 Elderly care programme as part of an educational system***

The development of an educational programme is like a plan of action to achieve something. This programme can contribute to the body of knowledge and can give caregivers a guideline for following the correct procedure.

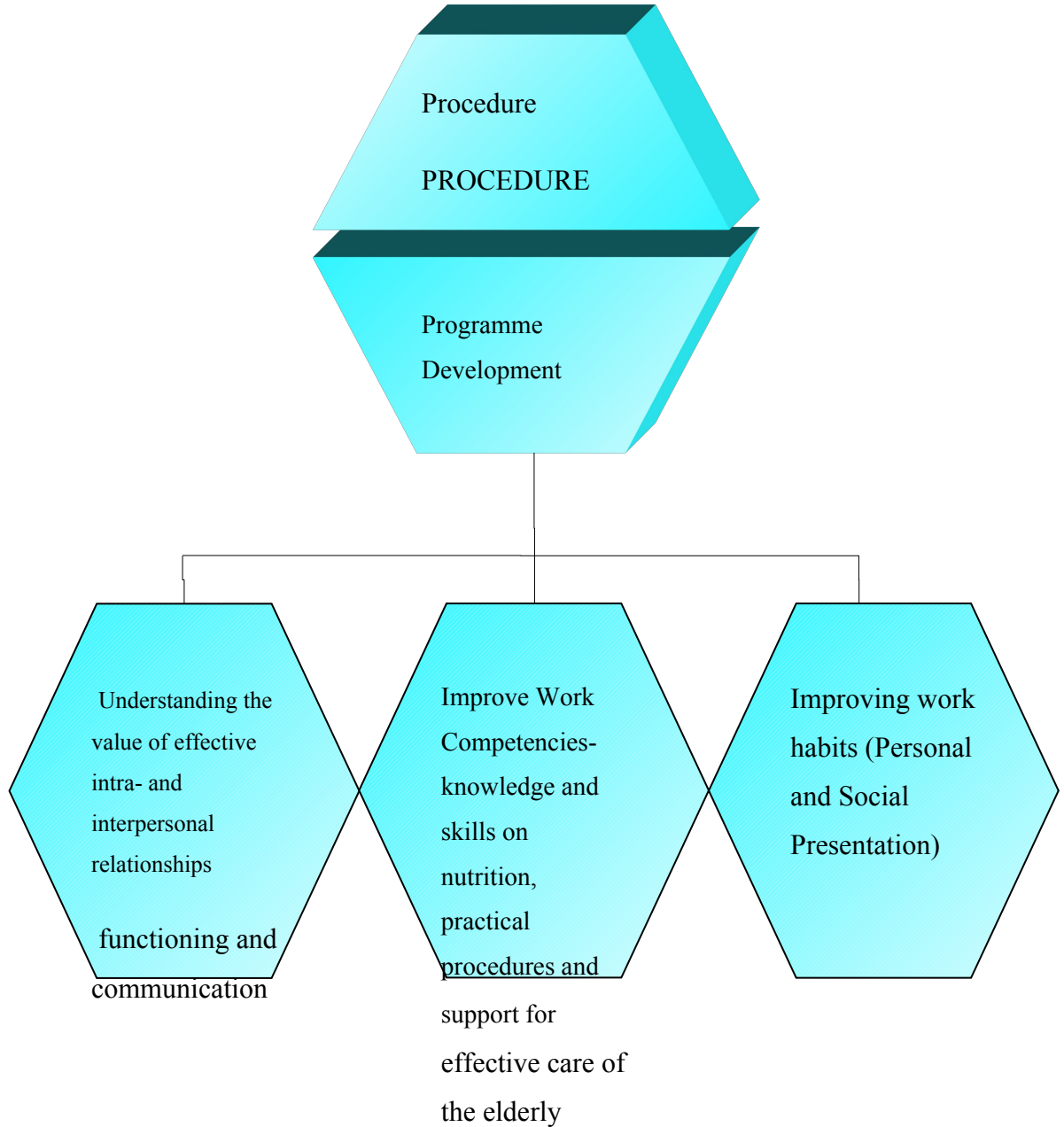
#### ***4.3.4.4 Concluding remarks regarding the dynamics***

In order to make the educational programme a success, there needs to be a good working relationship and cooperation between the caregiver and the facilitator.

The fifth activity of the practice-oriented theory described by Dickoff *et al.* (1996) is the procedures. For this study procedure refers to the educational programme for the elderly.

A discussion on procedure follows

#### 4.3.5 Procedure: Educational programme



**Figure 4.6:** Procedure: Educational programme

The Hornby (2006) states that “procedure” means to establish an official way of doing something or a series of actions done in a certain way. Thesaurus (n, d) 2010 explains “procedure “as manner of proceeding; a way of performing or effecting something: A series of steps taken to accomplish an end.

The aim in developing a programme was to address the needs and shortcomings of the caregivers in order to improve the quality of care rendered to the elderly. The slogan for programme development is “Caring, prevention and efficiency through knowledge, skills and attitude”.

In phase 1, a situational analysis was done using qualitative research. In-depth interviews were used to establish how the caregivers experience the caring that they render to elderly people and the elderly were asked how they experience the care that caregivers render to them. They were asked a simple question: “How do you experience the care that caregivers render to you?”

The concepts elicited were categorised into themes. Three themes were found.

#### ***4.3.5.1 Understanding the value of effective intra- and interpersonal relationships***

This was the first theme and it challenges caregivers with regard to negative and positive aspects. The sub-categories for this theme were emotions, communication, support and caring (*Elderly Communication*, 2010).

Although these were identified as interpersonal skills, it was necessary to address intrapersonal functioning as well. Watson, (2009) indicates that the human caring relationship is transpersonal in that it connotes a special kind of relationship, that is, a connection with the other person, a high regard for the whole person and their being in the world. We have different relationships with different people. Researchers say that interacting with a sales clerk in a store is different to interacting with friends and family members (Williams, Kemper, & Hummert, 2004).

#### ***4.3.5.2 Improving work competencies, knowledge and skills on practical procedures and nutrition***

Support and effective care for the elderly and educational sessions for caregivers comprised the second theme. Caregivers stated that they needed training in general procedures, for example, full wash, changing of linen and dressings and assessing vital signs and others.

#### ***4.3.5.3 Improving work habits (personal and social presentation)***

Caregivers voiced concern over the following aspects:

- Caregivers need support from management.
- There are shortages in human resources which influence their family life.
- There is no promotion for caregivers.
- There is a lack of resources, such as transport, medicine and food.
- Caregivers also want a board that could carry out inspections and look after their interests.

These experiences are comparable to a lack of motivators and hygiene factors as described in Herzberg's Motivation-Hygiene Theory, (2002-2010). These factors affect job attitudes and have implications for management. The focus of the educational programme is on the development of skills for caregivers in order to promote quality care of the elderly. Herzberg's theory has implications for management, thus providing scope for further research or inclusion in the further

development of the programme.

Although the focus of the programme is not on management, a third theme of improving work habits (personal and social presentation) was included. This theme focuses on improving work habits and social skills in the workplace and can be considered as an attempt to enable caregivers to improve their level of esteem concerning the totality of their work performance.

### **Caring**

Caring is the basis for looking after the elderly people. The *Encarta Dictionary* (n.d.) explains “caring” as being compassionate or showing concern for others. Caring is also related to professions that involve looking after people’s physical, medical, or general welfare, for example nursing. Leininger (1990) (in Seaton, 2010) predicts that, by the year 2010, “the central and major focus will be on caring and legitimising the discipline and profession of nursing care.” Consumers will seek caring behaviours, decisions, and actions that show respect for human beings Leininger, (1990) (in Seaton, 2010). Caring is grounded on a set of universal humanistic altruistic values, the basis of which is to ensure human caring and promote the best care. In a caring science model for practice, all knowledge is valuable in accessing clinical caring (Watson, 2009).

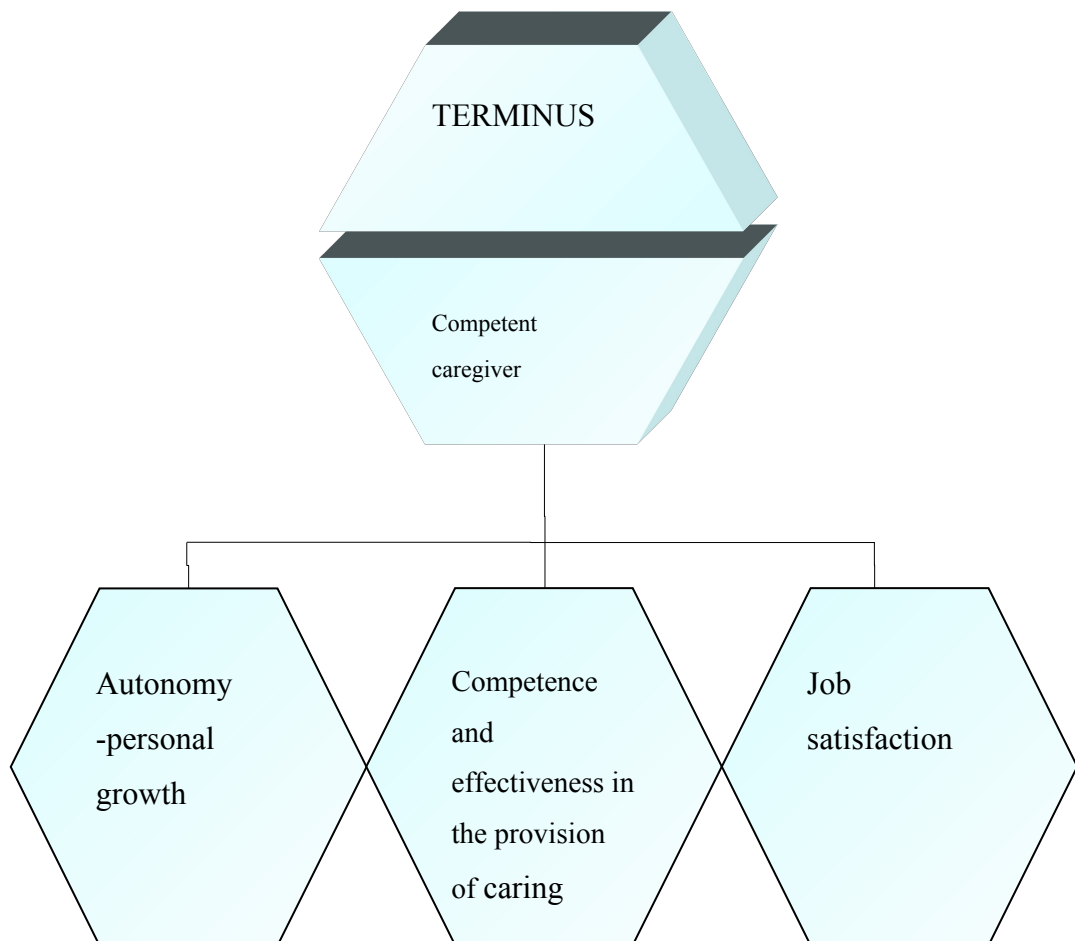
#### ***4.3.5.4 Concluding remarks regarding the procedure***

The development of the educational programme will ensure that caregivers will understand themselves and be able to form good interpersonal relationships with the

elderly, as well as with co-workers and with their own families.

The sixth aspect of the practice-oriented theory described by Dickoff *et al.* (1968) is the terminus. For this study, “terminus” refers to improvement of the quality of care of caregivers. A discussion on the terminus follows.

#### 4.3.6 Terminus: competent caregivers



**Figure 4.7: Terminus: Competent caregivers**

Terminus refers to a final point or end. According to Hornby (2006), a terminus is a point where something stops or reaches its end. The aim of the programme is to uplift

the standard of caring for caregivers in order to render better quality care for elderly people in old age homes. Caregivers need training in interpersonal skills; they need to know how to communicate with elderly people and what to expect from them. Owing to physical, psychological and social changes in the elderly, it is important for caregivers to know about these changes and how to handle them. Caregivers need to be competent. Coffey, (1999- 2011) define competency as encompasses the skills, knowledge and abilities to practice caring for the elderly. Competencies develop over time and are measurable. Core competencies of caring include, knowledge, professionalism and ethics, leadership, communication, teamwork and collaboration, safety, quality improvement and evidence based practice.

#### ***4.3.6.1 Autonomy – personal growth***

“Autonomy”, according to the Miller-Keane *Encyclopaedia and Dictionary* (2003). (n.d), means self-government and political independence. It also meant existence as an independent moral agent. The caregiver has to know how to make moral decisions and act on them. Autonomy or self-direction is a twofold attribute. Both the caregiver and the client tend to be more self-directed in an institutional health care setting. Caregivers and the elderly need to have greater control over health care decisions than in other settings. Caregivers exercise a significant degree of professional autonomy and could be the only providers of health care. They must then rely on their own decisions in choosing a course of action in consultation with other providers Rafael (1999) (in Chan, 2010). Autonomy is consistently associated with job satisfaction by several of authors (Leipert, 1996; Parahoo & Barr, 1994 in Klijn,

2010); Reuter & Ford, (1996) (in Klijn, 2010).

#### ***4.3.6.2 Competence and effectiveness in the provision of caring***

Harvey (2004-2009), explains “competence” as the ability to do something well measured against a standard, especially ability acquired through experience or training.

*The Dictionary.com.* (n.d.) Explains “effectiveness” as producing, causing a result, especially the desired or intended result. In the case of the caregiver her/his work must be done excellently with the result that she/he makes a successful, favourable impression on co-workers, the elderly and their families.

The *World Net 3.0.* (n.d.) refers to a professional as a competent skilled person who is normally qualified and experienced in a work environment.

*The American Heritage* (n.d.) explains growth as the process of becoming mature and increasing in experience, knowledge, skills and power.

#### ***4.3.6.3 Job satisfaction***

A study on job satisfaction was conducted with 111 primary care workers. The results revealed that varied personality types chose occupations in the caregiving field. Satisfaction tended to be independent of personality type, but issues such as pay, promotion, and relationships with supervisors and co-workers were important variables in job satisfaction (Carter, (1988) (in Goliath service, 2004).

An exploratory study was conducted with twenty in-home caregivers of the elderly in the Boston, United States, area about the interaction caregivers have on the job that both enhances and hinders their job performance. This research sheds light on the structural difficulties such as low salaries, long working hours, and lack of job benefits (Scanlon, 2001). Caregivers are both physical and emotionally exhausted and wages remain low, with no opportunities for advancement. The job benefits are another discouraging factor and health coverage is scarce. Many who perform the work live near and below the poverty level (Scanlon, 2001).

Namibia is no exception – caregivers who were interviewed in this study complained that to care for the elderly is hard and difficult. It involves long working hours due to staff shortages, there is no time for family life, and no advancement or working benefits and the wages are very low. These are factors that influence job satisfaction in the caregiver.

#### **4.4 SUMMARY**

In this chapter the development of the conceptual framework was described. In order to do so the elements of Dickoff *et al.*'s (1968) practice theory were selected to capture the framework.

##### **Agent**

In the study, the agent is a researcher, who has developed an educational programme. The agent needs to apply all her scientific knowledge and experience to influence caregivers to change their behaviour and to provide better care for the elderly in old age homes.

##### **Recipient**

The recipient of the educational programmes the caregiver who works in the old age homes. The recipient/caregiver needs to be empowered with the content presented in the programme, namely intra- and interpersonal functioning, basic caregiving procedures, nutrition and basic work habits. This is intended to help them to solve problems experienced by the elderly people they care for. Caregivers need to demonstrate characteristics such as competency, gentleness, respect, honesty, and punctuality in taking care of elderly.

##### **Context**

The context in this study is the old age homes where the elderly are cared for and the caregivers are employed. Old age homes have their own administrative rules and regulations, and need to be legally approved by the Ministry of Health and Social

Services to ensure a safe environment.

### **Procedure**

The purpose of the educational programme is to produce competent caregivers who will be able to improve the quality care to the elderly and manage their problems. The programme procedure involves developing, implementing and evaluating the programme with the aim of improving the quality of caring for the elderly in old age homes.

### **Dynamics**

Dynamics refers to the forces involved in bringing about change. The dynamics were derived from the situational analysis of the experiences of caregivers and the elderly, who allowed for increased insight into the specific difficulties experienced in caregiving for the elderly. Themes and sub-themes were formed from the data that were collected. The competencies of the agent and the dissemination of scientific-based knowledge about the way in which caregiving should ideally be performed provided the incentive for change.

### **Terminus**

The terminus refers to the end point or the result that this programme must have. It refers to the implementing of the educational programme in old age homes in Windhoek and later in other old age homes in the Namibia. The terminus should include a change in the caregiver's attitude towards and relationship with the elderly.

Autonomy and personal growth are characteristics of both the caregiver and the

elderly, who tend to be more self-directed in an institutional health care setting. Caregivers and the elderly need to have a greater control over their decisions made in a health care decisions than in other settings.

The competence involved in and the effectiveness of caring implies that caregivers should be skilled, qualified and experienced in their work environment.

Job satisfaction tends to be independent of personality type, and issues such as remuneration, promotion, and relationships with supervisors and co-workers have been identified as important variables in job satisfaction.

In chapter 5, the programme development will be discussed.

## **CHAPTER 5**

### **EDUCATIONAL PROGRAMME DEVELOPMENT (Addendums A, B, C &D)**

#### **5.1 INTRODUCTION**

The main concepts that formed the framework for the development of the educational programme were practically conceptualised and illustrated in the previous chapter; while chapters 1, 2, and 3 discussed phase 1 of the programme development process. Phase 2 of the programme development process involves the development of a conceptual framework using the information gathered in phase 1. The development of the conceptual framework was explained in chapter 4.

#### **5.2 PERSPECTIVE ON PROGRAMME DEVELOPMENT**

It cannot be assumed that care rendered to the elderly in institutions is holistic; nor can we pretend that caregivers do their best in caring for the elderly. The view that every person rendering a service requires lifelong education and training (Souers, 2002) supports this statement. Consequently, the researcher was convinced that the development of an educational programme could enhance the facilitation of care to the elderly by caregivers. In developing a programme, Macello (1998) (in Fuhling, Tülchin and Golding, 2003) suggests that the following four points are vital to its success: |

- Start from the simple and move to the more difficult.
  - Involve caregivers in daily caring for the elderly because in their daily practices they encounter many challenges.
  - The systematic flow of the programme was considered by using the developed themes from the data gathered from both groups and incorporating those themes in the programme.
  - Movement from mental to automatic refers to a point where a skill, not inborn genetically, has been mastered. Therefore, during the implementation of the programme the caregivers were exposed to different procedures that inculcated certain skills to facilitate caring for the elderly.

### **5.3 PURPOSE OF THE EDUCATIONAL PROGRAMME**

The purpose of the educational programme is to strengthen caregivers' knowledge and skills to enable them to render efficient care to the elderly.

### **5.4 APPROACHES INTEGRATED INTO THE DEVELOPMENT OF THE EDUCATIONAL PROGRAMME**

#### ***5.4.1 Philosophical approach***

The researcher incorporated the philosophy of humanistic existentialism as well as

the principles of constructivism as the basis for the programme.

Humanistic existentialism as a philosophical approach within this programme implies that caregivers should become aware of their ability to realise their own potential in the care for the elderly with dignity and respect. Existentialism is particularly applicable because it emphasises self-determination, freedom of choice and responsibility Dillard & Laiding, 1998) (in Pamerleau, (2009).

Constructivism emphasises the involvement of the caregivers in their own learning in order to construct new ideas from previous experiences in caring for the elderly. The principles of constructivism as applied to this educational programme were real practice situations and environment. These were incorporated in the programme, which assisted the caregivers to focus on the real challenges in their daily practice (Quinn & Hughes, 2007).

The facilitator of the educational programme served as a coach to facilitate thoughts and strategies for solving these problems in the following ways:

- Reflective practice was fostered.
  - Self-awareness in the construction of knowledge and skill was emphasised (Savard, 2004).

The role of the facilitator will be described in short. A facilitator is an individual whose job is to help to manage a process of information exchange and content discussion (Bacala, 2004).

The facilitator role is as follows:

- Distinguishes process from content and manages the client relationship and prepares thoroughly, uses time and space intentionally.
- Is skilled in evoking participation and creativity

A facilitator need to have certain characteristics

- Asking rather than telling
- Paying personal compliments
- Willing to spend time in building relationship, and sufficient confidence.
- Task orientated and listening without interruption (Distelhorst, 2011)

#### ***5.4.2 Educational approach***

For this programme the researcher endeavoured to keep the programme simple, but not simplistic (Quinn & Hughes, 2007). The educational programme was developed within the framework of Watson's theory of caring and principles of adult learning as indicated in Knowles's andragogical learning theory.

##### **5.4.2.1 Watson's philosophy and theory of human caring**

The focus of this programme was to enhance caregiving for the elderly. This was done by implementing Watson's philosophical principles on caring

For this programme, Watson's philosophy and theory of human caring was selected.

The process of human-to-human caring shows that there is a higher power or energy

in the universe that can be activated through the caring process. Human caring consists of the following transpersonal, intersubjective attempts: Firstly to protect, enhance and preserve humanity by helping a person find meaning in illness, suffering pain, and existence; and secondly to help gain self-knowledge, self-control and self-healing (Rielh-Siska, 1989). The human caring process consists of ten carative factors which were used in this research to give meaning to the structure of the programme. It is important to emphasise caregiving with conscious awareness of the following:

*Understanding existence, illness and suffering:* Various aspects discussed in the study contribute to gaining greater appreciation of the above-mentioned concepts. Understanding the life cycle and stages of human development and basic human needs (biophysical, psycho-physical, psycho-social and higher-order, growth-seeking needs), biological ageing and common ailments associated with ageing, contributes to the understanding of existence, illness and suffering (Watson, 2004).

*The importance of self-knowledge, self-control and self-healing:* The concept of the self (self functions) is explored as a necessary component of health. According to the Bio- Psychosocial Model, bio- psychosocial functioning incorporates all aspects of being human. The self is an aspect of intra-personal functioning, which relates to functioning in one's environment (psychosocial functioning). The self functions include one's body image, self-identity, self-worth, self-image, self-development, and rational self and proprium. Caregivers need to relate this concept to their own functioning and that of the elderly Watson, (1979) (in Black & Hawks, 2005).

*Always acting to protect, enhance, and preserve humanity:* In themes 1 and 2,

positive and negative experiences relating to interpersonal relationships and physical care are described. Negative experiences of the elderly display a decline in awareness of the importance of preserving and enhancing humanity.

Ten carative factors remain the timeless structural core of the theory. These factors evolve and emerge into the more fluid aspects of the model, which are captured by the ten caritas processes in the following table.

**Table 5.1:** Watson’s carative factors and caritas processes

<b>Carative factors</b>	<b>Corresponding caritas processes</b>
1. Humanistic altruistic values	1. Practising loving kindness and equanimity for self and others
2. Instilling/enabling faith and hope	2. Being authentically present and enabling, sustaining, and honouring deep belief systems and people’s subjective world
3. Cultivation of sensitivity to one’s self and others	3. Cultivating one’s own spiritual practices; deepening self-awareness, going beyond the “ego self”.
4. Development of helping-trusting human caring relationships	4. Developing and sustaining a helping-trusting, authentic caring relationship.
5. Promotion and acceptance of positive and negative feelings	5. Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the person being cared for.
6. Systematic use of scientific (creative) problem-solving caring process	6. Creatively using presence of self and all ways of knowing/multiple ways of being/doing as part of the caring process; engaging in caring-healing practices.
7. Promotion of transpersonal teaching-	7. Engaging in genuine teaching-

learning	learning experiences that attend to the whole person and their meaning; attempting to stay within other's frame of reference.
8. Provision for a supportive, protective, and/or corrective mental, social, spiritual environment	8. Creating a healing environment at all levels (physical, non-physical and subtle environment of energy and consciousness), whereby wholeness, beauty, comfort, dignity and peace are attained.
9. Assistance with gratification of human needs	9. Assisting with basic needs, with an intentional, caring consciousness of touching and working with the embodied spirit of the individual. Honouring the unity of being is also of significance.
10. Allowance for existential-phenomenological spiritual dimensions	10. Opening and attending to the spiritual-mysterious, unknown existential dimensions of life-death; attending to soul, care for self and the person being cared for.

The ten carative factors are explained in detail as follows:

*The formation of a humanistic–altruistic system of values*, the nurturing of faith and hope and the cultivation of sensitivity to one's self and others form the philosophical foundation for the science of caring (Watson, (1979) (in Black & Hawks, 2005).

*(Formation of a humanistic–altruistic system of values)* starts at an early stage with values shared with parents. The value system refers to one's own life experience, the learning one gains and the exposure to human knowledge. Caring can be developed by examining one's own views, beliefs and interaction with various cultures and growth experience. This brings forth maturation and personal growth George, (1995). (in Zaccagninia & White, 2011).

*Nurturing faith, and hope that includes the carative and curative factor.* Caregivers must believe in Western medicine but they must never lose hope. They need to assist the elderly to understand the healing process and believe in the self and spiritual healing. Where modern science has nothing to offer the caregiver can offer faith and hope Watson (1979) (in Black & Hawks, 2005).

*Cultivation of sensitivity of one's self and others.* It is only when the caregivers apply themselves that they develop their feelings to feel emotions as they present themselves, and can therefore really interact with the elderly. A person's mind and emotions are windows of the soul (George, 1995) (in Zaccagninia & White, 2011).

One needs to understand that the following seven carative factors originate from the foundation of the first three.

*Development of a helping, trusting relationship,* is the mode of communication that establishes a rapport of caring. Gazda (1975) (in Black & Hawks, 2005) defines the characteristics needed in the helping trust relationship. These characteristics are similar, empathy and warmth. This carative factor is applied in the educational programme for the caregivers. Congruence means the caregivers are genuine, honest and open in their interaction with the elderly where warmth means accepting the elderly. In a caregiving relationship, communication can either facilitate the development of a therapeutic relationship (helping or trust relationship) or create barriers (Stuart & Sundeen, 2008; Wilkie, 2010).

Body language speaks a lot, as does tone of voice and the way caregivers touch the elderly. Communication includes verbal and non verbal communication and listening

in a way that indicates empathy.

*Promotion and acceptance of the expression of positive and negative feelings* is carative factor five. According to Watson (1979) (in Black & Hawks, 2005) these expressions improve one's level of awareness and include feelings and thoughts and behaviour.

*Use of creative problem-solving processes.* The caregiver's needs to find alternative ways to solve their problems in caring, as long as they are not harmful or pose any health risk to the client Watson, (1979) (in Black & Hawks, 2005).

*Promotion of interpersonal teaching-learning.* This helps people to have control over their own health and provides them with information Dwyer, (2000). The learning process can be a teaching process and it helps caregivers to prepare a plan that works in terms of their caring (George, 1995) (in Zaccagninia & White, 2011).

*Provision for a supportive, protective, or corrective mental, physical socio-cultural and spiritual environment.* The caregiver dealing with daily routine like full wash, feeding, and perineal care and so on does it for maintaining health in the elderly and preventing illnesses. This carative factor can be applied to session two of the educational programme. Watson divides this factor into physical safety and environmental factors

*Assistance with gratification of human needs.* Assistance with another's basic needs give caregivers intimate access to the physical body of the elderly. Taking care of others when in need of care is a privilege and a gift to society. The caregiver not only touched the physical body, but also embodies the spiritual (Watson, 2005). This

carative factor teaches the caregiver that every human has basic needs that are similar to Maslow's (1954) hierarchy of needs. Maslow identified five basic human needs; namely

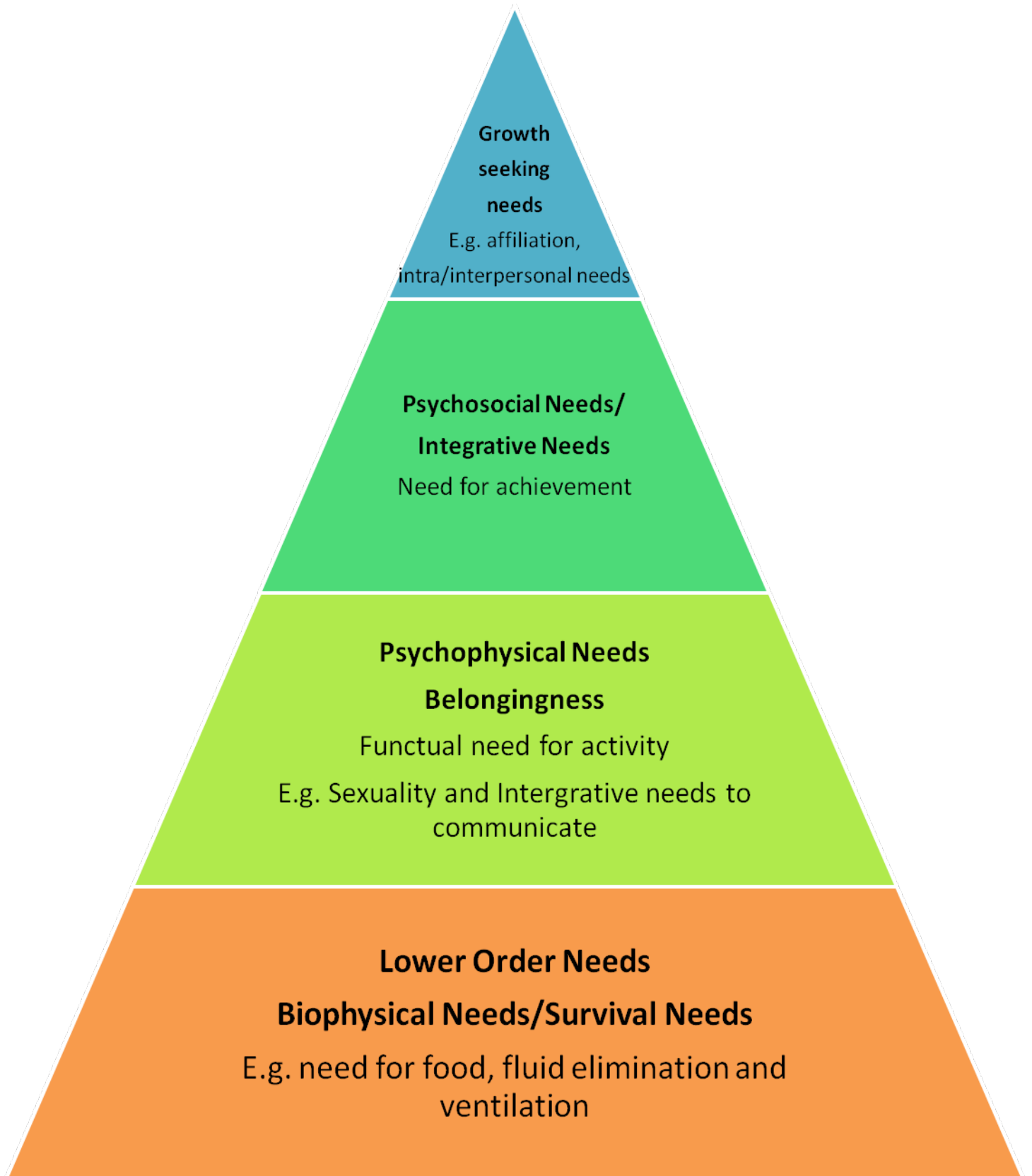
*Biological and Physiological needs*, for example air, food, drink, shelter, warmth, sex, sleep.

*Safety needs*, namely protection from elements, security, order, law, limits, stability.

*Belongingness and love needs* - work group, family, affection, relationships.

*Esteem needs namely self-esteem*, achievement, mastery, independence, status, dominance, prestige, managerial responsibility.

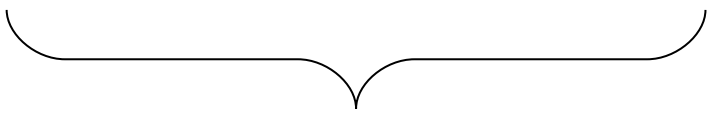
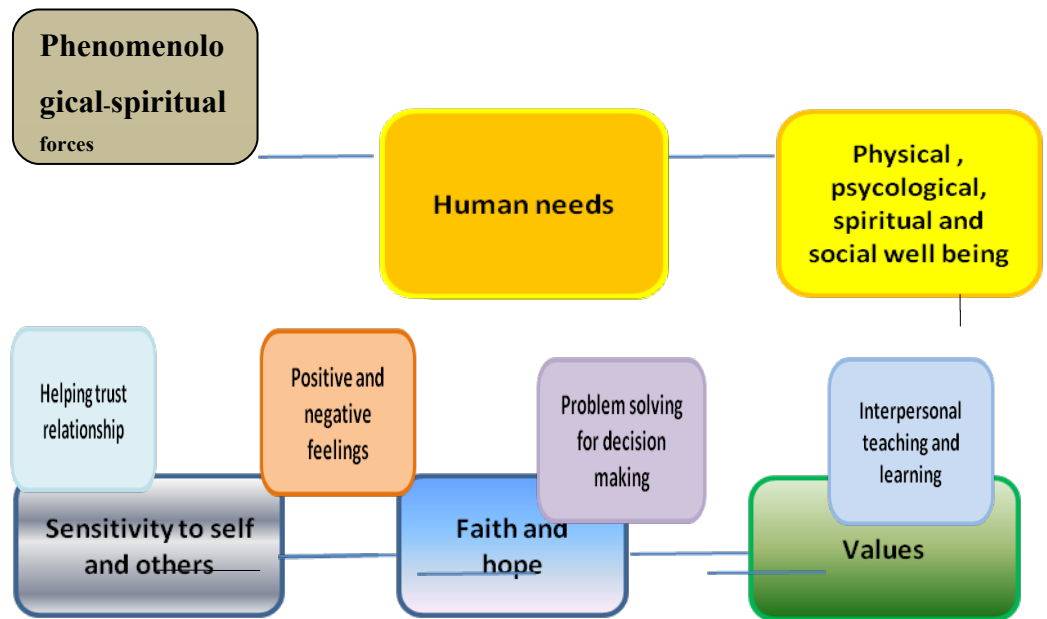
*Self-Actualization needs* like realizing personal potential, self-fulfillment, seeking personal growth and peak experiences (Chapman, 1995-2010). Maslow's needs are illustrated in the following diagram.



**Figure 5.1:** Maslow's hierarchy of human basic needs (Watson, 1979)

Caregivers of the elderly must know all these basic needs of human beings, in this case the elderly, so that they become better carers George, (1995) ( in Zaccagninia & White, 2011).

Allowance for existential-phenomenological-spiritual forces. This carative factor may assist the person to find the strength or courage to confront life and death. It also allows the caregiver to look inside her/himself before she can help others. Figure 5.2 shows Watson’s theory of humanistic care.



## Philosophical Foundation for caring

**Figure: 5.2** Watson's humanistic value system and caritive factors.

### 5.4.2.2 Knowles' andragogical learning theory

In this section the characteristics of adulthood and elements of andragogic learning are described. The key characteristics of adulthood, according to Knowles, are that adults: 1) are self-directed; 2) have a task or problem-centred orientation to learning; 3) are internally motivated; 4) have life experience; and 5) have a readiness to learn. A short description will be given on how these characteristics apply to the programme.

#### **Self-directness**

Implies that the person matures and moves from being dependent towards being a self-directed human being; that is, becoming an adult. At this point the person also experiences a deep need to be recognised by others as being self-directed Knowles, (1984) (in Robert, 2010) Self-directness is often associated with a preference for self-study and a probable inability to think critically (McAllister, 2001), thus learning support is essential.

As a person matures his/her self-concept moves from one of being a dependent

personality toward one of being a self-directed human being.

Knowles described **self-directed learning** as a process in which adults take initiative, with or without the support of others to do the following:

*Identify their learning needs.* During the situational analysis, where caregivers recounted their experiences, they expressed concern about aspects of caregiving and their work situation, which led them to identify their learning needs in order to improve the quality of their service to the elderly. Training in intra- and interpersonal skills, the basic caring needs of the elderly, nutrition and work habits during the educational programme further increased self-knowledge in terms of the need to improve the quality of their service.

*Create their learning objectives.* Caregivers' learning objectives were formed from the learning needs identified during the situational analysis. Further objectives were identified during the evaluation of the educational programme.

*Recognise resources for learning.* During the presentation and implementation of the educational programme, training was done by means of demonstrations, lectures, discussions and role-plays. Caregivers identified various further resources to enable improved quality of care. This included the need to establish a quality assurance board and further in-service training.

*Selecting and putting into practice suitable learning tactics.* During the implementation of the educational training programme, caregivers were given the opportunity to demonstrate the procedures they had learnt.

*Evaluate learning outcomes* (Kenny, 1998 in McCuddy, Van den Bosch & Martz Matveer & Morse 2007). In terms of this study, evaluation refers to the feasibility of the educational programme. The aim of this phase was to determine if the educational programme could be used to train caregivers of the elderly and also in other old age homes in the country.

### **Task or problem-centred orientation to learning**

Refers to the fact that a person matures. Their time perspective changes from one of postponed application of knowledge to immediacy of application; learning shifts from subject centeredness to problem centeredness. Knowles (1984) (in Robert, 2010) sees this not as something natural but as conditioned, as children are conditioned to be subject-centred and not problem-centred in their approach of learning. Adults have a greater wish for immediacy of application.

Within this study the educational programme addresses the needs identified by caregivers. These needs exemplify the problems encountered in their work activities and give them an opportunity to receive training based on self-identification of problems. It also activates caregivers to be proactive in their learning.

### **Internally motivate.**

Internal motivation according to Knowles (1984) (in Robert, 2010) refers to a person who matures, the motivation to learn is internal. Knowles does not see it as natural but as conditioned due to the effect of schooling. Adults' readiness to learn is the

result of the need to perform, which is externally imposed Tennant, (1996) (in Cook, Reynolds and Speight, 2010). Hasan (2011) argues that it could be said that these assumptions tend to focus on age and stage of development and also on the relationship between the individual and society.

It is a general expectation of society to have productive members, and a basic lifestyle requirement of all adults is to perform work tasks, whether remunerated or not. Work also affords status to persons (Weinstein, 2001). Caregivers, who do their work in order to receive a salary and attain a certain degree of satisfaction and status, are no exception (Changing minds. (n.d.) *Intrinsic motivation*. 2010).

### **Life experience**

Life experience is a rich source for learning which enables people to develop themselves. As a person matures he/she accumulates a growing reservoir of experience that becomes a resource for learning. Knowles maintains that education should be differently applied to adults and children Tennant, (1996) (in Cook, Reynolds and Speight, (2010)

Caregivers have varying levels of experience in caregiving, and varying levels of training. All caregivers have in common is the fact that they have encountered difficulties in their exposure to caring for the elderly. From this life experience caregivers have a frame of reference from which new learning experiences can be assimilated.

### **Readiness to learn**

Knowles (1980) in Keesee, (2010) makes some important points regarding “teachable” moments. Accordingly, the relevance of study or education becomes clear and is needed to carry out a particular task. Adult education should be organised around “life application” according to the learner’s readiness to learn.

A combination of caregivers’ exposure to problems and experiences in life situations, their internal motivation to learn and their self-directed nature contributes to being ready to learn. As Knowles indicates, the mode of andragogical learning is based on mental enquiry and not passive reception of transmitted content, which would be the case if readiness to learn has not been established (Knowles, Holton & Swanson, 2005).

Knowles states that the process elements are the following:

- Establishment of a relaxed collaborative, informal and supportive **climate** for learning. The real focus must be on creating a psychological climate of safety, acceptance, trust and respect. This is the key responsibility of the facilitator.
- The creating of **mutual planning**: The learner must be involved in planning what the learning will cover. This is a cardinal principle of andragogy Knowles, (1978) (in Smith, 2011). In this study this principle was applied during the in-depth inter-experiences where caregivers were asked what their learning needs were in terms of their needs.
- Diagnosis of **learning needs**: One basic way in which the adult learner can become involved in the planning is to hear what he or she wants to learn using a self-assessment test.

- **Setting objectives** by learners and facilitators. The adult should be involved in creating learning objectives together with input by learners. Objectives for the programme in this study were formed from the learning needs that caregivers mentioned during the in-depth inter-experiences as mentioned in number two above
- Designing of learning projects sequenced by readiness. Adults need to be involved in selecting and planning the learning events in the process.
- Operating programmes, independent study and experimental techniques

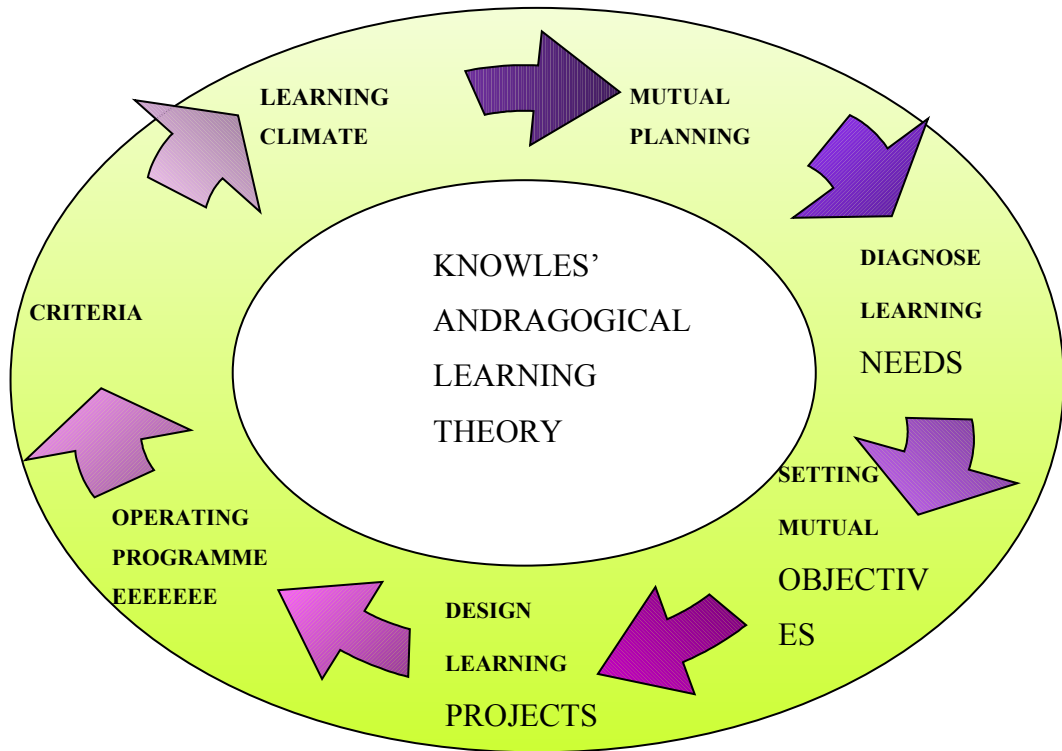
Here the researcher acts as more than a facilitator or resource person than as an independent expert.

The role of the facilitator is to set the initial mood or climate by doing the following:

- Helping participants to clarify learning expectations.
- Avoiding telling participants what he/she thinks.
- Conversing with students through questioning.
- Using problems as the basis for learning.
- Criteria-referenced evaluation by learners and validated by peers, facilitator

and experts. The learners should be involved in evaluating how well their learning outcomes have been met (Knowles, 1995).

**Figure 5.3** presents Knowles' andragogical learning theory.

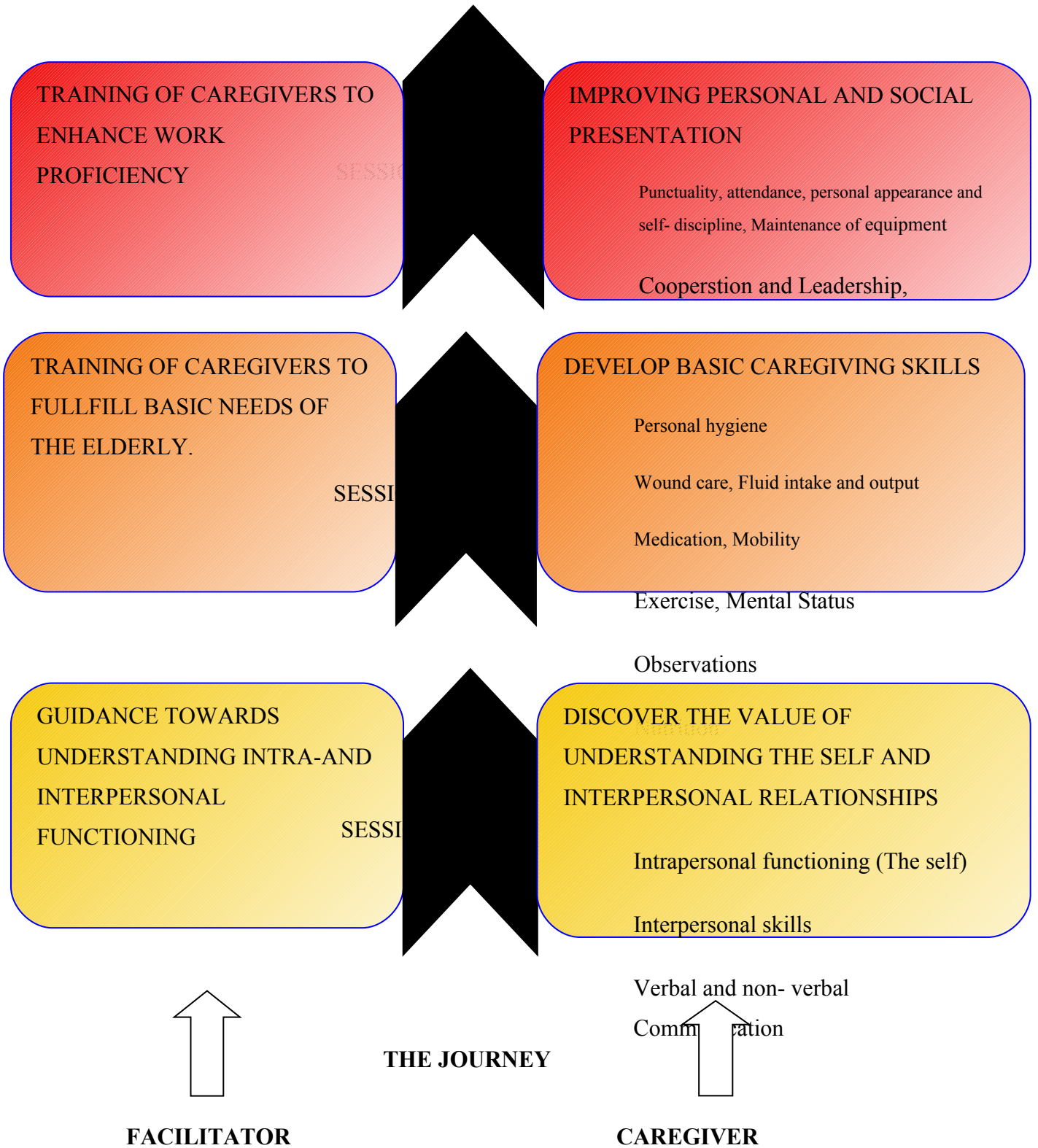


**Figure 5.3:** Knowles' andragogical learning theory

## 5.5 CONTENT OF THE EDUCATIONAL PROGRAMME

The content to be offered in the educational programme was based on information that was identified during data analysis (themes) and captured in the conceptual framework in chapter 4. An illustration on the way the main units of content will be offered during the programme sessions, as derived from the themes, appears in Figure 5.4

**OUTLINE OF EDUCATIONAL PROGRAMME**



**Figure 5.4:** Outline of educational programme

## **OUTLINE OF THE CONTENT OF THE PROGRAMME**

### **Purpose of the programme**

The overall purpose of the programme was to equip caregivers with knowledge and skills on how to care for the elderly.

### **Objectives of the programme**

The objectives of the programme were

- To equip caregivers with knowledge and skills regarding effective communication and interpersonal relationships
- To provide caregivers with knowledge and skills on basic practical procedures for effective caring.
- To enhance the self-esteem of the caregivers

The content of the programme was covered in three themes of which the application will be presented and discussed in table 5.2

Theme 1 refer to interpersonal relationships and communication

**Table: 5.2** The Intrapersonal functioning (The self), interpersonal relationship and communication

CONTENT	APPLICATION OF APPROACHES AND ASSUMPTIONS
<ul style="list-style-type: none"> <li>• <b>Intrapersonal Functioning (The Self)</b></li> <li>- Who is the caregiver?</li> <li>- The birth of the social self</li> <li>- Belief system</li> <li>- Helping a trust relationship</li> </ul>	<p>Watson's carative factor 1 (Values), 2 (Faith and Hope), 3 (Sensitivity to self and others), 5 (positive and negative feelings), 6 (Problem-solving for decision-making), 9 (Human needs) and 10 (Phenomenological spiritual forces) could be applied in these sessions (see Table 5.1 Watson's caritive factors).</p> <p>The following key characteristics of Adulthood, according to Knowles, can be applied in these sessions. (See page 184):- Self-directedness, Task/ problem centred approach to learning, internal motivation, life experiences, and readiness to learn.</p> <p>The axiological assumption can be applied in the way that people view themselves and their relationship with others. A person's values shared by people in society whether good or bad will influence their perceptions about themselves and their behavior in society. The value of community involvement rather than individuality would therefore guide the behavior of caregivers (Polit &amp; Beck, 2006).</p> <p>The philosophical assumption can be applied to both the elderly and caregiver where they live in a society and are exposed to many processes that influence</p>

	<p>their behavior for example pain, temper, aggressiveness, divorce, alcohol abuse, and woman and child abuse. These negative forces can lead to poor interpersonal relationships (Patton, 2002) (in Mertens, 2009).</p> <p>The ontological assumption can be applied in cases where the individual is subjective, self centered and constructs everything possible around him/ her. Factors which could play a role in this type of behavior include situations where the individual was never exposed to the experience of loving care and was possibly raised in a very hostile environment where it was necessary to fight for survival; or in a very disadvantaged home resulting in peer avoidance/ shunning; or being an only child, entitled to everything desired, with minimal discipline.</p>
<ul style="list-style-type: none"> <li>• <b>Interpersonal relationships and Communication</b></li> <li>- Define communication</li> <li>- Model of communication</li> <li>- Barriers to listening</li> <li>- Tips for active listening</li> <li>- Aids to active learning</li> </ul>	<p>Watsons's caritive factor 3 (Sensitivity to self and others), 4 (Helping trust relationship), 5 (Positive and negative feelings), 6 (Problem- solving for decision-making, 7 (Interpersonal teaching and learning, 9 (Human needs), 10 (Phenomenological spiritual forces) are applied here.</p>

<ul style="list-style-type: none"><li>- How to answer a telephone</li><li>- Communication with other staff members</li><li>- Different mediums and channels which can be used</li><li>- Ways of non-verbal communication</li><li>- Conversation</li><li>- Factors that influence communication</li><li>- Self-disclosure</li><li>- Stress, burnout</li><li>- Conflict Management</li></ul>	
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Theme 2 refers to training of caregivers to fulfil basic needs of the elderly.

**THEME: 2**

### Training of caregivers to fulfil basic needs of the elderly.

**Table: 5.3:** Outline of theme 2 basic procedures

Content	Application
<ul style="list-style-type: none"> <li>• Hand washing</li> </ul>	<p>Watson's carative factors 5, 9 can be applied to these aspects concerning fulfilment of basic needs. Promotion and acceptance of positive and negative feelings with deeper spirit of self. Watson's carative factor 9. Assisting with basic needs, with an intentional, caring consciousness of touching.</p> <p><i>Explaining and demonstrating procedures to be done.</i> Carative factors 6 and 7 (problem- solving for decision-making and interpersonal teaching and learning) are applicable to having a safe teaching and learning environment.</p>
<ul style="list-style-type: none"> <li>• How to remove contaminated gloves</li> </ul>	
<ul style="list-style-type: none"> <li>• Seven basic positions and supportive measures</li> </ul>	<p>Watson's carative factors 1 and 4 (Values and developing and sustaining a helping-trusting, authentic caring relationship). Are applicable to establish a relationship with the elderly person.</p>
<ul style="list-style-type: none"> <li>• Vital signs , Temperature, pulse, respiratory rate, blood pressure and urine testing</li> </ul>	<p>Provision for a supportive, protective, and/or corrective mental, social, spiritual environment be applied which include factor 8 of Watson. Watson's factor 9 is to assist the client with basic needs, with an intentional, caring consciousness of touching.</p>
<ul style="list-style-type: none"> <li>• Personal hygiene</li> <li>• Wound care</li> <li>• Medicine care</li> <li>• Nutrition</li> <li>• Cardiopulmonary resuscitation</li> </ul>	<p>Knowles' mutual planning, as well as characteristics of adults in learning can be applied to all procedures</p> <p>The theoretical- conceptual assumption can be applied in the caring process for the elderly. Although the elderly is old he/ she must still be treated with dignity</p>

<ul style="list-style-type: none"> <li>• Handling of fractures</li> <li>• Diseases, epilepsy, hypertension, diabetes mellitus, Parkinson, Alzheimer, Dementia</li> </ul>	<p>and respect as a human being (Pollit &amp; Beck, 2006).</p>
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Theme 3 refers to training of caregivers to enhance work managerial ability.

**THEME: 3**

**Training of caregivers to enhance work managerial ability**

**Table: 5.4** Training of caregivers to enhance work proficiency

<b>Content</b>	<b>Application of approaches</b>
<ul style="list-style-type: none"> <li>- Punctuality</li> <li>- Promptness</li> <li>- Appearance</li> <li>- Self-discipline</li> </ul>	<ul style="list-style-type: none"> <li>- Watson's carative factor 1 (Values), 3 (Sensitivity to one's self and others), 5 (positive and negative feelings), 6 (problem-solving for decision-making), 7 (interpersonal teaching and learning), and 9 (human needs), can be applied here.</li> </ul> <p>The characteristics of adults, i.e. being self-directed, problem-orientated, internally motivated, having certain life experiences and a readiness to learn, can facilitate change in these work habits.</p>
<ul style="list-style-type: none"> <li>- To enhance cooperation</li> <li>- Leadership</li> <li>- Handling of equipment</li> </ul>	<ul style="list-style-type: none"> <li>- Watson's carative factor 3 (Sensitivity to self and others), 4. (Developing and sustaining a helping-trusting, authentic caring relationship), 5 (Positive and negative feelings), 6 (Problem-solving for decision-making), 7 (Interpersonal teaching and learning and 9 (Human needs), can be applied to improving work habits.</li> <li>- Knowles Self-Directedness, Internal motivation life experiences and readiness to learn can be applied.</li> </ul>

## **5.6 ROLE OF THE FACILITATOR AND CAREGIVERS DURING SESSIONS INCORPORATING CONSTRUCTION**

Before the first session started the researcher explained the role and rules to all the

participants as indicated in table 5.5

**Table 5.5:** Roles and rules of facilitator and participants

<b>FACILITATOR</b>	<b>CAREGIVERS</b>
<b>Role of the facilitator</b>	<b>Role of caregivers</b>
Create an environment conducive to learning	Respectfulness cooperation and asking questions
Introduce caregivers to purpose of programme	Contribute to introduction of modules in the caring of the elderly
Involve caregivers in determining their own needs	Participate in learning experience, monitor own progress, and self-assessment.
Facilitate caregivers to use their experience optimally	Use prior experience in the execution of caring duties

## **5.7 TEACHING STRATEGIES**

There are various methods of training; which can be divided into cognitive and behavioural methods. It is important for trainees to know the pros and cons of each method. Cognitive methods are more about giving theoretical training to the trainees (Hasan, 2011). The teaching strategies that were used by the researcher in the implementation of the educational programme were the following: lectures, demonstrations, role-plays and group discussions. These methods were utilised to cover the content described in the aforementioned tables. A description of each of these methods will now follow.

### **Lecture**

The term lecture is a particular type of educational encounter in which the facilitator transmits information to a recipient, in this case the caregiver (Quinn & Hughes, 2007). The requirements of good lecturing are creativity, well developed verbal-exposition skills, clarity of ideas, an ability to make subject interesting, enthusiasm and self confidence.

The reason why the lecture method was selected to offer the programme is because of the fact that the lecture method is one of the oldest methods of training. It is an effective way to introduce new information to a group and to build upon learners' existing knowledge. It is also good for stimulating and motivating learners for further enquiry (Mohan, 2010).

### **Demonstrations**

A demonstration can be defined as a visualised explanation of facts concepts and procedures (Quinn & Hughes, 2007).

In this programme, demonstrations were of great value to show procedures to the caregivers so that, in turn, they could practise and demonstrate them to the facilitator in order to make sure they can perform a certain procedure. The demonstration method is usually accompanied by a lecture or discussion to enhance effectiveness, because discussion expand and deepens learner's knowledge (Hasan, 2011). Caregivers were provided an opportunity to observe for themselves the procedures they wanted to learn (Mohan, 2010).

### **Role play**

In this programme the method of role play is considered useful as it helps caregivers to apply their experiences to real-life situations. The enactment is helpful in developing awareness at individual group levels. Role play makes it easier to discuss complex social issues in a non-threatening environment and is a powerful training method as it helps to generate awareness (Hasan, 2011).

The researcher made use of role play to develop interpersonal and communication skills, as well as conflict resolution and group decision making (Hasan, 2011). This method can be used to convey important content. After a role play the researcher could consolidate and debrief the audience to enhance the success of the effort.

### **Group discussion**

This method focus on the utilisation of past experiences, attitudes and values in a deliberated manner. Real life experiences, relevant subject matter or questions were discussed. In the small group discussions, caregivers were provided with the opportunity to express themselves which can empower them to realise their ability for critical thinking and, accordingly, change through this medium (Quinn & Hughes, 2007).

### **Brainstorming**

The method of brainstorming was used for this programme, which is another effective method of obtaining creative solutions to a problem Osborne, (1962) (in Quinn and Hughes, 2007). The idea is that each member must be able to generate as many ideas as possible about the problems in the questions. The emphasis is on free expression of ideas, and no criticism is permitted (Hasan, 2011).

**Problem-solving**

Caregivers are given a problem to solve and are provided with certain sources of information from which they draw their solution. The main purpose is to encourage critical thinking of the caregivers. Brown and Atkins (1988) (in Quinn & Hughes, 2007) identify four main stages in problem solving that equate to the following questions:-

- What is the nub of the problem?
- Have you met a similar problem before
- What approaches can you use
- How should you check the solution

**5.8 SUMMARY**

In this chapter, the development of the educational programme was explained. The purpose of the programme, the approaches that will form the basis of the programme and a broad outline of the content of the programme were discussed.

The emphasis of this chapter was on teaching strategies which were utilised effectively to convey new information to caregivers in the caring of the elderly. In long- term care settings, caregivers are those people who spend most of the time with the elderly, and they can be important source of psychosocial information and support Miller (1999) (in Capezuti, Siegler, & Mezey, 2008).

In chapter 6, the implementation and evaluation of the educational programme will be discussed.

## **CHAPTER 6**

### **IMPLEMENTATION AND EVALUATION OF THE EDUCATIONAL PROGRAMME**

#### **6.1 INTRODUCTION**

In chapter 5 the educational programme development was discussed. In this chapter the implementation and evaluation of the educational programme will be discussed.

According to Family Health International (2004), evaluation is conducted to find out what has happened after the educational programme has been implemented. Evaluation can also be used to assess the extent to which the objectives have been met, and to determine the effectiveness of the programme. It can also be used to assess the changes in the target group, that is, the caregivers of the elderly.

#### **6.2 DYNAMICS OF THE PROGRAMME**

The dynamics of the programme include the context of implementation process by means of a workshop, period of implementation and purpose of the programme.

The programme was developed for the use of institutions where the elderly are cared for. The content was offered in five sessions – see Annexure 2.

**Who was involved?**

The persons involved in the educational programme were those caregivers working in old age homes who must help with the training of other caregivers and registered and enrolled nurses.

The researcher is also willing to offer the programme to caregivers in collaboration with the University of Namibia, which will issue a certificate to the successful participants.

**6.3 IMPLEMENTATION OF THE PROGRAMME**

The programme was implemented at the former Potgieter old age home now called Ouderust Oord, in Windhoek. All five old age homes: Tabitha, Ouderust Oord, Susanna Grauheim Katutura and Rehoboth, were invited to attend. The workshops was held on 18<sup>th</sup> and 20<sup>th</sup> December 2009, 30<sup>th</sup> March 2010, 13<sup>th</sup> and 20<sup>th</sup> April 2010 in five sessions on communication, personal hygiene and work proficiency.

Participants from only three old age homes attend the workshop: Tabitha, Katutura old age home and Ouderust oord. Altogether seven participants attended, including one registered nurse, one enrolled nurse and three caregivers, as well as one retired police women and one community caregiver.

Rehoboth and Susanna Grauheim apologised for not attending, owing to unforeseen circumstances.

The first part of the programme, “Discover the value of interpersonal relationships”

was offered to the group of caregivers on 18 December 2009. The second part of the programme, “Develop basic care giving skills” was offered from 20 December 2009, 30 March 2010, 13 and 20 April 2010 in five (5) sessions.

### **6.3.1 The workshop**

The researcher and the supervisor at Ouderust Oord old age home welcome all the caregivers to the workshop, and opened the workshop with a scripture reading and a prayer.

Participants introduced themselves using an ice breaker by playing the animal game in order to relax the atmosphere and get to know the other participants. They also had to say why they have chosen a certain animal, where they came from and what involvement they had with the elderly.

Ground rules for the workshop were set: cell phones to be turned off or put on silent mode so as not to disturb the workshop; only one meeting to be held at a time; and speak loud and clear so that everyone can hear.

There after participants were given background information on the workshop and the objectives were explained.

The workshop was held in the Ouderust oord old age home hall, which is beautiful and created a pleasant atmosphere. Cooperation was good and the nurse manager offered tea and sandwiches to the participants at tea time.

### **6.3.2 Implementation of the programme**

The programme was implemented over a period of five sessions in five days.

#### **Purpose of the programme**

The purpose of the programme was to equip caregivers with knowledge and skills on how to care for the elderly.

#### **Day 1**

##### **Guidance towards understanding intra and interpersonal communication**

##### **Aim:**

- To equip the caregivers with knowledge and skills on understanding the self (intrapersonal skills) as well as effective communication and interpersonal relationships.

**Table: 6.1** Intrapersonal functioning, Interpersonal Relationships and Communication

**THEME: 1**

<b>Intrapersonal functioning, Interpersonal Relationships and Communication</b>	
<b>CONTENT</b>	<b>ACTIVITIES</b>
<b>Communication</b>	<ul style="list-style-type: none"> <li>• Lecture</li> <li>• Group work: Brainstorming, to define communication</li> <li>• Demonstration on model of communication</li> <li>• Playing a game to emphasise the importance of communication and to point out obstacles in the process of communication</li> <li>• Pictures on various emotions (happy/ sad/ angry and scared) where participants had to recognize the different intensities of these emotions, with the help of the facilitator.</li> <li>• Game of charades was played to demonstrate the power of non- verbal facial expressions and gestures</li> </ul>
<b>Self-disclosure</b>	<ul style="list-style-type: none"> <li>• Johari's Window was explained to participants and feedback requested to personalise this model.</li> <li>• Participants from the same old - aged homes were grouped and requested to write something positive and constructive negative features about another participant. This information is then given to the involved person, who may give feedback on self- disclosure.</li> </ul>
<b>Stress and burnout</b>	<ul style="list-style-type: none"> <li>• Group discussions: Participants were asked to identify triggers which cause stress especially in their work and interpersonal relationships, which were then discussed.</li> </ul>
<b>Conflict handling</b>	<ul style="list-style-type: none"> <li>• Role play to emphasise effective and ineffective handling of potentially difficult situations.</li> </ul>

The aim of day two, three and four was to provide caregivers with knowledge and skills on basic practical procedures for effective caring, which links with theme

**THEME: 2**

**Table: 6.2** Outline of implementation of training of caregivers in basic care

<b>Training of caregivers to fulfil basic needs of the elderly.</b>	
<b>Session: 2 and 3</b>	
<b>CONTENT</b>	<b>ACTIVITIES</b>
<p><b>Basic nursing skills</b></p> <ul style="list-style-type: none"> <li>• Bed bath</li> <li>• Hair wash</li> <li>• Perineal care</li> <li>• Foot and toe nail care</li> <li>• Beard shave</li> </ul>	<ul style="list-style-type: none"> <li>• Lecture method</li> <li>• practical demonstrations</li> <li>• Simulation</li> <li>• Feedback by participants</li> </ul>
<b>Session: 4</b>	
<b>CONTENT</b>	<b>ACTIVITIES</b>
<ul style="list-style-type: none"> <li>• Mouth wash</li> <li>• Wound care</li> <li>• Medicine care</li> <li>• Nutrition</li> </ul>	<ul style="list-style-type: none"> <li>• Lecture Method</li> <li>• Demonstrations</li> <li>• Feedback by participants</li> <li>• Problem solving</li> </ul>

**Session: 5**

<b>CONTENT</b>	<b>ACTIVITIES</b>
<ul style="list-style-type: none"> <li>• Cardiopulmonary resuscitation</li> </ul>	<ul style="list-style-type: none"> <li>• Models (dolls) were used for exercise in simulating cardiopulmonary resuscitation to empower participants to handle emergency cases.</li> </ul>
<ul style="list-style-type: none"> <li>• Handling of fractures</li> </ul>	<ul style="list-style-type: none"> <li>• Participants were taught how patients with fractures should be lifted, turned and transferred.</li> </ul>
<ul style="list-style-type: none"> <li>• Management of diseases, epilepsy, hypertension, diabetes mellitus, Parkinson, Alzheimer, Dementia</li> </ul>	<ul style="list-style-type: none"> <li>• Participants were instructed to manage these various conditions, e.g. for hyper and hypo-glycemic clients. I.e. testing blood sugar and to remember to press the emergency bell to call for help.</li> </ul>

**THEME 3:****Table: 6.3** Outline of implementation of training of caregivers in enhancing work proficiency

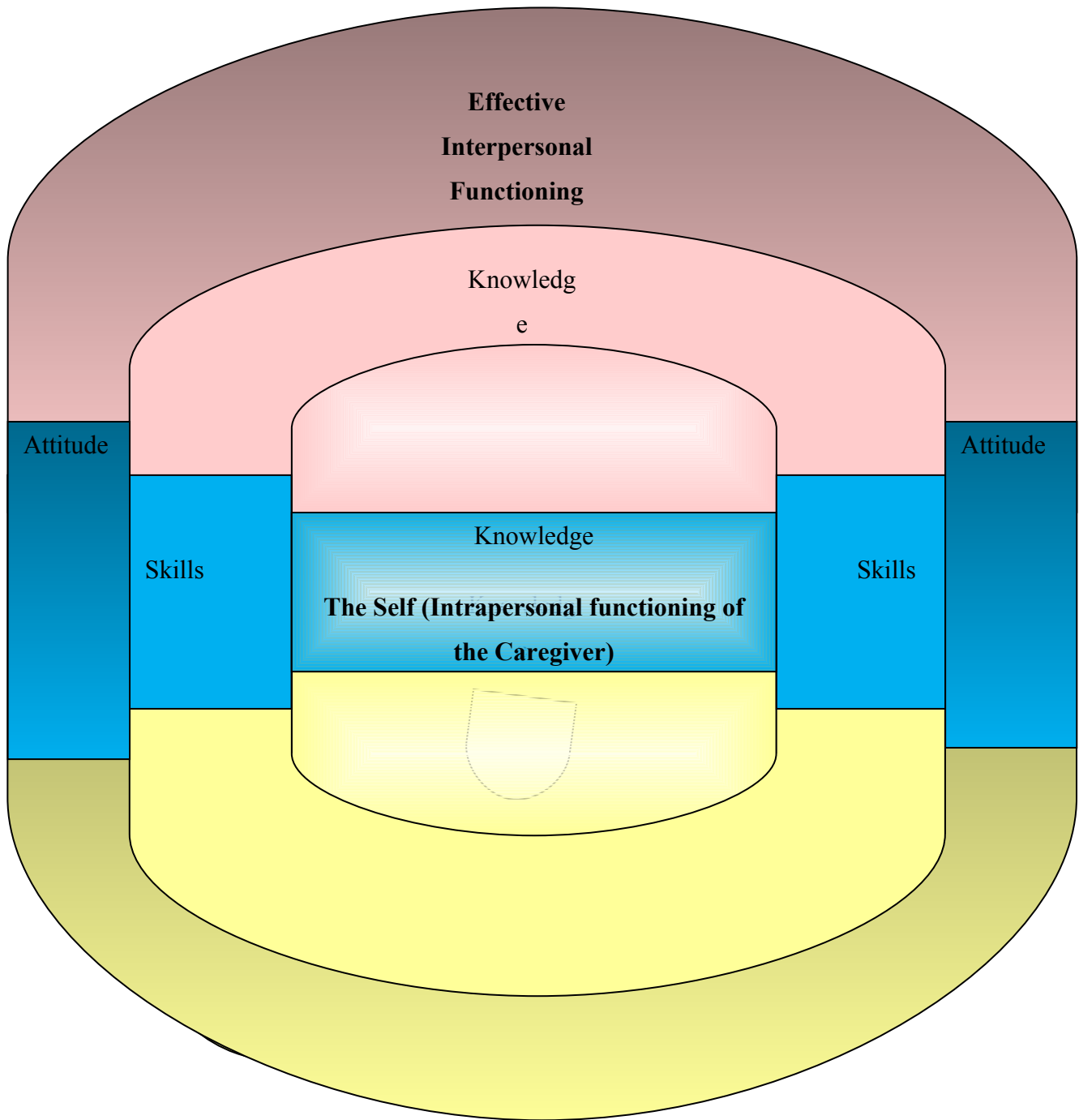
<b>Enhancing work proficiency</b>	
<b>CONTENTS</b>	<b>ACTIVITIES</b>
Appearance, punctuality, promptness, leadership, cooperation, self discipline equipment and material management.	<ul style="list-style-type: none"> <li>• Lecture method</li> <li>• Opportunity for introspection</li> <li>• Investigation of control systems implemented in the work place to ensure punctuality.</li> <li>• Discussion of time management as linked to self worth. (I.e. valuing yourself, will lead to valuing your time).</li> <li>• Discussion of appearance linked to self worth.</li> <li>• Discussion linked to communication skills.</li> <li>• Discussion of self- discipline as linked to personal integrity, self- worth and value systems.</li> <li>• Discussion of various leadership styles.</li> <li>• Participants had to explain the importance of taking inventory of equipment and materials as well as reporting broken and stolen equipment. They were also trained in using various types of equipment.</li> </ul>

Following is a description of the content disseminated to participants in Session 1 regarding intrapersonal functioning, interpersonal relations and communication.

Knowledge acquisition, skills training and a change in attitude are the three levels involved in acquiring or learning a skill. Below is a schematic representation figure

6.1 of the three strategies used to effect behaviour change and thus learning in caregivers, within the milieu of managing their work.

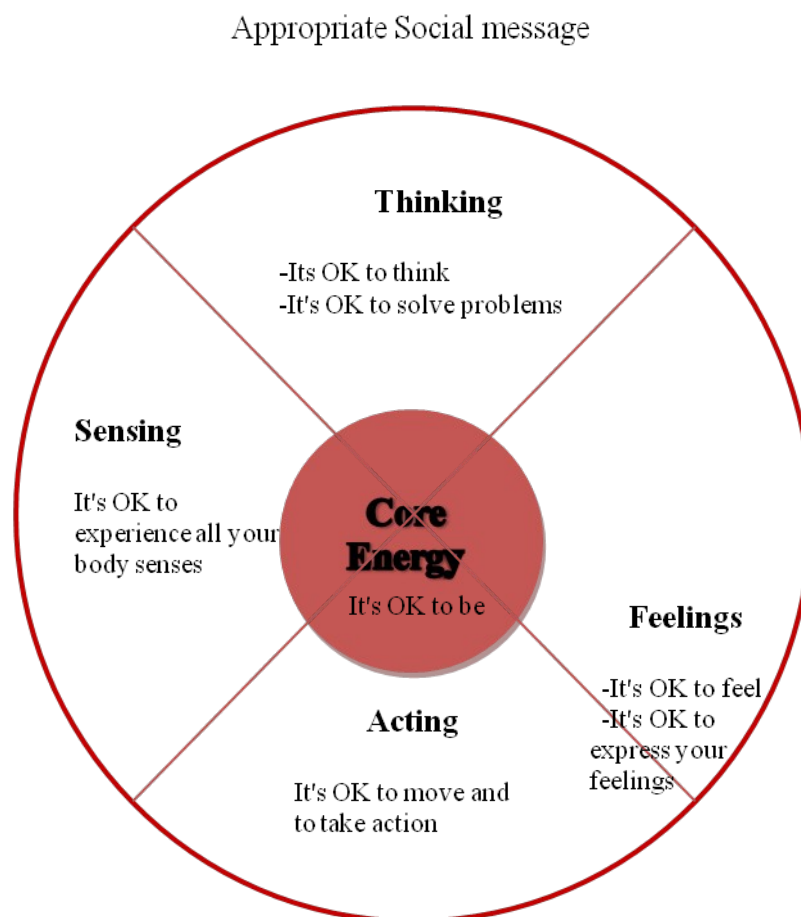
Attitude



**Figure 6.1:** Schematic representation of effective interpersonal functioning

Intrapersonal functioning is essentially characterised by the development of the self.

The figure below illustrates this “birth” of the self as a social being.

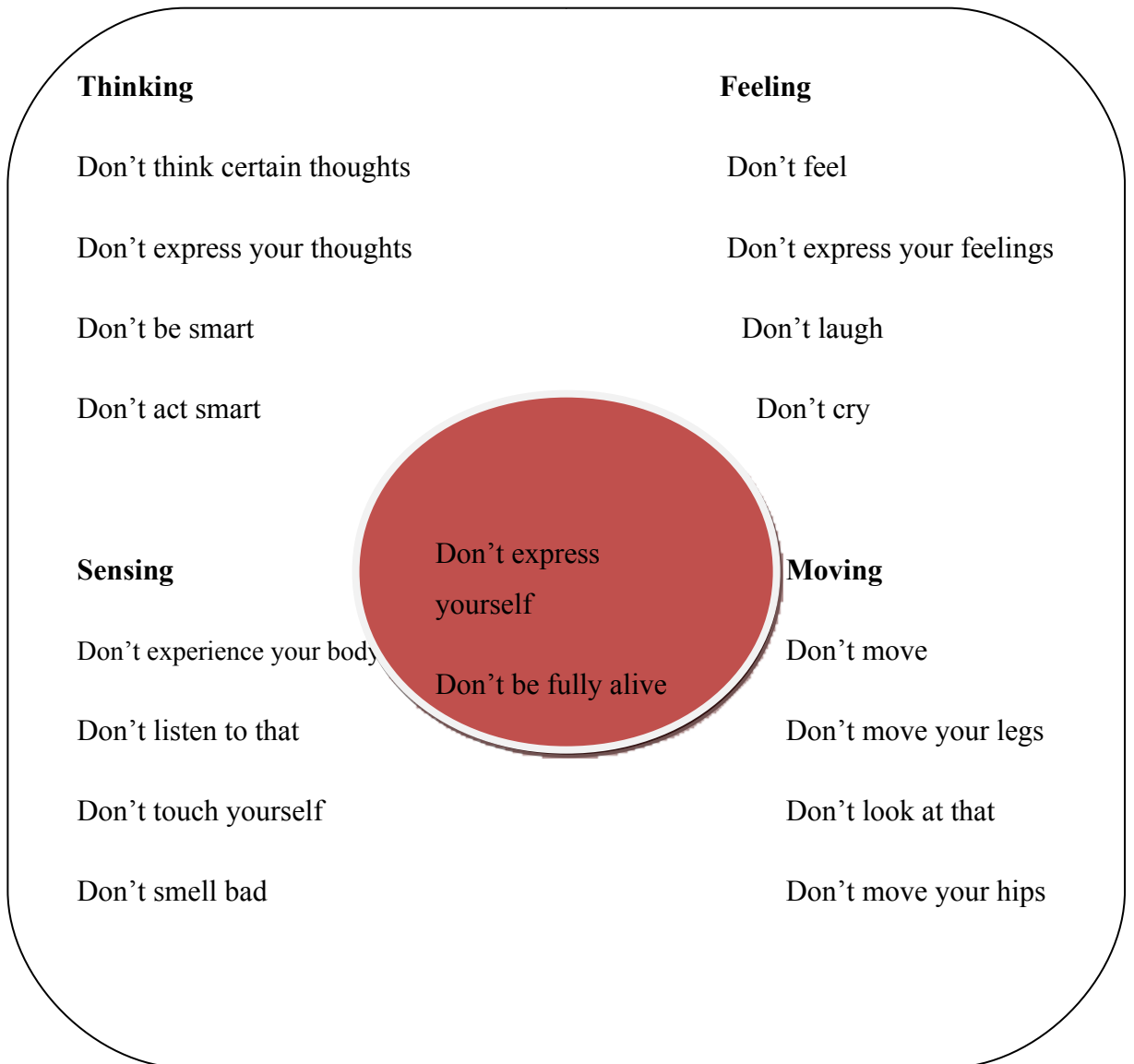


Original Wholeness

**Figure: 6.2** The birth of the social self (occupational notes, 2004)

**Social self-suppression leads to the loss of the self**

Figure 6.3 below illustrates how the actions or words of one person towards the thinking, feeling and sensing of another person can lead to suppression of the self in the latter.

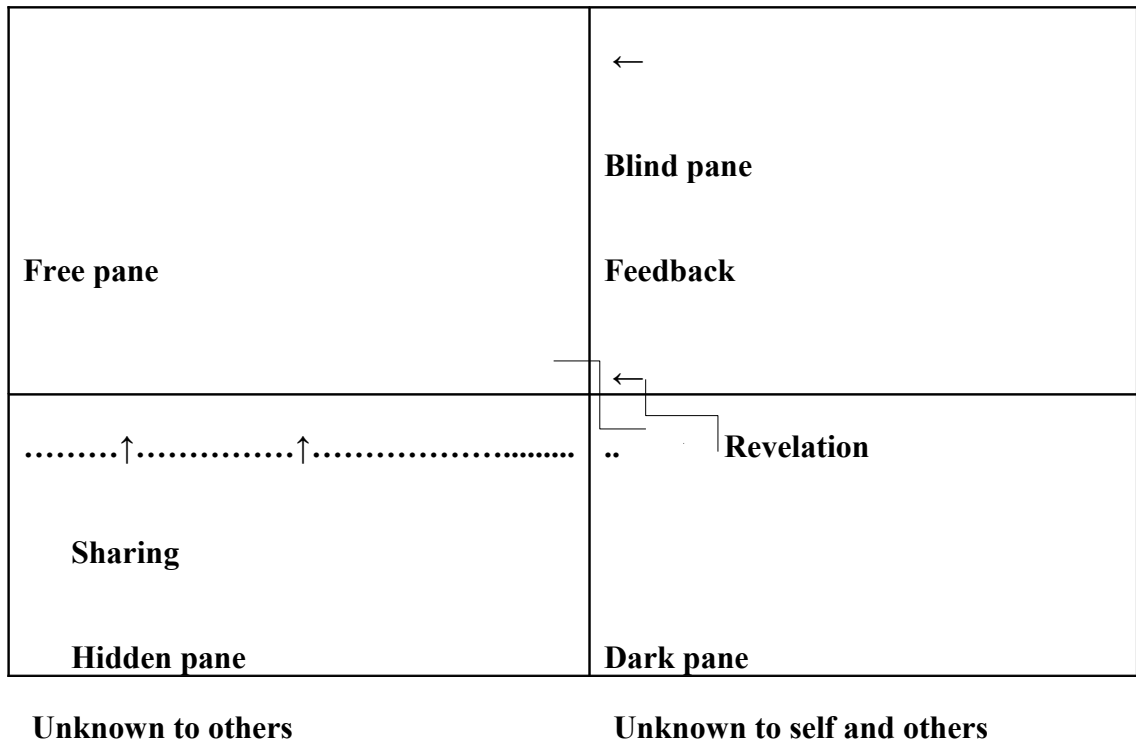


**Figure: 6. 3** The loss of the social self (Department Occupational notes 2004)

Johari's window below reflects self- disclosure.

**Known to self and others**

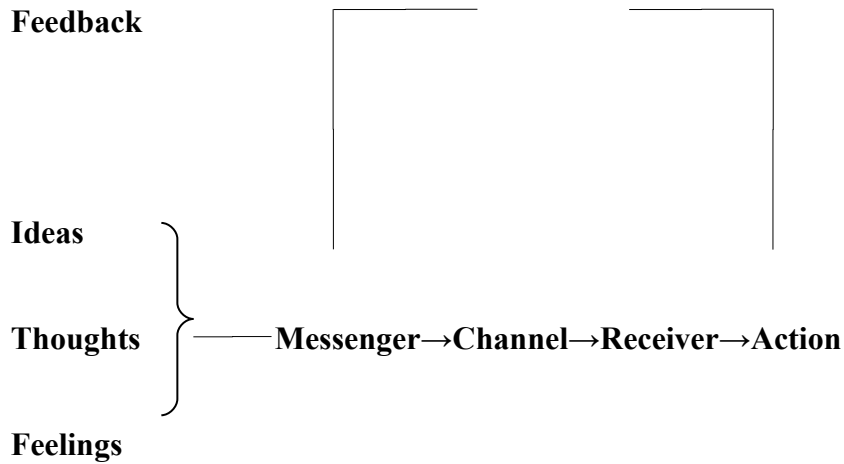
**Unknown to self**



**Figure 6.4:** Johari’s window (Ministry of Health Adolescent Friendly Health Service notes)

Communication is an integral part of interpersonal functioning.

The communication process can be explained by examining the following model:



**Figure 6.5:** Model of communication (Adolescent Friendly notes)

Important aspects relating to intra- and interpersonal relations have been highlighted above. Additional Information is available on this topic in Addendum A, B, C.

## **6.4 EVALUATION OF THE EDUCATIONAL PROGRAMME FOR CAREGIVERS OF THE ELDERLY**

### **6.4.1 Introduction**

Evaluation can be described as an act of appraisal and is essential to measure the effectiveness of goal attainment Dreyer, Hattingh & Lock, (1997) (in Netshikweta, 2009). In the research, the educational programme was developed and implemented, which provided exposure for recipients/caregivers to the content of the programme. Programme evaluation was thus possible, as recipients could measure its success

based on how well the programme breached the gap between their experiences of caregiving, and the scientific knowledge presented to them.

#### **6.4.2 Purpose of the evaluation of the programme**

The purpose of evaluating the programme was to determine whether the planned action met the recipients' (caregivers') needs and whether the programme was appropriate for the caregivers in rendering care to the elderly Dreyer *et al.*, (1997) (in Netshikweta, 2009).

#### **6.4.3 Objectives of evaluating the educational programme**

- To determine how the caregivers experience the educational programme.
- To find out whether the educational programme improves the participants' practice.
- To identify problems encountered by the caregivers during the implementation phase.

Evaluation was done three months after the implementation on 20 July 2010, at the Ouderust oord old age home hall.

The Tabitha old age home caregivers notified the researcher the morning of the evaluation that they could not attend the discussion owing to their duties. Accordingly, the researcher agreed to evaluate them on 27 July 2010.

#### **Focus group discussion**

Subsequently, focus group discussions were used as the group was small. According to Gorman and Clayton (2005), a focus group is a small group of 6 to 12 participants guided by a facilitator to observe the attitudes and perceptions relevant to a particular topic. The results of the focus group discussion were used to determine the success of the educational programme.

The participants were welcome to the session and refreshed their memory by previewing the educational programme content.

### **Session 1**

Discover the value of good interpersonal relationships.

### **Session 2**

Improve knowledge and skills on practical procedures to improve physical care and nutrition.

### **Session 3**

Improving personal and social presentation at work

#### **6.4.4 How the participants experienced the educational programme**

After asking the general question, probing questions were asked which elicited the following responses:

*“Die program was inspirerend vir my. Dit hou my op datum en dit het my werk aanbiedinge verbeter”* [It was inspiring for me. It keeps me up to date and improves

my work delivery.]

Five participants stated: *“Ons het baie geleer oor bejaardes en hoe om vir hulle te sorg.”* [We have learned a lot about old people and how to care for them.]

*“Ek dink dit was ‘n goeie ding,”* [I think it was a good thing.]

*“Ons het die klasse uitstekend gevind en baie kennis en vaardighede by geleer.”*

[The classes were excellent and we have gained more knowledge and skills.]

#### **6.4.5 How the educational programme improved participant’s practice**

All 12 participants responded positively: *“Die program het hulle geleer asook hulle werk uitvoering en het ‘n groot verbetering gebring.”* [The programme taught them to improve their work in order to bring great changes in their work.]

One (1) participant stated: *“Die klasse is uitstekend, bou meer kennis op, leer meer van bejaardes. Veral die prakties en die procedures omdat ons werk meer op die versorging is.”*[The classes were excellent she gained more knowledge on the elderly, for instance the practical’s and the procedures because their work is more on caring.]

Two participants stated: *“Die kommunikasie was goed. Het baie gehelp met sommige dinge wat ons al vergeet het. Dit het ons meer geleer oor die bejaarde se toestand wat agter uit gaan.”* [The communication (section A) was very good; it helps a lot with some of the things that we have forgotten. It teaches us more about the elderly

condition that can deteriorate.]

One caregiver who was previously in the police stated after the presentation of the session on communication that it had changed her: “I was so hard, it was only my word that count and the last word. The workshop on communication taught me to listen to others views.” One participant stated: “*Die opvoedkundige program het my gehelp om kalmte en geduld te kry.*” [The educational programme helped her to be calm and patient.]

Another caregiver stated: “I usually don’t give a chance to someone to finish talking than I interrupt. I have learned to listen first before answering.”

Another participant stated: “*Dit het my baie gehelp om met bejaardes te werk en ook om met minder bevoorregtes te help omdat ek ook ‘n doofstomme kind met epilepsie het om na te kyk.*” [The programme helped her to work with the elderly and also to help the disadvantaged because she also looks after her dumb, deaf and epileptic child.]

#### **6.4.6 Problems encountered by participants during the implementation**

Some participants experienced the programme as beneficial, despite the fact that too much information was disseminated in too short a time span. One participant stated: “*Ons gaan te vinnig deur die lesse, net ons tyd is kort en ek vat nie alles so vinnig nie anders baie lekker.*”

[We were going too fast through the lesson, our time is short and I can’t absorb

everything so quickly. Otherwise it was good.]

A summary of these findings follows:

The atmosphere during the feedback session was relaxed. The participants' were excited to see each other again, hugging each other and answering spontaneously.

## **6.5 SUMMARY**

It seems that the implementation and the evaluation of the educational programme was a success, based on the comments that the participants' made during the focus group discussion. In this focus group they were asked how they experienced the educational programme, to what extent the programme improved their practices and what were the problems encountered during the implementation of the programme.

The participants responded by stating that the programme was inspiring, kept them up to date, improve their work output and that they have learned a lot from the programme.

The next chapter, chapter 7, concludes the study. The conclusions, recommendations and limitation of the study as they emanated from the research will be discussed.

## **CHAPTER 7**

### **CONCLUSION, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY**

#### **7.1 INTRODUCTION**

In the previous chapter the educational programme was implemented and evaluated, and responses of the participants were elicited in this regard. The three old age homes that participated were Ouderust Oord, Tabitha and Katutura, all situated in Windhoek. A series of workshops was presented at the Ouderust Oord, commencing on 18 and 20 December 2009, 30 March 2010, 13 and 20 April 2010 in five (5) sessions. . The techniques used were demonstration, role play, lectures and discussions.

The purpose of this chapter is to justify the study in terms of its aim and objectives, as well as to evaluate the study in terms of its positive contribution to the body of scientific knowledge on caregiving for the elderly.

In this chapter the recommendations, conclusions and limitation of the study will be discussed to ensure the application of the educational programme and to improve the quality of care rendered to the elderly. The researcher will discuss further research to be done and make a final concluding remark on the study.

## 7.2 CONCLUSIONS

Objectives were set to develop the educational programme for the caregivers of the elderly. Phase 1 consists of three (3) objectives:

**7.2.1 Objective 1: To explore and describe the experiences of the elderly in respect of care**

### *7.2.1.1 Conclusion*

Objective 1 was attained in phase 1. To meet objective 1 the researcher held individual interviews with the elderly, irrespective of their age, on condition that they were willing to participate, and could communicate in English or Afrikaans. Written consent was also given. Interviews were held in five old age homes in Windhoek and Rehoboth. After interviewing the 29th elderly person, a trend of consensus between narratives was noticed, implying saturation of data (Shank, 2006). Saturation was first described by Glaser and Strauss (1967) (in Age, 2011) and it implies that an adequate amount of time has been invested on a particular setting.

The data obtained were analysed according to inductive analysis, described by Tesch, (1995). It was concluded that the fragile elderly experience inappropriate interpersonal interaction with caregivers with specific reference to disrespect and ineffective physical care, lack of proper nutrition and minimum support from family, members.

**7.2.2 Objective 2: To explore and describe the experiences of the caregivers in respect of caring**

**7.2.2.1 Conclusion**

Objective 2 was attained in phase 1. Twenty six (26) caregivers caring for the elderly in the five old age homes in Windhoek and Rehoboth were interviewed, except those who were off duty. One general question was posed to the participants: “How do you experience the care given to the elderly?”

The data obtained were analysed according to Tesch’s (1995, p.90) method and categorised into the following themes: poor interpersonal relationships and communication. Caregivers also indicated lack of support from management. It was concluded that caregivers experience poor interpersonal relations due to ineffective communication with the elderly.

**7.2.3 Objective 3: To determine the learning needs and support of caregivers in provision of health care to the elderly**

**7.2.3.1 Conclusion**

Objective 3 was attained in phase 1 during data collection with the elderly and the caregiver. Caregivers identified a need to know about interpersonal relationships and the communication process, practical procedures and the management of their

specific allocated areas, such hygiene, feeding and observations.

**7.2.4 Objective 4: To develop a conceptual framework and an educational programme for caregivers of the elderly**

**7.2.4.1 Conclusion**

Objective 2 was attained in phase 2. A conceptual framework was developed using Dickhoff *et al's* (1968,) practice theory.

For the development of the educational programme, Watson's theory and Knowles' andragogical learning theory and the themes identified during the interviews with the elderly and the caregiver were used. The educational programme was developed in three sessions: Session 1: Discovering the value of good interpersonal relationships; Session 2: Improving knowledge and skills in practical procedures; and Session 3: Guidance on specific managerial aspects (see Annexure A, B and C).

**7.2.5 Objective 5: To implement an educational programme for caregivers of the elderly**

**7.2.5.1 Conclusion**

Phase 3 represents objective 5: The practice – orientated educational training programme was implemented at the Ouderust Oord. All five old age homes were invited, Tabitha, Ouderust Oord, Susanna Grauheim Katutura and Rehoboth, but only

three could attend, Tabitha, Ouderust Oord and Katutura. Rehoboth and Susanna Graueim apologised for not attending due to work load. The training programme will be offered to the other old age homes that could not attend on a later stage.

The workshop that was held on 18<sup>th</sup>, 20<sup>th</sup> December 2009, 30<sup>th</sup> March 2010, 13<sup>th</sup> and 20<sup>th</sup> April 2010. The workshop was offered for five sessions on communication, personal hygiene and work proficiency.

The following methods were used: demonstration, role play, lectures and group discussion. The atmosphere was relaxed and caregivers were excited (the researcher was telephoned on several occasions, to enquire about follow-up sessions, even after the end of the programme). It appeared that a bond had formed between caregivers, as was evident from recurrent embraces, and exchange of positive and welcoming remarks. Twelve participants attended the workshops, ranging in age from 25 to 65 years.

<b>7.2.6 Objective 6: To evaluate the educational programme for caregivers of the elderly</b>
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#### ***7.2.6.1 Conclusion***

Phase 3 represents objective 6. The evaluation was done three months later on 20 July 2010 by means of an open discussion and it was attended by three old age homes. The purpose of this evaluation was to determine whether the educational programme could be offered as an in-service training session to caregivers employed

by old age homes

### **7.3 FEASIBILITY OF THE EDUCATIONAL PROGRAMME**

Most of the caregivers indicated that the programme had excellent characteristics, was well prepared and clear, and provided the opportunity to learn a great deal. They also emphasised the anticipation to apply the educational programme in their daily practice.

### **7.4 RECOMMENDATIONS**

The following recommendations were made as a result of the research study:

#### **RECOMMENDATION 1**

It is recommended that an environment that is conducive to quality care for the elderly is established. Such an environment can be established by managers of the geriatric units where the elderly are cared for. The following strategies can be used:

##### **Human resources**

Managers should plan their staff lists so to ensure that the necessary staff are available to care for the elderly. Managers should also clearly define and articulate the role and function of the caregiver in the sense that they are lay persons.

##### **Supervision and support**

Supportive supervision by managers is important. According to Werner and Bower (1991) (in Smith- Nonini, 2010), supervision should more about assisting and guiding than discipline. Caregivers prefer follow-up support and back up from managers when caring for the elderly.

### **Provision of the necessary equipment**

The necessary equipment should be available to care for the elderly, for example, napkins, feeding mugs, bedpans and wheelchairs.

## **RECOMMENDATION 2**

- Establish an environment that is conducive to teaching and learning. Managers should plan and facilitate regular in-service training and education sessions. The following topics could be covered:
- The orientation of newly appointed caregivers concerning the basic human needs of the elderly, and how to meet these needs.
- Relevant procedures to address the basic needs.
- Standard daily observation and assessment of cognitive functions in the elderly, which could yield valuable information (Persoon, Van der Crujisen, Schlatmann, Simmes & Achterberg, 2010).
- Nutrition and the elderly. The elderly need to eat a balanced diet with plenty of healthy foods such as vegetables, fruit, whole grain, fish (good for omega-

3fatty acids), nuts and legumes. They need to avoid inflammatory foods, such as processed foods, sugar, fructose, corn syrup and alcohol, and caffeine (Bader, 2008–2010). What is of importance is that the caregiver should ensure food intake. In many instances, a balanced diet is served but the elderly do not eat it. In a study that was done by Sidenvall (2001) on mealtimes in institutions for elderly people, it was revealed that the organisation was task-oriented, rather than patient-oriented – the elderly have individual meal customs, whereas the caregiver has work responsibilities.

### **RECOMMENDATION 3**

- It is also recommended that regular refresher courses be offered on a regular basis for the existing staff Werner & Bower, (1991) (in Smith- Nonini, 2010). Experts on different aspects of the ageing process and the care and treatment thereof could be invited to address the caregivers.
- Appraisal and performance systems could be implemented by managers. This would enable them to identify strengths and weaknesses.

### **7.5 FURTHER RESEARCH**

It is recommended that further research be conducted on the following:

The degree of job satisfaction of caregivers and means of improving levels of satisfaction.

Personal values of caregivers and the influence of these values on the concept of caring for the elderly.

The development of measuring instruments to determine the competence of caregivers.

The development of guidelines on procedures and competencies of caring. In a study done by Yamamoto- Mitani, Katakura, Fujita, Shinohara, Sonoda and Hayashi (2010), on reviewing charts for institutional care, it was evident that the evaluation by chart review generally matches self-evaluations. Regular self-check of quality indicators may remind the caregivers of the importance of preventative care.

The evaluation of the educational programme to determine whether any adjustments or additions are necessary

## **7.6 LIMITATIONS**

### **Limitations from the caregivers' perspective**

Some of the caregivers who were used as the sample for the study could not participate in the implementation of the educational programme owing to work responsibilities.

Environment interviews were done in the caregivers' tearoom. Consequently, there were always disturbances such as interruptions and movement outside. This setting did not meet privacy needs sufficiently. Caregivers could only be seen during their tea or lunch breaks were not all available to interview, owing to being off duty.

### **Limitations from the elderly's perspective**

The environment in which the elderly participants were interviewed plays a great role in the limitations. While the elderly were being interviewed there was no privacy at all, despite efforts to make provision for such. Caregivers moved in and out of the rooms, despite closed doors and informing the caregivers about the interviews. In certain circumstances, this led to the interruption of a narrative and sometimes even the expression of doubt and fear. According to Gorman and Clayton (2005), background noise can be an environmental constraint.

During interviews the tape recorder could not be used, as most of the elderly refused to be recorded. According to Gorman and Clayton (2005), recorders can be visually intrusive and noisy. Some of the elderly, while recounting their experiences, suddenly stopped, forgetting what they had intended to say. This forgetfulness could be due to normal ageing.

Often the elderly did not answer the questions posed to them directly and told long-winded stories that were time-consuming, leading to feelings of frustration on the part of the researcher, who nevertheless also empathised with them.

## **7.7 CONTRIBUTION TO THE BODY OF SCIENTIFIC KNOWLEDGE**

The contribution to the body of scientific knowledge of this study is summarised as follows;

- The study contributes to the knowledge base of health care provision of the elderly in Namibia. The gap in the knowledge concerning the familiarity of practice where caregivers care for the elderly in old age homes is addressed by the educational programme as this programme will equip caregivers with the necessary knowledge and competence in the care they rendered.
- The literature review revealed information about caring for the elderly at home by caregivers who could be family members or others. The literature is however, silent on care given by caregivers in old age homes who are usually untrained. Therefore the study enriches existing literature on caregivers of the elderly in old age homes
- By interviewing the elderly and the caregivers and by using an inductive approach, the researcher could align the conclusions with components of the conceptual framework. Accordingly, a new understanding of existing issues regarding care of the elderly was created and incorporated in the programme that was developed.
- Emerging issues worthy of investigation were identified during the study namely lack of interpersonal relationships and communication and lack of competence in performing procedures. These issues were addressed by the educational programme and therefore contributed to the knowledge and competence of caregivers who are often untrained.

## 7.8 CONCLUDING REMARKS

The study provides insight into caring for the elderly by caregivers. The findings of the study were used as a foundation upon which an educational programme was developed for the caregivers to enable them to render appropriate care for the elderly. Caregivers of the elderly must be competent with specific knowledge and skills to fulfil their daily tasks. This study shows that caregivers lack the necessary competencies to care for the elderly.

The purpose of the study is to develop, implement and evaluate a supportive programme for caregivers in old age homes. Phase 1 presents the situational analysis while Phase 2 deals with the development of a conceptual framework from the activities of Dickhoff et al.'s (1968: 433). A programme was developed from the findings of the situational analysis. Phase 3 deals with the implementation and evaluation of the programme. The programme was presented in three sessions. Session 1 discover the value of intra/ interpersonal relationships and communication. Session 2 deals with the competencies on practical procedures to improve physical care and proper nutrition. Session 3 comprised of enhancing work habits (Personal and social presentation).

The following recommendations were made as a result of the research study

It is recommended that an environment conducive to quality care for the elderly is established. Such an environment can be established by managers of the geriatric units where the elderly are cared for. The following strategies can be used:

Managers should plan their staff lists to ensure that the necessary staff are available to care for the elderly. Managers should also clearly define and articulate the role and function of the caregivers as lay persons.

Supportive supervision by managers is important. According to Werner and Bower (1991) (in Smith- Nonini, 2010) supervision should more about assisting and guiding than discipline. Caregivers prefer follow-up support and back up from managers when caring for the elderly.

The necessary equipment should be available to care for the elderly, for example, napkins, feeding mugs, bedpans and wheelchairs. See for other recommendations in this chapter.

The study was justified as an original contribution to the scientific body of knowledge in nursing science.

## **8. BIBLIOGRAPHY**

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**ANNEXURE A**

**PERMISSION LETTER TO THE STUDY**

# UNIVERSITY OF NAMIBIA

Private Bag 13301, 340 Mandume Ndemufayo Avenue, Pionierspark, Windhoek, Namibia



## FACULTY OF MEDICAL AND HEALTH SCIENCES

**Letter of Permission:  
Post-Graduate Students**

**Date:** 19 March 2007

**Dear Students:** Ms. J. Kloppers

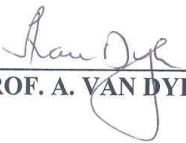
The Post-Graduate Studies Committee has approved your research proposal.


**Title: Care giving in old-age homes in Windhoek. A practice-orientated enquiry into care giving education**

You may now proceed with your study and data collection.

It may be required that you need to apply for additional permission to utilize your target population. If so, please submit this letter to the relevant organizations involved. It is stressed that you should not proceed with data collection and fieldwork before you have received this letter and got permission from the other institutions to conduct the study. It may also be expected that these organizations may require additional information from you.

Please contact your supervisors on a regular basis.

  
\_\_\_\_\_  
**PROF. A. VAN DYK**

  
\_\_\_\_\_  
**PROF. L. SMALL**

**ANNEXURE B**

PERMISSION LETTER TO DO THE STUDY AT OLD AGE HOMES

**Annexure B**

PO Box 10120

Windhoek

Annelie Olivier Old Age Home

Rehoboth

15 April 2007

Dear Madam,

**PERMISSION TO DO A STUDY ON THE ELDERLY AND CAREGIVERS**

I am performing a study as a doctoral student under the auspices of the faculty of Medical and Health Sciences at the University of Namibia. Professor van Dyk is the supervisor and Doctor L. Pretorius, the co-supervisor. The title of the study is "An educational practice-oriented programme for caregivers of the elderly in old age homes in Windhoek and Rehoboth."

The request is that you participate in phase one of the study. I require at least five to six elderly as well as caregivers to interview. The elderly will be interviewed on how they experience health care services provided to them.

The caregivers will be interviewed on their experiences relating to the services they provide to the elderly.

In conclusion, I will appreciate it if you can furnish me with a letter of permission. I thank you for participating in this study.

Should you have any questions or require further information relating to the above study, please do not hesitate to contact me. I can be reached in Windhoek at (061) 257367 (after hours) or (061) 2063224 (during office hours).

Thanking you in anticipation.

Yours sincerely,

MRS. J.M. KLOPPERS

P O Box 10120

Windhoek

15 April 2007

Mrs G. Heita

Katutura Old Age Home

WINDHOEK

Dear Madam

**PERMISSION TO DO A STUDY ON THE ELDERLY AND CAREGIVERS**

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Yours sincerely,

MRS. J. M. KLOPPERS

P. O. Box 10120

Windhoek

15 April 2007

Mrs Greeff

Oude-Rust Oord

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Thanking you in anticipation.

Yours sincerely,

Mrs. J.M. Kloppers.

P. O. Box 10120

Windhoek

15 April 2007

Sr Judith Madl

Susanne Grau-Heim

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Thanking you in anticipation.

Yours sincerely,

Mrs. J. M. Kloppers

PO Box 10120

Windhoek

15 April 2007

Pastor Pietersen

Tabitha Old Age Home

Dear Sir

**PERMISSION TO DO A STUDY ON THE ELDERLY AND CAREGIVERS**

I am performing a study as a doctoral student under the auspices of the faculty of Medical and Health Sciences at the University of Namibia. Professor van Dyk is the supervisor and Doctor L. Pretorius, the co-supervisor. The title of the study is “An educational practice-oriented programme for caregivers of the elderly in old age homes in Windhoek and Rehoboth.”

The request is that you participate in phase one of the study. I require at least five to six elderly as well as caregivers to interview. The elderly will be interviewed on how they experience health care services provided to them. The caregivers will be interviewed on their experiences relating to the services they provide to the elderly.

In conclusion, I will appreciate it if you can furnish me with a letter of permission. I thank you for participating in this study.

Should you have any questions or require further information relating to the above study, please do not hesitate to contact me. I can be reached in Windhoek at (061) 257367 (after hours) or (061) 2063224 (during office hours).

Thanking you in anticipation.

Yours sincerely

MRS JM KLOPPERS

**ANNEXURE C**

PERMISSION LETTER FROM THE PARTICIPANTS

**Annexure C**

**PERMISSION TO PARTICIPATE IN A STUDY ON THE ELDERLY AND CAREGIVERS**

Dear Participant

I am performing a study as a doctoral student under the auspices of the faculty of Medical and Health Sciences at the University of Namibia. Professor van Dyk is the supervisor and Doctor L. Pretorius, the co-supervisor.

Title: An educational practice orientated programme for caregivers of the elderly in old-age homes in Windhoek.

Purpose

The objective of this study: Explore and describe the experiences of the elderly and the caregiver's respect of care to the elderly

Ethical Measures

Your participation in this research is voluntary and you can withdraw at any stage of the study.

Confidentiality and anonymity will be ensuring. Records will be destroyed after transcripts have been made.

You will be informed of outcome

The benefit of the study will be that it will improve the quality care that caregivers give to the elderly. You as elderly will receive better care.

Thank you

Mrs JM Kloppers

**Signature:** .....

**Date:** .....

**ANNEXURE D**

**INTERVIEWS WITH THE PARTICIPANTS (ELDERLY)**

## **Annexure D**

### **Elderly Interviews**

Most of the interviews were performed in Afrikaans and English.

Twenty nine (29) elderly participated.

Twenty one (21) of the elderly were women and eight (8) were male.

Age group range from sixty (60) to ninety seven (97) years

### **The following question was posed to the elderly:**

**Question:** “Tell me how you experience the care that caregivers provide to you?”

### **Participant No. 1**

62 year-old female, diabetic, right leg amputated

*“Ek ervaar nie probleme met die versorging hier by die ouetehuis nie. Ek was vervoer van Rehoboth na Katutura hospital met ‘n wond aan my regter been. My wond was nie gereeld gedoen nie. Toe bel ek Rehoboth toe en Annelie het my kom haal. Dr. Mouton was ontevrede en later moes my been afgesit word. In 2004, word ek baie siek. My suiker was baie hoog. Ek kom by Dr. Solomons, en is nou op die insulien spuit:- 45 units in die oggend en 20 units in die aand. Ek spuit myself of soms een van die hulpe. My oë was blind. Verlede jaar was my oog gedoen. Sien is swak. Ek sal maar kyk om vir my lense in te sit. Sy is gelukkig hier sy en haar*

*bejaarde moeder. My broer sê: " Bly stil dan sal jy nie probleme het nie". Ervaar problem met rolstoel. Stoel is al so oud en baie keer reggemaak. Ek meng nie so baie met ander mense nie. Die radio is daar".*

[I don't experience problems with the caring here at the Old Age Home. I was transported from Rehoboth to Katutura Hospital with a wound on my (R) leg. Dressing was not done regularly. I phoned Mrs. Annelie at Rehoboth who came to fetch me from the hospital. Dr Mouton was disappointed about the condition of my wound and later my leg was amputated.

In 2004, I become sick. My glucose level was high. Dr Solomons treat me with 45 units of insulin in the morning and 20 units at night. I inject myself and sometimes one of the caregivers does it. I was blind. Last year my eyes were operated. Sight is weak. I will see if I can be operated on for cornea transplant. We are happy here me and my mother.

My brother use to say. "Keep quiet than you won't experience problems" My wheelchair is so old. Many times it is repaired. I don't mix so much. The radio is there.]

## **Participant No. 2**

82-year-old female

*"Eendag siek eendag gesond. Ek voel om hier vandaan begrawe te word. As ons 'n stryjtjie gehad het, praat ons weer more. Soms deel ons kamers. Ons het soms nie alles nie. Eendag drink ons swart koffie more weer melk. Watter huis het nie*

*probleme nie. Die kinders besoek ons nie. Ek is n kleremaakster en hou van borduur. Die kliniek besoek een keer per maand. Ek stap sommer self kliniek toe.”*

[One day sick, one day healthy. I feel as if we will be buried from here. If we argue, then we speak again the following day. Sometimes we share rooms. Sometimes we don't have everything. One day we drink black coffee, tomorrow, milk. Which house does not have problems? The children don't visit. I am a dressmaker. I like to embroider. The clinic staff visits once a month. I just walk to the clinic by myself.]

### **Participant No. 3**

88-year-old female

*“Ek gebruik kruie perske pit vir bloed maag. Voëlent kook vir kinders opgetel. Die Here het vir ons verstand gegee. Ek het my moeder opgepas met beroerte. Saam met 'n halfkroon het ek die pyn opgespoor waar dit is. Die half kroon trek vas waar die pyn is. Ek het nie klagtes nie oor die versorging nie.”*

[I use herbal peach pit to heal blood stools. Voëlent [a parasitic plant] boiled for mothers who give birth. The Lord gave us knowledge. I took care of my mother who suffered from a stroke. I used a “half a crown/ money coin” to find the pain. I could pick up where the pain was. The coin will stick tightly. I don't have any complaints concerning the caring.]

### **Participant No. 4**

88-year-old female (4 months in the Old Age Home)

*“Ek is in die rolstoel vir twee jaar. My bene is nie so lekker nie, doen ook nie oefeninge nie. Ek is gelukkig versorging is goed. Ons is drie wat saam bid.”*

[I am in the wheelchair for two years now. My legs are not so good and I don't do exercise. I am happy; the caring is good. We are three that pray together.]

### **Participant No. 5**

60 year old male

*“Dit gaan nie so goed met my nie. My bors trek toe. Ek kan nie so lekker asemhaal nie dan word ek ongeduldig en verloor my humeur. Ek kom van Otjiwarongo af. Ek het nie n problem hier by die ouetehuis nie. Ek het 'n asma pompie. My suster is hier in Rehoboth”.*

[I am not so well. My chest is tight. I can't breathe properly then I became impatient and lose my temper. I came from Otjiwarongo. I don't experience any problems in the Old Age Home. I have an asthma pump. My sister stays in Rehoboth.]

### **Participant No. 6**

86-year-old male (25 years in the Old Age Home)

*“Ek bly lekker hier. 'n Ovambo vrou, en Ragel, “Ronde meid” se suster en Global het gesorg vir kos. Ek kry baie swaar hier. Ek het n radio gehad “botsothos” maak mense sleg. As ou mense gepay het, hulle slaan jou en vat jou geld. Hoe maak ons. Hulle sny draad, doen niks, nie 'n security nie. Ek het 'n vel problem. Ek besoek*

*“central” hospitaal. As ek my medisyne kry, wys ek dit vir die “supervisor”, wat aan my verduidelik hoe om dit te gebruik. Ek was my klere self en stryk met die hand. Ek is baie netjies altyd met ‘n das aan. As ons genooi word gaan ek altyd saam. Ek skeer my baard self. Ek geniet my pay baie mooi. Ek koop vleis, groente, vrugte en brood. Ek eet self en gaan self winkel toe. Hulle rob my nie. Godsdien en musiek geniet ek en ek lag.”*

[It is nice to stay here. Ovambo ladies provide food as well as Ragel Rondemeid’s sister and Global provide the food. It is very difficult. I had a radio but the “botsothos” stole it. When we pay they assault you and take the money.

What can we do? They cut the fence. No security.

I suffer from a skin problem. I visit the central hospital and if they give me medicine I show it to the supervisor who explains how I must use it. I wash my clothes and iron them by hand. I’m very neat always with a tie. If we are invited, I always go with. Shave my beard myself. I enjoy my pay, very well. I buy meat, vegetables and fruit and bread. I feed myself and go by myself to the shop. They don’t rob me. I enjoy religion and music, and I laugh.]

### **Participant No. 7**

73-year-old female right hand and left femur fracture, hypertension

*“Ek is bedlënd vir drie jaar. Ek het gegly in die toilet en my been gebreek . Ek kry nie oefeninge nie. Ek het nie ‘n problem nie. Ek is rustig, luister na die radio. Word gereeld gewas deur die hulpe. Smeer my lyf met prep en Vaseline. Ek kan self eet.*

*Geen stokperdjie. Blaai boeke deur. Gebruik pot self. Geen bedsere nie. Kan koeldrank self oop maak. Netjies geen krummels in my bed nie”.*

[I have been bed ridden for three years. I slipped in the toilet and fractured my leg. I don't get exercise. I don't have a problem. I am at peace and listen to the radio. Caregivers wash me regularly and put some Vaseline or prep on my body. I can eat by myself. No hobbies. I page through books. I use the toilet myself. I have no pressure sores. I can open a cooldrink by myself. I am very neat and have no crumbs in my bed.]

### **Participant No. 8**

Male 98 years old

*“Ek bly al van 1982 af hier. Ag en twintig jaar in oue te huis. Ek bly lekker, het nie probleme nie. Ek lei aan mental disability, wat my soms ongeduldig maak. Ek kry elke maand pille. Ek is rustig loop rond. Ek is getroud. My vrou was klere en doen naaldwerk. Die kinders kan nie na ons kyk nie. Ek kom van Maltahöhe.*

*Ek was al vyf keer geopereer in (R) oog, oog nou uit gehaal. My (R) been is afgesit. Ek het n kuns been”.*

[I have been staying here since 1982; 28 years in the Old Age Home. I don't have any problems. I suffer from a mental disease which makes me impatient sometimes. I received my pills every month. I am at peace. I am married. My wife washes the clothes and does the needlework. Our children cannot look after us. I am from Maltahöhe. I have been operated on five times on my right eye. They removed the

right eye. My right leg has been amputated and I use an artificial leg.]

**Participant No. 9**

80-year-old male

*“Ek bly al vyf en twintig (25) jaar hier indie oue te huis. Ek het geen probleme nie. Ek was in n motor ongeluk en sit in n rolstoel en het geen problem nie. Ek word in ‘n skottel gewas. Ek lei nie aan n siekte nie. Ek is gelukkig hier. My suster kom kuier my wat by Kentucky werk”.*

[I have lived in the Old Age Home for 25 years. I don't experience problems. I was in a motor car accident and have been in a wheelchair for 10 years. I wash myself in a bucket. I don't suffer from any diseases. I am happy here. My sister visits me who work at Kentucky.]

**Participant No. 10**

88-year-old female – Hearing problem

*“Ek het op my linker been geval en gebreek hier buite kant die oue tehuis. Dit maak my soms stressvol om nie te kan doen wat ek wil doen nie. Ek was myself. Die kliniek besoek gereeld. Hulle kyk mooi na my. My kind kom my elke dag besoek. My klere word vir my gewas”.*

[I fell on my left leg and broke it outside of the Old Age Home. It makes me upset sometimes not to be able to do what I want to do. I wash myself. The clinic visits regularly. They take care of me. My child visits me very day. She washes my

clothes.]

### **Participant No. 11**

Male 84 years old

*“Ek woon van 2004 by die ouetehuis. Ek lei aan hoe bloeddruk, suiker siekte, vergrote hart, my (L) oog is stukkend geslaan. Ek kan nog lees. Dit is nie baie sleg nie. Partykeer kry ons honger, kos is te min. Toe ek by my eie werf gebly het, ek ook nie kos gehad nie. Pensioen is N\$370.00, trek af N\$220,00 vir klere was en kos. As jy siek word of baie siek is, kom jy by die hospital uit. Kinders moet jou terug vat as dit lyk na die dood. Dit is nie so baie goed nie”.*

### **Verbetering**

*Pensioen geld moet verhoog alles is duur ons kan nie met N\$150.00 klaar kom nie.*

*Die kerk het nie geld nie. Die ouetehuis gaan agter uit. Die gemeente het terug gegaan wat hulp verleen het.”*

[I have lived in the Old Age Home since 2004. I suffer from hypertension, diabetes mellitus and heart. My left eye was injured in an assault. I can read. The caring, it is not so bad. Sometimes we are hungry, the food is limited. When I stayed in my own, I also didn't have food. Pension money is N\$370.00; they withdraw N\$220.00 for food and clothes.

If you are sick and hospitalised, your children need to take you back if it looks as if you are going to die. This is not so good.

Suggestions for improvement:

Pension money needs to increase – cannot come out with N\$150.00.

The church does not have money. The Old Age Home is deteriorating. The congregation who gave support can no longer do so.

### **Participant No. 12**

Male: 87 years (Two months in old age home. Resident of Rehoboth)

*“Die versoring is nie so perfek nie soms wil ek nie was nie, as ek nie lekker voel nie. Die etes is nie so goed nie. Ek het nog nie die meisies gegroet nie. Ek is gesond soos ‘n vis in die water. Ek het geval en my bors beseer. Ek moet sê ons is nog ‘n bietjie agter. Jy wat die werk doen, kan nie so perfek wees nie. Die huise is te op mekaar. Die privaatheid, ons sal maar kyk. Wit mense se huise is beplan”.*

[The caring is not so perfect sometimes I don't want to wash because I am not feeling well. The food is not so good. I didn't greet the girls yet. I am as healthy as a fish. I fell and injured my chest. I must say we are a little behind. You who do the work cannot be so perfect. The houses are too near each other. The privacy we shall see. White people planned their houses.

### **Participant No. 13**

Male: 63 years (Damara has lived in the old age home for three years)

*“In die oggend kry ons mielie pap en tee. Middag kos hoender groente soos donasies in kom. Namiddag tee en brood ons wil nie altyd tee en brood eet nie.*

*Ons klere word gewas. Kamers word skoon gemaak. Naweke vee ons self. Ons het nie 'n verpleegster wat vir ons kyk nie. As ons siek is moet ons self hospital toe. In die aand is daar 'n meisie wat hier bly as ons siek word. Hierdie naweek is ons alleen. Nursing studente besoek ons ook vir hulle studie. Kliniek besoek ons ook eenkeer per maand om ons bloeddruk en suiker te toets. Ons is vier mense wat suiker het. Ons kry nie ons dieet nie. Ons eet maar wat hulle voorsit. My kinders besoek my sommige naweke, kom haal hulle my. Soms kuier hulle net. Gee my ook ietsie om te eet. Daar is een meisie wat nie weet hoe om met grootmense te praat nie. Daar is vier wat skoon maak. Een in die waskamer. Twee in die kombuis. Die sekretaris in die kantoor. Dit voel nie soos my huis nie, maar ek is gelukkig hier. Dit is stil hier so”.*

[In the morning we get maize porridge and tea. Lunch time we eat chicken and vegetables depending on the donations that come in. For supper we eat bread and tea. We don't always want tea and bread. Our clothes are washed. Rooms are cleaned. Weekends we sweep our rooms ourself.

We do not have a nurse who cares for us. If we become sick we have to go to the hospital. During the night there is a girl that takes care of us. This weekend we are alone.

Nursing students visit us for their studies. The clinic health workers visit us once a month to test our bloodpressure and glucose. We are four elderly people suffering from diabetes mellitus. We do not get our special diet. We eat what they serve us.

Support

My children visit me. Some weekends they take me out. They also give me something to eat. There is one caretaker that does not know how to speak to old people.

There are four caregivers who clean. One is in the laundry. Two caregivers work in the kitchen. The secretary is in the office. It does not feel like it is my house but I am happy. It is quiet here.]

#### **Participant No. 14**

68-year-old male (three months at Old Age Home)

*“Die klagtes is hoës, droë mond, en duiseligheid en oog probleme. Daar is nie fout nie. Ons bly is oraaït. Die sorg is goed. Daar kom nou en dan mense wat kos bring en kerk kom hou. Hulle het vir ons ook klere en komberse gebring. Daar is altyd probleempies, die kos is min en word nie op tyd gegee nie. Ek koop self pille as ek siek is”.*

[My complaints are coughing, dry mouth and dizziness and eye problems. Further there are no complainst. The stay is ok. The care is fine, now and than people bring food and hold church services. They bring us clothes and blankets. There is always a problem like too little food and we don't get food in time. I buy my own medicine when I am ill.]

#### **Participant No. 15**

**Female 88 years (four years in the Old Age Home)**

*“Is net gebed wat ons dra en uithou - vermoë gee. Vroeg opstaan. Was my lyf. Dan gaan ons eet. As ons klaar geëet het is daar iemand wat vir ons diens hou. Kom sit en Bybel lees. Ons praat met mekaar. Ons kan gesels en rondloop. Wag vir die middag tyd. Een uur eet ons.*

*As ou klere stukend is help met naaldwerk. Ek werk my rokke self. Familie kinders kom kuier ook. Op twee en tagtig het ek ‘n groot sny gehad. Ek is gesond. As ek siek is gaan ek kliniek toe. Mense versorg ons ook”.*

[It is only prayer that keeps us going and gives us perserverance. Get up early, wash myself then we go to eat. After eating some one gives us devotion. We communicate with each other and walk around. We wait for lunch then we eat again. I help with needlework if clothes are torn. I make my own dresses. Children come to visit. When I was 82 years of age, I cut myself. When I get sick, I go to the clinic. People care for us.]

### **Participant No. 16**

#### **Female 60 years (six months in the Old Age Home– asthma sufferer)**

*“Ek bly goed. Ek het nie klagte nie. Die versorging is nie so sleg nie. Ons was nie klere nie, ons maak nie skoon nie. Is rustig hier. My pastor het vir my plek hier gekry toe ek my huis verloor het. In die begin het ek hopeloos en skaam gevoel. Ek kry die asma aanvalle so erg dat my seun moet met my hospital toe jaag. Verder het ek nie probleme nie. Ek is n gelowige. Die Here is vir my te belangrik in my lewe. Hy gee my krag en uithou- vermoë. Ek kan nie sonder hom nie”.*

## Verbeterings

*“Die plek is nie so skoon nie. Hulle maak die vloere skoon, maar as jy op kyk die mure. Ek is n tuin mens. Die werkers steel ook ons se goed en dra dit huis toe. Ek wil nie oor sulke goed praat nie dan word ek sommer stressvol. In die aand is probleme. Die ambulans vra N\$500,00. Krediet vir selfone het ons nie. My bors verdra nie koue hier nie. My kamer maat lei aan suiker aanvalle. Ek weet nie wat om te maak nie. Ek sukkel om in die dorp te kom”.*

[I am comfortable. I do not have complaints. The caring is not so bad. We do not do washing or cleaning. It is peaceful here. My pastor got me this place here, when I lost my house. In the beginning I felt hopeless and shy. I suffer from asthma, so bad that my son had to take me to the hospital. Further I do not have complaints. I am a believer. The Lord is important in my life. He gives me strength and perserverance.

What changes do you want to see?

Place is not clean. They clean the floors but the walls are dirty. I am a gardener. The workers also steal our things and take them home. I don't want to speak over such things than I become upset. At night there are problems. The ambulance asks N\$500.00. We do not have credit for cellphones. My chest does not like the cold. My room mate gets sugar attacks. I do not know how to handle it. I struggle to go to town.]

## **Participant No. 17**

Female: 69 years (Herero, one year and one month in Old Age Home)

*“Hoe dit is ‘n moeilike proses ...? Ons kry wel etes en ons klere word gewas maar ons is eensaam en alleen. Die werkers behandel ons nie so goed nie soos ou mense nie. Soms skree van hulle op ons. Ons het nie n sosiale werkster nie, wat na ons klagtes kom luister nie. Mens voel of jy die mense aankla maar mens moet waarheid praat. Vervoer is wel hier. Ek het te voet van hospital geloop. Vervoer word nie vir ons gebruik nie. Ek moes agt uur by die hospital wees. Ek het twee seuns waar van die jongste my besoek met sy vriende. Moeders dag was ek by my kinders. Einde van die maand besoek die Rynse susters ons”.*

#### Verbetering

*“Ons slaap plekke moet verbeter. Ons beddens is nie so goed nie. Maak my rug seer. Baie vuil hier iemand kry wat hark. Tehuis kort nuwe verf. Ons het n oop veld ons kan tuin maak.*

*Ons kry kos maar dus nie alles nie. Soms dink ek om huis toe te gaan. Ek kom van Walvisbaai maar is oorspronklik van Rehoboth”.*

[How is it a difficult process ...? We receive food and our clothes are washed. We are so lonely and alone. The workers don't treat us as old people well. Some of them shout at us. We do not have a social worker, who can listen to our complaints. One feels if you accuse the people? But one needs to speak the truth. Although there is transport, I had to walk on foot to the hospital. Transport is not for our use.

What improvement do you want to see?

Participant: Our beds need improvement. The bed injured my back. Environment

very dirty. Home needs some paint. We have an open field. We can start with gardening. We receive food but this is not all. Sometimes I think of going home. I am from Walvisbay but original from Rehoboth.]

### **Participant No. 18**

Female 97 years (five years in Old Age Home)

*“Ek was gedwing om hier na toe te kom deur my seun. Ek het nie geweet nie. Ek het baie gehuil en was humeurig. Twee, drie maande gelede het ek my seun verloor. Hy was 61 jaar oud.*

*Die behandeling is baie goed. Ek behoort aan n mediese fonds. Ek wag vir dokter. Ek het n vleis wond, kanker aan my (R) been. Dit is nou al ses jaar daar. Ek maak my wond self skoon. Ek is gelukkig hier. Ek kry goeie kos, my wasgoed ook ingesluit. Ek kry net my man se pensioen. Hy is ses maande geledeoorlede. Ek kan nie die staats pensioen kry nie. Ek hekel met twee vingers. Ek het my (R) heup gebreek. Ek het gegly hier by die ouetehuis. Ek was die hele tyd in die hospital. Hier is verpleegsters soms is hulle op verlof. Hulle gee vir my verbande”.*

[I was forced by my son to live in the Old Age Home. I did not know. I cried and lost my temper. Two, three months ago I have lost my son. He was 61 years of age. The treatment is very good. I belong to a medical aid fund. I am waiting for a doctor. I have had a flesh wound cancer on my right leg for six years. I clean the wound myself. I am happy here. Good food and they do my washing. I only receive my husband's pension. He passed away six months ago. I cannot receive state medication. I crochet with two fingers. I fractured my right hip. I slipped here at the

Old Age Home. I was the whole time in the hospital. Here are nurses, sometimes they are on leave. They give me dressings.]

### **Participant No. 19**

Female: 86 years, now 12 years in Old Age Home.

*“Ek bly baie lekker, my susters is vir my baie goed. Hulle is baie vriendelik. Versorging is baie goed. Die een ou sê so en die ander sê dat. Dit hang af van geaardheid. Ek het nie iets om oor te kla nie. Ons kry ons tee en koffie op tyd. My wasgoed word in my kamer kom haal. As ek siek is gee hulle vir my pilletjies. Ek doen naaldwerk en verkoop die artikels. Laas vrydag was on uit genooi na Gobabis. Ons het vleis gebraai en niks betaal nie. Ek lei aan suiker en is op n spesiale diet. My toon naels was getrek want ek het gangrene gehad. Hulle wou my toon afgesit het. My familie het my na ‘n spesialis geneem. My seun boer en my ander seun is die baas van die swembad. Ou mense fonds hoef nie te worry, hulle bring dit tot in die kantoor. Doen dit alles vir ons”.*

[The sisters are very good. They are friendly, caring is good. The one says this and the other that. It depends on their nature. I don't no complaints. We receive our tea and coffee in time. My washing is done. When I am sick they give me pills. I do needlework and sell the articles. Last Friday we went out to Gobabis on an outing. We eat braaivleis. I suffer from diabetes mellitus and I am on a special diet. My toe nail was pulled out. I had gangrene. They want to amputate my toe. My family took me to a specialist.

My seun is a farmer and my other son is the boss of the swimming pool. We do not

have to worry about the pensionfund. They bring it to the office. They do everything for us.]

### **Participant No. 20**

Female 88 years(20 years in the Old Age Home)

*“Van dat ek hier bly moet ek maak wat vir my die gemaklikste is. Ek bedoel om op my rug te lê. Ek het my bene gebreek. Ek het geval toe breek my (L) knie. Ek bly lekker hier word goed versorg. Net al die kwale en skete. Ek loop met karretjie. Ek onthou nog so goed. Die Here is vir my goed. Hy het vir my gesond gemaak. Toe hulle vir my die tweede keer by die operasie saal instoot was ek kwaad. Toe sê n stemmetjie vir my jy sal weer loop. Ek kry vreeslik koud, daar is nie ‘n plek in my liggaam wat pyn nie. Ek was bedlêend in die hospital het ek nie klagtes gehad nie. Ek is van Kakemis. Ek was een jaar oud toe ek hier gekom het. Ek het hier groot geword. Ek en my broer is nog oor. Ons was sestien kinders. Om so oud te wees is nie lekker nie want jy is hulpeloos. ‘n Been breek is baie seer, veral in ons weer. Ek is dood tevrede”.*

[Since I have been in the Old Age Home must I do what is more comfortable for me by lying on my back.I fractured my legs; I slipped and fractured my knee. I am happy here with all my complaints. I walk with a walker.I remember. The Lord is good for me. He healed me.

When they pushed me in for operation for a second time, I was annoyed. Then a voice told me you will walk again. It is very cold; there is not a place on my body that doesn't hurt.

I am from Kakemis, in South Africa. I was, one year when we came to Windhoek. I grew up here. It is only me and my brother. We were 16 children. To be so old is not nice because you are helpless. The fractured leg is sore in our weather. I am satisfied and at peace.]

### **Participant No. 21**

82-year-old female (three years and three months in Old Age Home – hypertension).  
*“Ek is baie tevrede. Ek het twee dogters wat my kom besoek en uit neem. Almal is baie lief vir my. Ek wil nie by ‘n kind kom bly nie. As hulle iewers gaan wonder hulle, wat van my kan word. Ek sien die dokter hier. Dr. Swiegers van Swakopmund is my dokter. Ek huil maar oor my man”.*

[I am satisfied. I have two daughters that visit and take me out. Everybody loves me. I don't want to live with one of my children, because they worry about me. The doctor came to see me here. Dr Swiegers is my doctor from Swakopmund. I cry about my husband.]

### **Participant No. 22**

Female 80 years old (one year and two months in Old Age Home)

Suffers from high blood pressure, diabetes mellitus, asthma and rheumatism

*“In Februarie die jaar geval in die ouetehuis. Nek kussing tussen werwel en boonste werwel is skeef. Ek was vyf dae in die hospital. Toe het ek teruggekom.*

*Ek kan nie kla oor die versorging nie. Die eerste tyd toe ek my huis verlaat het was*

*ek nie gelukkig nie, want ek verlang terug en ek was skaam om in 'n oue tehuis te bly. Ek weet nie of daar n beter plek is waar ek beter versorging kan kry nie. My skouers is die ergste. Ek kan nie my arms op lug nie. Ek kom van Aranos. Ek het n swart vrou wat my gehelp het. My bene is swak. Ek moet weer leer loop. As ek nog op Aranos was weet ek nie wat sou gebeur het nie. Ek toets my suiker self. Ek spuit myself in. Ek het dit ook op Aranos gedoen. Daar is party dae dat daar agterloosheid maar 'n mens sien dit oor. Daar is nie n beter plek nie''.*

[In February this year I slipped and fell in the old age home. I injured the cushions of my vertebra of the neck. I spent five days in hospital then I came back. I can't complain of the caring for the first time I left my house I was unhappy because I long back and I was shy to be in an old age home. I don't know if there is a better place where I can get better care. My shoulders are the worse. I can't lift my arms up. I am from Aranos and there a black woman helped me. My legs were weak, I must walk again. I test my sugar and inject myself. I have done this in Aranos. There is sometimes negligence in the caring but one overlooks it.]

### **Participant No. 23**

89 old female (four years in old age home) – suffers from hypertension

*“Ek is in my kamer dag vir dag. Ek gaan nie eetsaal toe nie. Verlede jaar het ek sinus gehad. Nou is my kop nie lekker nie. Ek lees nie meer nie. Ek sien nie lekker nie, het nou al 'n tweede bril. Ek het baie gebrei en gehekel. Nou kan ek nie meer nie. In die more voel ek nie lekker nie, voel golwe in my kop. Dan gaan lê ek en slaap. Ek het baie operasies gehad to ek jonk was heup en knieervanging. Dit is 'n*

*bietjie seer as ek loop. Ek het niks om oor te kla nie. Die staff is behulpsaam”.*

[I am day and night in my room. I don't go to the dining hall. Last year I suffered from sinusitis. Now my head is not nice. I don't read. I can't see properly. I previously knitted and crocheted a lot. Now I can't. In the morning I don't feel well, feel like waves in my head. Then I go to sleep. I had many operations when I was young like a hip and knee replacement. It is a little sore when I walk. I have nothing to complain about. Staff is helpful.]

#### **Participant No. 24**

Female 75 years (three months in Old Age Home) German suffers from diabetes

*“My ervaring is baie goed. Kry mense hier wat jou was, wat nie so goed is nie so 80%....! Ete en versorging is baie goed. Kan nie sê of daar enige te kort is nie. Die kos in tehuis is nie so goed. Moet meer Duits kook. Hulle dra meer kos weg as wat ons eet. Die meeste hier kan Duits en Engels praat. Ek het geen familie hier nie. Net my vriende wat kom kuier. My (R) onder been is geamputeer in die jaar en my gal is uitgehaal. Ek het ook n oog operasie gehad. Ek het net goeie ervaring”.*

[My experience is very good. Here are people that wash you, that is not so good so 80%. Food and caring is good. They should cook more German. They carry the food away. Most caregivers can speak English and German.

I don't have family only friends that come to visit. My right lower leg has been amputated. Last year my gall bladder was removed. I also had an eye operation. I only have good experiences.]

**Participant No. 25**

82-year-old female (two years in Old Age Home) – arthritis

*“Ons moet tevrede wees wat ons hier kry. Die mense in die kombuis hulle kook. Die kos is in tussen. Soms goed kan nie kla oor susters of staff nie. Niks kan beter gemaak word nie. Meer bananas gee. My heup was geopereer. Ek het een dogter, sy is getroud. Sy besoek my drie maal per week”.*

[We have to be satisfied with what we get here. The food is in between. I cannot complain about the staff.]

Researcher: Is there any changes you want to see?

Nothing can be improved. They must give us more bananas. My hip was operated on. I have one daughter; she is married and visits me three times a week.]

**Participant No. 26**

90-year-old female (16 years in old age home – suffers from osteoporosis).

*“Ek wil gaan. Ek is net verniet hier. Dit kos net geld. Ek kan nie gaan, nie as die Here my nie wil hê nie. Die mense hier sê koppe is nie meer so mooi nie. Ek het twee kinders wat ek waardeer. Ek voel “langewali” (vervelig) weet nie wat om te doen nie. Ek dink hulle het ‘n bietjie te min personeel vir aantal mense wat hier bly. Ons is die baas van die land hier. Julle is net gaste. Ek is hier gebore en is geregtig om hier te bly. So ver is dit oraait. Elke aand dieselfde brood en wors n koppie sop en vla.*

*Vleis is te klein. Ek het my flat op gegee. Ek was 10 jaar n boarder gewees. My bene kon nie meer loop nie. My dogter besoek my om vyf uur”.*

*“Die meisies is nie soms so goed nie behandel my soos n st. 1. Dit is waarvan ek nie hou nie. Hulle dink tog sy is mal. Party baie gaaf. Dit is tog oral dieselfde procedures doen dit dieselfde. Oor die algemeen is ek nie n moeilike mens nie.”*

[I want to go? I am just here. It only costs money. I can't go if the Lord does not want me. The peoples head is not so good. I have 2 children whom I appreciate. I feel “langewali” lonely. I don't know what to do. I think they have few staff for the total people living here. Some caregiver says I am the boss of this land. You are just the guest. I am born here and I have the right to stay here. So far ok!

Every night it is the same food such as bread, sausage and a cup of vanielje. The meat is so small. I gave up my flat. I was 10 years a boarder. I cannot walk. My daughter comes to visit me at five. The girls is sometimes not so good, they treat me as a grade 1. I don't like it. They think I am mad. Some of them are very good. The procedures they do it all the same. In general I am not a bad person.]

### **Participant No. 27**

73 year old female, 3 years in Old Age Home – suffering from Parkinson disease.

Boarding N\$4 600.00

*“Ek het vergeet wat ek wou sê...!. Partykeer is dit moeilik om dit te aanvaar dat die tyd van rus gekom het. Daar is n verskil van die huis en om hier te bly. Jou familie lede kan jy iets vra, en die kinders kom gereeld besoek. My dogter besoek my*

*eenmaal per week. Een seun is in Duitsland. Die ander seun in Windhoek. Die nurses kyk mooi na my met vertroue, die ander een nie. Ek lei aan Parkinson in die vroeë stadium. Nog kan ek loop en iets doen maar eendag sal dit klaar wees. Dit is n siekte wat oorerflik is. My moeder het die siekte ook gehad. Ek kan my vooraf voorberei. Dit is n bietjie beter in die sieke boeg. Die ergste ding is dat ek by rustyd gekom het. Ek dit met die vreeslikste siekte nog daar by. Ek verloor die woorde dan stop dit skielik in my mind dan weet ek nie wat ek wou sê nie. Voedsel is genoeg en lekker. Nou en dan iets extra by.”*

[I forget what I want to say. It is difficult to accept that the time of rest had come. There is difference between your house and the Old Age Home. Your family members you can ask. My children visit regularly. My daughter visits me once a week. My one son is in Germany. The other son is in Windhoek. The nurses take good care of me. I suffer from Parkinson in the early stage. Now I still can walk and do something but one day it will be finish with me. This is a disease that is inherited. My mother also has suffered from it. I can prepare myself. It is better here as in the sick bay. The worse is that I came to a time of rest... and with this bad sickness. I loose words than I don't know what to say....? It suddenly stop in my mind. Food is nice sometimes something extra.]

### **Participant No. 29**

92 year old female, 5 years in Old Age Home.

*“Die versorging is baie goed. Daar is niks wat verkeerd is nie. Ek was eers met my man hier. My man is twee jaar gelede oorlede. Ek het op my kop geval buite. Ek het*

*een dogter in Pretoria. Een het twee kinders. Ek het n tweeling gehad. My man was 'n pilot by die Katolieke mission. My dogter kuier elke dag vir my. Geen klagtes nie. Die kos is goed. Nurses is goed”.*

[The caring is very good. There is nothing wrong. I first stay with my husband. He died two years back. I fall on my head outside. I had one daughter in Pretoria. One has 2 children. I had a twin. My husband was the pilot of the Catholic Mission. My daughter visits me everyday. No complaints. The food is good. Caregivers are good.]

## **ANNEXURE E**

### **INTERVIEWS WITH THE PARTICIPANTS (CAREGIVERS)**

## **Annexure E**

### **INTERVIEWS WITH CAREGIVERS OF THE ELDERLY**

Interviews were done on 15-5-2007, Saturday morning, sunny and windy day and also on the 21- 5- 2007, 5- 6- 2007 and on the 11-7-2007,

The medium of communication were Afrikaans.

Twenty five of the caregivers were women and only one male.

The age group range from twenty one (21) up to sixty three (63).

Twenty six (26) caregivers were interviewed.

**The following questions were posed to the caregivers:**

**“ Tell me how do you experience the caring ofelderly in old age homes”**

**What are your training needs?**

**What other support is needed to provide quality care?**

#### **Participant No. 1**

*“Ou mense is baie stress vol. Ek het voorheen by Dr. Lemmer skool hostel gewerk.*

*Ou mense is liewe mense. Soms is hulle olik dan moet jy weet hoe om hulle te*

*hanteer, Soms wil hulle nie was nie, dan se jy kom ek maak vir ouma mooi vandag.*

*Soms is hulle hardkoppig. Ek het my base, wat kom en myopdragte gee. Ek is diehele*

*dag hier. Sy is in bevel van almal”.*

*Routine: Ek haal in die oggend die pap en koffie tee uit en die vleis uit. Aandete brood, sop, koffie en tee. Ek beplan alles. Daar is ‘n meisie wat die wasgoed was. Ek is die hele dag op en af.*

*Bejaardes kry N\$370.00 nou opgeskyf na N\$500.00 pensioen. Die kinders betaal N\$ 200.00. Bejaardes kry N\$60.00 sakgeld. Die tehuis betaal N\$1000.05 vir krag. Ons het sponsers in die gemeenskap. U-Save gee groente, surf en staysoft. Ons kry rolstoel van Duitsland af.*

[Old people are very stressful. I previously work at Dr. Lemmer High school Hostel. Old people are loving people. Sometimes they do not feel well than you had to know how to handle them. If you had to wash them and they do not want to wash you could say” Come let me make you beautiful.” Old people are stubborn.

I have my boss. She gave me instructions because I am the whole day here. The routine: Take out the porridge tea and coffee and meat. Supper; Bread, soup, coffee and tea. I planned everything. There is one lady doing the laundry.

I am the whole day up and down. The pension is N\$ 370.00 now it is increased tons 500.00. Children pay an extra contribution of N\$ 200.00. Elderly get N\$ 60.00 pocket money. We paid per month N\$1000.05 for the electricity bill. We have our sponsors in the community. A shop U-Save sponsors us with vegetables, surf and stay soft. Wheelchairs we get from Germany.]

**Participant No. 2**

Experience 4 years; Standard8; Salary N\$500.00

*“Dit is moeilik om met ou mense te werk. Daar is nie ‘n verskil tussen kind en groot mense nie. Soms word jy kwaad vir hulle, maar jy kan nie heeldag kwaad wees nie. Soms is daar wonderlike ervarings. Soms het jy gevoelens in jou self. Soms deel jy dit met hulle. Soms voel jy siek dan vra hulle you hoekom lyk jy vandag so. Hulle gee jou raad. Eenkeer was ek swanger met my laaste baba. Dan se die ouma dat ek swanger is. Ek glo dat jy gesond sal wees. Finansiële saak is moeilik daar is n tekort aan staff. Moet in staan, voer of vas hou, nie kans vir om draai nie.”*

### Opleiding

*“Ek het nog nie training ontvang nie. Wil graag training het oor hoe om wonde skoon te maak asook bedseere. In noodhulp spuite en mond versorging. Boudjies raak sensitief sagte hand wat hulle aanraak. Hier is n tekort aan equipment. Hier was ‘n oupa wat se rug en buttock vol bedseere was. Doctors het nie kans gesien day hy in die hospital op geneem moes word nie omdat hy hier in die outehuis beter versorging kry. Ou mense lyk nie gelukkig nie. Kinders kom nie besoek nie veral die wat nie n by betaling doen nie. Kinders kom begrawe ook nie hulle afgestorwenes nie. Die gemeenskap is onbetrokke. Kliniek besoek een keer per maand. Hulle kontroleer die bloeddruk en glucose. Staff is traag kan nie gevors work om te werk nie. Een wat twintig (20) jaar gewerk het, het geen pensioen of behuising of mediese fonds nie net social security. Al die meisies sal nie meer kinders kry nie”.*

### Veranderinge

*Ete moet verander soms is daar nie uie of spice nie.*

*Salaris moet verbeter van N\$700.00 na N\$800.00. Kliniek besoeke elke tweede week.*

[It is difficult to work with old people. There is no difference between a child and an elderly person. Sometimes you are angry but you can't stay angry for long. Sometimes there is wonderful experience. Sometimes you had feelings in yourself. Sometimes you share it with the elderly people. Sometimes you feel sick and they asked you: Why are you looking like this today. Elderly people also give advice. Once I was pregnant with my last born. Than one elderly said that you are pregnant and that it will be a healthy baby.

Finances are difficult and there is a shortage of staff. I had to stand in, wash feed hold there is no change to turn.]

Training needs

I did not receive training. I want training over wound care, bedsores, emergency care injection and to clean a mouth and perineal care.

Here is a shortage of equipment. Here was an old man whose back and buttock was full of sores. The doctor did not admit him in hospital but prefer to keep him in the oldage home for better care.

Old people are not happy because their children do not visit them. The children who did not visit them are those who do not pay their contribution.

Children do not bury their diseased parents. The community is not involved. The clinic visits the oldage home once a month. They control the bloodpressure and glucose of the elderly.

The staff cannot be forced to work. There is one caregiver that works over twenty (20) years. She do not have pension, housing loan or medical fund. The only thing she has is social security. This will make that the girls do not want to be pregnant again.

Changes want

The food need to change sometimes there is no onions or spices

Salaries need to change from N\$ 700.00 to N\$800.00

Clinic to visit us every second week.]

### **Participant No. 3**

Female 40 years 16 years experience

*“Begin te werk met drie- drie ou mense in n kamer en met N\$100.00. Ek het gebid vir werk. Die Here het my die Oue te huis gewys. Ek het gekom en gesê Here ek moet nie wag nie en het begin werk met die ou mense. Ons moet net aanpas ons kom uit verskillende huise. Later was ek in die was huis waar ek hulle klere was. Nou werk ek naweke in die mans kamer. Ek het drie kinders. Mans het soms moods.*

*Maak hulle droog asook hulle beddens. Hulle wil nie hê ons moet hulle droog maak nie dit kos mooi praat. Hulle is nou gewoon aan my. As jy nut is, is hulle skaam. Nie een mens is volmaak nie, soms word ek kwaad byvoorbeeld as hulle vuil maak dan stry hulle. Pastoor Philander gee soms vir ons leringe. Ons het ons eie water voorsiening.”*

## *Opleiding*

*“Mense wat aanvalle kry wil weet hoe om dit te behartig.*

*Drips hoe om dit te hanteer”.*

[I start working with three old people in a room and with a salary of NS100.00 per month. I have prayed for the work. The Lord shows me the old age homes. I told the people that I want to start immediately to work. We just adapt as we are from different houses.

Later on I was transfer to the laundry to wash clothes of the elderly. On weekends I work in the male wards. Men have a lot of work to be done; to dry them, and to make up their beds. Sometimes they do not want us to dry them. You had to convince them. They had accepted me. When you are new they are shy but later on they accepted you.

Sometimes I become angry, for example when they wet themselves and than they denied it. Here is one pastor that gives us the word of God. We have our own water provision.

Training needs

How to manage epileptic patients.

How to change drips.

Caregivers Interview done on the 05/06/2007

**Participant No. 4**

47 years, 23 years work experience

*“Ek werk gelukkig met die ou mense. Soms is dit moeilik as hulle koppe nie reg is nie. Hulle is deurmekaar. Ons wat jare werk weet hoe om hulle te hanteer. Verder is dit verpleging wat ons toe pas. Was, voer koors, bloeddruk dressings al die basiese. Op nag diens gee ons self die pille. Meeste van die tye voer ons die opdragte uit. Jy wat die naaste met die person werk jy weet hoe die person is. Gebruik eie diskressie. Daar is not die outydse apartheid van diefstaf. Goed word gebêre en weer gekry. Ek was n verpleegster my papiere het weggeraak. Ek sal bly wees as ons nog opleiding kan dry. Ons is die persone wat illegal werk. Ons will ook by die Namibian Nursing Board in gaan vir beskerming. Ons kry pensioen, medies. Salaris nie oraait nie. Een goeie ding ek het duits geleer. Sister Platt het vir ons opleiding gegee meer as wat ons geleer het by Juanita.”*

[I am happy with my job. Sometimes it is difficult if their heads are not right they are confused. We who work for a long time know how to handle them. We wash them feed them, Take their bloodpressure and temperature, and dressing and all the basic care.

During night duty we give the tablets. Most of the time we do the orders (doctors and nurses occupational therapist). You who work with an elderly you know how the elderly is. You can use your own common sense.

There is still the old colonial racism of stealing. Old people put things away and find it again. I was an assistant nurse my papers got lost. I would be glad if I can get training.

We are the persons that work illegal. We also want to be registered at the Namibian nursing board.

We received benefits such as pension, medical fund. Salary is not so good. One good thing is that I learned to talk German. One sister gave us training we learned a lot from her more as from Juanita the training institution.]

### **Participant No. 5**

42 years Female Damara

*“My ervaring is dat ou mense soms moeilik is, hang af van jou geaardheid. Dit bring ook bedaring. Jy kan probeer goed met hulle te wees maar hulle is sleg met jou. Vir jou sleg te sê soos in die apartheids jare. Ons moet aanvaar wat hulle sê. Wat vir my nie lekker is nie. As jy op die laaste trap werk geen bevordering om van die trap op te gaan nie. Ons sal baie waardeer as daar iets gedoen word aan die opleiding. Nodig nog meer kursusse vir versorging. Dis al.”*

[My experience is that old people are difficult. It depends on your attitude. Your attitude can also influence you to be calm. You can try your best with them but still old people treat you bad. We need to accept what they said.

What is not right for me is that you work so long but there is no progress to the next level. We will appreciate it if something could be done to our training. We need more courses this is all.]

### **Participant No.6**

Female 36 years male Dam 14 years experience; Training six (6) weeks Juanita.

“Wat ek moeilik vind is met my gesondheid. Dat dit op my rug werk. Meeste van ons kla van rug beserings. Ou mense is moeilik veral die Alzheimer. Hulle het baie geduld en aandag en landmoedigheid nodig. Die werk wat ons doen moet n roeping wees nie enige mens kan dit doen nie. Ou mense beskuldig ons vals apartheid week wie is swart. Ek is gelukkig ek geniet die werk. Ek hou om met ou mense te werk. Verdere studies is belangrik. Ons lewer n belangrike werk dat ons kan strewe nie n diploma nie net sertifikaat nie. Ons werk so lank kan upgrade word na enrollment. Ek het Duits geleer.”

[What I find difficult is my back. Almost all of us complaining of back injury. Old people are difficult mostly those suffering from Alzheimer. They need patience and attention as well as endurance. The work that we do must be a calling not any person can do it.

Old people accuse us falsely due to colonial time's discrimination on who is black. I am happy and enjoy my work.

Training needs

Further training is important. We do a very important work so that we can strive to a diploma and not only a certificate. We work so long we can be upgrade. I have learned to speak German.]

### **Participant No. 7**

Female 50 years; 8 years experience, Coloured

*“Eerstens ek geniet die werk. Ons het ons goeie dae en ons slegte dae met die ou mense. Ek het ook al met n klap deur gestap. Dit was oor n kleding stuk. Sy wou blou slaap klere hê. Toe het ek die hele klere uit gehaal en gewys want daar was nie blou klere nie. Ek moes maar net sluk.... en voort gaan.*

*As ek vanaand huis toe gaan voel ek goed want ek het iets goeds gedoen. Ek het goeie ervaring op gedoen. Daar is ook dae dat ons lag oor die ou mense se goed. Daar is van hulle wat goeie woorde vir ons het. Daar is ook lag goedjies een dame kreun so baie. Toe vra ek of sy 'n baba kry. Sy sê toe ja, maar sy sal nie die pa se naam sê nie.*

*As daar enige moontlikheid is vir opleiding sal ons bly wees. Basiese verpleging doen ons. Indeling van medikasies word gedoen deur die geregistreerde verpleegsters. Ons gee dit net. Kateter versorging doen ons, maar nie in sit nie. Bloeddruk doen ons. Op nagdiens is ons net twee dan doen ons alles. Een keer per week besoek n dokter ons. Noodgevalle kan hy geskakel word. Staff is 2 saal hulpe, 2 assistant verpleegsters, 5 registreerde verpleegsters. Lida firma maak skoon asook die laundry. Kombuis is Alphine Cathering.”*

[Firstly I enjoyed my work. We have good and bad days. I also received a smack from an elderly. It was about a blue nighty that she wants to put on but there was no blue nighty. So I took all the cloths out to show her. After the smack I just had to swallow and to work on.

When I go home at night I feel good because I have achieved something good for the day. I gain a lot of experience. There are days that we laugh for the things of the

elderly. There are those who say good words to us. Laugh things: One lady make sounds as if she is in pain than I asked her if she is having a baby. She answered yes but I won't tell you who the father is.

#### Training needs

If there is a need for training we would be glad. Basic nursing we do. Dividing of medicines is done by the professional nurse. We just give the medicine to the elderly and make sure that they swallow the medicine. We give catheter care but not to insitu it. Blood pressure we do.

On night duty we are only two and we do everything. Once a week the doctor visits. In case of emergency we call him. The staff consists out of two caregivers, two assistant nurses and five professional nurses. Lidas firm do the cleaning and Alpine a catering service the food.]

#### **Participant No. 8**

32 years, 1 year experience, 6 weeks training Juanita.

*“Ek geniet my werk. Jy moet meer geduld het. Soms is die ou mense deur mekaar. Ons kry soms probleem. Soms wil hulle nie was nie. Wil soms nie uittrek nie. Soms is die ou mense se kinders ook probleem. Die kinders glo alles wat die ou mense sê dan is dit nie so nie. Ek weet hoe om ou mense te hanteer.*

*Wil weet wat om te doen om ons te upgrade. As hulle daar bo is hoe om hulle daar uit te kry. Soms is hulle deur mekaar, soms wil hulle nie eet of aantrek. Hoe om hulle te kalmee. Ek het eers tuisversorging gedoen.*

*Ek het baie dinge geleer. Hoe om koors te meet en bloeddruk te neem. As ou mense siek is kan jy gou agter kom. Soms wil hulle nie eet nie deurmekaar. Net soos kinders. Soms kan hulle nie loop nie en voel swak in die bene.*

### **Participant No. 9**

*Female: 44 years, 5 years in old age homes on (1) year experience*

*“Ek hou baie van die werk. Ek geniet dit. Dit is soms moeilik om met hulle te werk. Wil nie gewas word nie. Soms wil hulle nie eet nie, maar as jy weet hoe om met hulle te werk is dit maklik. Soms word hulle ook kwaad en beskuldig jou dat jy iets van hulle gevat het. Ons werk met al die ou mense.*

*Ek hoop dat ons verdere opleiding kan kry. Ek het opleiding by suster Platt gekry. Hoe om bloeddruk, pols en temperatuur te neem asook die versorging van wonde te doen.’ n Mens moet baie geduld en liefde hê.”*

[I enjoy my work. It is sometimes difficult to do your work. Sometimes the elderly do not want to wash or to eat or to dress. But if you know how to handle them it is easy. Sometimes they are angry and accuse us of stealing. We work with all the old people

### **Training needs**

I hope to receive further training. I received training on how to take a blood pressure and pulse as well as temperature and how to do a dressing. You need a lot of serenity and love.]

### **Participant No. 10**

*“Old people are just like children. If you give something to one you must also give to the other. People look down on us. They say “Oh, she is just working at an Old Age Home”. We are also human; sometimes we had to forget about ourselves. Just drink water, swallow and continue working. We don’t get counselling to talk our feelings.*

*Old people accuse us of stealing their things. They are also rude to us. For training to start something like in Germany, where they train the caregivers and they get certificates and also do advance courses.”*

**Interviews held on 25/5/2007, Africa Day.**

### **Participant No. 11**

**Female: 47 years experience 4 years previously was a cleaner.**

Training 6 months (2006) Grade 10, Salary N\$1003.00

*“My ervaring was ek is nie gewoond die reuke nie. Alles raak later maklik hoe langer jy werk. Sommige kliente is moeilik veral die Alzheimer. Ons moet hom voer, vergeet alles. Hulle kan nie onthou nie. Jy het hom nou koffie gegee dank om hy weer die gang af met sy beker vir koffie. Hulle is heeltemal afhanklik vir versorging moet twee uurliks gedraai word. Dring met mond soms moeilik om vloestowwe in te kry twee uurliks. Dra doeke. Twee persone wees vir ‘n groot persoon. Daar is van hulle wat raad gee. Ons doen ook observasies. Soms sien jy die ou mense is bleek. Sommiges sê dat hulle nie lekker voel nie. Ou mense is hulpelose mense, ons is daar om hulle te help. Ek sal bly wees as ons verdere opleiding kry.”*

[My experience is that I am not use to bad smells. The longer you work things becomes easier. There are some elderly that are difficult to handle for instance those suffering from Alzheimer. They forget everything, we had to feed them, you had just given him coffee than he came again with his cup down the passage. They are totally dependent on caring and need turning two hourly. It is difficult to give them fluids. You need two caregivers to attend to them. They are also incontinence wear also kimbies. Some of the elderlies give us advice. We also do observations like temperature. Sometimes you will fine the elderly looks pale and say that they do not feel well.

### **Training needs**

I would be glad for further training]

### **Participant No. 12**

#### **46 years and experience 6 months training**

*“Sommige ou mense is moeilik, ons moet geduld het. Toe ek in sieke boeg begin het, as jy hom vol was gee dan voel jy of jy maak hom seer. Vel is baie teer. Maak hulle gemaklik, stap saam met hulle, stap buite. Sommiges is baie moeilik hulle vloek vir my. Maar ons weet dat hulle dit nie bedoel nie. Ek het nie veel om te sê nie.”*

[Some of the elderly are difficult; we need to have patience when I start working in the sick bay of the elderly. If you gave a full wash it felt if you hurt him. Skin is very tender. Make them comfortable. Walk with them outside. Some are very difficult they swear at you but you know that they do not mean it. Further I do not have much

to say.]

### **Participant No. 13**

#### **21 years and 2 years experience**

*“Baie moeilik geduld hê en respek. Volwas moeilik in die winter te koud. Ander sê ek word nie deur n kleinkind gewas nie. Die Alzheimer baie moeilik jy moet kyk of hulle hul tee gedrink het en of hulle toilet toe was. Hulle ken jou vandag en more nie. Ons moet nog beter opleiding kry. As jy slaap dink jy aan jou pasiente. Sal ek hom nog, môre kom kry. Oumense word so eie and jou.*

[I experience the elderly as difficult. You need patience and respect. Full wash is difficult in the winter. Elder say I will not be washed by a child. The Alzheimer elderly are very difficult. You need to check if they drink their tea and if they went to the toilet. They knew you today but tomorrow not. We need more training. If you think of your patients. Will I find him/her tomorrow? Old people become own to you, part of your life.]

### **Participant No. 14**

#### **31 years – saal hulp and experience 3 years**

*“Die eerste dag wanneer hulle deur die kinders gebring word, voel hulle skaam hantseer en teruggetrokke. As jy jou werk lief het kan jy respek en geduld hê.*

*Soms voel die ou mense baie ongelukkig as die kinders nie kom kuier nie. Ons hang die fotos van die kinders op teen die muur as n troos. Soms will die ou mense nie eet*

*nie of hulle vergeet om te eet. Soms vergeet hulle name veral die Alzheimer. Vergeet waar hulle die geld gesit het. Soms geniet hulle dit om buite te stap onder toesig. Die beleid is om alles te doen vir die ou mense. 'n Goeie ding is ek geniet die ou mense. Soms is hulle grappig en praat hard, dan stuur hulle jou weer. Hulle is deel van my lewe. Ek leer baie van ou mense. Hulle gee raad doen so dan werk dit.”*

### **Training needs**

“Ek sal bly wees as ons nog opleiding kan kry. As ek op verlof is bel ek om te vra hoe dit gaan met so en so.”

[My experience is that the first day when the old people are brought to the old age home. They are shy, heartbroken, and reserved. If you love your work you will have respect and patience. Sometimes old people are unhappy if the children do not visit. We hang the photos of the children on the walls to comfort them. Sometimes old people do not want to eat or they forget to eat. Sometimes they forget mostly those who suffer from Alzheimer. They forget where they have put the money. Sometimes they enjoy it to walk outside under supervision. The rule is to do everything for the elderly. The good thing is I enjoy the elderly.

A good thing is I enjoy the old people. Sometimes they are joyful and talk loud. Then they send you. They are part of my life. I learn a lot from old people. They give advice do so and it work.

I will be glad if we can have further training. When I am on leave than I phone to find out how is it going with so and so....]

## **Participant No. 15**

### **Male 41 years one year training 2003 four (4) years experience**

*“Die moeilikste vir my is die wonde veral as die hele lyf deurtrek is met wonde, moet iemand jou kan tou wys. Ek kan nie eet nie. ‘n Mens moet gewoon raak aan die werk. Jy word somer prontuit gesê dat jy die baaitjie gesteel het. Baie keer kry hulle weer gesteelde artikel. ; mens raak lief vir die ou mense. Hulle se goed by “Goeie more tannie”. Ek sê vir jou ek was nog nie daar nie “n mens raak gewoon aan die werk”. Al se hulle iets wat jou kwaad maak gaan maar net aan.*

*Ek het agt (8) manne om te versorg. ‘n Mens moet oplettend wees. Kyk dat die person hom was, cream aan smeer. Die kas afstof, toilet ware kontroleer, baard skeer en naels knip en bietjie buite sit. As die kinders nie kom kuier nie begin hulle hul goed te pak om huis toe te gaan. Dit is belangrik dat kinders kom kuier. ‘n Mens moet met hom sit en paai en mooi praat om hom af te koel. ‘n Mens voel om op gegradeer te word en nie net n saalhulp te wees nie.”*

[My experience is that the most difficult part is the wounds that are all over the body. You need someone to instruct you. I cannot eat. One needs to become use to the work. The old people accuse you of stealing their jacket. Most of the times they find the article back.

One become in love with the old people. They say things for example “Good morning aunt”. I tell you I was not yet there. Even if they say things that annoyed you just continue.

I took care of eight (8) men one need to be observant. You had to look that the person is wash put on lotion check for pressure sores wounds. Dust the cupboard, control the toiletries. Cut nails and see that beard is shaved. If the children do not visit they start packing there things and they want to go home....! It is very important that children come to visit.

Training needs:

One needs to be upgraded and not stay at the level of caregiver.]

### **Participant No. 16**

42 years female Ten (10) years experience, 2000 training

*“2002 het ek en ‘n paar meisies n kursus onder gaan oor fracture deur n dame van uit die Kaap. As ons kan verder opleiding kry oor frakture en by die raad geregistreer kan word. Nasogastriese buise, kateters al daardie opleiding gekry. Op n stadium het ons pille, dressings gedoen. Suurstof gegee en observasies gegee. Ons het kennis van al die werke. Ons doen meeste werke. Ons voer die ou mense, was die ou mense. Aanmeld by die matrone of suster as iets nie reg is nie. As ons net ‘n kursus kry oor frakture is alles reg.*

*Ons as saalhulpe doen nag diens. Die ou mense wat nie toilet gebruik nie help ons. Ons doen die meeste werk. Ons soek erkenning. Ons kan ook HB ( hemoglobien) doen. Daar is nie bedsere nie.*

*Ons will ook leer. Wil erkenning hê. Hierdie werk wil geduld hê. God het vir ons die werk gegee. Ou mense ken ons stemme.*

*Stappe wat gedoen kan word is dat ons aan n organisasie moet behoort. Die kinders ken ons name. Daar is saal hulpe wat al vyf en twintig (25) jaar ervaring het. Ons werk saam met privaatt dokters. Ons dek die trollie. Ons is ook bereid willig om uitgeruil te word. Ons kan hulle (ander oue te huise help). Ons werk twee dae 7-7. Twee dae is ons af. Ons ken water pille die ou mense kry. Al word tien mense se pille gegee. Ons goeie kommunikasie met dokters en nurse.”*

[In 2002 I and a few of the girls attend a course on fractures offered by a lady from Cape Town. If we can have training on how to handle fractures, and be registered at the counsel.

Feed the old people. One needs to report to the supervisor if you see something strange. We have knowledge of all the work. We do most of the work feed the old people and report if we see something strange

We as caregivers do also night duty. Those who cannot use the toilet on their own we help them. We do the most of the work. We want recognition. We can also check haemoglobin. There are no bedsores in our unit.

We also want to learn this type of work. Old people know our voices. Steps need to be taken that we first must belong to an organization. The children of the elderly know our names. There are caregivers who work already 25 years.

We work with private doctors. We set the trolley. We are also willing to be exchanged to other old age homes to share our knowledge. We work seven to seven shifts. Two days we are off. We know what medications old people get even if we had ten (10) peoples medications. We have good communication with the doctors.

## Training needs

Training on fractures, and to be registered at a board. If we can have training to put in nasogastric tubes catheters. On some stage we have done dressings and pills.]

### **Participant No. 17**

*“20 years experience as assistant verpleegster. Werk nou een en n half jaar met die ou mense. Ek werk in blok 6. Ek het ‘n paar ou mense om te was en te versorg. As hulle siek is, moet ek hulle behandel vir verkoue, moet ek die medisyne gaan haal. As iemand siek is raadpleeg ons die dokter. Ek geniet die werk baie. As ek volgende jaar klaar maak met die opleiding wil ek weer hier kom werk. Net die tyd as jy werk is dit goed. As jy iets verkeerds doen moet jy uit...? Byvoorbeeld., het ek by Sunshine gewerk. Ek het n privaat werkie gedoen en die ou mense het my vergoed. Toe is dit ‘n disseplinêre hearing.*

*Ek wil graag hê die saal hulpe moet matriek doen. Dan moet hulle vir twee jaar leer vir enrollment. Jy kan nie , ‘n papier kry nie, die reel is so.*

*Ek werk baie goed met ou mense. Ek het hier aansoek gedoen hier nadat ek my ouma op gepas het. Ek is baie lief vir ou mense. Jy moet nie op hulle skree nie al is jy hoe haastig nie. Jy moet wag. We do most of the work.”*

[I work in block 6. I have a few old people to wash. If they are sick I treat them for cold. If someone is sick we consult the doctor. I enjoy the work. If I complete my studies I want to come back and work with the elderly. If I finish my training I want to work at the old age home again. The time you work is good. If you have done

something wrong than it is a disciplinary hearing.

### **Training needs**

I would like the caregivers to do their grade 12. Then they can be trained for two years for enrollment, you can't get papers without training. I work very well with old people. I apply here at the old age home after looking after my grand mother. I loved old people. You must not scream at them if you are in a hurry you had to wait. We do most of the work.”]

### **Participant No. 18**

Professional nurse 3 years experience

*“Meeste fasiliteite is nie hier nie. Doen net oppervlakige nursing. Deel medisyne uit volgens voorskrifte. Doen geen screening nie. Is nie soos ‘n hospital nie. Ek kan self ‘n maagspoeling doen. Limit activities. Ons werk saam met saal hulpe. “Dit is of ons met groot babas werk”. Hulle kan nie sê ek voel siek nie. Ons sien net die wange is rooi, en ons moet voel of hulle nat is. By voer moet jy kyk wie moet sagte kos kry veral as hulle van operasie af kom. Ou mense nodig baie aandag. ‘n Mens moet lankmoedig wees.*

*Die oom wat so kaal loop lei aan n neurogeen wat oor erflik is. Gesin is beperk tot een kind. Waarvoor ons nie opleiding het nie. Ons het nie die evaluering nie. Higiene is goed. Doeke, linne savers toiletpaper en extra klere is genoeg. Het winter sowel as some klere. “blanke mense” sommige goed word net met die matron bespreek. Ons het mooi uniforms. As ons kan workshop en seminars kry oor geriatric care. Ons het*

*nie opleiding. Ek het onlangs gehoor dat alzheimers nie in 'n lang gang moet wees nie maar in 'n kamer dan sal hulle meer georiënteerd wees.*

*Ons nodig etiket training. Gevare knip van naels, ringe. Mediese geregtelik val baie. Weet wanneer om meer vloeistowwe te gee en wat om te doen as urine sterk ruik. Werk span is daar goeie samewerking. Jy moet na almal se problem luister. Jou werk beïnvloed familie sake wat jy nie kan by woon nie. Daar is nie genoeg geld om meer personeel aan te stel nie.”*

[Most of the resources are not here; we do only superficial training, administer medicine according to prescription, and do screening. It not like a hospital, I can do a bowl washout, there are limited activities. We work with care givers and old people who are big babies, they cannot they are sick, you just notice that their cheeks are red and feel if they are wet. With feeding you need to check who need soft diet. Old need a lot of attention and you need to have patience. The man whom you see walking naked, suffer from neurogen which is an inherited disease. Where this disease is present in a family, such a family is only supposed to have one child. We don't have training for this disease.

Hygiene is good. We have kimbies, linen safers and toilet papers as well as extra clothes and it is enough for winter and summer. Some of the things were only discussed only with the matron. We have beautiful uniforms.

### **Problems**

Your work interfere with family matters that one cannot attend family gatherings or any functions; and there is not enough money to appoint more staff.

## **Training needs**

We need training in ethics, medical health risks and the care givers need when to give fluids and what to do when the urine smells strong.]

## **Participant No. 19**

Female 1 year experience – opgetree as a medic vir n sokkerspan

*“Ou mense is moeilik, `n mens moet baie geduld hê. Hulle is soos klein kinders en soms deurmekaar, baie aandag kry en keer ook. Soms het ons ou mense wat aan Alzheimer lei dan moet ons kyk waar hulle rondloop. Hier is nie so baie gevra nie. In die oggend bad, die beddens op maak en voer. Dit is all wat hulle doen. Hier is ek meer in die kombuis, kos gee, koffie gee. Ek moet weet watter mense moet sagte kos eet en nie sout eet nie.*

*Ek is nie bereid om in `n kombuis te werk nie. Persoonlik het ek `n dogter in graad 10. As sy klaar is, kan ek gaan. Die geld is nie genoeg vir twee mense se losies nie, kry N\$150.00, vir housing allowance. Behoort aan Blue Diamond mediese fonds en betaal N\$347.00.”*

[Old people are difficult you need patience. Old people are like small children and sometimes confused. They need a lot of attention. You need to watch them closely. There are old people suffering from Alzheimer and we had to take care where they are walking around.

The routine in the morning is as follows: They bath; we make up beds and feed those who can't eat themselves. Here I'm more in the kitchen to give food and coffee. I

need to know who must get salt free and soft diet.

I'm willing to work in the kitchen. I still had a daughter in grade ten to support. If she is finished then I can leave the work. The money is not enough for two peoples boarding. I got N\$150.00 for housing allowance. Belong to Blue Diamond Medical fund. I paid N\$ 370.00 per month.]

### **Participant No. 20**

Katutura Old Age Home – 21-5-2007, Maandag namiddag

Female 63 years- 19 years experience – Salary N\$1 200.00 sponsored by Mr. Karel Persendt. Training enrolled nurse during Old hospital.

*“Ek was nie in ‘n skool vir bejaarde sorg nie. Ek het ou mense by hul huise op gepas. Ek het toe vir Mev. Muballe ontmoet. Sy sê toe dat sy ‘n pos vir my het. Karel Persend, Florence Hiluti en Mev Muballe het my aangestel. Ek werk nog onder Karel. Hy het gesê dat hy my drie maande gee. Ek werk vrydae en vakansie dae en naweke half dae. Toe ek begin het was die mense sewentig (70). Hulle het so uit gesterf. Die kamers behoort aan die Munisipaliteit. Die bejaardes betaal N\$10.00. Die bejaardes kry oggend en middag ete. Hulle moet self sorg vir aand ete. Drie honderd en vyftig in hul sak. Ek is ‘n supervisor. Ek werk ook soos die werkers. Ek maak skoon, was hulle. As iemand siek is bel ek die ambulans en bly by die hospital tot persoon klaar is.*

*Ons plek word onderhou deur die sponserskerke winkels soos Shoprite vir ingelegde blikkies kos. As iemand vir ons groot geld will gee, roep ons vir Mev. Muballe in.*

*Kersfees tye is ons saam met die ou mense. Familie kom besoek nie. Kerke besoek ook. Matriek student kom kuier ook. Kry drie vier keer komberse per jaar. Kry gaar soppe van buite. Die Government sorg ook vir n koedoe. Karel bring vis, ambasideers soos Ghana, Nigeria kom besoek ons met groceries. Die advertiste hou diens en voorsien etes. Hou braai kersfees en Goeie Vrydag. My mense is rustig. Ons het nie n wag nie. Hek word gesluit.”*

### ***Staff***

*“We are four (4) vroue en een man, 3 bly in. As iemand siek is in die aand staan hulle op. Doen begrafnis hier, soek ouderling. United help met N\$2000.00. Die begrafnis ondernemer help. Die familie vat die liggaam huis toe, ons weier nie. My kolegas het elkeen sy eie baas. NG Kerk blankes sponsor een. Youth centre sponsor die ander een. Die hof stuur ook stout kinders hier na toe.”*

### ***Versorging***

*“Vyf mense wat ons moet was die ander was hulle self. Niemand word gewas nie. Niemand word gevoer nie. Almal eet self. Een bedlêend. Help haar met bed pan, maak dit leeg.*

*Social worker reël dat ou mense saam trek. Ons gaan met die wat loop. Hulle word afgelaai.*

*Kliniek besoek een keer per maand, nie gereeld nie ondersoek en gee pille. Hipertensie en hart neem ons hospital toe. Het nie pensioen. Vra krag by die Here. Groente en vrugte het die mense se liggaam nodig.”*

## ***Verbetering***

*“Terein verbeter, besig om ‘n muur te bou. Die mense steel ons se water. Security gevaar. Kantoor was ingebreek. Voorrade was gesteel. Mense is hardkoppig will nie oefening doen nie. Nodig equipment soos verbande, salf, ontsmetings middle soos dettol, savlon en stinksalf.*

[I did not attend training in elderly care. I first look after old people at their houses. I met with the supervisor of the old age home and she offered me a post. I now work under gentle men that sponsor my salary. He told me he will give me a prove period of three months. I work on Fridays and on holidays and week ends half day. The time I had started at the old age home the old people were seventy. Most of them had died.

The building belongs to the Municipality. The elderly only paid N\$10.00. The elderly get food in the morning as well as lunch. They had to cater for themselves for supper. The rest of the pension money which is N\$490.00 they put in their pocket.

I’m a supervisor but I work as the others. I clean them, wash the washing and if someone is sick I informed the ambulance and stay with the elderly until he is done.”

Our old age home is sponsored by shops for tins of food. If someone want to donate us a big amount of money. We call the management team. Christmas time we are with the old people. Family members do not visit. Churches visit the old people. Matric students come and visit us. In a year we receive three to four times blankets. The Government provides a Kudu and another man brings fish. Ambassador like Ghana and Nigeria bring groceries. Church organizations provide church service and food. There is a security at the gate.

## **Staff**

Consist of four (4) caregivers and one man. Three of them stay on the premises. If someone is sick at night they attend to them. If someone dies we look for a pastor or elder to bury the person. The funeral attendance helps us. If the family wanted the body we do not refuse.

My other collegus are sponsored by some other organizations for their salary. Children with minor offences are also sending here to do community service.

## **Caring**

There are only five (5) old people that we wash. The others washed themselves. There is one bedridden we help her with the bedpan to empty. The social worker arrange for social gatherings of old people. The clinic visits once a month and treat minor illnesses. Those suffering from high blood pressure and heart diseases we take them to hospital for their follow ups.

## **Improvement**

The environment needs to improve. People are busy building a wall. The people around the clinic stole the water of the old age home. Our security is in danger. Our office was broken in. The equipment was stolen. Old people need equipment like wound dressings, ointment lotions like dettol or savlon and wintergreen ointment.]

## **Participant No. 21**

Female 33 years – 9 years experience – Sponsored by Standard bank – N\$500.00

*“I volunteer for my people. Leave a big gap. Wait for any body to help. You need to respect “Old people they are like children”. Know that this one likes this. Some old people are happy some difficult it depend on what kind of temperament he/she has.*

*I learn a lot to care. I have no experience to look after my parent. Every day I learn more. One day they talk bad and they are angry. Next they are happy. I learn also different languages i.e. Damara, Ovambo, Xhosa. Difficult thing is when they are new you don't know how they will react. The problem is that the head of his house is not the government. You go to the stores you find problems. The government must help us with an ambulance.*

*Changes you want to see*

*Need training in cooking, exercise needle work? Gas must stay outside. Our office not occupied by someone. Need fax. Need training first aid, HIV/AIDS. Want to travel to other old age homes like Swakopmund. Need transport.*

*During night someone collapses suffer a lot.*

*Need security at the gatefold people go out? The public tell us come your old people are lying there and deliver the old person in a Shoprite trolley. Most of the time the elderly under the influence of alcohol are involved in accidents by walking over the street. Lot of people doesn't know that there is an old age home nearby. We need a board at the road that people don't know that there is an old age home nearby. We are only 5 workers. With they that are working in the yard is old and weak. People are busy building us a wall. We can work shifts as in the hospital but we are too few. Salary is low. I stay in Havana no taxi money to go home so I sleep at the Old Age*

*Home.*

*During the morning we give breakfast. Five o' clock put water to boil to make Kloof coffee. No bread no eggs eat once a day. Lunch, soup, porridge, rice, and meat or macaroni, Sundays chicken. Old people pay N\$20.00 to fill the gass. A sameritan bring soup every Tuesday. There are 25 people old people of which seven (7) is women and nineteen (19) is man. If someone collapses we know what to do. We give the whole statement to the police."*

## **Participant No. 22**

40 years since 1996 work with the elderly 11 years of experience. Under went an emergency training course at school.

*"Ou mense is moeilik en stressvolle mense veral as hulle nuut is dis moeilik om aan te pas. As ek hom moet was sê hy ek is te jonk om hom te was. Bedlêendes word elke dag gewas. Hulle is 'n bietjie cheeky as hulle gepay het dink jy wil hulle onderdruk. Hulle wil graag uit gaan. Ons sê nee. Dit is gedurende die tyd dat hulle gestamp word.*

*Nooit goeie kos nie of dit is te sout. Ons probeer ons bes om dit eetbaar te maak. Ons kry mediese help. Veral as dit winter is verkoue, hoesstroop en stinksalf moet altyd beskikbaar wees asook maag werk medisyne. Ou mense het baie liefde nodig. Sommiges het familie maar hulle kom kuier nie dan word die ou mense gefrusteerd. Ek sou graag n home health care uit my eie sak doen. Ek kan lyk versorging doen. Ek kan self n wond toe werk. Partykeer gee die ou mense vir ons om. Sy gee my die liefde deur te vryf, dan dink jy aan jou eie ouma wat jy nie meer het nie."*

[Old people are difficult and stressful when they are new it is difficult to adapt. If I had to wash the old people he say that I'm too young. Bedridden old people are washed every day. Old people are cheeky if they had received their pension money they thought you want to put pressure on them. They want to go out and this is the time that they are involved in in accidents. Food is not always good. Sometimes food is too salty. We try our best to make it more eatable. We received medical help. We received medical help. In winter cough mixture and wintergreen ointment and also diarrhea medicine. Old people need a lot of love.

Interviews at Old Age Home, Caregivers 11-7-2007, Wednesday, 14h00

### **Participant No. 23**

**Female 43 years start in 1992. 15 years of experience.**

*“My verantwoordelikheid is kos maak en skoonmaak. Ons is twee hier die een is op verlof. Die spyskaart is soos volg:*

*Oggend: Oats, maize, weetbix, brood eiers tee en koffie.*

*Middag: Mince, fish, Goulash, Chicken, Vleis, Rys, Macaroni, Bone papoen, Aartappels*

*Aand ete: Brood en sop soms vrugte, soms vetkoek*

*Altesaam twee en twintig bejaardes, elf vroue en elf mans, Aand ete bedien ons tussen vier en vyf uur. Ou mense kla dat hulle honger is omdat hulle so vroeg eet. Ek het gepraat met nuwe pastor wat oorneem, dat ou mense 'n bietjie later kan, eet*

*byvoorbeeld ses of sewe uur en tienuur 'n snack aan die diabete te gee.*

*Versorging van ou mense is dat hulle gebad moet word, naels gesny en voete en ore gekyk moet word. Onder klere en beddegoed moet gekyk wordof dit skoon is. Die versorging gaan nie so goed nie. Hulle sê dit is nie my afdeling nie. Hulle gee nie die ou mense oefeninge nie. Kry hulle swaar uit die kamers uit, om na eetsaal te kom. Daar is 'n dame wat na die ou mense kyk in die aand. 'n Mens kyk tog of die deure toe is, of die kussing reg lê, is die bejaarde toe.*

### **Opleiding:**

*Een suster het vir ons a Home Based kursus aangebied, hoe om bloeddruk te neem. Hoe om oefeninge te doen. Hoe om 'n pasient uit die bed te haal, en skoon linne oor te trek.*

*Net inspuiting het ons nie gekry nie. Ek het 'n mondelinge toets gedoen. Ons het sertifikate gekry.*

### **Support**

*Sekretaris het 'n skenking gekry van rame, matrasse, kussings. As ons termofles kan kry kan ek koffie of tee in plaas vir ou mense.*

*Nodig om 'n kursus te gee. Die dinge wat hulle moet doen en nie doen nie.*

*Moet die reels gesê word. In die kamers is daar werk dan sit hulle.*

*Meer aandag aan ou mense skenk.”*

[My experience is to make food and do cleaning. We are two here one is on leave.

The menu is as follows: Breakfast oats, maize, wheatbix, bread and eggs tea and coffee.

Lunch: Mince, fish, goulash, chicken, meat, rice, macaroni, bone pumpkin, potatoes

Supper: Bread and soup, sometimes fruit and fat cake.”

We have twenty two elderlies of which eleven is female and eleven is man. Supper we serve between four or five o'clock. The elderly usually complain that we eat too early. I have brought this concern to the new pastor attention who took over. To change the time to seven o'clock and ten o'clock a snack for the diabetic patients.

The caring of old people includes bathing cutting of nails feet care and the ears need to be check. Elderly peoples under clothes and bedding need to be checked. The caring is not so good. The other caregivers say that it is not my unit. They do not give exercises to the old people. It is difficult for the old people to go to the hall. There is one lady that looks after the old people at night, and she need to check if the doors are locked, is the pillow right and is the elderly covered.

### **Training**

One sister gave us a home based care training how to take a blood pressure; How to give exercise and how to take an elderly out of bed. I have done an oral examination and received a certificate. It is needed to give training. The things they need to do. They do not do. They need to be told the rules. In the rooms there are works than they sit. They need to pay more attention to the elderly.

## **Support**

The secretary received a donation of mattress and pillows. If we can have thermo flask I can give the elderly tea or coffee for the night.]

## **Participant No. 24**

Female 51 Years, Fifteen (15) years experience.Home based training

*“Die behandeling wat jy gee moet jy vir jou instel. Jy moet liefdevol wees. Die liefde oorwin alles. Jy kan nie net kom praat nie. “Ou mense is net soos kinders”. Jy moet mooi met die person praat. Vra of hy/sy belangstel om te was. As jy vra of ek vir u kan bad en sy sê nee dit is te koud, dan sê jy “O” ....! ons sal more bad. As jy soms weer nee gesê is dan moet jy maar wag. Jy sal sê borde mag nie na die kamers toe gedra word nie.*

*Borde sal afgedra word kamer toe en more kry jy dit daar. ‘n Mens moet lankmoedig wees. Een ouma baie moeilik, sy sê onssteel ons word beledig.*

*Dit hang af wie jy is, hoe het jy groot geword het. Jy moet gesalf wees. Dit moet ‘n roeping van die Here wees. As ek neerslagtig en hartseer voel, gaan ek oor in gebed. Soms sal dit gesê word die werk wat ons doen moet geestelik wees en ons moet oor die Bybel gesels, ons moet die ou mense na die Here draai. Geestelik voor te berei.*

*Ou mense moet skoon en gelukkig wees. Waar hulle woon moet dit netjies wees sodat jy trots kan wees.*

*Die medikasies gee ons vir hulle na oggend ete, en na middag en aand ete. Vir my is dit moeilik ek was nog hierdie tyd vloere 11h30 ure. Ek bestee min tyd aan ou mense.*

*Nursing student kom af en toe. Die kliniek besoek nou elke maand en vereis nou N\$4.00. Nood geval vat ons hospital toe. Daar is dae dat die ou mense uit gaan. Mense kom besoek ons altyd by die tehuis. Gebeds vroue gee vir hulle Bybel studie. Pastoor hou dienste op Maandae, Woensdae, en Vrydae. Dinsdae en Donderdae is oumense op hul eie. Ons besit nou 'n eie kombi vir gebruik. Bejaardes word soms uitgenooi na ander kerke byvoorbeeld Lutherse of Katolieke Kerk.*

### **Training needs:**

Training in bejaarde sorg

Wat die doel van n ouetehuis is.

Basiese opleiding oor netheid; skoonheid; mediese gedrags kode. Ons netheid moet uit staan.”

### **Support**

As die Government training aanbied om ons uit te nooi.

As ons tog 'n uniform kan kry. Ek dra n size 50 sodat ons eendragtig kan lyk. Ons netheid moet uit staan.”

[The caring you give you needs to prepare yourself. You must love them. Love overcomes everything. You cannot just speak. Old people are just like children. You had to speak politely with them and asked them if they are interested in bathing and

he/she said it is too cold then you answer ok we will bath tomorrow. If you asked again and they refuse you had to wait.

You will tell them not to put plates in the room but you will find the plates in rooms. One needs to have perseverance. There is one very difficult grandma she insults and accuses you of stealing her things. It depends on you who you are, how did you grow up. You need to be anointed to take care of old people it is a calling. When I feel depressed and heart broken I just pray. I will say the work we do is spiritual and we had to read the bible. We had to bring the old people nearer to the Lord.

Old people need to be clean and tidy and also their rooms. The medications are given after breakfast lunch and supper. This time 11h30, I am still busy with floors. I spent limited time on the elderly.

Nursing students visit now and then. The clinic visit once a month and ask NS 4.00. Emergency cases we refer to the hospital. There are days that the elderly goes out for social gatherings. People visit us. There is a women's group. There is a pastor that gives services three days in the week. We have a Kombi. Elderly are invited by the Lutheran and Catholic Church to visit.

### **Training needs:**

Training in elderly care .What is the meaning of an oldage home.

We need basic training on cleanliness and medical hazards.

### **Support:**

If the Government gives training they must invite us.

We want a uniform my size is no 50 so that we can look the same. Our cleanliness must stand out.”

### **Participant No. 25**

**Female 38 years, Two (2) Years experience, 6 weeks training at Juanita**

*“Ek moet die ou mense aanvaar met hulle swakhede dat hy nie verdwaal nie. Ek moet geduldig wees en lief wees vir ou mense. My gesig moet nie suur wees as ek met die ou mense werk nie. “Die ou mense lyk soos kinders want hulle vergeet as jy iets sê”. Die kamers moet skoon gemaak word sodat die kieme nie kan kom nie. Ek moet kyk dat die toilet skoon is sodat hulle nie infeksie kry nie. As die ou mense tee op die vloer mors moet ek skoon maak.”*

### **Training needs**

*“Ons nodigt ‘n computer kurses kry. Naaldwerk kursus Koskook kursus; Mediese versorging”*

*Siekte toestande soos bloeddruk, suiker, asma, rumatiek, vallende siekte, lae bloeddruk, hart siekte, siekte wat mense se kop laat ruk”.*

[I must accept the old people with their weaknesses that he does not get lost. I must be patient and loving with old people. My face must not be sour when I am busy with old people. Old people are like children and they forget when you say something. The rooms need to be cleaned the floors the toilets so that germs can be killed. If they

mess you had to clean.

### **Training**

We need a computer course; Needle work and cooking; and medical course. We also need a course in the following sickness high blood pressure arthritis, sugar disease, epileptic and heart disease.]

### **Participant No. 26**

49 jaar, geen opleiding, 5 jaar ervaring graad 6

*“Ou mense is lieflike mense. Ek het geen probleem met hulle nie. Ek werk saam met hulle. My werk is baie wonderlik ‘n mens moet geduld hê. Ek het by die Here gevra of ek met die ou mense kan werk. Ek het die antwoord gekry. Party is moeilik om hulle pille te drink. Party sê ons is gesond ons kan nie pille drink nie. Party wil nie was nie dan word hulle kwaad. Ons wil hulle nie forseer nie. As hulle sê nee, dan los ons. Party stry en hulle sê dat hulle goed is gesteel. Hulle kyk soms nie mooi in hulle kaste nie. Dis tog maar al.”*

### **Opleiding**

*“Hoe om pille te gee. Om bloeddruk te neem is moeilik.*

*Hoe om aanvalle te hanteer.*

*Homebased care opleiding gaan kry. Dit is my toekoms. Ek sal ou mense dien.”*

[Old people are really lovely. I don't have any problem with them. I work with them and my work is wonderful and you must have patience. I had asked the Lord to work

with old people and He gave it to me. I experienced that it is difficult for old people to drink their tablets. Some of them say that they are healthy; and some of them do not want to wash. In this case we do not force them. If they say no we leave them. Some of them argue and say we stole their things. They don't look nicely in their cupboards. This is all.....?

### **Training**

We need training on how to give medicines and how to take a blood pressure. How to manage fits. Home based care nursing. This is my future to serve old people.]