LEARNING NEEDS OF CAREGIVERS OF OLDER PERSONS IN RESIDENTIAL CARE FACILITIES: AN EXPLORATIVE CASE STUDY

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DECLARATION

I, Cecilia Marais declare that the dissertation that I herewith submit for the Master Degree (MNursing) at the University of the Free State, is my independent work, and that I have not previously submitted it for a qualification at another institution of higher education.

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CLARIFICATION AND OPERATIONALISING OF CONCEPTS

The concepts in the title are clarified and the application in this study is explained.

Caregiver

A caregiver is a person who helps another with basic caring tasks such as bathing, feeding, dressing and personal hygiene (Council, 2020; SIFAR, 2017; Vantage Mobility International, 2016; Watson, 2020). Growing old is inevitable and with ageing the older person becomes more dependant on others to provide in their daily needs (Garvelink *et al.,* 2017:32-33; Holthe & Wulff-Jacobsen, 2016:492). Caregivers in this study, are the individuals in residential care facilities who render basic care to older persons.

Learning Needs

A learning need refers to the knowledge that an individual requires to bridge the gap between that which they already know and what they require to know to perform certain tasks (Ashton & Oermann, 2014:288). Caregivers are key in rendering basic care to older persons in residential care facilities and need to acquire knowledge to fulfil their demanding role as primary care providers (Lichtenstein *et al*., 2015; Mapira *et al*., 2019:2; Robbins *et al.,* 2013:2; Williams, 2017:3). In this study, the learning needs of caregivers caring for older persons in residential care facilities were explored.

Older persons

The World Health Organisation (WHO) regards an individual aged 60 years or more to be an older person (Alderslade, 2020). The definition presented in the Older Persons Act 13 of 2006, however, applies in this study, namely: “a person who, in the case of a male, is 65 years of age or older and, in the case of a female, is 60 years of age or older’’.

Residential care facilities

Residential care facilities are long-term care settings that provide full-time help for older persons, including personal care and medical services (NIA, 2016). The residential care facilities included in this study are non-profit organisations that operate either under the auspices of the Afrikaanse Christelike Vrouevereninging (ACVV) or Caritas and are affiliated with the Department of Social Development (DoSD).

ACRONYMS

List the acronyms and their meanings in alphabetical order, e.g.:

ACVV	Afrikaanse Christelike Vrouevereniging
APA	American Psychiatric Association
DoSD	Department of Social Development
HSREC	Health Sciences Research Ethics Committee
NGT	Nominal Group Technique
NC DoH	Northern Cape Department
NIA	National Institute on Ageing
PPE	Personal Protective Equipment
RN	Registered Nurse
SANC	South African Nursing Council
SAQA	South African Qualification Authority
SARS-CoV2	Severe Acute Respiratory Syndrome Coronavirus 2
SGB	Standards Generating Body
SIFAR	Samson Institute for Ageing Research
Stats SA	Statistics South Africa
UFS	University of the Free State
UN	United Nation
WHO	World Health Organisation

ABSTRACT

Caregivers play a prominent role in rendering basic care to older persons in residential care facilities, whose needs are intricate and unpredictable. Yet, caregivers were found to be underprepared, especially in rural areas of the Northern Cape province in South Africa. Sub-standard education, training and the absence of formal in-service training programmes contribute to varied quality of care, as well as caregiver stress and burnout. Therefore the question arose: *What are the learning needs of caregivers of older persons in residential care facilities in two sub-districts of the Northern Cape province?*

Guided by constructivism, knowledge was socially constructed by incorporating the perspectives of various role players. In accordance with the research question and the need to obtain multiple perspectives within a particular geographical context, an explorative case study design was applied. Data were collected by means of four respective nominal groups with caregivers and family members of residents, as well as a small group interview with the registered nurses working at three facilities. During data analysis the different data sets were individually analysed and then consolidated. Eight main categories of learning needs were identified, namely: basic nursing skills, hygiene, Alzheimer's disease, medication, communication, rights and responsibilities, as well as staff monitoring and evaluation.

Many of the suggested learning needs were, however, beyond the expected tasks of caregivers set by the South African Qualifications Authority unit standard for the provision of care to a frail person. The ignorance of the caregivers with regard to essential aspects such as their rights and job description revealed unfair labour practices. Ethics of employment emerged from the findings as underlying theme with unrealistic work expectations and a power disadvantage as subthemes. A formal in-service training programme addressing the learning needs, appropriate for the caregivers' expected level of functioning could enrich the quality of their caring for older persons in the particular residential care facilities. Action should also be taken to address the emerging issues affecting both the caregivers and quality of care rendered to older persons in this setting. Further, larger scale research could cast light on the research issue in other contexts and ostensibly inform policy development in this regard.

Keywords: learning needs, caregivers, older persons, residential care facilities, Northern Cape province.

CHAPTER 1
Overview of the study

Ernie Brummer

CHAPTER 1
OVERVIEW OF THE STUDY

> “Old age may have its limitations and challenges, but in spite of them, our latter years can be some of the most rewarding and fulfilling of our lives.”
>
> [1]Billy Graham

1.1 Introduction and Background

Growing old is one of the certainties of life. Once one has reached that stage, there is nothing you can do but to accept your situation. Although inevitable, old age is not a disease but a reflection of the achievements as well as disappointments during the course of one’s life. As Billy Graham relates in the quotation, growing old can be very fulfilling. Although everyone is exposed to adversity at different times in their lives, older persons are more likely to experience vulnerability (Barbosa *et al.,* 2019:338; Sarvimäki & Stenbock-Hult, 2016:372-373). Therefore these persons deserve to be treated with kindness, respect and dignity in the autumn years of their lives (Clancy *et al*., 2020:2).

Vulnerability increases with age and challenges the ongoing meaning and quality of life. The older a person becomes, the less they are able to function independently and require additional support from others (Garvelink *et al.,* 2017:32-33; Holthe & Wulff-Jacobsen, 2016:492). Everyday tasks such as bathing, toileting and/or dressing become increasingly burdensome and related skills may be lost (Ansah *et al*., 2014:105-106; Strout *et al*., 2018:5). Many older persons inevitably reach a stage when they require care, whether it be at home or in a residential care facility (Breytspraak, 2016). There is a growing demand for residential care, greatly due to the fact that the population worldwide is ageing (De Jager *et al.,* 2015:189; Fernandes & Paùl, 2017:2-3; Gardiner *et al.*, 2020:749; UN, 2019). In the residential care facilities, it is caregivers who provide most of the basic care, which varies from making beds, helping the older persons with personal hygiene and providing assistance with

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[1] Brainy Quote. (n.d.). *Billy Graham quotes*. https://www.brainyquote.com/quotes/billy_graham_626307 Date of access: 16 Jan. 2020.

exercise, such as walking (Council, 2020; Molinari *et al*., 2017:3; SIFAR, 2017; Vantage Mobility International, 2016).

Assistance becomes necessary because ageing is characterised by the emergence of several health conditions that tend to occur later in life. These include, amongst other conditions, hearing loss, osteoarthritis and neurocognitive disorders (Prince *et al*., 2015:550-551; WHO, 2018). Breytspraak (2016) reports that approximately 14% of people over the age of 65 have two to three chronic conditions that erode their ability to live independently. Concurrently, the experience of ageing could create stress and anxiety within the older person, which, in turn, could affect their physiological, psychological and social functioning (Gardiner *et al*., 2020:749; Grønning *et al.*, 2018:2; Sadana *et al.,* 2016:180; Lim *et al.*, 2017:6). Increasing levels of physical dependence, cognitive impairment and the emergence of psycho-social issues therefore complicate caring (Burke & Orlowski, 2015; Gottesman & Stern, 2019; Sepe-Monti *et al.*, 2016:2). The complexity and diversity of older persons' needs emphasise the importance of quality care for them and their families provided by adequately prepared caregivers (Kar, 2015:1).

The quality of care has, however, often been found to be unsatisfactory. Overall, there is a lack of respect and person-centred focus, thus neglecting the dignity of residents (Gardiner *et al*., 2020:749; Smythe *et al*., 2017:2; North & Fiske, 2015:933). Inefficiency in meeting the complex and unpredictable health needs of residents is most often attributed to caregivers lacking the appropriate skills and training (Bosch, 2015:3; Mapira *et al*., 2019:2). Being underprepared not only affects those being cared for, because it gives rise to “fear, anxiety, stress and feelings of insufficiency and uncertainty specific to the caregiver role” (Williams, 2017:3). A combination of factors were found to leave caregivers underprepared and uncertain in dealing with the needs and behaviour of older persons (Martin *et al*., 2016:2; SAQA, 2017; Williams, 2017:3). Amongst these factors are their education level, stress and burnout.

Although caregivers play a crucial role in the quality of care, the required level of education for them is lower than that of other healthcare staff (Molinari *et al*., 2017:3-4; Porter *et al*., 2018:3). Caregivers require no more than basic education to be employed. Inadequate education is problematic, especially when considering that caring for older persons can be demanding. There is a mismatch between the actual training that the caregivers receive and the needs of older persons, thus reducing their competence in fulfilling their role as primary care providers (Lichtenstein,*et al*., 2015; Mapira *et al*., 2019:2; Robbins *et al.,* 2013:2; Williams, 2017:3). A lack of proper education and training subsequently negatively affects the quality of caregivers' work.

Another factor leading to inadequate quality of care is stress. Caregivers are often exposed to physical and mental stress in the course of their daily work (Musich *et al.,* 2017:1; Sepe-Monti *et a*l., 2016:2; Tang *et al.,* 2015:3; Williams, 2017:3). In addition to primary stressors, such as hardships and problems anchored directly in caring for older persons, caregivers could experience secondary stressors in their roles outside of the work situation (Mapira *et al.,* 2019:2; Smythe *et al.,* 2017:2). Feelings of inadequacy negatively affect their emotional status, which could reduce caregivers' decision-making ability and judgement (Lerner *et al.,* 2015:801; Williams, 2017:3).

When caregivers become increasingly negative, demotivated and burnt out, the quality of care could suffer and adverse incidents could occur (Mapira *et al.*, 2019:2; Sepe-Monti *et al.*, 2016:2; Tang *et al.,* 2015:3). Ineffective care could, in turn, lead to unnecessary distress, hospitalisation and costs for older persons and their families (Alzheimer's Disease International, 2016:58; Prince *et al.,* 2015:550-551; Robbins *et al.,* 2013:2). Moreover, caregiver stress and burnout result in a high staff turnover in residential care facilities (East, 2017). Staff replacement is a challenge because of the lack of experienced caregivers available (Martin & Ramos-Gorand, 2017). Residential care facilities consequently have to contend with staff shortages that impact on the quality of care and incur additional costs (Martin & Ramos-Gorand, 2017; Zúñiga *et al.,* 2015:3-4). In addition, the morale of the remaining caregivers and the older persons is affected by the loss of persons they have become accustomed to (Boerner *et al*., 2015:4-5).

Caring for the caregivers through support, education and communication consequently forms a vital part of the treatment strategy for older persons (Jack *et al*., 2019:3; WHO, 2017; Miranda *et al*., 2019:3399). For them to meet the expectations set before them, caregivers have to be adequately equipped, which could result in a more person-centred approach and better quality care (Mapira *et al.*, 2019:2; Smythe *et al.,* 2017:2; Williams, 2017:2). In addition, training could increase their self-confidence and willingness to change and improve the quality of care they render (Affifi, 2012; Timmons *et al*., 2019; Williams, 2017:3-4).

Educational interventions for caregivers are therefore essential in achieving sustainable improvement of quality care for older persons and reducing caregiver stress and burnout (Mapira *et al.*, 2019:2; Smythe *et al.,* 2017:2; Williams, 2017:2). Although training courses are available, they are not well regulated and vary in terms of duration and geriatric-care focus (American Geriatrics Society, 2016; Booker, 2015:3; Molinari *et al*., 2017:4; Porter *et al.,* 2018:3). More specifically, a study conducted by the Samson Institute for Ageing Research (SIFAR) on caregiver training in South Africa revealed inconsistencies in the duration and geriatric-care focus of caregiver training programmes. A knowledge gap was found to exist relating to specific caregiver skill requirements in the different care settings for older persons in the country (Booker, 2015:3; Mapira *et al*., 2019:2; SIFAR, 2017; Solanki *et al.,* 2019:178).

The quality of care in South African residential care facilities was found to be lacking, attributed to sub-standard education and training of caregivers (Maphumulo & Bhengu, 2019; SIFAR, 2017; Solanki *et al.,* 2019:178). Neither certification of training programmes nor skill requirements nor registration of caregivers with a governing body are required (Falk-Huzar, 2017:125; Nursing Act 33 of 2005; SIFAR, 2017). The level of education needed for employment as a caregiver is Grade 10, the senior phase of basic education (SAQA, 2020). It is therefore quite possible that caregivers are employed without having received any additional training.

Caregivers are vital in providing healthcare services in South African residential care facilities, particularly in poorly resourced rural settings (Mashau *et al*., 2016:1-2; Moshabela *et al*., 2015). Healthcare services, including geriatric healthcare, were found to be less efficient in the Northern Cape province than in more affluent provinces (Burger & Christian, 2018; Delobelle, 2013:161; Kelly *et al*., 2019:1-2; Northern Cape Department of Health [NC DoH], 2018; Stellenberg, 2015:10-11). Lack of resources due to poverty, unemployment and the migration of younger people to metropolitan areas leaves families without proper means to care for their older persons (Mashau *et al*., 2016:1-2; Moshabela *et al.*, 2015). This results in a higher demand for residential care and consequently for caregivers (Porter *et al*., 2018:3; Solanki *et al.,* 2019:178).

Formal in-service training and staff performance assessment are lacking in registered residential care facilities in the Northern Cape province (Department of Social Development [DoSD], 2010:50-51, 62). Within the two local municipalities, the Siyancuma and Thembelihle Municipalities, where this study was conducted, there is no formal training at the residential care facilities. Caregivers also do not necessarily have the financial means and/or support to travel hundreds of kilometres from their homes to receive training elsewhere (Delobelle, 2013:161; Mapira *et al*., 2019:2; Mashau *et al*., 2016:1; Nursing Act 33 of 2005; Stats SA, 2017b). Budgetary constraints are a major factor (further discussed in section 2.4.2). Taking all the mentioned factors into consideration, the disadvantages faced by caregivers living in the area could result in sub-standard care to older persons.

It is therefore clear that the need for a formal in-service training programme exists at the residential care facilities for older persons in the mentioned municipal sub-districts. In implementing this programme, the standard of care could be enhanced whilst the caregivers receive the necessary preparation, acknowledgement and support. To ensure that the training is relevant to the caregivers who are providing services within this specific context, it is important to know what their learning needs are. The inclusion of as many role players as possible in the research would be most informative and could also enhance the implementation of any actions indicated by the research.

1.2 Problem Statement

A lack of knowledge, prerequisite skills and training about caring for older persons, specifically in residential care facilities, presents challenges to caregivers. As the older person's needs are intricate and unpredictable and the complexity and diversity of those needs progress with time, caregivers are often unable to live up to the expectations of the older persons and their families (Martin *et al*., 2016:2; Robbins *et al.,* 2013:2; Smythe *et al*., 2017:2; Williams, 2017:2). The healthcare needs of older persons are intricate and unpredictable and caregivers often fail to meet these needs due to the absence of prerequisite skills and training (Mapira *et al*., 2019:2).

Research conducted by SIFAR (2017) on caregiver training found that the quality of care provided to older persons in South Africa was inconsistent. Sub-standard education and training of caregivers, as well as variations regarding their skill requirements, were found to be present in some residential care facilities as certification was not required (Maphumulo & Bhengu, 2019; SIFAR, 2017; Solanki *et al.,* 2019:178). Moreover, no benchmarks of the skills caregivers need to have in order to work with older persons are available, further contributing to caregiver ineffectiveness and the diverse quality of care provided (SIFAR, 2017).

Underpreparedness and negative work-related experiences of caregivers lead to a high staff turnover which, in turn, results in inadequate quality of care provided to the older persons (East, 2017; Mapira *et al.*, 2019:2; Martin & Ramos-Gorand, 2017; Smythe *et al.,* 2017:2). This situation could generate unnecessary physical, emotional and financial consequences for the older person and their families (Alzheimer's Disease International, 2016:58; Prince *et al.,* 2015:550-551; Robbins *et al.,* 2013:2).

Caregivers are increasingly acknowledged as a crucial part of healthcare, easing the burden on healthcare professionals, especially in resource-limited settings like the rural areas of South Africa (Mashau *et al*., 2016:1; Moshabela *et al.,* 2015). Difficulties such as high poverty rates and unemployment contribute to the disadvantages faced by caregivers living in these areas. There is no formal training programme or identified skill requirements for the caregivers working in the residential care facilities of the Northern Cape province. In addition, health services, including geriatric healthcare, are less efficient than in other provinces where economies of scale are more possible (Kelly *et al.,* 2019:1-2; NC DoH, 2018).

The challenge is that without proper training, which includes a clear geriatric-care focus, caregivers could compromise the health of older persons in their care (Mkhonto & Hanssen, 2018; SIFAR, 2017). A meaningful training programme focussing on the learning needs of the caregivers in these facilities could therefore enhance their role in rendering respectful care to older persons. To enhance deep learning, it is deemed crucial for the caregivers to voice their own learning needs, rather than imposing irrelevant knowledge upon them. Furthermore, incorporating the inputs from various role players could not only address specific concerns, but also enhance buy-in for any suggested actions stemming from the research. A tailor-made training programme could support the caregivers' health and wellness and reduce stress and burnout amongst them (Mapira *et al.*, 2019:2; Martin & Ramos-Gorand, 2017; Smythe *et al.,* 2017:2). Caregivers who are better equipped are likely to be more contented and take pride in their work.

1.3 Research Question

What are the learning needs of caregivers of older persons in residential care facilities in two sub-districts of the Northern Cape province?

1.4 Purpose

The purpose of this study was to explore and describe the learning needs of caregivers of older persons in residential care facilities in two sub-districts of the Northern Cape province.

1.5 Demarcation of the Research

The domain within which this explorative case study is situated is education with a focus on the learning needs of caregivers caring for older persons. More specifically, the research site included three residential care facilities in the Siyancuma and Thembelihle Local Municipal sub-districts within the Pixi ka Seme district of the Northern Cape province, South Africa (Stats SA, 2016).

Employment requirements at these facilities indicate that applicants should be in possession of an intermediate certificate, which is on Level 3 of the National Qualifications Framework (SAQA, 2019). There being no formal training or licencing requirements for caregivers, as indicated by SIFAR (2017), they are not regarded as nursing staff.

Caregivers provide basic care for older persons in the residential care facilities and work under supervision of registered or enrolled nurses. However, not all of the facilities have registered nurses (RNs) in their employ to offer the necessary guidance. Appropriately trained caregivers are therefore an essential requirement not only to ensure quality care of older persons but also to enhance a positive work experience for the caregivers. A tailor-made training programme compiled from the learning needs of caregivers within this context is an urgent need.

1.6 Research Paradigm

Constructivism, which is associated with qualitative research, was foundational to this study. The basic belief of constructivism is that individuals actively construct reality and knowledge from their personal experiences (Denzin & Lincoln, 2018:56; Mertens, 2015:16; Savin-Baden & Howell Major, 2013:23). A brief explanation of the ontology, epistemology, methodology and axiology of constructivism within the context of this study is set out in Table 1.1.

Table 1.1: Constructivism and this research

PHILOSOPHICAL ASSUMPTION	APPLICATION IN CONSTRUCTIVISM	APPLICATION IN THIS STUDY
Ontology The nature of reality	*Relative* Reality is an internal construction that is unique to every person based on their ideas and meaning-making.	Perceived truth about the learning needs of caregivers at specific residential care facilities for older persons resided within the perspectives of the participants.
Epistemology The nature of knowledge	*Transactional* Knowledge is actively created from the meaning individuals assign to their experiences.	Participants were actively involved in creating/constructing new meanings relating to the learning needs of the caregivers within this particular context.
Methodology The procedures to obtain the best evidence	*Hermeneutic, contextual and dialectic* Various interactive methods are employed to come to a deeper understanding of the participants' knowledge construction from their respective perspectives.	Through nominal groups and a small group interview, the researcher tried to come to a deeper understanding of the learning needs of the caregivers at the research sites.
Axiology The role of ethics and values	*Subjective* Researchers' values influence the research because of their active involvement and therefore they endeavour to establish respectful rapport with the participants.	The researcher was reflexive when making sense of the caregivers' learning needs and applied principle- and virtue-based approaches to address ethical considerations.

Compiled from Botma *et al.* (2010:39-41); Killam (2013:43-46); Mertens (2015:16-20); Polit and Beck (2017:10); Savin-Baden and Howell Major (2013:63); Scotland (2012:9)

The research was conducted in accordance with the ontology, epistemology and methodology associated with constructivism. The *relative ontology* of constructivism in this study related to the perceived truth about the learning needs of caregivers at residential care facilities within a specific context. This knowledge was actively created from the meaning that different participants assigned to their experiences of the research problem, thus adhering to the *transactional epistemology*. By exploring the research problem from the diverse perspectives (dialectic) of various persons holding an interest in the caregiving of older persons at specific residential care facilities (contextual) through different techniques to come to a deeper understanding (hermeneutic), *a hermeneutic, contextual and dialectic methodology* was applied. Nominal groups and a group interview were employed to elicit the views of the caregivers, family members of residents and RNs at the respective facilities. These actions enabled the researcher to engage with the participants and build rapport with them in an effort to develop a deeper understanding of the learning needs of caregivers at the research sites. In further support of the *subjective axiology*, the researcher applied virtue- and principle-based approaches to address the ethical issues (refer to sections 1.13 and 3.8).

1.7 Research Design and Method

Guided by constructivism, a qualitative research approach was taken and flowing from the research question, an explorative case study design was chosen. The exploration and description of the learning needs of caregivers of older persons in residential care facilities in two sub-districts of the Northern Cape province could not have been fully answered by means of closed questions. A qualitative approach enabled detailed descriptions of the learning needs of these caregivers and allowed the researcher to incorporate multiple perspectives in the exploration (refer to section 3.3.1).

Case study research was appropriate to engage in an in-depth exploration of the learning needs of caregivers in this particular geographical context (Yin, 2018:45-46). As the topic had not previously been investigated in depth, an explorative case study was indicated (Harrison *et al.,* 2017:6; Heale & Twycross, 2018; Yin, 2018:45-46). The flexibility of this design enabled a comprehensive, detailed inquiry of a unit of analysis as a bounded system within in a real-world setting (Creswell & Creswell, 2018:42; Harrison *et al.,* 2017:7; Heale & Twycross, 2018; Yin, 2018:45-47). Rich, descriptive data that provided more insight into the research phenomenon were obtained through the use of various data collection methods and multiple sources (Astalin, 2013:118; Cohen *et al*., 2018:387; Yin, 2018:153). Data collection were implemented by using the nominal group technique (NGT) and a small group interview (refer to sections 1.10 and section 3.5).

1.8 Population and Units of Analysis

In accordance with Majid (2018:3-4) and Sharma (2017:749), the entire group of information-rich data sources who shared similar characteristics of interest to the researcher were the caregivers and the RNs working at the mentioned residential care facilities, as well as family members of residents. At the time of the study, 36 caregivers and three RNs were collectively caring for a total of 92 older persons at the three facilities. It was, however, a challenge to approximate the number of family members due to the variation in number per older person, as well as their location.

By including all the residential care facilities in the Siyancuma and Thembelihle Local Municipalities of the Northern Cape province as well as all the RNs in their employ, complete collection sampling was applied (Cohen *et al*., 2018:220). The caregivers and family members were selected through purposive sampling (Botma *et al.* 2010:201; Palinkas *et al*., 2015:5-6; Sharma, 2017:751). The eligibility criteria set for the caregivers were that they had to have:

- at least 12 month’s experience in caring for older persons; and
- been employed at one of the residential care facilities for at least 12 months.

Due to the wide geographical distribution of family members, it was not possible to facilitate a nominal group with them at each setting. The most accessible group was therefore purposively selected. Family members who visited their relatives at least once a month were invited to participate. The total number of participants was 39 and the units of analysis consisted of 25 caregivers, three RNs and 11 family members of residents. (Refer to Table 3.3 and section 3.4 for more information on the population and sampling in this study.)

1.9 Explorative Interview

In an effort to improve upon the data collection process, an explorative interview is usually conducted prior to performance of a full-scale research project. Explorative interviews are often conducted to test the research question and to have a practice run of the data collection technique (Botma *et al.,* 2010:291). Participants who meet the inclusion criteria could be included, in which case the data could be incorporated if no changes were made.

The intention was to conduct an explorative interview to test the research questions to be posed to the respective groups of participants. Two or more caregivers, family members and RNs from an adjacent municipal sub-district were to be asked to read the question and provide feedback on clarity. Having been assessed on her nominal group facilitation skills as part of a nursing education module, the researcher was already proficient in conducting nominal groups.

The explorative interview was unintentionally omitted. This omission is noted as a limitation of the study, which is further explained in sections 1.15 and 5.7. Although the explorative interview was not conducted, the questions posed during the four nominal groups and small group interview were clearly understood. This is evidenced by the fact that no clarifying questions were asked and relevant answers were provided. (Refer to Chapter 4 for a discussion of the findings as well as Addenda D and F where the raw data are summarised).

1.10 Data Collection

Rich data were tilled from multiple sources at residential care facilities in different towns in the mentioned municipal districts. An effort was made to include different voices to elicit the data (Hammarberg *et al.,* 2016:499; Mertens, 2015:19-20; Polit & Beck, 2017:10). The researcher implemented the NGT with the caregivers and family members of the residents and held a small group interview with the RNs. Field notes were made after each data collection session to capture the researcher's observations and reflections.

Prior to data collection and after gaining the necessary approval and permission, the researcher visited each of the mentioned residential care facilities by appointment to discuss the proposed research with the caregivers and to extend an invitation. During these visits, the researcher also met with the RNs to invite them to participate. The administration departments of the mentioned residential care facilities contacted the family members of the residents electronically to inform them of the study and invite them to contact the researcher if they wanted to participate. Voluntary participation was emphasised throughout the recruitment process. Appointments were made for the various data collection sessions according to the schedules of those who indicated that they would participate. An information leaflet combined with the consent form (Addendum C) was handed to each participant before onset of data collection (3.8.4).

1.10.1 Nominal group technique

The NGT as a structured consensus method facilitating brainstorming that allows every participant to have an equal voice (McMillan *et al.,* 2016:655; Thier & Mason, 2018:428-431). The technique is called *nominal* because it is group in name only. In this technique each participant has a turn to give his or her answer in response to the question posed by the facilitator (Dening *et al.,* 2012:2; Harvey & Holmes, 2012:188; McMillan *et al.,* 2016:656). The NGT process involves four steps, namely silent generation, a round-robin sharing of ideas, open discussion and anonymous voting on priorities (Olsen, 2019:5; Van Jaarsveldt & Ndeya-Ndereya 2013:4). (Refer to Table 3.4 in section 3.5.1.1 for an elaboration on these steps.)

This participatory technique is a versatile method through which information can be collected from groups of people in various contexts and for different purposes (Foth *et al.,* 2016:6). Additional benefits of the technique are that the structured four-step process saves time, makes provision for validation of data by the participants and improves the consistency of data collection amongst different groups (Boddy, 2012:10; Harvey & Holmes, 2012:188; McMillan *et al.,* 2016:657; Van Jaarsveldt & Ndeya-Ndereya, 2013:3-4). The structured nature of the NGT process makes it straightforward to execute. It is effective in obtaining maximum information in a limited time frame because data reduction forms part of the process (Olsen, 2019:2; Roets & Lubbe, 2015:15; Spassiani *et al.,* 2016:4).

The researcher gathered four sets of data through the NGT to explore the learning needs of the caregivers. Data were collected from the viewpoints of the caregivers and the family members of the residents. Three groups of caregivers from the respective residential care facilities and one group of family members participated.

Each nominal group session started with the posing of a predetermined open-ended question. The respective questions asked to the caregivers and family members were:

> What do you need to learn about caring for an older person? (caregivers)
>
> What should caregivers learn about caring for your loved one? (family members)

A time of silence followed during which the participants could jot down their answers to the question. The responses were recorded on a flipchart during the round-robin, after which the participants engaged in a discussion before voting on priorities. (A discussion of the NGT is offered in sections 3.5.1.1 and 3.5.2.3.)

1.10.2 Small group interview

A group interview is a data collection technique in which the researcher collects data from a gathering of persons by asking a predetermined, open-ended question. A focus group could not be conducted with the RNs, because literature indicates a minimum of six participants for focus groups (Brink *et al*., 2018:144; McMillan *et al.*, 2016:656; Olsen, 2019:3; Polit & Beck, 2017:511). As only three RNs were employed at the residential care facilities in the chosen municipal sub-districts, a small group interview was held. A question similar in content to those used during the nominal groups, but relating more specifically to the RNs, was posed, as follows:

> What should caregivers learn about caring for older persons, including those with neurocognitive disorders, in a residential care facility?

A phrase relating to neurocognitive disorders was added because the RNs would be able to provide this specific information. The high prevalence of neurocognitive disorders amongst residents at the time of data collection made adding this phrase relevant.

The session was audio recorded in order to enable the researcher to focus on the discussion content and the verbal prompts (Grove & Gray, 2019:116; Greene, 2014:3; Jamshed, 2014:87; Merriam & Tisdell, 2015:149). After the session, the audio recording was transcribed in preparation for data analysis (Refer to section 3.5 for an elaborate discussion of the data collection process).

1.11 Data Analysis

Data collected from the various sources were organised to provide structure and meaning. As is often the case in qualitative studies, data collection and analysis occurred simultaneously (Astalin, 2013:122; Barrett & Twycross, 2018:63; Polit & Beck, 2017:530; Rice *et al.,* 2018).

During the *nominal groups,* the participants were involved in reducing, validating and prioritising data, thus partaking in data analysis (Harvey & Holmes, 2012:188; McMillan *et al.,* 2016:656-657; Rice, *et al.,* 2018:2; Thier & Mason, 2018:1; Van Jaarsveldt & Ndeya-Ndereya, 2013:3-4). The four data sets from the nominal groups were combined by following the guidelines provided by Van Breda (2005:7-12). Concurrently, the transcript of the *small group interview* was analysed by means of a content analysis (Astalin, 2013:118; Bengtsson, 2016:11; Polit & Beck, 2017:537-538; Vaismoradi *et al.,* 2016:100-101). (A thorough description of the data analysis follows in section 3.6.)

The categories identified from the small group data were incorporated with those from the combined list of the four nominal groups, resulting in one integrated list. Data analysis was therefore "based on a dynamic, intuitive and creative process of inductive reasoning, thinking and theorising of the unstructured text-based, narrative data" from the nominal groups and small group interview (Armat *et al.,* 2018:219-220; Sutton & Austin, 2015:8-9; Polit & Beck, 2017:530-531). (The findings are presented in Chapter 4.)

1.12 Role of the Researcher

At the onset of the study, the researcher was employed by one of the residential care facilities and this involvement provided the impetus for the study. She was therefore known to one of the groups of caregivers, as their supervisor, as well as to family members of the residents at the facility. The positionality of the researcher implied insider-research and as a member of a segment of the social group under study, she was a partial insider (Berger, 2015:222; Greene, 2014:2; Heslop *et al.,* 2018:2; Ross, 2017:326).

Although the advantages and disadvantages of insider-research are argued in section 3.7, cognisance should be taken of the fact that subjectivity introduces complexity. The researcher therefore implemented various measures to address methodological issues, as identified by Greene (2014:5-7), such as threat to objectivity and trustworthiness, as well as power imbalance and shifting of social identity. (The measures taken to address these emerging issues are discussed in sections 1.13, 1.14, 3.8 and 3.9.)

1.13 Ethical Considerations

The research proposal was submitted for ethical clearance to the Health Science Research Ethics Committee (HSREC) of the University of the Free State (Addendum A). Department of Social Development (DoSD), the Afrikaanse Christelike Vrouevereniging (ACVV) and Caritas granted permission to do this study at the research sites (Addendum B). The ACVV and Caritas, respectively, are the regulatory bodies of the residential care facilities. In addition, the administration boards of each of the residential care facilities granted permission for conducting the study (Addendum B).

An augmentation view to ethics was taken by following both principle- and virtue-based approaches (Resnik, 2012:5). The three fundamental ethical principles, as set out in the *Belmont Report* – beneficence, respect for human dignity, and social justice – were pursued to ensure the integrity of the study (Botma *et al.*, 2010:3; Polit & Beck, 2017:139-142). In response to a risk/benefit assessment, various actions were taken to respect and protect the human rights of the participants (Bernabe *et al.*, 2012:4). The following rights were taken into consideration: freedom from harm and discomfort; protection from exploitation; self-determination; full disclosure; fair treatment; and privacy (Polit & Beck, 2017:139-142). Informed consent, voluntary participation and confidentiality were amongst the implemented measures (Brink *et al.*, 2018:32).

Acknowledging that it is often difficult to foresee potential threats in qualitative research, a virtue-based approach was added (Polit & Beck, 2017:142). Here, the focus is on *being* rather than *doing* because character development of the person who must confront the emergent issues is encouraged (Morris & Morris, 2016:202-204). More specifically, the complexities of insider-research were addressed through the virtues of courage, sincerity and humility (Macfarlane 2010:8-9). *Courage* urges a researcher to challenge their personal presuppositions and to freely disclose any problems that occurred. *Sincerity* relates to providing a true reflection of the data and findings without yielding to the temptation of concealing information that could harm the reputation of the researcher or the facilities involved. *Humility* encourages reflexivity and welcomes critique from others to ensure integrity of the research. (An elaborate discussion of the ethical considerations pertaining to this study follows in section 3.8.)

1.14 Rigour of the Research

The researcher endeavoured to achieve high-quality research by implementing five criteria of trustworthiness, namely credibility, dependability, confirmability, transferability and authenticity (McInnes *et al.,* 2017:9-15; Polit & Beck, 2017:559-560). The criteria for trustworthiness are presented in Table 1.2.

Table 1.2: Criteria for trustworthiness

CRITERION	APPLICATION OF CRITERION IN THIS STUDY
Credibility	Confidence in the truth and interpretations of the data.
Dependability	Stability of data over time and conditions.
Confirmability	Objectivity or neutrality of the data.
Transferability	Ability to apply the findings in different contexts.
Authenticity	Extent of fair and faithful portrayal of a range of realities throughout the research process.

Compiled from McInnes *et al.* (2017:7-13); Polit and Beck (2017:559-560)

Trustworthiness comprises of the five criteria set out in Table 1.2 and relates to the strategies qualitative researchers implement to ensure the quality of a study (Polit & Beck, 2017:559-560). Lincoln and Guba (1985) initially developed four criteria for the enhancement of trustworthiness in qualitative research, namely credibility, dependability, confirmability and transferability. They later added a fifth criterion, authenticity, which related more specifically to constructivism (Denzin & Lincoln, 2018:219; Polit & Beck, 2017:559). (The criteria of trustworthiness are further discussed in section 3.9.)

Various measures were taken to ensure the truth and interpretations of the data, stability of data over time and conditions, objectivity, applicability of the research to other contexts, and the fair and faithful portrayal of a range of realities throughout the research process. The structured nature of the NGT and involvement of the participants during the nominal groups were of great benefit because it addressed credibility, dependability, confirmability and authenticity of the data. This confidence in the truth, stability and objectivity of the data enables replication in other settings, which is further enhanced by thick descriptions of the research process, consequently addressing transferability. (Refer to section 3.9 for a more complete discussion of the rigour applied in this study.)

1.15 Limitations of the Research

In qualitative research, the subjectivity and biases of the researcher could influence the findings of a study. As a partial insider-researcher, the researcher of this study's previous experience could have prevented her from fully understanding the different perspectives offered during data collection, as well as the interpretations made during data analysis. Rigour could have been enhanced through the involvement of a moderator during data collection. The exclusion of older persons in this particular study is a limitation because the voices of those receiving care are not heard. At the time of the study, however, there was a high prevalence of neurocognitive disorders amongst the residents at the research sites, which could influence the accuracy of such data collected. In addition, the omission of the explorative interview prevented the researcher from being certain that the research questions and respective group interview processes did not need improvement or further refinement.

Although data collection and analysis were completed well in advance of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) pandemic and this could not be seen as a limitation, the repercussions of this pandemic are immense. Subsequently, a whole new dimension regarding the protection of the caregivers, the older persons and the families of the caregivers emerged. The availability and correct use of personal protective equipment (PPE) have led to concerns for the safety, health and wellbeing of the caregivers as well as the older persons. (Refer to section 5.5.4 for an elaboration.)

1.16 Summary

A synopsis of the study was provided in this chapter in which the researcher attempted to provide answers to the questions: “What is this research about?” and “Why should I care?” The problematic situation was introduced and the necessity of the research was argued, after which the research question and purpose were stated. Having delineated the boundaries of the study, constructivism, as the guiding paradigmatic perspective, was briefly described. The ensuing research methodology – including the research design and method; population and sampling; data collection and subsequent analysis – was summarised. In pursuit of research integrity, the researcher reflected on her role in the investigation and gave consideration to ethical issues and measures to ensure trustworthiness.

1.17 Layout of the Study

The dissertation is presented in five chapters, as follows:

CHAPTER 1	Overview of the study
CHAPTER 2	Perspectives from literature
CHAPTER 3	Research methodology
CHAPTER 4	Data analysis and findings
CHAPTER 5	Conclusions

An overview of the study was presented in the first chapter. The second chapter provides perspectives from literature pertaining to the research. In Chapter 3 a description of the research methodology as well as ethical considerations and measures taken to ensure trustworthiness are elaborated on. Furthermore, the researcher critically discussed the research findings in Chapter 4. Lastly in Chapter 5, conclusions are drawn, propositions are forwarded for consideration, limitations were highlighted and future research possibilities are explored.

CHAPTER 2

Perspectives from literature

Ernie Brummer

CHAPTER 2
PERSPECTIVES FROM LITERATURE

> "To care for those who once cared for us is one of the highest honors."
>
> Tia Walker

2.1 Introduction

Caring for older persons is challenging when considering the complexity and diversity of their needs. Her inspiration to provide quality care for older persons amidst these challenges, Tia Walker, a caregiver, says is drawn from the view that it is an honour to return the care once received by the older generation (Speers & Walker, 2013). Intrinsic motivation should, however, be supported by proper training. In the previous chapter, the predicament of caregivers in residential care facilities being underprepared in meeting the needs of older persons was stated. Subsequently, the employment of a case study to explore the learning needs of caregivers in a specific context was justified. An elaboration on concepts deemed foundational to this study – older persons, residential care facilities and caregivers – follows in this chapter (Figure 2.1).

Figure 2.1: Concepts foundational to the study

Perspectives from literature, including previous research and legislation, are discussed. Various databases were employed. Academic sources were selected according to the topic of the study, time frame and context. (Refer to Table 2.1 for a presentation of the databases and keywords used in the search.) Publications from 2010 up to and including 2020 were chosen in an attempt to present recent scholarly work. Although international publications were included, the focus was on South African literature.

Table 2.1: Databases and keywords used in the search for literature

DATABASES	
• Academic Search Ultimate • Africa-Wide Information • Business Source Ultimate • CAB Abstracts • CINAHL with Full Text • Communication & Mass Media Complete • ERIC • GreenFILE • Health Source – Consumer Edition	• Health Source: Nursing/Academic Edition • Humanities Source Ultimate • Open Dissertations • APA PsycArticles • APA PsycInfo • Sociology Source Ultimate • MEDLINE • MasterFILE Premier 2000 -
KEYWORDS	
Caregiver	caregiver* or "care giver*" or carer* or "care worker*" or "healthcare provider*" or staff* or personnel*
Older person	"older person*" or "older people" or elderly or "old age*" or "aged care" or "older adult*"
Residential care facilities	residential or “nursing home*” or “care facility*” or “Housing for the Elderly”
Learning needs	Education* or Learning or training or development* or Skill* n2 need*

In this qualitative study, it was important, as indicated by Polit and Beck (2017:59, 87-88), to present foundational information from literature to provide context for the research. Data analysis included a further exploration of literature to conceptualise findings and make interpretations. (Refer to Chapter 4 where research findings are triangulated with literature.) On recommendation of various research experts, an effort was made to illustrate where this study fits into the existing body of knowledge and to strengthen the justification for the research (Botma *et al.*, 2010:64, 310; Brink *et al.*, 2018:58-59; Polit & Beck, 2017:87-88; Trafford & Leshem, 2008:67). It is believed that these perspectives from literature will increase insight by providing a reasonable reflection on what is known about aspects directly relating to the study and, more specifically, the learning needs of caregivers working in residential care facilities for older persons. The knowledge gaps in literature are also identified.

2.2 Older Persons

Older persons are regarded as a vulnerable population for whom a variety of challenges progressively accumulate and complicate the meaning and quality of life. Their independence is ultimately compromised, causing them to need assistance in tasks of everyday living.

2.2.1 Vulnerability

Whilst people of all ages are equally affected by exogenous events such as droughts and floods, older people are more susceptible to health problems and other endogenous vulnerabilities (Golaz & Rutaremwa, 2011:606-607). A decline in the physical, psychological and social aspects of functioning in an older person’s life contributes to them becoming progressively vulnerable (Agu, 2013:2; Barbosa *et al.,* 2019:338; Sarvimäki & Stenbock-Hult, 2016:372-373).

About 14% of all people 65 years and older have two to three chronic health conditions that cause a decline in the previously attained level of functioning and erode their ability to live independently (Breytspraak, 2016; Garvelink *et al.,* 2017:32-33; Holthe & Wulff-Jacobsen, 2016:492). Arthritis, diabetes, hypertension and heart disease, as well as cognitive disorders and disability after cerebro-vascular incidents, have been confirmed to be the main causes of disability and dependence amongst older persons (Prince *et al*., 2015:550-551; WHO, 2018; Hou *et al.,* 2018:1; Maresova *et al.*, 2019:10; Shrivastava *et al.,* 2013:2). The deterioration that occurs negatively impacts on their quality of life and could lead to psychosocial issues, such as depression, low self-esteem, communication problems and isolation (Gardiner *et al*., 2020:749; Maresova *et al*., 2019:12). It is inevitable that the culmination of emergent adverse issues could lead to functional impairment and undermine quality of life, including the opportunity to live independently (Agu, 2013:2; Breytspraak, 2016; He & Chou, 2017:4-5; Maresova, 2019:4).

2.2.2 Care needs

The loss of independence increases the probability of older persons needing full-time care or admission to a residential care facility. Physical and neurocognitive impairment may lead to loss of ability to perform everyday tasks. Execution of basic activities of daily living, which are essential for the maintenance of life, becomes increasingly problematic, resulting in a need for personal care from others. These activities typically include bathing, dressing, eating, toileting and being mobile (Ansah *et al*., 2014:105-106; Strout *et al*., 2018:5). Although it is important to meet the physical needs of the older person, psychosocial support also plays a vital role in their health and wellbeing. Depression, anxiety, fear, loneliness and lack of social networks could influence the health and wellbeing of the older person and could lead to behavioural issues (Gardiner *et al*., 2020:749; Maresova *et al*., 2019:12; Ross *et al.,* 2017:1; Shrivastava *et al.,* 2013:2-3).

The complexity and diversity of their caring needs are likely to present more challenges as their condition progresses (Burke & Orlowski, 2015; Gottesman & Stern, 2019; Manne-Goehler *et al*., 2019; Sepe-Monti *et al*., 2016:2). Consequently, the primary caregivers are consistently obligated to navigate these challenges. It is understandable that there would be times when these caregivers would fail to meet the complex and unpredictable health needs of the older persons in their care. Yet, inappropriate caregiver behaviour could have detrimental effects.

Older persons may suffer a loss of self-esteem from being patronised, excluded from decision making and treated as an *object* (North & Fiske, 2015:933; Smythe *et al.,* 2017:2). Furthermore, discrimination, social exclusion, economic marginalisation, neglect and different forms of abuse pose actual threats (Horning *et al.,* 2013:1). Although the various forms of abuse, accidental or intentional, may not be as violent as direct physical abuse, it is just as harmful and dangerous (Pillemer *et al.,* 2016:8-9; WHO, 2020; Yon *et al.,* 2019:58-59). Elderly abuse is associated with psychosocial distress, morbidity and sometimes even mortality. Studies have shown the association between elderly abuse and the negative impact it has on emotional and physical health, as well as premature mortality (Evandrou *et al.,* 2017:1-2; Schofield *et al.,* 2013:697).

These threats emphasise the need to respect older persons' vulnerabilities and to treat them as beings of worth to preserve their dignity (Gardiner *et al.*, 2020:749; North & Fiske, 2015:933; Wyman *et al.,* 2018:194). Respect, privacy and autonomy are therefore important attributes in their care (Cairns *et al.*, 2013:1-2; Matiti, 2015:108-109). In this regard, the Older Persons Act 13 of 2006 provides a specific framework for older persons' empowerment and protection. This act aims to promote and maintain their status, rights, security, safety and wellbeing and to regulate services and residential facilities caring for them.

2.3 Residential Care Facilities

There is an increased demand for residential care worldwide. Residential care, however, holds implications for the older person, family members and caregivers.

2.3.1 Increased demand for residential care

The need for residential care facilities for older persons is growing as the world's population continues to age (Blachnio & Bulinski, 2013:675; De Jager *et al.,* 2015:189; Fernandes & Paùl, 2017:2-3; Rezgale-Straidoma & Rasnaça, 2016:203). When older persons reach a stage when they require additional care, families need to consider alternative long-term care options (Vahid *et al.*, 2016:346-347). Older persons from resource-limited settings may have to relocate for reasons of access to healthcare services (Kar, 2015:1; Solanki *et al.,* 2019:178; Stellenberg, 2015:10). As these are some of the main reasons for older persons to be admitted to the residential care facilities where this research was conducted, these aspects will receive attention in this sub-section.

2.3.1.1 Ageing population

The mean age of citizens in countries across the world is rising rapidly. Advances in medical technology and improved healthcare have contributed to an increase in life expectancy, yet there are varying rates in different countries (UN, 2019; UN, 2020:5-6). Projections indicate that by 2050, nearly a third of the world's population will be aged 60 years and older, with an estimated number of 2.1 billion older persons (UN, 2020:5). Currently, in developed countries, over a fifth or 21% of the population is aged 60 years and older. In the 31 low-income and less developed countries, which are mostly located in sub-Saharan Africa, older persons aged 60 years and older account for 8% of the population (Murphy, 2018; UN, 2019; UN, 2020:5-6). By 2050, this number will increase to 20%, implying that the developing countries will reach the same stage in the process of population ageing as the developed countries (Shetty, 2012; UN, 2017:9-16). The United Nations' publication *World Population Prospects: The 2017 Revision* illustrates the astronomical increase in the global population according to age. Figure 2.1 presents this visually.

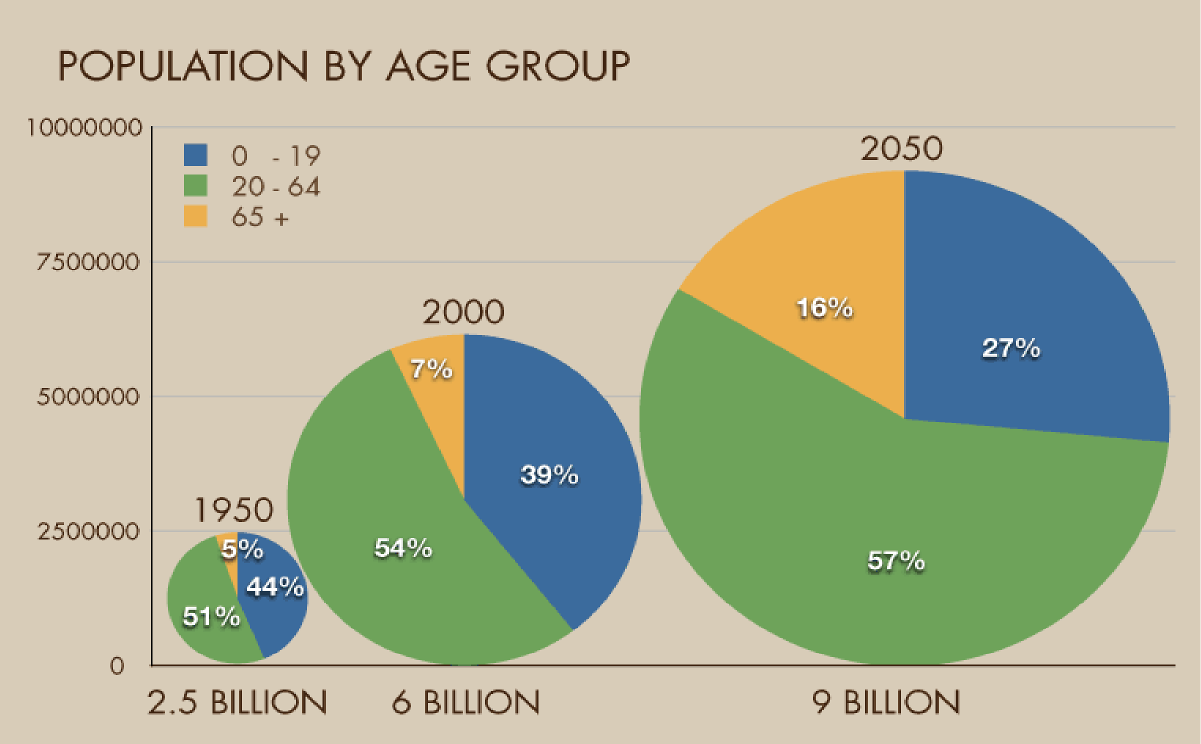


Figure 2.2: Global ageing population

Taken from UN (2017:3)

Although older persons are indicated as those who are above the age of 65, which causes the statistics to differ from those mentioned previously, the figure clearly depicts the ageing population in the century 1950 to 2050. Fundamentally, every country in the world will be experiencing considerable increases in the proportions of the population aged 60 years and older between 2017 and 2050. Projections indicate that the number of older persons may exceed the number of children for the first time in 2045 (UN, 2017:2, 14).

The South African population's age structure has begun to experience significant increases in older persons as well due to the combination of fertility and mortality declines (Stats SA, 2019). This demographic trend represents South Africa as one of the most rapidly ageing countries in Africa. A recent increase in the youth population, which will eventually transition to an older population, predicts a greater number of older persons in coming generations (UN, 2017:3-7). According to Statistics South Africa in 2017, the countries population was estimated to be 56.5 million people (Stats SA, 2017a). In the same year, the proportion of persons aged 60 years and older in the country reached 8.1%, resulting in an estimate of 4.6 million people (Stats SA, 2017a). Regional variations of ageing exist in South Africa, with an uneven distribution over the country's nine provinces (Perey, 2016:2-3; Stats SA, 2020a). The distribution of older persons in South Africa (2020) is presented in Table 2.2.

Table 2.2: Distribution of older persons in South Africa (2020)

Province	Percentage of older persons
Eastern Cape	11.45%
Western Cape	10.31%
Northern Cape	10.21%
Free State	9.95%
North West	8.98%
Limpopo	8.95%
Gauteng	8.46%
KwaZulu Natal	8.13%
Mpumalanga	7.90%

Compiled from Stats SA (2020a)

The highest proportion of older persons reside in the Eastern Cape, Western Cape and Northern Cape provinces (Stats SA, 2020a). Although the Northern Cape is the province in South Africa with the least dense population spread over the widest surface area, it has the third highest percentage of older persons (10.21%) in the country (Stats SA, 2017b; Stats SA, 2020a). A large proportion of this province's population reside in urban-rural areas which comprises of small towns and secondary cities, influencing the accessibility to healthcare (Delobelle, 2013:161; Solanki *et al.,* 2019:178; Stellenberg, 2015:10). The prevalence of high poverty, unemployment and less education or no schooling is leaving families without resources and support to care for their older persons (Burger & Christian, 2018).

The growing proportion of older people is indicative not only of a demographic and health transition, but also alerts us to the new social, health and financial demands South Africa is bound to face (Stats SA, 2017a). An ageing population may result in challenges such as payment of pensions for longer periods of time as well as a greater need for healthcare and old-age support (Madhavan *et al.,* 2017:10-11; Midtsundstad, 2019:13-14; WHO, 2018). Residential care forms part of the support offered to older persons in this regard.

2.3.1.2 Inability of families to take care of the person

Although in Africa it is mainly families who take care of older persons. Due to the economic, mental and physical strain of caregiving there is a growing need for care service (Hoffman & Pype, 2016:1-2). Furthermore, there is a tendency for family members to migrate to industrialised and urbanised societies in search of better opportunities of employment and access to perceived higher quality education. This migration leads to older persons being placed in residential care facilities (Perey, 2016:2). Emigration of younger people has also contributed to an increased number of older persons in need of residential care, including in the rural and poorer provinces in South Africa (DoSD, 2010:65; Labontè *et al*., 2015:2; Province of the Northern Cape, 2019). The departure of family members has reported negative consequences for ageing relatives, such as loneliness, isolation and loss of basic support (Thapa *et al.,* 2018:4-5). The older persons' standard of living is therefore fundamentally affected by demographic change.

In addition, changes in family structure and social values have rendered residing with family an increasingly unreliable source of support and care. Makiwane *et al*. (2017:49-51) explain that the family system is disrupted by structural changes as well as functional adaptions. Extended families are restructured due to death, separation or migration and changed circumstances alter the behavioural functions, interactional patterns and social ties (Makiwane *et al.,* 2017:49-51). Changes in the living arrangements of older people consequently increase the demand for the provision of long-term care (Gardiner *et al.*, 2020:749; He & Chou, 2017:4; Ralston *et al.*, 2018:2).

The social positioning of older persons in South Africa is determined by cultural norms regarding co-residence, intergenerational ties and family support (DoSD, 2013:5; Makiwane *et al.,* 2017:50). Cultural norms are reflective of the social positioning of older persons as either dependent or productive members of the household (Schatz *et al.*, 2015:582). In rural South Africa, however, older persons are in the situation of being both dependent and productive. Diminished physical and cognitive abilities cause them to become dependent, whilst their access to government-funded pensions renders them *productive* (Schatz *et al*., 2015:582-583). These living arrangements are not all protective of the older persons' wellbeing as their social roles shift with time (Ralston *et al.,* 2018:2). The result is that older people are no longer part of a multi-generational household and need alternative means of care (Stats SA, 2017c; UN, 2019).

2.3.1.3 Resource-limited settings

Decision-making about a long-term solution for care poses its own challenges. The decision for or against admission of an older person is dependent on the availability, quality and affordability of residential care facilities (Lang & Hoey, 2017:1; Ostaszkiewicz *et al*., 2020:2). There is a dilemma between affordability and quality of care, which is a particular cause of concern when the older persons have limited resources to sustain themselves (Riley, 2012:2-3; Stellenberg, 2015:9-10).

Residential care is one of the three most expensive areas of healthcare worldwide, including in South Africa (Burger & Christian, 2018; Du Preez, 2015; Meyer *et al.,* 2016:48). Furthermore, the demand for residential care has exceeded the market (Porter *et al*., 2018:3; Solanki *et al*., 2019:178). This situation poses a challenge for the government to satisfy the growing demand for affordable and secure housing for older persons (De Jager *et al*., 2015:1088; Fernandes & Paùl, 2017:2-3; Stats SA, 2017a). Moreover, in providing affordable services, the challenge remains to uphold the quality of care.

Historically in South Africa, access to healthcare services has largely been class-based, with the majority of the poor and low-income households having to travel long distances to access public health services (Burger & Christian, 2018). The decades of discrimination and disadvantage in South Africa have negatively affected the health and socio-economic wellbeing of older persons too (Burger & Christian, 2018). High unemployment, old-age pensions and frailty related to ageing all play a role in the older person's social positioning and whilst resources were used to improve the situation of women and children, older persons were not seen as a priority (Kelly *et al.,* 2019:2). Nevertheless, since 1996, progress has been made to improve public healthcare services of poor and vulnerable people (Burger & Christian, 2018; Mayosi *et al.,* 2012:5). Regrettably, significant disparities in health service delivery and the availability of residential care facilities between rural and urban settlements still exist, with evidently lower levels of access in remote rural areas (Delobelle, 2013:161; DoSD, 2010:5; Madhavan *et al.,* 2017:7-8; Stats SA, 2017b). Relocation of older persons from rural areas may therefore be necessary for access to healthcare services more readily available (Solanki *et al.,* 2019:178; Stellenberg, 2015:10).

2.3.2 Negative implications of residential care

Transitioning to residential care has implications for the older person and their family members, as well as the facilities and employees. Social expectations and perceptions about caring for older family members, as well as varying affordability and quality of residential care, impact on the individuals involved.

2.3.2.1 Implications for older persons and their families

Relocating causes tension and fear in the older person as well as in their family (Vahid *et al.,* 2016:347). When the perception exists that it is the responsibility of the family to take care of their elderly members, the dynamics of moving can be complicated. A social and cultural stigma may be attached to admission due to the disruption of family cohesion and the loss of a feeling of *belonging* (Vahid *et al.,* 2016:351). In addition, tension and fear are fostered by inadequate and incorrect information regarding residential care (Fitzpatrick & Tzouvara, 2019:57-58; Vahid *et al.,* 2016:349). The transition from home to a residential care facility represents a vulnerable time for older adults, particularly because they are more medically and socio-economically challenged than the general population.

Although a period of adjustment is usually required, such a transition could result in stress and changes in the older person's self-esteem. The magnitude of changes associated with being admitted to a care facility is often one of the most pervasive sources of fear affecting older persons (McKechnie *et al*., 2018:17). In addition, problems of seclusion and loneliness are a reality (East, 2017; Gardiner *et al.,* 2020:749). A positive outlook could support the individuals involved in the transition and make it a less traumatic experience (Fitzpatrick & Tzouvara, 2019:57-58). In this regard, caregiver self-efficacy and preparedness could contribute positively to making this transition less challenging (Fitzpatrick & Tzouvara, 2019:58; Sullivan & Williams, 2017:41-42).

Conversely, poor quality of care in residential care facilities is also a reality (East, 2017; Gardiner *et al.,* 2020:749; North & Fiske, 2015:933; Smythe *et al*., 2017:2). The trauma of adjusting to residential care could pose an actual physical threat due to incidents of neglect, abuse and even death (East, 2017; Mahomedy, 2017; Phelan, 2015:216-217). Several cases of maltreatment in residential care facilities have come to the attention of the South African public. In 2018, for example, the MEC of Social Development in Gauteng reported that a residential care facility in Pretoria was under investigation following allegations of elderly abuse (African News Agency, 2018). Another example of abuse reported in the media at the time of this study was an incident that occurred at a residential care facility in the Western Cape. Surveillance camera footage captured an employee sexually assaulting two older women in the early hours of the morning (Van der Merwe, 2020). Such incidents have led to government action to curtail maltreatment of older persons in residential care.

2.3.2.2 Implications for the residential care facilities

The *Constitution of the Republic of South Africa* laid the foundation for the transformation agenda for the protection and care of all older persons. More specific regulations and standards are stipulated in Section 34 of the Older Persons Act 13 of 2006. Nonetheless, there is inconsistency in the management and regulation of residential care facilities.

According to the latest statistics available, there are an estimated 1 150 state-funded residential care facilities for older persons in South Africa, with only 415 being registered with the DoSD (SIFAR, 2017). As a result, many of the older people requiring long-term care were, and most likely are still, living in unlicensed and unregulated residential care facilities that do not comply with the provisions of the Older Persons Act 13 of 2006 (Mahomedy, 2017). Assessments of residential care facilities in the Northern Cape province to determine the state of compliance to the act found several facilities to be non-compliant (Beangström, 2018; DoSD, 2010:31-33, 84; Mahomedy, 2017; SIFAR, 2017).

The consequence of these findings is that residential care facilities in South Africa are under unrelenting pressure to document the care they provide and report to various stakeholders. There is, however, a lack of systematic outcome measures to assist facilities to identify, report and manage the quality of care provided to residents (Uitenbroek *et al*., 2016:2). In addition, there is little consensus on and guidance given as to how to measure the quality of care (Akpan *et al*., 2018:1; SIFAR, 2017).

2.3.2.3 Implications for the caregivers

Caregivers are expected to render services of high quality whilst being faced with major challenges. Not only are the measures of quality unclear, but residents of care facilities often present with a wide range of needs, as discussed in section 2.2.2. Navigating these challenges holds personal as well as work-related implications for the caregivers.

Caregiving is often an emotionally exhausting and physically demanding occupation, with difficult working conditions such as social isolation and extended working hours (East, 2017). Caregivers may experience distress in response to demanding and disruptive behaviour often encountered in older persons. A study conducted by D'Onofrio *et al*. (2015:1-2) showed that caregivers' emotional reaction and distress directly relate to older persons' needs and behaviour. Cognitive impairment, behavioural disorders and a decrease in functional capabilities of older persons were identified as sources of stress for caregivers (Burke & Orlowski, 2015; Gottesman & Stern, 2019; Sepe-Monti *et al.*, 2016:2). Caregivers of persons with neurocognitive disorders were found to carry a greater burden and were at a higher risk for depression than caregivers of other chronically ill and older persons (Cheng, 2017:1; Cheng *et al*., 2017:521-522; Dehdari *et al*., 2015:2). The adverse physical and psychological outcomes associated with caregiving as well as limited availability and accessibility of support systems in the community further contribute to their challenges (Bosch, 2015:3; Burger & Christian, 2018; Mapira *et al.*, 2019:2; Smythe *et al.,* 2017:2).

Caregiving is a low-paid and low-status occupation, affected by the stigma connected with old-age diseases such as neurocognitive disorders (DoSD, 2013:62; Famakinwa, 2020; Kahn *et al*., 2016:3-4; Mehta *et al.,* 2018:2). A particular disadvantage is that the average wage for caregivers is lower than that of many other jobs with similar entry-level requirements (Famakinwa, 2020). It comes as no surprise, then, that job dissatisfaction and poor coping contribute to a high turnover amongst caregivers (East, 2017; Martin & Ramos-Gorand, 2017; Zúñiga *et al.,* 2015:3-4). Caring for older persons could therefore impose substantial strain on caregivers and put them at risk of experiencing physical, psychological, social and financial burdens (East, 2017; Musich *et al.,* 2017:1; Sepe-Monti *et al*., 2016:2; Tang *et al.,* 2015:3; Williams, 2017:3).

The mentioned challenges, such as below average remuneration, lack of education, skill mix, less than desirable conditions and inadequate organisational structures, faced by caregivers in residential care facilities are the focus of global debate (Famakinwa, 2020; Mapira *et al*., 2019:2; Shannon & McKenzie-Green, 2016:140-141). Despite the increased international acknowledgement of caregivers regarding a number of policies intended to enhance the recognition of rights of caregivers, many of them remain invisible and receive little support to the detriment of their own health and wellbeing (Larkin & Milne, 2014). Caregivers often feel undervalued as they are not acknowledged as trained healthcare staff (DoSD, 2013:62; O'Donoghue *et al*., 2014). These factors contribute to a negative attitude amongst caregivers, which leads to poor and inadequate quality of care (North & Fiske, 2015:933; Smythe *et al*., 2017:2). Failure to meet the basic needs of older persons is considered neglect and could have legal consequences (Myhre *et al*., 2020:2; Phelan, 2015:216-217; Pillemer *et al*., 2016:44; Robbins *et al*., 2013:2; WHO, 2020). Neglect and abuse in residential care facilities for older persons are, however, most often the result of inadequately trained staff who are overworked, stressed and unable to provide quality care. Furthermore, lack of education and support leave them ill prepared in navigating the challenges in the workplace, consequently leading to caregivers becoming negative, burnt out and demotivated (Elliot *et al.,* 2015:5; Kusmaul, 2016:19-20; Mapira *et al*., 2019:2; Musich *et al*., 2017:9-10; Sepe-Monti *et al*., 2016:2; Tang *et al.,* 2015:3).

2.4 Caregivers

Caregivers play an important role in the care of older persons and high expectations are set. Yet, many of them lack the necessary training to meet these expectations and render effective care for this vulnerable population.

2.4.1 Expectations

Older persons in residential care facilities are dependent on the daily support and assistance of caregivers. Daily tasks such as making beds and assisting with bathing, dressing, feeding and personal hygiene are rendered as basic terms of the caregiver’s employment (Council, 2020; SIFAR, 2017; Vantage Mobility International, 2016). In addition to providing basic care, they spend time with older people, offering companionship, and assist in walking the frail and mobilising those who are bedridden (Council, 2020; Vantage Mobility International, 2016). At the residential care facility where the researcher was previously employed, caregivers also helped the older persons to tidy and organise their rooms. In addition, they regularly accompanied those who were ambulant to leave the facility to run personal errands.

In South Africa, caregivers provide the majority of basic care and they are increasingly acknowledged as a crucial part of healthcare. Nevertheless, employment requirements vary according to institution specifications as neither certification nor registration are mandated (Falk-Huzar, 2017:125; SIFAR, 2017). In addition to caring for daily basic needs, various sources mention that caregivers are required to manage deterioration of cognitive and mental health associated with ageing (Burke & Orlowski, 2015; Gottesman & Stern, 2019; Martin *et al.,* 2016:2; Sepe-Monti *et al.*, 2016:2). Despite the expectations set before them, caregivers were found to have a less than average knowledge to recognise care needs related to cognitive impairment and declining mental health (Molinari *et al*., 2017:3-4; Porter *et al*., 2018:3; Robbins *et al.,* 2013:2; Smythe *et al*., 2017:2; Williams, 2017:3).

Little is known about the benefits of interventions for caregivers of older persons. However vital improvements in caregiver burden, depression symptoms and work-related stress over a period of six months after implementation of a multidisciplinary supportive programme was noted (Mehta *et al.,* 2018:2). Studies have shown that caregivers who have training in caring for older persons, including those with neurocognitive disorders, become more attuned to their patients (Williams, 2017:13). This helps caregivers to achieve their caring tasks more easily and without causing distress to the older persons they care for (Courcha, 2015:286).

To provide residents with this diversified level of care, residential care facilities need to ensure that their caregivers are educated and trained effectively and efficiently (Falk-Huzar, 2017:125; Raymond *et al*., 2014:367; Tropea *et al*., 2019:3-4). Considering the residents' health, safety and welfare, a training programme should be able to disseminate and sustain itself, increase the skills and knowledge of caregivers and improve the lives of the older persons living in residential care facilities (Ballard *et al.,* 2018; Birkenhäger-Gillesse *et al.,* 2018:2; Rapaport *et al.*, 2016:1-2; Rubinstein, 2014:107-108; Uitenbroek *et al*., 2016:2). The training of caregivers leads to their preparedness through the acquisition of knowledge and new skills (Jack *et al.,* 2019; Lichtenstein *et al.,* 2015; Williams, 2017:3).

For the caregivers to meet the expectations set before them, they must be adequately prepared to cope with the physical as well as emotional challenges presented whilst caring for an older person (Adler *et al.,* 2015:903-904). Caregiver preparedness is vital in equipping them to be successful in their work (Williams, 2017:3). They too should have access to lifelong learning opportunities to enable them to improve what they are doing (Van Jaarsveldt & Joubert, 2018:88). Inclusive and quality education for all, as well as the promotion of lifelong learning, could enhance the caregivers' role as care providers to older persons (Jenkins & Chandola, 2014; Kilpi-Jakonen *et al*., 2015:529-531; Olexsovich, 2016:1; Smidt, 2018).

2.4.2 Education and training

Caregivers working with older persons need specific training to effectively perform the tasks expected of them. The South African Qualifications Authority (SAQA) has a registered unit standard relating to the provision of care to a frail person, which is summarised in Table 2.3.

Table 2.3: Summary of the SAQA registered unit standard: Provide care to a frail person

Originator	
SGB Ancillary Health Care	
Field	**Sub-field**
Field 09 Health Sciences and Social Services	Curative health
NQF Level	**Credits**
NQF Level 1	12
Purpose of the unit standard	
This unit standard is for caregivers who are required to provide fundamental nursing care for a frail person on a continuous basis and under the direct or indirect supervision of a qualified health worker.	
Unit standard range	
A frail client means a person of any age who is in need of twenty-four-hour care either on a temporary or a permanent basis. Frail care is fundamental nursing care.	
Specific outcomes	
Specific outcome 1	Demonstrate a fundamental understanding of the normal functioning of the body systems.
Specific outcome 2	Identify the common degenerative, disease and trauma processes and their effect on the body systems of the frail person.
Specific outcome 3	Assess the condition and environment with reference to the specific needs of the frail.
Specific outcome 4	Provide for the needs of the frail person.
Specific outcome 5	Demonstrate the use of a variety of basic frail care equipment.
Specific outcome 6	Demonstrate knowledge of the human rights of the frail person.

Compiled from SAQA (2020)

The SAQA qualification is on an *NQF level* 1 and 12 *credits* are awarded. According to the *purpose* of the unit standard, tasks should be performed under the supervision of a qualified health worker. Although persons of all ages are included in the *range of the unit standard*, the descriptions apply to residential care too, where persons receive twenty-four-hour care on a permanent basis. Frail care is noted as being fundamental nursing care. The *specific outcomes* portrayed in the table serve as a guideline because caregiver education and training are not mandatory.

Neither evidence of training nor registration with a governing body is required for employment of a caregiver (Maphumulo & Bhengu, 2019; Nursing Act 13 of 2006; SIFAR, 2017). At the residential care facilities that formed part of this study, only a Grade 10 basic education with no additional education or training is required. This situation is not unique, as Chisagiu (2015:66-68) found that the main recruitment pool for caregivers consists of the low-skilled adult population, early school leavers and dropouts. In addition, a large study conducted by SIFAR (2017) found that although training courses were available in South Africa, they were not well regulated and their content varied. With no standard training programme, caregivers can compromise the health and safety of persons in their care.

Another challenge is that development opportunities are mainly available in cities (Mapira *et al*., 2019:2; Perey, 2016:2). Caregivers from rural areas face daunting obstacles as they have limited access to uncoordinated resources regarding training, education and support, as well as more barriers to formal service provision than their metropolitan peers (Gurayah, 2015:194; Harling *et al*., 2020:297; Innes *et al.,* 2011; Manderson *et al*., 2019; Talley *et al.,* 2011:9-10). Furthermore, limited budgets of the residential care facilities included in this study do not allow trainers to come from the city. Concomitantly, if the caregivers should attend courses in the city, there are challenges regarding adequate staffing, and additional expenses are incurred by travel, accommodation and registration fees (Mashau *et al.,* 2016:1; Moshabela *et al*., 2015). More specifically, persons residing in the Northern Cape province, with its large surface area, need to travel extensive distances to attend training courses (NC DoH, 2018; Stats SA, 2017b). Caregivers from rural areas therefore mainly receive informal in-service training regarding the basic care of older persons, such as bathing and feeding (Maphumulo & Bhengu, 2019; SIFAR, 2017). There is thus a gap between what is expected of caregivers and what is offered to equip and support them.

Various authors agree that for caregivers to meet the increasingly complex and diverse needs of older persons, they need adequate training. Mastel-Smith and Stanley-Hermanns (2012:1008) found that training programmes most often address basic care, but do not focus on educational deficits and none consider the caregivers' learning needs. The learning needs of caregivers therefore have to be identified (Moyakhe, 2014:80; Thampy, 2013:138; Timmons *et al*., 2019). Kar (2015) continues that the learning needs of caregivers should be explored at individual and community level according to the care needs of the older persons for whom they are caring.

2.5 Summary

Older persons are considered to be a vulnerable population and as ageing is associated with functional decline, the complexity and diversity of their caring needs tend to make older persons reliant on others. The systematic ageing of the population worldwide and the change in family structures further contribute to the increased demand for residential care facilities. When having to consider long-term-care options, the availability, affordability and quality of care provided in these facilities play a role in decision-making. Admission to a residential care facility has implications for the older person and their families, the care facility, as well as the caregivers. As caregivers are expected to provide quality care, they should be well prepared and skilled to render respectful care to the growing number of older persons. They should also be able to deal with the challenges associated with ageing. Maintaining the health and wellbeing of caregivers and providing them with the necessary support, education and training are imperative in enabling them to navigate the challenges set before them.

The three concepts regarded as foundational to this study, namely older persons, residential care facilities and caregivers, discussed in this chapter are therefore unreservedly linked together. For caregivers to be adequately prepared in providing quality care to older persons, an exploration of their learning needs is necessary and was identified as a knowledge gap in literature as well as in the local municipal sub-districts, as described in Chapter 1. The ensuing research is discussed in Chapter 3. An elaboration on the overview provided in Chapter 1 regarding constructivism and the research methodology is offered in the following chapter. Consideration of ethical issues related to the research and measures implemented to enhance trustworthiness of the study are also discussed.

CHAPTER 3

Research methodology

Ernie Brummer

CHAPTER 3 RESEARCH METHODOLOGY

“Teaching is more than imparting knowledge; it is inspiring change.
Learning is more than absorbing facts.”
William Arthur Ward

3.1 Introduction

Caregivers within the context of this study are challenged on multiple levels in providing quality care to a vulnerable group of people in a rural setting. Moreover, their general health and wellbeing are threatened, partially due to a lack of training, development and support. The uniqueness of their situation in relation to the gaps in literature identified in Chapter 2 serves as justification for the research, and more specifically, the formulation of the research question:

> What are the learning needs of caregivers of older persons in residential care facilities in two sub-districts of the Northern Cape province?

To avoid imparting – or rather imposing – knowledge, but rather to inspire change, the researcher agrees with William Arthur Ward that we need to learn with the purpose of acquiring understanding (School of Education, 2018). In an attempt to support the learning of caregivers, rather than the mere absorption of facts, it is necessary to understand what they need to learn. In pursuit of inspiring change, developing a deeper understanding of their learning needs could best be achieved by obtaining the perspectives of different role players, including those wanting to learn – the caregivers. In this chapter, the choice of paradigm and research methodology in response to the research question and purpose is explained.

3.2 Research Paradigm

The research paradigm adopted for this study was constructivism because its collection of beliefs and values was best suited to guide the research. A paradigm is, in essence, a *worldview* and relates to how one sees the world or a typical, acceptable way of doing things, including how the world should be comprehended (Denzin & Lincoln, 2018:56; Mertens, 2015:8; Patel, 2015; Polit & Beck, 2017:9). The research paradigm guides what should be studied, what questions should be asked, how these should be asked and what rules or guideline have to be followed to interpret the answers that have been obtained from the study (Amineh & Asl, 2015:9-10; Scotland, 2012:9; Theys, 2018:1-2).

In qualitative studies, such as this one, social researchers are often guided by constructivism, which “represents a major alternative system for conducting disciplined research in nursing” by focusing on the individual (Polit & Beck, 2017:10-11). Constructivism relates to how persons “socially construct” meaning from their own perspectives (Savin-Baden & Howell Major, 2013:23). In this study, as suggested in literature, knowledge was socially constructed by the participants (Amineh & Asl, 2015:9; Mertens, 2015:64-65; Polit & Beck, 2017:11; Theys, 2018:1). It was important to attempt “to understand the complex world of experience” from the participants’ viewpoints (Mertens, 2015:65). Individuals’ ability to interpret a situation from their perspective and decide how to act in response to it is therefore accentuated in constructivism.

The philosophical assumptions of constructivism guided the researcher’s thinking and actions regarding how reality was observed (*ontology*), the nature of knowledge (*epistemology*), the nature of the methods (*methodology*), and the nature of values (*axiology*) (Botma *et al.,* 2010:40-41; Mertens, 2015:66-69; Patel, 2015; Polit & Beck, 2017:10; Savin-Baden & Howell Major, 2013:63; Scotland, 2012:9). Each of these assumptions will be briefly discussed below. In Chapter 1, Table 1.1. refers to the application of constructivism in this research.

3.2.1 Ontology

Ontology urges researchers to think about and question “the nature of reality” of their studies (Brink *et al.*, 2018:19; Brown & Dueñas, 2020:546; Polit & Beck, 2017:10). In contrast to positivism, there is no single reality or truth because constructivism considers multiple realities created by humans (Polit & Beck, 2017:10). Reality exists within a context and is not a fixed entity, but rather a social construction of the individuals participating in the study (Mertens, 2015:67; Patel, 2015; Polit & Beck, 2017:11). Therefore, the researcher should try to understand reality within the particular context by coming to an understanding of the meaning participants assign to phenomena (Brown & Dueñas, 2020:548; Mertens, 2015:64-65; Polit & Beck, 2017:10-11). In this study, the researcher attempted to focus on “the dynamic, holistic and individual aspects” of the participants’ contributions in order to discover the learning needs of the caregivers caring for older persons in the specific context (Polit & Beck, 2017:12).

3.2.2 Epistemology

Epistemology relates to the nature of knowledge within the reality of the study and essentially asks what knowledge is and how knowledge is attained (Botma *et al.,* 2010:40; Brown & Dueñas, 2020:548). Within constructivism, knowledge is seen to be a human construction, where individuals actively give meaning to their thoughts and experiences from their worldview (Brown & Dueñas, 2020:548; Mertens, 2015:68; Savin-Baden & Howell Major, 2013:23, 63). Savin-Baden and Howell Major (2013:63) explain that as constructivist researchers make an effort to understand the participants’ perspectives, they inductively develop theoretical understandings or patterns of meanings during the course of the research. The researchers are therefore also in a process of knowledge construction as they derive meaning from the data.

During the nominal groups and small group interview, knowledge was generated about the learning needs of the caregivers from the different perspectives of the participants. Throughout data analysis, the researcher attempted to make meaning of the different contributions to come to a deeper understanding of the research issue. As a partial insider, the researcher could not be distant and objective and had to make sure that the reality of the learning needs was the interpretation of the participants and not her own. (The role of the researcher is described in sections 1.12 and 3.7 to indicate her positionality, and measures taken to ensure rigour are discussed in sections 1.14 and 3.9.)

3.2.3 Methodology

Methodology involves the plan and procedures followed to obtain knowledge or best evidence (Botma *et al.*, 2010:41; Brown & Dueñas, 2020:546). The question to ask in determining the methodology is how evidence is best obtained (Polit & Beck, 2017:10). Within the constructivist paradigm, researchers often make use of different methods to collect data from various sources (Savin-Baden & Howell Major, 2013:63). The researchers interact with the participants and make use of techniques such as interviews through which individuals can express their perspectives (Mertens, 2015:19-20; Polit & Beck, 2017:10). Mertens (2015:19-20) explains that the methodology could be described as *hermeneutical*, because multiple perspectives are sought to enhance interpretation, and *dialectical*, as conflicting ideas are considered. Furthermore, the research relates to how the participants make meaning of the research phenomenon in their particular *context* (Polit & Beck, 2017:10; 723).

In this study, multiple data sources were included to construct meaning from different perspectives. The researcher conducted nominal groups and a small group interview to obtain information-rich data. Knowledge was constructed through integration of the various perspectives of the participants (caregivers, family members and RNs). The information that was gathered from the participants was based on their personal understanding relating to their work regarding the learning needs of caregivers in residential care facilities for older persons within two sub-districts of the Northern Cape province. A more comprehensive discussion of the methodology follows in this chapter.

3.2.4 Axiology

Axiology is concerned with the role of values and ethics in the research (Mertens, 2015:66-67; Polit & Beck, 2017:10). Brown and Dueñas (2020:547) indicate that axiology asks “what ought to be” within the context of the study. Although constructivist researchers typically adhere to ethical principles, the interaction between the researcher and participants asks for an approach to rigour that makes provision for the subjective nature of the inquiry (Mertens, 2015:64).

The researcher, as a partial insider-researcher, was subjective and values-bound during the study. An augmentation view to ethics was therefore taken by integrating both principle- and virtue-based ethics (Resnik, 2012:330, 333-334). (Refer to sections 1.13 and 3.8 where the ethical considerations of the study are discussed. The criteria of trustworthiness were applied to address methodological rigour and are outlined in sections 1.14 and 3.9.)

The researcher values all persons and respected the inputs of each participant. For the participants to freely share their views, the researcher was approachable, honest and empathic (Greene, 2014:3-4; Merriam & Tisdell, 2015:142-143). Having established rapport, the researcher honoured the participants' trust by remaining reflexive. Through critical self-awareness, the researcher became more aware of her beliefs, experiences, values and opinions, as well as the influence her worldview could have on interpretation of the data (Zuber-Skerritt, 2018:519). (Refer to sections 1.12 and 3.7 for an elaboration on the role of the researcher.)

3.3 Research Design and Method

Flowing from the paradigm and in answer to the research question, an explorative case study design, a tradition of qualitative inquiry, was deemed most appropriate. The qualitative approach enabled the researcher to collect rich data which could provide more insight into the problem at hand (Brink *et al*., 2018:103).

The explorative design was chosen as the topic had not previously been investigated within the particular context (Harrison *et al.,* 2017:6; Heale & Twycross, 2018). True to qualitative work, an emergent design made it possible for the researcher to adapt to new ideas, concepts or findings whilst conducting the research (Pailthorpe, 2017; Polit & Beck, 2017:463). Ongoing decisions were made by reflecting on what had already been learnt, therefore continuously integrating data regarding the learning needs of caregivers at residential care facilities for older persons (Creswell & Creswell, 2018:35; Pailthorpe, 2017; Polit & Beck, 2017:463). Contextually, the case study method facilitated an in-depth exploration of the learning needs of caregivers within a bounded system (Polit & Beck, 2017:476; Yin, 2018:45-46). Such an exploration was made possible by involving different sources and methods to collect data (Astalin, 2013:118; Cohen *et al.*, 2018:387; Yin, 2018:153). Data were collected through the involvement of different role players and the use of the NGT, as well as a small group interview.

3.3.1 Qualitative approach

Three approaches are often used in social research, namely qualitative, quantitative and mixed methods (Creswell & Creswell, 2018:35; Grove & Gray, 2019:34). A qualitative approach was chosen for this study as it is flexible and capable of eliciting rich information from various sources through active involvement of the researcher (Brink *et al*., 2018:103; Polit & Beck, 2017:506).

In general terms, Polit and Beck (2017:464) are of the opinion that there are three design features in qualitative research, namely comparisons, settings and time frames. Researchers reportedly do not necessarily plan to incorporate these features in their study, but they nevertheless emerge. In this study, the researcher used all three features. The data from the multiple nominal groups were compared to merge similar ideas and identify the unique contributions from the different data sources, thus making *comparisons.* The data were collected in real-world, natural settings over a period of three months at multiple data collection points – *settings* and *time frames*. These three features add both uniqueness and complexity to qualitative research.

Denzin and Lincoln (2018:17, 45) add that qualitative researchers are “bricoleurs” who not only employ various research methods, but who are engaged in multiple actions, such as interviewing, reflecting and being critically self-aware. The researcher strives to understand the narrative, descriptive account given by the participants, of how they make sense of the world and the experiences they encounter in daily living (Astalin, 2013:118; Bhandari, 2020; Mertens, 2015:16; Savin-Baden & Howell Major, 2013:23). This active involvement is demanding because it requires patience, multi-tasking, integrative thinking and the ability to be critically self-aware.

In spite of the challenges, qualitative research offers several distinguishing strengths that can be applied across disciplines (Polit & Beck, 2017:463). In Table 3.1 the advantages and disadvantages of qualitative research that applied to this study, are presented.

Table 3.1: Advantages and disadvantages of qualitative research in this study

Advantages	Disadvantages
Qualitative research: • is flexible – makes provision for adjustment as new information emerges; • is holistic – facilitates a deeper understanding; and • enables triangulation – incorporates different data sources and data collection techniques. **Qualitative researchers:** • are actively involved and get to know the participants; • dwell close to the data; • can come to a deeper understanding of the research issue; and • are engaged in continuous learning through ongoing analysis, often simultaneous with data collection.	**Qualitative research:** • findings are not generalisable: o studies are context-bound, o units of analysis are fairly small, and o data and findings are subjective; • is time consuming because it involves collecting data from all the data sources; and • is challenging to navigate – a bricolage, requiring multi-tasking, presenting the complexity of the findings. **Qualitative researchers:** • could be biased; and • could be coercive.

Compiled from Bhandari (2020); Miller (2019); Polit and Beck (2017:463)

The researcher, being a partial insider, became deeply *involved in the research* and through a *holistic* approach could come to a *deeper understanding* of the learning needs of the caregivers. Her previous experience and partial familiarity with the context and participants enabled her to *dwell close* to the data. The *flexibility* of qualitative research facilitated *continuous learning* as she had to adjust to new information during data collection. This occurred, for instance, when participants passionately shared information and problematic situations that were not anticipated. (Refer to section 4.5 for a more elaborate description.) *Triangulation* was accomplished through the inclusion of different groups of participants and research sites, two data collection techniques and the integration of literature during data analysis (Bhandari, 2020; Miller, 2019; Polit & Beck, 2017:463, 563-564; Roulston, 2018).

In this research, the purpose was not to *generalise* the findings, because it was important to come to a deeper understanding of the learning needs of caregivers in the specific context in order to offer the necessary support and development. It was *time consuming* to travel and conduct the various nominal groups and the small group interview. The researcher did indeed find the process *challenging*, as discussed in section 5.5. Measures were taken to address the issues of possible *bias* and *coercion*. (Refer to sections 3.8 and 3.9 where the ethical considerations and methodological rigour of the study are discussed.)

3.3.2 Case study

A case study is a method through which an in-depth exploration of a phenomenon is conducted within its real-world context (Yin, 2018:45-46). The learning needs of caregivers of older persons in the specific residential care facilities had not previously been investigated in depth, indicating the necessity of an explorative case study (Harrison *et al.,* 2017:6; Heale & Twycross, 2018; Yin, 2018:45-46).

Case study research, including an explorative case study, is known to be a flexible approach, which is often used to investigate and understand complex issues (Harrison *et al.*, 2017:5; Yin, 2018:45-46). Such an investigation provides insight into the research problem and may indicate relationships amongst the phenomena of interest (Polit & Beck, 2017:476). This descriptive information lays the foundation for action to address the emerging issues (Grove & Gray, 2019:379; Harrison *et al.,* 2017:12; Yin, 2018:35). The complexity of the learning needs of the caregivers was therefore best explored through the mentioned design (Astalin, 2013:122-123; Cohen *et al*., 2018:378-379; Yin, 2018:45-46).

Grove and Gray (2019:27) add that practice-related research has been conducted within nursing by use of case studies. This study employed an explorative case study to discover the learning needs of caregivers working in residential care facilities for older persons. It was hoped that the findings would inform learning and development of the caregivers, which could improve the quality of care rendered. As with any other method, case study research has strengths and disadvantages, which are outlined in Table 3.2.

Table 3.2: Advantages and disadvantages of a case study in this context

Advantages	Disadvantages
Case study research: • explores phenomena in depth; • enables triangulation – incorporates different data sources and data collection techniques; • provides abundant, rich, descriptive data; • is holistic – facilitates a deeper understanding; • can maximise learning about the phenomenon of interest; • indicates discrepancies; and • enhances democratic decision-making for readers.	**Case study research:** • may present challenges in delineating the boundaries to the case; • may not be representative of the case; and • findings are not fully replicable, because it is highly context-bound. **Case study researchers:** • could display bias by over- or understating the case.

Compiled from Cohen *et al*. (2018:378-379); McLeod (2019); Polit and Beck (2017:476-477)

In addition to the strengths already mentioned, *triangulation* rendered a *wealth* of *deeply* descriptive data. The inclusion of different role players afforded a *comprehensive view* of the learning needs of the caregivers, including *differences of opinion* that *enhanced learning* and made the research believable. By presenting the findings as truthfully as possible, *democratic decision-making* can be facilitated for improved future practice.

The vastness of the Northern Cape province did present challenges in *delineating the boundaries* to the case, and in selecting two sub-districts only it is acknowledged that the case is *not representative*. Furthermore, the isolation of the small rural towns where the study was conducted introduced a uniqueness that made the findings *highly context-bound*. The integrity of the research is dependent on the sensitivity and moral conduct of the researcher, who, as a partial insider-researcher could be tempted to *over- or understate the case* (Cohen *et al*., 2018:378). Measures were therefore taken to enhance research integrity, as explained in sections 3.7, 3.8 and 3.9.

3.4 Population and Units of Analysis

The multiple data sources who shared an interest in this case study were various role players from three residential care facilities for older persons in the Siyancuma and

Thembelihle sub-districts of the Northern Cape province. Each of the facilities is situated in a small rural town. The two local municipalities are in close proximity and formed “a bounded system” for the case study (Cohen *et al.*, 2018:375; Creswell & Creswell, 2018:42). The population comprised of three groups, namely the family members of residents, and the caregivers and the RNs working at the residential care facilities. As indicated in literature, they all had exposure to the same phenomenon, but from different perspectives (Cohen *et al.*, 2018:375; Yin, 2018:47). The older persons residing in the care facilities while the study was in progress were not included because of the high incidence of neurocognitive disorders amongst them, which affected their ability to provide informed consent. A total number of 36 caregivers and three RNs were in the employment of the facilities. Determining the number of family members of the 92 residents was difficult because of the variation in the size as well as the distribution of the families.

Information-rich sources, extracted from the population, formed the units of analysis (Botma *et al.*, 2010:290; Polit & Beck, 2017:743). Particular sources of data could be, for example, a group of people or documents or events (Botma *et al.*, 2010:51, 290). Units of analysis who could provide a truthful reflection on the learning needs of the caregivers, as well as on the research sites, are set out in Table 3.3.

Table 3.3: Units of analysis and sampling methods

Information-rich data sources in the Siyancuma and Thembelihle Local Municipalities				
	Research sites	**Unit of analysis**		
	Residential care facilities	**Caregivers**	**RNs in charge**	**Family members of residents**
Number	3	25	3	11
Sampling method	Complete collection in the sub-districts	Purposive sampling	Complete collection sampling	Purposive sampling
Inclusion criteria	Include all	Inclusion criteria: • Had at least 12 months experience in caring for an older person. • Had been employed at one of the residential care facilities for at least 12 months.	Include all	Inclusion criterion: Those who visited their relative(s) at least once a month

The researcher deemed the caregivers and RNs working at the facilities and the family members of residents to be resourceful for purposes of this research (refer to section 1.8). It was decided not to include the residents because of the high prevalence of neurocognitive disorders amongst them, which could influence the accuracy of the data. All the residential care facilities in the sub-districts were chosen as research sites. (Refer to sections 3.4.1, 3.4.2 and 3.4.3 for more detailed information on the units of analysis.)

3.4.1 Caregivers

Purposive sampling, a non-probability sampling method, was employed in selecting the caregivers who formed part of this study (Botma *et al.,* 2010:201; Palinkas *et al*., 2015:533). Purposive sampling applies when the researcher relies on his/her own judgement in choosing members of the population to participate in the study (Grove & Gray, 2019:317).

These individuals must meet certain criteria to be eligible for inclusion (Polit & Beck, 2017:249; Creswell & Creswell, 2018:213; Botma *et al*., 2010:201). The inclusion criteria for caregivers stipulated they had to have:

- at least 12 months experience in caring for older persons; and
- been employed at one of the three residential care facilities for at least 12 months.

Thirty two of the 36 caregivers met the inclusion criteria and 25 of them volunteered to take part in the study.

3.4.2 Registered nurses (RNs)

The complete collection of RNs who were employed at the three mentioned care facilities at the time of data collection were invited to participate. By including all data sources belonging to a particular population, the researcher made use of complete collection sampling (Cohen *et al.*, 2018:220). All three RNs were willing to participate.

3.4.3 Family members of residents

Purposive sampling, as in the selection of the caregivers, was used for the family members of residents. They had to meet one inclusion criterion to participate in the study and that is that they had to:

- visit their relative(s) at least once a month.

In addition, the family members were included based on their availability and willingness to partake in the study. Eleven out of the 48 family members who initially indicated their willingness to participate responded to the invitation to the nominal groups.

3.5 Data Collection

In this section, the techniques employed and process followed to collect data are discussed. The use of field notes in the research is also explained.

3.5.1 Data collection techniques

A variety of data sources can be useful in case study research, for example documents, artefacts, archival records, observations and interviews (Cohen *et al.,* 2019:387; Yin, 2018:153). To gain the richest evidence about the learning needs of caregivers, the researcher made use of interviews. Yin (2018:161) regards interviews to be the “most important sources of case study evidence”.

The researcher decided on group interviews because it was anticipated that the participants might be more at ease in the company of others (Grove & Gray, 2019:110; Polit & Beck, 2017:511; Miller, 2020). This was of particular importance concerning the caregivers, who could possibly feel anxious about research participation. Furthermore, the synergy created by persons working together and exchanging ideas generates rich data (Olsen, 2019:2; Van Jaarsveldt & Ndeya-Ndereya, 2013:4). Acknowledging that participants should be given equal *airtime*, as far as possible, the nominal group technique and a small group interview were selected. Both techniques enabled each voice to be heard.

3.5.1.1 Nominal group technique (NGT)

The NGT, as described in section 1.10.1, is a structured consensus method which facilitates effective group decision-making. Although authors differ on the range of participants, the recommended group size is seven (McMillan *et al.*, 2016:656; Olsen, 2019:3). The nominal group process generally involves four steps: silent generation of ideas, a round-robin sharing of ideas, open group discussion and clarification, and anonymous voting on priorities (Olsen, 2019:5; Thier & Mason, 2018:1; Van Jaarsveldt & Ndeya-Ndereya, 2013:4). Table 3.4 presents a summary of the four steps of the NGT.

Table 3.4: Nominal group technique steps

STEP	EXPLANATION
STEP 1 Silent generation of ideas	• A question is posed orally and in writing. • Participants generate and write down ideas in silence.
STEP 2 Round-robin recording of ideas	• Each participant shares one idea at a time, which is numbered and recorded, for example written on a flipchart. • Participants verify the accuracy of the written information. • Participants do not repeat what has already been shared. • Sharing continues until no new ideas are generated.
STEP 3 Discussion and clarification	• The entire list of responses is displayed. • Participants engage in a discussion to clarify and elaborate on the recorded items. • The facilitator adds any new contributions.
STEP 4 Anonymous voting	• Each participant receives five blank note cards to identify and prioritise their five favourite ideas. • Scores are allocated to the selected five ideas. • The scores are noted on a tally sheet and final scores are calculated. • The top five priorities of the group are identified.

Compiled from McMillan *et al.* (2016:656-657); Roets and Lubbe (2015:152); Van Jaarsveldt and Ndeya-Ndereya (2013:4)

Various authors agree on the basic process that is followed during data collection. Nominal groups typically start with the facilitator posing a specific question to the participants. The question is often presented orally and in writing to allow the participants to familiarise themselves with what is asked. A time of silence is then granted for idea generation and participants are encouraged to write down as many ideas as possible. After a few minutes, when the participants are ready, each person has a turn to share one idea, which the facilitator records in a way that it is clearly visible to the group, for example on a flipchart or electronic display. This makes it possible for everyone to remain engaged by seeing what was shared and verifying that the contributions were accurately recorded. Participants are asked not to repeat what anyone else has said, thus reducing data. The round-robin of sharing continues until no-one has anything new to add and saturation is reached. On completion of this step, the list of items is displayed and group discussion is invited. Additions are made to the list, if necessary, and finally, participants are guided through a process of ranking and prioritising the recorded answers (McMillan *et al.,* 2016:656-657; Rice, *et al.,* 2018:2; Thier & Mason, 2018:2-3; Van Jaarsveldt & Ndeya-Ndereya, 2013:4). (The application of the nominal group process in this study is discussed in section 3.5.2.3.)

The structured process of the NGT holds several benefits, as well as limitations (Table 3.5). In comparison, the benefits far outweigh the limitations.

Table 3.5: Benefits and limitations of the NGT

BENEFITS	LIMITATIONS
• Minimises interruption of thought • Encourages reflection • Produces abundant data • Equalises voices and balances influence amongst participants • Time efficient and user friendly • Problem-focused problem-solving • Diminishes misunderstandings • Offers satisfaction for participants on conclusion • Simplifies data analysis • Reduces researcher subjectivity • Enhances rigour • Requires minimal resources	• Focuses on one question or topic • Restricts spontaneity • Reduces flexibility • Limits exchange of ideas

Compiled from McMillan *et al.* (2016:656-657); Roets and Lubbe (2015:152); Thier and Mason (2018:2-3); Van Jaarsveldt and Ndeya-Ndereya (2013:3-4)

The NGT is economic because it is time efficient, user friendly and requires few resources. Yet, abundant data are generated through focused reflection. Power imbalances are addressed by the round-robin sharing of ideas which equalises voices and balances influence amongst participants. Opportunity for clarification minimises misunderstandings and supports confirmability of the data. Most importantly, the active involvement of the participants in data reduction and verification not only simplifies data analysis but also reduces researcher subjectivity and enhances rigour. On conclusion of the session, participants are known to express a sense of satisfaction with their involvement in prioritising and with the immediate availability of the findings (Boddy, 2012:10; McMillan *et al.,* 2016:657; Olsen, 2019:2; Roets & Lubbe, 2015:152; Van Jaarsveldt & Ndeya-Ndereya, 2013:3-4).

3.5.1.2 Small group interview

A small group interview was facilitated with the three RNs because the number of participants was too small for a focus or nominal group. Focus groups generally consist of six to twelve people, and nominal groups ideally include seven participants (Brink *et al.*, 2018:144; McMillan *et al.*, 2016:656; Olsen, 2019:3; Polit & Beck, 2017:511). Whereas joint interviews could be held with two or more persons, the participants are usually intimately related and the purpose for these interviews is often to observe the dynamics amongst them (Polit & Beck, 2017:512). Therefore, the option of a small group interview was considered suitable for the purposes of this study.

The small group interview was conducted using a process similar to both a focus and nominal group. The research question was posed, after which the participants were given time to think about possible answers. An effort was made to create a comfortable atmosphere and to welcome different perspectives. Similar to a nominal group, each participant was granted a turn to share their ideas. With the permission of the participants, the session was audio-recorded to allow the researcher to have a transcript of verbatim responses for improved rigour of data analysis (Grove & Gray, 2019:116). The session did not include a prioritising of ideas. It was anticipated that benefits and limitations similar to those of focus groups may occur (Table 3.6).

Table 3.6: Anticipated benefits and limitations of the small group interview

ANTICIPATED BENEFITS	ANTICIPATED LIMITATIONS
• Creates synergy for effective idea generation • Group interaction minimises the influence of the researcher • Stimulates consideration of different viewpoints • Time efficient	• Some participants may be reserved or uncomfortable in sharing views in the presence of others • Group think – participants may conform to the norm • Dominant voices may limit the participation of others

Compiled from Brink *et al*. (2018:144); Cohen *et al*. (2018:532-533); Polit and Beck (2017:511)

Group dynamics offer the benefit of obtaining rich data in a relative short time span in relation to individual interviews (Botma *et al.,* 2010:210-211). The researcher hoped for a fruitful discussion that would generate copious ideas and reduce the influence of the researcher (Nyumba *et al.*, 2017:1). By creating a comfortable atmosphere of mutual respect, different views could be expressed to enrich the data. It is acknowledged that some persons may be hesitant to express their views in the company of others and could conform to strongly held opinions. Care was therefore taken to encourage maximum participation (Brink *et al*., 2018:144; Cohen, *et al*., 2018:532-533; Polit and Beck, 2017:511).

3.5.2 Process of data collection

In pursuit of research integrity, the researcher tried to conduct the group sessions in accordance with the measures set out to enhance the ethics and rigour of the study (refer to sections 3.8 and 3.9).

3.5.2.1 Access to participants

Ethical clearance was granted and the necessary gatekeeper permission was obtained from all the authoritative parties involved before recruiting participants. (Refer to sections 1.13 and 3.8 for more information.) Participant recruitment took place in advance when the researcher met with caregivers face to face at each of the care facilities after pre-determined appointments had been made telephonically.

The meetings took place at a time that suited the caregivers as well as their employers. Each group of caregivers met with the researcher in the tearooms of the respective facilities, where the importance of possible involvement in the proposed study was voiced. After each meeting with the caregivers, the RN at each respective setting was invited to participate. Furthermore, the administrative departments of the mentioned residential care facilities contacted family members of the older persons electronically to inform them of the research. The willing participants were asked to telephonically confirm with the researcher. Appointments for the respective group sessions were arranged to suit the schedules of the participants.

3.5.2.2 Preparation and introductory phase of data collection

In collaboration with the management at each respective research site, a suitable room was selected for data collection. These rooms adhered to the *criteria* for a suitable environment. They were situated in the administrative section, where it is quiet. The rooms were spacious, well ventilated and well lit. The nominal group participants sat at a table facing the researcher in a U-pattern with the flipchart and the researcher at the open end of the U. The small group interview with the RNs had the same logistical structure as the nominal groups.

The official languages of communication at the residential care facilities are English and Afrikaans, which is reflective of the language profile of the province. An estimated 53.8% of the population in the Northern Cape province are first-language speakers of Afrikaans, with other primary languages being English, Xhosa and Setswana (South Africa Gateway, 2020). Although all participants were fluent in both Afrikaans and English, their first language and language of preference was Afrikaans. To encourage productive participation, the nominal group and the small group interview were facilitated in Afrikaans.

The researcher welcomed the participants and everyone introduced themselves. Participants were identified by use of name tags. This was followed by an explanation of the purpose of the study, as well as the procedures to be followed, depending on whether a nominal or small group interview was to be held. Clarification of any uncertainties about the study were regarded as crucial and participants were encouraged to ask questions. On receiving confirmation of voluntary participation, the researcher proceeded to obtain informed consent, as explained in section 3.8.4. After obtaining consent the researcher asked participants to provide information, anonymously, on a demographic sheet regarding their gender, age. race and home language. The caregivers were asked to indicate their years of work experience with an older person at a residential care facility and highest level of education to confirm that they met the inclusion criteria. The purpose of this information, as explained to the participants, was to describe the group of people who participated in the study.

During the nominal groups and small group interview, mints and water were available on the table. A refreshment break was also given during the nominal groups, just before the voting on priorities, to allow time for participants to refresh. Fruit juice was also available. However, the participants were not informed regarding the refreshments beforehand in order to avoid coercion.

3.5.2.3 Data collection sessions

The researcher endeavoured to conduct the various group sessions in a similar way to enhance the dependability of the data. Achieving consistency was supported by the structured nature of the NGT process. Care was taken to create a relaxed atmosphere where participants would not feel intimidated and freely express themselves.

Nominal group sessions

Three nominal groups were conducted with caregivers at the respective residential care facilities and a fourth was held with family members of residents. In a study conducted by Rice *et al.* (2018:2, 4, 6), the NGT was found to be effective in engaging informal caregivers, as well as family members, in idea generation. This confirmed that the NGT would be useful in collecting data with these groups of participants.

Upon completion of the formalities at the onset of each session, as explained in section 3.5.2.2, the researcher started the nominal group by posing the question relevant to the group being interviewed. (Refer to Table 3.7 in section 3.5.1.1 for a presentation of the questions posed to the respective groups of participants.) The question was asked orally and written on a flipchart sheet in large print and displayed for all to see. No clarification was needed as the questions (Table 3.7) were clearly understood by each group.

Table 3.7: Questions posed during the nominal groups

GROUPS OF PARTICIPANTS	QUESTION
Caregivers	What do you need to learn about caring for an older person?
Family members	What should caregivers learn about caring for your loved one?

A time of *silence* was granted for idea generation. The participants were asked to think about the question and write down as many answers as possible. They were requested to remain silent until everyone was ready to share their ideas. The water and mints on the table kept the participants occupied whilst they waited for their fellow participants to finish. The time needed was four to eight minutes.

On indicating that they were ready, each participant was given an opportunity to *share one idea* from their list. Every contribution was recorded on the flipchart. The researcher numbered each item and asked the group to co-check for accuracy. Participants were asked not to repeat what had already been said and in so doing, the data were reduced. The round-robin sharing continued until no new ideas were generated.

A brief *discussion* followed, where the participants were invited to clarify any uncertainties and/or misinterpretations. Different perspectives were entertained and participants could add new ideas. On conclusion of the discussion, the participants were given a 10-minute refreshment break before continuing with the next step.

On return, participants were engaged in *voting on priorities*. The researcher gave each participant five blank note cards that were numbered from one to five. Each number represented a score. The participants were asked to choose five ideas from the list that were most important to them. They were then asked to score the items by indicating the number of the most important idea on the card with a score of five. This would be followed by their second choice on the note card numbered four. They continued this process until they had scored each of their five priorities.

A tally sheet was prepared with all the numbers of the generated ideas. The cards were gathered and in each group a participant was asked to read the item number and the score it was given. A second participant checked the accuracy of reporting whilst the rest of the group ensured that the researcher recorded the answers correctly. The group of participants checked with the researcher that all the scores had been captured. The scores were calculated and written down to determine the top five priorities.

At the end of the session, the participants were able to see which ideas had received priority for them as a group. Some participants voiced their surprise on noticing that others had voted for similar items. There was a general atmosphere of satisfaction on completion of the nominal groups. (Refer to Addendum D for the electronic versions of the respective tally sheets, as well as Chapter 4 for the discussion of the findings of the multiple nominal groups.) On conclusion of the nominal group sessions, participants were thanked for their participation. The nominal groups lasted approximately one and a half hours each.

Small group interview

On obtaining informed consent, the researcher asked the group's permission to make an audio recording of the session, to which all parties agreed. A similar process was followed as with the NGT, where a question was posed, after which participants were granted time to think about their responses. The question, displayed in Table 3.8, was similar to that posed during the nominal groups, but was adapted to elicit more specific data from the perspectives of the RNs.

Table 3.8: Question posed during the small group interview

GROUP OF PARTICIPANTS	QUESTION
Registered nurses (RNs)	What should caregivers learn about caring for older persons, including those with neurocognitive disorders, in a residential care facility?

The participants were requested to remain silent until everyone was ready to share. It took approximately five minutes for them to generate ideas. Care was taken to give each participant a turn to answer, elaborate on what others had said or to offer different probes. The session lasted one hour 35 minutes, after which the participants enjoyed refreshments.

3.5.2.4 Closing of the data collection sessions

On conclusion of the nominal group and small group interview sessions, the participants were given feedback on the results, where after they were thanked for their time and contributions. The raw data were stored for safekeeping. The flipchart sheets and note cards from the nominal groups were each put in a separate marked container and locked in a safe at a location only known to the researcher. The audio recording of the small group session was downloaded onto an electronic storage device that was also locked in the safe, after which the original recording was deleted. The safe where the data was stored were only accessible to the researcher.

3.5.3 Field notes

In addition to the nominal groups and small group interview, the researcher utilised field notes for subjective observations made during data collection. Polit and Beck (2017:521) explain that the concept of a field note traditionally referred to notes that provided a narrative account of "what was happening in the field". Field notes are, in fact, detailed notes that are made after data collection to capture the researcher's observations of activities and behaviour at the research site (Creswell & Creswell, 2018:213; Polit & Beck, 2017:521). Field notes add to the richness of research findings by providing contextual information, and further enhance trustworthiness (Phillippi & Lauderdale, 2017:381). Field notes could be descriptive and reflective in nature. Descriptive notes typically include factual encounters of occurrences, actions and dialogue, whereas reflective notes contain the researcher's personal narrative of feelings, experiences, assumptions and expectations (Polit & Beck, 2017:521-522).

Yin (2018:176) indicates that case study researchers' notes could be in various formats, for instance handwritten jottings, electronic notes, or audio or video recordings. It is important, however, to convert the notes into more formal writings as soon as possible (Grove & Gray, 2019:112; Polit & Beck, 2017:522; Yin, 2018:191). Although this may be a cumbersome process, Cohen *et al*. (2018:388) assert that writing offers the benefit of stimulating thought.

In this study, the researcher made handwritten notes immediately after each data collection session to record information whilst it was still fresh in the memory. On returning home, more detailed writings were made on computer. The notes included descriptions of behaviour, non-verbal communications and dialogue between participants, as well as any situations or distractions that could influence the data. In addition, the researcher's personal experiences, reflections and progress whilst conducting the data collection processes were noted. The reflective process of continious engagement with field notes enhanced the researcher's ability of self-awarenes which guarded against personal bias (Refer to section 4.3 for a discussion on the field notes.)

3.6 Data Analysis

In qualitative research, the researcher experiences the world from the viewpoints of the participants. Being "true to the participants" is an intricate and intellectual phase that is "the most important part of data analysis" (Sutton & Austin, 2015:8). Qualitative data analysis involves a process of inductive reasoning to organise, structure and derive meaning from the data (Polit & Beck, 2017:530, 535). In order to generate findings that transform raw data into new knowledge, the researcher must engage in active and demanding analytic processes throughout all phases of the study (Barrett & Twycross, 2018:63; Polit & Beck, 2017:530-531). The data collection and data analysis in qualitative studies, such as this one, often occur concurrently, which is challenging (Bazeley & Jackson, 2013:1, 3; Suter, 2012:346). Figure 3.1, taken from Creswell and Creswell (2018:218-219), is a visual representation of the steps generally followed in the process of qualitative data analysis.

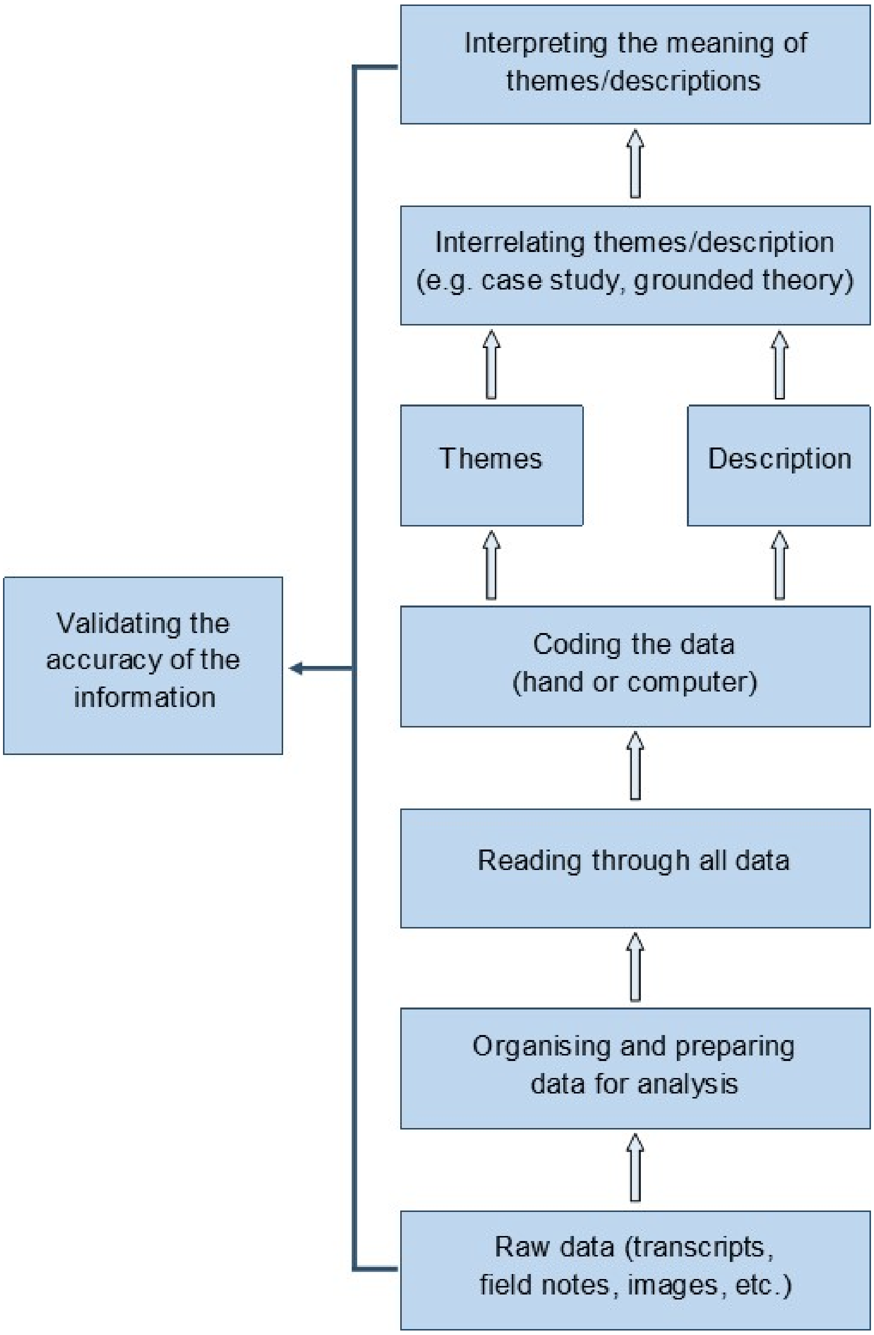


Figure 3.1: Qualitative data analysis process

Taken from Creswell and Creswell (2018:218-219)

The data collected from the nominal groups were transferred to electronic spreadsheets (refer to section 3.6.1). The audio recording from the small group interview was transcribed (refer to section 3.6.2). Group codes were assigned to each of the five individual data sets in order to organise the collected data. Nominal group data were coded C1, C2 and C3 with caregivers respectively and F for the family members. Data from the small group interview was coded RN. The researcher read through each data set several times, making summarising notes in the margin of the transcript, after which categories and sub-categories were identified. As the categories were identified, an underlying theme emerged. A comprehensive explanation of the categories and sub-categories and the emergent themes is presented in Chapter 4. The data sets from the nominal groups and small group interview were analysed separately and combined into one integrated list by following the steps suggested by Creswell and Creswell (2018:218-219) and Van Breda (2005:2-10), respectively. Interpretations of the meaning of the theme were made in triangulation with literature.

3.6.1 Nominal group data analysis

The NGT, as a consensus method, includes participants in data analysis (Olsen, 2019:2; Roets & Lubbe, 2015:152; Thier & Mason, 2018:1). The ideas generated during the nominal groups were prioritised and verified by the participants. To make sense of the data as a whole, the data from each group were individually coded, categorised and then combined (McMillan *et al.,* 2014:10, 13-14).

The process followed to separately analyse and then combine the nominal group data sets involved six of the seven steps described by Van Breda (2005:2-10), as follows:

Step 1 **– Capture data on computer**

Each data set, that is to say the listed items from each nominal group, was transferred to a spreadsheet (Table 3.9). The spreadsheet consisted of six columns, as suggested by Van Breda (2005:4). The researcher added an extra column before the average score column for the total score of each idea. The column headings were Column A – Group code; Column B – Category and sub-categories; Column C – Statement (participants' ideas); Column D – Scores; Column E – Total score; Column F – Average score; and Column G – Top 5. The visual layout of the spreadsheet can be seen in Table 3.9. (Also refer to Addendum E for the actual summary.)

Table 3.9: Spreadsheet for the capturing of nominal group data

Group code	Category and sub-categories	Statement	Scores	Total score	Average score	Top 5
e.g. C3	Learning need in broad terms • Descriptive information	Quotation captured on the flipchart	e.g. 5, 4, 6	15	5	3

Compiled from Van Breda (2005:4)

The group code, for example C1, was typed in Column A to indicate which of the four group's information was used. Column B was left blank to start off with. The categories that emerged were typed in later, next to the idea from which it was identified. In Column C, the ideas, from the list obtained from the participants during the nominal group, were typed in bold to distinguish them from the descriptions. The ideas that received a score from the group were inserted first. However, those that did not receive a score were listed beneath. These statements were not discarded, as they added to the understanding of the problem being addressed by the nominal group. In column D, the individual scores from each idea were typed as listed on the flipchart. Column E represented the total score of each idea. The total score was divided by the number of participants in the group to determine the average score, which was captured in Column F. Column G was left blank at that stage. The top five statements of each group were identified here later.

Step 2 **– Identifying the top five**

In this step, each group's set of statements was ordered according to the priority determined by the group. The data were sorted according to each group. In Column A, the group codes were typed starting with the group that was first interviewed followed by the rest in ascending order. The statements of each group were subsequently ordered and typed in Column C in ascending order according to their average scores as indicated in Column F. The five most important statements for each group were now identified by marking it in Column G.

Step 3 – Content analysis of the data

Content analysis enabled the researcher to combine individual ideas into groups with similar suggestions. As the researcher read through the list of ideas several times, categories and sub-categories began to emerge. These categories and sub-categories were listed and numbered on a separate sheet of paper as it represented the issues that the groups had raised in response to the question that was posed. The individual ideas were categorised according to the list, reducing the many specific ideas, which made the data more interpretable. The categories on the list were distinct and mutually exclusive, enabling each idea to fall meaningfully into one and only one category. The ideas on the spreadsheet were now sorted according to the categories and sub-categories noted in Column B.

Step 4 – Confirmation of the content analysis (optional)

Although Van Breda (2005:7) indicates that confirmation of content analysis is optional, the supervisor and co-supervisor of this study who has expertise in NGTs could increase the trustworthiness of the content analysis. The content analysis was presented to the researcher's study supervisor and co-supervisor to check if the categories and sub-categories made sense and the placement of the ideas were correct. Trustworthiness of the data analysis was therefore enhanced. Co-checking ensured confirmability and prevented potential researcher bias.

After completion of the first four steps, a new spreadsheet was created for the following steps to combine the data in one consolidated list.

Step 5 – Calculation of the combined ranks

Using the spreadsheet created in Step 1, the top five ideas in ascending order from each group, with their individual scores, as well as total scores and average scores, were typed on a new spreadsheet. Two extra columns were added for category and final rank, as visually represented in Table 3.10 (the template). The average score incorporated all the ideas from the highest to the lowest scores for all groups irrespective of group size. The combination of these four scores into the final ranks provided a holistic and multidimensional consolidation of the many ideas generated and ranked by the participants. The relative importance of each category to all the groups combined was determined during this step without compromising the participants' perspectives.

Table 3.10: Calculation of the combined ranks (template)

Top five	Individual scores	Total score	Average score	Category	Final rank

Step 6 – Comparison of demographic groups (optional – omitted)

This step involves the ranking and relative importance of the categories for each of the demographic groups, such as gender, race and socioeconomic status. Van Breda (2005:10), however, indicates that this step too is optional. The researcher chose not to make a demographic comparison.

Step 7 – Reporting of the NGT data

This step related to the dissemination of the findings to the participants and stakeholders and on relevant academic platforms. The findings of this analysis are discussed in Chapter 4 and the conclusions drawn from the research are presented in Chapter 5.

3.6.2 Small group interview data analysis

The process indicated in Figure 3.1 was followed in the analysis of the small group interview data. *Raw data* in the form of an audio recording of the interview were transcribed verbatim to *prepare the data for analysis*. The transcription was done by the researcher herself to enhance immersion in the data (Grove & Gray, 2019:574). Audible sounds such as coughing, laughing, hesitation or background noises were indicated (Grove & Gray, 2019:116). To ensure the accuracy of the transcription, the researcher listened to the recording over and over to ensure that she had heard and transcribed correctly. On completion of the transcript, the researcher listened to the recording again and checked the transcript line for line, as recommended by Grove and Gray (2019:109, 116). This was an important step in preparing for data analysis. The transcript was kept in Afrikaans, but quotations taken from the transcript were translated into English. As a measure to address rigour, the researcher in accordance with her study supervisor and co-supervisor ensured that translation was accurate. The original statements are included with the English translations in Chapter 4.

The researcher read and re-read the transcribed data carefully and deliberately in search of meaning and understanding to “dwell with the data” (Grove & Gray, 570; Polit & Beck, 2017:530-531). In this process of fitting data together and making links, data were organised as the researcher became familiar with the data categories that emerged as a result of inductive reasoning (Savin-Baden & Howell Major, 2013:63; Polit & Beck, 2017:530, 535). Categories were highlighted with quotations from the transcript to recognise and merge similar information, thus avoiding duplication. Categories and sub-categories that emerged were tabulated (Addendum F) to simplify grouping with the categories and sub-categories from the combined list of nominal group data, resulting in a single consolidated list of categories and sub-categories.

All the data collected during the multiple nominal groups and small group interview were accounted for in this single integrated list. The traditional manual methods of organising the data were used (Polit & Beck, 2017:533; Saldaña, 2016). With data triangulation and transferability, bias affecting data analysis was minimised. Analytic and critical thinking skills of the researcher played a significant role in the data analysis process. A comprehensive description of the data analysis process is set out in Chapter 4.

3.7 Role of the Researcher

As mentioned in section 1.12, the researcher was positioned as an insider-researcher because she belonged to the same group and community as the participants (Greene, 2014:1; Ross, 2017:326). The researcher was employed as an RN at one of the residential care facilities and lived in the Siyancuma Local Municipal sub-district. Researchers could be either total or partial insiders, depending on the extent of their involvement (Ross, 2017:326). Her detachment from the other residential care facilities and her thus being a member of a segment only of the social group being studied made the researcher of this study a partial insider.

Insider-researchers have advantages over other researchers (Berger, 2015:222-223; Greene, 2014:3-4). Their pre-existing knowledge regarding the environment and the participants allows for easy access to both. Furthermore, contextual insight gives the researcher “a head start in knowing about the topic” (Berger, 2015:223). Familiarity with the social group or society being researched allows for a more relaxed, natural interaction without passing judgement (Heslop *et al.,* 2018:2; Greene, 2014:3). The same factors, however, present challenges.

Pre-existing relationship between researcher and participants could have an influence on discussions regarding sensitive topics or could lead to misunderstandings (Saidin & Yaacob, 2017:850). Participants may be more reserved and cautious about sharing sensitive information. The researcher’s view could also cloud her judgement, preventing her from understanding the participants’ perspectives. Familiarity with the research context could consequently introduce bias (Heslop *et al.,* 2018:2; Ross, 2017:327). Loss of objectivity and researcher bias could negatively impact not only the researcher’s perceptions but also data analysis and the reporting of findings (Barrett *et al.*, 2020; Greene, 2014:4-5; Palaganas *et al.*, 2017:426-427; Polit & Beck, 2017:161).

The mentioned disadvantages of insider-research is a reality, especially in small rural communities. These close-knit communities face methodological issues regarding where the participants and researcher stand in relation to each other, and ethical difficulties such as “overlapping relationships and role duality” (Greene, 2014:1; Heslop *et al.*, 2018:2). Membership of the same social groups, as well as social divides, introduces an ethical dilemma. This is where the complex issue of power imbalance between the researcher and the participants could emerge and have a negative effect on the research relationship and process (Berger, 2015:221; Greene, 2014:6-7; Raheim *et al.,* 2016:1-2). Power imbalance was a factor in this study, considering that the researcher worked in a supervisory capacity in relation to a third of the caregivers who participated. Emotional implications for the researcher as well as the participants could therefore influence the research process in its entirety (Ross, 2017:327). For this reason, measures were taken to address ethical issues arising and to enhance the trustworthiness of the study. These are discussed in sections 3.8 and 3.9.

3.8 Ethical Considerations

Before the onset of data collection, ethical clearance and the necessary gatekeeper permission were sought. (Refer to section 1.13 as well as Addenda A, B and C for more information.) An augmentation view to ethics was taken by incorporating both a principle- and virtue-based approach (Resnik, 2012:335). The principle-based approach incorporated the three broad principles described in the *Belmont Report*, namely beneficence, respect for human dignity and justice (Grove & Gray, 2019:134; Polit & Beck 2017:139). In addition, the researcher chose to live certain virtues to guide her ethical decision-making. Potential threats in qualitative research are often difficult to see, thus making an augmentation view to ethics appropriate to deal with such issues (Resnik, 2012:335). Figure 3.2 represents a visual of the ethical principles considered in this study.

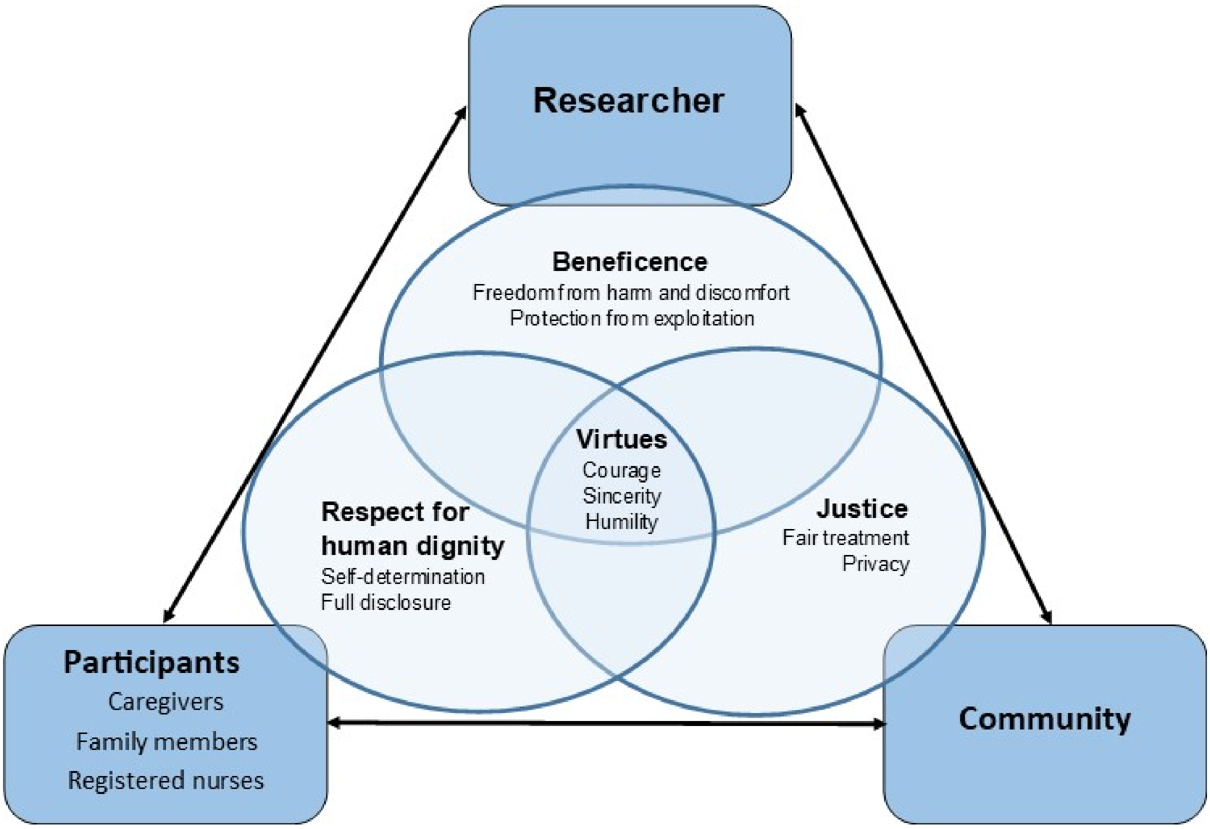


Figure 3.2: Ethical Considerations of this research

Compiled from Botma *et al.* (2010:1-2); Macfarlane (2010:24-25); Polit and Beck (2017:139-142)

The figure incorporates various conceptualisations regarding research ethics. The outer edge of the research triad, consisting of the researcher, the participants and the community, as described by Botma *et al*. (2010:2), forms a frame. Enclosed within the frame are the components of the augmentation view to ethics that applied to this research. The three components of the triad are all inter-related and influenced by the ethical principles of beneficence, respect for human dignity and justice (Polit & Beck, 2017:139-142). In the centre, the selected virtues form the core of the figure, representing the character-driven nature of virtue-based ethics (Morris & Morris, 2016:202; Resnik, 2012:333-334). The virtues describe the characteristics of the people involved and not the principles or rules they follow (Macfarlane, 2010:24-25). For the purposes of this research, the virtues of courage, sincerity and humility applied.

3.8.1 Principle-based ethics

The principle-based approach provides guidance with regard to ethical decision-making by following prescribed rules for behaviour and specific rules for duties, rights and responsibilities (Resnik, 2012:330). These rules form the foundation for the three fundamental ethical principles as set out in the *Belmont Report*, namely beneficence, respect for human dignity and justice (Grove & Gray, 20189:134; Polit & Beck, 2017:139-142; Vanclay *et al.*, 2013). Each principle protects two human rights, as portrayed in Table 3.11.

Table 3.11: Application of Belmont principles in the study

PRINCIPLE	ANTICIPATED RISKS
BENEFICENCE	
Freedom from harm and discomfort	• Emotional harm, for example stress and fear • Social harm, for example stigma and work-related consequences
Protection from exploitation	• Power imbalance
RESPECT FOR HUMAN DIGNITY	
Self-determination	• Prejudicial treatment/bias • Coercion
Full disclosure	• Deception
JUSTICE	
Fair treatment	• Imposition
Privacy	• Intrusion

Compiled from Polit and Beck (2017:139-142)

The researcher adhered to the Belmont principles in an attempt to protect the participants from the risks that could occur were their rights not protected. Various measures were taken to address the anticipated risks and, often, the same measures address more than one possible dilemma.

3.8.1.1 Beneficence

This principle motivates the researcher to "maximise the benefits" or to do good and "minimise harm" (Polit & Beck, 2017:139). This principle includes *the right to freedom from harm and discomfort*, as well as *the right to protection from exploitation* to protect the rights of the participants (Kalu, 2018:98; Ross, 2017:327; Smith & Noble, 2014:3).

The researcher had a responsibility to protect participants against physical and emotional harm (Polit & Beck, 2017:139). Furthermore, the participants should be protected against any social and/or financial harm (Polit & Beck, 2017:139). Participants were not exposed to financial harm because no costs were incurred for transport. Group sessions were arranged at times when the participants were in the vicinity of the residential care facilities. Physical discomfort was prevented during the data collection session by giving participants a refreshment break. Negotiated time limits were respected.

There was a risk of emotional harm because participants, and the caregivers in particular, could feel anxious or stressed about sharing information that could hold negative consequences for them. Living in a small community further contributed to the risk of stigmatisation if they should share sensitive information. The risk of exploitation was exacerbated by the power imbalance that existed in that the researcher is a registered nurse who worked at one of the facilities.

Participation was voluntary and confidentiality was pledged amongst all those who were involved in the research. The researcher did not wear a uniform during the data collection sessions and built rapport with the participants to create a relaxed atmosphere and minimise the power imbalance. During the nominal groups, participants were given an equal voice and the verified recording of each contribution on the flipchart conveyed the message that they were taken seriously.

3.8.1.2 Respect for human dignity

Respect for human dignity includes *the right to self-determination* and *the right to full disclosure* (Polit & Beck, 2017:140-141; Vanclay *et al.*, 2013:245, 246-248). Humans are considered to be autonomous; therefore, participants have the right to decide whether or not to partake in research without fear or risk of being penalised for their decision (Vanclay *et al.*, 2013:247).

All persons who met the inclusion criteria were invited to participate to eliminate the risk of prejudicial treatment. Coercion was avoided by not offering a stipend or informing participants beforehand of the availability of refreshments. Gatekeepers were used to inform the caregivers and contact family members during the process of recruiting potential participants. Participation was voluntary and prospective participants could ask questions before deciding to partake. Informed consent was obtained, which included full information of the study in accordance with the guidelines provided by the HSREC (UFS, 2019:17-18). Participants could determine the extent to which they were willing to share information and could withdraw at any time without any negative consequences.

3.8.1.3 Justice

The participants' *rights to fair treatment* and *privacy* conclude the three principles of the *Belmont Report*. Selection of participants was fair and persons had the right to decline participation. Justice was further addressed by treating all the participants equally and respecting their privacy. They were made aware of their right to withdraw from the study without negative consequences. There was no discrimination regarding age, gender, race, religion or language and all the participants could benefit equally from the research. Participants were under no obligation to disclose any information that made them feel uncomfortable. The researcher was respectfull and did not pry so as to protect their privacy. The researcher maintained a professional stance.

Due to the face-to-face interactions with the researcher during the nominal groups and group interview, participation could not be anonymous. The researcher, however, assured participants that the information they provide would be kept confidential with only research staff having access to it. The nominal group data were captured on the flipchart and only the researcher could possibly connect statements to the participants. The transcribed small group data contained no names. Data sets were coded according to the different groups (refer to section 3.6), thus ensuring that none of the information could be linked back to the participants.

3.8.2 Virtue-based ethics

The virtue-based approach does not focus on rules and ethical principles, but on the development of good personality qualities. Humans are capable of rational thoughts and actions and in order to be a good person, one must perform human functions to the best of their ability (Resnik, 2012:334).

Within this study, the virtue-based ethics did not replace the principle-based ethics. The two approaches supplemented each other in that the researcher was guided to "act morally by practicing virtue and following rules" (Resnik, 2012:335). Although Macfarlane (2010:24) only discusses six virtues, namely courage, respectfulness, resoluteness, sincerity, humility and reflexivity, for guidance in decision-making, several other virtues could be added to the list. The researcher chose to live the virtues of courage, sincerity and humility. It took *courage* to engage in critical self-reflection, disclose what went wrong during the research and to correct mistakes. By providing an accurate portrayal of events and findings, the researcher was guided by *sincerity*. The researcher tried to be *humble* by acknowledging her indebtedness to others, crediting academic and other sources of information, engaging in reflexivity and endeavouring to be open to critique.

3.8.3 Benefit/risk ratio

Researchers usually conduct a benefit/risk assessment prior to the study to evaluate the anticipated benefits and costs or risks. Cost does not only relate to the financial aspects of the study, but also to the potential physical, emotional and social effects on participants (Brink *et al.*, 2018:36; Polit & Beck, 2017:142). Any research holds benefits as well as risks to participants, but these factors vary and depend on the study (Arifin, 2018:30; Polit & Beck, 2017:143). The benefits should outweigh the risks (Botma *et al*., 2010:10; UFS, 2019:31). In this research, the benefit/risk assessment was done based on the ethical principle of beneficence, in accordance with literature, as well as the guidelines of the HSREC (Polit and Beck, 2017:142-143; Siegle, 2020; UFS, 2019:31).

The caregivers could benefit from a tailor-made training programme flowing from the research, as indicated in sections 1.4 and 5.6.1. Caregiver participants were also granted a voice to express their learning needs, thus countering imposition. All of the participants were open to the idea of having an opportunity to expand their knowledge regarding the care of older persons by hearing the perspectives of others.

The assessment indicated that the research involved minimal risk to the participants, which was mainly of a personal and social nature. In addressing the risks, particular consideration was given to the caregivers because they were more susceptible due to their socio-economic standing and the power imbalance that existed.

Emotional distress as a result of the power imbalance (refer to section 3.7) could lead to stress and fear from disclosing information that might have repercussions. The caregiver-family member interactions are not always positive, which could have led to the caregivers fearing that inappropriate and untrue statements regarding them and the care they provide could surface during the session with the family members. The stigma and socio-economic status associated with caregiving could consequently result in social harm.

To address these potential risks, the researcher continuously monitored the benefit/risk ratio throughout the study to prevent participants from exposure to unnecessary and unforeseen risks. The issue of emotional distress was addressed through the open and approachable attitude of the researcher to counter power imbalance and enable the caregivers to have the willingness and courage to share information. Participants' fear of being discussed by others after the data collection sessions was countered by including a confidentiality agreement. Discussions were focussed on the research question to avoid derailment. The risk for physical harm was minimal as the participants were given a comfort break during the data collection sessions. Discomfort brought by a loss of time remained as participants had to commute to the research site and sacrifice their personal time.

3.8.4 Informed consent

Obtaining consent plays an important part in conducting ethical research and protecting the participants (Arifin, 2018:30; Siegle, 2020). The consent forms had all the requirements as set out in literature and the HSREC guidelines (UFS, 2019:17-18). The information leaflets were phrased differently for each of the participating groups, namely caregivers, family members of residents and RNs. The reading level of language for the caregivers and family members was pitched at Grade 8, as indicated in the HSREC guidelines (UFS, 2019:10). (Refer to Addendum C for the respective consent forms.) The language used in the care facilities are Afrikaans and English and therefore the consent forms were available in both languages.

The preparation phase preceding obtaining consent, as explained in section 3.5.2.2, were followed. A detailed explanation of the purpose of the study was provided to the participants at the onset of each of the data collection sessions. The researcher then handed out the consent forms and allowed ample time for the participants to read through it and ask questions regarding uncertainties. The consent forms were combined with an information leaflet. Participants signed the consent forms voluntarily and kept the information leaflet. Data collection started after receiving the signed consent forms. The consent forms were stored with the raw data, as described in section 3.5.2.4.

3.9 Rigour of the Study

In qualitative studies, rigour of the study is often pursued by means of trustworthiness, where the researcher implements various strategies to ensure that the study findings are credible, dependable, confirmable, transferable and authentic (Brink *et al.*, 2018:158; Connelly, 2016; Noble & Smith, 2015; Polit & Beck, 2017:559-560). The measures taken to ensure trustworthiness are set out in Table 3.12.

Table 3.12: Trustworthiness in the study

CRITERION FOR TRUSTWORTHINESS	APPLICATION IN THIS STUDY
Credibility Confidence in the truth of the data and interpretations	*Proficiency of the researcher* – Researcher is skilled in the facilitation of nominal and small group interviews as it formed part of formal training received. *Prolonged engagement* – Researcher was a partial insider and remained in contact with the participants during and after the study. *Observation* – Field notes were kept to enrich data analysis. *Triangulation* – Data, method, person and space triangulation. *Member checking* – Participants were involved in data reduction, validation and saturation, as well as voting on priorities during the nominal groups. *Self-disclosure* – Personal beliefs, biases and feelings about the research topic and context were addressed by being reflexive throughout.
Dependability Stability of data over time and conditions	*Similarity of process* – Structured nature of the NGT and use of the same question to the three groups of caregivers assured consistency during the data collection process. *Thick and dense description* – Accurate portrayal of the processes followed.
Confirmability Objectivity or neutrality of the data	*Member checking* – Participants confirmed data and voted on priorities during the nominal groups, thus reducing possible misrepresentation and misinterpretation by the researcher. *Confirmability audit* – Audio recording of the small group interview and raw data recorded on flipcharts serve as evidence of accurate reporting of data. *Investigator triangulation* – Study supervisors co-checked transfer of data to electronic spreadsheets and data analysis to confirm the accuracy of reporting.
Transferability Applicability in other contexts	*Thick and dense description* – Rich and thorough description of the research process, the participants and their contexts enables replication of the study in other contexts and makes it possible for readers to judge the extent to which interpretations apply within their contexts.
Authenticity Fairness and faithfulness of presented realities	*Mindful construction* – Research questions received thorough consideration to ensure accurate application to the different groups of participants whilst retaining the core of the main research question. *Reflexivity* – The researcher remained critically self-reflective throughout the research process. *Presentation of data* – Verbatim quotations that convey the feeling and tone of the participants' responses were used.

Compiled from McInnes *et al.* (2017:9-16); Polit and Beck (2017:559-560)

An explanation and application of each of the five criteria of trustworthiness, as summarised in the table, are discussed in the sub-sections that follow.

3.9.1 Credibility

Research is credible when the reader is confident that the presented data and findings are a truthful reflection of the participants' views (Grove & Gray, 2019:449). In this research, the proficiency of the researcher, prolonged engagement, observation, various forms of triangulation and member checking contributed to achieving credibility.

The *researcher is proficient* in facilitating a nominal group, having received formal training and experience during a nursing education module that was completed in 2017. Similar facilitation skills were used during the small group interview, as described in section 3.5.1.2. Furthermore, *member checking* is built into the NGT process, where participants were continuously asked to verify the capturing of their contributions and where they were involved in the reduction, saturation and prioritising of data.

Prolonged engagement with the participants as a partial insider-researcher further contributed to the researcher's credibility by ensuring that the participants' meanings were understood (Connelly, 2016; Polit & Beck, 2017:561). The *persistent observation* of non-verbal expressions was applied during data collection by use of field notes and the audio recording with a verbatim transcription of the small group interview (Cohen *et al.,* 2018:249).

Triangulation, where multiple referents are used to draw conclusions, enabled the researcher to address the intrinsic bias that could arise from single methods, single theory and single observer (McInnes *et al.*, 2017:9-10; Polit & Beck, 2017:563-564). Polit and Beck (2017:563-564) elaborate on the different forms of triangulation, which were applied as follows:

- *Data and method triangulation* contributed to a more complete and contextualised portrait of the learning needs of the caregivers. This was done through the involvement of multiple sources of data (three sets of caregivers, as well as family members and RNs) and different methods (nominal groups and a small group interview).

- *Person triangulation* was employed, where different types or levels of individuals participated and brought different perspectives from that of only family members, RNs or the caregivers themselves.
- *Space triangulation* involved data being collected at three different care facilities in different locations and at different times.

The researcher also made use of the triangulation of literature in the interpretation of data.

3.9.2 Dependability

Accurate recording of the research process accounts for dependability. Steps taken and decisions made during data analysis provided evidence of consistency over time (Cohen *et al., 2*018:268; Grove & Gray, 2019:449). In this research, similar process and a thick description enhance dependability.

The structured nature of the NGT provided consistency and ensured that the data collection *process remained similar* for all of the groups of participants, with the exception of the RNs, with whom a small group interview was held (Boddy, 2012:10; Grove & Gray, 2019:110; Miller, 2020; Polit & Beck, 2017:511). Dependability was further supported by posing the same question to the different groups of caregivers. A *thick and dense description* applies because the context of the study, the research process and findings are richly and thoroughly described (Botma *et al.*, 2010:232; Cohen *et al*., 2018:250; Polit & Beck, 2017:569).

3.9.3 Confirmability

Confirmability makes provision for other researchers to review the data and research findings to determine the extent to which an accurate portrayal of the participants' contributions is presented (Brink *et al*., 2018:159; Grove & Gray, 2019:449). Member checking and an investigator triangulation were applied and a confirmability audit is possible to assure the confirmability of the research findings.

The use of the NGT, once again, contributed to trustworthiness by enhancing confirmability. This is because the participants were essentially engaged in *member checking* throughout the respective sessions. Member checking was done more discreetly through deliberate probing during the small group interview to ensure that the participants' meanings were understood correctly (Botma *et al.*, 2010:231-232; McInnes *et al.*, 2017:15-16; Polit & Beck, 2017:564-565).

A *confirmability audit*, where an external auditor scrutinises the data and any supporting documentation, can be performed, if necessary. The audio recording and transcription of the small group interview and the raw data recorded on flipcharts during the nominal groups serve as evidence of accurate reporting of data. *Investigator triangulation* was performed by the supervisors of this study, who co-checked transfer of data to electronic spreadsheets and participated in data analysis to confirm the accuracy of reporting.

3.9.4 Transferability

Transferability is compared to generalisability in quantitative research, but relates to the transfer of qualitative findings to other contexts (Polit & Beck, 2017:747). A *thick and dense description*, as described in section 3.9.2, will make it possible for other researchers to replicate the study in other contexts. Readers will also be better equipped to decide to which extent interpretations apply to the learning needs of caregivers within their contexts.

3.9.5 Authenticity

To achieve authenticity, a researcher should fairly and faithfully present a range of realities throughout the research process (Brink *et al*., 2018:160). Polit and Beck (2017:560) add that a reader's attention is drawn to the lives of the participants when researchers provide engaging descriptions, including the feelings, experiences, language and context of the participants. Such descriptions would enable the readers of this dissertation to put themselves in the shoes of the caregivers and develop a heightened sensitivity to their predicament, as well as that of the family members, RNs and residential facilities included in the study. This was of exceptional importance in light of the power imbalance that was identified. The researcher therefore made a conscious effort to be authentic through mindful construction, reflexivity and an accurate presentation of the data.

Mindful construction was applied by giving thorough consideration to the phrasing of the questions posed to the various groups of participants. It was important to ensure that the questions were phrased in a way that made sense to the particular group of participants whilst retaining the core of the main research question (Brink *et al.*, 2018:141). In accordance with the guidelines of the HSREC, the choice of language was simple, clear and pitched at a Grade 8 reading level (UFS, 2019:10). The researcher was *reflexive* by engaging in critical self-reflection throughout the research process. In the *presentation of the data,* the information captured on the flipcharts during the nominal groups and the verbatim quotations of the RNs, which convey the feeling and tone of their responses, are included.

3.10 Summary

In response to the explanation of the context of the caregivers working at residential care facilities for older persons provided in the previous chapter, a summary is provided of the research methodology that ensued from the research question:

> What are the learning needs of caregivers of older persons in residential care facilities in two sub-districts of the Northern Cape province?

The most appropriate paradigm and design for a thorough exploration of the caregivers' learning needs were explained. A thorough description of the research approach and methods, including the benefits and limitations of each, was provided. Readers were introduced to the participants through an exposition of the population and units of analysis in the specific local municipalities. The processes of data collection and analysis, as well as ethical considerations, role of the researcher and the methods to ensure rigour of the study were presented to provide the reader with the contentment of a well-planned and -executed study.

CHAPTER 4
Data analysis and findings

CHAPTER 4
DATA ANALYSIS AND FINDINGS

> "Tell me and I forget. Teach me and I remember. Involve me and I learn."
> Benjamin Franklin

4.1 Introduction

Having received ethical clearance and the necessary gatekeeper permission, the researcher explored the learning needs of caregivers caring for older persons at residential care facilities in two sub-districts of the Northern Cape province. The participation of five groups of participants brought a variety of perspectives to enrich the data and facilitate a deeper understanding of the research phenomenon. In accordance with Benjamin Franklin, the researcher believes that involving the caregivers in identifying their learning needs would strengthen their learning (School of Education, 2018). To ensure that relevant data were elicited, the research question was adjusted to relate to the respective groups of participants as explained in section 3.5.2.3. The questions posed to caregivers, family members of residents and the RNs, respectively, were:

> What do you need to learn about caring for an older person? (Caregivers)
>
> What should caregivers learn about caring for your loved one? (Family members)
>
> What should caregivers learn about caring for older persons, including those with neurocognitive disorders, in a residential care facility? (RNs)

In this chapter the findings forthflowing from the content analysis of the data were discussed.

The context is put into perspective by presenting information about the participants together with the field notes made in response to the four nominal groups and small group interview. Thereafter, the factual conclusions flowing forth from the analysis of the various data sets are extrapolated through an integrated discussion of the categories and sub-categories in triangulation with literature. The chapter concludes with the relation of the emergent theme and sub-themes.

4.2 Contextual Information about the Participants

More detailed personal information was obtained from the participants before each data collection session by use of a demographic sheet that was handed to them on receipt of their written informed consent (refer to section 3.5.2.2). Creswell and Creswell (2018:183) describe the demographic characteristics of participants to include aspects such as gender, age and ethnicity.

In this study, the researcher wanted to determine whether the participating caregivers met the inclusion criteria by enquiring about their years of work experience with older persons in a residential care facility, as indicated in sections 1.8 and 3.4.1. The highest level of education was requested as a point of comparison to literature (sections 1.5 and 2.4.2). In addition, gender, age and race were noted for the sake of interest. Their language preference was confirmed for purposes of the facilitation of the nominal groups.

The contextual information about the participants is set out in Table 4.1, which also reflects the composition of the unit of analysis (n = 39). The participants included caregivers (n = 25), family members of residents (n = 11) and RNs (n = 3) from the three residential care facilities in the two mentioned sub-districts. (Refer to Table 3.3 in section 3.4 for a detailed description of the data-rich sources of the research.)

Table 4.1: Contextual information of participants (n = 39)

Group of participants	Caregivers	RNs	Family members	Total
GENDER				
Male	0	0	1	1
Female	25	3	10	38
AGE				
18 – 24	2	0	0	2
25 – 34	8	2	0	10
35 – 44	12	0	0	12
45 – 54	3	0	1	4
55 – 64	0	0	7	7
65 years and older	0	1	3	4
RACE				
White	0	2	11	13
Mixed race	25	1	0	26
Other	0	0	0	0
HOME LANGUAGE				
Afrikaans	25	3	11	39
YEARS OF WORK EXPERIENCE WITH AN OLDER PERSON AT A RESIDENTIAL CARE FACILITY				
one year or more	2	N/A	N/A	2
1 – 5 years	13			13
5 – 10 years	7			7
10 – 20 years	1			1
> 20 years	2			2
HIGHEST LEVEL OF EDUCATION				
Grade 10	19	N/A	N/A	19
Grade 11	0			0
Grade 12	6			6
Further training	0			0
Higher education	0			0

The female participants (38) outnumbered the male participants by far, with only one male participant in the nominal group for family members. Most of the participants fell in the “younger” age categories, with 10 caregivers and two of the RNs being younger than 35 years of age and a further 12 caregivers being between 35 and 45 years of age. All 25 caregivers were aged 54 years or younger, whilst all of the family members and one of the RNs were aged 45 years and above. More than half of the participants were mixed race. All of the caregivers and one of the RNs belonged to this racial group, whilst all of the family members who participated were white. The home language of all the participants was Afrikaans. The highest level of education and years of work experience with older persons at a residential care facility were only applicable to the caregivers. Nineteen (19) caregivers indicated their highest level of education was Grade 10. Only six of them had successfully completed Grade 12 and none of these participants had received general/further or higher education. All the caregivers had had one year or more work experience with older persons at a residential care facility and two of them had been employed at one of the facilities for 25 and 28 years, respectively. These two had spent their entire working life at the particular residential care facility.

4.3 Field Notes

The researcher's field notes relating to the participants' non-verbal communication served to augment their verbalised experiences, emotions and feelings (Phillippi & Lauderdale, 2017:381; Polit & Beck, 2017:521). Observations were captured at the end of each of the sessions whilst still fresh in the memory. These field notes are discussed according to the data collection techniques that were employed.

4.3.1 Field notes for nominal groups

Data collection sessions were conducted as set out in sections 1.10.1, 3.5.1 and 3.5.2 and Table 3.4. The researcher did not wear her uniform and introduced herself by her first name to minimise the power imbalance and ensure fruitful participation (refer to section 3.5.2.2). Caregivers who worked with her, however, preferred to call her by her surname. All of the participants were addressed by their first names.

On inviting questions from the participants, the same question or concern regarding the study surfaced at each of the three groups of caregivers. Some of these participants were under the impression that these sessions were some sort of test. They were concerned about their performance and how it would affect their employment. The researcher welcomed the questions and to alleviate any anxiety or nervousness, she explained that there were no incorrect or irrelevant answers. No one was there to judge another person and the session was not about testing knowledge, but rather about generating ideas resulting from their personal experiences. She patiently referred them back to the information leaflet and consent form, which noted that their participation was voluntary and that there would be no negative effects on sharing any sensitive information. Any information shared would be kept confidential and nobody, including their supervisors at work, would be informed about what had transpired in the session. Their employment would therefore not be affected in a negative way. (Refer to Addendum C for a copy of the information leaflet and consent form.) This explanation and the reassurance from the researcher put them at ease and they were more relaxed and enthusiastic to continue with the session. The researcher did, however, sense an atmosphere of resistance with one of groups of caregivers who were not known to her. However, during the course of the nominal group process, when they could freely share and discuss their views, the tension lifted. (A more elaborate description follows in section 5.5.)

In facilitating the sessions, the researcher ensured consistency of the process amongst the groups. The researcher encouraged the participants to give careful thought to the question that would be asked and to be honest and open with their inputs. None of the participants had enquiries or difficulty in understanding the question posed to their respective groups and immediately started making notes. It took an average of five to ten minutes for each of the groups to generate ideas during the time of silence.

Gentle guidance was offered during the various steps of the nominal group process. When, for example, some of the participants gave more than one suggestion with the first round of the round-robin, they were reminded to mark the additional idea and offer it with the next round of sharing. Reassurance was given that each suggestion was valuable and that they should remember to share it when the next opportunity arose. During the nominal group with family members, one of the participants had grievances about unrelated matters. The researcher assured the participant that these grievances had value and could be addressed more appropriately at a board meeting. She offered to meet with the participant after the nominal group session to discuss the problems and try to resolve it. The participant was satisfied with the arrangement and the discussion continued without further interruption. By attempting to correct the participants in a non-offensive way, the power imbalance was further addressed.

During the short break, the participants engaged in spontaneous conversation whilst enjoying the refreshments provided. The voting continued on reassembly of the groups and when the results were confirmed, the participants expressed their surprise at the fact that others had voted for similar statements. This served as confirmation to them that their ideas were relevant. Furthermore, the fact that the caregivers were able to independently provide a prioritised list of learning needs confirmed their ability to make a positive contribution. The participants' responses confirmed literature that participants experience a sense of satisfaction on completion of the NGT (Boddy, 2012:10; McMillan *et al*., 2016:657; Olsen, 2019:2; Roets & Lubbe, 2015:152; Van Jaarsveldt & Ndeya-Ndereya, 2013:3-4).

After completion of the nominal group when the researcher thanked the participants, some responded that they had enjoyed the session and discovered that it was unnecessary to be nervous. As promised, she met with the participant to discuss the complaints and problems mentioned during the nominal group. The issues raised were brought to the attention of the relevant authorities during a board meeting without disclosing the source and the concerns were addressed.

4.3.2 Field notes for small group interview

Logistical arrangements for the small group interview were similar to that of the nominal groups (refer to section 3.5.2.2). The researcher invited one of the participants, who did not reside in the town where the small group discussion was conducted, to travel with her so as not to incur additional costs. Upon arrival at the research site, we were informed that the session had to be postponed for an hour because a memorial service of one of the residents was being held at the facility. The other two RN participants attended the service and the researcher felt that it was important to include them in the interview. The researcher assured them that it would be in order and the session commenced as soon as they were ready. Their participation was not negatively affected and the small group interview proceeded as planned.

This group of participants was more comfortable with sharing their experiences, in spite of the audio recording, which could have inhibited participation. As tea was served to the attendees of the funeral across the hall from the room where the session was in progress, the researcher was concerned that the group would be disrupted. Participation was, however, not affected, because the participants were not distracted. Nevertheless, the researcher found it personally distracting and needed to exert extra effort to remain engaged.

On two occasions, the researcher had to remind the participants to focus on answering the research question. The older RN often became side-tracked and wanted to share anecdotes of past personal experiences. Taking care not to offend the participant, the researcher kindly reminded her that although her experiences sounded very interesting, there was a time limit to the session. She offered to meet with the participant after completion of the interview to hear more about her experiences. The offer was accepted and the discussion continued without further disruption. After the session, the researcher met with the participant and an interesting conversation followed. It was confirmed that these experiences did not relate to the question posed for the study.

4.4 Data Analysis

On conclusion of data collection, the content of the flipchart and tally sheets of the respective nominal groups was transferred to electronic data sheets, as presented in Addendum D, together with the priorities indicated by each of the nominal groups. The four data sets were then analysed and combined according to six of the seven steps as described by Van Breda (2005:2-10), as explained in section 3.6.1. (The spreadsheet containing the categories and sub-categories from the analysis is included in Addendum E.)

A verbatim transcription of the audio recording from the small group interview enabled the researcher to organise this data as discussed in section 3.6.2. as indicated in Addendum F. After individual analysis, seven categories with sub-categories identified from the nominal groups and the small group interview were consolidated. The integrated categories and sub-categories are clarified in Table 4.2.

Table 4.2: Categories and sub-categories of the identified learning needs

Category	Sub-categories	Group of origin
Basic nursing skills	- Clinical skills - Interpersonal skills - Responding to emergencies	C1, C2, C3, F and RN
Hygiene	- General hygiene, infection control and cross contamination - Personal and older persons	F and RN
Alzheimer's disease	- Stages of the disease - Caring for an older person who has Alzheimer's disease	C1, C2, C3, F and RN
Medication	- Knowledge – actions/interactions of medication - Administration of medication	C1, C2, C3, F and RN
Communication	- Amongst staff members, authority figures and older persons - Conflict management and prevention - Reporting	C1, C3, F and RN
Rights and responsibilities	- Human rights - Responsibilities	C1, C2, C3, F and RN
Staff monitoring and evaluation	- Orientation and in-service training	C1, C2, C3, F and RN

Column C indicates the origin of the data by means of codes assigned to each of the groups. The caregiver groups were coded C1, C2 and C3, respectively; the family members as F and the small group with the RNs was coded RN. The main categories of learning needs related to basic nursing skills, hygiene, Alzheimer's disease, medication, communication, rights and responsibilities, as well as staff monitoring and evaluation. There were overlaps of some of the categories and/or sub-categories, which are indicated in the discussion.

4.5 Findings

The findings are discussed supported with statements listed during the nominal groups and quotations from the transcription of the small group interview. To distinguish between the origins of the evidence, the assigned group codes family (C1, C2, C3, F or RN) are added. (Triangulation with literature includes cross referencing to Chapter 2.)

4.5.1 Basic nursing skills

All three groups of caregivers (C1 – C3) as well as the RNs prioritised basic nursing skills when considering the learning needs of caregivers. Although not prioritised, the family members (F) also made mention of caregivers being knowledgeable about basic nursing "tasks". The basic nursing skills identified were sub-categorised into clinical skills, interpersonal skills, and response to emergencies. (Hygiene was identified as a separate category and is discussed in section 4.5.2.)

4.5.1.1 Clinical skills

Clinical skills are generally understood to be those discrete and observable acts within the overall process of caring for a person in a clinical environment, such as taking blood pressure and oxygen administration (Seale *et al.,* 2018:1). The participants identified several clinical skills they felt necessary in caring for older persons residing in care facilities.

All the caregiver groups (C1, C2 and C3) mentioned taking blood pressure as a skill they would like to be more competent in. Two groups (C2 and C3) added that they wanted to interpret whether the reading was too high or too low and how to manage the situation accordingly. Groups C1 and C2 also indicated that they felt uncertain in performing tasks such as urine testing and testing of blood glucose levels. Group C2 wanted to know how to identify urine tract infection. Caregivers (C2 and C3) also voiced the need to measure body temperature, distinguish between normal and abnormal readings and respond appropriately. Some participants (C3) were unsure where to locate a person's pulse and for how long it should be counted. Group C2 voiced the need to be competent in administering oxygen and nebulising the older persons. The family members (F) felt that the caregivers should learn to perform "basic nursing tasks” such as hydration. The RNs related the need for caregivers to receive more in-service training in performing basic nursing skills such as full bed washes and wound care. In addition, they emphasised the importance and advantages of oral hygiene in light of negative consequences when it is neglected. In addition, one group of caregivers (C3) was concerned about the prevention of back injuries from mobilising older persons unable to assist them. Body mechanics should therefore form part of their training.

According to the SAQA registered unit standard for providing care to a frail person, caregivers are required to provide “fundamental nursing care … on a continuous basis and under the direct or indirect supervision of a qualified health worker” (SAQA, 2020). The SAQA (2020) outcomes state that the caregiver should “demonstrate a fundamental understanding of the normal function of the body systems” and “provide for the needs of the frail person”. These aspects were reflected in the data.

Basic nursing care skills usually involve hygiene, including oral hygiene; feeding; elimination; fluid balance; ambulation; turning; communication; emotional support; and surveillance (Cleary-Holdforth, 2019:89). In section 2.4.1, however, tasks relating specifically to caregivers were noted as “making beds, assisting with bathing, dressing, feeding and personal hygiene” (Council, 2020; SIFAR, 2017; Vantage Mobility International, 2016). Of the basic skills identified, oral hygiene, as a component of personal hygiene, was the only task that the participants mentioned. In addition, they pointed out several skills that were above the level of what would usually be expected of caregivers in the experience of the researcher. Taking and interpreting vital signs, testing urine and blood glucose levels, nebulising, as well as administering oxygen are usually performed by qualified nursing staff in residential care facilities. In section 4.6, a comparison is made between the caregiver tasks noted by the participants and the actual scopes of practice of different categories of nursing staff according to the Nursing Act 33 of 2005.

4.5.1.2 Interpersonal skills

Four groups of participants identified interpersonal skills as a learning need for caregivers (C1, C2, F and RN). Interpersonal skills are the actions and diplomacies we as humans use to communicate and interact effectively with one another (Tarver, 2020). These are life skills that facilitate understanding of another person’s needs and feelings. Interpersonal skills enable one to relate to another person by being attentive and empathetic by listening and providing support in the context of a "helping-relationship" (Grant & Goodman, 2019:14; Ong, 2017; Vertino, 2014).

One of the caregiver groups (C1) conveyed comprehension of the concept by expressing the need to be in a "friendship relationship" with the older persons. Being aware of and sensitive to the experiences of the older persons could help caregivers to understand what they are going through (Moolani, 2020). In this regard, two caregivers specifically wanted guidance on being empathetic and sympathetic in their caring role (C1 and C2). One caregiver group (C1) elaborated by emphasising the need for good interpersonal relationships in the work environment as a whole. In every occupation, interpersonal skills are necessary to manage difficult situations (Ong, 2017). Empathetic caregivers could improve their stress-management and problem-solving abilities, which will result in better handling the emotional aspects of their caring role (Larkin & Milne, 2014; Kusmaul, 2016:19-20).

Family member participants (F) voiced the specific need for caregivers to have a calm attitude and to be patient whilst caring for their loved ones. The family members also felt that caregivers should avoid being in a hurry whilst feeding the older persons and administering their medication. Jordan Halter (2018:441) offers person-centred care as a solution and explains that focus on the uniqueness of each person facilitates prioritisation of relationship over tasks. This author continues that a person-centred approach to caregiving "can significantly reduce agitation in people with dementia living in residential care settings" (Jordan Halter, 2018:441).

An additional concern for the family members (F) was that caregivers often talk amongst themselves about irrelevant and, sometimes, unacceptable topics whilst caring for the older persons. Education about professional work behaviour was therefore suggested. Interpersonal skills are affected by a person's values and beliefs and are portrayed in the way we engage with someone (Grant & Goodman, 2019:18). Instilling the constitutional values underpinning the Older Person's Act 13 of 2006, namely human dignity, equality and freedom, could promote a positive work ethic (refer to section 2.3.2.2).

Dignified end-of-life care surfaced in the small group interview with the RNs. The participants voiced the need for caregivers to receive additional training in this regard. One of the participants mentioned an incident where:

> One of the caregivers totally flipped out and had a panic attack when she was present for the first time during the death of one of the older persons / *Een van die versorgers het heeltemal uitgehaak en 'n "panic attack" gekry toe sy vir die eerste keer by was tydens die afsterwe van een van die oumense.* (RN3)

The RNs therefore recommended that the caregivers receive training on what to expect when being with a person who is dying and how to deal with the death of residents. Information on the process of dying and the "art of presence" could help the caregivers come to terms with the trauma of losing someone to whom they have grown attached (Jordan Halter, 2018:557).

4.5.1.3 Responding to emergencies

An emergency situation poses an immediate risk to the health and/or life of a person. It is unexpected and usually dangerous, requiring urgent intervention to prevent worsening of the situation (Coppa, 2019; Engineer, 2018; Mackintosh & Sandall, 2010:1683-1684).

All of the caregivers expressed the need to be prepared for emergency situations. One group (C1) expressed the need for a manual with guidelines on managing general medical emergencies. The other two caregiver groups (C2 and C3) expressed the need to know how to recognise and appropriately manage the signs and symptoms of certain conditions. Some of the examples mentioned amongst the group members (C2 and C3) were epileptic seizures, hyper- or hypoglycaemic incidents and cerebrovascular incidents. Group C2 explained that they did not know how to control bleeding or how to dress the wound. Additionally, they mentioned emergency situations, such as fainting, falls, how to identify and manage anxiety attacks and dehydration. One group (C3) specifically noted "heart attacks", including signs and symptoms and responding accordingly, as an incident of one of the residents dying from it was still fresh in their memories. Family members (F) were concerned with the older persons choking on pieces of food or their medication and whether the caregivers could appropriately manage these potentially harmful incidents. During the small group interview, emergency situations needing attention were:

> … basic first aid, including things like bleeding, choking, an older person stumbling and falling, stroke and fractures, with emphasis on hip fractures \ … *basiese noodhulp wat goed soos bloeding, verstikking, 'n bejaarde wat struikel en val, beroerte en frakture, met die klem op heup frakture, insluit*. (RN1)

In addition, the RNs voiced the need for caregivers to be up to speed with the emergency response procedures during a fire. They felt that knowledge regarding the evacuation process, each person's duties and points of assembly is a necessity.

There is merit in preparing caregivers for adverse incidents, because medical emergencies are more common amongst older persons, especially those with underlying medical conditions such as diabetes and hypertension (Maresova *et al.,* 2019:2). Emergency situations which could be associated with any age group but pose a greater risk to older persons are chest pain, breathing difficulties, falls and abdominal pain (Liu *et al.*, 2015:2-3). In the experience of the researcher, emergency situations that usually occur in residential care facilities are falls, fractures, bleeding, myocardial infarctions, variations in blood glucose levels and cerebrovascular incidents.

The fact that qualified healthcare professionals are not present at the residential care facilities for 24 hours a day raises a concern for the safety of the residents, especially during the nightshift, when caregivers are without supervision from 19:00 until 07:00. This was a concern to the family members (F), who expressed the need for regular rounds during the night as well as daytime. In such a way, caregivers could at least report any situations that could possibly pose a risk.

As indicated in sections 2.1 and 2.4.1, there is no standard training requirement for caregivers, which leaves them unsure and unprepared as to how they should respond and what actions to take in emergency situations (Falk-Huzar, 2017:125; SIFAR, 2017). If they have the basic knowledge to recognise the signs and symptoms of a medical emergency, they would be able to take action to give relief or offer comfort until help arrived. First aid treatment could save time and prevent a small incident from becoming a medico-legal hazard. More advanced actions could be lifesaving in the event of emergencies such as bleeding, choking or a hypo-glycaemic incident (Engineer, 2018; Hepler, 2018).

4.5.2 Hygiene

Only the family members (F) and RNs mentioned hygiene when considering the learning needs of the caregivers. The fact that none of the caregiver groups mentioned that they wanted to learn more about hygiene, which is considered to be a basic nursing skill, is a concern and indicative of their need for training in this regard. In the analysis of the data, hygiene was sub-categorised into general hygiene, including infection control and cross contamination, as well as personal hygiene of the caregivers and older persons.

4.5.2.1 General hygiene, infection control and cross contamination

The majority of family members (F) felt that general hygiene and cleanliness were important aspects for caregivers to take into consideration. They gave examples such as cleaning up spills on the floor, putting clean linen on the bed more than once a week and removing dirty dishes from the room. One of the family members (F1), as mentioned in section 4.3.1, elaborated on the consequences of laundry services offered once a week only. He added that the returned laundry was not clean. Although the problem did form part of hygiene, his complaint related to service provision and was a matter to be dealt with by management.

Other family members (F) were concerned about infection control and cross contamination, specifically with the correct handling and disposal of used adult diapers. Lack of hygiene, including hand hygiene performed by caregivers in residential care facilities, could negatively affect the health of older persons, leading to infection and even death (Boshell, 2012). Several older persons at the facilities were suffering from incontinence at the time of data collection, which was a cause of concern. In this regard, personal hygiene not only maintains body cleanliness, but also preserves dignity, enhances personal pride and promotes self-respect (Gardiner *et al.*, 2020:749; Jenkins & Chandola, 2014; North & Fiske, 2015:933; Smythe *et al*., 2017:2).

The RNs also voiced the need for the caregivers to have knowledge and understanding regarding infection control and cross contamination. One participant mentioned that:

> The old caregivers are very hard-headed and stubborn to change their habits, where those who haven't worked that long are more willing to make

> adjustments. / *Die ou versorgers is baie hardkoppig en steeks om hulle gewoontes te verander, waar die wat nie so lank werk meer gewillig is om aanpassings te maak.* (RN2)

It is difficult to “teach an old dog new tricks”. Once their behaviour has become a habit, it is difficult for caregivers with several years of caring experience to change their ways. An additional challenge was that they tended to transfer their habits to the newer caregivers. To illustrate their lack of questioning old habits regarding infection control and cross contamination, one of the RNs continued:

> Everybody’s toothbrushes were thrown into one washbowl during the morning-routine work. / *Almal se tandeborsels is saam in een wasskottel gegooi gedurende die oggendroetine werk.* (RN2)

When the RN asked the caregivers why they did that instead of keeping each individual’s toothbrush separate, in their own room, no one could apparently provide an explanation.

In addition, the RN (RN2) mentioned an incident where a caregiver took soap from one person’s room to wash another. This was not only unhygienic, but the owner of the soap accused the caregiver of theft. Although the RN did not mention what the consequences of the incident were, the caregiver could have been exposed to disciplinary action. Poor hygiene is regarded as negligence and a form of abuse that could have health, social and economic consequences (Pillemer *et al*., 2016:8-9; WHO, 2020; Yon *et al*., 2019:58-59). (Refer to section 2.2.2 for a discussion regarding abuse of older persons.)

It is therefore vital for caregivers to understand what the possible consequences of failing to maintain hygiene can be. According to the outcomes of the SAQA registered unit standard for providing care to a frail person, caregivers are supposed to be able to “assess the condition and environment with reference to the specific needs of the frail” and “provide for the needs of the frail person” (SAQA, 2020). The researcher’s interpretation is that hygiene forms part of these outcomes.

4.5.2.2 Personal hygiene of caregivers and the older persons

The only group that referred to personal hygiene was the family members (F), who suggested that the caregivers learn about the importance of personal hygiene. The family members observed dry mouths and cracked lips amongst the older persons and they were concerned about their oral hygiene. A dry mouth is common amongst older people due to reduced functioning of salivary glands and it holds a variety of negative consequences (Razak *et al.,* 2014:111). Poor oral health most commonly affects their ability to chew and limits the variety of foods they can eat, resulting in poor dietary intake and weight loss (SA Health, 2020). More serious conditions can also result, such as oral infection, tooth loss, wider spread infections and associated complications (Coll *et al.*, 2020:411; Razak *et al.*, 2014:111). Ultimately, the person's dignity, self-esteem and self-confidence are compromised (SA Health, 2020). Maintenance of oral health is therefore of utmost importance.

The group (F) added that the older persons' clothes should be changed immediately after a spill. They continued that using bibs could also prevent them from soiling their clothes and consequently having to change three times a day. Intriago (2020) explains that poor vision, dental problems, cognitive impairment and problems with digestion present challenges during mealtimes. This author therefore emphasises the importance of preserving the dignity of the older persons (Intriago, 2020). Reddy (2016) suggests that the person must be presentable before leaving the table and that spills be cleaned immediately.

Additionally, the family members (F) voiced the need for personal hygiene amongst the caregivers. They explained that caregivers should see to it that their uniforms, shoes and hair are always neat and clean. Personal hygiene is important for both health and social reasons. Maintenance thereof stops the spread of germs and illness, not only affecting the particular person, but also the lives of those they come into contact with (Johnson, 2020). This was of particular concern with the outbreak of severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) during 2020. The repercussions of SARS-CoV2 are briefly explored in section 5.5.4.

4.5.3 Alzheimer's disease

All the caregiver participants (C1 – C3) were enthusiastic to learn more about Alzheimer's disease, as evidenced by their prioritisation of this item. This learning need was also identified by the family members (F). At the various care facilities, some residents had officially been diagnosed with Alzheimer's disease, whilst several others presented with similar neurocognitive declines. The researcher is consequently of the opinion that the caregivers and family members, as lay people, referred to Alzheimer's disease because they were not familiar with the term neurocognitive disorders.

Group C3 indicated the disease as their first-priority learning need. All the caregivers had experienced the challenges associated with neurocognitive disorders, such as Alzheimer's disease, first-hand, hence their need to know more about it. The family members (F) and RNs therefore also expressed the need for caregivers to receive additional training regarding Alzheimer's disease.

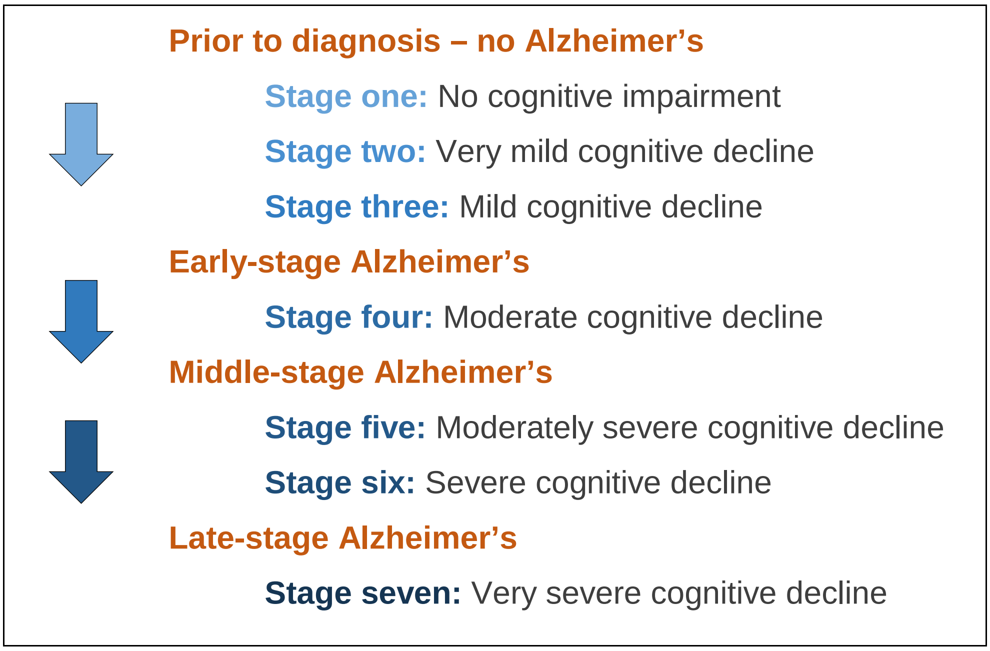
Not one of the three facilities were registered as speciality care facilities and, as a result, no measures, for instance separate facilities and safety precautions, were taken into consideration (DoSD, 2010:31-33, 84). Caregivers are therefore challenged to care for the persons with Alzheimer's disease along with the other residents.

Two sub-categories relating to Alzheimer's disease were identified, namely stages of the disease and caring for an older person who has Alzheimer's disease.

4.5.3.1 Stages of Alzheimer's disease

Every group of participants indicated that caregivers should know the stages of Alzheimer's disease and one group of caregivers (C1) in particular wanted guidance on how to manage the different stages. The same group also voiced the need to recognise the "mood" the older person was experiencing. Another group of caregivers (C3) voiced their need to be able to recognise the onset of the disease. Group C2 stated their need to learn about all the aspects surrounding the disease in general.

Alzheimer's disease is the most common of the neurocognitive disorders and causes cognitive decline and changes in behaviour (Alzheimer's News Today, 2017; APA, 2013:591-592). The disease typically progresses slowly and affects each person differently, but there are three general stages – early, middle and late – associated with the disease (Alzheimer's Association, 2018). The three stages are subdivided to form a seven-stage model (McIvor, 2020). Figure 4.1 presents a clarification of the seven stages.



Prior to diagnosis – no Alzheimer's

Stage one: No cognitive impairment

Stage two: Very mild cognitive decline

Stage three: Mild cognitive decline

Early-stage Alzheimer's

Stage four: Moderate cognitive decline

Middle-stage Alzheimer's

Stage five: Moderately severe cognitive decline

Stage six: Severe cognitive decline

Late-stage Alzheimer's

Stage seven: Very severe cognitive decline

Figure 4.1: The seven stages of Alzheimer's disease

Compiled from McIvor (2020)

Preclinical Alzheimer's disease is characterised by minor cognitive decline (McIvor, 2020). Symptoms such as memory loss, indicated in the first three stages of the seven-stage model, are commonly associated with ageing and could go undetected (Alzheimer's Association, 2018; Jordan Halter, 2018:437; MacGill, 2020; McIvor, 2020). It is consequently unlikely for anyone to distinguish between early-stage Alzheimer's disease and cognitive decline due to ageing.

Early-stage Alzheimer's disease is usually associated with the person experiencing memory lapses, such as forgetting names, familiar words and misplacing valuable objects (Jordan Halter, 2018:438; McIvor, 2020). It is, however, still possible for these persons to make decisions regarding their health and future (MacGill, 2020).

Middle-stage Alzheimer's disease is typically the longest stage and symptoms associated with the disease become more noticeable. The person would require more care as their ability to perform routine tasks declines (apraxia). Control over bladder and bowel movements is often lost (Mayo Clinic, 2020a). Amnesia is more pronounced and they may forget important information such as their personal history and contact details (Jordan Halter, 2018:438). Disorientation to time and place occurs and they may wander off and get lost (Alzheimer's Association, 2018; Mayo Clinic, 2020a). Aphasia, a loss of language ability, making it difficult for them to find the right word, and agnosia, the inability to recognise familiar objects and sounds, occur (APA, 2013:616; Jordan Halter, 2018:439). The person may need assistance in making simple choices, for instance about wearing the right clothes for the season or an event. Compulsive behaviour such as handwringing and tissue shredding is also often observed (Alzheimer's Association, 2018; Jordan Halter, 2018:438).

It is also in this middle stage that agitation is common, which may manifest in "combative behaviours" such as refusal to bathe and resisting dressing (APA, 2013:606). Amnesia, agnosia and disorientation are likely to cause the older person to be frightened, which could lead to agitation and escalate to aggression when approached by people they do not recognise and are asked to go somewhere unfamiliar to them (Jordan Halter, 2018:515). A person who is agitated is usually restless or worried, whilst those who are aggressive could attempt to hurt someone verbally or physically (MacGill, 2020; NIA, 2017). A catastrophic reaction could ensue, where the person may "scream, strike out, or cry because of overwhelming fear" (Jordan Halter, 2018:516).

In addition, hoarding or hiding objects and suspiciousness often complicate caregiving and could lead to conflict situations (Alzheimer's Association, 2018; APA, 2013:607; Jordan Halter, 2018:438; McGill, 2020). A change in sleep patterns most often occurs and the older person may be awake, agitated and restless at night, also known as sundowning (Jordan Halter, 2018:438-439). Apathy eventually sets in and the person presents with a lack of motivation and reduced emotional responsiveness (APA, 2013:607).

Symptoms are very severe in the *late stage* of Alzheimer's disease and the person will require 24-hour care. They typically have difficulty communicating and there are changes in physical abilities, including walking, sitting and swallowing (Jordan Halter, 2018:438). Eventually, there is a loss of awareness of their surroundings and recent experiences (Alzheimer's Association, 2018; MacGill, 2020; McIvor, 2020). During the last stage of the disease, the person's physical condition declines and they become susceptible to infections, such as pneumonia (Alzheimer's Association, 2018; Jordan Halter, 2018:438). The focus of caregiving is on providing comfort and dignity at the end of life.

4.5.3.2 Caring for an older person who has Alzheimer's disease

Family members (F) were concerned about the general care their loved ones with Alzheimer's disease were receiving. They made a well-supported suggestion that information leaflets about the different stages of Alzheimer's disease and guidelines on caring for such a person should be made available in the rooms of these persons. The caregivers were to follow these guidelines in their daily work. Although the approach about providing information is positive, it is unlikely that the availability of reading material, without training, will alleviate ignorance and enhance skills (Sustersic *et al*., 2016:532; Wrench *et al*., 2019:2 of 9).

In addition, the family members (F) felt that there are "extra caring tasks" involved, such as having a set routine and considering the older person's preferences regarding clothes and different food types. Effectively managing daily tasks can play a crucial role in reducing frustration and agitation. Keeping a daily routine and allowing the person to maintain control over their lives do indeed assist in curbing agitation and aggression (Alzheimer's Association, 2020; Jordan Halter, 2018:516; NIA, 2017).

Two of the caregiver groups (C1 and C3) expressed their need to learn how to manage situations in general, whilst the third group (C2) specifically pointed out managing aggression in these older persons. The RNs agreed that:

> There are definitely gaps in the knowledge that our caregivers have about the management and caregiving of our oldies who get Alzheimer's. / *Daar is verseker leemtes in die kennis wat ons versorgers het oor die hantering en versorging van ons oumensies wat Alzheimer's kry.* (RN1)

As noted by Burke and Orlowski (2015) and several other authors (Gottesman & Stern, 2019; Sepe-Monti *et al*., 2016:2), the complexity and diversity of the caring needs of these older persons present more challenges to their caregivers as their condition progresses. Knowledge is power and being equipped with information about the stages of the disease could assist caregivers in knowing what to expect and how to respond (Alzheimer's Association, 2020).

Two RNs specified skills caregivers need to have when interacting with someone who has Alzheimer's disease:

> … how to approach a person with Alzheimer’s disease. / *… hoe om ’n persoon wat Alzheimer’s het te benader.* (RN1).

> … the caregiver’s attitude, body language and tone of voice when she tries to approach the older person who has Alzheimer’s and is aggressive. / *… die versorger se houding, liggaamstaal en stemtoon wanneer sy die bejaarde wat Alzheimer’s het en aggressief is probeer benader.* (RN2)

The older person could suddenly become aggressive if a caregiver’s tone of voice or attitude upsets them or they are “forced” into an activity, for example bathing (NIA, 2017). When persons with Alzheimer’s disease are approached with the intention of entering their world and providing contextually relevant care, however, they tend to relax (Jordan Halter, 2018:441). “Patience and flexibility” to adapt to the needs and expectations of the older person could therefore reduce challenges such as aggression (Mayo Clinic, 2020b).

Jordan Halter (2018:441) emphasises an attitude of unconditional positive regard because it encourages people to “cooperate with care, reduces catastrophic outbreaks, and increases family members’ satisfaction with care”. Person-centred care applies, not only to older persons with Alzheimer’s disease, but to all of the residents and their families.

4.5.4 Medication

All of the caregivers (C1 – C3) voiced feeling uninformed about medication prescribed to the older persons, as well as over-the-counter medication some of the residents were using. The category of medication was divided into two sub-categories: knowledge, including actions/interactions of medication, and administration of medication.

4.5.4.1 Knowledge – actions/interactions of medication

All of the caregiver groups (C1 – C3) voiced that they lacked knowledge regarding the actions/interactions of the medications being used. Although it would be very helpful for them to know more, they did not want an intensive training course on medication. They felt that they just needed enough insight to recognise which medication was used for what condition. The family members (F) supported the idea that caregivers had to have knowledge regarding the interactions of the different medications they were administering.

Breytspraak (2016) indicates that a significant proportion of older persons have two to three chronic conditions, such as hypertension and diabetes, that require the use of medication. In the experience of the researcher, most of the older persons in residential care facilities receive prescribed medications. They also tend to self-medicate and sometimes take the wrong dosage, or overmedicate because they had forgotten that they had already taken their medication. Polypharmacy and resulting adverse drug reactions are common amongst older people (Dagli & Sharma, 2014:i; Jordan Halter, 2018:576; Nguyen *et al*., 2020; Sansgiry *et al.*, 2016:3-4). Cameron (2017) indicates that caregivers are therefore key in noticing changes in the condition of older persons and describing their observations to healthcare professionals. Caregivers and family members should therefore have a basic knowledge of the intended use, directions for use, common side effects and possible interactions of the medications that the older persons are using (Cameron, 2017).

4.5.4.2 Administration of medication

Several caregivers (from C1 and C2) felt that because they were the ones who handed out medication during the night, a broad overview regarding the uses of medication could put them more at ease. Group C3 added that they needed to know about “emergency medication”, such as painkillers, which the older persons requested during nightshift. Caregivers are not supposed to take responsibility for medication. In terms of the Nursing Act 33 of 2005, an RN is the only category of nurse allowed to administer prescription medication.

The RNs confirmed that although caregivers did not handle any medication during the day, they were expected to hand out medication during the nightshift, when the RNs were off duty.

> There is unfortunately no other choice but for caregivers to hand out prescription medication before bedtime. Most of the older persons receive a sleeping tablet and we cannot give it before going off duty. / *Daar is ongelukkig nie ’n ander keuse dat versorgers voorskrifmedikasie moet uitdeel voor slaaptyd nie. Meeste van die bejaardes kry ’n slaappil en ons kan dit nie al uitgee voordat ons van diens af gaan nie.* (RN1)

Consequently, caregivers are unavoidably responsible for administering prescription and over-the-counter medication, without having the necessary training.

In spite of caregivers’ inadequate knowledge, however, one group of caregivers (C1) explained that it has happened on more than one occasion that they noticed a difference in the colour and shape of the tablets usually handed to the older persons. The caregivers queried the medication and the person responsible for dispensing realised their mistake.

Faulty administration could result from pre-packing. Medication rounds take up a lot of time and although pre-packing of medication is not advised, facilities do permit this practice on provision that the necessary policies and guidelines are followed. Nursing staff are allowed to pre-pack medication for no more than three days in advance (SANC, 2011).

Another problem that occurred was raised by the family members (F), who expressed their concern about older persons not taking their medication, as the tablets were put next to their bed without someone making sure that they actually swallowed the medication. Medication errors are serious and could have harmful effects for the older person, thus posing a medical legal risk (Cameron, 2017; Winston, 2020). Caregivers should therefore be informed about the basic principles of administering medication.

Reflection A

At the onset of the study, the researcher’s greatest concern was for the older people who were dependent on persons who were underprepared to provide the necessary care. During the course of data collection and analysis, however, it became progressively alarming to discover to what extent the caregivers were expected to perform tasks beyond those stipulated in the SAQA registered unit standard for caregivers providing fundamental nursing care to frail persons. The researcher was challenged to question not only the ethics of their employment, but also what she had expected of them in the workplace. (Refer to section 4.6 and Table 4.3 for a comparison of the scope of practice of RNs, enrolled nurses and enrolled nursing assistants with caregiver tasks indicated by the participants.)

4.5.5 Communication

All of the groups but one (C1, C3, F and RN) identified communication as a learning need for caregivers. The caregivers (C1 and C3) explained that stressful situations are often the result of a lack of communication. Jordan Halter (2018:138) agrees that ineffective communication “often results in stress and negative feelings”.

Communication is the process of passing information and understanding from one person to another (Doyle, 2020; Sprangers *et al*., 2015:311-312). It is a reciprocal process of transmitting and sharing ideas, information, opinions, facts, feelings and values from one person to another and essential to the existence and survival of humans (Doyle, 2020; Grant & Goodman, 2019:14; Littlejohn & Foss, 2011:3-4; Sprangers *et al*., 2015:311-312). According to Maslow’s hierarchy of human needs, one could categorise communication as part of self-actualisation. This highest human need includes traits such as spontaneity and problem-solving skills. Establishing person-to-person understanding in a resourceful and flexible way is the foundation for effective communication (Vertino, 2014).

The sub-categories emerging and discussed next are communication amongst staff members, authority figures and older persons; conflict management and prevention; and reports on changes in the condition of the older person and handovers.

4.5.5.1 Communication amongst staff members, authority figures and older persons

Two of the caregiver groups (C1 and C3) as well as the RNs expressed the need for better communication amongst caregivers themselves, between the caregivers and RNs, and between the caregivers and older persons. One group of caregivers (C1) expressed having a lack of confidence to communicate freely with authority figures, such as board members paying informal visits to the facility. The RNs pointed out, however, that communication between caregivers and the manager and/or board members could be of benefit. This would grant them an opportunity to build a relationship that would pave the way for them when having to address the board in an official capacity.

During the small group interview, an incident was brought up where an older person claimed that caregivers had abused her. Upon investigation, it came to light that a lack of communication caused the older person, who had Alzheimer’s disease and hearing loss, to accuse the caregivers of abuse when:

> The night caregivers went to her to turn her and give a backrub. They did not wake the lady to tell her what they were going to do. The lady got a big fright when they suddenly turned her on her side in the dark without anybody saying a word. The lady told her children that someone had jerked and hurt her during the night. Fortunately, there is a camera in the lady's room and we could show the children that their mother had not been assaulted. / *Die nagversorgers het na haar toe gegaan om haar te draai en smeer. Hulle het nie die tannie wakker gemaak om te sê wat hulle gaan doen nie. Die tannie het groot geskrik toe hulle haar skielik in die donker op haar sy draai sonder dat iemand 'n woord praat. Die tannie het vir haar kinders vertel iemand het haar rondgepluk en seergemaak in die nag. Gelukkig is daar 'n kamera in die tannie se kamer en kon ons die kinders wys dat hulle ma nie aangerand is nie*. (RN2)

The lack of communication between caregivers and the older persons could therefore lead to unnecessary conflict, distress and negative emotional reactions (Burke & Orlowski, 2015; D'Onofrio *et al*., 2015:1-2; Dehdari *et al*., 2015:2; Gottesman & Stern, 2019; Sepe-Monti *et a*l., 2016:2). Conversely, improving communication could have a positive effect not just on the caregivers, but also on the quality of life of the older person (Courcha, 2015:286; Gardiner *et al*., 2020:749; Maresova *et al*., 2019:12; Mehta *et al.,* 2018:2; Williams, 2017:13). Grant and Goodman (2019:9) therefore regard communication skills as essential in keeping people, their families and caregivers safe.

The RNs added that by listening to, informing and involving the older person in whatever task the caregivers were about to perform, they would make a better impression. Older persons would more readily participate during daily tasks such as bed washes, oral hygiene and basic wound care (RNs). The family members (F) agreed that better communication and teamwork amongst caregivers could assist in older persons participating in activities provided by the facility, such as regular exercise sessions and "movie afternoons".

In talking with, rather than talking to, older persons, caregivers convey respect and caring, thus enhancing quality of life whilst reducing depression and aggression (James, 2018; Sprangers *et al.*, 2015:311-312). Trust develops with effective communication, improves relationships between those involved and facilitates deeper engagement in the working environment (Portland Community College, 2019). Slight (2010:1) aptly summarises the benefit of good caregiver communication as follows:

> Both the stress and reward of being a caregiver seemed to be wrapped up a great deal in communication that goes on not just between patient and caregiver, but between the caregiver and families, the caregiver and fellow staff members and even the local welfare office and other elderly care facilities.

The responsibility of engaging in a reciprocal process of sending and receiving messages in a respectful way therefore resides with all the role players at residential care facilities. Everyone should make it a priority to be competent in effective communication. Moreover, in relating more effectively with others, communication becomes a means to enhance their interpersonal skills.

4.5.5.2 Conflict management and prevention

Conflict resolution amongst various groups of people arose as a learning need in the nominal groups with the caregivers as well the small group interview with the RNs. Conflict is natural and inevitable in any group or work situation, but may have a negative effect on staff, reduce quality of care and threaten the safety of the residents (Jones *et al.,* 2019:27).

Two caregiver groups (C1 and C3) felt that they needed to learn how to avoid and appropriately manage aggression and opposition when engaging with the older persons. The RNs agreed that caregivers needed to acquire the necessary skills to manage conflict with older persons. One participant of Group C1 explained that they found it difficult to manage conflict situations that arose when the older persons refused to eat, wash or sleep. Three others (C1), however, agreed that by respectfully performing caring tasks for a person with Alzheimer’s, better cooperation could be achieved. This statement received fifth priority.

As explained in section 4.5.3, resistant behaviour is common amongst older persons who have neurocognitive disorders such as Alzheimer’s disease. Knowledge about the condition of the older person and effective communication whilst performing daily tasks were deemed important in avoiding aggression. Recognising that they are afraid and offering reassurance, rather than entering a power struggle, could neutralise the situation. Moreover, taking a person-centred stance, including being patient, calm and flexible, was offered as solution to defuse situations that could lead to agitation and aggression in the older persons (James, 2018; Jordan Halter, 2018:441; Mayo Clinic, 2020b).

A caregiver group (C1) added that they wanted to know how to deal with resistance from family members and how to communicate with an unfair/insensitive person in charge without negative consequences. This type of conflict management is different because the caregiver is at a power disadvantage in relation to the family members and RN in charge. Family members could lodge complaints that may have repercussions that threaten their work security. Furthermore, an unequal power distribution amongst staff members in a healthcare setting leads to conflict, particularly when an authoritarian leadership style is followed (Amestoy *et al*., 2014:82; Cullati *et al.,* 2019:43; Jones *et al*., 2019:26). The caregivers should be informed about the grievance procedures to follow if conflict is not managed to their satisfaction. Authoritarian leadership, however, is counterproductive and should be addressed. Democratising leadership, with a focus on participation, joint decision-making and open communication, counters power imbalance and facilitates conflict resolution (Amestoy *et al*., 2014:82). This component is beyond the control of the caregivers and should therefore be addressed by the management of residential care facilities.

Caregivers (C1 and C3) also expressed the need to learn how to effectively manage conflict amongst themselves. In agreement, the RNs stated that better communication and cooperation amongst the different staff members were necessary. They also emphasised the importance of teamwork and mentioned that cooperation relies on communication. The respectful joint effort of two or more individuals to meet the goals set for them and to cooperate to provide care to the best of their ability is foundational for teamwork (Bonsall, 2017; Dehdari *et al*., 2015:2).

Discordant personalities and diverse belief systems are known to cause conflict amongst co-workers, which negatively affects harmony in the workplace (Jones *et al.,* 2019:26). Unresolved conflict can disrupt team functioning, lead to mistrust and result in mental health issues amongst staff members (Cullati *et al.,* 2019:43). The quality of care provided in residential care facilities can also be linked to the caregivers' ability to resolve conflict, communicate effectively and uphold teamwork (Zúñiga *et al.,* 2015:4).

However, to deal with conflict in an appropriate manner, one has to develop conflict-resolution skills, which requires a conscious effort to improve communication (Hiemer, n.d.; Jones *et al*., 2019:26; The Trusted Team, 2019). Jones *et al*. (2019:28) add that introspection on one’s response to conflict, an exploration of more effective ways in dealing with conflict and making adjustments, such as ways of expressing yourself, could contribute to more efficient conflict management. Conflict resolution could therefore not only lead to positive change in the work environment, but could result in personal growth for those involved (Hiemer, n.d.).

4.5.5.3 Reporting

Family members (F) asserted that caregivers should report any observations they had made to the RN in charge. Considering that caregivers provide the majority of care to older persons (refer to section 2.4) and are in close contact with them, they are in the best position to observe any changes in the older person’s condition or behaviour (Kaire, 2014). Neglecting to report their observations to the RN and the caregivers of the next shift could have detrimental effects. Risks of patient-safety errors could be minimised by effective communication and teamwork (Maryville University, 2019). Failure to respond appropriately could lead to complications in the person’s condition, or even death (Oyeleye, 2019). Adverse events could result in malpractice lawsuits, which may have been prevented (Singh & Mathuray, 2018:124). Although the RNs did not mention reporting as a learning need, one did mention that:

> … our caregivers observe quite quickly if something changes in the condition of the older persons and then they swiftly come and call for help. / *… ons versorgers sien nogal vinnig raak as iets met die toestand van die bejaardes verander en dan kom roep hulle gou-gou vir hulp.* (RN2)

Timeous reporting enabled the RN to respond quickly. Working together as a team, sharing information and reporting concerns regarding the health of the older persons therefore create a “safe” work environment (AHRQ, 2018; Kaire, 2014).

The family members (F) added that caregivers should learn to exchange information with their co-workers regarding the caring tasks performed and information relating to the overall condition of the older person. In so doing, everyone would be updated and would know what else needed to be done. Caregivers also needed to grasp the importance of detailed handover reports from one shift to the next (F). Handovers are expected practices for healthcare staff who are working shifts. “Poor handover communication” could lead to adverse events, such as medication errors or deterioration in the person’s condition (Salem, 2019:175).

The RNs differed once again by illustrating that the caregivers in their facilities were meticulous about recordkeeping and handover reports.

> … fairly precise in the sense that they write everything down that happened during the course of the night. / *… nogal presies is in die opsig dat hulle alles neerskryf wat gebeur het deur die loop van die nag.* (RN1)
>
> … they report every incident precisely as it happened when they hand over to the next shift. / *… hulle rapporteer elke insident presies soos dit gebeur het wanneer hulle oorgee aan die volgende skof.* (RN2)

Thorough recordkeeping promotes continuity of care through clear communication and bares testimony of the quality of care rendered to the residents. Clear communication during handover reporting could enhance safety and reduce staff stress (Pearce, 2018).

The family members (F) suggested that staff distribution for caring tasks in the different sections of the facility is necessary for them to learn how to work with all the residents. In addition, they mentioned that a workbook of delegated duties could be implemented in which caregivers could sign on completion of tasks, such as a full wash. An arrangement of this nature could give clarity to the caregivers as to what was expected of them whilst serving as a record of accomplished tasks (F). The RNs added that staff rotation is an effective measure to get the caregivers out of their "comfort zone" and provide equal exposure to all the caring tasks and prevent caregivers from stagnating and eventually becoming neglectful. Staff rotation could therefore provide a means for continuous learning.

Reflection B

In the discussion of the sub-categories relating to communication, the onus on caregivers to master advanced skills was reiterated. In this case, interpersonal skills were required of them to communicate effectively with different levels of people and function well in a team. The need was identified for them to learn how to navigate situations that could give rise to conflict, and manage conflict when it would arise. This included engaging professionally, even therapeutically, with older persons. Not only should they be astute in observing the older persons' condition, but be eloquent in conveying these observations orally or in writing. An expectation was expressed that they should engage in continuous learning to free themselves from a "comfort zone”. Yet, they found themselves at a power disadvantage in their lack of education and the position they held. In this capacity, they were exposed to accusations and the possibility of litigation if an adverse event should occur.

4.5.6 Rights and responsibilities

Learning about human rights scored top priority for Group C3, which was supported by all the other groups (C1, C2, F and RN), who spoke about protecting the rights of the caregivers and the older persons. The group of caregivers who initially appeared to be resistant (C3), as indicated in sections 4.3.1 and 5.5, voiced the need to learn in more detail about the rights of the caregiver as an employee and a person. During the discussion round of the NGT, participants from Group C3 elaborated about issues at the workplace that had caused dissatisfaction, such as family responsibility leave. According to these participants (C3), they needed clarity about their rights regarding family responsibility leave. They were uncertain about what family relation would qualify them for family responsibility leave. In their opinion, it was unfair that it did not apply when, for instance, extended family members were to pass away.

Rispel (2020:7) supports the right to dignified healthcare work and adds that this is a problematic issue in South Africa, where working conditions are often less than satisfactory. Section 108 of the Constitution of South Africa 108 of 1996 states that human rights are basic rights that everyone is entitled to. The constitutional rights of caregivers are protected by the Labour Relations Act 66 of 1995 and the Basic Conditions of Employment Act 75 of 1997. Specifications regarding family responsibility leave are set out in Section 27 of the latter act. Section 30 of the Basic Conditions of Employment Act 75 of 1997 also stipulates that an employer must inform employees of their rights and these rights must be displayed in the languages used by the employees and in a place where everyone has access to it. In terms of this act, failure to disclose the rights of the caregivers as individuals, as well as their family responsibility leave, could have legal consequences.

Additionally, Group C2 expressed the importance of acknowledging the work caregivers do daily. Another group (C3) added that they needed acknowledgment from the older persons as well as the RNs. As healthcare workers rendering a primary service, caregivers are regarded as an overworked, underpaid and unappreciated workforce (Dikolomela-Lengene, 2020:6; Kinder, 2020). In accordance with Section 23 of the Constitution of South Africa 108 of 1996, acknowledgement should therefore include fair labour practices, such as minimum wages with constant upward adjustment, adequate staffing and reasonable work schedules.

One caregiver group (C1) explained that they needed to know how the rights of the caregivers as well as the older persons should be protected. They explained that not only the human rights of both groups of people should be protected, but their health and wellbeing too. An incident was mentioned where vital information about an older person's health condition was withheld, thereby compromising the safety and wellbeing of the caregivers, fellow residents and other staff members. Section 32 of the Constitution of South Africa 108 of 1996 refers to access to information, which the staff were entitled to regarding the particular older person's disease. From the point of view of a trade union, Dikolomela-Lengene (2020:6) explains that healthcare workers are "put under enormous strain" as they are exposed to communicable diseases and most often do not have a medical aid. Their lives and those of the people they are caring for are put in danger. The predicament of caregivers is the same because they too are expected to provide compassionate, quality healthcare in spite of low wages, insecure contracts, strenuous working conditions and limited resources (Rispel, 2020:7).

A group of participants (C1) elaborated that caregivers have a responsibility to care for the well-being of the older person as well as their own whilst respecting their co-workers and the older persons. The family members (F) added that the caregivers should treat older persons the way they themselves would want to be treated. The RNs stated that caregivers have a responsibility to respect themselves, the RNs, as well as the older persons. To illustrate the point, a participant mentioned that during the past winter season, nearly all their frail residents contracted pneumonia. Upon investigation, it came to light that:

> … the caregivers were in a hurry to finish washing everybody, so then they completely undressed the lady who had to be washed and let her lie open like that and shiver while they were busy washing her. / *… die versorgers was haastig om almal klaar gewas te kry, so dan het hulle die tannie wat gewas*

> *moet word heeltemal kaal uitgetrek en haar so oop laat lê en bibber terwyl hulle besig was om haar te was.* (RN2)

Caregivers have a responsibility to do the tasks assigned to them to the best of their ability. One of the outcomes set by SAQA (2020) is that caregivers should "demonstrate knowledge of the human rights of the frail person". Nevertheless, Section 17(i) of the Older Person's Act 13 of 2006 stipulates that residential care facilities are responsible for training caregivers who are providing care to the frail. This violation of the dignity of the older persons therefore raises concerns about the lack of training presented to caregivers.

4.5.7 Staff monitoring and evaluation

The caregiver group that was uncertain about labour practices (C3) also prioritised staff evaluations as a learning need. Group C3 voiced wanting to learn about the staff evaluation guidelines used at their facility. They explained that they were uncertain about the set standards and whether the same rules applied for everyone regardless of experience, years of employment or prior learning. Staff evaluation is performed to assess the tasks performed by caregivers to identify areas for development, and also to record improvement on performance with time (Vu *et al.*, 2020). Individuals must be evaluated in comparison to their past performance, however, and not according to the performance of others in the workplace (Chun *et al.*, 2018).

Group F and the RNs addressed monitoring of the caregivers during the trial period prior to permanent employment to assess whether they had the personality, potential and preference to work with older persons. Their concern was legitimate because the employment of caregivers who are not adequately trained and committed to the tasks of caring for an older person could result in numerous problems (Gurayah, 2015:194; Harling *et al*., 2020:297; Innes *et al.,* 2011; Manderson, 2019; Molinari *et al*., 2017:3-4). Although this aspect did not directly address a learning need, the RNs added that evaluation during the trial period would provide an opportunity to determine training needs in advance. Madlabana *et al*. (2020:2) agree that staff evaluation is one of the processes used to facilitate training.

The RNs continued that staff evaluations created an awareness of the expectations set before the caregivers.

> … caregivers are much more aware of what they are doing every day after we started doing staff evaluations on a regular basis. / *… versorgers is baie meer bewus van wat hulle doen elke dag nadat ons personeelevaluerings op ‘n gereelde basis begin doen het.* (RN1)

The strengths and weaknesses of caregivers as individuals and a team could also be assessed (RNs). Regular staff evaluations assess how an individual is performing in the workplace and could help identify the individual’s learning needs and provides proof of their competency in practice (Moyle, 2019). Furthermore, it could assist in recognising problem areas regarding the care provided as well as insufficient knowledge on the side of the caregivers (Dhai & McQuoid-Mason, 2011:6-7; Guerrero *et al.,* 2018; Meldgaard Hansen & Kamp, 2018).

Regarding training provision, the RNs were of the opinion that the content should comprise of basic nursing skills and be presented in a way that was in line with the educational level of the participants. Repetition for retaining information would be essential to increase the caregivers’ confidence in performing their tasks (RN). The RNs also explained that the in-service training could inspire and equip the caregivers. Madlabana *et al.* (2020:2) agree that in order to provide person-centred, quality healthcare, the health workforce must have the knowledge, skills, motivation and preparedness to fulfil these expectations.

There was a willingness amongst the caregivers to receive training. Group C2 requested “study leave” for caregivers who were permanently instated to receive formal training. They explained that there was an expectation for them to use vacational leave or resign to complete training. Group C2 suggested a selection process to identify caregivers who qualify for training and “study leave” to attend courses in the city. In section 2.4.1, it was indicated that caregivers should have access to lifelong learning. The OXFAM report on *The right to dignified healthcare work*, which was released in July 2020, also recommends that all staff in the healthcare sector be “upskilled” through continuous learning and training (OXFAM South Africa, 2020:50).

Reflection C

During data analysis, the researcher realised a complex issue emerging. The dignity of the caregivers and their right to fair labour practices came into focus in the last two categories relating to their learning needs. Here, the caregivers related issues pertaining to their rights and responsibilities. As identified in section 2.3.2.3 and confirmed in this discussion, the caregivers found themselves in a job where they are overworked, underpaid and unappreciated. The facilities were found to fail in their legal obligation to display and convey the necessary information about employee rights and to provide training. Withholding information that put their health at risk and a question transpired about access to private medical care. Furthermore, there was uncertainty about the purpose and consistency of staff evaluation. Caregivers who wanted to receive formal training had to do so in their own time and at their own cost.

4.6 Expected Caregiver Tasks in Comparison to the Scopes of Practice of Nurses

As a qualitative researcher should expect, according to Polit and Beck (2017:463), an emergent design unfolded through continuous critical reflection on the realities uttered by the participants. In response to Reflections A and B, in particular, the researcher felt compelled to compare the learning needs expressed in the study in relation to the actual tasks set by SAQA (2020) for caregivers. The researcher also wanted to indicate the expectations with the scopes of practice of various categories of nurses stipulated in Sections 4, 7 and 10 of the Nursing Act 33 of 2005. This comparison is indicated in Table 4.3. The tasks indicated by the SAQA registered unit standard for providing care to a frail person (refer to section 2.4.2 and Table 2.3) are indicated by blue ticks in column E, whilst the learning needs of caregivers identified in the study that exceed those set in the unit standard are indicated in red. Evidence is indicated by stating the section numbers where the specific learning needs were discussed.

Table 4.3: Comparison of caregiver tasks indicated by participants in relation to the scopes of practice of RNs, enrolled nurses, enrolled nursing assistants and the SAQA registered unit standard for providing care to a frail person

Scope of practice				Tasks
SANC	**RNs**	**Enrolled nurses**	**Enrolled nursing assistants**	**Care-givers**
Nursing Act 33 of 2005	**Professional Nurse**	**Staff Nurse**	**Auxiliary Nurse**	
Diagnosing of a health need and the prescribing, provision and execution of a nursing care to meet the need of the patient	X	X		**X** 4.5.1.3 4.5.3.1
Handing out and administration of medication	X			**X** 4.5.4
Maintenance of hygiene, physical comfort and re-assurance of patient	X	X	X	**X**
Monitoring vital signs: temperature, pulse, blood pressure and observation of reactions to medications and treatment	X	X	X	**X** 5.1.1 4.5.4
Supervision over and supply of oxygen	X	X	X	**X** 4.5.1.1
Supervision over and maintenance of fluid balance of patient	X	X		**X** 4.5.1.1
Facilitation of the healing of wounds and fractures, the protection of the skin and the maintenance of sensory functions in a patient	X	X		**X** 4.5.1.3
Facilitation of the maintenance of bodily regulatory mechanisms and functions in a patient	X	X	X	**X**
Promotion of exercise, rest and sleep, with a view to healing and rehabilitation of a patient	X	X	X	**X**
Supervision over and maintenance of elimination of a patient	X	X	X	**X**
Facilitation of the attainment of optimum health for the individual, the family and the community in the execution of the nursing care	X	X		**X** 4.5.2.2
Facilitation of communication by and with a patient in the execution of the nursing care	X	X	X	**X**
Facilitation of the maintenance of nutrition of a patient	X			
Feeding of a patient		X	X	**X**
Establishment and maintenance of an environment in which the physical and mental health of a patient are promoted	X	X		**X**
Facilitation of body mechanism and the prevention of bodily deformities in a patient in the execution of nursing care	X	X	X	**X**
Provision of effective patient advocacy to enable the patient to obtain the health care they need	X			**X** 4.5.1.3 4.5.5.3

Care of the dying patient and the care of the recently deceased patient within the execution of the nursing regimen	X	X	X	**X**

Compiled from the Nursing Act 33 of 2005 and SAQA (2020)

As pointed out in Table 4.3, some of the expectations set before caregivers by the participants in this study matched the scopes of practice of nurses. In the extreme, only RNs are permitted to hand out and administer medication. When working without supervision at night, as indicated in section 4.5.1.2, caregivers are compelled to fulfil all the roles expected of an RN in that situation. This includes the management of medical emergencies. The ethical dilemma of caregivers having to make decisions to prevent compromising the health of the older person under their care comes into question.

The SAQA registered unit standard for providing care to a frail person stipulates that caregivers should work “under the direct or indirect supervision of a qualified health worker” (SAQA, 2020). Caregivers are not adequately trained to carry the responsibility of nurses, let alone RNs. Moreover, they are not licenced to practice or guided by the specifications provided by a regulatory body. They are therefore exploited because they have never expressed the realisation that they were performing tasks beyond what is expected of a caregiver. The caregivers who were involved in this study were caught in an ethical dilemma. Even if they had been aware of the unfair expectations, the question arises whether they would have the power to refuse to perform tasks for which they were unqualified. Contrariwise, if they had performed these tasks, there could be negative consequences, even adverse incidents, due to their ignorance. Upon further reflection (Reflection C), the dignity of caregivers and their right to fair labour practices became apparent. The moral implications are that the caregivers are exposed to unfair labour practices, the quality of care they provide is negatively affected and the health and wellbeing of the older persons in their care are put at risk.

4.7 Emerging Theme

On embarking on this research journey, it was anticipated that a tailor-made training programme would result from the expressed learning needs (section 1.2). The actual theme that emerged during data collection and became progressively stronger during the discussion of the findings was unexpected. The question that kept coming to mind was the *ethics related to the employment* of the caregivers. Although rarely expressed out loud by the participants, the unrealistic expectations with resulting load of responsibility and accountability due to a lack of training and unfair labour practices came to the fore. The dignity of caregivers in the workplace came into focus through confirmation that their rights were not fully taken into consideration and they did not have the power to question authority. The ethics of employment therefore emerged as theme, with unrealistic work expectations and a power disadvantage as sub-themes. The conceptual conclusions of the study are further unpacked in Section 5.4.

4.8 Summary

In this penultimate chapter, the culminating findings were presented. Data were generated having asked the research question: What are the learning needs of caregivers of older persons in residential care facilities in two sub-districts of the Northern Cape province? To start off with, the context of the participants was put into perspective. In order to obtain more clarity about the background of the participants the demographic information provided insight. Field notes made during data collection provided insight into the context of the data collection sessions. Subsequently, the identified categories and sub-categories were discussed in triangulation with literature. The learning needs emanating from the data related to basic nursing skills, hygiene, Alzheimer’s disease, medication, communication, rights and responsibilities, as well as staff monitoring and evaluation. Although these learning needs were important to the participants and deemed necessary for adequate training of the caregivers, a deeper, more complex issue emerged. The ethics of employment came into question and emerged as central theme, together with two sub-themes, namely unrealistic work expectations and a power disadvantage. The emergent theme and sub-themes were briefly described and are further elucidated in Chapter 5. In this final chapter, the researcher provides a concluding reflection over the study.

CHAPTER 5

Conclusions

CHAPTER 5
CONCLUSIONS

> “Knowing is not enough; we must apply. Wishing is not enough; we must do.”
> Johann Wolfgang Von Goethe

5.1 Introduction

In this chapter, the researcher comes to a conclusion on the discoveries made in answer to the research question:

> What are the learning needs of caregivers of older persons in residential care facilities in two sub-districts of the Northern Cape province?

The research problem and process are briefly summarised before the factual and conceptual conclusions are presented. Through critical self-reflection, the researcher reveals deeper learning that occurred and, in so doing, shows that gaining knowledge through research and hoping that circumstances would change are insufficient. As portrayed in the quotation by Johann Wolfgang von Goethe, action is necessary to meet the learning needs of the caregivers and to address the issues arising from the research (Tracy, 2020). Propositions are therefore made for consideration in response to the learning that took place in the course of the study. Implications for practice as well as suggestions for future research are set out and limitations to the study are addressed. In closing, the significance of the research is highlighted.

5.2 Summary of the Research Problem and Process

Ageing of the population is a worldwide fact and whilst old age holds a sense of accomplishment and triumph, it is characterised by deteriorating health and strength. Older persons become vulnerable as their dependence on other people increases and due to a variety of reasons, many are admitted to residential care facilities. Furthermore, their care needs become progressively complex, posing challenges to their caregivers.

In South Africa, it was found that the quality of care rendered to older persons in residential care facilities was negatively affected by substandard training of the caregivers. Inadequate knowledge and skills could not only compromise the health of the persons in their care, but also the health and wellness of the caregivers themselves. Stress and burnout were therefore reported to be common occurrences amongst caregivers. In the Northern Cape province, where this study was conducted, caregivers were faced with additional challenges, such as poor socio-economic circumstances, limited education and a lack of formal training. A tailor-made training programme focussing on the particular learning needs of the caregivers could not only enhance their learning, but also support respectful care rendered to the older persons residing in the respective facilities.

The intent of this study was therefore to explore and describe the learning needs of caregivers of older persons in residential care facilities in two sub-districts of the Northern Cape province. Guided by constructivism as foundation of the study, an explorative case study was employed to discover the truth about the learning needs of caregivers within the specific context. To socially construct knowledge, data were collected from different role players at the three respective residential care facilities, namely the caregivers, RNs and family members of residents. The NGT and a small group interview were employed to capitalise on the synergy created within a group context and generate rich data.

Data analysis was performed by the qualitative methods suited to the data collection techniques. The structured nature of the NGT enabled the caregivers and family members who participated to identify, reduce, validate and prioritise the caregivers' learning needs. Van Breda's (2005:2-10) method was employed to analyse and combine the nominal group data. A content analysis was performed on the small group interview data and the categorised inputs from the RNs were incorporated with the findings of the nominal groups.

5.3 Factual Conclusions

The factual conclusions of the study are the facts uncovered during data collection (Trafford & Leshem, 2008:140; 2017). In this study, the learning needs of caregivers of older persons in residential care facilities in two sub-districts of the Northern Cape province were derived from the data. The findings were categorised into basic nursing skills, hygiene, Alzheimer's disease, medication, communication, rights and responsibilities, as well as staff monitoring and evaluation. Sub-categories emerged from each category, as presented in Table 4.2. The findings discussed in section 4.5 are briefly summarised below.

5.3.1 Basic nursing skills

The participants expressed the need for the caregivers to be more competent in clinical skills that included monitoring of vital signs and blood glucose levels, urine testing, administering oxygen and nebulising, hydration, full bed washes, wound care and oral hygiene. For caregivers to perform their daily tasks effectively, they should display good interpersonal skills, stemming from a "friendship relationship" with the residents. They needed to learn to be calm and patient when caring for the older persons, in an empathetic and sympathetic manner. This calm disposition had to extend to caring for someone who was dying. Additionally, participants voiced the need for caregivers to learn first aid to enable them to manage emergency situations that included choking, seizures, cerebrovascular incidents, myocardial infarction, varying blood glucose levels, bleeding, wound care and falls.

5.3.2 Hygiene

Maintaining general hygiene and cleanliness during caring was important to the family members and RNs. Changing the linen, mopping spills on the floor and keeping the room tidy by removing dirty dishes were mentioned as some of the tasks caregivers should be able to perform. Infection control and cross contamination had to be applied as the caregivers work with several older persons during the day. Hand hygiene, specifically in handling and disposal of used adult diapers, was essential. Participants expressed the importance of maintaining the personal hygiene of the older persons, which included oral hygiene and keeping their clothes clean during and after mealtimes. Caregivers were also to learn about personal hygiene with reference to their hair, uniforms and shoes.

5.3.3 Alzheimer's disease

All the participants voiced the importance of knowledge regarding the different stages of Alzheimer's disease and guidelines on caring for someone accordingly. Following a daily routine and providing person-centred care to reduce frustration and agitation were deemed necessary. Recognising the “mood” of the older person and dealing appropriately with aggression were specified as necessary skills.

5.3.4 Medication

Caregivers needed to know the actions/interactions of the prescribed and over-the-counter medication that the older persons used. Administering medication correctly was a concern for the participants because it was expected of caregivers to hand out medication during nightshift. Some of the caregivers mentioned that they were uncertain about giving medication, such as painkillers, that older persons requested during the night. Several participants felt that there was a need for caregivers to make sure that the older persons swallowed their medication. A problem was identified with pre-packing, where caregivers had noticed that the appearance of the medication differed from what the older person usually received, although they did not know what the medication was for.

5.3.5 Communication

Participants expressed the need for caregivers to communicate more effectively amongst themselves, with authority figures and the older persons. In addition, there was the need for them to effectively manage resistance, aggression and conflict. They were also expected to take measures to prevent conflict. Several participants pointed out the importance of observing any changes in the condition or behaviour of the older persons and reporting of it orally and in writing. The implementation of measures to delegate and control caring tasks could prevent tasks being neglected.

5.3.6 Rights and responsibilities

Learning about human rights received priority. The rights of the caregivers as well as the older persons should be respected and protected. The caregivers had a need to be informed of their rights in the workplace, with specific reference to leave. They felt that acknowledgement for what they do could make them feel more appreciated. In addition, participants voiced that caregivers have a responsibility for the health and safety of the older persons and themselves. They needed to perform the tasks assigned to them to the best of their ability as a sign of respect towards the RNs, fellow caregivers and the older persons.

5.3.7 Staff monitoring and evaluation

Caregivers voiced the need for clarity regarding evaluation of staff members, with reference to guidelines on the process and criteria used for evaluations. Staff monitoring prior to permanent employment to evaluate potential, preference and personality was voiced as an assessment measure. In facilitating training for caregivers, the RNs felt that evaluations could be instated to monitor the strengths and weaknesses of individual caregivers and as a team to help identify their learning needs.

5.4 Conceptual Conclusions

The factual conclusions of the study were conceptualised, as Trafford and Leshem (2008:140; 2017) suggest, through interpretation in triangulation of literature. As briefly described in section 4.7, one main theme, namely ethics of employment, emerged from the findings. Although the participants never expressed the issue as such, unrealistic work expectations and a power disadvantage became apparent in the discussion of the findings and formed the sub-themes.

5.4.1 Unrealistic work expectations

At commencement of the research, the researcher was concerned about the caregivers being underprepared in providing care to the older persons at the mentioned residential care facilities. However, during data collection, examples mentioned to motivate the identified learning needs were above the expectations usually set for caregivers. The caregivers also at various times mentioned feeling inadequately prepared for some of their daily tasks. They were working under constant pressure to perform tasks without having had the necessary training, whilst having to take responsibility for their actions. In analysing the data, this predicament was confirmed in triangulation with literature. The researcher realised that the caregivers were exposed to unrealistic work expectations and that some of the tasks expected from them or even which they were already performing aligned with those of RNs. More specifically, they were expected to fulfil the role of an RN when working nightshift.

Performing tasks that form part of the scope of practise of trained nursing staff, who are registered with SANC, is not permitted and is regarded as exploitation of the caregivers. They do not have the necessary education and training, are not licenced to perform these tasks and are not on the salary scale of someone who meets the requirements of that position. It was found that the caregivers' right to fair labour practices was undermined. Caregivers, like all healthcare workers, have the right to dignified healthcare work, which include reasonable working conditions and expectations, fair remuneration and appreciation for what they do.

5.4.2 Power disadvantage

Caregivers are at a power disadvantage, especially in the Northern Cape province, where poverty and unemployment are a reality. They are not in a position to dispute their working conditions or wages because there are several other people who could fill their position. Furthermore, their lack of education and the low status associated with their occupation put them in a subservient position. The researcher was alerted about this fact when the need to learn about conflict management with family members, the RN in charge and the board members was expressed.

Another concern was raised when it came to light that the caregivers were expected to empower themselves through lifelong learning to get them out of their "comfort zone". Again, the researcher questioned the so-called *comfort zone*. How could they be comfortable in the given situation? Moreover, it was learnt that they were expected to educate themselves in their own time and at their own expense. If the duration of the course exceeded the period of available vacation leave, they reportedly had to resign to attend the course. In the researcher's experience, their work position would not be reserved and upon returning home, reinstatement in their previous position could not be guaranteed. If they were to be reinstated, there would be no financial benefits. This is because all the caregivers received the same wages, regardless of education, work experience or years of employment. The expectation that the caregivers should engage in lifelong learning is in contrast with the fact that there are no benefits associated with expanding their education.

Withholding of information was a further issue that put the caregivers at a disadvantage. They were allegedly not informed about their rights as employees and they were, for instance, ignorant about the policies and guidelines related to family responsibility leave and the motivation behind staff monitoring and evaluation. An additional area of concern was that they were not informed when an older person in their care had a contagious disease that could compromise their health and that of the persons they come into contact with. In expressing learning needs beyond what is expected of a caregiver, they appeared to be ignorant of the fact that tasks were inappropriately delegated to them. Their right of access to information and the right to education were violated. The facilities not only exploited the caregivers, but neglected their legal obligation to inform these employees of their rights.

5.5 Reflexive Notes

In an effort to conduct rigorous and ethical research, the researcher made a commitment to engage in continuous critical self-reflection. To remain true to herself and the virtues she had stated in section 3.8.2, it was important for her to question her personal beliefs, biases and feelings throughout the research process. During this reflexive process, issues regarding research integrity, insider-research and her response to the research findings became apparent.

5.5.1 Research integrity

Adhering to the research process, as indicated in the research proposal, was not as easy as it seemed. Several methodological errors were made and the researcher found comfort in the words of Trafford and Leshem (2008:16; 2017), who explain that “most researchers encounter some problems during their research – even if they choose not to admit it”. In honouring the virtue-based-ethics approach that was taken, including the virtues of courage and humility, the errors were disclosed in the dissertation.

The emergent nature of qualitative research, as described by Polit and Beck (2017:463), necessitated a change of focus from caring for persons with neurocognitive disorders to older persons in general. It would be difficult for the participants to focus on one aspect of caregiving only and, with the exception of the RNs, understanding the concept of neurocognitive disorders could be problematic. (Refer to Addendum A for the letter of approval from the HSREC for the change of title.) The question posed to the RNs still included the concept of neurocognitive disorders, as explained in section 1.10.2, but interestingly enough, all of the participants expressed and prioritised the need to learn about “Alzheimer’s disease” (refer to section 4.5.3).

Having struggled to obtain gatekeeper approval from all the role players, the researcher was eager to start. She later realised that she had rushed into data collection before doing an explorative interview. Feelings of shock and disappointment for neglecting to do something she had intended to do and being frightened of the repercussions it could have on the research, surfaced. It was too late to do the explorative interview as the research population was small and the most data-rich sources had participated. Changing the research site to another district would not serve the local community and would delay the research process considerably. Although it would have been ideal to include an explorative interview to test the questions posed to the participants, there were no noticeable repercussions as the research questions were understood and all the participants provided relevant answers. In actual fact, rich data were collected.

Maintaining a neutral and accommodating stance during data collection was a challenge at one of the research settings. On conducting a nominal group in a remote town, the researcher sensed a feeling of hostility when first engaging with the group of participating caregivers. The researcher took it personally at first, but the tension seemed to lift once the participants were free to voice their learning needs. During the voting process, the researcher noticed that all the participants of this specific group had voted for rights and responsibilities. After the session, she asked the participants to elaborate on the reason they felt so strongly about the particular point. They explained that there had been several incidents of disagreement in the workplace about issues, such as family responsibility leave, which were not managed to satisfaction. Unresolved negative feelings towards the persons in charge led to the strong support of the statement and the hostile attitude at the onset of the session.

Throughout the data collection process, the researcher observed that participants expressed the need for regular in-service training for the caregivers. Their positive attitude towards the idea did not come as a surprise, because she sensed the need whilst working at one of the facilities. On realising that the researcher had neglected to satisfy the caregivers’ need for knowledge, education and training, feelings of guilt surfaced. At the same time, she felt a sense of satisfaction in the fact that the caregivers who had previously worked under her supervision were more eloquent in describing their learning needs. They, for instance, made use of the concept of in-service training and displayed insight into interpersonal relationships by referring to having a “friendship relationship” with the older persons. The positive reaction of the participants and the relevant answers they provided with regard to the research questions gave the researcher a feeling of contentment on conclusion of data collection.

When analysing the data, the researcher realised that she had made a mistake during the nominal groups by recording ideas that were not directly related to learning needs. Some of the statements offered suggestions or served as motivation for previous statements. At the time of data collection, the ideas sounded logical and were accepted as learning needs. The researcher felt frustrated at not recognising the difference at the time of data collection, but realised that she had been too absorbed in hearing the perspectives of the participants to make the distinction. As the voting had been completed and some of these suggestions had received scores, they could not be discarded. All the data, however, were incorporated in analysis, not just the top five priorities of each group. The suggestions or explanations were noted as such in the discussion of the findings.

Analysing the data proved to be a challenging process for the researcher as it required creativity and “conceptual sensitivity”. The need to be concise was balanced with the need to maintain the richness of the data and evidential value of the findings. Although data analysis was difficult, seeing the world from the participants’ viewpoint and truthfully portraying their views led to valuable findings.

5.5.2 Insider-research

As a resident the researcher was familiar with the surroundings and the community. By considering the norms and values they deemed important, a deeper understanding of the challenges caregivers face in their daily caring tasks was possible.

The researcher was more relaxed with the participants who were known to her, but this also urged her to be more aware of any bias. Having worked with this group of caregivers challenged her to question what she had expected of the caregivers in the workplace as the RN in charge. Initially, the expectation was that the caregivers should be trained to provide respectful care to the older persons. As the study progressed, however, the researcher realised that the caregivers were the ones who were being neglected and whose dignity was compromised not just by other people, but by the researcher herself.

There was a distinct power imbalance in relation to the caregivers. This imbalance was not limited to the researcher being an authority figure at one of the research sites, but also in the professional hierarchy, on an educational level, in her socio-economic standing and with regard to her race. Memories from the “apartheid” era were triggered when the higher status occupations were reserved for white people and people of other racial groups had to contend with whatever jobs were available.

5.5.3 Response to the research findings

During the course of the study, it became clear that the caregivers were performing tasks that were outside their job description. The researcher felt that caregivers were being exploited due to a lack of knowledge regarding their job description as well as their rights and responsibilities as caregivers. The below-average wages the caregivers receive are no compensation for the criticism, false allegations and negative attitudes they often have to deal with. Having to perform tasks outside their field of knowledge and training raises an ethical dilemma not just for the caregivers, but also for the facilities employing them. After the nominal group with the caregivers, who had raised the issue of rights, the researcher highlighted the fact that the rights of the caregivers, who had worked under her supervision, had also been violated. The thought never crossed her mind that they were not informed of their rights, policies and guidelines, for example, about family responsibility leave. Being in a subservient position caused them to accept their circumstances and prevented them from questioning authority. After that nominal group session, the researcher made a point to inform the caregivers she knew about their rights.

Having developed a deeper understanding of the caregivers’ plight, the researcher was of the opinion that no one else would have the compassion or will to do something about the exploitation of the caregivers. The researcher realised that she would have to be their advocate and having made contact with the relevant authorities to obtain permission to conduct the study, she had gained access to them. She therefore made use of the opportunity to contact one of the main regulatory bodies regarding the issue. Unfortunately, after several attempts, there has been no response. It is hoped that the submission of a formal research report to the various gatekeepers, including the

DoSD, and an academic publication would have a positive effect. Through this experience, the researcher realised that the dissemination of research findings is equally important to the research process.

5.5.4 Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2)

As mentioned in section 1.15, the research was conducted well in advance of the SARS-CoV2 pandemic, but having gained deeper insight into the research problem, the safety of the caregivers and the residents became a concern. The availability of PPE was unlikely because none of the research sites have the resources to make the necessary purchases. If they should have access to the PPE, it was uncertain whether the caregivers would be adequately informed of the correct use and disposal of the gear. Furthermore, the researcher’s discoveries relating to the lack of knowledge regarding hygiene, cross contamination and infection control amongst the caregivers withheld the consolation that they would at least be able to apply basic principles of asepsis.

All the research sites were under quarantine since a week before the national lockdown started on 27 March 2020. Caregiver stress and burden were a concern as they had to work without adequate channels for debriefing. Although only staff members were allowed to enter the facility, several of the older persons did indeed contract the virus. Caregivers at one of the facilities informed the researcher that those of them who tested positive without showing symptoms were asked to continue working. The ethical and legal implications regarding such an action could be immense.

5.5.5 Concluding thoughts

The researcher now understands why qualitative research is equated to a process of deep learning where underlying issues are uncovered and assumptions are overcome. The discoveries made during the process also helped the researcher to make better sense of the literature. Critical self-reflection contributed not only to the authenticity of the research, but the researcher experienced growth on multiple levels. Academic growth was facilitated by learning to conduct rigorous and ethical research; making sense of the data; and mastering academic writing to convey the research process and findings. Personal growth was facilitated by her having to question and overcome assumptions. The researcher became aware of her positionality in relation to the caregivers concerning her educational, professional, socio-economic and racial status. She was also challenged to extend her role as a researcher to that of an advocate.

5.6 Propositions for Consideration

In response to the factual and conceptual conclusions of the study as well as critical self-reflection, the researcher gave consideration to the implications for practice and future research. The contextual nature of the research does not allow for the making of recommendations, but in accordance with Trafford and Leshem (2008:159; 2017), the researcher is presenting propositions for the enhancement of practice and considerations for future research.

5.6.1 Implications for practice

Underpreparedness of the caregivers in caring for the complex needs of the older persons at the respective residential care facilities is a reality. The benefit of a formal in-service training programme focussing on the identified learning needs that are within their expected level of functioning and in line with SAQA's registered unit standard for providing care to a frail person could enrich their caring. They could become more attuned to the older persons' needs, respond more effectively with day-to-day situations in the workplace and deal with the emotional consequences of their caring role. In so doing, the quality of care could improve.

Some of the topics arising from the research that could be covered in such a training programme are:

- Basic caregiving tasks, including body mechanisms;
- First aid;
- Hygiene and infection control;
- Caring for an older person in a responsive way;
- Basic interpersonal skills and communication;
- Reporting;
- Rights and responsibilities in the workplace; and
- Staff monitoring and evaluations.

A strong motivation will be offered to the management of the respective facilities to develop a tailor-made training programme in accordance with the findings of the study.

The researcher, as mentioned in section 5.5, is required to be an advocate who must communicate the unfair labour practices and exploitation of the caregivers to the authorities. A report on the findings of the study will be provided to the DoSD, the ACVV, Caritas and management of the three residential care facilities, respectively.

Although the researcher does not have enough authority to make an impact, not disclosing the information would be unethical. Ongoing negotiations with management of the various facilities on the training of these individuals could prove valuable.

5.6.2 Suggestions for future research

This explorative case study research was conducted within a bounded system involving a relatively small number of participants in two sub-districts of the Northern Cape province. Larger scale research is necessary to inform policy. A quantitative survey based on the findings of this study and replication of the explorative case study in other sub-districts of the Northern Cape province could be informative for the development or changing of policy and guidelines.

The DoSD in the Northern Cape, as well as the regulatory bodies of the care facilities, indicated in their permission letters that they would appreciate feedback on the research. This lays the foundation to expand the research for the purposes of policy development relating to the training of caregivers in the rural areas, but also to address unfair labour practices.

5.7 Limitations to the Study

The older persons at the respective residential care facilities were not included in the population of this study due to the fact that many of them had neurocognitive impairments. Care rendered by the caregivers nevertheless concerns the older persons directly and their perspectives could provide valuable insight into the learning needs of the caregivers. In-depth interviews with older persons who were lucid could therefore have enriched the data.

Possible bias was a concern as the researcher was a partial insider-researcher. (Refer to sections 1.12, 1.15, 3.7 and 3.9 for an elaborated discussion.) Furthermore, the methodological errors made during the course of the research process could have influenced the data negatively (refer to section 5.5.1).

5.8 Significance of the Research

Several aspects concerned with the significance of research are set out by Botma *et al.* (2010:281), which include propositions for consideration (refer to section 5.6), influence on programmes or policy, practical problems and more importantly, “what will improve” and “how should it be implemented”.

By exploring the learning needs of the caregivers from different perspectives, the problem statement discussed in section 1.2 was addressed. The research was not of such scale that it could influence programmes or inform policy development. A tailor-made training programme for the caregivers could nevertheless be developed. The questions of “what will improve” and “how should it be implemented” on a larger scale will depend on the DoSD and the regulatory bodies of the care facilities to take the research findings seriously and implement measures to address the concerns. It is envisioned that the caregivers’ preparedness to deal with their demanding occupation as well as the quality of care in the residential care facilities included in the study could be enhanced. Ultimately, the hope remains that the study will contribute to the caregivers being treated with the dignity and respect they deserve.

5.9 Concluding Summary

Considering the wellbeing and respectful care of older persons, the focus of this study was on the learning needs of caregivers. In answering the research question it not only led to the discovery of the learning needs of the caregivers, but also their predicament.

The main themes that emerged related to the ethics of their employment, with the sub-themes of unrealistic work expectations and a power disadvantage. Unfair labour practices exploiting the caregivers and undermining their dignity raise concern and need to be addressed. The researcher’s reflexive notes provided deeper insight into her experiences and learning during the research process. Propositions were forwarded for future practice and research. Limitations of the study were presented and the perceived significance of the study was shared.

By identifying the caregivers’ learning needs, the researcher hopes that a training programme and course of action to address the emerging issues will make a difference in the lives of the people involved. As Robert H. Schuller portrays in his quote, the things that you thought were impossible to achieve could be your victories if you are willing to do something about your shortcomings (Tracy, 2020).

Ernie Brummer

> "Today's accomplishments were yesterday's impossibilities."
>
> Robert H. Schuller

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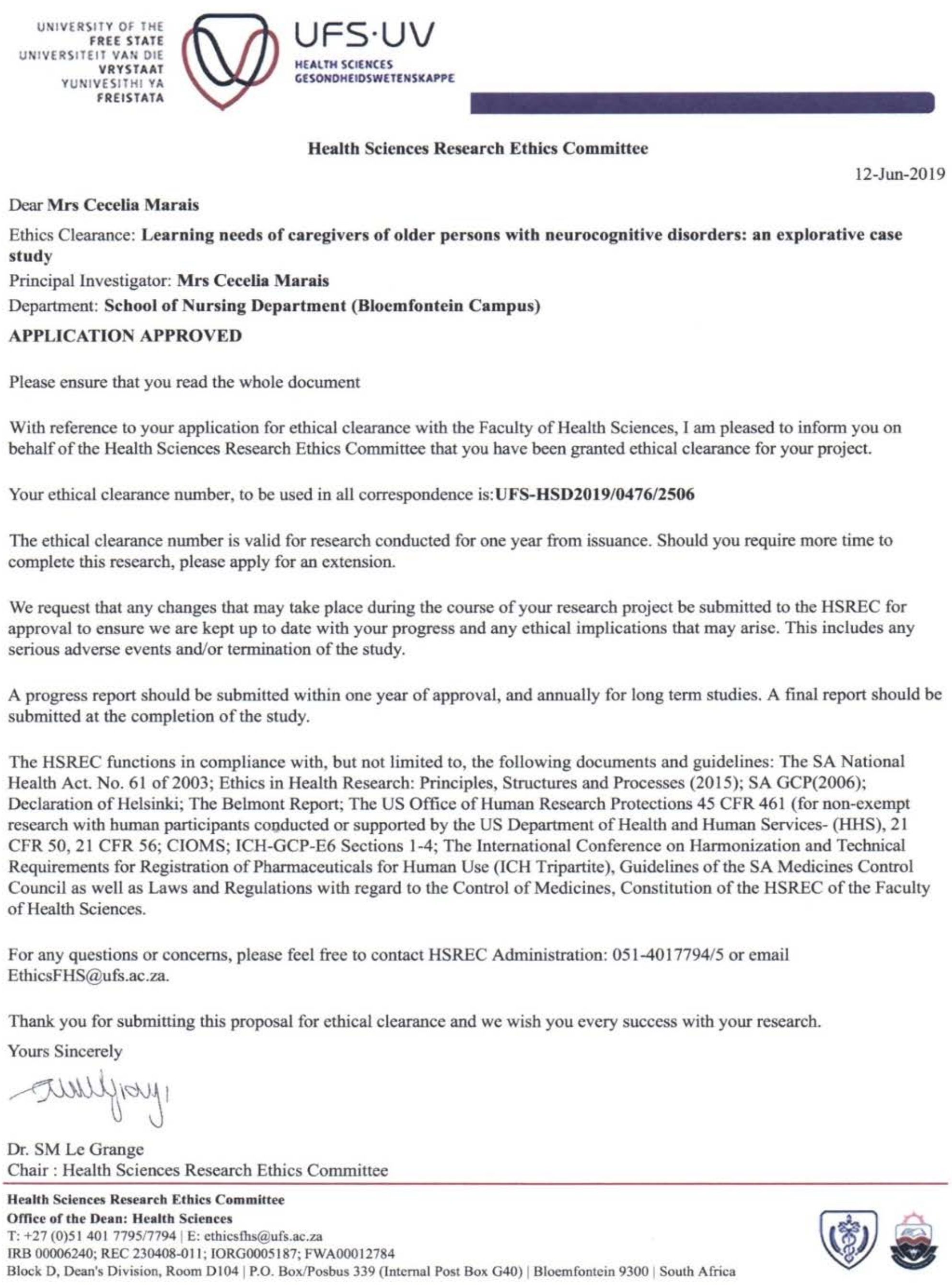
ADDENDUM A: Ethics approval

Ethical clearance granted



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GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

12-Jun-2019

Dear **Mrs Cecelia Marais**

Ethics Clearance: **Learning needs of caregivers of older persons with neurocognitive disorders: an explorative case study**

Principal Investigator: **Mrs Cecelia Marais**

Department: **School of Nursing Department (Bloemfontein Campus)**

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is:**UFS-HSD2019/0476/2506**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

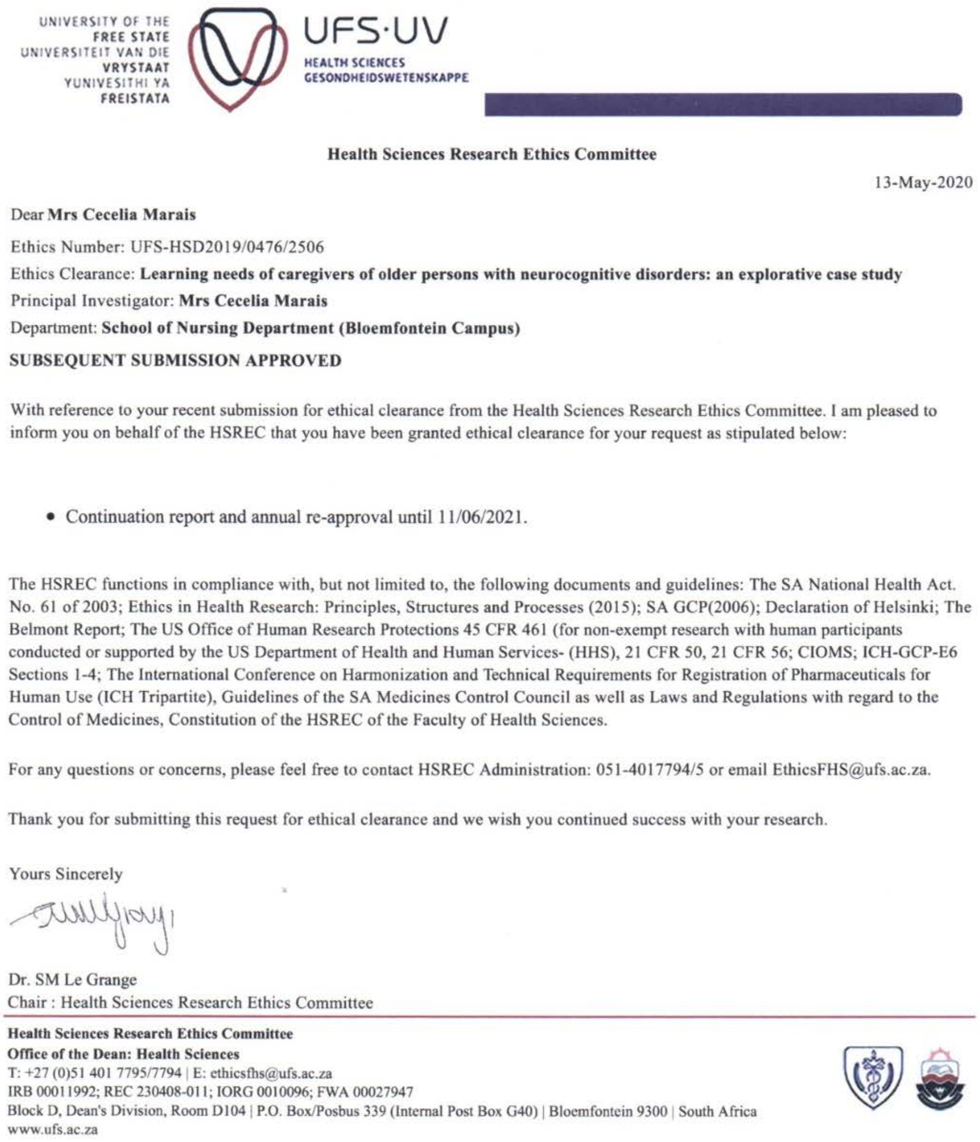
Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Dr. SM Le Grange
Chair : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00006240; REC 230408-011; IORG0005187; FWA00012784
Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G40) | Bloemfontein 9300 | South Africa

Ethical clearance – annual reapproval



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Health Sciences Research Ethics Committee

13-May-2020

Dear **Mrs Cecelia Marais**

Ethics Number: UFS-HSD2019/0476/2506

Ethics Clearance: **Learning needs of caregivers of older persons with neurocognitive disorders: an explorative case study**

Principal Investigator: **Mrs Cecelia Marais**

Department: **School of Nursing Department (Bloemfontein Campus)**

SUBSEQUENT SUBMISSION APPROVED

With reference to your recent submission for ethical clearance from the Health Sciences Research Ethics Committee. I am pleased to inform you on behalf of the HSREC that you have been granted ethical clearance for your request as stipulated below:

- Continuation report and annual re-approval until 11/06/2021.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

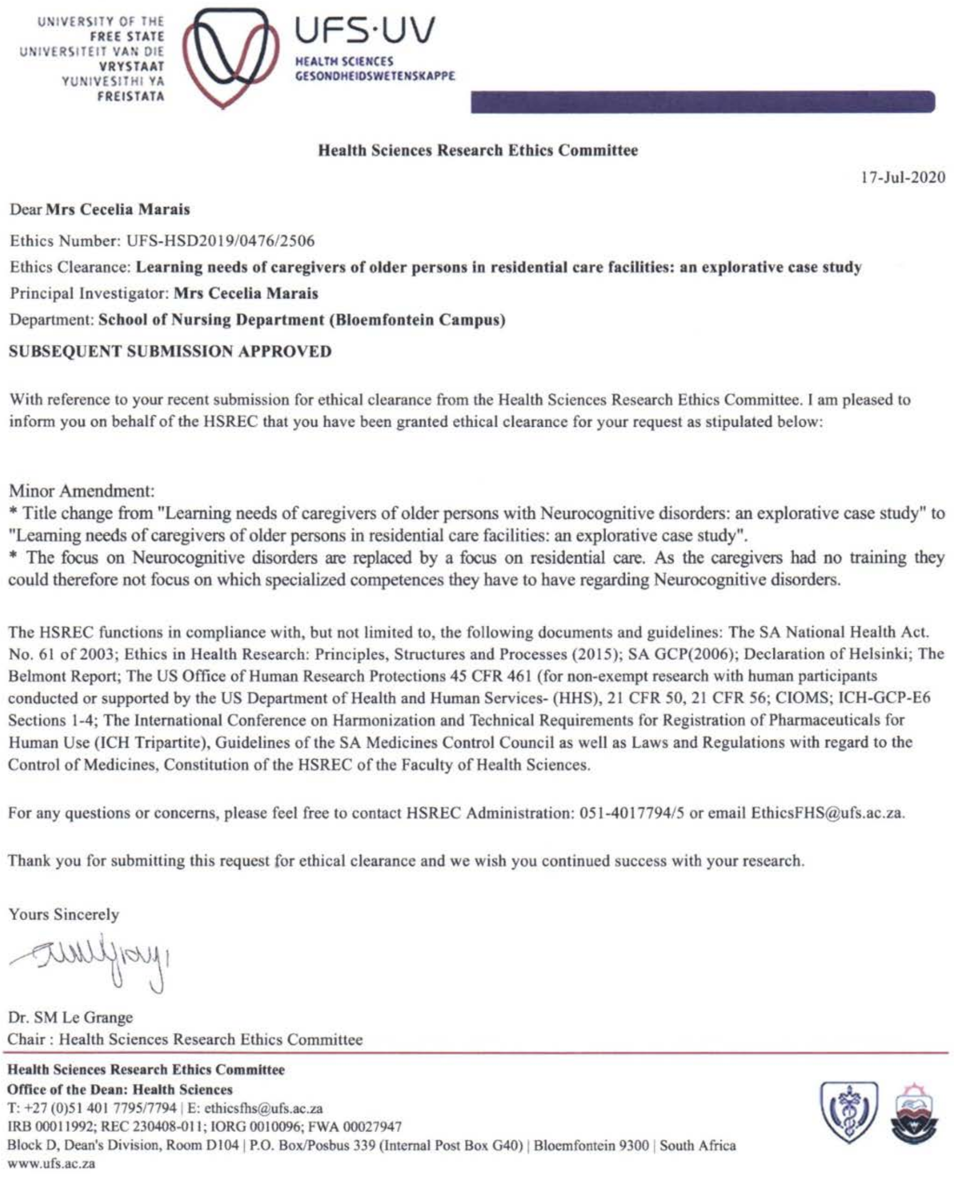
Thank you for submitting this request for ethical clearance and we wish you continued success with your research.

Yours Sincerely

Dr. SM Le Grange
Chair : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00011992; REC 230408-011; IORG 0010096; FWA 00027947
Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G40) | Bloemfontein 9300 | South Africa
www.ufs.ac.za

Ethical clearance – amendment of title



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Health Sciences Research Ethics Committee

17-Jul-2020

Dear **Mrs Cecelia Marais**

Ethics Number: UFS-HSD2019/0476/2506

Ethics Clearance: **Learning needs of caregivers of older persons in residential care facilities: an explorative case study**

Principal Investigator: **Mrs Cecelia Marais**

Department: **School of Nursing Department (Bloemfontein Campus)**

SUBSEQUENT SUBMISSION APPROVED

With reference to your recent submission for ethical clearance from the Health Sciences Research Ethics Committee. I am pleased to inform you on behalf of the HSREC that you have been granted ethical clearance for your request as stipulated below:

Minor Amendment:
* Title change from "Learning needs of caregivers of older persons with Neurocognitive disorders: an explorative case study" to "Learning needs of caregivers of older persons in residential care facilities: an explorative case study".
* The focus on Neurocognitive disorders are replaced by a focus on residential care. As the caregivers had no training they could therefore not focus on which specialized competences they have to have regarding Neurocognitive disorders.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this request for ethical clearance and we wish you continued success with your research.

Yours Sincerely

Dr. SM Le Grange
Chair : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00011992; REC 230408-011; IORG 0010096; FWA 00027947
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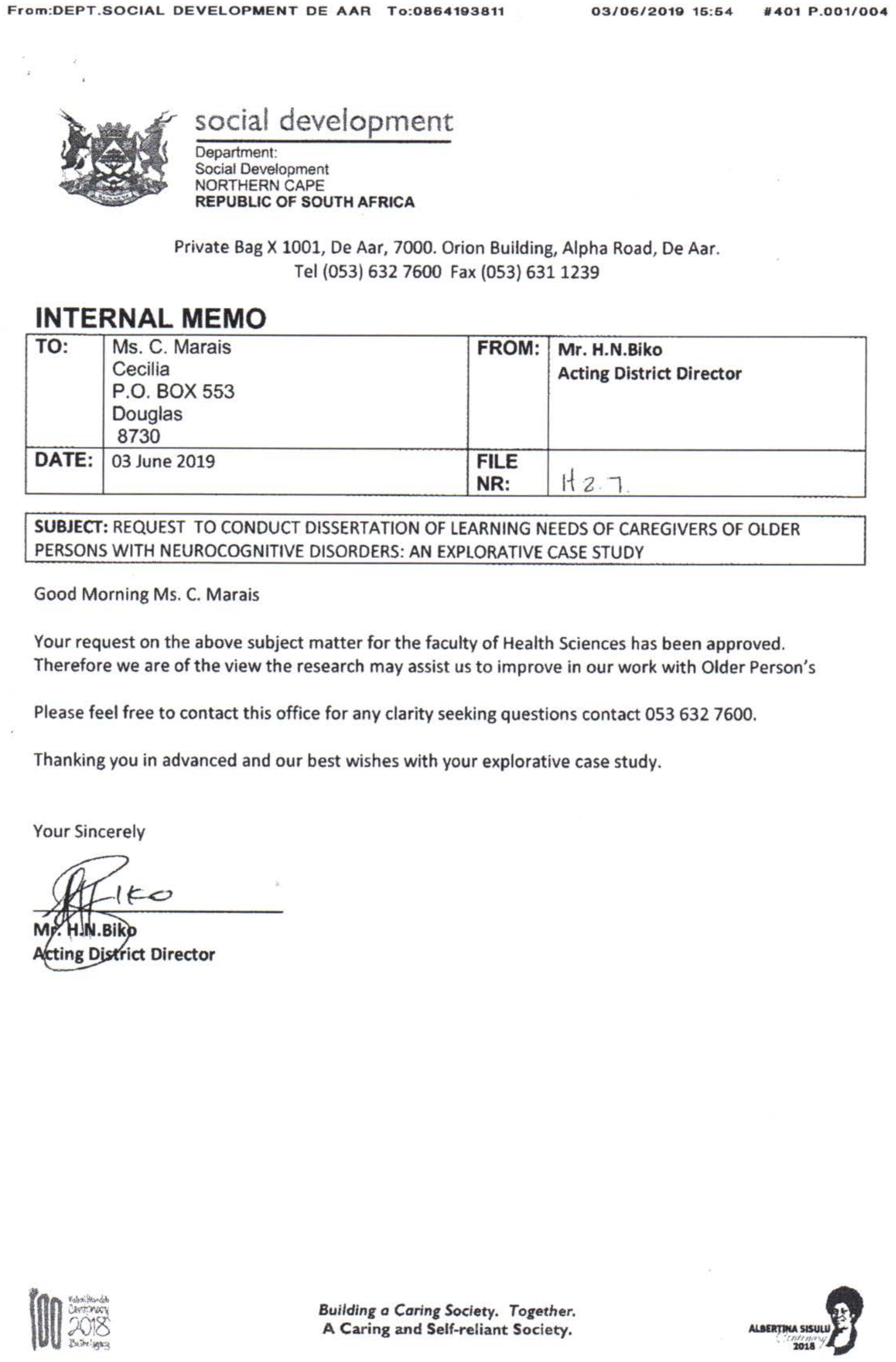
ADDENDUM B: Gatekeeper permission

Department of Social Development, Northern Cape



From:DEPT.SOCIAL DEVELOPMENT DE AAR To:0864193811 03/06/2019 15:54 #401 P.001/004

social development

Department:
Social Development
NORTHERN CAPE
REPUBLIC OF SOUTH AFRICA

Private Bag X 1001, De Aar, 7000. Orion Building, Alpha Road, De Aar.
Tel (053) 632 7600 Fax (053) 631 1239

INTERNAL MEMO

TO:	Ms. C. Marais Cecilia P.O. BOX 553 Douglas 8730	**FROM:**	**Mr. H.N.Biko** **Acting District Director**
DATE:	03 June 2019	**FILE NR:**	H2.7.

SUBJECT: REQUEST TO CONDUCT DISSERTATION OF LEARNING NEEDS OF CAREGIVERS OF OLDER PERSONS WITH NEUROCOGNITIVE DISORDERS: AN EXPLORATIVE CASE STUDY

Good Morning Ms. C. Marais

Your request on the above subject matter for the faculty of Health Sciences has been approved. Therefore we are of the view the research may assist us to improve in our work with Older Person's

Please feel free to contact this office for any clarity seeking questions contact 053 632 7600.

Thanking you in advanced and our best wishes with your explorative case study.

Your Sincerely

Mr. H.N.Biko
Acting District Director

Building a Caring Society. Together.
A Caring and Self-reliant Society.

ALBERTINA SISULU Centenary 2018

Permission granted by ACVV

ACVV Hoofkantoor / Head Office
ACVV-Sentrum/Centre, Caledonstraat 61/ 61 Caledon Street
Posbus / P O Box 3834, Kaapstad /Cape Town, 8000
Tel : (021) 4617437, 461 1109
Faks/Fax : (021) 4610074
Epos/email: headoffice@acvv.org.za
www.acvv.org.za

ACVV
HOOFBESTUUR/
NATIONAL COUN

002 834 NPO
930004921 PBO

29 Mei 2019

Mev Cecilia Marais
Posbus 553
Estate 12, Vaallus
Douglas
8730

Beste Cecilia

<u>Navorsing: ACVV Residensiële fasiliteite</u>

Toestemming word hiermee verleen dat u mag voortgaan met die navorsingsprojek soos beplan by Huis Heldersig, Griekwastad en Huis Spes Bona, Douglas. Beide fasiliteite het ook skriftelik aangedui dat u aansoek om navorsing te doen goedgekeur is deur hulle.

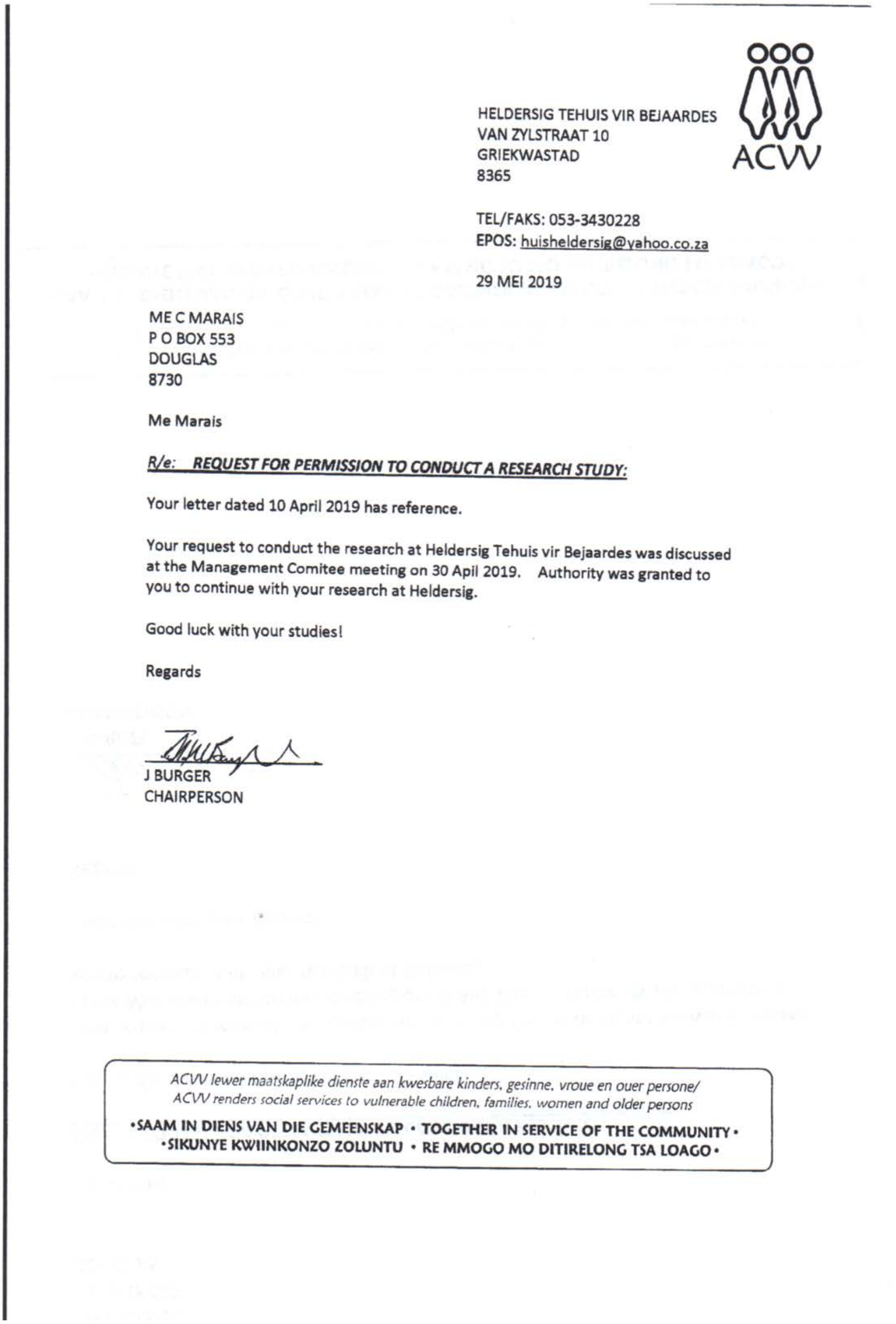
Ons versoek u vriendelik om u navorsingsresultate met ons te deel vir benutting in die ACVV as geheel.

My beste wense vergesel jou met die afhandeling van jou navorsingsprojek.

Vriendelike groete

Maggy Botha
Nasionale Bestuurder: Ouer Persone

Permission granted by the board – ACVV Huis Heldersig



HELDERSIG TEHUIS VIR BEJAARDES
VAN ZYLSTRAAT 10
GRIEKWASTAD
8365

TEL/FAKS: 053-3430228
EPOS: huisheldersig@yahoo.co.za

29 MEI 2019

ME C MARAIS
P O BOX 553
DOUGLAS
8730

Me Marais

R/e: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY:

Your letter dated 10 April 2019 has reference.

Your request to conduct the research at Heldersig Tehuis vir Bejaardes was discussed at the Management Comitee meeting on 30 Apil 2019. Authority was granted to you to continue with your research at Heldersig.

Good luck with your studies!

Regards

J BURGER
CHAIRPERSON

ACVV lewer maatskaplike dienste aan kwesbare kinders, gesinne, vroue en ouer persone/
ACVV renders social services to vulnerable children, families, women and older persons

•SAAM IN DIENS VAN DIE GEMEENSKAP • TOGETHER IN SERVICE OF THE COMMUNITY •
•SIKUNYE KWIINKONZO ZOLUNTU • RE MMOGO MO DITIRELONG TSA LOAGO •

Permission granted by the board – ACVV Huis Spes Bona

Huis Spes Bona

ACVV

ACVV Douglas
P.O. Box 160, 601LochRoper Street, Douglas, 8730
Telephone : 053 298 1035
Fax: 086 450 5722
E Mail: ernie@spesbona.org

23 April 2019

Me C. Marais
P.O. Box 553
Douglas
8730

Me Marais

REQUEST FOR PERMISSION TO CONDUCT A RESERCH STUDY

Your letter dated 30 March 2019 has reference.

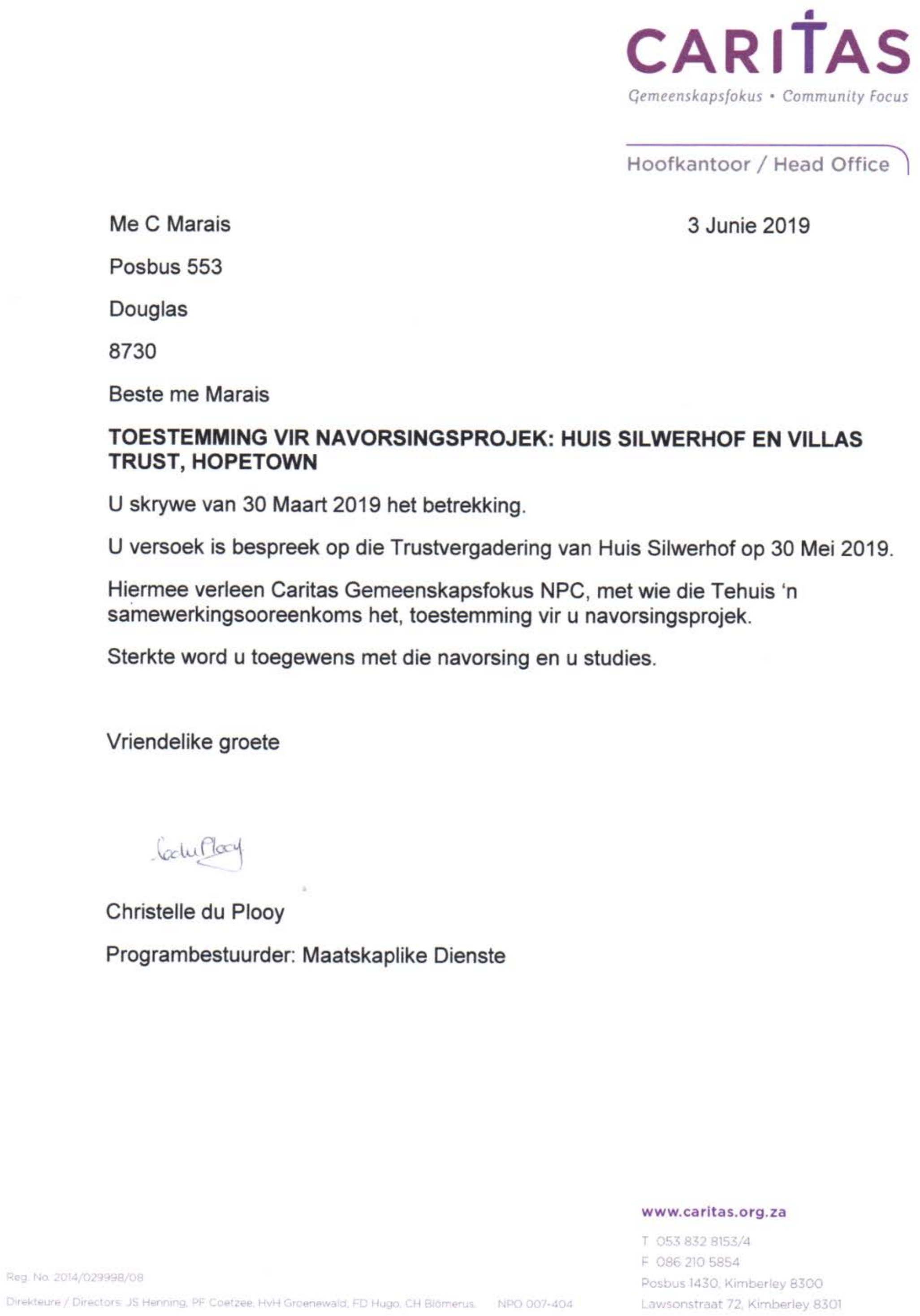
Your request to conduct the research at Huis Spes Bona was discussed at the Management Committee meeting on 15 April 2019. Authority was granted to you to continue with your research at Huis Spes Bona.

Good luck with your studies!

Regards

ERNIE BRÜMMER
MANAGER HUIS SPES BONA

Permission granted by Caritas



CARITAS
Gemeenskapsfokus • Community Focus

Hoofkantoor / Head Office

Me C Marais

Posbus 553

Douglas

8730

3 Junie 2019

Beste me Marais

TOESTEMMING VIR NAVORSINGSPROJEK: HUIS SILWERHOF EN VILLAS TRUST, HOPETOWN

U skrywe van 30 Maart 2019 het betrekking.

U versoek is bespreek op die Trustvergadering van Huis Silwerhof op 30 Mei 2019.

Hiermee verleen Caritas Gemeenskapsfokus NPC, met wie die Tehuis 'n samewerkingsooreenkoms het, toestemming vir u navorsingsprojek.

Sterkte word u toegewens met die navorsing en u studies.

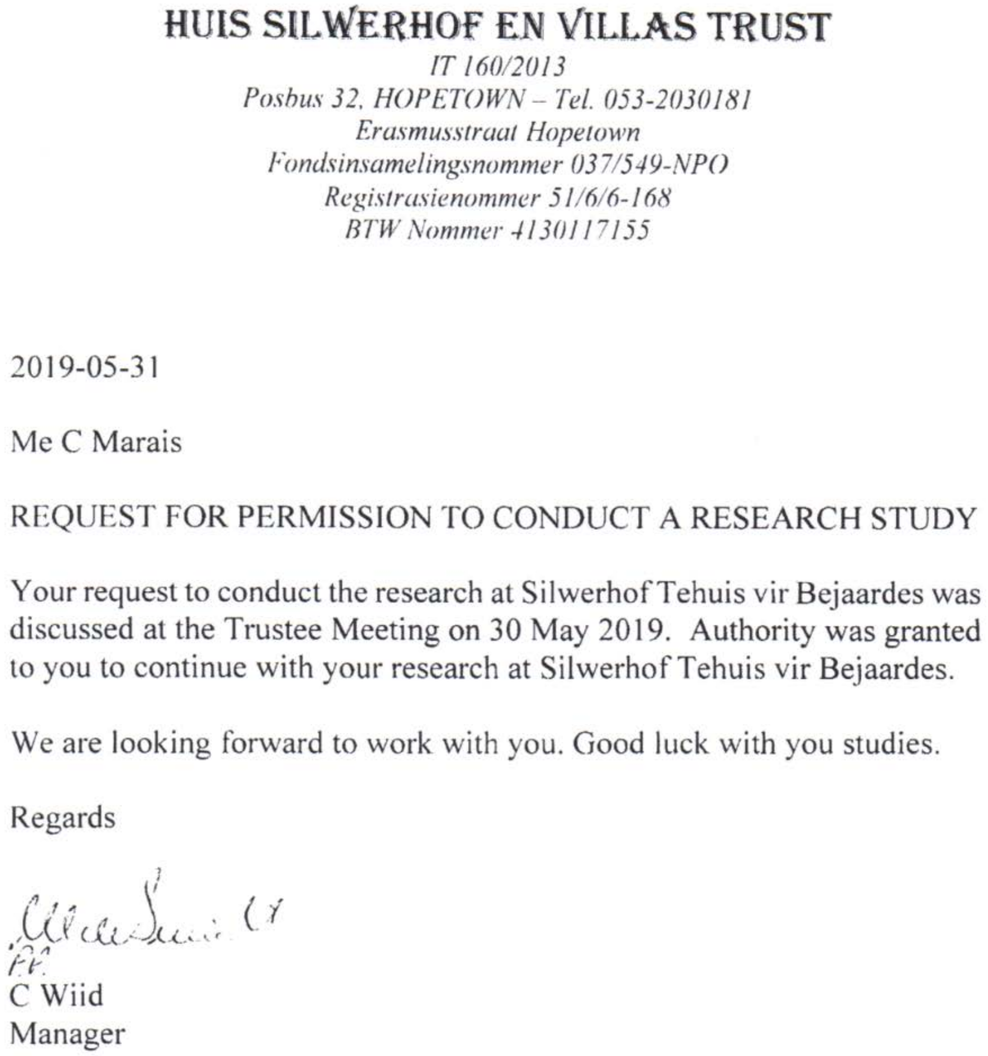
Vriendelike groete

Christelle du Plooy

Programbestuurder: Maatskaplike Dienste

www.caritas.org.za
T 053 832 8153/4
F 086 210 5854
Posbus 1430, Kimberley 8300
Lawsonstraat 72, Kimberley 8301

Permission granted by the board – Caritas Huis Silwerhof



HUIS SILWERHOF EN VILLAS TRUST
IT 160/2013
Posbus 32, HOPETOWN – Tel. 053-2030181
Erasmusstraat Hopetown
Fondsinsamelingsnommer 037/549-NPO
Registrasienommer 51/6/6-168
BTW Nommer 4130117155

2019-05-31

Me C Marais

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

Your request to conduct the research at Silwerhof Tehuis vir Bejaardes was discussed at the Trustee Meeting on 30 May 2019. Authority was granted to you to continue with your research at Silwerhof Tehuis vir Bejaardes.

We are looking forward to work with you. Good luck with you studies.

Regards

C Wiid
Manager

ADDENDUM C: Participant information leaflets and consent forms

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM: CAREGIVERS

LEARNING NEEDS OF CAREGIVERS OF OLDER PERSONS WITH NEUROCOGNITIVE DISORDERS: AN EXPLORATIVE CASE STUDY

INVESTIGATOR: Cecilia Marais
Estate 12, Vaallus
Douglas
CONTACT NUMBER: 063 655 6056

STUDY SUPERVISORS: Dr D van Jaarsveldt and Dr C Spies
School of Nursing
Health Science Department
University of the Free State
Bloemfontein
CONTACT NUMBERS: 051 401 3646
051 401 9721

Valued Participant

You are being invited to partake in a research study. Please take some time to read the information presented here, which will explain the details of this study. Please ask me, the investigator or my study supervisor/s any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely **of your own free will** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you agree to take part. Any data gathered during this study will be kept **private**. No information given by you, the participant, will or can be linked back to you personally.

This study has been approved by the Health Science Research Ethics Committee at the University of the Free State, Bloemfontein Campus and will be conducted according to the ethical guidelines and principals for Research.

The study will take place in two of the eight sub-divisions of the Pixi ka Seme Municipal district in the Northern Cape. There are three residential care facilities for older persons in these two local municipal districts. They are situated in the towns of Griekwastad, Douglas and Hopetown. There is approximately 24 caregivers in total at these three residential care facilities that adhere to the inclusion criteria and are willing to partake in the study.

The aim of this study is to identify the learning needs the caregivers have in their daily tasks looking after and caring for older persons.

You will be asked to participate in a group interview where I will ask a question. You will have time to think before answering. There are no incorrect answers. Each person will have a turn to talk and your answers will be written down on a big sheet of paper so that you can check that I have understood you correctly. It is important that I write down your ideas and not my own. There will be time for you to discuss the information that you and your fellow participants shared. After the discussion you will have an opportunity to vote for the answers that you think are most important. This will show what the group thinks are the most important answers to the question.

After I have completed group interview sessions with the caregivers at each of the three care facilities, I will be able to combine the results and conclude which learning needs are the most important to all of you who participated.

The reason for the research is to know what you need to learn so that a training programme can be developed for caregivers at the three care facilities.

Permission will be obtained from your employer as well as the Department of Social Development before conducting the study. There is no risk of losing your job, loss of working hours or part of your salary when participating. The answers that you provide during the group interview will be respected and there will be no negative consequences for information that you have shared. You will not receive any money and/or other payment for participating in this study.

You can contact me, Cecilia, any time during the study if you have any questions, queries or uncertainties on the number 063 655 6056.

You are welcome to contact my study supervisors, Dr Van Jaarsveldt (051 401 3646) or Dr Spies (051 401 9721), if you have any questions, concerns or complaints about the research.

You can contact the Health Science Research Ethics Committee on the number 051 4017794/5 about any concerns or complaints about the research which the investigator, Cecilia, or her supervisors, Drs Van Jaarsveldt and Spies did not address adequately.

DECLARATION BY PARTICIPANT

By signing below, I …………………………………………………………agree to take part in the research study identifying the learning needs of caregivers in residential care facilities for older persons in the Northern Cape.

I declare that:

- I have read this information and permission form and it is written in a language with which I am comfortable with and understand completely.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **at my own free will** and I have not been pressured to take part. The information provided by me will be treated **privately**.
- I may choose to leave the study at any time and will not be punished for it or be treated unfair in any way.

Signed at …………………………………on………. …………………………….2019.

____________________________ ____________________________

Signature participant Signature witness

DECLARATION BY INVESTIGATOR

I, Cecilia Marais declare that:

- I explained the information in this document to ………………………………….
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research study, as discussed above.

Signed at ……………………………on…………………………………………….2019.

____________________________ ____________________________

Signature investigator Signature witness

DEELNEMER INLIGTINGSPAMFLET EN TOESTEMMING VORM: VERSORGERS

LEERBEHOEFTES VAN VERSORGERS VAN OUER PERSONE MET NEUROKOGNITIEWE VERSTEURINGS: 'n EKSPLORATIEWE GEVALLE STUDIE

NAVORSER: Cecilia Marais
Perseel 12, Vaallus
Douglas
KONTAK BESONDERHEDE: 063 655 6056

STUDIE LEIERS: Dr D van Jaarsveldt en Dr C Spies
Skool van Verpleging
Departement van Gesondheidswetenskappe
Universiteit van die Vrystaat
Bloemfontein
KONTAK BESONDERHEDE: 051 401 3646
051 401 9721

Gewaardeerde deelnemer

U word vriendelik uitgenooi om te deel aan 'n navorsingstudie. Neem asseblief 'n paar minute om die inligting, wat die besonderhede van hierdie studie sal verduidelik, te lees. Voel asseblief vry om my, die navorser, of my studieleier/s enige vrae oor enige deel van hierdie studie wat u nie ten volle verstaan, te vra. Dit is baie belangrik dat u ten volle verstaan wat die navorsing behels en hoe u betrokke kan wees. U deelname is heeltemal **uit vrye wil** en u is geregtig om deelname te weier. Indien u deelname weier sal dit onder geen omstandighede teen u gehou word nie. U is ook geregtig om te enige tyd gedurende die studie deelname te staak, al het u toestemming gegee om deel te neem. Alle data wat ingesamel sal word tydens hierdie studie sal **privaat** gehou word. Geen inligting gegee deur u, die deelnemer sal of kan gekoppel word aan u persoonlik nie.

Hierdie studie is deur die Gesondheidswetenskappe Navorsings Etiese Kommittee van die Universiteit van die Vrystaat, Bloemfontein kampus goedgekeur en sal uitgevoer word volgens die etiese riglyne en beginsels vir navorsing.

Die studie sal plaasvind in twee van die agt sub-afdelings van die Pixi ka Seme Munisipale distrikte in die Noord-Kaap. Daar is drie residensiële sorg fasiliteite vir ouer persone in hierdie twee plaaslike Munisipale distrikte. Hulle is geleë in die dorpe van Griekwastad, Douglas en Hopetown. Daar is ongeveer 24 versorgers in totaal by hierdie drie residensiële sorg fasiliteite wat voldoen aan die insluiting kriteria en wat moontlik bereid sal wees om aan die studie deel te neem.

Die doel van hierdie studie is om die leerbehoeftes van versorgers te identifiseer in hul daaglikse versorging en hantering van ouer persone.

U sal gevra word om deel te neem aan ‘n groepbespreking waar ek ‘n vraag gaan vra. U sal tyd gegee word om oor die vraag te dink voordat u antwoord. Geen van die antwoorde sal verkeerd wees nie. Elke versorger sal ‘n beurt kry om te praat en al u antwoorde sal op ‘n groot vel papier neer geskryf word. Dit word gedoen om seker te maak dat ek u reg verstaan het. Dit is belangrik dat die antwoorde wat neergeskryf word u eie is. Daar sal tyd gegee word vir u om die inligting wat u en u mede-versorgers gedeel het, te bespreek. Na afloop van die bespreking sal u ‘n geleentheid gegee word om vir die antwoorde, wat u dink die belangrikste is, te stem. Die stemproses sal aandui watter antwoorde u as groep dink die vraag die beste beantwoord.

Na afloop van die groepbesprekings sal die navorser die resultate kombineer en die mees belangrike leerbehoeftes, van die versorgers wat aan die studie deelgeneem het, kan identifiseer.

Die rede vir die navorsing is om te bepaal wat u moet leer sodat ‘n opleidingsprogram ontwikkel kan word vir versorgers by die drie sorg fasiliteite.

Toestemming sal verkry word van u werkgewer asook die Departement van Sosiale Ontwikkeling voor aanvang van die studie. Daar is absoluut geen risiko vir u om u werk te verloor, verlies van werksure of verlies van salaris indien u aan die studie deelneem nie. Al die inligting sal met respek behandel word en daar sal geen negatiewe nagevolge wees in verband met die inligting wat u met my gedeel het nie. U sal geen geldelike en/of enige ander vergoeding ontvang vir u deelname nie.

U kan my, Cecilia, enige tyd kontak gedurende die studie aangaande vrae, klagtes of onsekerhede op die volgende nommer: 063 655 6056.

U is welkom om my studieleiers, Dr Van Jaarsveldt (051 401 3646) en Dr Spies (051 401 9721), te kontak indien ek, Cecilia, nie u vrae, onsekerhede of klagtes rakende die navorsing bevredigend hanteer het nie.

U kan ook die Gesondheidswetenskappe Navorsings Etiek Kommittee kontak op die nommer 051 4017794/5 rakende die navorsing indien ek, Cecilia, of my studieleiers, Drs Van Jaarsveldt en Spies u vrae nie bevredigend beantwoord het nie.

VERKLARING DEUR DEELNEMER

Hierdeur gee ek, ……………………………………………………………my toestemming vir deelname aan die navorsingstudie om die leerbehoeftes van versorgers van ouer persone in residensiële sorg fasiliteite in die Noord Kaap te identifiseer.

Ek verklaar hiermee dat:

- Ek die inligtings en toestemmingsvorm gelees het en dat dit in ‘n taal is wat ek ten volle verstaan en kan praat is.
- Ek voldoende tyd gehad het om vrae te vra en dat al my vrae voldoende beantwoord is.
- Ek verstaan dat deelname absoluut **uit vrye wil** is en dat ek nie beinvloed is om deel te neem nie. Al die inligting wat deur my verskaf sal word, sal **privaat** hanteer word.
- Ek mag onttrek te enige tyd gedurende die studie en sal onder geen omstandighede, onregverdig behandel word of gestraf word, vir my besluit nie.

Geteken te ……………………………………op……… …………………………….2019.

Handtekening deelnemer

Handtekening getuie

VERKLARING DEUR NAVORSER

Hiermee verklaar ek, Cecilia Marais, dat:

- Ek die inligting in hierdie dokument verduidelik het aan ………………………….
- Ek haar/hom aangemoedig het om vrae te vra en dat ek voldoende tyd gebruik het om die vrae te beantwoord.
- Ek tevrede is dat sy/hy alle aspekte van die studie, soos hierbo beskryf, voldoende verstaan.

Geteken te ………………………………op ……………………………………….2019.

Handtekening Navorser

Handtekening Getuie

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM: FAMILY MEMBERS

LEARNING NEEDS OF CAREGIVERS OF OLDER PERSONS WITH NEUROCOGNITIVE DISORDERS: AN EXPLORATIVE CASE STUDY

INVESTIGATOR: Cecilia Marais
Estate 12, Vaallus
Douglas
CONTACT NUMBER: 063 655 6056

STUDY SUPERVISORS: Dr D van Jaarsveldt and Dr C Spies
School of Nursing
Health Science Department
University of the Free State
Bloemfontein
CONTACT NUMBERS: 051 401 3646
051 401 9721

Valued Participant

You are being invited to partake in a research study. Please take some time to read the information presented here, which will explain the details of this study. Please ask me, the investigator or my study supervisor/s any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely **voluntarily** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you agree to take part. Any data gathered during this study will be kept **confidential**. No information given by you, the participant, will or can be linked back to you personally.

This study has been approved by the Health Science Research Ethics Committee at the University of the Free State, Bloemfontein Campus and will be conducted according to the ethical guidelines and principals for Research.

The study will take place in two of the eight sub-divisions of the Pixi ka Seme Municipal district in the Northern Cape. There are three residential care facilities for older persons in these two local municipal districts. They are situated in the towns of

Griekwastad, Douglas and Hopetown. There is approximately 12 family members of residents in these mentioned facilities who are willing to partake in the study.

The aim of this study is to identify the learning needs the caregivers have in their daily tasks looking after and caring for older persons.

You will be asked to participate in a group interview where I will ask a question. You will have time to think before answering. There are no incorrect answers. Each person will have a turn to talk and your answers will be written down on a big sheet of paper so that you can check that I have understood you correctly. It is important that I write down your ideas and not my own. There will be time for you to discuss the information that you and your fellow participants shared. After the discussion you will have an opportunity to vote for the answers that you think are most important. This will show what the group thinks are the most important answers to the question.

The reason for the research is to identify what the caregivers need to learn so that a training programme can be developed for them at the three care facilities.

The focus will be on developing the positive aspects of the care your realitive/s will receive in future. You will not receive any money and/or other payment for participating in this study.

You can contact me, Cecilia, any time during the study if you have any questions, queries or uncertainties on the number 063 655 6056.

You are welcome to contact my study supervisors, Dr Van Jaarsveldt (051 401 3646) or Dr Spies (051 401 9721), if you have any questions, concerns or complaints about the research.

You can contact the Health Science Research Ethics Committee on the number 051 4017794/5 about any concerns or complaints about the research which the investigator, Cecilia, or her supervisors, Drs Van Jaarsveldt and Spies did not address adequately.

DECLARATION BY PARTICIPANT

By signing below, I ……………………………………………………………agree to take part in the research study identifying the learning needs of caregivers in residential care facilities for older persons in the Northern Cape.

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressured to take part. The information provided by me will be treated **confidentially**.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

Signed at …………………………………on………. …………………………….2019.

Signature participant

Signature witness

DECLARATION BY INVESTIGATOR

I, Cecilia Marais declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research study, as discussed above.

Signed at ……………………………on…………………………………………….2019.

Signature investigator

Signature witness

DEELNEMER INLIGTINGSPAMFLET EN TOESTEMMING VORM: FAMILIE LEDE

LEERBEHOEFTES VAN VERSORGERS VAN OUER PERSONE MET NEUROKOGNITIEWE VERSTEURINGS: 'n EKSPLORATIEWE GEVALLE STUDIE

NAVORSER: Cecilia Marais
Perseel 12, Vaallus
Douglas
KONTAK BESONDERHEDE: 063 655 6056

STUDIE LEIERS: Dr D van Jaarsveldt en Dr C Spies
Skool van Verpleging
Departement van Gesondheidswetenskappe
Universiteit van die Vrystaat
Bloemfontein
KONTAK BESONDERHEDE: 051 401 3646
051 401 9721

Gewaardeerde deelnemer

U word vriendelik uitgenooi om te deel aan 'n navorsingstudie. Neem asseblief 'n paar minute om die inligting, wat die besonderhede van hierdie studie sal verduidelik, te lees. Voel asseblief vry om my, die navorser of my studieleier/s enige vrae oor enige deel van hierdie studie wat u nie ten volle verstaan, te vra. Dit is baie belangrik dat u ten volle verstaan wat die navorsing behels en hoe u betrokke kan wees. U deelname is heeltemal **vrywillig** en u is geregtig om deelname te weier. Indien u deelname weier sal dit onder geen omstandighede teen u gehou word nie. U is ook geregtig om te enige tyd gedurende die studie deelname te staak, al het u toestemming gegee om deel te neem. Alle data wat ingesamel sal word tydens hierdie studie sal **vertroulik** gehou word. Geen inligting gegee deur u, die deelnemer sal of kan gekoppel word aan u persoonlik nie.

Hierdie studie is deur die Gesondheidswetenskappe Navorsings Etiese Kommittee van die Universiteit van die Vrystaat, Bloemfontein kampus goedgekeur en sal uitgevoer word volgens die etiese riglyne en beginsels vir navorsing.

Die studie sal plaasvind in twee van die agt sub-afdelings van die Pixi ka Seme Munisipale distrikte in die Noord-Kaap. Daar is drie residensiële sorg fasiliteite vir ouer persone in hierdie twee plaaslike Munisipale distrikte. Hulle is geleë in die dorpe van Griekwastad, Douglas en Hopetown. Daar is ongeveer 12 familie lede in totaal by hierdie drie residensiële sorg fasiliteite wat voldoen aan die insluiting kriteria en wat moontlik bereid sal wees om aan die studie deel te neem.

Die doel van hierdie studie is om die leerbehoeftes van versorgers te identifiseer in hul daaglikse versorging en hantering van ouer persone.

U sal gevra word om deel te neem aan ‘n groepbespreking waar ek ‘n vraag gaan vra. U sal tyd gegee word om oor die vraag te dink voordat u antwoord. Geen van die antwoorde sal verkeerd wees nie. Elke versorger sal ‘n beurt kry om te praat en al u antwoorde sal op ‘n groot vel papier neer geskryf word. Dit word gedoen om seker te maak dat ek u reg verstaan het. Dit is belangrik dat die antwoorde wat neergeskryf word u eie is. Daar sal tyd gegee word vir u om die inligting wat u en u mede-versorgers gedeel het, te bespreek. Na afloop van die bespreking sal u ‘n geleentheid gegee word om vir die antwoorde, wat u dink die belangrikste is, te stem. Die stemproses sal aandui watter antwoorde u as groep dink die vraag die beste beantwoord.

Die rede vir die navorsing is om te bepaal wat die versorgers moet leer sodat ‘n opleidingsprogram ontwikkel kan word vir hulle by die drie sorg fasiliteite.

Daar is geen risiko betrokke vir u as familielid, tydens u deelname aan die studie nie. Die studie sal hoofsaaklik fokus op ontwikkeling van die positiewe aspekte van die versorging van u geliefde/s in die toekoms. U sal geen geldelike en/of enige ander vergoeding ontvang vir u deelname nie.

U kan my, Cecilia, enige tyd kontak gedurende die studie aangaande vrae, klagtes of onsekerhede op die volgende nommer: 063 655 6056.

U is welkom om my studieleiers, Dr Van Jaarsveldt (051 401 3646) en Dr Spies (051 401 9721), te kontak indien ek, Cecilia, nie u vrae, onsekerhede of klagtes rakende die navorsing bevredigend hanteer het nie.

U kan ook die Gesondheidswetenskappe Navorsings Etiek Kommittee kontak op die nommer 051 4017794/5 rakende die navorsing indien ek, Cecilia, of my studieleiers, Drs Van Jaarsveldt en Spies u vrae nie bevredigend beantwoord het nie.

VERKLARING DEUR DEELNEMER

Hierdeur gee ek, ………………………………………………………………my toestemming vir deelname aan die navorsingstudie om die leerbehoeftes van versorgers van ouer persone in residensiële sorg fasiliteite in die Noord Kaap te identifiseer.

Ek verklaar hiermee dat:

- Ek die inligtings en toestemmingsvorm gelees het en dat dit in 'n taal is wat ek verstaan en magtig is.
- Ek voldoende tyd gehad het om vrae te vra en dat al my vrae voldoende beantwoord is.
- Ek verstaan dat deelname absoluut **vrywillig** is en dat ek nie beinvloed is om deel te neem nie. Al die inligting wat deur my verskaf sal word, sal **vertroulik** hanteer word.
- Ek mag onttrek te enige tyd gedurende die studie en sal onder geen omstandighede onregverdig behandel word vir my besluit nie.

Geteken te ……………………………………op……… …………………………….2019.

______________________________ ______________________________

Handtekening deelnemer Handtekening getuie

VERKLARING DEUR NAVORSER

Hiermee verklaar ek, Cecilia Marais, dat:

- Ek die inligting in hierdie dokument verduidelik het aan ………………………………………………………………………..
- Ek haar/hom aangemoedig het om vrae te vra en dat ek voldoende tyd gebruik het om die vrae te beantwoord.
- Ek tevrede is dat sy/hy alle aspekte van die studie, soos hierbo beskryf, voldoende verstaan.

Geteken te ………………………………op ……………………………………….2019.

______________________________ ______________________________

Handtekening Navorser Handtekening Getuie

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM: REGISTERED NURSES

LEARNING NEEDS OF CAREGIVERS OF OLDER PERSONS WITH NEUROCOGNITIVE DISORDERS: AN EXPLORATIVE CASE STUDY

INVESTIGATOR: Cecilia Marais
Estate 12, Vaallus
Douglas
CONTACT NUMBER: 063 655 6056

STUDY SUPERVISORS: Dr D van Jaarsveldt and Dr C Spies
School of Nursing
Health Science Department
University of the Free State
Bloemfontein
CONTACT NUMBERS: 051 401 3646
051 401 9721

Valued Participant

You are being invited to partake in a research study. Please take some time to read the information presented here, which will explain the details of this study. Please ask me, the investigator or my study supervisor/s any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely **voluntarily** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you agree to take part. Any data gathered during this study will be kept **confidential**. No information given by you, the participant, will or can be linked back to you personally.

This study has been approved by the Health Science Research Ethics Committee at the University of the Free State, Bloemfontein Campus and will be conducted according to the ethical guidelines and principals for Research.

The study will take place in two of the eight sub-divisions of the Pixi ka Seme Municipal district in the Northern Cape. There are three residential care facilities for older persons in these two local municipal districts. There are three Registered Nurses currently employed at the mentioned facilities, respectively. All three RN's will be invited to participate in the study.

The aim of this study is to identify the learning needs the caregivers have in their daily tasks looking after and caring for the older persons.

I will conduct a group interview with the three Registered nurses willing to participate. I will ask a question related to the research study. You are then given a few minutes to think in silence about the question and what you are going to answer. Thereafter a healthy debate will follow regarding the question. Valuable input from a health professional viewpoint will help to assess the problem at hand from different perspectives. After completion of the group interview you, as Registered Nurses, will be able to identify the learning needs of the caregivers under your supervision.

The reason for this research is to identify what the caregivers need to learn so that a training programme can be developed at the three care facilities.

Permission will be obtained from your employer as well as the Department of Social Development before conducting the study. There is no risk of losing your job, losing working hours or part of your salary when participating. You will not receive any money and/or other payment for participating in this study.

You can contact me, Cecilia, any time during the study if you have any questions, queries or uncertainties on the number 063 655 6056.

You are welcome to contact my study supervisors, Dr Van Jaarsveldt (051 401 3646) or Dr Spies (051 401 9721), if you have any questions, concerns or complaints about the research.

You can contact the Health Science Research Ethics Committee on the number 051 4017794/5 about any concerns or complaints about the research which the investigator, Cecilia, or her supervisors, Drs Van Jaarsveldt and Spies did not address adequately.

DECLARATION BY PARTICIPANT

By signing below, I ……………………………………………………………agree to take part in the research study identifying the learning needs of caregivers in residential care facilities for the older persons in the Northern Cape.

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressured to take part. The information provided by me will be treated **confidentially**.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

Signed at …………………………………on………. …………………………….2019.

Signature participant

Signature witness

DECLARATION BY INVESTIGATOR

I, Cecilia Marais declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research study, as discussed above.

Signed at ……………………………on…………………………………………..2019.

Signature investigator

Signature witness

DEELNEMER INLIGTINGSPAMFLET EN TOESTEMMING VORM: GEREGISTREERDE VERPLEEGKUNDIGES

LEERBEHOEFTES VAN VERSORGERS VAN OUER PERSONE MET NEUROKOGNITIEWE VERSTEURINGS: 'n EKSPLORATIEWE GEVALLE STUDIE

NAVORSER: Cecilia Marais
Perseel 12, Vaallus
Douglas

KONTAK BESONDERHEDE: 063 655 6056

STUDIE LEIERS: Dr D van Jaarsveldt en Dr C Spies
Skool van Verpleging
Departement van Gesondheidswetenskappe
Universiteit van die Vrystaat
Bloemfontein

KONTAK BESONDERHEDE: 051 401 3646
051 401 9721

Gewaardeerde deelnemer

U word vriendelik uitgenooi om te deel aan 'n navorsingstudie. Neem asseblief 'n paar minute om die inligting, wat die besonderhede van hierdie studie sal verduidelik, te lees. Voel asseblief vry om my, die navorser of my studieleier/s enige vrae oor enige deel van hierdie studie wat u nie ten volle verstaan, te vra. Dit is baie belangrik dat u ten volle verstaan wat die navorsing behels en hoe u betrokke kan wees. U deelname is heeltemal **vrywillig** en u is geregtig om deelname te weier. Indien u deelname weier sal dit onder geen omstandighede teen u gehou word nie. U is ook geregtig om te enige tyd gedurende die studie deelname te staak, al het u toestemming gegee om deel te neem. Alle data wat ingesamel sal word tydens hierdie studie sal **vertroulik** gehou word. Geen inligting gegee deur u, die deelnemer sal of kan gekoppel word aan u persoonlik nie.

Hierdie studie is deur die Gesondheidswetenskappe Navorsings Etiese Kommittee van die Universiteit van die Vrystaat, Bloemfontein kampus goedgekeur en sal uitgevoer word volgens die etiese riglyne en beginsels vir navorsing.

Die studie sal plaasvind in twee van die agt sub-afdelings van die Pixi ka Seme Munisipale distrikte in die Noord-Kaap. Daar is drie residensiële sorg fasiliteite vir ouer persone in hierdie twee plaaslike Munisipale distrikte. Hulle is geleë in die dorpe van Griekwastad, Douglas en Hopetown. Daar is tans drie Geregistreerde Verpleegkundiges werksaam by die bogenoemde sorg fasiliteite onderskeidelik. Al drie Geregistreerde Verpleegkundiges sal genooi word om deel te neem aan die studie.

Die doel van hierdie studie is om die leerbehoeftes van versorgers te identifiseer in hul daaglikse versorging en hantering van ouer persone.

Ek beoog om ‘n groepbespreking die Geregistreerde Verpleegkundiges te hou, indien hulle inwillig om deel te neem aan die studie. Ek gaan ‘n vraag vra wat verband hou met die navorsing. U gaan dan ‘n paar minute kry om in stilte oor die vraag te dink en hoe u gaan antwoord. Hierna gaan u ‘n gesonde debat voer rakende die vraag. Waardevolle inligting, uit ‘n professionele oogpunt, kan bydra tot die assessering van die probleem uit verskillende perspektiewe. Na afloop van die bespreking sal u, as Geregistreerde Verpleegkundiges, die leerbehoeftes van die versorgers onder u toesig kan identifiseer.

Die rede vir die navorsing is om te identifiseer wat die versorgers moet leer sodat ‘n opleidingsprogram vir hulle ontwikkel kan word by die drie sorg fasiliteite.

Toestemming sal verkry word van u werkgewer asook die Departement van Sosiale Ontwikkeling voor aanvang van die studie. Daar is absoluut geen risiko vir u om u werk te verloor, verlies van werksure of verlies van salaris indien u aan die studie deelneem nie. U sal geen geldelike en/of enige ander vergoeding ontvang vir u deelname nie.

U kan my, Cecilia, enige tyd kontak gedurende die studie aangaande vrae, klagtes of onsekerhede op die volgende nommer: 063 655 6056.

U is welkom om my studieleiers, Dr Van Jaarsveldt (051 401 3646) en Dr Spies (051 401 9721, te kontak indien ek, Cecilia, nie u vrae, onsekerhede of klagtes rakende die navorsing bevredigend hanteer het nie.

U kan ook die Gesondheidswetenskappe Navorsings Etiek Kommittee kontak op die nommer 051 4017794/5 rakende die navorsing indien ek, Cecilia, of my studieleiers, Drs Van Jaarsveldt en Spies u vrae nie bevredigend beantwoord het nie.

VERKLARING DEUR DEELNEMER

Hierdeur gee ek, ………………………………………………………………my toestemming vir deelname aan die navorsingstudie om die leerbehoeftes van versorgers van ouer persone in residensiële sorg fasiliteite in die Noord Kaap te identifiseer.

Ek verklaar hiermee dat:

- Ek die inligtings en toestemmingsvorm gelees het en dat dit in ‘n taal is wat ek verstaan en magtig is.
- Ek voldoende tyd gehad het om vrae te vra en dat al my vrae voldoende beantwoord is.
- Ek verstaan dat deelname absoluut **vrywillig** is en dat ek nie beinvloed is om deel te neem nie. Al die inligting wat deur my verskaf sal word, sal **vertroulik** hanteer word.
- Ek mag onttrek te enige tyd gedurende die studie en sal onder geen omstandighede onregverdig behandel word vir my besluit nie.

Geteken te ……………………………………op……… …………………………….2019.

Handtekening deelnemer Handtekening getuie

VERKLARING DEUR NAVORSER

Hiermee verklaar ek, Cecilia Marais, dat:

- Ek die inligting in hierdie dokument verduidelik het aan ………………………..
- Ek haar/hom aangemoedig het om vrae te vra en dat ek voldoende tyd gebruik het om die vrae te beantwoord.
- Ek tevrede is dat sy/hy alle aspekte van die studie, soos hierbo beskryf, voldoende verstaan.

Geteken te ………………………………op ………………………………………….2019.

Handtekening Navorser Handtekening Getuie

ADDENDUM D: Raw data: Nominal groups

Researcher's flip chart notes C1 (n=7)

Item No.	Statement	Scores	Total score	Priority
1	Empathy + Sympathy - Friendship relationship with older person	2,2	4	
2	Rights in the workplace - Protect the caregivers + older persons	1,2,5	8	5
3	Medication - Knowledge - Uses/actions - Interactions	1,3,4,4	12	4
4	In-service training - Blood pressure - Blood glucose - Urine testing	4,5,5,5	19	1
5	Communication - Collegues - Older persons - Registered nurses and management	4,4,4,5	17	2
6	Handling of resistance - Co-workers - Older persons - Family members	3	3	
7	Unfair/insensitive person in charge	1,3	4	
8	Cooperation - Training - Mutual communication - Alzheimer's disease persons	2,3,3	8	5
9	Alzheimer's disease - Stages - Handling thereof - Identifying mood	1,2,2,3,3,5	16	3
10	Handling of difficult older persons (behaviour) - Refusal to eat/wash/sleep	1,5	6	
11	Conflict - How to avoid - Appropriate handling	4	4	
12	Respect + protection of rights - Caregiver - Older person	1,1,2	4	
13	Interpersonal relationships	-	0	
14	Pre-existing treatment guidelines - All conditions	-	0	

Researcher's flip chart notes C2 (n=8)

Item No.	Statement	Scores	Total score	Priority
1	Acknowledgement for what caregiver do	1,1	2	
2	Urine testing - Urinary tract infection	3,4	7	
3	Administration of oxygen	4	4	
4	Testing blood sugar levels - All aspects	2	2	
5	Taking blood pressure - Interpretation of reading - Handling ↑/↓ blood pressure	4,4,5	13	3
6	Signs and symptomes of a stroke - Handling/responding	2,2,3,5	12	4
7	Diabetes - All aspects of the condition - Responding - Handling	3,3	6	
8	Study leave/ In-service training	2,2	4	
9	Alzheimer's disease - Stages - All aspects - Aggression	4,4,5,5	18	1
10	Medical conditions - Epilepsy - Woundcare	3	3	
11	Nebulising - All aspects	-	0	
12	Prevention of back injuries - Handling of person not able to provide any assistance	3,3,5,5	16	2
13	Anxiety attacks - Identification - Handling/responding	2	2	
14	Body temperature - Normal/abnormale readings - Handling/responding	-	0	
15	Responding to emergencies - Fainting - Bleeding - Falls	2,2,3,5	12	4
16	Medication - Interaction - Uses/actions	1,1,1,1,1,1,4	10	5
17	Empathy - In touch with the job	4	4	
18	Dehidration	5	5	

Researcher’s flip chart notes C3 (n=10)

Item No.	Statement	Scores	Total score	Priority
1	Stroke - Signs and symptomes - Handling/responding	1,3,4	8	
2	Heart attack - Signs and symptomes - Handling/responding	2,3,3,3	11	4
3	Epilepsy - Signs and symptomes - Handling/responding	1	1	
4	Protection of the rights of the caregivers and protections as a person	1,4,4	9	5
5	Emergency medication for caregivers and older persons	1,2,3	6	
6	Evaluation guidelines - Clear - No double standards - Experience regarding caregiver capacity	1,1,2,2,3	9	5
7	Rights and responsibilities of caregivers - Personal (leave and compassion leave) - Towards older persons - Towards Registered Nurses/person in charge/ manager	2,3,4,5,5,5,5,5,5,5	44	1
8	Alzheimer’s disease - Stages - Handling of situations - Diagnosis/recognition of onset of disease	1,2,3,4,5	15	3
9	Diabetes - Signs and symptomes - Handling/responding	-	0	
10	Blood pressure - All aspects regarding ↑/↓ blood pressure - Handling situation - Emergency response	5	5	
11	Puls counting + time + temperature measure	-	0	
12	Communication - Caregivers - Registered Nurses - Older persons	1,1,2,2,4,4,5	19	2
13	Acknowledgement for what caregiver do - From the older persons - From the person in charge	2,2,3,4	11	4
14	Handling of aggression + opposition - Older persons - Collegues	1,3	4	
15	Medication - Interactions - Indications	4,4	8	

Researcher’s flip chart notes F (n=11)

Item No.	Statement	Scores	Total score	Priority
1	Information leaflets - Alzheimer’s disease - Stages - Handling	3,4,5	12	
2	Personality as employment requirement - Patience	2	2	
3	Use of medication - Supervision - Knowledge - Interactions	2,3	5	
4	Patience/Use time - Feeding - Medication handout/administering	3,4	7	
5	Staff distribution for caring tasks	1,2,2	5	
6	Patience and calm attitude while caring - Use time - Relaxed and quiet	4,5,5,5	19	2
7	Cleanliness with caring	1,4,4	9	
8	Hygiene - Personal/Older person - General - Diaper changes/regularity	1,1,3,4,4	13	5
9	Workbook - Duties of different sections - Staff rotation - Daily tasks to be done and signed for	1,3,3,3,4,4,5	23	1
10	Communication - Daily information - Caring duties - Handover report	1,4,5,5	15	4
11	Regular rounds - Night - Day	2,3	5	
12	Professional behaviour	1,1,3	5	
13	Employment - Selection process - Orientation - Training	2,4,5,5	16	3
14	Extra caring tasks for Alzheimer’s persons	2	2	
15	Treat older person as you would want to be treated	2	2	
16	Caregiver hygiene	5	5	
17	Basic nursing tasks	2,3,5	10	
18	Responding to emergencies - Choking	-	0	
19	Hydration - Enough fluids	2	2	
20	Handover Reports	1,1,2,3	7	
21	Participate in activities	1	1	
22	Frail person’s laundry	-	0	

Priorities C1 (n=7)

Priority	Item No.	- Statement	Scores	Total score
1	4	In-service training - Blood pressure - Blood glucose - Urine testing	4,5,5,5	19
2	5	Communication - Collegues - Older persons - Registered nurses and management	4,4,4,5	17
3	9	Alzheimer’s disease - Stages - Handling thereof - Identifying mood	1,2,2,3,3,5	16
4	3	Medication - Knowledge - Uses/actions - Interactions	1,3,4,4	12
5	2	Rights in the workplace - Protect the caregivers + older persons	1,2,5	8
	8	Cooperation - Training - Mutual communication - Alzheimer’s disease persons	2,3,3	8

Priorities C2 (n=8)

Priority	Item No.	Statement	Scores	Total score
1	9	Alzheimer’s disease - Stages - All aspects - Aggression	4,4,5,5	18
2	12	Prevention of back injuries - Handling of person not able to provide any assistance	3,3,5,5	16
3	5	Taking blood pressure - Interpretation of reading - Handling ↑/↓ blood pressure	4,4,5	13
4	6	Signs and symptomes of a stroke - Handling/responding	2,2,3,5	12
	15	Responding to emergencies - Fainting - Bleeding - Falls	2,2,3,5	12
5	16	Medication - Interaction - Uses/actions	1,1,1,1,1,1,4	10

Priorities C3 (n=10)

Priority	Item No.	Statement	Scores	Total score
1	7	Rights and responsibilities of caregivers - Personal (leave and compassion leave) - Towards older persons - Towards Registered Nurses/person in charge/ manager	2,3,4,5,5,5,5,5,5,5	44
2	12	Communication - Caregivers - Registered Nurses - Older persons	1,1,2,2,4,4,5	19
3	8	Alzheimer's disease - Stages - Handling of situations - Diagnosis/recognition of onset of disease	1,2,3,4,5	15
4	2	Heart attack - Signs and symptomes - Handling/responding	2,3,3,3	11
	13	Acknowledgement for what caregiver do - From the older persons - From the person in charge	2,2,3,4	11
5	4	Protection of the rights of the caregivers and protections as a person	1,4,4	9
	6	Evaluation guidelines - Clear - No double standards - Experience regarding caregiver capacity	1,1,2,2,3	9

Priorities F (n=11)

Priority	Item No.	Statement	Scores	Total score
1	9	Workbook - Duties of different sections - Staff rotation - Daily tasks to be done and signed for	1,3,3,3,4,4,5	23
2	6	Patience and calm attitude while caring - Use time - Relaxed and quiet	4,5,5,5	19
3	13	Employment - Selection process - Orientation - Training	2,4,5,5	16
4	10	Communication - Daily information - Caring duties - Handover report	1,4,5,5	15
5	8	Hygiene - Personal/Older person - General - Diaper changes/regularity	1,1,3,4,4	13

ADDENDUM E: Spreadsheet: Nominal group data

Spreadsheet: Nominal group data sets

Group code	Category and sub-categories	Statement	Scores	Total score	Average score	Top 5
C1	Basic nursing skills - Interpersonal skills	Empathy + Sympathy - Friendship relationship with older person	2,2	4	0.57	
C1	Rights and responsibilities - Human rights	Rights in the workplace - Protect the caregivers + older persons	1,2,5	8	1.14	5
C1	Medication - Knowledge - actions/interactions	Medication - Knowledge - Uses/actions - Interactions	1,3,4,4	12	1.71	4
C1	Basic nursing skills - Clinical skills	In-service training - Blood pressure - Blood glucose - Urine testing	4,5,5,5	19	2.71	1
C1	Communication - Among staff members, authority figures and older persons	Communication - Collegues - Older persons - Registered nurses and management	4,4,4,5	17	2.42	2
C1	Communication - Conflict management and prevention	Handling of resistance - Co-workers - Older persons - Family members	3	3	0.42	
C1	Communication - Conflict management and prevention	Unfair/insensitive person in charge	1,3	4	0.57	
C1	Communication - Among staff members, authority figures and older persons	Cooperation - Training - Mutual communication - Alzheimer's disease persons	2,3,3	8	1.14	5

C1	Alzheimer’s disease - Stages of the disease - Caring for an older person who has Alzheimer’s disease	Alzheimer’s disease - Stages - Handling thereof - Identifying mood	1,2,2,3,3, 5	16	2.28	3
C1	Communication - Conflict management and prevention	Handling of difficult older persons (behaviour) - Refusal to eat/wash/sleep	1,5	6	0.85	
C1	Communication - Conflict management and prevention	Conflict - How to avoid - Appropriate handling	4	4	0.57	
C1	Rights and responsibilities - Human rights - Responsibilities	Respect + protection of rights - Caregiver - Older person	1,1,2	4	0.57	
C1	Basic nursing skills - Interpersonal skills	Interpersonal relationships	-	0	-	
C1	Basic nursing skills - Responding to emergencies	Pre-existing treatment guidelines - All conditions	-	0	-	
C2	Rights and responsibilities - Human rights	Acknowledgement for what caregiver do	1,1	2	0.25	
C2	Basic nursing skills - Clinical skills	Urine testing - Urinary tract infection	3,4	7	0.88	
C2	Basic Nursing skills - Clinical skills	Administration of oxygen	4	4	0.5	
C2	Basic nursing skills - Clinical skills	Testing blood sugar levels - All aspects	2	2	0.25	
C2	Basic nursing skills - Clinical skills	Taking blood pressure - Interpretation of reading - Handling ↑/↓ blood pressure	4,4,5	13	1.63	3
C2	Basic nursing skills - Responding to emergencies	Signs and symptomes of a stroke - Handling/responding	2,2,3,5	12	1.5	4
C2	Basic nursing skills - Responding to emergencies	Diabetes - All aspects of the condition - Responding - Handling	3,3	6	0.75	
C2	Staff monitoring and evaluation - Orientation and in-service training	Study leave/ In-service training	2,2	4	0.5	

C2	Alzheimer’s disease - Stages of the disease - Caring for an older person who has Alzheimer’s disease	Alzheimer’s disease - Stages - All aspects - Aggression	4,4,5,5	18	2.25	1
C2	Basic nursing skills - Responding to emergencies	Medical conditions - Epilepsy - Woundcare	3	3	0.38	
C2	Basic nursing skills - Clinical skills	Nebulising - All aspects	-	0	-	
C2	Basic nursing skills - Clinical skills	Prevention of back injuries - Handling of person not able to provide any assistance	3,3,5,5	16	2	2
C2	Basic nursing skills - Responding to emergencies	Anxiety attacks - Identification - Handling/responding	2	2	0.25.	
C2	Basic nursing skills - Clinical skills	Body temperature - Normal/abnormale readings - Handling/responding	-	0	-	
C2	Basic nursing skills - Responding to emergencies	Responding to emergencies - Fainting - Bleeding - Falls	2,2,3,5	12	1.5	4
C2	Medication - Knowledge - actions/interactions	Medication - Interaction - Uses/actions	1,1,1,1,1, 1,4	10	1.25	5
C2	Basic nursing skills - Interpersonal skills	Empathy - In touch with the job	4	4	0.5	
C2	Basic nursing skills - Responding to emergencies	Dehidration	5	5	0.63	
C3	Basic nursing skills - Responding to emergencies	Stroke - Signs and symptomes - Handling/responding	1,3,4	8	0.7	
C3	Basic nursing skills - Responding to emergencies	Heart attack - Signs and symptomes - Handling/responding	2,3,3,3	11	1.1	4

C3	Basic nursing skills - Responding to emergencies	Epilepsy - Signs and symptomes - Handling/responding	1	1	0.1	
C3	Rights and responsibilities - Human rights	Protection of the rights of the caregivers and protections as a person	1,4,4	9	0.9	5
C3	Medication - Knowledge - actions/interactions	Emergency medication for caregivers and older persons	1,2,3	6	0.6	
C3	Staff monitoring and evaluation - Orientation and in-service training	Evaluation guidelines - Clear - No double standards - Experience regarding caregiver capacity	1,1,2,2,3	9	0.9	5
C3	Rights and responsibilities - Human rights - Responsibilities	Rights and responsibilities of caregivers - Personal (leave and compassion leave) - Towards older persons - Towards Registered Nurses/person in charge/ manager	2,3,4,5,5, 5,5,5,5,5	44	4.4	1
C3	Alzheimer’s disease - Stages of the disease - Caring for an older person who has Alzheimer’s disease	Alzheimer’s disease - Stages - Handling of situations - Diagnosis/recognition of onset of disease	1,2,3,4,5	15	1.5	3
C3	Basic nursing skills - Responding to emergencies	Diabetes - Signs and symptomes - Handling/responding	-	0	-	
C3	Basic nursing skills - Clinical skills	Blood pressure - All aspects regarding ↑/↓ blood pressure - Handling situation - Emergency response	5	5	0.5	
C3	Basic nursing skills - Clinical skills	Puls counting + time + temperature measure	-	0	-	
C3	Communication - Among staff members, authority figures and older persons	Communication - Caregivers - Registered Nurses - Older persons	1,1,2,2,4, 4,5	19	1.9	2

C3	Rights and responsibilities - Human rights	Acknowledgement for what caregiver do - From the older persons - From the person in charge	2,2,3,4	11	1.1	4
C3	Communication - Conflict management and prevention	Handling of aggression + opposition - Older persons - Collegues	1,3	4	0.4	
C3	Medication - Knowledge - actions/interactions of medication	Medication - Interactions - Indications	4,4	8	0.8	
F	Alzheimer’s disease - Stages of the disease - Caring for an older person who has Alzheimer’s disease	Information leaflets - Alzheimer’s disease - Stages - Handling	3,4,5	12	1.09	
F	Staff monitoring and evaluation - Orientation and in-service training	Personality as employment requirement - Patience	2	2	0.18	
F	Medication - Knowledge - actions/interactions - Administration of medication	Use of medication - Supervision - Knowledge - Interactions	2,3	5	0.45	
F	Basic nursing skills - Interpersonal skills	Patience/Use time - Feeding - Medication handout/administering	3,4	7	0.64	
F	Communication - Among staff members, authority figures and older persons - Reporting	Staff distribution for caring tasks	1,2,2	5	0.45	
F	Basic nursing skills - Interpersonal skills	Patience and calm attitude while caring - Use time - Relaxed and quiet	4,5,5,5	19	1.73	2
F	Hygiene - General hygiene, infection control and cross contamination	Cleanliness with caring	1,4,4	9	0.81	

F	Hygiene - General hygiene, infection control and cross contamination - Personal and older person	Hygiene - Personal/Older person - General - Diaper changes/regularity	1,1,3,4,4	13	1.18	5
F	Communication - Among staff members, authority figures and older persons - Reporting	Workbook - Duties of different sections - Staff rotation - Daily tasks to be done and signed for	1,3,3,3,4, 4,5	23	2.09	1
F	Communication - Among staff members, authority figures and older persons - Reporting	Communication - Daily information - Caring duties - Handover report	1,4,5,5	15	1.36	4
F	Communication - Among staff members, authority figures and older persons	Regular rounds - Night - Day	2,3	5	0.45	
F	Basic nursing skills - Interpersonal skills	Professional behaviour	1,1,3	5	0.45	
F	Staff monitoring and evaluation - Orientation and in-service training	Employment - Selection process - Orientation - Training	2,4,5,5	16	1.45	3
F	Alzheimer’s disease - Caring for an older person who has Alzheimer’s disease	Extra caring tasks for Alzheimer’s persons	2	2	0.18	
F	Rights and responsibilities - Responsibilities	Treat older person as you would want to be treated	2	2	0.18	
F	Hygiene - Personal and older person	Caregiver hygiene	5	5	0.45	
F	Basic nursing skills - Clinical skills	Basic nursing tasks	2,3,5	10	0.9	

F	Basic nursing skills - Responding to emergencies	Responding to emergencies - Choking	-	0	-	
F	Basic nursing skills - Clinical skills	Hydration - Enough fluids	2	2	0.18	
F	Communication - Reporting	Handover Reports	1,1,2,3	7	0.64	
F	Communication - Among staff members, authority figures and older persons	Participate in activities	1	1	0.09	
F	Hygiene - Personal and older person	Frail person’s laundry	-	0	-	

Spreadsheet: Nominal group data - colour coded and categorised

Group code	Category and sub-categories	Statement	Scores	Total score	Average score	Top 5
C1	Basic nursing skills - Clinical skills	In-service training - Blood pressure - Blood glucose - Urine testing	4,5,5,5	19	2.71	1
C2	Basic nursing skills - Clinical skills	Urine testing - Urinary tract infection	3,4	7	0.88	
C2	Basic Nursing skills - Clinical skills	Administration of oxygen	4	4	0.5	
C2	Basic nursing skills - Clinical skills	Testing blood sugar levels - All aspects	2	2	0.25	
C2	Basic nursing skills - Clinical skills	Taking blood pressure - Interpretation of reading - Handling ↑/↓ blood pressure	4,4,5	13	1.63	3
C2	Basic nursing skills - Clinical skills	Nebulising - All aspects	-	0	-	
C2	Basic nursing skills - Clinical skills	Prevention of back injuries - Handling of person not able to provide any assistance	3,3,5,5	16	2	2
C2	Basic nursing skills - Clinical skills	Body temperature - Normal/abnormale readings - Handling/responding	-	0	-	
C3	Basic nursing skills - Clinical skills	Blood pressure - All aspects regarding ↑/↓ blood pressure - Handling situation - Emergency response	5	5	0.5	
C3	Basic nursing skills - Clinical skills	Puls counting + time + temperature measure	-	0	-	
F	Basic nursing skills - Clinical skills	Basic nursing tasks	2,3,5	10	0.9	
F	Basic nursing skills - Clinical skills	Hydration - Enough fluids	2	2	0.18	

Group code	Category and sub-categories	Statement	Scores	Total score	Average score	Top 5
C1	Basic nursing skills - Interpersonal skills	Empathy + Sympathy - Friendship relationship with older person	2,2	4	0.57	
C1	Basic nursing skills - Interpersonal skills	Interpersonal relationships	-	0	-	
C2	Basic nursing skills - Interpersonal skills	Empathy - In touch with the job	4	4	0.5	
F	Basic nursing skills - Interpersonal skills	Patience/Use time - Feeding - Medication handout/administering	3,4	7	0.64	
F	Basic nursing skills - Interpersonal skills	Patience and calm attitude while caring - Use time - Relaxed and quiet	4,5,5,5	19	1.73	2
F	Basic nursing skills - Interpersonal skills	Professional behaviour	1,1,3	5	0.45	
C1	Basic nursing skills - Responding to emergencies	Pre-existing treatment guidelines - All conditions	-	0	-	
C2	Basic nursing skills - Responding to emergencies	Signs and symptomes of a stroke - Handling/responding	2,2,3,5	12	1.5	4
C2	Basic nursing skills - Responding to emergencies	Diabetes - All aspects of the condition - Responding - Handling	3,3	6	0.75	
C2	Basic nursing skills - Responding to emergencies	Medical conditions - Epilepsy - Woundcare	3	3	0.38	
C2	Basic nursing skills - Responding to emergencies	Anxiety attacks - Identification - Handling/responding	2	2	0.25.	

Group code	Category and sub-categories	Statement	Scores	Total score	Average score	Top 5
C2	Basic nursing skills - Responding to emergencies	Responding to emergencies - Fainting - Bleeding - Falls	2,2,3,5	12	1.5	4
C2	Basic nursing skills - Responding to emergencies	Dehidration	5	5	0.63	
C3	Basic nursing skills - Responding to emergencies	Stroke - Signs and symptomes - Handling/responding	1,3,4	8	0.7	
C3	Basic nursing skills - Responding to emergencies	Heart attack - Signs and symptomes - Handling/responding	2,3,3,3	11	1.1	4
C3	Basic nursing skills - Responding to emergencies	Epilepsy - Signs and symptomes - Handling/responding	1	1	0.1	
C3	Basic nursing skills - Responding to emergencies	Diabetes - Signs and symptomes - Handling/responding	-	0	-	
F	Basic nursing skills - Responding to emergencies	Responding to emergencies - Choking	-	0	-	
F	Hygiene - General hygiene, infection control and cross contamination	Cleanliness with caring	1,4,4	9	0.81	
F	Hygiene - General hygiene, infection control and cross contamination - Personal and older person	Hygiene - Personal/Older person - General - Diaper changes/regularity	1,1,3,4,4	13	1.18	5
F	Hygiene - Personal and older person	Caregiver hygiene	5	5	0.45	
F	Hygiene - Personal and older person	Frail person’s laundry	-	0	-	

Group code	Category and sub-categories	Statement	Scores	Total score	Average score	Top 5
C1	Alzheimer's disease - Stages of the disease - Caring for an older person who has Alzheimer's disease	Alzheimer's disease - Stages - Handling thereof - Identifying mood	1,2,2,3,3, 5	16	2.28	3
C2	Alzheimer's disease - Stages of the disease - Caring for an older person who has Alzheimer's disease	Alzheimer's disease - Stages - All aspects - Aggression	4,4,5,5	18	2.25	1
C3	Alzheimer's disease - Stages of the disease - Caring for an older person who has Alzheimer's disease	Alzheimer's disease - Stages - Handling of situations - Diagnosis/recognition of onset of disease	1,2,3,4,5	15	1.5	3
F	Alzheimer's disease - Stages of the disease - Caring for an older person who has Alzheimer's disease	Information leaflets - Alzheimer's disease - Stages - Handling	3,4,5	12	1.09	
F	Alzheimer's disease - Caring for an older person who has Alzheimer's disease	Extra caring tasks for Alzheimer's persons	2	2	0.18	
C1	Medication - Knowledge - actions/interactions	Medication - Knowledge - Uses/actions - Interactions	1,3,4,4	12	1.71	4
C2	Medication - Knowledge - actions/interactions	Medication - Interaction - Uses/actions	1,1,1,1,1, 1,4	10	1.25	5
C3	Medication - Knowledge - actions/interactions	Emergency medication for caregivers and older persons	1,2,3	6	0.6	
C3	Medication - Knowledge - actions/interactions	Medication - Interactions - Indications	4,4	8	0.8	

Group code	Category and sub-categories	Statement	Scores	Total score	Average score	Top 5
F	Medication - Knowledge - actions/interactions - Administration of medication	Use of medication - Supervision - Knowledge - Interactions	2,3	5	0.45	
C1	Communication - Among staff members, authority figures and older persons	Communication - Collegues - Older persons - Registered nurses and management	4,4,4,5	17	2.42	2
C1	Communication - Conflict management and prevention	Handling of resistance - Co-workers - Older persons - Family members	3	3	0.42	
C1	Communication - Conflict management and prevention	Unfair/insensitive person in charge	1,3	4	0.57	
C1	Communication - Conflict management and prevention	Handling of difficult older persons (behaviour) - Refusal to eat/wash/sleep	1,5	6	0.85	
C1	Communication - Conflict management and prevention	Conflict - How to avoid - Appropriate handling	4	4	0.57	
C3	Communication - Among staff members, authority figures and older persons	Communication - Caregivers - Registered Nurses - Older persons	1,1,2,2,4, 4,5	19	1.9	2
C3	Communication - Conflict management and prevention	Handling of aggression + opposition - Older persons - Collegues	1,3	4	0.4	

Group code	Category and sub-categories	Statement	Scores	Total score	Average score	Top 5
F	Communication - Among staff members, authority figures and older persons - Reporting	Communication - Daily information - Caring duties - Handover report	1,4,5,5	15	1.36	4
F	Communication - Reporting	Handover Reports	1,1,2,3	7	0.64	
C1	Communication - Among staff members, authority figures and older persons	Cooperation - Training - Mutual communication - Alzheimer's disease persons	2,3,3	8	1.14	5
F	Communication - Among staff members, authority figures and older persons	Staff distribution for caring tasks	1,2,2	5	0.45	
F	Communication - Among staff members, authority figures and older persons - Reporting	Workbook - Duties of different sections - Staff rotation - Daily tasks to be done and signed for	1,3,3,3,4,4,5	23	2.09	1
F	Communication - Among staff members, authority figures and older persons	Regular rounds - Night - Day	2,3	5	0.45	
F	Communication - Among staff members, authority figures and older persons	Participate in activities	1	1	0.09	

Group code	Category and sub-categories	Statement	Scores	Total score	Average score	Top 5
C1	Rights and responsibilities - Human rights	Rights in the workplace - Protect the caregivers + older persons	1,2,5	8	1.14	5
C1	Rights and responsibilities - Human rights - Responsibilities	Respect + protection of rights - Caregiver - Older person	1,1,2	4	0.57	
C2	Rights and responsibilities - Human rights	Acknowledgement for what caregiver do	1,1	2	0.25	
C3	Rights and responsibilities - Human rights	Protection of the rights of the caregivers and protections as a person	1,4,4	9	0.9	5
C3	Rights and responsibilities - Human rights - Responsibilities	Rights and responsibilities of caregivers - Personal (leave and compassion leave) - Towards older persons - Towards Registered Nurses/person in charge/ manager	2,3,4,5,5, 5,5,5,5,5	44	4.4	1
C3	Rights and responsibilities - Human rights	Acknowledgement for what caregiver do - From the older persons - From the person in charge	2,2,3,4	11	1.1	4
F	Rights and responsibilities - Responsibilities	Treat older person as you would want to be treated	2	2	0.18	
C2	Staff monitoring and evaluation - Orientation and in-service training	Study leave/ In-service training	2,2	4	0.5	
C3	Staff monitoring and evaluation - Orientation and in-service training	Evaluation guidelines - Clear - No double standards - Experience regarding caregiver capacity	1,1,2,2,3	9	0.9	5
F	Staff monitoring and evaluation - Orientation and in-service training	Personality as employment requirement - Patience	2	2	0.18	

ADDENDUM F: Raw data: Small group interview

Small group interview summary RN (n=3)

Item No.	Statement
1	Observation/perception • Changes in condition • Abnormal behaviour
2	Emergency Treatment • Choking • Stroke • Bleeding • Fractures • Falling
3	Wound care • Aseptic • Correct order of actions • Required equipment/products
4	Full bed wash • Correct procedure • According to condition of older person
5	Handling of death • preparation • Counselling
6	Communication • Caregivers • Older persons • Person in charge • Manager/ board members
7	Infection control • Cross contamination
8	Emergency response during fire • Evacuation • Each person’s duty • Fire plan
9	Cooperation (connects with communication) • Between caregivers • Between caregivers and Registered nurses • Teamwork
10	Alzheimer’s disease persons • Stages • Handling of aggression • Importance of body language • Voice tone
11	Oral hygiene • Importance thereof • Advantages • Consequences of insufficient oral hygiene
12	Handling conflict • Staff • Older persons

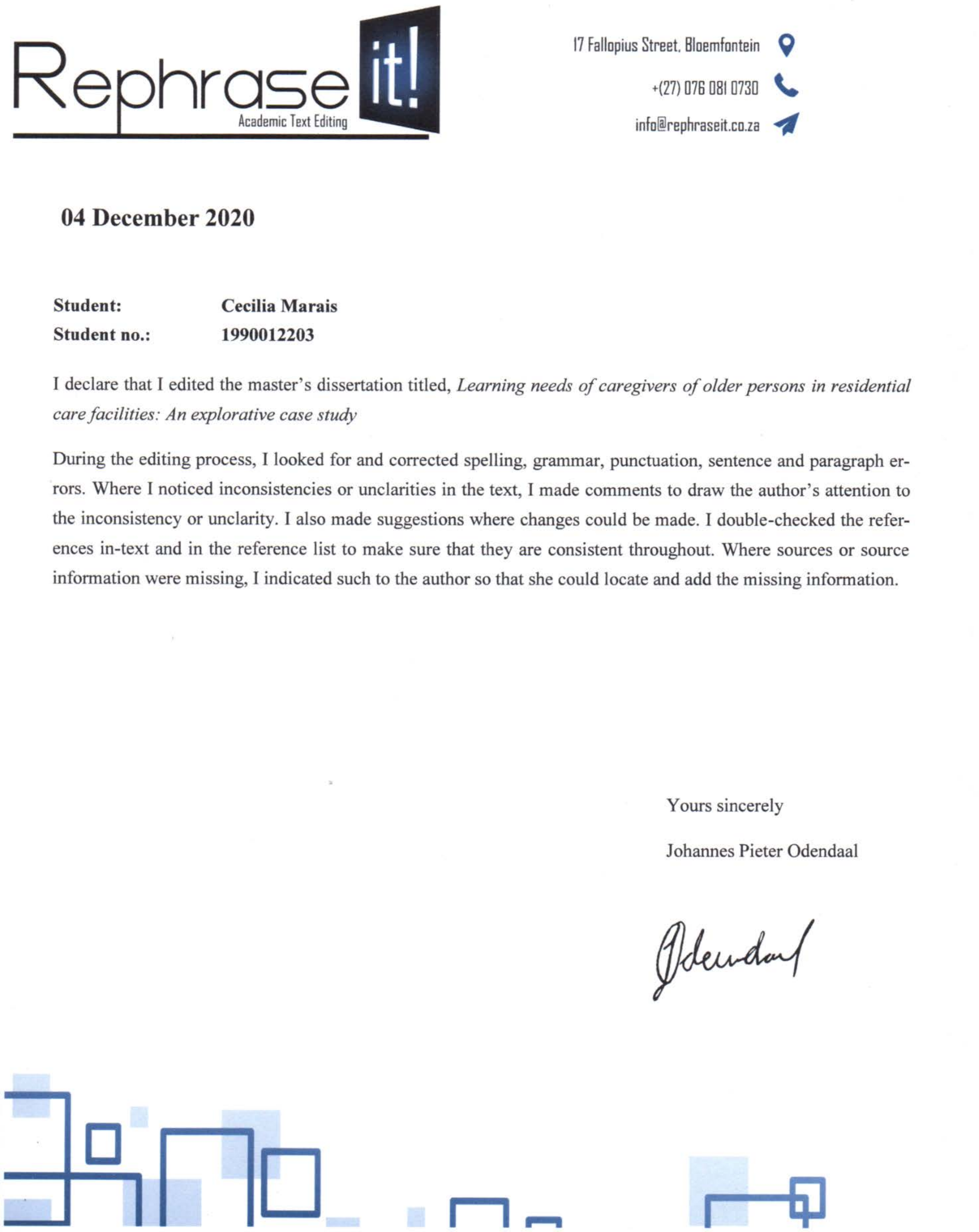
13	Staff rotation • Comfort zone • exposure
14	Respect • Personal • Registered Nurses • Older persons
15	In-service training • Basic nursing tasks • Not to complicated • Repetition for retaining • Uplifting and empowerment as caregivers and as persons

Small group interview data – colour coded and categorised

Item No.	Statement
1	Observation/perception • Changes in condition • Abnormal behaviour
2	Emergency Treatment • Choking • Stroke • Bleeding • Fractures • Falling
3	Wound care • Aseptic • Correct order of actions • Required equipment/products
4	Full bed wash • Correct procedure • According to condition of older person
5	Handling of death • preparation • Counselling
6	Communication • Caregivers • Older persons • Person in charge • Manager/ board members
7	Infection control • Cross contamination
8	Emergency response during fire • Evacuation • Each person’s duty • Fire plan
9	Cooperation (connects with communication) • Between caregivers • Between caregivers and Registered nurses • Teamwork
10	Alzheimer’s disease persons • Stages • Handling of aggression • Importance of body language • Voice tone
11	Oral hygiene • Importance thereof • Advantages • Consequences of insufficient oral hygiene
12	Handling conflict • Staff • Older persons
13	Staff rotation • Comfort zone • exposure

14	Respect • Personal • Registered Nurses • Older persons
15	In-service training • Basic nursing tasks • Not to complicated • Repetition for retaining • Uplifting and empowerment as caregivers and as persons

ADDENDUM G: Declaration by language editor



Rephrase it!
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04 December 2020

Student: **Cecilia Marais**
Student no.: **1990012203**

I declare that I edited the master's dissertation titled, *Learning needs of caregivers of older persons in residential care facilities: An explorative case study*

During the editing process, I looked for and corrected spelling, grammar, punctuation, sentence and paragraph errors. Where I noticed inconsistencies or unclarities in the text, I made comments to draw the author's attention to the inconsistency or unclarity. I also made suggestions where changes could be made. I double-checked the references in-text and in the reference list to make sure that they are consistent throughout. Where sources or source information were missing, I indicated such to the author so that she could locate and add the missing information.

Yours sincerely

Johannes Pieter Odendaal

Odendaal