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Learning needs of caregivers of older persons in residential care facilities in rural South Africa: Unveiling unrealistic expectations

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A R T I C L E I N F O

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A B S T R A C T

Introduction: The complexity of the caring needs of older persons in residential care facilities pose challenges for which South African caregivers were found to be underprepared. Their inadequate education and training led to varied quality of care, caregiver stress and burnout. The need was consequently identified to explore and describe the learning needs of caregivers working in residential care facilities in a resource limited setting.
Methods: An explorative case study was undertaken and the multiple perspectives of stakeholders within the geographical context were elicited by use of four nominal groups and a small group interview.
Results: Following a content analysis, the topics of basic nursing skills, hygiene, Alzheimer's disease, medication, communication, rights, and responsibilities, as well as staff monitoring, and evaluation were identified.
Conclusion: Most of the learning needs were beyond the expected caregiver tasks stipulated by the South African Qualifications Authority. The authors question the unrealistic expectations set before these caregivers.

1. Introduction

As first line care providers of older persons in residential care facilities, caregivers play an essential role in the quality of care provided. Yet, the educational requirements for their employment are lower than that of other healthcare staff (Molinari et al., 2017; Porter et al., 2018). The highest level of education for employment as a caregiver in South Africa is the senior phase of basic education (SAQA, 2020). There are no additional skill requirements and caregivers do not register with a governing body (Falk-Huzar, 2017; Nursing Act 33 of 2005; SIFAR, 2017). Moreover, caregiver training offered in the country was found to be unstructured and insufficient (Falk-Huzar, 2017; Molinari et al., 2017; Porter et al., 2018; Robbins et al., 2013; SIFAR, 2017; Smythe et al., 2017; Williams, 2017). Research conducted in South Africa revealed inconsistencies in caregiver training programmes, which could partially be attributed to the fact that the courses were presented by different non-government organisations (Booker, 2015; Mapira et al., 2019; SIFAR, 2017; Solanki et al., 2019).

Various studies indicate that caregivers are underprepared to meet the intricate needs of older persons and/or navigate difficult situations that could arise during the course of caring work (Booker, 2015; Bosch, 2015; Mapira et al., 2019; Martin et al., 2016; SAQA, 2017; SIFAR, 2017; Solanki et al., 2019; Williams, 2017). Caregivers reportedly often fail to deal with functional decline, chronic conditions and other health related issues that tend to make older persons reliant on others, because the caregivers lack prerequisite skills and training (Gardiner et al., 2020; Grønning et al., 2018; Lim et al., 2017; Mapira et al., 2019; Sadana et al., 2016). As a result, the quality of care rendered is often unsatisfactory, characterised by a lack of respect towards, as well as neglect or maltreatment of the older persons in their care (East, 2017; Gardiner et al., 2020; North & Fiske, 2015; Smythe et al., 2017). Maltreatment and elder abuse, of both a physical and emotional nature, have been associated with caregivers being inadequately trained, overworked and underpaid (East, 2017; Gardiner et al., 2020; North & Fiske, 2015; Smythe et al., 2017; WHO, 2020). The same factors, however, contribute towards caregivers experiencing physical and mental stress, negativity, demotivation and burnout (Mapira et al., 2019; Musich et al., 2017; Sepe-Monti et al., 2016; Tang et al., 2015; Williams, 2017). There is consequently a high staff turnover among caregivers (East, 2017).

The known challenges and risks of caregiving are accentuated in resource limited settings, such as the sparsely populated Northern Cape Province in South Africa. (Refer to Fig. 1 for a visual representation of the number of people per square kilometre in the nine provinces of South Africa). Long distances between towns compel persons in need of specialised healthcare to make use of whatever healthcare services are available. Here, residential care facilities are greatly dependent on the

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services of caregivers, because healthcare services, including geriatric care, are less accessible and efficient than in the wealthier provinces (Burger & Christian, 2018; Delobelle, 2013; Kelly et al., 2019; Mashau et al., 2016; Moshabela et al., 2015; Northern Cape Department of Health [NCDoH], 2018; Stellenberg, 2015).

This particular province has the third highest percentage of older persons (10.21%) in the country (Stats SA, 2017; Stats SA, 2020). Poverty, unemployment and lack of further education opportunities cause younger people to migrate to metropolitan areas, leaving older persons in need of residential care (Mashau et al., 2016; Moshabela et al., 2015; Porter et al., 2018; Solanki et al., 2019). The migration also limits the recruitment pool for caregivers, which, as is the case in other parts of the world, consists of lower-skilled adults or early school leavers (Chisagiu, 2015). Within the sub-districts where the research was conducted there is no formal in-service training programmes at the residential care facilities. There is consequently a knowledge gap relating to caregiver training in these sub-districts of Northern Cape Province. The purpose of the 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 in South Africa.

2. Methods

2.1. Research design

The research was guided by a constructivist paradigm because the authors wanted to come to a deeper understanding of the multiple social constructions of meaning and knowledge about the research phenomenon (Mertens, 2015; Polit & Beck, 2017). An explorative case study design was deemed appropriate to gain the perspectives of different stakeholders situated within a specific geographical context (Harrison et al., 2017; Heale & Twycross, 2018; Yin, 2018).

2.2. Study setting, population, and data collection

Data were collected at three residential care facilities in two sub-

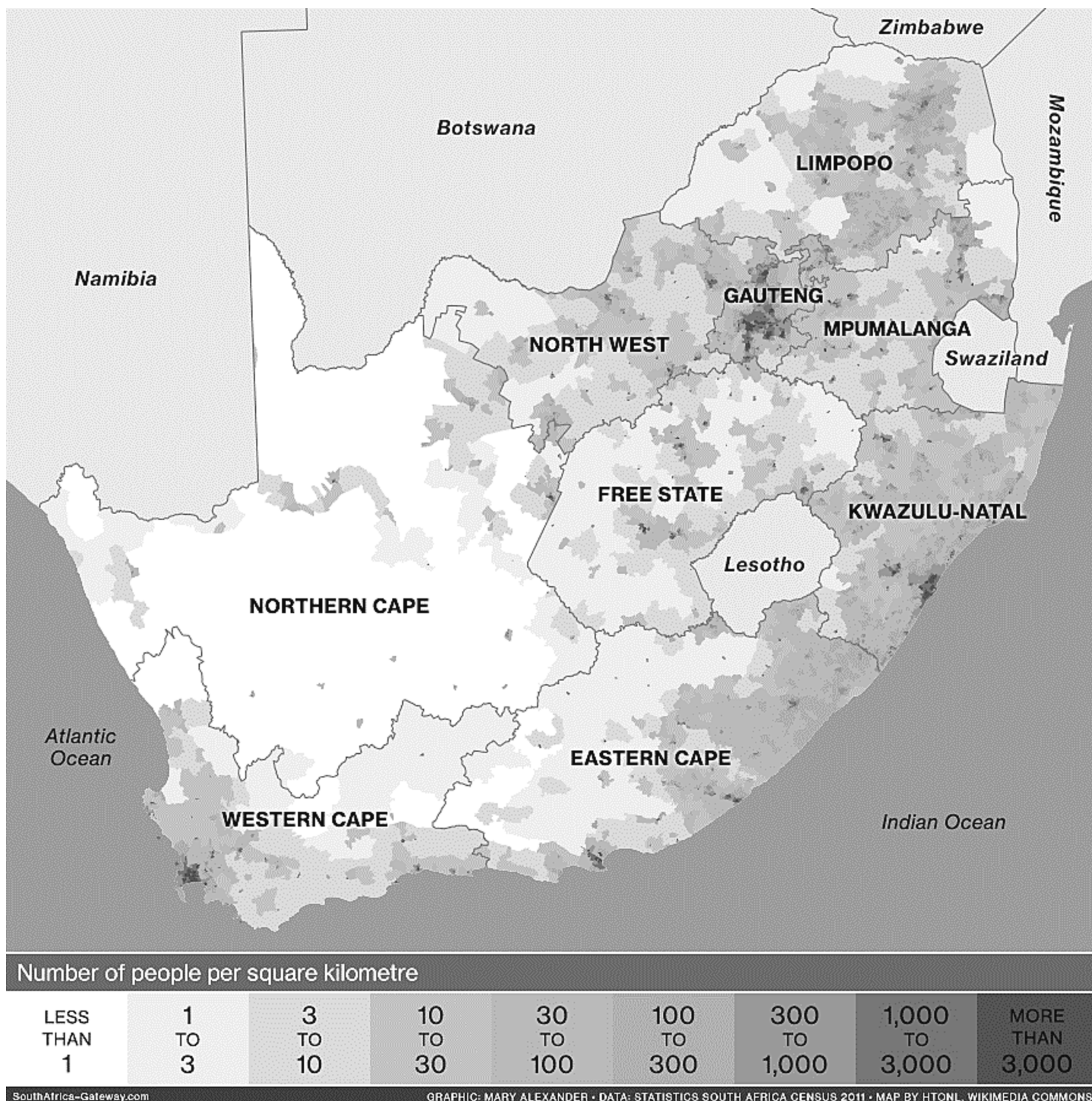

Fig. 1. Population density in the nine provinces of South Africa (Stats SA, 2019).

districts of the Northern Cape Province in South Africa by means of nominal groups and a small group interview. Three nominal groups were facilitatied with caregivers at the respective facilities, one nominal group with family members, and a small group interview with the registered nurses (RNs) employed at the time of the study. Purposive sampling was used for the nominal groups and complete collection sampling for the small group interview. A total number of 25 caregivers, three RNs and 11 family members of residents participated in the study. For sake of consistency, all the group interviews were facilitated by an experienced qualitative researcher.

The Nominal Group Technique (NGT), as a consensus method, was applied and conducted in four sequential phases, namely silent generation of ideas in response to an open-ended question, round-robin sharing, discussion and lastly voting, during which the participants prioritise the verified generated ideas (Olsen, 2019; Roets & Lubbe, 2015; Thier & Mason, 2018). As there were too few RNs to form a focus group, a small group interview was facilitated by posing an open-ended question similar to that of the other groups (Refer to Table 1 for the respective questions). The question posed to the RNs included an enquiry about caring for persons with neurocognitive disorders, because there was a high incidence among the residents and the authors felt that the RNs would understand the concept. The small group interview was audio recorded with the permission of the participants and a transcript thereof was prepared for data analysis (Grove & Gray, 2019).

2.3. Data analysis

The collected data were organised manually by assigning group codes, as explained in Table 2, to each of the five individual data sets. Data were organised and structured by following inductive reasoning (Polit & Beck, 2017). Content analysis was implemented to combine individual ideas into groups with similar statements in order to identify categories and sub-categories (Polit & Beck, 2017; Savin-Baden & Major, 2013). The complete data sets of the four nominal groups and the small group interview transcript were analysed separately and combined into one integrated list by following the steps suggested by Creswell and Creswell (2018) and Van Breda (2005). All the data collected during the nominal groups and small group interview were accounted for in one consolidated list of categories and sub-categories.

2.4. Ethical concerns and researcher positionality

Prior to data collection, approval was obtained from an accredited research ethics committee and gatekeeper permission was provided by the Department of Social Development in the NC Province, as well the administration boards of the residential care facilities. Written informed consent was obtained from each of the participants and a confidentiality pledge was taken.

The authors assumed an augmentation view to ethics by incorporating both a principle- and virtue-based approach (Resnik, 2012). In addition to the Belmont principles of beneficence, respect for human dignity and justice, the authors adhered to the virtues of courage, sincerity and humility (Grove & Gray, 2019; Macfarlane, 2010; Polit & Beck 2017). The virtues represented character traits that the authors chose to guide their decision-making and actions throughout the research. Trustworthiness was pursued by implementing measures to ensure that the findings were credible, confirmable, transferable and authentic (Brink et al., 2018; Connelly, 2016; Noble & Smith, 2015; Polit & Beck, 2017).

Table 1
Questions posed to the various groups of participants.

Groups of participants	Type of group	Question
Caregivers	Nominal groups	What do you need to learn about caring for an older person?
Family members	Nominal group	What should caregivers learn about caring for your loved one?
Registered nurses (RNs)	Small group interview	What should caregivers learn about caring for older persons, including those with *neurocognitive disorders, in a residential care facility?

Table 2
Categories and sub-categories of learning needs.

Category	Sub-categories	Mentioned by Participant's Groups
1. Basic nursing skills	- Clinical skills Interpersonal skills Responding to emergencies	C1, C2, C3, F and RN
2. Hygiene	- General hygiene, infection control and cross contamination Personal and older persons	F and RNs
3. Alzheimer's disease	- Stages of the disease Caring for an older person who has Alzheimer's disease	C1, C2, C3, F and RN
4. Medication	- Knowledge – actions/interactions of medication Administration of medication	C1, C2, C3, F and RN
5. Communication	- Amongst staff members, authority figures and older persons Conflict management and prevention Reporting	C1, C3, F and RN

3. Results and discussion

The categories identified during data analysis were basic caregiving skills, hygiene, Alzheimer's disease, medication, and communication. Subcategories and groups of participants from which these topics originated are presented in Table 2. In addition, the caregivers expressed a need to learn about their rights and responsibilities in the workplace, whilst the RNs and family mentioned that caregivers should be informed about staff monitoring and evaluation. These topics evoked elaborate and intense discussion amongst the participants, thus yielding rich data. During data analysis, exploitation of the human rights of caregivers became apparent, which was unexpected in a study about learning needs. The authors decided that the serious nature of the topic warranted a separate publication. The first five categories, however, hold significant implications for practice and form the focus of this article.

In Table 2, codes assigned to each group are indicated for ease of reading. The caregiver groups are coded as C1, C2 and C3 respectively; the family members as F and the small group with the RNs is coded RN.

Each of the categories of participants indicated that caregivers should learn about basic caregiving skills, Alzheimer's disease, and medication. It was surprising that only the family members (F) and RNs referred to hygiene, considering that it is essential in caring for older persons. Communication was identified as a learning need by all but one caregiver group. The identified categories with their related subcategories are subsequently discussed in triangulation with literature.

Although the suggested learning needs do not appear to be irrelevant to the care needs of older persons, inadequate caregiver training or knowledge poses potential risks to caregivers and older persons alike, as highlighted in the discussion.

3.1. Basic nursing skills

Basic nursing skills were sub-categorised into clinical skills, interpersonal skills and responding to emergencies.

Basic *clinical skills*, such as hydration (F), full bed washes and oral hygiene (RNs) were identified as learning needs. The RNs added that caregivers should also demonstrate good body mechanics to prevent injuries. These skills are aligned with tasks usually expected from caregivers, i.e. making beds, assisting with bathing, dressing, feeding,

personal hygiene, as well as back and pressure care (Council, 2020; SIFAR, 2017; Vantage Mobility International, 2016). The caregivers, however, expressed the need to learn how to assess and interpret vital signs, including blood pressure (C1, C2 and C3). In addition, urine testing, determining blood glucose levels, administering oxygen and nebulising were mentioned. Wound care was an addition made by the RNs. All the caregivers wanted to be prepared for unforeseen incidents, for instance falls, acute bleeding, epileptic seizures, and medical emergencies, which would require basic first aid training.

Interpersonal skills, such as having a "friendship relationship" with the older persons and good work-related interpersonal relationships (C1), as well as an empathetic and sympathetic approach from the caregivers in their caring role (C1 and C2) were identified as learning needs. The family members felt that a calm, relaxed attitude and appropriate behaviour in the workplace could assist the caregivers in their caring role. The RNs added that training in end-of-life care could be beneficial. The category of interpersonal skills was kept separate from communication as the focus here was on awareness of and sensitivity to the experiences of the older persons, and the development of a better understanding of what the older persons are going through (Moolani, 2020). Jordan Halter (2018) adds that by focusing on the uniqueness of each person, relationships are prioritised over tasks. It was concluded that caregivers with improved stress-management and problem-solving abilities could cope better with the emotional aspects of their caring role (Kusmaul, 2016; Larkin & Milne, 2014; Ong, 2017).

Each of the groups verbalised the need for caregivers to be able to *respond to emergencies.* The family members suggested that caregivers should learn to do regular rounds and report any situations that could pose a risk. Conversely, the caregivers wanted to be prepared for, recognise, and manage medical emergency situations, such as epileptic seizures, hyper- or hypoglycaemic incidents and cerebrovascular incidents (C1, C2 and C3). In addition, emergency situations such as choking (F), bleeding, wounds, falls, fainting, dehydration, anxiety attacks and heart attacks were mentioned (C2 and C3). Medical emergencies could be associated with any age group, but chest pain, breathing difficulties, falls and abdominal pain are more common amongst older persons, especially those with underlying medical conditions such as diabetes and hypertension (Liu et al., 2015; Maresova et al., 2019). Immediate and urgent interventions could prevent an emergency situation from escalating (Coppa, 2019; Engineer, 2018; Mackintosh & Sandall, 2010).

The RNs confirmed the emergency situations mentioned by the other participants and further emphasised the importance of knowledge regarding the emergency response procedures during a fire. Within this context there is pressure on the caregivers to be competent in managing emergency situations, because of the shortage of professional staff. The absence of qualified healthcare professionals during the night and the lack of standard training requirements for caregivers leaves them unsure and underprepared as how to respond and what actions to take in emergency situations (Falk-Huzar, 2017; SIFAR, 2017).

In summary, most of the skills expected of the caregivers were above the level of what would usually be expected of caregivers in comparison to the South African Qualifications Authority (SAQA) registered unit standard for providing care to a frail person caregivers (SAQA, 2020). Many of the tasks were in fact within the scope of practice of professional nurses as indicated by the South African Nursing Act 33 of 2005. Refer to Table 3 for a comparison.

3.2. Hygiene

Hygiene was sub-categorised into general hygiene, including infection control and cross contamination, as well as personal hygiene of the caregivers and older persons.

General hygiene and cleanliness such as cleaning spills, removing dirty dishes from the rooms and regularly changing linen were given as examples (F). They also felt the need for personal hygiene among the

Table 3
Comparison of responsibilities among healthcare staff.

Scope of practice as stipulated in the South African Nursing Act 33 of 2005:	RNs (Professional Nurse)	Enrolled nurses (Staff Nurse)	Enrolled nursing assistants (Auxiliary Nurse)	Caregiver tasks compared to the SAQA Unit Standard
Diagnosing of a health need and the prescribing, provision, and execution of a nursing care to meet the need of the patient	√	√	x	x
Handing out and administration of medication	√	x	x	x
Maintenance of hygiene, physical comfort, and re-assurance of patient	√	√	√	√
Monitoring vital signs: temperature, pulse, blood pressure and observation of reactions to medications and treatment	√	√	√	x
Supervision over and supply of oxygen	√	√	√	x
Supervision over and maintenance of fluid balance of patient	√	√	x	x
Facilitation of the healing of wounds and fractures, the protection of the skin and the maintenance of sensory functions in a patient	√	√	x	x
Facilitation of the maintenance of bodily regulatory mechanisms and functions in a patient	√	√	√	√
Promotion of exercise, rest, and sleep, with a view to healing and rehabilitation of a patient	√	√	√	√
Supervision over and maintenance of elimination of a patient	√	√	√	√
Facilitation of the attainment of optimum health for the individual, the family, and the community in the execution of the nursing care	√	√	x	x
Facilitation of communication by and with a patient in the execution of the nursing care	√	√	√	√

(*continued on next page*)

Table 3 (*continued*)

Scope of practice as stipulated in the South African Nursing Act 33 of 2005:	RNs (Professional Nurse)	Enrolled nurses (Staff Nurse)	Enrolled nursing assistants (Auxiliary Nurse)	Caregiver tasks compared to the SAQA Unit Standard
Facilitation of the maintenance of nutrition of a patient	√	x	x	x
Feeding of a patient	√	√	√	√
Establishment and maintenance of an environment in which the physical and mental health of a patient are promoted	√	√	x	√
Facilitation of body mechanism and the prevention of bodily deformities in a patient in the execution of nursing care	√	√	√	√
Provision of effective patient advocacy to enable the patient to obtain the healthcare they need	√	x	x	x
Care of the dying patient and the care of the recently deceased patient within the execution of the nursing regimen	√	√	√	√

caregivers, with emphasis on clean uniforms, shoes, and hair. A further cause for concern was maintenance of *personal hygiene* of the older persons, which included their oral hygiene and clean clothing (F and RNs). Maintenance of personal hygiene is important, because older persons are more prone to infections, the most common source of sepsis being respiratory tract infections followed by genitourinary infections (Doughty et al., 2012; Martin et al., 2016; Nasa et al., 2012; Retamar et al., 2014; Yealy et al., 2014). In addition, infection control and cross contamination with the incorrect handling of adult diapers was a concern (F and RNs). At the time of data collection several older persons at the facilities were suffering from incontinence and it is well-known that poor hygiene could negatively affect their health (Boshell, 2012; Coll et al., 2020; Razak et al., 2014). Incontinence-associated dermatitis could, for instance, lead to infection and even death as a result of sepsis (Doughty et al., 2012; Martin et al., 2016; Nasa et al., 2012; Retamar et al., 2014; Yealy et al., 2014).

Personal hygiene not only maintains body cleanliness and health, but preserves dignity, enhances personal pride and promotes self-respect (Gardiner et al., 2020; Jenkins & Chandola, 2014; North & Fiske, 2015; Smythe et al., 2017). Compromising the health of an older person could subsequently be regarded as negligence and a form of abuse, which could hold legal consequences for the caregivers (Boshell, 2012; Pillemer et al., 2016; WHO, 2020; Yon et al., 2019). Although basic, the task of maintaining hygiene remains essential.

3.3. Alzheimer's disease

All the participants expressed the need for caregivers to learn about Alzheimer's disease as some of the residents had officially been diagnosed with the disease, whilst others presented with similar neurocognitive declines. In South Africa, and specifically in the province where the study was conducted, there is a lack of registered specialised care facilities thus obligating caregivers to care for the persons with Alzheimer's disease alongside other residents. (DSD, 2010).

All the participant groups indicated that caregivers should know the stages of Alzheimer's disease. As the complexity and diversity of their caring needs increase as their condition progresses, being equipped with foundational information about the stages of the disease could assist caregivers in knowing what to expect and how to respond (Alzheimer's Association, 2020; Burke & Orlowski, 2015; Gottesman & Stern, 2019; Sepe-Monti et al., 2016).

The caregivers wanted to know more about the disease In general (C2), how to recognise the onset of the disease (C3), as well as the "mood" of the person (C1), and how to manage problematic situations involving persons with Alzheimer's disease (C1 and C3). The RN's agreed that there were knowledge gaps regarding caregiving of the persons with Alzheimer's disease. Family members felt that having a set routine and considering the older person's preferences regarding clothes and favourite foods could be beneficial. A family member responded by offering a well-supported suggestion to distribute information leaflets about Alzheimer's disease. Such endeavours were however, found to be unsuccessful for persons with a low education level (Sustersic et al., 2016; Wrench et al., 2019).

Learning to manage aggression in residents with Alzheimer's disease was mentioned (C2). The RNs added that caregivers should know how to approach a person with Alzheimer's disease, including their attitude, body language and tone of voice (RNs). By effectively managing daily tasks with a set routine and allowing the older persons to maintain control over their lives caregivers could reduce frustration and agitation (Alzheimer's Association, 2020; Jordan Halter, 2018; NIA, 2017). Respectful care could therefore reduce depression and aggression amongst the older persons (James, 2018; Portland Community College, 2019; Sprangers et al., 2015). Furthermore, an attitude of unconditional positive regard encourages people to "cooperate with care, reduces catastrophic outbreaks, and increases family members' satisfaction with care" (Jordan Halter, 2018: 441). Such person-centred care could not only benefit persons with Alzheimer's disease, but all the residents as well as their families.

3.4. Medication

The caregiver groups (C1, C2 and C3) and family members indicated medication as a learning need where *knowledge regarding the actions/interactions of medication* could prove helpful. More specifically, a broad overview regarding the uses of medication (C1 and C2) and knowledge about "emergency medication" such as painkillers (C3) was voiced. In spite of caregivers' inadequate knowledge they noticed inconsistencies regarding medication on several occasions (C1). Caregivers are key in noticing changes in the condition and describing their observations to healthcare professionals (Breytspraak, 2016; Cameron, 2017; Dagli & Sharma, 2014; Jordan Halter, 2018; Nguyen et al., 2020; Sansgiry et al., 2016). However, for caregivers to be able to recognise these symptoms they should have a basic knowledge of the appearance, intended use, directions for use, common side effects and possible interactions of the medications that the older persons are using (Cameron, 2017).

Each of the groups (C1, C2, C3, F and RN) identified *administration of medication* as a learning need. Family members were concerned about the older persons taking their medication without the necessary supervision. This is a realistic concern, because in old age, multiple pathology, and polypharmacy are the most frequent safety issues resulting in adverse medication events (Mira, 2019). The RNs confirmed that although caregivers are not supposed to take the responsibility, it is unavoidable for them to administer prescription and over-the-counter medication. In terms of the South African Nursing Act 33 of 2005, only RNs are permitted to administer prescription medication. Medication errors could have harmful effects for the older persons and pose medical legal risks, which in both cases could have serious consequences

(Cameron, 2017; Winston, 2020).

3.5. Communication

All of the groups, but one (C1, C3, F and RN), identified communication as a learning need, with a focus on: communication amongst caregivers, with authority figures and older persons; reporting changes in the condition of the older persons and handovers; conflict management and prevention.

Improved *communication amongst the role-players* at the residential care facility could prevent unnecessary stressful situations (C1, C3 and RNs). The family members added that teamwork and better communication could have a positive effect for the older persons, as well as their caregivers. Some caregivers (C1), however, expressed having a lack of confidence in communicating freely with authority figures, for example when board members paid informal visits to the facility. Considering over subservience to authority figures, the RNs mentioned that free communication between caregivers and the manager and/or board members could facilitate timely problem solving. Caregivers also needed to learn to involve the older person in the tasks they were about to perform (RNs). Communication could be optimised by establishing person-to-person understanding in a resourceful and flexible way (Vertino, 2014). Conveying respect and caring builds trust, improves relationships and enhances quality of life (James, 2018; Portland Community College, 2019; Sprangers et al., 2015). In connecting more appropriately and effectively with others, communication consequently becomes a tool in enhancing interpersonal skills.

Communicating work-related content was an additional component needing attention. Family members felt that caregivers should *report any observations* they had made to the RN in charge. Examples mentioned were a loss of appetite and changes in physical condition or behaviour. As caregivers provide the majority of hands on care to older persons they are indeed the first to observe any changes in a person's condition and reporting these could prevent adverse events (AHRQ, 2018; Kaire, 2014; Maryville University, 2019). Similarly, caregivers should exchange information among themselves regarding caring tasks they had already performed or that the next shift needed to cover (F). Unnecessary conflict had arisen about essential tasks, such as diaper changes, not being performed when caregivers had been waylaid and they had neglected to communicate this during handover (C1, C3, F and RNs). Effective communication, teamwork, sharing information and reporting concerns regarding the health of older persons could minimise risks of patient-safety errors and create a conducive work environment (AHRQ, 2018; Kaire, 2014; Maryville University, 2019).

Conflict management and prevention, with focus on how to avoid and appropriately manage aggression and opposition when engaging with the older persons, was deemed necessary in caregiving (C1, C3 and RNs). Situations that could lead to agitation and aggression in older persons could undeniably be diffused by taking a person-centred stance, including being patient, calm and flexible (James, 2018; Jordan Halter, 2018; Mayo Clinic, 2020). Within the context of the workplace, caregivers voiced a need for effective conflict management among themselves (C1 and C3) and the RNs agreed that better communication and cooperation among staff members could address work-related conflict. 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). A respectful joint effort among staff members 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). An additional concern arose in that one of the caregiver groups wanted to be empowered to manage resistance from family members and communicate equitably with an unfair or insensitive person in charge (C1). The power disadvantage was found to be a serious obstacle that needed to be overcome in this context.

4. Implications for caregiver education

The findings of the study confirmed the under-preparedness of the caregivers within the specific context. It was evident that their basic education and lack of training were inadequate in equipping them to deal with the challenges caregivers usually face. The perspectives shared by all the participants, however, indicated that the caregivers were having to perform tasks beyond what is generally expected of them. A comparison was therefore made between the learning needs expressed in this study, the responsibilities of caregivers, as noted in the SAQA Registered Unit Standard for Providing Care to a Frail Person and the Scope of Practice of different categories of nurses, as stipulated in the South African Nursing Act 33 of 2005. Refer to Table 3 for a summary of the comparison. The approved tasks are confirmed by a tick, whilst the tasks not expected from a certain category of employee are indicated by a cross. The learning needs expressed in this study are highlighted by shading the appropriate cells under caregiver tasks in the last column.

4.1. Compiled from SAQA (2020) and the nursing Act 33 of 2005

The majority by far of the learning needs identified in this study were not aligned with the expectations as noted in the SAQA Registered Unit Standard for Providing Care to a Frail Person (SAQA, 2020). Some of the responsibilities, such as dispensing of medication; risk management and patient advocacy were in fact assigned to RNs only. It is also noteworthy that some of the expected tasks, according to the unit standard, such as being competent in the use of a variety of basic frail care equipment and demonstrating a fundamental understanding of normal body functions and the effect of aging on the body systems, were not mentioned (SAQA, 2020).

Many of the caregivers' daily tasks were imposed upon them because trained nursing staff were not available. Due to short staffing, caregivers at the residential care facilities often had to work in the absence of health professionals and subsequently, without the necessary guidance and supervision. This situation not only posed a great risk to the health and wellbeing of the older persons, but also undermined the caregivers' right to fair labour practices. In explaining their predicament, the negative effect of a power disadvantage also came to the fore. Unrealistic work expectations and a power disadvantage emerged as themes, which were unexpected in this research that explored learning needs.

In response to the findings of the study, a training programme for the caregivers at the three facilities should be developed in alignment with the unit standard. Additionally, consistent guidance and support should be offered in the workplace to enhance their learning. To address the unrealistic expectations set before the caregivers, the findings were shared with the administration boards of the residential care facilities to create awareness and recommend ways in which the problems could be addressed. A report was provided to the Department of Social Development with a request that the matter be further investigated to determine the width of the problems, address unfair labour practices, and ensure that policies protect the rights of all involved.

5. Limitations

The research was limited to two sub-districts in a rural area of South Africa. Widening the population and adding research methods, such as a survey, could assist in determining the generalisability of the findings. Moreover, non-participation by older persons is regarded as a limitation. A decision was made to exclude this population, because many of the residents presented with neurocognitive impairments at the time of the study and they were therefore considered to be a vulnerable group. Nevertheless, the inclusion of the views of those receiving care would have enriched the data.

6. Conclusion

Insufficient education and training were found to contribute to the caregivers being underprepared for their demanding caring role. Additionally, it was discovered that responsibilities far beyond those outlined by SAQA were expected from the caregivers. During the research process, the main issues that were uncovered were unrealistic work expectations and unfair labour practices towards caregivers. Unclear guidelines, regulations and policies ostensibly contributed to unfair labour practices. Exploitation of the human rights of the caregivers are discussed in a separate article focussing on the ethics of employment.

Author contributions

The data analysis, drafting, and revising of the article were all done by all of the authors. The paper was reviewed, edited and compiled by all three authors. The final manuscript was read and approved by all authors.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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