

**AN INVESTIGATION INTO RESIDENT SATISFACTION FOLLOWING
THE IMPLEMENTATION OF A QUALITY ASSURANCE PROGRAMME
AT A HOME FOR THE ELDERLY**

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Nursing Science in the Faculty of Medicine and Health Sciences at Stellenbosch



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Declaration

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Abstract

A growing number of elderly citizens are being cared for in residential facilities in South Africa. They are highly dependent on those caring for them to meet their basic needs, as well as maintaining their well-being and human dignity. The quality of care provided to them could thus have a distinctive influence on their wellness and experience of quality in their daily lives.

The aim of the study was to investigate resident satisfaction following the implementation of a quality assurance programme at a home for the elderly. The objectives of the study included resident satisfaction about structure and process standards related to the programme, as well as residents' opinion of areas for further improvement. The relationship between the demographic variables and study variables was also investigated.

Ethics approval to conduct the study was obtained from the Health Research Ethics Committee of Stellenbosch University. Permission was further obtained from the Board of Directors of the facility.

A descriptive research design with a quantitative approach was applied. The population consisted of all the residents of the home for the elderly. No sampling method was applied. After application of the inclusion and exclusion criteria, 103 (N=103) residents were invited to participate in the study. A self-administered questionnaire designed by the researcher was used to collect the data. It consisted mainly of closed-ended questions and a few open-ended questions. A return rate of 50 (n=50) questionnaires was obtained.

Reliability and validity were supported by an in-depth literature review, a pilot study and consultations with experts in geriatric nursing care, a nursing researcher and a statistician.

The data was analysed with the assistance of a statistician and computer software. Cronbach's alpha coefficient was used to test the internal reliability of the questionnaire. The results were 0.926, 0.919 and 0.879 respectively for the questions related to structure-, process – and outcome standards. Non-parametric

statistical tests and correlations were applied to the variables. This included the Mann-Whitney U test and Spearman's rank-order correlational coefficient. The narrative data generated from the open-ended questions were thematically analysed.

The results showed that the participants (n=50) were satisfied with most aspects of the facility. They were highly satisfied with the environment, safety aspects and positive attitude of the staff. However, they were less satisfied with the food services, bathroom facilities and communication processes. Many participants (44%) were dissatisfied with the input they have into the management of the facility.

Almost all the participants (98%) indicated that they would recommend the facility to their friends and family, while only two participants (4%) indicated they would prefer to live at another facility.

The recommendations were aimed at improvements in the food services and communication processes. Other recommendations focused on the maintenance of the infrastructure, social interaction and nursing care.

It was concluded that a quality assurance programme is needed in homes for the elderly to ensure their well-being. The level of resident satisfaction could furthermore be used as an indicator of excellence.

Keywords: quality assurance, resident satisfaction, homes for the elderly

Opsomming

Daar is 'n toenemende aantal bejaarde burgers wat in Suid-Afrika in inrigtings woon en versorg word. Hulle is hoogs afhanklik van diegene wat hulle versorg om in hulle basiese behoeftes te voorsien, asook vir die handhawing van hulle welsyn en menswaardigheid. Die gehalte van die versorging wat aan hulle gebied word, het dus 'n bepalende invloed op hulle welsyn en ervaring van gehalte in hulle daaglikse lewe.

Die doel van hierdie studie was om inwoner-tevredenheid te bepaal nadat 'n gehalte versekeringsprogram by 'n tehuis vir bejaardes geïmplementeer is. Die doelwitte van die studie het inwoner-tevredenheid met die struktuur- en proses-standaarde, wat verband hou met die program, ingesluit, asook inwoners se opinie omtrent areas vir verdere verbetering. Die verhouding tussen demografiese veranderlikes en die studies veranderlikes is ook ondersoek.

Etiese goedkeuring vir die uitvoer van die studie was verkry van die Gesondheidsnavorsings-etiekkomitee van die Universiteit van Stellenbosch. Toestemming was verder ook verkry van die Raad van Direkteure van die inrigting.

'n Beskrywende navorsingsontwerp met 'n kwantitatiewe benadering is toegepas. Die teikengroep het bestaan uit al die inwoners van die tehuis vir bejaardes. Geen steekproef metode was toegepas nie. Na toepassing van die insluitings- en uitsluitingskriteria was 103 (N=103) inwoners uitgenooi om aan die studie deel te neem. 'n Self-voltooid vraelys wat deur die navorser ontwerp is, was gebruik om die data in te samel. Dit het hoofsaaklik uit geslote vrae, asook 'n paar oop vrae bestaan. 'n Terugbesorgingstempo van 50 (n=50) vraelyste is verkry.

Geldigheid en betroubaarheid is ondersteun deur 'n in-diepte literatuur-studie, 'n loodsstudie en konsultasies met kenners in geriatrisse verpleegsorg, 'n navorser in verpleegkunde en 'n statistikus.

Die data was geanaliseer met behulp van 'n statistikus en rekenaar-sagteware. Cronbach se alfa-koeffisiënt was gebruik om die interne betroubaarheid van die vraelys te toets. Die resultate was 0.926, 0.919 en 0.879 onderskeidelik vir die vrae

in verband met struktuur-, proses- en uitkomsstandaarde. Nie-parametriese statistiese toetse en korrelasies was op die veranderlikes toegepas. Dit sluit in die Mann-Whitney U toets en Spearman's rangorde korrelasie koëffisiënt. Die geskrewe data wat deur middel van die oop-einde vrae gegeneer is, was tematies geanaliseer.

Die resultate het getoon dat die deelnemers (n=50) tevrede was met die meeste aspekte van die inrigting. Hulle was hoogs tevrede met die omgewing, veiligheidsaspekte en die positiewe gesindheid van die personeel. Daarenteen, was hulle minder tevrede met die voedselvoorsienings-dienste, badkamer-geriewe en kommunikasie-prosesse. Baie deelnemers (44%) was ontevrede met die insette wat hulle kon lewer in die bestuur van die inrigting.

Byna al die deelnemers (98%) het aangedui dat hulle die inrigting sou aanbeveel by hulle vriende en familie, terwyl slegs twee deelnemers (4%) aangedui het dat hulle sou verkies om by 'n ander inrigting te gaan woon.

Die aanbevelings was gerig op verbeteringe in die voedselvoorsienings-dienste en kommunikasie prosesse. Ander aanbevelings het gefokus op die instandhouding van die infrastruktuur, sosiale interaksie en verpleegsorg.

Die gevolgtrekking was dat 'n gehalteversekeringsprogram benodig word in tehuise vir bejaardes om hulle welsyn te verseker. Die vlak van inwoner-tevredenheid kan verder gebruik word as 'n aanwyser vir uitnemendheid.

Kernwoorde: Gehalteversekering, inwoner-tevredenheid, tehuise vir bejaardes

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Table of contents

CHAPTER 1 SCIENTIFIC FOUNDATION OF THE STUDY	1
1.1 Introduction and background	1
1.2 Study context and rationale	3
1.3 Significance of the study	5
1.4 Problem statement	5
1.5 Research question	6
1.6 Aim of the study	6
1.7 Objectives of the study	6
1.8 Conceptual framework	7
1.9 Research methodology	8
1.9.1 Research design	8
1.9.2 Population and sampling	9
1.9.2.1 <i>Inclusion criteria</i>	9
1.9.2.2 <i>Exclusion criteria</i>	9
1.9.3 Pilot study	9
1.9.4 Data collection instrument	9
1.9.5 Reliability and validity	10
1.9.6 Data collection	10
1.9.7 Data analysis	10
1.10 Ethical considerations	10
1.11 Operational definitions	12
1.12 Chapter outline	15
1.13 Summary	15
1.14 Conclusion	16

CHAPTER 2 LITERATURE REVIEW	17
2.1 Introduction	17
2.2 The elderly	17
2.3 Quality of care	19
2.4 Quality assurance	20
2.5 Quality standards	21
2.5.1 Structure standards	22
2.5.1.1 <i>Infrastructure</i>	22
2.5.1.2 <i>Activities and services</i>	24
2.5.1.3 <i>Staffing</i>	25
2.5.1.4 <i>Equipment and supplies</i>	27
2.5.1.5 <i>Policies and guidelines</i>	27
2.5.1.6 <i>Legislative framework</i>	28
2.5.1.7 <i>Philosophy of care</i>	30
2.5.2 Process standards	30
2.5.2.1 <i>Nursing care</i>	31
2.5.2.2 <i>Communication</i>	33
2.5.3 Outcome standards	34
2.6 Summary	35
2.7 Conclusion	36
CHAPTER 3 RESEARCH METHODOLOGY	37
3.1 Introduction	37
3.2 Aim and objectives of the study	37
3.3 Study setting	38
3.4 Research design	38
3.5 Population and sampling	39

3.5.1	Inclusion criteria	40
3.5.2	Exclusion criteria	40
3.6	Data collection instrument	41
3.7	Pilot study	43
3.8	Reliability and validity	44
3.9	Data collection	45
3.10	Data analysis	47
3.11	Ethical considerations	49
3.12	Summary	51
 CHAPTER 4 STUDY RESULTS		52
4.1	Introduction	52
4.2	Reliability analysis	52
4.3	Statistical analysis	53
4.4	Section A – Demographic data	54
4.4.1	Variable A1: Gender	54
4.4.2	Variable A2: Age	55
4.4.3	Variable A3: Years living at the facility	56
4.5	Section B – Resident satisfaction	57
4.5.1	Structure standards	58
4.5.1.1	<i>Variable B1.1 – B1.5 – Structure: exterior environment</i>	58
4.5.1.2	<i>Variable B1.6 – B1.11 – Structure: interior environment</i>	59
4.5.1.3	<i>Variable B1.12 – Structure: availability of nursing staff</i>	60
4.5.1.4	<i>Variable B1.13 – B1.14 – Structure: food</i>	60
4.5.1.5	<i>Variable B1.15 – B1.16 – Structure: activities</i>	60
4.5.2	Process standards	61
4.5.2.1	<i>Variable B2.1 – B2.3 – Process: housekeeping</i>	61

4.5.2.2	<i>Variable B2.4 – B2.5 – Process: safety procedures</i>	62
4.5.2.3	<i>Variable B2.6 – B2.8 – Process: food</i>	62
4.5.2.4	<i>Variable B2.9 – Process: laundry services</i>	63
4.5.2.5	<i>Variable B2.10; B2.13; B2.14 & B2.19 – Process: illness</i>	63
4.5.2.6	<i>Variable B2.11 – B2.12 – Process: staff attitude</i>	63
4.5.2.7	<i>Variable B2.15 – B2.18 – Process: management of facility</i>	64
4.5.2.8	<i>Variable B2.20 – Process: reaction time of nurses</i>	64
4.5.2.9	<i>Variable B2.21 – Process: family access</i>	65
4.5.3	Outcome standards	65
4.5.3.1	<i>Variable B3.1 – B3.3 – Outcome: safety</i>	66
4.5.3.2	<i>Variable B3.4 & B3.7 – Outcome: facility in general</i>	66
4.5.3.3	<i>Variable B3.5; B3.6 & B3.8 – Outcome: care and dignity</i>	66
4.5.3.4	<i>Variable B3.9 – Outcome: family</i>	67
4.6	Section C – Improvements	67
4.6.1	Variable C1: Best improvement at the facility	68
4.6.2	Variable C2: Aspect liked most at the facility	68
4.6.3	Variable C3: Aspect liked least at the facility	69
4.6.4	Variable C4: Suggestions for further improvements at the facility	70
4.7	Summary	70
CHAPTER 5 DISCUSSION, RECOMMENDATIONS AND CONCLUSION		71
5.1	Introduction	71
5.2	Validity of results	71
5.3	Discussion of results	73
5.3.1	To investigate resident satisfaction about safety and security measures of the facility	74

5.3.2	To investigate resident satisfaction about the maintenance of the infrastructure, including the buildings and gardens	75
5.3.3	To investigate resident satisfaction about the availability of nursing staff	76
5.3.4	To investigate resident satisfaction about provision in basic needs including meals, laundry- and cleaning services	76
5.3.5	To investigate resident satisfaction about recreational activities	77
5.3.6	To investigate resident satisfaction about communication with management	77
5.3.7	To investigate resident satisfaction about communication with the nursing staff	78
5.3.8	To investigate resident satisfaction about the nursing care they receive	78
5.3.9	To investigate the residents' opinion of areas for further improvement	78
5.3.10	To determine the relationship between demographic variables and resident satisfaction related to the various standards	79
5.4	Recommendations	79
5.4.1	Communication structures	79
5.4.2	Nursing care	80
5.4.3	Social interaction	81
5.4.4	Continuous quality improvement	82
5.5	Limitations of the study	83
5.6	Further research	84
5.7	Conclusion	84
	List of references	86

List of tables

Table 3.1 – Data collection plan	46
Table 4.1 – Reliability statistics	53
Table 4.2 – Gender	55
Table 4.3 – Mann-Whitney U test	55
Table 4.4 – Structure: exterior environment	59
Table 4.5 – Structure: interior environment	59
Table 4.6 – Structure: availability of nursing staff	60
Table 4.7 – Structure: food	60
Table 4.8 – Structure: activities	60
Table 4.9 – Process: housekeeping	62
Table 4.10 – Process: safety procedures	62
Table 4.11 – Process: food	62
Table 4.12 – Process: laundry services	63
Table 4.13 – Process: illness	63
Table 4.14 – Process: staff attitude	64
Table 4.15 – Process: management of facility	64
Table 4.16 – Process: reaction time of nurses	64
Table 4.17 – Process: family access	65
Table 4.18 – Outcome: safety	66
Table 4.19 – Outcome: facility in general	66
Table 4.20 – Outcome: care and dignity	67
Table 4.21 – Outcome: family	67
Table 4.22 – Best improvement at the facility	68
Table 4.23 – Aspect liked most at the facility	69
Table 4.24 – Aspect liked least at the facility	69

Table 4.25 – Suggestions for further improvements70

List of figures

Figure 1.1 – Conceptual framework for quality of care (by the researcher based-on Donabedian, 1997:1745-1746)	8
Figure 4.1 – Age distribution	56
Figure 4.2 – Years living at the facility	57
Figure 4.3 – Level of resident satisfaction pertaining to structure standards	58
Figure 4.4 – Level of resident satisfaction pertaining to process standards	61
Figure 4.5 – Level of resident satisfaction pertaining to outcome standards	65

Annexures

Annexure A – Ethics approval from the Health Research Ethics Committee 1	
Stellenbosch University.....	92
Annexure B – Permission letter from the George and Annie Starck Homes.....	94
Annexure C – Information letter to staff and residents at the George and Annie	
Starck Homes.....	96
Annexure D – Participant information leaflet and consent form (English	
and Afrikaans).....	97
Annexure E – Data collection instrument (Questionnaire).....	105
Annexure F – Confirmation of language correctness.....	112
Annexure G – Quality assurance programme	113

CHAPTER 1

SCIENTIFIC FOUNDATION OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Ageing populations are a world-wide phenomenon with many of the elderly living in dedicated long-term facilities often referred to as nursing homes or homes for the elderly. Here they are mainly cared for by nurses (Hall, Dodd & Higginson, 2014:55). Nakrem, Vinsnes, Harkless, Paulsen and Seim (2009:849) emphasises the importance of meeting the individual needs of these residents as the facility is not only providing healthcare, but is considered to be their home.

The quality of nursing care provided to residents in homes for the elderly has a direct impact on their physical and psychosocial health. Many of these residents are extremely frail with complex health problems. Consequently, they become vulnerable and dependent on comprehensive and competent nursing care (Mueller & Savik, 2010:270).

Bakerjian and Zisberg (2013:1) highlight some of the frequently observed problems specifically related to the quality of nursing care in homes for the elderly. These include a high incidence in resident falls, pressure ulcers, restraint usage and poor pain management. Furthermore, homes for the elderly are often challenged by limited resources, as well as a lack of competent nursing staff (Nakrem *et al.*, 2009:849).

While quality assurance programmes have been successfully implemented in acute care settings, few homes for the elderly have embarked on the implementation of similar initiatives (Compas, Hopkins & Townsley, 2008:209). Therefore, based on their review of quality improvement literature, the authors recommend the use of a multifaceted programme to address the specific needs and challenges associated with residential care of the elderly.

A cross-sectional study, which included 65 Dutch homes for the elderly, indicates that the implementation of a quality assurance programme significantly lowers the

amount of undesirable clinical outcomes (Wagner, Ikkink, Van der Wal, Spreeuwenberg, De Bakker & Groenewegen, 2006:237). In this study, undesirable clinical outcomes were defined as the “*prevalence of pressure ulcers, bladder incontinence, indwelling catheters, restricted mobility and behavioural problems*” (Wagner et al., 2006:232).

Furthermore, quality assurance programmes are implemented in healthcare facilities to at least fulfil and strive to exceed the needs and expectations of its customers. Customer satisfaction can thus be used as a key indicator to determine the quality of care provided by the healthcare facility. It can further be used to identify areas for further improvement (Berglund, 2007:46).

This is supported by a qualitative study which explored the perceptions of the care needs of elder residents in two nursing homes in Taiwan (Chuang, Abbey, Yeh, Tseng & Liu, 2015:44). The researchers point out the strong link between meeting the needs of the residents and their perception of good quality care.

In South Africa, like the rest of the world, homes for the elderly provide healthcare services to a growing number of elderly citizens (City of Cape Town Demographics Discussion Paper, 2010:np). The Department of Social Development is responsible for providing and monitoring residential care facilities for the elderly in South Africa according to the Older Persons Act 13 of 2006 (Republic of South Africa, 2006).

The Department of Social Development of the Provincial Government of the Western Cape listed 129 homes for the elderly within the province of which 53 are situated in Cape Town. These homes are either owned by, funded by or endorsed by the Department of Social Development of the Provincial Government of the Western Cape (Provincial Government of the Western Cape, 2014:np).

There are non-governmental organisations, such as the Cape Peninsula Organisation for the Aged and Elcare that are managing retirement villages. Frail care facilities offering fulltime nursing care are available at some of the villages. As these facilities are not owned, funded or endorsed by the Department of Social Development of the Provincial Government of the Western Cape it does not appear on the above mentioned list (Cape Peninsula Organisation for the Aged, 2014:np).

Currently, very little is known about quality assurance programmes being implemented in homes for the elderly and less about the outcomes of such programmes. In the proposed study the researcher will investigate resident satisfaction following an implemented quality assurance programme at one of these homes for the elderly.

1.2 STUDY CONTEXT AND RATIONALE

In 2009 a quality assurance programme (Annexure G) was implemented at a home for the elderly. The programme is briefly described after an overview of the facility is provided. The facility is owned and mainly funded by a trust established in the testament of its benefactor who bequeathed the property and money to be used as a legacy in caring for persons in need of care. It included children, but they were moved to a children's home, which left the facility as a home for the elderly only. It is managed by a board of directors appointed by the trust. The facility is further endorsed by the Department of Social Development of the Provincial Government of the Western Cape.

The facility encompasses a frail care unit with 56 beds for long term care and eight beds for temporary admissions. This unit is supervised and managed by a compliment of nursing staff that provide direct nursing care. They are assisted by a team of care-workers. In addition, 10 individual houses are situated on the premises which accommodate a further 100 elderly residents who require minimal assistance. Each home accommodates 10 residents who are cared for by a house mother and father with the nursing staff overseeing the total well-being of the residents. Furthermore, nursing staff provide emergency and limited care to the owners of the 60 retirement apartments which have been built in recent years on the grounds.

The permanent nursing staff currently includes a nursing service manager, three registered professional nurses and five enrolled nurses of whom two are allocated for night duty. The rest of the nursing staff is provided by an external nursing agency and consists of eight enrolled nursing auxiliaries for day duty and two for night duty. The agency provides a further 18 care-workers for day duty and 10 for night duty. These care-workers are not nurses, but they assist the nursing staff in providing

basic care to the residents. They work under the direct supervision of qualified nursing staff. Administrative staff includes the general manager, assistant manager, an accountant and a social worker.

The quality assurance programme that was implemented at this home for the elderly has been based on quality assurance literature and the Older Persons Act, No 13 of 2006 (Annexure G). A variety of structure standards were used as indicators for the quality assurance programme that was implemented. These included safety aspects of the facility, maintenance of the infrastructure and the interior of the buildings. Adequate staff and the availability of equipment and supplies to deliver safe resident care were emphasised. Practice guidelines and procedure manuals were updated. Communication structures were evaluated for effectiveness.

A number of process standards were also used as indicators for the programme. Communication processes between the various role players were reviewed. The placement of residents and continuity of care were emphasised. The establishment of a house-hold routine, as well as a nursing care routine also received attention.

Clinical outcome indicators that were introduced for measuring quality nursing care included falls, pressure ulcers, urinary tract infections, wound sepsis, scabies and other common problems found in homes for the aged. These indicators were selected based on gerontological literature and best practices related to caring for the elderly. The indicators are monitored and reported monthly to the management board of the home. In addition, all negative incidents such as negative behaviour from staff, as well as residents or family members are monitored and reported. The programme is attached as annexure G.

Huber (2010:532) argues that although structure and process standards are important determinants of quality care, it is the outcome standards that provide evidence of the effectiveness and hence the quality of care. According to Booyens (2008:269) patient satisfaction is an important indicator of quality of care as it provides strong evidence about the true nature of care from the patient's perspective. If a healthcare facility wants to improve patient satisfaction, the opinions and desires of patients about their care should be established (Booyens, 2008:269).

Berglund (2007:46) stated that resident satisfaction provides a basis for improving quality of care in a home for the elderly. Residents will be able to provide valuable information about the care they receive, the living conditions and the ability of the staff to meet their needs (Berglund, 2007:46).

In a culture of quality care, emphasis is placed on positive outcomes in terms of resident satisfaction. This can be achieved through changes towards resident centred care. In this approach teamwork is encouraged by allowing the elderly to take part in decisions regarding their care (Bellot, 2012:264).

Chou, Boldy and Lee (2002:188) refer to research that indicated a positive relationship between resident satisfaction and the quality of care in homes for the elderly. According to the authors resident satisfaction is useful to identify areas for improvement in order to increase the quality of life in a vulnerable population.

An external audit of the facility was undertaken in 2014 by Dr A. Bruwer of the Department of Social Development of the Provincial Government of the Western Cape. The results of the external audit indicated a compliance of 192 (87%), partial compliance of 22 (10%) and a non-compliance of 7 (3%) with standards (Department of Social Development of the Provincial Government of the Western Cape, 2014:np). However, the audit did not include a survey about resident satisfaction.

Resident satisfaction about the implemented quality assurance programme at this facility is thus unknown. Hence the study was aimed at investigating resident satisfaction as an outcome of the quality assurance programme in order to identify the strengths and weaknesses of the programme. The programme is due to be re-evaluated in 2016.

1.3 SIGNIFICANCE OF THE STUDY

Resident satisfaction following the implementation of a quality assurance programme would be important to amend and further improve the programme. Weaknesses within the programme could be identified and addressed. The strengths of the programme could also be identified and sustained as it is based on the feedback from the residents. Financial and other resources necessary to maintain and

continuously improve the programme would be justifiable based on scientific evidence. This study could be used as a bench-mark for similar programmes to be implemented and be evaluated due to the vulnerable population to be cared for in homes for the elderly.

1.4 PROBLEM STATEMENT

A quality assurance programme was implemented at a home for the elderly. However, resident satisfaction following the implementation of the programme is unknown. Resident satisfaction is a strong indicator of quality care. It has thus become essential to scientifically investigate resident satisfaction as an outcome following the implementation of the quality assurance programme that was implemented.

1.5 RESEARCH QUESTION

The research question which guided this study was: "What is the resident satisfaction following the implementation of a quality assurance programme at a home for the elderly?"

1.6 AIM OF THE STUDY

The aim of the study was to investigate resident satisfaction following the implementation of a quality assurance programme at a home for the elderly.

1.7 OBJECTIVES OF THE STUDY

The objectives of the study were to investigate resident satisfaction about the indicators of the structure and process standards related to the quality assurance programme.

- To investigate resident satisfaction about structure standards:

- safety and security measures of the facility
- maintenance of the infrastructure, including the buildings and gardens
- availability of nursing care
- provision in the basic needs including meals and laundry- and cleaning services
- recreational activities
- To investigate resident satisfaction about process standards:
 - communication with management
 - communication with staff
 - the nursing care they receive
- To investigate the residents' opinion of areas for further improvement
- To determine the relationship between demographic variables and resident satisfaction related to the various standards

1.8 CONCEPTUAL FRAMEWORK

A conceptual framework is defined by LoBiondo-Wood and Haber (2010:58) as an arrangement of concepts related to the research question and which provides the foundation for the intended study. A concept can further be defined as an abstract description of a specific event, idea or object in order to give meaning to it (Burns & Grove, 2011:230).

The proposed relationship that exists between the various concepts is also indicated in a conceptual framework. In a graphic display of the conceptual framework, arrows are used to show the relationship between the different concepts (Burns & Grove, 2011:233).

The conceptual framework for this study was based on the Donabedian model for the assessment of quality in healthcare (Figure 1.1). According to this model, information used to assess the quality of care can be categorised into three distinct groups namely: *structure*, *process* and *outcome*. *Structure* refers to the characteristics of the setting in which care is provided, whereas *process* refers to the various actions in the provision of care. *Outcome* on the other hand indicates the ultimate outcome of care in relation to the health of the receiver. This includes not

only an improved health status, but also improved knowledge of behavioural changes and the level of satisfaction with the care received (Donabedian, 1997:1745).

Donabedian (1997:1745) further states that an improvement in quality of care is possible based on the intended relationship between these three categories. Excellent structure improves the possibility of excellent process and that in turn would increase the possibility of excellent outcome. The level of satisfaction with care from the receiver's point of view would thus be increased with the availability of good structure and process (Donabedian, 1997:1745; Nakrem, Vinsnes, Harkless, Paulsen & Seim, 2009:849).

The conceptual framework for this study is illustrated by the researcher in figure 1.1.

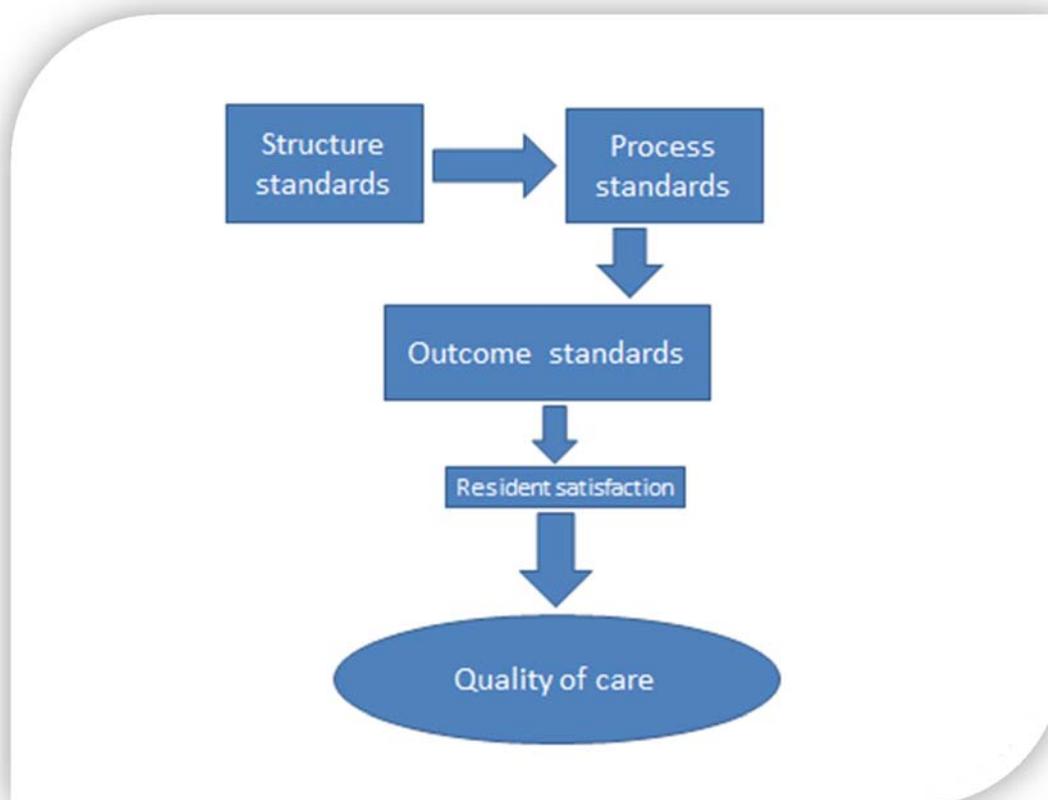


Figure 1.1 Conceptual framework for quality of care (by the researcher based on Donabedian, 1997:1745-1746)

1.9 RESEARCH METHODOLOGY

The research methodology as applied in the study is briefly described in this chapter. A more in-depth description is given in chapter three.

1.9.1 Research design

For the purpose of this study a descriptive research design with a quantitative approach was applied to investigate resident satisfaction following the implementation of a quality assurance programme at a home for the elderly.

1.9.2 Population and sampling

The population consisted of all the residents of the home (N=139). No sampling method was applied as all the residents meeting the eligibility criteria were included in the study.

1.9.2.1 Inclusion criteria

All residents who have been living at this specific home for the elderly for more than six months were included in the study.

1.9.2.2 Exclusion criteria

Residents who were in the advanced stages of dementia, comatose and confused residents were excluded from the study.

1.9.3 Pilot study

A pilot study was conducted with participants from each house and the frail care unit. The results of the pilot study were not included in the findings of the main study.

1.9.4 Data collection instrument

A self-administered questionnaire was used in this study. It was designed by the researcher based on personal experience, relevant literature, the objectives of the study and the Older Persons Act, No 13 of 2006.

1.9.5 Reliability and validity

Consultants in the field of geriatric care, research methodology, nursing and statistics were consulted to support the reliability and validity. Furthermore, a pilot study was conducted and the Cronbach's Alpha coefficient test was used to test the internal consistency of all the questions used in the instrument.

For this study face and content validity have been ensured by the opinion of three experts in the field of geriatric care. A nurse academic and researcher have also reviewed the instrument. Relevant literature further supported content validity.

1.9.6 Data collection

The data was collected by the researcher according to a predetermined plan approved by the General Manager of the facility, the nursing staff, house parents and the residents.

1.9.7 Data analysis

Descriptive statistical analysis was done for this study with the support of a qualified statistician from Stellenbosch University. The computerised statistical package SPSS version 22 was used.

1.10 ETHICAL CONSIDERATIONS

The core ethical principles that guide research are respect for persons, justice and beneficence. These principles are used to protect the rights of participants by ensuring freedom of choice, privacy, anonymity, confidentiality, fair treatment and safety during research (Burns & Grove, 2011:110).

Beneficence specifically refers to the participant's right to be protected against any form of injury or discomfort during research. This includes physical, emotional, social and financial injury or discomfort (Burns & Grove, 2011:118). Since any study has the potential to cause some form of discomfort to some degree, the risk-benefit ratio should be considered. If the potential risk of injury or discomfort is more than the anticipated benefit to the participant, the intended study could be seen as unethical (Burns & Grove, 2011:134 – 135).

The elderly and persons in dependent relationships, such as residents in homes for the aged are considered vulnerable populations and specific attention should be given to protecting them during research (Department of Health, 2015:27). Furthermore Grove, Burns and Gray (2013:165) state that persons with diminished autonomy are seen as vulnerable and need additional protection during research. Application of the aforementioned ethical principles for the purpose of this study is described in the next paragraphs.

Ethics approval to conduct the study was obtained from the Health Research Ethics Committee of the Faculty of Medicine and Health Science, Stellenbosch University – reference number S14/05/115 (Annexure A). Written approval to conduct the study was obtained from the Board of Directors of the particular home for the elderly where the quality assurance programme was implemented (Annexure B).

Residents who took part in the study were informed of the purpose of the study. Informed written consent (Annexure C) was obtained from each participant before completing the questionnaire. It was confirmed through the records that all the residents at the time of the study were either English or Afrikaans speaking. Thus, the consent forms were available in both English and Afrikaans to reduce any possibility of a language barrier. It was furthermore printed in font size 16 to accommodate participants with weakened eye-sight.

Residents were furthermore informed that they have the right to refuse participation or to withdraw from the study at any given time without any negative consequences. It was also pointed out that services were available for emotional support should any participant feel the need for debriefing after completing the questionnaire.

They were assured about the anonymity and confidentiality of answering the questionnaire. Clear instructions not to write their names on the questionnaires were printed on the document (Annexure D). They were also assured that the only persons who will have access to data from the questionnaires will be the researcher, the supervisor and the statistician. The completed questionnaires would be kept in a locked cupboard at the researcher's residence.

The researcher was a former employee of the home for the elderly where the quality assurance programme was implemented. Although initially part of the

implementation of the quality assurance programme, the researcher has not been involved with the programme for the past four years. Currently, there is thus no conflict of interests.

1.11 OPERATIONAL DEFINITIONS

The following operational definitions apply for the purpose of this study:

Caregiver

A caregiver means any person providing physical, psychological or social assistance and services to an older person in order to enhance the quality of life and well-being of that person as described in the Older Persons Act, Act 13 of 2006 (Republic of South Africa, 2006:3).

Care-worker

A care-worker means a person who assists in the provision of healthcare services under the direct supervision of a healthcare provider in terms of the National Health Act, no 61 of 2003 (Republic of South Africa, 2003:12).

Continuous quality improvement

It refers to an ongoing process of improvements related to every aspect of an organisation (Booyens, 2008:252).

Enrolled nursing auxiliary

An enrolled nurse means a person who is enrolled with the South African Nursing Council in terms of section 16 of the Nursing Act, no 50 of 1978 (Republic of South Africa, 1978:13).

Enrolled nurse

An enrolled nurse means a person who is enrolled with the South African Nursing Council in terms of section 16 of the Nursing Act, no 50 of 1978 (Republic of South Africa, 1978:13).

Frail older person

A frail older person refers to an older person in need of full time care due to a physical or mental illness which results in the person being unable to perform self-care and activities of daily living (Republic of South Africa, 2006:3).

Home for the elderly

For the purpose of this study it refers to a building mainly used for providing accommodation and a 24-hour service to older persons as described in the Older Persons Act, Act 13 of 2006 (Republic of South Africa, 2006:3). It is however referred to as a residential facility in the aforementioned act.

Indicators

It refers to valid and reliable measures related to performance (Huber, 2010:562).

Older person

An older person is seen as a person who is, in case of a male, 65 years of age or older, and, in case of a female, 60 years of age or older (Republic of South Africa, 2006:3). According to the World Health Organisation most countries define an elderly or older person as 65 years of age or older (World Health Organisation, 2015:1). For the purpose of this study the term elderly person will be used.

Outcome standards

It refers to the end results of healthcare interactions as measured in terms of patient satisfaction, staff satisfaction and clinical outcomes (Huber, 2010:531).

Process standards

It refers to the effectiveness, appropriateness and efficiency of actions needed to achieve excellence in healthcare (Huber, 2010:531).

Quality

It refers to the attributes of and the pursuit of excellence (Huber, 2010:526).

Quality assurance

It refers to a systematic process where problems are identified, remedial actions are designed, implemented and followed up to ensure the desired outcomes have been met (Booyens, 2008:251).

Registered professional nurse

A registered professional nurse means a person who is registered with the South African Nursing Council in terms of section 31 of the Nursing Act, Act 33 of 2005 and who is qualified and competent to practise comprehensive nursing independently, taking responsibility and accountability for such practice (Republic of South Africa, 2005:25).

Resident

A resident mean an older person living permanently at a residential facility as describe below (Republic of South Africa, 2006:9).

Residential facility

It referrers to a permanent structure or building which provide full time accommodation and a 24-hour service to older persons (Republic of South Africa, 2006:3).

Satisfaction

It refers to a person's perception and subjective reaction, influenced by personal preferences and prior expectations in relation to the experience of a specific service (Hawthorne, Sansoni, Hayes, Marosszeky & Sansoni, 2014:527).

Standards

It refers to written descriptions of the minimum performance requirements to attain excellence in healthcare (Booyens, 2008:266).

Structure standards

It refers to what is needed to provide excellent healthcare in terms of infrastructure, human and other resources (Huber, 2010:5310).

1.12 CHAPTER OUTLINE

Chapter 1: Scientific foundation of the study

This chapter describes the background, rationale, problem statement, aim and objectives of the study. The conceptual framework which guided the study is included in this chapter. It further provides a brief overview of the research methodology as applied in this study.

Chapter 2: Literature review

This chapter provides a discussion of the literature review about the elderly, quality assurance, standards of care and resident satisfaction in homes for the elderly.

Chapter 3: Research methodology

The research methodology which was applied during the study is discussed in depth in this chapter.

Chapter 4: Study results

The results of the study are presented and analysed in this chapter.

Chapter 5: Discussion, recommendations and conclusion

In this chapter the results of the study are discussed in relation to the aim and objectives of the study. Recommendations, based on the scientific evidence obtained during the study are formulated. The limitation of the study and further research is also described.

1.13 SUMMARY

This chapter describes the background and rationale for the study. The significance of the study is explained, including the research problem, aim, objectives of the study and the research question. In addition, the research methodology, ethical considerations, operational definitions, and the chapter layout are described. In the next chapter the literature review which supports the study is discussed.

1.14 CONCLUSION

Meeting the different care needs of the elderly in residential facilities is challenging, but it has a profound effect on the quality of their lives. Numerous studies have indicated that quality assurance is an important aspect within these facilities. Investigating the level of resident satisfaction could contribute to improvements based on the resident's perspective and scientifically obtained information.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In chapter two the elder person, as the receiver or care in homes for the elderly, is described. It gives an overview of the scientific literature about quality of care specifically in homes for the elderly. Furthermore, the concept of quality assurance is explored. It also focuses on the utilisation of various standards to ensure positive outcomes and resident satisfaction as a way to measure success.

A literature review is done to obtain scientific and theoretical information about the topic to be studied. It is used to describe existing knowledge, identify gaps in the knowledge and how the intended study will add to the knowledge base about the topic (Burns & Grove, 2011:189). According to De Vos, Strydom, Fouché and Delport (2011:134) the purpose of a literature review is to get a better understanding of the nature and meaning of the problem that will be investigated.

The computer databases of Cinahl and Science Direct, as well as E-journals were used to source the literature in addition to the textbooks as referenced.

2.2 THE ELDERLY

Older adults are commonly defined as people aged 65 years and older. However, the physical, mental and social level of functioning may be vastly different between individuals of the same age group. Therefore, chronological age is not an accurate predictor of the functional abilities and needs of older people. The perception of “*being old*” may also differ between older persons. At a specific age, some older adults may see themselves as being old, whereas others of the same age may see themselves as “*relatively young*”. This is being referred to as age identity in the literature (Eliopoulos, 2014:4).

The presence of chronic illnesses is a major health problem associated with increased age. More problematic is the multiple co-morbidities often experienced by the elderly, as well as the debilitating effect it often has on the functional abilities of the individual (Bakerjian & Zisberg, 2013:1). According to Redfern and Ross (2006:31) functional ability is seen as the degree to which an individual can perform activities of daily living independently. In order to live independently in a community, the individual thus has to be mobile enough to perform self-care activities as well as carry out domestic tasks. It is not only physical deterioration of the elder person that could lead to increased dependency, but also mental deterioration. Dementia is an important health related problem associated with increased age. This has a significant influence on an individual's functional ability and thus independence (Redfern & Ross, 2006:32).

Another challenge faced by ageing adults is described by Eliopoulis (2014:36 - 38) in terms of changes in family roles and other relationships. Those who may have children will experience their children's transition into adulthood, leaving home and starting a family of their own. The parenting role of the elder person will thus change accordingly and may even extend into that of a grandparent. In addition, many older adults will most likely be faced with losing their spouse or significant other (Eliopoulis, 2014:39).

Other meaningful relationships may rapidly change as well. This is usually the time when the majority of older adults will be facing retirement. With that comes the possibility of a reduced income which may in turn result in major changes in terms of living arrangements and other lifestyle changes (Redfern & Ross, 2006:10).

Furthermore, the changes associated with ageing contribute to a loss in social relationships. The social world of the elderly becomes smaller and with that, the risk for loneliness and isolation increase. This risk could increase when they become dependent on others for activities of daily living and subsequently have to move into long-term care facilities (Bergland & Kirkevold, 2005:682).

Joubert and Bradshaw (2005:215) point out that, despite the ageing population, geriatric services in South Africa have been marginalised. This is an area of great concern as statistics predict that the ageing population will continue to rise rapidly in the years to come. Therefore, more emphasis should be placed on the provision of

geriatric services in line with the needs of the elderly. This includes the care offered by long-term facilities such as homes for the elderly (Joubert & Bradshaw, 2005:216).

2.3 QUALITY OF CARE

Attree (1993:367) describes quality as a relative and multifaceted concept with ethnographic principles attached to it, thus making it context specific. Quality is often linked to the perception of excellence and the value attached to specific phenomena. Literature related to healthcare emphasises the application of the quality concept in various ways to reach specific objectives during service delivery (Attree, 1993:360).

Huber (2010:526) refers to quality care as being based on scientific evidence with the emphasis on the receiver of care. This is supported by Yoder-Wise (2014:394) who states that quality is ultimately defined by the customers using the healthcare service. Therefore, customer satisfaction is often used as one of the strategies to determine the quality of care provided by a healthcare facility.

As the public nowadays has a wider choice in healthcare, the healthcare market has become more competitive. The escalating cost of healthcare has resulted in an increase in the demand for safe, efficient and effective care. Hence, quality of care is becoming an important marketing strategy used by healthcare organisations to ensure their profitability and thus sustainability (Muller, Bezuidenhout & Jooste, 2011:473).

Healthcare professionals are responsible and accountable for the care they provide; it is thus expected of them to practise within the ethical and legal parameters of their various professions. Quality is therefore seen by them as being able to provide care with the necessary knowledge, skills and resources. In addition, their values and beliefs could influence their perception of quality care (Muller, 2009:250 – 251).

Stelfox and Straus (2013:1321) define quality of healthcare as the degree to which these services increase the possibility of improved health related outcomes of society based on the professional knowledge of the healthcare practitioners. They furthermore state that healthcare should be equally provided in a safe and timely

manner to those who need it. Not only should healthcare be based on scientific evidence, it should also be cost-effective and adapted to meet the individual needs of the receivers of care (Selfox & Straus, 2013:1321).

Homes for the elderly are uniquely challenged to provide quality care. This stems from the varying and complex needs of frail residents with diminished levels of functioning, often accompanied by multiple co-morbidities and chronic diseases (Bakerjian & Zisberg, 2013:1). Mueller and Savik (2010:270) further state that the quality of nursing care provided to residents in homes for the elderly has a direct impact on their physical and psychosocial well-being. Many of these residents are extremely frail with complex health problems. Consequently, they become vulnerable and dependent on comprehensive and competent nursing care.

This is supported by Du Moulin, Van Haasregt and Hamers (2010:288) who is of the opinion that quality of care in homes for the elderly remains problematic as a result of the multiple dimensions of residential care. Not only are residents in need of professional care, but also a homely environment to live in (Du Moulin *et al.*, 2010:288).

2.4 QUALITY ASSURANCE

Quality assurance is defined by Whittaker, Shaw, Speiker and Legar (2011:60) as a systematic process generating data to analyse service delivery. It is customer orientated and focuses on a team approach towards problem-solving and quality improvement within healthcare services. According to Booyens (2008:251 – 252) healthcare facilities make use of this process to design, implement and evaluate quality assurance programmes in order to achieve excellence in healthcare.

Muller, Bezuidenhout and Jooste (2011:506) state that quality assurance programmes should be aimed at creating a safe environment by managing the risks associated with the provision of healthcare hence leading to improved outcomes. This is supported by Yoder-Wise (2014:391) who further states that these programmes should be integrated in the philosophy of healthcare organisations, thereby ensuring a culture of quality applicable to all staff and aspects of care.

Quality assurance programmes are implemented in healthcare facilities to at least fulfil and strive to exceed the needs and expectations of its customers. This is reflected in measuring work performance against specific pre-determined standards based on best practices and scientific evidence (Muller, 2009:258).

While quality assurance programmes have been implemented in many acute care facilities, fewer homes for the elderly have embarked on similar initiatives (Compas *et al.*, 2008:209). According to the authors this could be due to differences in regulatory processes pertaining to the different types of facilities.

However, homes for the elderly are constantly being faced with numerous quality related concerns such as falls, pressure ulcers, high usage of restraints and inadequate incontinence management. Therefore, quality assurance programmes should be implemented to address these and other quality issues specifically related to homes for the elderly (Bakerjian & Zisberg, 2013:1).

Dellefield, Kelly and Schnell (2013:44) emphasise the importance of a quality assurance programme which incorporates evidence-based nursing practices specific to geriatric care. The authors suggest the use of a comprehensive range of quality indicators to monitor the success of the programme. This is supported by Nakrem *et al.* (2009:855) who describe a variety of quality indicators to be used in homes for the elderly based on a review of the literature. In addition, the framework for everyday excellence as developed by Lyons, Specht, Karlman and Maas (2008:221) provides a guideline for quality assurance programmes in homes for the elderly.

Wagner, Ikkink, Van der Wal, Spreeuwenberg, De Bakker and Groenewegen (2006:230) conducted a cross-sectional study in 65 Dutch homes for the elderly to explore the impact of a quality assurance programme on clinical outcomes. They concluded that the implementation of such a programme had a significant influence on the number of undesirable clinical outcomes.

2.5 QUALITY STANDARDS

Standards are used as the building blocks in the design, implementation and evaluation of quality assurance programmes in healthcare facilities (Booyens,

2008:251). Huber (2010:526) defines a standard as a written statement to describe the minimum level of required work performance. According to Whittaker *et al.* (2011:60) standards define the quality of healthcare against which all activities and outcomes are measured.

Furthermore, best practices in healthcare are used as a point of reference when developing quality standards. This ensures a scientific basis for the measurement of quality care (Yoder-Wise, 2014:399). In addition, Booyens as updated by Bezuidenhout (2014:416) states that standards should comply with the ethical and legal requirements as provided by professional healthcare bodies and government.

Quality standards in healthcare can be divided into three distinct categories, namely structure standards, process standards and outcome standards. This is based on the theoretical framework for quality measurement in healthcare as postulated by Donabedian (Whittaker *et al.*, 2011:61).

Donabedian's three prong approach towards quality assessment is based on the principle that adequate structure increases the possibility of an efficient and effective process which in turn will lead to improved outcomes (Donabedian, 1997:1147).

2.5.1 Structure standards

Donabedian (1997:1147) describes the structure category as the characteristics of the setting within which healthcare is being provided. Structure standards are further defined by Huber (2010:531) as to what is needed to provide quality healthcare in terms of infrastructure, human and other resources of the facility.

2.5.1.1 Infrastructure

One of the many challenges faced by homes for the elderly is provision of professional healthcare in an environment which has to be both homely and conducive to safe healthcare. The environment should further be adapted to accommodate the decreased levels of sensory functionality, mobility and independency of frail residents (Molony, 2010:292).

According to the Regulations regarding older persons (Regulation 260, 2010:28 – 30) the following aspects should be considered in order to establish an adequate infrastructure at homes for the elderly:

- Safe areas for walking inside and outside the buildings
- Ramps and handrails at door entrances
- Doors and corridors wide enough to allow for the easy and safe use of wheelchairs and other walking aids
- Handrails in the corridors
- Non-slippery floors
- Adequate lighting inside and outside the building, especially at night
- Proper ventilation and temperature control
- Enough space in the various rooms for wheelchairs, walking aids and hoists
- Availability of a sitting room, dining room and other communal rooms
- Nearness of bathrooms and bedrooms
- Bathrooms adapted for special needs of the elderly
- Bedrooms equipped with a call bell and linked to the nursing office
- Availability of outdoor areas for walking and resting
- Maintenance of the buildings
- Security measures in place to enhance the physical safety of residents
- General fire precautions, including firefighting equipment and guidelines

Once admitted to a home for the elderly, the facility becomes the new home where the resident will permanently live in and most probably die in. It is therefore necessary for such facilities to create a therapeutic environment that would resemble the comforts and décor expected to be found in a home (Moloney, 2010:292). Residents' perception of identity and self-worth is linked to the place they would call home. In order for them to still feel valued, attention should be given to create a homely environment that is both safe, but also comfortable and aesthetically acceptable to the residents. These include aspects such as the interior decoration, furniture, pictures and indoor plants. The absence of odours and noise level control are essential in homes for the elderly (Edvardsson, 2008:33).

In addition, Rantz, Zwygart-Stauffacher and Flesner (2005:294) developed a theoretical framework for quality assurance in homes for the elderly. A homelike environment and the absence of odours were identified as two of the seven critical observable indicators in this framework.

In a qualitative study by Bengtsson and Carlsson (2013:399) it was found that the outdoor environment contributed to the residents' perception of "*feeling at home*". During interviews with 12 residents and 7 family members at 3 different homes for the elderly in Sweden, participants explained the value of having access to gardens where they could enjoy nature and fresh air. According to the participants, it improved their senses and gave them a connection with the past, as well as creating opportunities for social interaction. Some participants further commented on the importance of safety and security aspects. These aspects included smooth walking paths, handrails along the paths and the availability of sitting areas (Bengtsson & Carlsson, 2013:394 – 400).

2.5.1.2 *Activities and services*

Residents in homes for the elderly often experience feelings of loneliness, loss and boredom. This not only has a negative influence on their psychological and spiritual well-being, but also on their physical well-being (Maas, Spect, Buckwalter, Gittler & Bechen (2008:130).

In a qualitative study by Bergland and Kirkevold (2005:686) residents described the importance of social interaction and recreational activities. Although family contact remained desirable, they regarded positive relationships with fellow residents and caregivers as meaningful. It was even more important for these residents to have opportunities to participate in recreational activities. It alleviated the boredom and offered them time to interact with other people. A variety of activities were seen by the residents as adding value to their care. Special consideration was given to opportunities to go outside the facility (Bergland & Kirkevold, 2005:686 – 688).

This is supported by Van Malderen, Mets and Gorus (2013:146) who refer to the influence of the social environment in homes for the elderly on the resident's wellness. A variety of activity programmes should be available to allow for group, as well as individual participation. Personal preferences, as well as the physical and mental functioning levels of residents should be taken into account when designing these programmes. The aim should be to improve social interaction, whilst providing meaningful leisure time (Van Malderen *et al.*, 2014:148). The authors also point out that having meals and refreshments together in a family style could further improve the social interaction between residents.

According to the Older Persons Act (No 13 of 2006:9) homes for the elderly may provide specific services to accommodate the needs of the residents. Not only does this include fulltime care and support services, but also recreational activities and counselling services.

Eliopoulos (2014:500) emphasises the importance of special services at homes for the elderly. These would include services such as physical therapy, occupational therapy, podiatry and counselling services. Having access to a chapel, library, hair salon and transport services are some of the basic services that would add value to the daily lives of residents in homes for the elderly (Eliopoulos, 2014:500 – 501).

The provision of food and refreshments are one of the most basic, yet challenging services at homes for the elderly. Not only is nutritionally balanced meals required, but it has to be tasty and well-prepared. Many residents would need special diets as a result of chronic illnesses and or age-related changes to the gastro-intestinal tract. Personal preferences, food allergies and ethnic factors of residents would also have to be taken into account (Maas *et al.*, 2008:126).

2.5.1.3 Staffing

Since residents in homes for the elderly depend in variable degrees on the staff for assisting them in their activities of daily living, staffing plays an important role in quality assurance programmes (Spilsbury, Hewitt, Stirk & Bowman, 2011:733).

Quality of care in homes for the elderly is influenced by staffing characteristics, such as the number of care hours per nurse, turnover and the skills mix of the nursing staff (Collier & Harrington, 2008:158). According to a literature review by these authors, higher staffing levels, especially the ratio of professional nurses, and a lower turnover have been positively associated with improved outcomes for residents. These included clinical outcomes, such as less pressure ulcers, fewer urinary tract infections and an improved nutritional status.

A systematic review by Spilsbury *et al.* (2011:746) confirmed these findings. The authors stated that inadequate staffing and poor skills mix are some of the main reasons why substandard nursing care is provided in homes for the elderly. They further argued that the imbalance between more support workers and less professional nurses is problematic when it comes to the diverse and complex care

requirements of the frail residents. They also pointed out that although many studies focused on clinical outcomes, some included quality indicators, such as resident satisfaction and quality of life measures (Spilsbury *et al.*, 2011:746 - 747).

A literature review by Lyons *et al.* (2008:218) provides more evidence that a higher ratio of professional nurses is needed to ensure that residents in homes for the elderly receive proper nursing care. They argue that professional nurses have greater autonomy and knowledge to apply evidence-based nursing practices, thereby ensuring better outcomes for the residents. Professional nurses are also better equipped to guide and supervise the care being delivered by other categories of nurses and auxiliary staff (Lyons *et al.*, 2008:219).

Dellefield (2008:198) points out that safe and quality care in homes for the elderly would require knowledgeable and competent nursing staff. This is supported by Maas *et al.* (2008:130) who recommend the use of highly-trained and well-skilled staff to provide in the unique needs of the elderly in residential care facilities.

Since caring for the elderly has unique challenges, professional nurses with specialised knowledge and skills of gerontological nursing would be beneficial in homes for the elderly. As experts they would be able to provide role modelling, guidance and support to other nursing staff (Cohen-Mansfield & Parpura-Gill, 2008:378).

In addition, Castle (2009:193) states that the quality of care in homes for the elderly is also being compromised by the predominant use of agency staff. A correlational survey done by the author revealed a strong association between improved quality of care and the use of less agency staff in homes for the elderly (Castle, 2009:199).

In order to provide quality care to residents on an ongoing basis, opportunities should be provided for staff development. In-service training programmes that focus on risks and challenges related to geriatric care should be developed and implemented by the management of the facility. New information and the latest research related to geriatric care practice have to be included to ensure nursing staff provides evidence-based care to residents. The aim of such programmes should not only be to improve the knowledge and skills of staff, but also include interpersonal

skills development to ensure a positive attitude (Cohen-Mansfield & Parpura-Gill, 2008:380; Dellefield, Kelly & Schnelle, 2013:49 – 50).

2.5.1.4 Equipment and Supplies

The availability of adequate equipment and supplies will allow staff to provide the care needed by the residents. The necessary equipment should not only be available, but in a working condition as well. This will not only allow staff to provide safe care, but also to improve the quality of care (Whittaker *et al.*, 2011:63).

The nursing staff in homes for the elderly needs specific equipment, for example bathing assisting devices, to enable them to assist residents with activities of daily living. Special mattresses are required to prevent pressure ulcers of bedridden residents. They further need equipment to do regular health assessments and to monitor clinical markers of those residents with chronic illnesses. Adequate supplies are also needed for infection control and incontinence care. In order to keep residents as independent as possible, a variety of walking aids and wheelchairs should be freely available (Nakrem *et al.*, 2009:853 – 854).

Booyens (2008:172) recommends that equipment should be correctly used and stored to prevent damage. Supplies have to be controlled and preferably be kept in locked cupboards, especially medication. Supplies should only be used for the intended purpose to improve cost-effectiveness.

Sufficient linen and cleaning materials are essential in homes for the elderly as many residents may suffer from incontinence. Well-groomed residents and a clean, fresh-smelling environment is the hallmark of quality care in homes for the elderly (Maas *et al.*, 2008:125).

A fully-equipped laundry and kitchen are further needed to provide the necessary domestic services. Annexure B of the Regulations regarding older persons (Regulation 260, 2010:37 – 42) makes provision for specific guidelines about these services in homes for the elderly.

2.5.1.5 Policies and guidelines

Just like in any other healthcare facility, policies and guidelines are important documents and should be available in homes for the elderly. Policies provide the

framework and guide the activities necessary to achieve the goals of the facility. Together with guidelines, procedure manuals and other written documentation, they form the basis for the delivery of safe and quality care. Policies furthermore assist staff and management in decision-making and problem-solving. It is also used to ensure fair treatment of all staff (Cohen-Mansfield & Parpura-Gill, 2008:379).

Policies related to high risk, problem prone and high-frequency interactions specific to caring for the elderly would be required in a home for the elderly (Muller, 2009:141). These would include, but are not limited to the management of resident falls, pressure ulcers, infection control, wound care, medication, valuables and fire drills (Nakrem *et al.*, 2009:854).

Policies should be in line with the legislative framework of the country, as well as the professional regulations and ethical guidelines of the relevant statutory professional bodies (Booyens, 2008:45). Policies should further be communicated to all staff members of the healthcare facility and be available at all times as a resource document.

2.5.1.6 Legislative framework

Chapter 2 of the Constitution of South Africa (South Africa, 1996:7 - 39) contains The Bill of Rights for citizens of the country. This includes basic health related rights, which are further expanded within the South African Patients' Rights Charter (Department of Health, 1999:3). One of the main aims for introducing this Charter was to improve the quality of healthcare services in South Africa (Muller, 2009:15). In addition, Chapter 4 of the Older Persons Act (No 13 of 2006) stipulates specific rights of older persons in residential facilities in South Africa.

Furthermore, Chapter 4 outlines the services that may be provided by the residential facility. It also stipulates that residential facilities, offering care to the elderly, should be registered in terms of the Act and identifies the conditions for registration. Provision is also made for the admission of the elderly into residential care facilities. The last subsections in Chapter 4 deals with the monitoring of registered residential facilities (Older persons Act, No 13 of 2006).

The Older Persons Act (No 13 of 2006) was promulgated to empower and protect elderly citizens of the country, as well as to enhance their safety and well-being.

Regulations in terms of this Act have been issued by the Government. Chapter 3 of Regulation 260 (No 260 of 2010) deals specifically with residential care facilities. Annexure B of the same regulation sets out the National Norms and Standards such facilities should comply with.

Nursing staff employed by homes for the elderly are practising under the control of The South African Nursing Council. It has been established in terms of section 2 of the Nursing Act, 1978 (Act No 50 of 1978) and continues to be the statutory body for the profession in terms of section 2 of the new Nursing Act (No 33 of 2005). The Council is responsible to ensure that safe nursing care is provided to the citizens of the country. It further strives to maintain the professional and ethical standards of the nursing profession in South Africa (Nursing Act, No 33 of 2005:6 – 7).

The South African Nursing Council is also responsible for the drafting, publishing and enforcing of specific regulations pertaining to the practice and responsibilities of all registered and enrolled nurses in the country. There are two important regulations to consider in this regard. Regulation 767 (promulgated in terms of the Nursing Act No 33 of 2005) deals with the acts or omissions in respect of which the Council may take disciplinary steps against any person registered in terms of this Act. Regulation 2598 (promulgated in terms of the Nursing Act No 50 of 1978) delineates the scope of practice for all categories of nurses (Nursing Act, No 33 of 2005:7 – 8; SANC, 2014: np). Currently, a new scope of practice for all categories of nurses is being drafted by the Council. New regulations from the South African Nursing Council about conditions for continuous professional development are also awaited. These regulations will be in terms of the Nursing Act, no 33 of 2005 (Nursing Act, No 33 of 2005: 25 – 29).

Relevant provisions from other health related Acts, such as the National Health Act (No 61 of 2003) and Mental Health Care Act (No 17 of 2002) should also be considered when structure standards are compiled. Homes for the elderly are further obligated to observe all other Acts of Parliament applicable to the facility, for example labour related laws and occupational health and safety laws. (Booyens, 2008:45).

2.5.1.7 Philosophy of care

The philosophy of a healthcare facility forms the basis for all decision-making. It contains the belief and value statements of the staff which guide their actions in order to achieve the goals of the facility (Yoder-Wise, 2014:284).

Homes for the elderly have been established to provide care to those senior citizens who are no longer able to take care of themselves. A loss of dignity is often experienced when there is a constant need and dependence on others for care. The elderly regard dignity as an essential aspect of quality of life. Maintaining the dignity of the elderly residents should therefore be embedded within the philosophy of the residential facility (Hall, Dodd & Higginson, 2014:55).

The philosophy of homes for the elderly should further focus on the provision of individualised care (Bellot, 2012:264). Lyons *et al.* (2008:222) have also identified individualised resident care as being a prerequisite for attaining excellence in homes for the elderly. The authors developed a framework to maintain excellence in homes for the elderly. “*Envisioning excellence*” through a caring and resident-centred philosophy is one of the pillars of this framework (Lyons *et al.*, 2008:222).

Cohen-Mansfield and Parpura-Gill (2008:378) identified certain values to be central for achieving excellence in homes for the elderly. This includes respect for the elderly as human-beings. Having compassion for the special needs of the elderly will result in quality care rather than just good care.

The philosophy of the facility should be applied by management during their leadership activities. Staff should be constantly reminded thereof and ideally it should be displayed within the facility (Dellefield, 2008:197).

2.5.2. Process standards

The process category is described by Donabedian (1997:1147) as the specific activities included in the provision of healthcare. Process standards can therefore be defined as the effectiveness, appropriateness and efficiency of actions needed to achieve excellence in healthcare (Huber 2010:531). Booyens (2008:267) indicates that process standards are often included in procedure manuals as they describe the various steps needed to perform a specific procedure.

2.5.2.1 Nursing care

Process standards describe the scientific elements of the nursing process which include assessment, planning, implementation and evaluation of care needed by the residents (Muller, 2009:259). In addition, clinical decision-making should follow a systematic process by using existing research findings and best practice guidelines (Bakerjian & Zisberg, 2013:7).

Specific knowledge and competencies related to caring for the elderly are required from the nursing staff. Residents in homes for the elderly often suffer from chronic conditions associated with either mental or physical impairment or both. A holistic approach should thus be followed to ensure optimum care. The inner strengths and abilities that are still intact in older persons should be recognised and taken into account. The elderly should therefore play an active part in their own care by being involved in decision-making. Independence and individuality should be promoted during all nursing care activities (Dellefield *et al.*, 2013:47).

Individuality has been identified as one the main themes in a qualitative study on how residents view their care. Quality of care was linked to residents being able to take part in decision-making and given choices during their care. Residents felt that their individual worth was being recognised and respected when their personal preferences were taken into account during their care. They further felt in control of their own care, which gave them a greater sense of independence and autonomy (Hall *et al.*, 2014:57 – 58).

A resident's level of dependency related to activities of daily living should therefore be determined during assessment. These include aspects associated with physical wellness such as personal hygiene, nutrition, elimination, mobility and comfort. Aspects related to mental, social and spiritual wellness should also be assessed. In addition, risk factors linked to resident care such as falls, pressure ulcers, infection, weight loss and confusion should be identified. Specific assessments may be necessary for those residents suffering from chronic illnesses, as well as acute illness (Eliopoulos, 2014:75 – 89; Regulation 260, 2010:66 – 68; Maas *et al.*, 2008:125).

According to their scope of practice (Regulation R 2598, 1984:2) registered nurses are responsible to draw up an individual nursing care plan to meet the needs of each person under their care. The specific nursing interventions of the care plan should focus on meeting the physical, mental, social and spiritual needs of the person. It should also provide specific interventions to minimise the risk factors that have been identified during the assessment phase (Regulation 2598, 1984:2 – 3).

The registered nurse has a further responsibility to coordinate and supervise the implementation of nursing care. Continuity of care has been identified by Mueller and Savik (2010:271) as an important factor to consider when assigning other categories of nursing staff and care workers. Continuity of care refers to the consistent assignment of staff members to care for specific residents. Continuity of care in homes for the elderly has been associated with better outcomes in terms of resident satisfaction, individualized care and clinical outcomes (Mueller & Savik, 2010:272).

Registered nurses are also responsible for collaborating with other healthcare professionals to ensure optimal care is provided to the elderly (Regulation 2598, 1984:3). Once the healthcare needs of the resident have been identified, the necessary referrals should be made. The registered nurse continues to function in a coordinating capacity to ensure that the care plan is adjusted to accommodate new information and treatments.

Nursing care interventions should be carried out in a manner that would reflect the values central to the caring philosophy. Respect and compassion for the resident's vulnerable position should be the basis from which care is provided. Ensuring privacy and comfort remains a sign of respect towards residents and should therefore be maintained at all times (Hall *et al.*, 2014:58).

Since many care interventions are carried out by non-professional nurses and care givers, it remains the responsibility of the registered nurse to supervise these activities. The manner in which care is being provided to the residents has to be supervised too. (Cohen-Mansfield & Parpura-Gill, 2008:384).

Supervision can further be utilised to evaluate the effectiveness of nursing care plans. It is important to adjust care plans to meet the changing needs of the elderly.

By providing constant feedback to the residents and caregivers, ongoing quality of care will be assured (Dellefield, 2008:201).

2.5.2.2 Communication

Interpersonal communication was one of seven dimensions Rantz, Zwygart-Stauffacher and Flesner (2005:294) included in their theoretical framework for quality assurance in homes for the elderly. Hall *et al.* (2014:58) confirmed the importance of effective communication between staff and residents as part of ensuring autonomy in decision-making and thus self-worth of the residents. The authors emphasised the value of good communication skills not only to calm aggressive residents, but also to persuade residents in making non-detrimental choices where activities of daily living are concerned. This is particularly important for residents with dementia, but also for those with chronic illnesses (Hall *et al.*, 2014:58).

Carpac-Claver and Levy-Storms (2007:59) further point out that effective communication may increase the potential for quality relationships between staff and residents in homes for the elderly. They also caution against the use of “*elder-speak*”, which they define as a speech style using oversimplified language in a slow and loud manner, as well as the use of terms of endearment. Compassion should rather be expressed by the tone of voice used during communication.

The management of homes for the elderly are further responsible to create opportunities for residents to communicate with them. By providing a formal structure such as a resident’s council, residents are able to voice their concerns and participate in decision-making processes. This could have a positive influence on the way they experience living in long-term facilities and ultimately on their sense of self-worth (Baur & Abma, 2011:391).

Family involvement plays an important role in the well-being and care of residents in homes for the elderly. They can provide significant support and information that could assist staff in caring for the residents. It is therefore imperative that staff communicate effectively and build positive relationships with families (Maas *et al.*, 2008:130).

According to Majerovitz, Mollott and Rudder (2009:12) increased communication and involvement of family members will not only reduce complaints, but also increase

satisfaction. It is therefore important to improve communication with family members in order to enhance quality of care in homes for the elderly.

Effective communication between staff members is further needed to utilize information, thus ensuring quality care is continuously being provided to residents in long-term care (Mueller & Savik, 2010:277 - 278). Good communication between staff members was identified as a critical organisational component in highly recommended homes for the elderly (Scott-Cawiezell, Schenkman, Moore, Vojir, Connolly, Pratt, & Palmer, 2004:243).

2.5.3. Outcome standards

Donabedian (1997:1147) describes the outcome category as the results of care on the health status of the patient, as well as the patient's level of satisfaction with care. Outcome standards are thus defined by Huber (2010:531) as the end results of healthcare interactions as measured by improved health status, changes towards healthy lifestyles and satisfaction with care.

Various clinical indicators can be used to measure the quality of care in homes for the elderly. These are mainly related to the physical and mental deterioration often faced by the elderly. Therefore resident falls, pressure ulcers, infections, and weight loss should be monitored on a regular basis. These figures could offer valuable information about the effectiveness of the nursing care being provided to residents (Rantz *et al.*, 2010:7)

Van Malderen *et al.* (2013:142) explain that residents in homes for the elderly are largely dependent on others to meet their daily care needs. Therefore, residents' perceptions of the quality of care they receive are an important outcome parameter in a quality assurance programme (Van Malderen *et al.*, 2013:142).

Chou, Boldy and Lee (2002:188) argue that residents in homes for the elderly are vulnerable to substandard care and that this has a direct impact on their quality of life. Resident satisfaction can therefore provide important information about improving residential care and thus the quality of their lives.

Substantiated by Berglund (2007:46), resident satisfaction may be used as a key indicator to determine the quality of care provided by homes for the elderly.

Residents will be able to provide valuable information about the care they receive, the living conditions and the ability of the staff to meet their individual needs. Resident satisfaction may thus be used to identify areas where improvement is needed.

According to Chou, Bouldy and Lee (2003:460) various factors can influence resident satisfaction and should therefore be taken cognisance of. These factors are related to the facility, the staff and the residents themselves. The authors used a cross-sectional survey to examine the interrelationship between these factors on resident satisfaction. The most significant result from the study was the positive link between staff satisfaction and resident satisfaction. Older residents were found to be more satisfied with staff care and smaller, well established facilities scored better levels of resident satisfaction (Chou, Bouldy & Lee, 2003:466 - 469).

In a comparative study by Hasson and Arnetz (2009:5) the perceptions of nursing staff, residents and their relatives related to the quality of care were examined. Although some residents rated the overall quality of care higher than the other groups, some low scores were given, especially for activities. This confirms the fear some residents may have in answering questions about their care as they are in a dependent and vulnerable position. The study emphasised the need to provide confidentiality in order to obtain valid information from the elderly when determining their level of satisfaction with the care they receive (Hasson & Arnetz, 2009:11 - 12).

Determining resident satisfaction is thus an important strategy to complete the quality assurance process. The results can provide valuable information towards quality improvement as specific areas of concern could be identified (Yoder-Wise, 2014:394).

2.6 SUMMARY

In this chapter the elder person, as the receiver of care in homes for the elderly, is described. An in-depth discussion on quality of care is provided. This included the quality of care concept, as well as the quality assurance process. Furthermore, the types of standards which should be included in a quality assurance programme in a

home for the elderly were identified and comprehensively discussed. In the next chapter, chapter three, the research methodology which was applied in the study will be discussed.

2.7 CONCLUSION

The quality of care provided to frail, elderly residents in homes for the elderly is essential to their overall well-being. The implementation of a formal quality assurance programme is necessary to monitor and improve the standards of care applicable to these facilities. Determining resident satisfaction is a scientific and meaningful way to obtain information about the quality of care being provided by homes for the elderly. Only then improvements can be made which will be valuable to the residents themselves.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter provides an in-depth discussion of the research methodology that was applied to investigate resident satisfaction following the implantation of a quality assurance programme at a home for the elderly. The study setting, research design, population, sample and data collection instrument will be discussed. The data collection, including the pilot study, will be explained. The process of data analyses, as well as the reliability and validity of the study will be discussed. In addition, the ethical principles which guided the study will be discussed.

3.2 AIM AND OBJECTIVES OF THE STUDY

The aim of the study was to investigate resident satisfaction following the implementation of a quality assurance programme at a home for the elderly. The objectives of the study were:

- To investigate resident satisfaction about structure standards:
 - safety and security measures of the facility
 - maintenance of the infrastructure, including the buildings and gardens
 - availability of nursing care
 - provision in the basic needs including meals and laundry- and cleaning services
 - recreational activities
- To investigate resident satisfaction about process standards:
 - communication with management
 - communication with staff
 - the nursing care they receive
- To investigate the residents' opinion of areas for further improvement

- To determine the relationship between demographic variables and resident satisfaction related to the various standards

3.3 STUDY SETTING

Grove, Burns and Gray (2013:373) explain that a study setting is the place where the research is conducted. The researcher could introduce various degrees of control towards the study setting which could result in a partially or highly controlled setting. If the researcher does not introduce any control mechanisms towards the study environment it is referred to as a “*natural setting*”. The participants are thus studied within their everyday environment. This kind of setting is often used for descriptive and correlational quantitative studies (Grove, Burns & Gray, 2013:373).

This study was conducted at a home for the elderly where a quality assurance programme was implemented. The facility is situated in a well-established area of the Cape Metropole. As explained in chapter one, the facility offers assisted living to a 100 elderly residents in 10 separate houses on the premises. A frail care unit with 56 permanent and eight temporary beds are available for those residents in need of moderate to full frail care.

The participants were visited by the researcher and completed the questionnaires in their own living area. No manipulation of the environment was introduced by the researcher. The study setting could thus be described as a natural setting. This would be appropriate for a descriptive quantitative study.

3.4 RESEARCH DESIGN

A research design is defined by Grove, Burns and Gray (2013:214) as the “*blueprint for conducting a study*”. It is the foundation of the research methodology, as the choice of a specific design will have a determining influence on the decisions to follow in the planning of the research. A research design is further intended to provide control over conducting the study in order to increase the validity or truthfulness of the findings. This is essential if the results of a study are to be

implemented in scientific practice (Burns & Gove, 2011:253). The choice of a research design is based on the research problem. The design that would best answer the research question should thus be chosen (Burns & Grove, 2011:49).

Descriptive research is described by Burns and Grove (2011:34) as “*the exploration and description of phenomena in real-life situations*”. It is intended to obtain more information about a specific phenomenon. It further forms part of the quantitative approach to research as it specifically deals with numerical data obtained through an objective and systematic process (Burns & Grove, 2011:20).

According to Grove, Burns and Gray (2013:216) descriptive designs are critical in providing and expanding knowledge about phenomena where little is known about it, or where little research has been conducted about it. As descriptive studies often use questionnaires to provide more knowledge about a specific phenomenon, it is applicable to this study.

For the purpose of this study a descriptive research design with a quantitative approach was applied to investigate resident satisfaction following the implementation of a quality assurance programme at a home for the elderly. The study was conducted in a natural setting which is a further characteristic of descriptive quantitative research (Burns & Grove, 2011:35).

3.5 POPULATION AND SAMPLING

Population refers to the people who are of interest to the researcher. The target population is defined as the people who are eligible for the study (Burns & Grove 2011:290). For the purpose of this study the population was all the residents of the home who met the specific inclusion criteria.

A sample refers to a small portion representative of the target population. Sampling is mainly used to enhance the feasibility of a study, especially when the target population is large and widely dispersed (De Vos *et al.*, 2011:224). No sampling was used in this study as all the residents meeting the eligibility criteria were included in the study.

The purpose of the study was to determine resident satisfaction following the implementation of a quality assurance programme. As this programme was only implemented at a specific home for the elderly, other homes for the elderly could not be included in the study. This supports the decision not to apply sampling.

At the time of the study there were 139 residents living at the facility. As indicated below, six residents did not meet the inclusion criteria and a further 18 had to be excluded from the study as per exclusion criteria. A total of 115 residents were thus eligible to take part in the study. Twelve residents took part in the pilot study. The remaining 103 (N=103) residents formed the final population who could participate in the main study. A total of 50 participants consented to take part in the main study and completed the questionnaires. All 50 questionnaires which were handed out were completed by the participants and returned to the researcher. This gives a return rate of 50 (n=50). It further means that of the possible 103 participants who could have participated, 49% agreed to do so.

The researcher had a discussion with the statistician about population size prior to the study. As the study population was relatively small for the proposed study, the final population size was also expected to be small.

3.5.1 Inclusion criteria

Inclusion criteria refer to specific features relating to a participant to be included in the target population of a study (Burns & Grove, 2011:291). In this study all the residents that have been living at the facility for more than six months were included. This included both males and females. A list was obtained from the administration office which showed the admission date of all the residents. As indicated above, there were six newly admitted residents who could not be included in the study.

3.5.2 Exclusion criteria

Exclusion criteria refer to specific features relating to a participant to be excluded from the target population of a study (Burns & Grove, 2011:391). Residents who were in the advanced stages of dementia were excluded from the study as their memory incapability could have led to false or distorted information. Comatose and confused residents were also excluded from the study.

The researcher together with the nursing service manager identified those residents who met the exclusion criteria. At the time of the study there were 18 residents who had to be excluded from the study. The total population who were eligible to take part in the study was thus reduced to 115 (N=115). However, 12 participants of the total population participated in the pilot study which could only be done at the home under study as there was no other home who had introduced such a programme.

3.6 DATA COLLECTION INSTRUMENT

Various techniques can be applied by the researcher to measure study variables during data collection. Questionnaires are typically used in descriptive quantitative designs to obtain a wide variety of information from study subjects in order to answer the research question. Nominal and ordinal levels of measurement are often used with questionnaires (Burns & Grove, 2011:353).

Grove, Burns and Gray (2013:425) further describe a questionnaire as a way of obtaining written responses from subjects in order to gather specific information. The questions can either be closed-ended with selected responses pre-determined by the researcher or open-ended where subjects have to provide their own written responses.

A specific advantage of a questionnaire is the great sense of anonymity and confidentiality it provides to study subjects. This could have a positive influence on the validity of the information it would give, especially if the information is of a sensitive nature (LoBiondo-Wood & Haber, 2010:277).

A self-administered questionnaire was used in this study (Annexure D). As the elderly living in residential facilities is seen as a vulnerable population, the use of a questionnaire is an ideal way to obtain information they could consider sensitive.

The questionnaire was designed by the researcher and the questions were based on personal experience, relevant literature and the objectives of the study. The provisions of Chapter 4 of the Older Persons Act, No 13 of 2006, were also taken into account. The content and nature of the questionnaire was evaluated by three

experts in the field of geriatric nursing care, an academic in the field of geriatric nursing and the supervisor of the study.

The questionnaire contained both closed-ended and open-ended questions. The questions were divided into three sections. The first section was aimed at obtaining demographical information about the respondents. This included gender, age and length of stay at the facility. Nominal data were thus collected in this section.

The second section contained closed-ended questions which had to be answered with the use of a four point Likert scale. Likert scales are often used to determine the respondents' opinion about aspects relevant to the research question (Grove, Burns & Gray, 2013:430). In this study each statement was followed by a set of four response categories ranging from negative to positive. Interval data was collected in this section as a numeric value was assigned to each response category. The number 1 corresponded with *strongly disagree* and 4 with *strongly agree*.

Grove, Burns and Gray (2013:431) suggest an equal number of positively and negatively phrased questions when using a Likert scale in an instrument to prevent response-set bias. According to the authors this can occur when study subjects do not read the questions and merely respond to a specific category.

The questions in the second section were further subdivided into three categories aligned with the objectives of the study. The structure standards consisted of 16 questions, the process standards 21 questions and the outcome standards nine questions.

The last section contained four open-ended questions where the respondents could provide the researcher with their own opinions about the questions asked. These questions were formulated to counterbalance the limitations set by the predetermined responses of the closed-ended questions.

LoBiondo-Wood and Haber (2010:277) cited Horgas and colleagues when referring to the possibility of "*respondent burden*" when using a questionnaire as a data collection tool. This included the complexity of the questions and readability of the questionnaire.

In order to address the above-mentioned issues, the questionnaire was available in English and Afrikaans. At the time of the study all the residents living at the home for the elderly were either English speaking or Afrikaans speaking. In order to ensure consistency between the English and Afrikaans questionnaires a language expert in both these languages were consulted. Clear instructions to the respondents were printed at the beginning of the questionnaire.

Given the expected deterioration in physical and mental abilities associated with the elderly the questionnaire was printed in a larger font size to increase ease of reading. Furthermore, the use of negatively phrased questions was limited in order to simplify the questions. The Likert scale was provided in full after each question to remind the participant of the possible options, thereby limiting respondent burden further.

3.7 PILOT STUDY

A pilot study is similar to the proposed study but on a smaller scale. It is undertaken to refine the methodology before the actual study commences (Grove, Burns & Gray, 2013:46). According to De Vos *et al.* (2011:237) the pilot study is further used to pre-test and validate the data collecting instrument.

In this study the questionnaire was pilot tested to determine the clarity of the instructions and questions. The time taken to complete the questionnaire was also established. The residents who participated in the pilot study were not included in the main study. The pilot study was further used to test the methodology of the study before the main study commenced.

In order for the sample to be representative of the population 12 residents were included in the pilot study. This represents 12% of the population (N = 103) eligible to participate in the study. A letter explaining the purpose of the study and requesting a volunteer to complete the questionnaire was sent to all the houses. The same letter was sent to the frail care unit requesting two volunteers.

The letter indicated the date, time and place when the data would be collected. The pilot study was conducted by the researcher during the morning hours after

breakfast. The residents who were willing to take part in the pilot study gathered in the dining room of the frail care unit where the purpose of the study was explained to them. After voluntary written consent was obtained from each participant, the questionnaires were handed to them. One resident from each house and two residents from the frail care unit completed the questionnaire.

The researcher was available for questions during the time the residents completed the questionnaires, although none were asked. A discussion took place afterwards to allow participants to give feedback regarding any possible problems they might have experienced while completing the questionnaire. None were reported and no recommendations were made by the participants. In their view the questions were clear. The results of the pilot study were not included in the results of the main study.

3.8 RELIABILITY AND VALIDITY

Reliability is defined by LoBiondo-Wood and Haber (2010:286) as the degree of consistency with which an instrument measures the characteristics of a concept. Validity refers to the degree of accuracy with which an instrument measures the characteristics of a concept (LoBiondo-Wood & Haber, 2010:288). Reliability and validity are thus used to ensure the rigour of the study.

Rigour is an important aspect of research as it refers to the degree of excellence that is associated with the findings of a study. If steps are taken to ensure that research findings are an accurate and a true reflection of reality it can be applied in the broader context (Grove, Burns & Gray, 2013:36).

As reliability refers to the internal consistency with which an instrument measures study variables, it can thus be used to predict random error. An instrument with a high degree of internal consistency will minimise the risk for random error when measuring the study variables. As reliability can vary in degree, it is usually indicated as a correlation coefficient (Grove, Burns & Gray, 2013:389).

Cronbach's Alpha is a statistical procedure that can be applied to determine internal consistency of interval and ratio level data. In this study Cronbach's Alpha coefficient was used to test the internal consistency of the questions used in the second section

of the instrument as these questions provided interval level data. As stated in Burns and Grove (2011:334) a Cronbach alpha coefficient of 1.00 indicates a perfect reliability, whereas a coefficient of 0.00 indicates no reliability. A qualified statistician from Stellenbosch University was consulted in this regard (see paragraph 4.2 for the results). The reliability is further supported by the pilot study.

Various types of validity are described in the literature. It is also measured to the degree it exists. Face validity refers to the readability and clarity of the questions. This is a more subjective form of validity as it can be influenced by the perceptions of the researcher or the potential study subjects (Grove, Burns & Gray, 2013:394).

Content validity refers to the degree to which the instrument represents all the main elements applicable to the construct being measured. The questions included in the questionnaire should reflect the elements that will be considered as representative for investigating resident satisfaction. Construct validity refers to the theoretical framework underpinning the instrument (Burns & Grove, 2011:335).

For this study face and content validity were ensured by the evaluation of three experts in the field of geriatric care, a nurse academic and a researcher. Relevant literature further supported content validity. The questionnaire was based upon Donabedian's theoretical model for quality which could have contributed to construct validity. Further testing of the instrument would be needed to enhance construct validity, for example factor analysis (LoBiondo-Wood & Haber, 2010:291). In addition, the instrument was pre-tested during the pilot study to support validity.

3.9 DATA COLLECTION

According to Grove, Burns and Gray (2013:45 – 46) data collection refers to the accurate and systematic assembling of information in order to answer the research question and forms part of the implementation phase in quantitative research. The study variables are thus measured by using the data collection instrument which had been selected during the planning phase. The authors further point out that the data can only be collected once permission has been obtained from the specific facility and the participants.

In this study the data was collected by the researcher during August 2014 according to a predetermined plan. The plan was approved by the General Manager of the facility after permission was granted to conduct the study (Annexure B). A letter was sent to the houses and the frail care unit in order to inform the nursing staff, house parents and residents about the purpose of the study - (Annexure E), including the proposed days for the data to be collected. Table 3.1 shows the days when the houses were visited to collect the data.

Table 3.1 Data collection plan

House	Date
Bow Bells	20 August 2014
Rupee	20 August 2014
Trovato	20 August 2014
Kenilworth	20 August 2014
The Barn	21 August 2014
Bon Accord	21 August 2014
Oram	21 August 2014
Oosterzee	21 August 2014
Willow Lodge	26 August 2014
Lidcote	26 August 2014
Mary Port – frail care unit	26 August 2014

The researcher visited the respective houses on the planned days. The first house was visited in the morning just after breakfast was served. Residents who were interested in participating in the study were asked to gather in the dining room. The participants could then sit at a table and comfortably complete the consent form as well as the questionnaire.

The purpose of the study was explained to the residents. The voluntary nature of participation was emphasised, as well as the confidentiality of the information provided. They were reminded that they could withdraw at any time during the study if they wish to do so without any negative consequences. Time was allowed for questions or any concerns they might have had about their participation in the study. Written informed consent was obtained from each participant in either Afrikaans or English as per request. Upon completion of consent forms, it was collected by the researcher and put in an envelope.

Thereafter the questionnaires were handed out to each participant by the researcher. Only those who consented voluntarily to participate were given a questionnaire. The instructions were explained to the participants in the language of their choice. Participants completed the questionnaires themselves and were allowed enough time to complete it. The researcher was available for any questions. Some of the participants needed confirmation, not sure whether they should make a tic or a cross. Some of them confirmed with the researcher that they had to answer all the questions. Completed questionnaires were put into a separate envelope by the researcher. The same procedure was then followed at the next three houses. The procedure was repeated at the houses visited on the remaining two days of data collection, as well as in the frail care unit.

A debriefing session was done after completion of the questionnaires. The aim of this session was to give residents who might have felt uncomfortable about completing the questionnaire a chance to talk about their feelings.

After data collection a total of 50 questionnaires were completed. Thus, of the final population of a 103, the acceptance rate was 49% and the decline rate 51%. During consultation with the statistician about the final completion rate, the researcher was assured that the data could be statistically analysed and correlations could be done.

3.10 DATA ANALYSIS

Quantitative data analysis refers to the process where the newly collected data is converted into a numerical format for the purpose of statistical analysis. Once data has been analysed it can be interpreted in order to give meaning to the findings (De Vos *et al.*, 2011:249). Statistical analysis use mathematical processes mainly performed on a computer equipped with statistical software packages (Grove, Burns & Gray, 2013:534).

According to Burns and Grove (2011:373) descriptive analysis is used to describe the variables related to the sample used in the study. This includes demographical information, such as age and gender and is aimed at providing an accurate picture of the sample.

Exploratory analysis is used to examine each variable to determine the nature of variation and to detect the outliers by calculating central tendency and dispersion of the data. Outliers are defined as data with extreme values that do not seem to fit the rest of the data (Burns & Grove, 2011:374). Variability is seen as the extent to which an individual score differs from the rest of the sample (Burns & Grove, 2011:387).

In this study each completed questionnaire was given a random number before entering the responses. The questionnaire which was used consisted of 46 closed-ended questions divided into three categories aligned with the objectives of the study. For the purpose of statistical analysis the questions were coded and given a short title. The collected data pertaining to the closed-ended questions was entered on a Microsoft Excel sheet by the researcher according to the codes. If the length of stay was less than a year, it was captured as 0.5, which indicated half of the year. The inclusion criterion was set at six month or more.

After all the data was entered an independent person was asked to randomly check the entered responses against the real responses of the questionnaire to verify the accuracy of the data capturing process.

The responses pertaining to the open-ended questions were entered on a different Microsoft Excel sheet. As these questions consisted of narrative data, content analysis was done. For each question, the various responses were categorised and grouped together according to the meaning of the response. The responses were mostly a few short words. The number of similar responses for each category was counted and converted to a percentage of those who opted to answer the question.

A qualified statistician from Stellenbosch University assisted the researcher in the data analysis for this study. Statistical analysis was done by using a computer and the Statistical Package for the Social Sciences (SPSS) version 22 software programme.

Descriptive statistical analysis was done for this study. This included frequency distributions, measures of central tendency and measures of dispersion. The data was further organised and presented in custom tables, frequency tables and bar graphs.

In addition, statistical tests were done to determine statistical associations between the dependent and independent variable. This included the Mann-Whitney U test and Spearman's rank-order correlation coefficient. Spearman's rank-order correlation coefficient is a non-parametric statistic used with ordinal data (LoBiondo-Wood & Haber, 2010:327).

3.11 ETHICAL CONSIDERATIONS

As indicated in chapter one, his study was guided by the core ethical principles of respect for persons, justice and beneficence. These principles are used to protect the rights of participants by ensuring freedom of choice, privacy, anonymity, confidentiality, fair treatment and safety during research (Burns & Grove, 2011:110).

Beneficence specifically refers to the participant's right to be protected against any form of injury or discomfort during research. This includes physical, emotional, social and financial injury or discomfort (Burns & Grove, 2011:118). Since any study has the potential to cause some form of discomfort to some degree, the risk-benefit ratio should be considered. If the potential risk of injury or discomfort is more than the anticipated benefit to the participant, the intended study could be seen as unethical (Burns & Grove, 2011:134 – 135).

The elderly and persons in dependent relationships, such as residents in homes for the aged are considered vulnerable populations and specific attention should be given to protecting them during research (Department of Health, 2015:27). Furthermore Grove, Burns and Gray (2013:165) state that persons with diminished autonomy are seen as vulnerable and need additional protection during research. Application of the aforementioned ethical principles for the purpose of this study is described in the next paragraphs.

Ethics approval to conduct the study was obtained from the Health Research Ethics Committee of the Faculty of Medicine and Health Science, Stellenbosch University – reference number S14/05/115 (Annexure A). Written approval to conduct the study was obtained from the Board of Directors of the particular home for the elderly where the quality assurance programme was implemented (Annexure B).

According to the principle of respect for persons, people should be given the opportunity to choose whether or not they would like to participate in a research project (De Vos *et al.*, 2011:117). The participants were informed by the researcher of the purpose of the study. Informed written consent (Annexure C) was obtained from each participant before handing out of the questionnaires. It was confirmed through the records that all the residents at the time of the study were either English or Afrikaans speaking. Thus, the consent forms were available in both English and Afrikaans to reduce any possibility of a language barrier. It was furthermore printed in font size 16 to accommodate participants with weakened eye-sight.

Voluntary participation is an essential guiding principle in research (De Vos *et al.*, 2011:116). Participants were thus informed that they have the right to refuse participation or to withdraw from the study at any given time without any negative consequences. At no point was any resident of the facility coerced or forced to participate in the study. It was also pointed out that services were available for emotional support should any participant feel the need for debriefing after completing the questionnaire.

Individuals have the right to privacy and that any information about them is kept confidential (De Vos *et al.*, 2011:119). Participants were asked to complete the questionnaires anonymously, thereby protecting their right to privacy. Clear instructions not to write their names on the questionnaires were also printed on the document (Annexure D). Participants were further assured of the confidential nature of the information provided by them. They were assured that the only persons who will have access to data from the questionnaires will be the researcher, the supervisor and the statistician. The completed questionnaires would be kept in a locked cupboard at the researcher's residence. This further contributed to the confidential nature of the information provided.

The fundamental principle of beneficence was applied by providing a debriefing session after completion of the questionnaires. The aim of this session was to give residents who might have felt uncomfortable about completing the questionnaire a chance to talk about their feelings. This was important as institutionalised persons are seen as a highly vulnerable group in terms of research.

The researcher was a former employee of the home for the elderly where the quality assurance programme was implemented. Although initially part of the implementation of the quality assurance programme, the researcher has not been involved with the programme for the past four years. Furthermore, a number of residents has either passed away since then or have become confused and bedridden. Currently, there is thus no conflict of interests.

3.12 SUMMARY

This chapter contains an in-depth discussion of the research methodology and how the various steps were applied within the study. It describes the study setting and design that were used. The population is identified and the instrument for data collection is explained in detail. The pilot study, data collection process and data analysis are described. The rigour of the study is discussed with specific reference to validity and reliability. In addition the ethical principles which guided the study were discussed. In the next chapter the results of the data analysis will be discussed.

CHAPTER 4

STUDY RESULTS

4.1 INTRODUCTION

This chapter provides the presentation and analysis of the data which was collected as described in chapter three. A descriptive research design with a quantitative approach was applied in the study and therefore the results are mainly presented in the form of tables, frequencies and bar graphs. The data was analysed with the support of a statistician using the SPSS version 22 computerised statistical package after the researcher had captured the data from the closed-ended questions on a Microsoft Excel sheet. The narrative data obtained from the open-ended questions were analysed thematically and further quantified by the researcher.

4.2 RELIABILITY ANALYSIS

The reliability of the data collection instrument used in this study was determined by the calculation of Cronbach's alpha coefficient to verify the internal consistency of the questions.

The questionnaire which was used in this study consisted of 46 closed-ended questions divided into three categories aligned with the objectives of the study. For the purpose of statistical analysis the questions were coded and given a short title. A total of 50 participants completed the questionnaire (n=50).

The 16 questions related to structure standards were coded S1 – S16 and given a short title. The calculated Cronbach's alpha coefficient for these 16 questions was 0.926 as shown in table 4.1.

The 21 questions related to process standards were coded P1 – P21 and were also provided with a short title. The calculated Cronbach's alpha coefficient for these 21 questions was 0.919 as indicated in table 4.1.

The same procedure was followed for the 9 questions related to the outcome standards. These were coded O1 – O9. One question in this section was phrased negatively and it was reversed by the statistician before the data analysis. The calculated Cronbach's alpha coefficient for these 9 questions was 0.879 as shown in table 4.1.

The data collection instrument could thus be seen as reliable in terms of internal consistency due to the high Cronbach's alpha coefficient levels.

Table 4.1 – Reliability statistics

Question category	Items	Cronbach's alpha	n
Structure standards	16	0.926	50
Process standards	21	0.919	50
Outcome standards	9	0.879	50

4.3 STATISTICAL ANALYSIS

The results of the study are further presented systematically according to the demographic information and other variables pertaining to the questionnaire. The information is discussed and illustrated in the form of tables, frequencies and bar graphs according to the results of the data analysis done with the SPSS version 22 statistical package.

Non-parametric tests and correlations were applied as the variables were measured on ordinal scales. Furthermore, the scores were not evenly distributed which is an indication for the use of non-parametric statistics (LoBiondo-Wood & Haber, 2010:323). This included the Mann-Witney U test which was used to test for a statistical significant relationship between gender and the three groups of variables, namely structure, process and outcome.

Statistical significance is used to express the difference between groups when testing a specific hypothesis between groups of the same population and study variables. The cut-off point is considered as 0.05 and referred to as a *p* value. A *p* value of ≤ 0.05 is thus seen as statistically significant (Burns & Grove, 2011:377).

Statistical significance is further based on the logic of the normal curve which considers the distribution of values within a specific population. According to this statistical theory there will be a 95% probability that any measured value in a single population will fall within 2 standard deviations of the mean of that particular population. There is a further 5% probability that the value would fall in the extreme ends of the curve (Burns & Grove, 2011:379 – 380).

Spearman's rank-order correlation coefficient was applied to test the relationship between age and the variables of structure, process and outcome. It was also applied to test the relationship between years living at the facility and the structure, process and outcome variables. The questionnaire contained only one negatively phrased question and that was reversed by the statistician before the analysis was done.

Measures of central tendency were determined for both the age of the participants and the years they have been living at the facility. This included the mean which was calculated by adding up the numbers and then dividing it by the number of participants. The median was determined by ranking the numbers from lowest to highest and then finding the midpoint score. The median is regarded as a meaningful value of central tendency for interval data (Burns & Grove, 2011:385 – 387).

Furthermore, the standard deviation was calculated for age and years living at the facility. Standard deviation indicates the average deviation of a score from the mean of a particular sample. It thus indicates the extent to which an individual score differs from the rest of the sample (Burns & Grove, 2011:387).

4.4 Section A – Demographic data

4.4.1 Variable A1: Gender

Table 4.2 shows that the majority of the participants who completed the questionnaires were females, n=40(80%) compared to males, n=10(20%). A total of 50 questionnaires were handed out with a 100% return rate.

Table 4.2 – Gender

Gender	Frequency (n)	Percent (%)
Female	40	80
Male	10	20
Total	50	100

As Summarised in table 4.3 The Mann-Whitney U test was applied to test for statistical significance between gender and the categories: structure, process and outcomes as independent variables. The results were not statistical significant as the p value was > 0.05 . The null hypothesis was thus retained.

Table 4.3 – Mann-Whitney U test

No	Null Hypothesis	Test	Significance	Decision
1	The distribution of structure is the same across categories of gender	Independent samples Mann-Whitney U test	0.144	Retain the null hypothesis
2	The distribution of process is the same across categories of gender	Independent samples Mann-Whitney U test	0.067	Retain the null hypothesis
3	The distribution of outcome is the same across categories of gender	Independent samples Mann-Whitney U test	0.079	Retain the null hypothesis

4.4.2 Variable A2: Age

In figure 4.1 the age distribution of the participants is presented. The youngest participant was 70 years of age and the oldest 96 years of age. Most of the participants, $n=20(40\%)$ were between 85 and 89 years of age followed by those

between 80 and 84 years of age, $n=13(26\%)$. The mean age was calculated as 82.98 years, the median 84.5 years and a standard deviation of 5.71 years.

No statistical association was found between age and structure ($p=0.738$) with a correlation coefficient of -0.049 using Spearman's rank-order correlation coefficient. The same was found with age and process ($p= 0.254$) with a correlation coefficient of -0.164 , as well as with age and outcomes ($p= 0.506$) with a correlation coefficient of -0.096 . A strong positive statistical association is seen as a rank-order value of > 0.5 and a strong negative statistical association as a rank-order value of > -0.5 using Spearman's rank-order correlation coefficient.

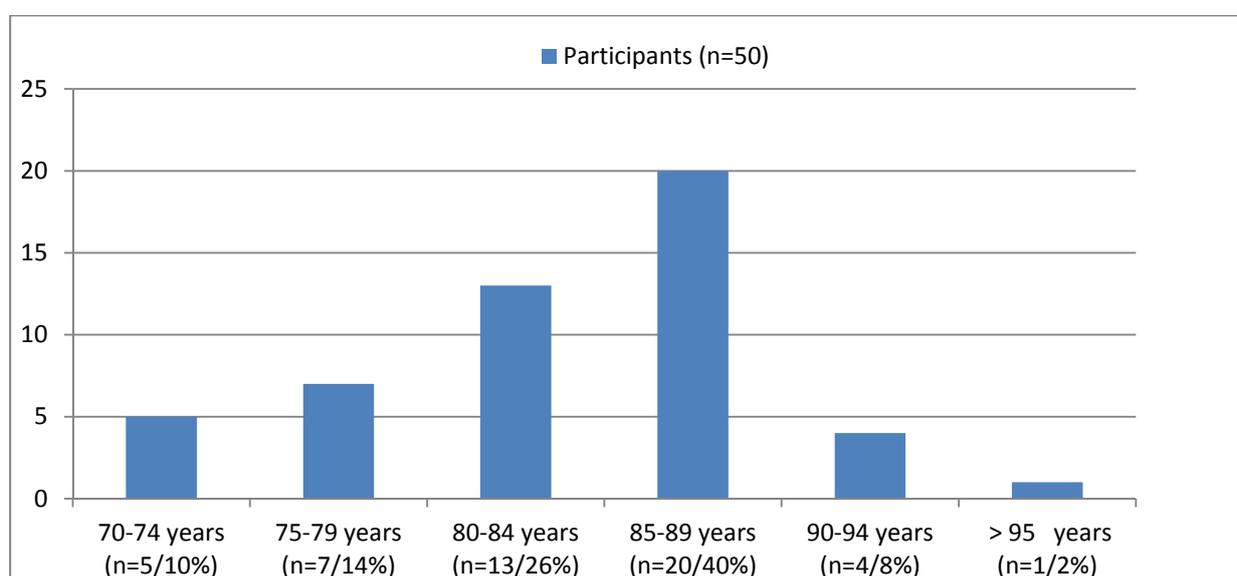


Figure 4.1 – Age distribution

4.4.3 Variable A3: Years living at the facility

Figure 4.2 illustrates the number of years that the participants have been living at the facility. It indicates a wide distribution with three persons, $n=3(6\%)$ living there between six and 11 months. Most of the participants, $n=12(22\%)$ lived at the facility between one and two years followed by those, $n=10(20\%)$ who lived there between three and four years. The longest time of residency was 18 years, $n=1(2\%)$. The mean time of residency at the facility was calculated at 5.73 years, the median 4.50 years and a standard deviation of 4.52 years.

No statistical association was found between years living at the facility and structure ($p=0.446$) with a correlation coefficient of -0.110 using the Spearman rank-order correlation coefficient. Similarly, no statistical association was found between years living at the facility and process ($p=0.296$) with a correlation coefficient of -0.151 and between years living at the facility and outcome ($p=0.182$) with a correlation coefficient of -0.192 .

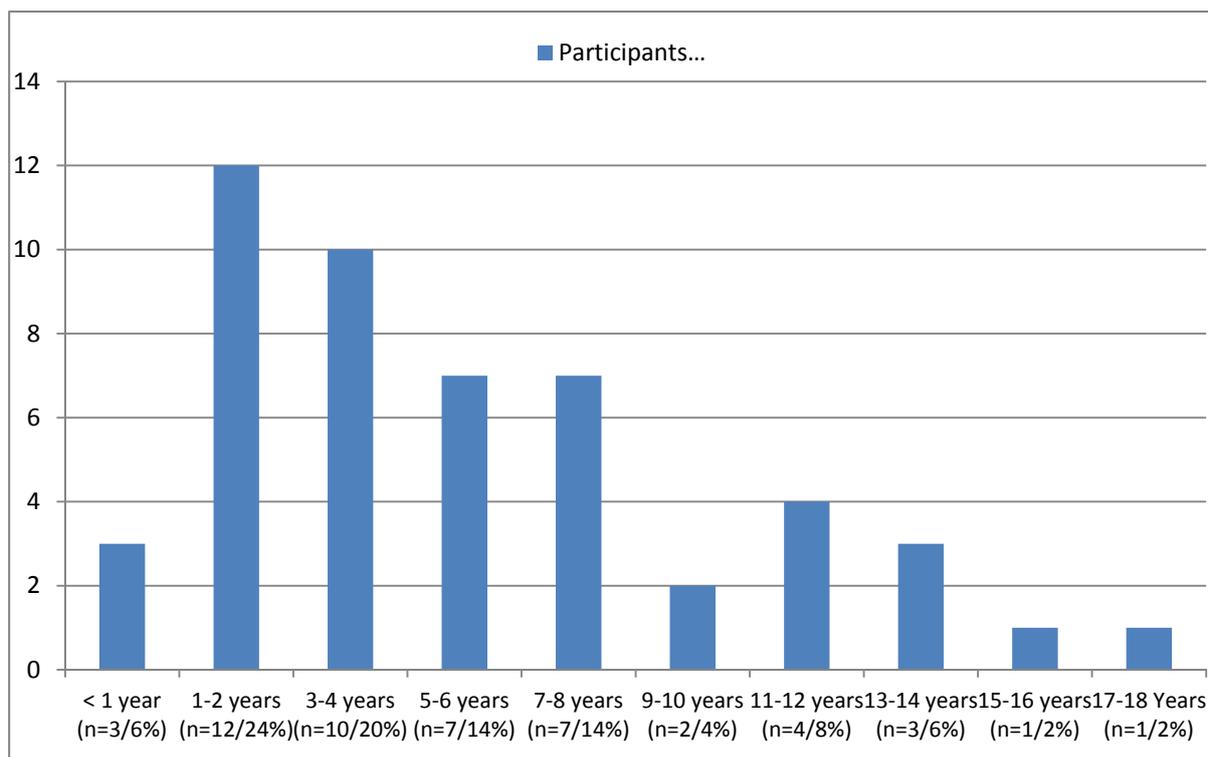


Figure 4.2 – Years living at facility

4.5 Section B – Resident satisfaction

Various questions were used to measure resident satisfaction pertaining to each of the three types of standards namely: structure, process and outcomes used in the quality assurance programme. The questions of this section were grouped together and are presented in tables with the response rates next to each item. The responses from residents were measured on four point Likert scales, namely strongly agree, agree, disagree and strongly disagree. The residents' responses for strongly agree and agree have been collapsed into one category namely: agree.

Similarly, the responses for strongly disagree and disagree have been collapsed into one category namely: disagree.

4.5.1 Structure standards

This part of the questionnaire provided information about residents' level of satisfaction pertaining to structure standards and included questions B 1.1 – 1.16 of the questionnaire. Figure 4.3 gives a summary of the responses related to the variables measured for structure standards.

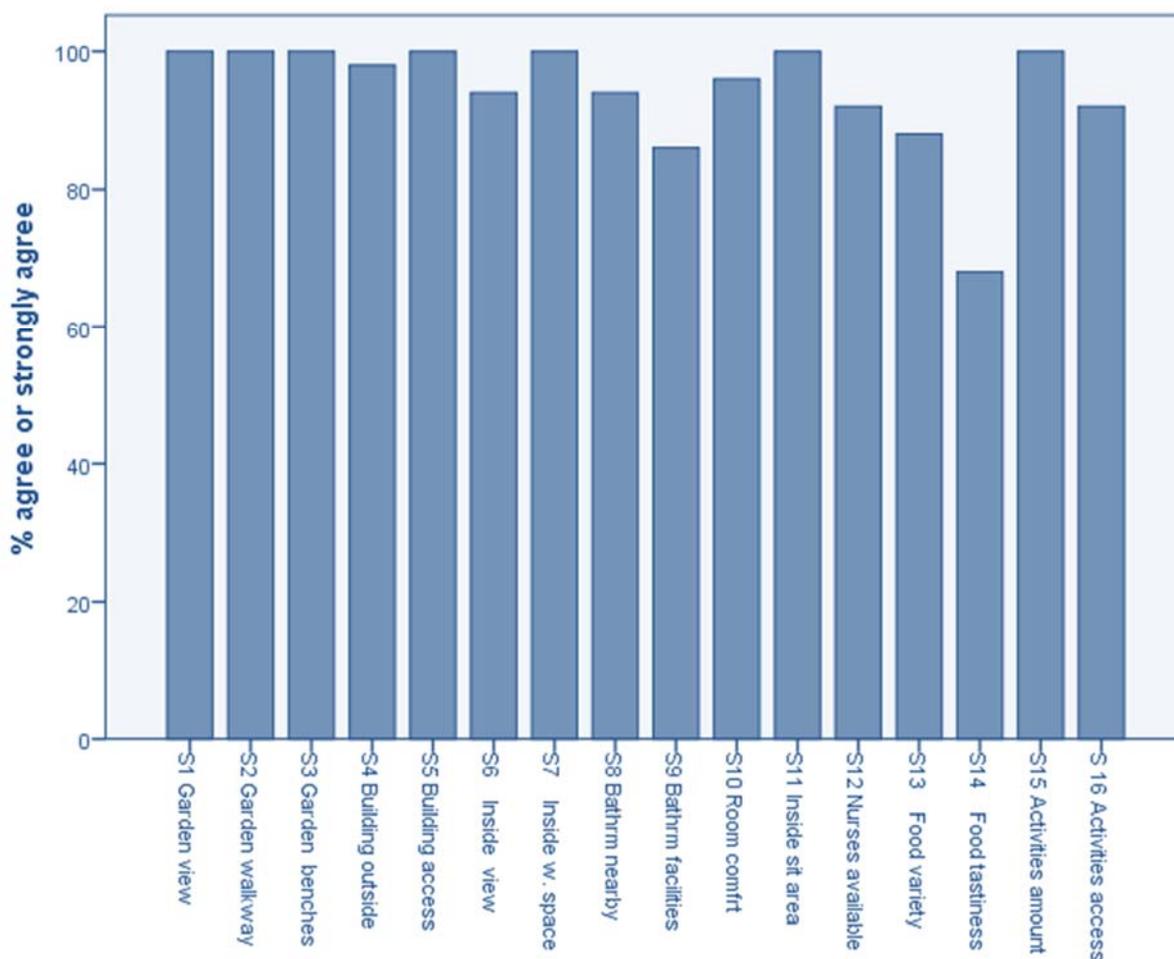


Figure 4.3 – Level of resident satisfaction pertaining to structure standards

4.5.1.1 Variable B1.1 – B1.5 – Structure: exterior environment

Table 4.4 shows that only one participant, $n=1(2\%)$ disagreed that the exterior structures of the buildings were kept in a good condition. All the participants,

n=50(100%) agreed that the gardens were kept in a good condition with easy walk ways and benches to sit on. They further agreed that access to all the buildings were wheelchair friendly.

Table 4.4 – Structure: exterior environment (n=50)

Variable	Agree n (%)	Disagree n (%)
B1.1 Garden view	50 (100%)	0 (0%)
B1.2 Garden walk ways	50 (100%)	0 (0%)
B1.3 Garden benches available	50 (100%)	0 (0%)
B1.4 Exterior of buildings	49 (98%)	1(2%)
B1.5 Access to buildings	50 (100%)	0 (0%)

4.5.1.2 Variable B1.6 – B1.11 – Structure: interior environment

As shown in table 4.5 there were three participants, n=3(6%) who felt that the interior of the buildings were not homely and three participants, n=3(6%) also felt that there were not enough recreational areas inside the buildings. Only one participant, n=1(2%) felt that the bathroom facilities were unacceptable. All the participants, n=50(100%) agreed that their rooms were comfortable, it was easy for them to move around inside the buildings and the bathrooms were within an acceptable distance from their rooms.

Table 4.5 – Structure: interior environment (n=50)

Variable	Agree n (%)	Disagree n (%)
B1.6 Homely interior environment	47 (94%)	3 (6%)
B1.7 Ease of movement of inside	50 (100%)	0 (0%)
B1.8 Nearness to bathroom	50 (100%)	0 (0%)
B1.9 Acceptable bathroom facilities	49 (98%)	1 (2%)
B1.10 Comfort of room	50 (100%)	0 (0%)
B1.11 Recreational areas inside	47 (94%)	3 (6%)

4.5.1.3 Variable B1.12 – Structure: availability of nursing staff

The majority of participants, n=46(92%) agreed that the nursing staff were available when needed as indicated in table 4.6. Yet, there were four participants, n=4(8%) who disagreed and felt that the nursing staff were not available when they needed them.

Table 4.6 – Structure: availability of nursing staff (n=50)

Variable	Agree n (%)	Disagree n (%)
B1.12 Availability of nursing staff	46 (92%)	4 (8%)

4.5.1.4 Variable B1.13 – B1.14 – Structure: food

According to table 4.7 many of the participants, n=16(32%) disagreed that the food served by the facility was tasty. A further six participants, n=6(12%) disagreed that the menu was alternated to prevent prediction in the food to be served daily.

Table 4.7 – Structure: food (n=50)

Variable	Agree n (%)	Disagree n (%)
B1.13 Alternation of menu	44 (88%)	6 (12%)
B1.14 Tastiness of food	34 (68%)	16 (32%)

4.5.1.5 Variable B1.15 – B1.16 – Structure: activities

As shown in table 4.8 all the participants, n=50(100%) agreed that a variety of activities were offered by the facility. However, there were four participants, n=4(8%) who indicated that it was not possible for them to attend the activities being offered.

Table 4.8 – Structure: activities (n=50)

Variable	Agree n (%)	Disagree n (%)
B1.15 Variety of activities	50 (100%)	0 (0%)
B1.16 Access to activities	46 (92%)	4 (8%)

4.5.2 Process standards

This part of the questionnaire provided information about residents' level of satisfaction pertaining to process standards and included questions B 2.1 – 2.21 of the questionnaire. Figure 4.4 gives a summary of the responses related to the variables measured for process standards

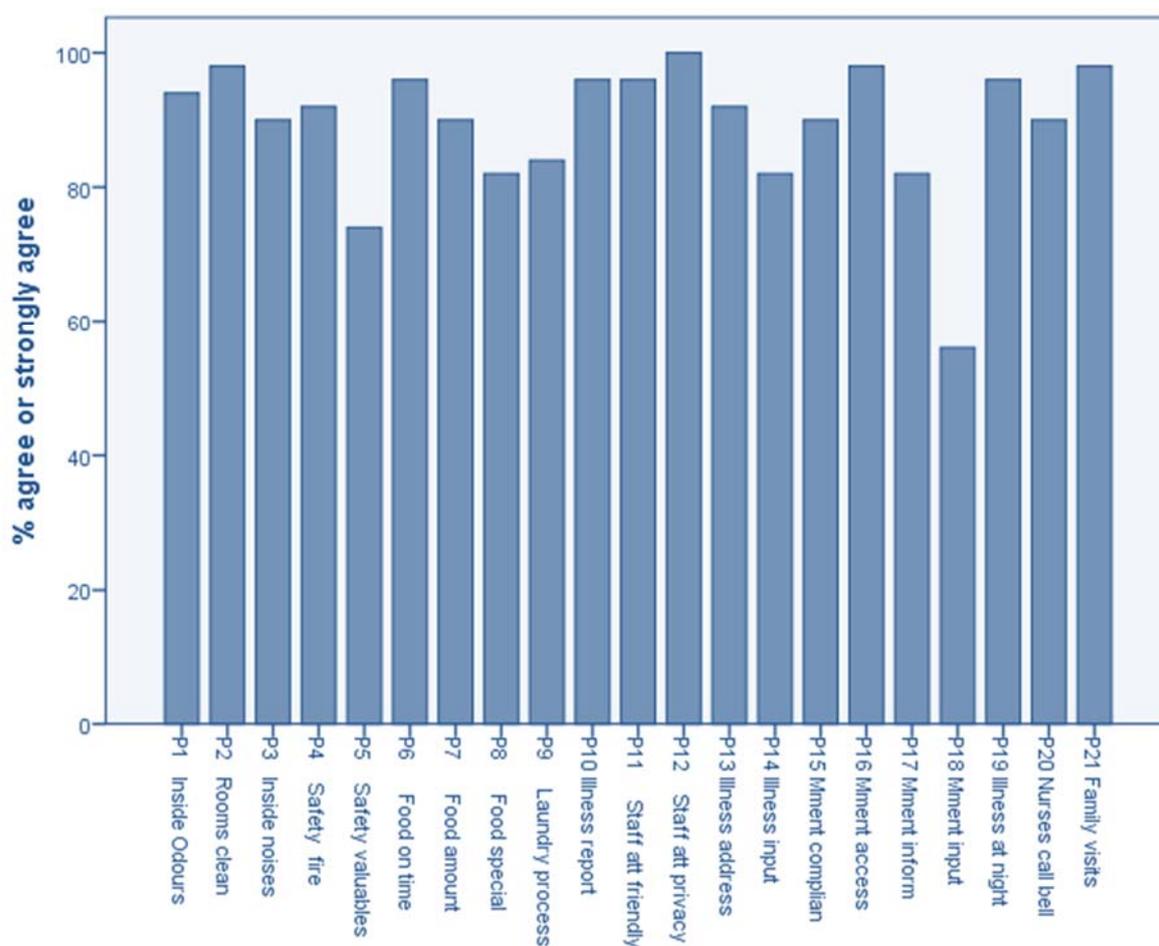


Figure 4.4 – Level of resident satisfaction pertaining to process standards

4.5.2.1 Variable B2.1 – B2.3 – Process: housekeeping

As indicated in table 4.9 the majority of participants, n=47(94%) were of the opinion that there were no bad odours present in the passages. Only one participant, n=1(2%) indicated that the rooms were not kept clean. Five participants, n=5(10%) were of the opinion that the noise levels of the environment was not acceptable during the night.

Table 4.9– Process: housekeeping (n=50)

Variable	Agree n (%)	Disagree n (%)
B2.1 Absence of bad odours	47 (94%)	3 (6%)
B2.2 Rooms kept clean	49 (98%)	1 (2%)
B2.3 Quiet environment at night	45 (90%)	5 (10%)

4.5.2.2 Variable B2.4 – B2.5 – Process: safety procedures

Table 4.10 shows that 26% of the participants, n=13(26%) disagreed that there was a procedure in place to safeguard their money and valuables. The table further indicates that 8% of the participants, n=4(8%) did not know what to do in the event of a fire.

Table 4.10 – Process: safety procedures (n=50)

Variable	Agree n (%)	Disagree n (%)
B2.4 Knowledge about fire safety	46 (92%)	4 (8%)
B2.5 Safety procedure - valuables	37 (74%)	13 (26%)

4.5.2.3 Variable B2.6 – B2.8 – Process: food

Nine (18%) of the participants disagreed that a special diet could be arranged with the kitchen if needed as shown in table 4.11. Another 5 participants, n=5(10%) felt that the amount of food served during a meal was insufficient. However, the majority of participants, n=48(96%) indicated that meals were served on time.

Table 4.11 – Process: food (n=50)

Variable	Agree n (%)	Disagree n (%)
B2.6 Meals served on time	48 (96%)	2 (4%)
B2.7 Meal portions adequate	45 (90%)	5 (10%)
B2.8 Availability of special diets	41 (82%)	9 (18%)

4.5.2.4 Variable B2.9 – Process: laundry services

According to table 4.12 there were eight participants, n=8(16%) who indicated that they were not satisfied with the way their laundry was being dealt with by the facility.

Table 4.12 – Process: laundry services (n=50)

Variable	Agree n (%)	Disagree n (%)
B2.9 Laundry services	42 (84%)	8 (16%)

4.5.2.5 Variable B2.10; B2.13; B2.14 & B2.19 – Process: illness

As shown in table 4.13 some of the participants, n=9(18%) were of the opinion that they had no input when decisions about their health care were being taken. Four participants, n=4(8%) disagreed that their concerns about their health were being addressed. However, the majority of participants, n=48(96%) indicated that they knew whom to report to when they did not feel well. Only two participants, n=2(4%) stated that they did not know how to ask for help at night time.

Table 4.13 – Process: illness (n=50)

Variable	Agree n (%)	Disagree n (%)
B2.10 Reporting of illness	48 (96%)	2 (4%)
B2.13 Illness being taken care of	46 (92%)	4 (8%)
B2.14 Input in treatment	41 (82%)	9 (18%)
B2.19 Assistance at night	48 (96%)	2 (4%)

4.5.2.6 Variable B2.11 – B2.12 – Process: staff attitude

All the participants, n=50(100%) agreed that the staff respected their privacy as indicated in table 4.14. The majority of participants, n=48(96%) were of the opinion that the staff was friendly towards them. Only two participants, n=2(4%) disagreed with the statement.

Table 4.14 – Process: staff attitude (n=50)

Variable	Agree n (%)	Disagree n (%)
B2.11 Friendliness of staff	48 (96%)	2 (4%)
B2.12 Staff respecting privacy	50 (100%)	0 (0%)

4.5.2.7 Variable B2.15 – B2.18 – Process: management of facility

Table 4.15 shows that many participants, n=22(44%) were of the opinion that they did not have an opportunity to give input into the management of the facility. A further 18% of participants, n=9(18%) felt that they were not informed of new developments at the facility by management. Another five participants, n=5(10%) were of the opinion that the manager did not attend to their complaints. Almost all of the participants, n= 49(98%) agreed that they knew whom to talk to when they felt unhappy.

Table 4.15 – Process: management of facility (n=50)

Variable	Agree n (%)	Disagree n (%)
B2.15 Attention to complaints	45 (90%)	5 (10%)
B2.16 Reporting complaints	49 (98%)	1 (2%)
B2.17 Receiving information	41 (82%)	9 (18%)
B2.18 Input into management	28 (56%)	22 (44%)

4.5.2.8 Variable B2.20 – Process: reaction time of nurses

According to table 4.16 a few participants, n=5(10%) were of the opinion that the call bell was not promptly answered by the nursing staff.

Table 4.16 – Process: reaction time of nurses (n=50)

Variable	Agree n (%)	Disagree n (%)
B2.20 Call bell answered promptly	45 (90%)	5 (10%)

4.5.2.9 Variable B2.21 – Process: family access

The majority of participants, n=49(98%) agreed that their family members were not restricted to specific visiting hours at the facility and could visit them any time according to table 4.17.

Table 4.17 – Process: family access (n=50)

Variable	Agree n (%)	Disagree n (%)
B2.21 Family can visit any time	49 (98%)	1 (2%)

4.5.3 Outcome standards

This part of the questionnaire provided information about residents’ level of satisfaction pertaining to outcome standards and included questions B 3.1 – 3.9 of the questionnaire. Figure 4.5 gives a summary of the responses related to the variables measured for process standards

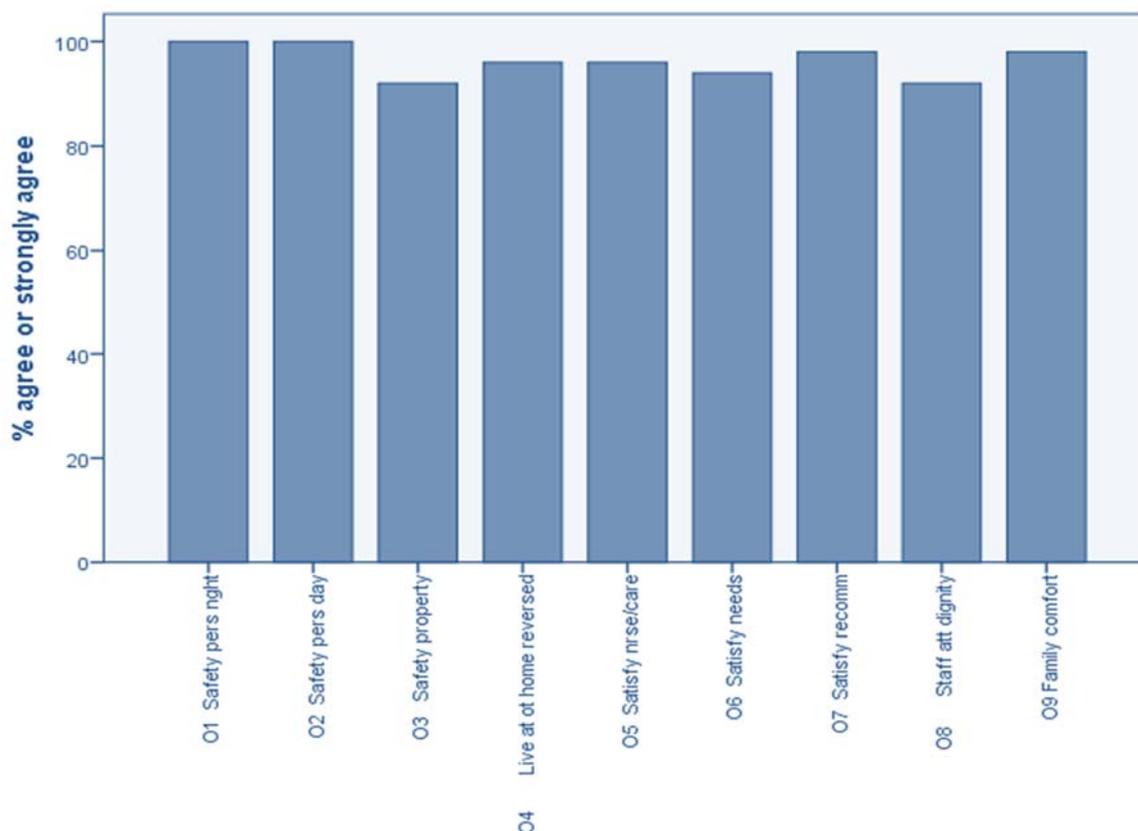


Figure 4.5 – Level of resident satisfaction pertaining to structure standards

4.5.3.1 Variable B3.1 – B3.3 – Outcome: safety

Table 4.18 shows that all the participants, n=50 (100%) agreed that they felt safe both during the night and during the day. Most of the participants, n=46 (92%) further indicated that they felt that their property was safe in their rooms.

Table 4.18 – Outcome: safety (n=50)

Variable	Agree n (%)	Disagree n (%)
B3.1 Feel safe at night	50 (100%)	0 (0%)
B3.2 Feel safe during the day	50 (100%)	0 (0%)
B3.3 Safety of property	46 (92%)	4 (8%)

4.5.3.2 Variable B3.4 & B3.7 – Outcome: facility in general

As shown in table 4.19 only n=2(4%) of the participants would prefer to live at another home for the elderly. Almost all the participants, n=49(98%) indicated that they would recommend the facility to their friends.

Table 4.19 – Outcome: facility in general (n=50)

Variable	Agree n (%)	Disagree n (%)
B3.4 Prefer another facility	2 (4%)	48 (98%)
B3.7 Recommend facility to friends	49 (98%)	1 (2%)

4.5.3.3 Variable B3.5; B3.6 & B3.8 – Outcome: care and dignity

According to table 4.20 only two participants, n=2(4%) indicated that they were not satisfied with the nursing care they received. A further 94% of participants, n=47(94%) felt that their needs were being taken care of while n=46 (92%) of participants agreed that their dignity as human-beings were being protected by the staff.

Table 4.20 – Outcome: care and dignity (n=50)

Variable	Agree n (%)	Disagree n (%)
B3.5 Adequate nursing care	48 (96%)	2 (4%)
B3.6 Needs are taken care of	47 (94%)	3 (6%)
B3.8 Dignity is protected	46 (92%)	4 (8%)

4.5.3.4 Variable B3.9 – Outcome: family

The majority of participants, n=49(98%) agreed that they felt comfortable whenever their family members came to visit them at the facility as shown in table 4.21.

Table 4.21 – Outcome: family (n=50)

Variable	Agree n (%)	Disagree n (%)
B3.9 Comfort during family visits	49 (98%)	1 (2%)

4.6 Section C – Improvements

This part of the questionnaire provided information about residents' views on improvements made at the facility, as well as further improvements they would like to see. Two open-ended questions were used for this, namely question 4.1 and 4.4. Two additional open-ended questions, namely question 4.2 and 4.3 were used to allow participants the opportunity to provide additional information about their likes and dislikes of the facility which they might have wished to mention. These open-ended questions further allowed the participants to voice their opinion about any other aspect of the facility which might not have been covered in the section with the closed-ended questions of the questionnaire.

The responses to these four questions were entered on an Excel sheet by the researcher. Similar responses for each question were grouped together. Some of the participants gave more than one response for a specific question. The responses were entered into the applicable groups.

These response groups were then analysed by the researcher in order to identify a common theme. The number of responses for each of the emerging themes was

quantified and is presented in the form of frequency tables. With each question there were a number of participants who opted not to answer the question. The frequency of responses has been adapted to reflect only those who answered the specific question.

4.6.1 Variable C1: Best improvement at the facility

As shown in table 4.22 most of the participants, n=6(22%) indicated improvements to the buildings and amenities followed by 19% of participants, n = (5) who selected safety and security. Some participants (19%) were unable to select anything specific, while others (15%) indicated that there were continuous improvements taking place. Participants also referred to improvements in food preparation (11%), activities (11%) and management (11%).

Table 4.22 – Best improvement at the facility (n=27)

Theme	Frequency (n)	Percent (%)
Buildings and amenities	6	22%
Unable to select anything specific	5	19%
Safety and security	5	19%
Continually improving	4	15%
Food preparation and menu	3	11%
More activities	3	11%
Management	3	11%
More domestic staff	1	4%
Gardens	1	4%

4.6.2 Variable C2: Aspect liked most at the facility

Table 4.23 shows that the majority of participants, n=11(31%) responded to the positive attitude of staff as the aspect they liked most about the facility. Nine participants, n=9(25%) selected the gardens and eight participants, n=8(22%) commented on the homeliness of the facility. A further seven participants, n=7(14%) referred to the range of activities provided by the facility as the best liked aspect.

Table 4.23 – Aspect liked most at the facility (n=36)

Theme	Frequency (n)	Percent (%)
Positive attitude of staff	11	31%
Gardens and environment	9	25%
Homeliness	8	22%
Range of activities	7	19%
Difficult to select anything specific	6	17%
Individual care and attention	5	14%
Safety	3	8%
Meals	1	3%

4.6.3 Variable C3: Aspect liked least at the facility

According to table 4.24 a number of participants, n=10(37%) selected the meals provided by the facility as the least liked aspect. Seven participants, n=7(26%) indicated that there was nothing about the facility they did not like. A further six participants, n=6(22%) stated that the bathrooms, especially sharing of bathrooms was the aspect they liked the least about the facility.

Table 4.24 – Aspect liked least at the facility (n=27)

Theme	Frequency (n)	Percent (%)
Food, supper, amount of bread	10	37%
None	7	26%
Bathrooms, sharing	6	22%
No residents committee	3	11%
Lack of consultation with residents	3	11%
Routine followed	1	4%
Distance from shopping centres	1	4%

4.6.4 Variable C4: Suggestions for further improvements

Table 4.25 shows that 42% of participants, n=11(42%) indicated that they could not suggest any further improvements. Five participants, n=5(19%) suggested improvements in the quality and variety of the food served during meals. More leafy vegetables, less bread and starchy foods were suggested. Improvements to the bathrooms and better quality toilet paper were suggested by four participants, n=4(15%).

Table 4.25 – Suggestions for further improvements (n=26)

Theme	Frequency (n)	Percent (%)
Nothing more, satisfied	11	42%
Food, menu changes, less bread	5	19%
Bathrooms, toilet paper	4	15%
More meetings with management	3	12%
Establish residents committee	2	8%
Quicker response from nurses	2	8%
Problems with cats	2	8%

4.7 SUMMARY

The analysis of the data collected during the study has been described in this chapter. The results of the study were presented in the form of frequency tables and bar graphs. The statistical tests which were performed on the data have been interpreted and the reliability analysis of the questionnaire was discussed.

In the next chapter the key results will be discussed. Conclusions will be made in relation to the objectives of the study. Recommendations based on the results of the study will be provided and the limitations of the study will be described.

CHAPTER 5

DISCUSSION, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

In this chapter the results of the study which were presented analysed in chapter four will be discussed. The validity of the results will be described and a discussion, based on the research question, the objectives and results of the study will be provided. In addition to this, recommendations will be made. The limitations of the study will be described and aspects for further research will be identified.

5.2 VALIDITY OF THE RESULTS

The high value of the Cronbach's alpha coefficient is a clear indication of the internal consistency of the questions used in the data collection instrument. Therefore, the questionnaire may be regarded as a reliable instrument. The data obtained with the use of the instrument may thus be seen as reliable.

Rantz *et al.* (2005:295) emphasised the importance of a reliable and valid instrument to assess residents' opinions related to quality of care in residential aged care settings. It is further highlighted by Berglund (2006:50) that the quality of care in homes for the aged should be measured from the perspective of the elderly themselves.

Hassan and Arnetz (2009:12) mentioned that although the elderly in residential care may tend to give high ratings for the care they receive, facilities should not take it for granted that all residents may be highly satisfied with their care. The authors accentuate the necessity to guarantee anonymity when soliciting the views of elderly about the quality of care they receive due to their vulnerable position.

From the data collected during the study it appears as if the participants were satisfied with some aspects related to the living conditions and care they received at the facility where the quality assurance programme was implemented. Most

participants ($\geq 90\%$) were satisfied with the physical environment. This included the gardens and buildings as well as clean and comfortable living areas. Of the 36 participants who commented on what they liked most at the facility, 47% referred to the homeliness and the gardens of the facility. This is consistent with the findings of a study by Berglund (2007:49) where 79% of participants indicated they were satisfied with the comfortable environment the facility offered.

It is further supported by findings from a qualitative study exploring the experiences of the elderly about the environment in residential facilities (Edvardsson, 2008:38). The physical environment has been identified as one of the main themes, including subthemes such as homeliness, absence of bad odours, comfortable furniture, the presence of familiar objects and well maintained buildings.

It was found in the study that another satisfying aspect, from the residents' point of view, related to the care and positive attitude of the staff. Most participants ($\geq 90\%$) were satisfied about the nursing care they received and the respectful manner in which they were treated. Of the 36 participants who commented on what they liked, 44% referred to the individual care and positive attitude of the staff as being noteworthy.

This is consistent with the themes identified by Hall *et al.* (2014:56 - 57) in a qualitative study on the views of staff, residents and their families about maintaining the dignity of residents in care homes. The most prevalent themes included privacy, respect, individuality and autonomy.

However, the study results showed that there were areas where the level of satisfaction was lower and where some participants were clearly not satisfied. This included communication with management and the food services. As many as 44% of participants were not satisfied with the input they had into the management of the facility while 18% were not satisfied with the information provided to them by management. Of the 26 participants who answered the open-ended question about suggestions for further improvements, 12% asked for more meetings with management while 8% were in favour of a residents committee to be established.

These findings are supported by an evaluation study conducted by Baur and Abma (2011:391) into communication processes and residents councils in homes for the

elderly. The study pointed out that such councils provide an excellent platform for improved communication between management and residents. Effective communication is also emphasised by Chou *et al.* (2002:192) as one of the components leading the improved resident satisfaction.

Although only 50 residents completed the questionnaire, they were well representative of the study population. The majority were females, n=40(80%) compared to males, n=10(20%). This is consistent with the gender distribution at the facility at the time of the study. There were 112 females (81%) compared to 27 (19%) males living at the facility according to the resident list for August 2014. This is further supported by the overall gender distribution of older people living in South Africa. Results from the 2011 census indicate that 65% of persons over the age of 65 years are females (Statistics South Africa, 2012:18).

The mean age of the participants was 83 years and most of them, (58%) were living at the facility between one and six years. These results are aligned to studies which measured resident satisfaction in homes for the aged which identified that participants were mostly over 80 years of age and residing at the facility for more than two years (Chou, Boldy & Lee, 2002:191; Berglund, 2006:48).

5.3 DISCUSSION OF RESULTS

The aim of the study was to investigate resident satisfaction following the implementation of a quality assurance programme at a home for the elderly. In the next section the study findings will be discussed according to the objectives that were set based on the aim of the study and guided by the research question.

The objectives of the study were:

- To investigate resident satisfaction about structure standards:
 - safety and security measures of the facility
 - maintenance of the infrastructure, including the buildings and gardens
 - availability of nursing care
 - provision in the basic needs including meals and laundry- and cleaning services

- recreational activities
- To investigate resident satisfaction about process standards:
 - communication with management
 - communication with staff
 - the nursing care they receive
- To investigate the residents' opinion of areas for further improvement
- To determine the relationship between demographic variables and resident satisfaction related to the various standards

5.3.1 To investigate resident satisfaction about safety and security measures of the facility

In order to measure this standard from the participants' perspective it was asked as both a process and an outcome standard in the questionnaire. Not only did all the participants (100%) indicate that they feel safe during the day, but they also agreed that they felt safe at night (table 4.17). Three participants (8%) stated that the safety aspects of the facility is best liked by them (table 4.22). A further 19% of the participants viewed the improvements to the safety and security of the facility as being noteworthy (table 4.21). Most participants (92%) knew what to do in the event of a fire. However, there were 13 participants (26%) who were not aware of procedures to safeguard their valuables and money (see table 4.9).

According to annexure B of the Regulations regarding older persons (Regulation 260, 2010:55) residential care facilities should provide residents with a safe and secure environment. Eliopoulos (2014:500) emphasises the importance of security measures in homes for the elderly in order to protect the residents. Fire precautions and fire-fighting equipment with the necessary guidelines are specifically referred to by the author.

It can thus be concluded that the residents are highly satisfied with the safety and security measures that are currently in place at the facility; however, there was a lack of knowledge amongst the residents about procedures to safeguard their money and valuables.

5.3.2 To investigate resident satisfaction about the maintenance of the infrastructure, including the buildings and gardens

The importance of providing a homely environment to residents in homes for the elderly has been identified as one of the critical indicators in the quality assurance framework provided by Rantz *et al.* (2005:294). In addition, Bengtsson and Carlsson (2013:399) points out that access to a garden as part of the outdoor environment hugely contribute to a sense of well-being amongst residents in homes for the elderly. In this study all the participants (100%) were satisfied with the gardens and outdoor environment (table 4.3). This aspect was also pointed out as: “*the most liked about the facility*” by nine of the participants who answered this particular open-ended question (table 4.22). One participant indicated that “*the gardens here make the difference towards living here and not somewhere else*”.

A homely environment is further described by Edvardsson (2008:33) in terms of the absence of bad odours and interior decoration that resembles a home-like environment. Only 6% of participants disagreed that the interior environment is homely, while 94% of participants were satisfied with the interior environment. A further 22% of participants specifically noted that they “*feel at home*” and that this was the aspect which they liked most about the facility (table 4.22). According to table 4.8, 94% of participants agreed that there were no bad odours in the corridors.

Eliopoulos (2014:500) emphasises the importance of not only the provision, but also the maintenance of an adequate infrastructure at homes for the elderly that would meet the special needs of frail and often physically challenged residents. Most of the participants (98%) were satisfied with the exterior of the buildings (table 4.3). Improvements to the buildings and amenities have been highlighted by six of the participants who answered this specific open-ended question (table 4.21). One participant mentioned the “*installation of fire sprinklers and fire doors*”, while another mentioned the “*opening of Rose’s Café on the premises*” as the best improvement at the facility.

It can thus be concluded that the residents were highly satisfied with the infrastructure of the facility, especially the gardens. The only aspect according to the narrative data with which some participants, n=6(22%) were not satisfied with, was the bathroom facilities, especially the fact that they have to share bathrooms (table

4.23). One participant indicated that “*the bathrooms need to be upgraded*” and two participants mentioned that the “*lack of warm water in the bathrooms at times*” is the aspect which they liked least about the facility.

5.3.3 To investigate resident satisfaction about the availability of nursing staff

Although the majority of participants (92%) agreed that the nursing staff was available when needed, some did not agree (8%) (table 4.5). The majority (90%) of participants felt that the call bell was answered promptly by the nursing staff (table 4.15). Spilsbury *et al.* (2011:733) state that the elderly in residential aged care is often highly dependent on nursing staff to provide in their needs. Having adequate nursing staff available at all times is thus an important aspect in a quality assurance programme. This is supported by Maas *et al.* (2008:125) who point out that improved clinical outcomes, such as less falls are associated with the availability of adequate nursing staff.

5.3.4 To investigate resident satisfaction about provision in basic needs including meals and laundry- and cleaning services

Providing in the nutritional needs of the elderly in residential aged care facilities can be challenging due to various factors such as individual preferences, chronic illnesses and other age-related changes (Eliopoulos, 2014:500). Therefore, meal services is one of the aspects included in the conceptual framework developed by Chou, Boldy and Lee (2003:460) to determine resident satisfaction in homes for the elderly.

Many participants (32%) were not satisfied with the food provided by the facility at the time of the study (table 4.6). A further 18% of participants disagreed with the availability of a special diet if needed (table 4.10). In addition, there were a number of participants (37%) who indicated that the food, especially the supper meal, is the aspect they liked least about the facility (table 4.23).

House-keeping services form an essential part of meeting the basic needs of residents (Chou *et al.*, 2001:626). Some of the participants (16%) were not satisfied with the laundry services (table 4.11), but almost all the participants (98%) were satisfied that their rooms were kept clean (table 4.8).

The majority of participants (94%) were of the opinion that their needs were being taken care of (table 4.19). According to the narrative data presented in table 4.22 a further five participants indicated that the “*individual care and attention*” they received at the facility “*is the best like aspect*”.

5.3.5 To investigate resident satisfaction about recreational activities

The importance of social interaction and recreational activities in homes for the elderly has been accentuated by Bergland and Kirkevold (2005:686). This is supported by Van Malderen *et al.* (2013:146) who argue that a variety of activities should be available to provide for the individual preferences, as well as the deteriorating physical abilities of the elderly.

All the participants (100%) were satisfied with the variety of activities offered by the facility (table 4.7). There were seven participants who viewed the many activities offered by the facility as the “*most liked aspect*” as shown by the narrative data (table 4.22).

5.3.6 To investigate resident satisfaction about communication with management

Baur and Abma (2011:391) refer to the importance of effective communication between the residents and the management of homes for the elderly. This could be achieved by the establishment of a residents committee. It was indicated in this study that there was a real need for improved communication with management. Many of the participants (44%) were not satisfied with the extent to which they have an input in decisions taken by management (table 4.14). As many as 82% of the participants were satisfied with the information they received from management about new developments (table 4.14). This is supported by the comments from three participants who indicated the lack of consultation from management’s side was the aspect they “*liked least*” about the facility (table 4.23). One of the participants wrote: “*some of the rules changes quickly without talking to the residents beforehand*”.

5.3.7 To investigate resident satisfaction about communication with the nursing staff

Nursing staff are the primary caregivers in homes for the elderly. Therefore effective communication between them and these residents is essential, not only to ensure that the various needs of the residents are being met, but also to establish a trusting relationship (Hall *et al.*, 2014:58). Showing respect towards the elderly and maintaining their dignity are seen as prerequisites for effective communication (Carpac-Claver & Levy-Storms, 2007:60).

All the participants (100%) stated that the staff showed respect towards them and 96% of participants were satisfied that the staff displayed a positive attitude towards them (table 4.13). The majority of participants (92%) were satisfied that their dignity was being protected by the staff (table 4.19).

5.3.8 To investigate resident satisfaction about the nursing care they receive

Mueller and Savik (2010:270) emphasise the importance of comprehensive nursing care in homes for the elderly in order to meet the complex clinical and psychological needs of the vulnerable residents. This is supported by Hall *et al.* (2014:58) who refer to the importance of individualised care and involving residents in decision-making regarding their care.

A number of participants (18%) were not satisfied with the degree of input they have in decision-making towards their healthcare (table 4.12). In comparison only 4% of the participants were not satisfied with the nursing care they received (table 4.19). All the participants (100%) agreed that the nursing staff respected their privacy (table 4.13).

It could thus be concluded that most participants (96%) were satisfied with the nursing care they received (table 4.19). However, not all the participants were satisfied with their level of involvement in the decision-making process about their healthcare.

5.3.9 To investigate the residents' opinion of areas for further improvement

In order to provide quality care on a continuous basis, it is necessary to identify specific areas that need improvement. Residents in homes for the elderly can

provide valuable information towards this end as they are the recipients of care (Hasson & Arnetz, 2010:13).

In this study, almost half of the respondents (48%) chose to not answer the question. However, 42% of those participants who chose to answer the question responded that they were satisfied and could not add any suggestions (table 4.24).

A number of participants (37%) suggested improvements to the meals served. This included changes to the menu, less bread to be served and more vegetables (table 4.24). Suggestions were also made to have more meetings with management and to establish a residents committee (table 4.24).

5.3.10 To determine the relationship between demographic variables and resident satisfaction related to the various standards

There was no statistical association between the variables and the demographical data, such as age and the length of residency. It is thus clear that age and the length of residency had little influence on the level of satisfaction as measured with the questionnaire. Similarly, the gender of participants provided no statistical significance when tested against the variables. Therefore, gender did not influence the level of satisfaction expressed by the participants in this study.

5.4 RECOMMENDATIONS

The recommendations that follow are based on the scientific evidence obtained from the study.

5.4.1 Communication structures

The scientific evidence obtained from the study identified the need for improved communication between residents and management. It is thus recommended that a residents committee is established with a transparent process to be followed for the election of members. Each resident should have a fair and equal chance to serve on the committee. Regular meetings should take place to give residents a platform to raise their concerns as supported by Baur and Abma (2011:396).

It is further recommended that a process of consultation with residents is followed when changes in the management of the facility is being considered. The residents should receive adequate information about proposed changes, especially when it may have a direct impact on their living conditions and activities of daily living.

It should also be noted that the elderly may need more time for decision-making and that some information may have to be repeated a few times. Specific barriers to effective communication with the elderly should be identified and dealt with timeously. This is supported by Carpiac-Claver and Levy-Storm (2007:64) who pointed out that the communication style of staff may have to be adapted to match the individual communication preferences and abilities of elderly.

5.4.2 Nursing care

Individualised and comprehensive nursing care should be provided by competent nursing staff. This would further contribute towards the quality and safety of care. Continuous professional development should thus be encouraged and in-service training provided to all staff members. Maas *et al.* (2008:130) emphasise the importance of skilled and knowledgeable staff to improve the quality of nursing care provided to the elderly. It is further recommended that the topics for in-service training should be relevant to address specific developmental needs identified by staff, as well as the nurse manager.

Continuity of care is essential to improve clinical outcomes, as well as resident satisfaction in homes for the elderly. Changes in the emotional and physical status of a resident would be identified more accurately if the same staff member cares for the same residents on a continuous basis. This can be achieved by consistent nursing team assignments with a professional nurse to coordinate and supervise the nursing care process.

Consistent care assignments will also be beneficial to enhance a trusting relationship between the residents and the staff, thus improving outcomes such as resident satisfaction. This is further supported by Dellefield (2008:203) who points out that consistent care assignments provide the nursing staff with a greater sense of accountability and thus improved clinical outcomes.

Nurses should be encouraged to involve residents in decision-making about their care and activities of daily living. This will provide residents with a greater sense of independence, thus enhancing their perception of self-worth. Since the residents in homes for the elderly are mostly cared for by non-professional nurses or care workers with limited skills and knowledge, adequate supervision by a professional nurse is essential on each shift.

In order to sustain the positive results related to the nursing staff, the nursing staff to resident ratio should be maintained. Similarly, other resources should also be carefully considered in order to continue to provide quality care and to reduce risks associated with elder care. This is supported by Collier and Harrington (2008:166) who point out that higher staff levels and characteristics such as staff mix have been associated with improved outcomes in homes for the elderly.

The implementation of evidence-based geriatric care is further recommended. International best practices should be followed and nursing care standards should be benchmarked against these practices. Therefore, research findings related to elder care should be taken cognisance of, and where applicable, be implemented.

In order to improve the safety of residents, a risk management programme should be in place. Various risks related to resident care should be assessed and the necessary steps implemented to minimise these risks. It should further be a continuous process based on the monitoring and evaluation of improved outcomes in relation to the risks reduction. These include, but are not limited to resident- falls, infection control and fire safety.

Furthermore, clinical indicators related to resident care should be monitored on a continuous basis. Strategies should be implemented to improve clinical outcomes in terms of problems associated with long term geriatric care. These include resident falls, pressure ulcers, weight loss, urinary tract infections and depression as supported by Lyons *et al.* (2008:218).

5.4.3 Social interaction

Maintaining the human-dignity of residents by treating them with respect and protecting their privacy is the foundation for good relationships in homes for the elderly. Management should therefore encourage staff to display a positive attitude

towards the residents at all times. According to the narrative data from the study, many residents commented on the positive attitude of the staff as one of the aspects they liked most about the facility. Maintaining good relationships amongst the staff, residents and their families should therefore be part of the caring philosophy of the facility. This will also contribute to improved communication and thus positive outcomes in terms of less complaints and higher levels of satisfaction as supported by Berglund (2006:49).

The positive results of the study related to the various activities offered by the facility should be used as motivation to sustain the provision of opportunities for social interaction by the residents. Dedicated recreational areas could be used to offer more activities that would accommodate the different levels of both physical and mental abilities, as well as the interests of the residents.

Similarly, it is recommended that the gardens and outdoor environment be maintained as it resulted in highly positive responses from the participants in the study. It could further be utilised for social events to improve interaction between the residents, their families and staff.

5.4.4 Continuous quality improvement

It is further recommended that the quality assurance programme be sustained in view of the positive results from the study. Areas for further improvements should be continuously identified, new goals set and evaluated. In addition, improvements in quality should be balanced against the cost of such improvements in order for the programmes to be cost-effective and thus be sustainable as supported by Spilsbury *et al.* (2011:746).

Donabedian's three prong approach towards quality of care has proven to be useful in determining quality indicators to monitor and evaluate the quality assurance process in homes for the elderly. It is thus recommended that this approach be continued in order to monitor the outcome indicators as referred to in the quality assurance programme that was implemented.

It has been identified that many of the participants were not satisfied with the food services. It is thus recommended that the menu and food provided to the residents are reviewed by the management of the facility on a three monthly basis at least. In

addition, comments from the residents about the food services can be collected on a regular basis and evaluated by management during the three monthly review processes. When changes to the menu have been implemented, feedback should be provided in order for management to evaluate the residents' satisfaction about these changes.

Furthermore, a lack of knowledge about the procedures to safeguard their money and valuables has been identified among the participants. It is thus recommended that such procedures be available in writing and displayed on the notice boards. Residents should regularly be reminded of these procedures.

During the admission process of new residents, an orientation file containing important information should be provided. These include procedures concerning valuables and money as well as their safety in the event of disasters. Other important information related to their care should also be provided.

Mock fire drills and evacuation procedures should be implemented on a regular basis. This could be preceded by an information session about the procedures. On completion the residents should sign a register as proof of their participation.

Regular surveys could prove useful, as well as the use of a complaint box. The complaints should further be seen in context and be monitored for the frequency of a specific complaint related to a specific aspect of the service.

5.5 LIMITATIONS OF THE STUDY

Although the number of residents who took part in the study was representative of the eligible population (49%), it would have been ideal if more residents could have participated in the study. Furthermore, the study was conducted at only one home for the elderly where the quality assurance programme was implemented. This, together with the small return rate, means that the findings of study cannot be generalised.

In addition, this home for the elderly could be considered as a rather upmarket, privately owned facility which is supported by funding from the trust as the facility does not receive any subsidy from government.

5.6 FURTHER RESEARCH

Further research is needed in homes for the elderly specific to the South-African context. This includes the establishment and evaluation of quality assurance programmes at various types of facilities. The focus should be on improving the clinical outcomes and thus reducing the risks associated with caring for the elderly in residential facilities. In addition, satisfaction surveys which include not only the residents, but their families as well should be carried out.

Qualitative research that focus on the shrinking world and care experiences of the institutionalised elderly could hugely contribute to an understanding of the needs of these persons in a South African context. This could strengthen quality initiatives as the emphasis should be on the receiver of care as a person and not just the positives outcomes of care.

Furthermore, studies should be conducted in the state subsidised homes for the elderly as well as other dedicated facilities which care for the elderly on a permanent basis.

5.6 CONCLUSION

Meeting and exceeding the expectations of residents cared for in homes for the elderly are one of the ultimate goals of a quality assurance programme. This requires a multi-dimensional approach due to the complexity of the needs of increasingly frail and vulnerable residents.

Besides this, residents are cared for by a diverse workforce who is mostly guided by the legislative framework of the country, as well as institutional policies and practice standards. Improving the quality of care should be reinforced by effective leadership, open communication and an organisational culture which value excellence. The necessary resources should be available and a therapeutic environment should be maintained.

Cost-effective care should thus be provided by skilled and knowledgeable staff with the aim of achieving excellence. The elderly residents should be the focus point and their opinions should be valued.

Lastly, it should be remembered that no facility will be able to provide services that will meet all the needs of a diverse group of residents at all times. However, each facility providing care to the elderly should at least strive towards excellence and maintaining the dignity of residents who are nearing the end of their lives.

List of references

Attree, M. 1993. An analysis of the concept “quality” as it relates to contemporary nursing care. *International Journal of Nursing Studies*, 30(4):355 – 369.

Bakerjian, D. & Zisberg, A. 2013. Applying the Advancing Excellence in America’s Nursing Homes Circle of Success to improving and sustaining quality. *Geriatric Nursing*, [Online]. Available: www.gnjournal.com [2013, August 2].

Baur, V.E & Abma, T.A. 2011. Resident councils between life world and system: Is there room for communicative action? *Journal of Aging Studies*, 25(4):390 – 396.

Bellot, J. 2012. Nursing Home Culture Change. What does it mean to Nurses? *Research in Gerontological Nursing*, 5(4):264 – 273.

Bengtsson, A. & Carlsson, G. 2013. Outdoor environments at three nursing homes – qualitative interviews with residents and next of kin. *Urban Forestry & Urban Greening*, 12(3):393 – 400.

Bergland, A. & Kirkevold, M. 2005. Thriving in nursing homes in Norway: Contributing aspects described by residents. *International Journal of Nursing Studies*, 43(6):681 – 691.

Berglund, A-L. 2007. Satisfaction with caring and living conditions in nursing homes: Views of elderly persons, next of kin and staff members. *International Journal of Nursing Practice*, 13(1):46 – 51.

Booyens, S.W. (ed.). 2008. *Introduction to Health Service Management*. 3rd edition. Cape Town: Juta.

Booyens, S.W. as updated by Bezuidenhout, M. 2014. *Dimensions of Healthcare Management*. 3rd edition. Cape Town: Juta.

Burns, N. & Grove, S.K. 2011. *Understanding Nursing Research Building an Evidence-based Practice*. 5th edition. Missouri: Elsevier.

Cape Peninsula Organisation for the Aged. 2014. [Online]. Available: www.cpoa.co.za [2014, February 13].

- Carpac-Claver, M.L. & Levy-Storms, L. 2007. In a Manner of Speaking: Communication Between Nurse Aides and Older Adults in Long-Term Care Settings. *Health Communication*, 22(1):59 – 67.
- Castle, N.G. 2009. Use of Agency Staff in Nursing Homes. *Research in Gerontological Nursing*, 2(3):192 – 201.
- Chou, S-C., Boldy, D.P. & Lee, A.H. 2001. Measuring Resident Satisfaction in Residential Aged Care. *The Gerontologist*, 41(5):623 – 631.
- Chou, S-C., Boldy, D.P. & Lee, A.H. 2002. Residential Satisfaction and Its Components in Residential Aged Care. *The Gerontologist*, 42(2):188 – 198.
- Chou, S-C., Boldy, D.P. & Lee, A.H. 2003. Factors Influencing residents' Satisfaction in Residential Aged Care. *The Gerontologist*, 42(2):188 – 198.
- Chuang, Y-H., Abbey, J.A., Yeh, Y-C., Tseng, I-J. & Liu, M.F. 2015. As they see it: A qualitative study of how older residents in nursing homes perceive their care needs. *Collegian*, 22(1):43 – 51.
- City of Cape Town Demographics Discussion Paper*. 2010. [Online]. Available: www.capetown.gov.za/DemographicsDiscussionPaperAugust2010 [2013, April 5].
- Cohen-Mansfield, J. & Parpura-Gill, A. 2008. Practice style in the nursing home: dimensions for assessment and quality improvement. *International Journal of Geriatric Psychiatry*, 23(4):376 – 386.
- Collier, E. & Harrington, C. 2008. Staffing Characteristics, Turnover Rates, and Quality Care in Nursing Facilities. *Research in Gerontological Nursing*, 1(3):157 – 170.
- Compas, C., Hopkins, A. & Townsley, E. 2008. Best Practices in Implementing and Sustaining Quality of Care. A Review of the Quality Improvement Literature. *Research in Gerontological Nursing*, 1(3):209 – 216.
- Dellefield, M.E. 2008. Best Practices in Nursing Homes. Clinical Supervision, Management, and Human Resource Practices. *Research in Gerontological Nursing*, 1(3):197 – 207.

- Dellefield, M.E., Kelly, A. & Schnelle, J.F. 2013. Quality Assurance and Performance Improvement in Nursing Homes. Using Evidence-Based Practice Protocols to Observe Nursing Process in Real Time. *Journal of Nursing Care Quality*, 28(1):43 – 51.
- Department of Health. 1999. *A patients' right charter*. Pretoria: Government Printer.
- Department of Health. 2015. *Ethics in Health Research: Principles, Processes and Structures*. Second edition. Pretoria: Government Printer.
- De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2011. *Research at Grass Roots for the social and human service professions*. 4th edition. Pretoria: Van Schaik.
- Donabedian, A. 1997. The Quality of Care. How Can It Be Assessed? *Archives of Pathology and Laboratory Medicine*, 121(11):1145 – 1150.
- Du Moulin, M.F.M.T., Van Haasregt, J.C.M. & Hamers, J.P.H. 2010. Monitoring quality of care in nursing homes and making information available for the general public: State of the art. *Patient Education and Counselling*, 78(3):288 – 296.
- Edvardsson, D. 2008. Therapeutic Environments for Older Adults. Constituents and Meanings. *Journal of Gerontological Nursing*, 34(6):32 – 40.
- Eliopoulos, C. 2014. *Gerontological Nursing*. 8th edition. Philadelphia: Lippincott Williams & Wilkins.
- Grove, S.K., Burns, S. & Gray, J.R. 2013. *The Practice of Nursing Research Appraisal, Synthesis, and Generation of Evidence*. 7th edition. Missouri: Elsevier.
- Hall, S., Dodd, R.H. & Higginson, I.J. 2014. Maintaining dignity for residents of care homes: A qualitative study of the views of care home staff, community nurses, residents and their families. *Geriatric Nursing*, 35(1):55 – 60.
- Hasson, H. & Arnetz, J.E. 2009. A comparative study of nursing staff, care recipients' and their relatives' perceptions of quality of older people care. *International Journal of Older People Nursing*, 5(1):5 – 15.

Hawthorne, G., Sansoni, J., Hayes, L., Marosszeky, N. & Sansoni, E. 2014. Measuring patient satisfaction with health care treatment using the Short Assessment of Patient Satisfaction measure delivered superior and robust satisfaction estimates. *Journal of Clinical Epidemiology*, 67(5):527-537.

Huber, D.L. 2010. *Leadership and Nursing Care Management*. 4th edition. Missouri: Elsevier.

Joubert, J. & Bradshaw, D. 2005. Population Ageing and Health Challenges in South Africa. [Online]. Available: <http://www.mrs.ac.za/chronic/cd/chapter15>. [2014, 7 February].

LoBiondo-Wood, G. & Haber, J. 2010. *Nursing Research Methods and Critical Appraisal for Evidence-Based Practice*. 7th edition. Missouri: Elsevier.

Lyons, S.S., Specht, J.P., Karlman, S.E. & Maas, M.L. 2008. Everyday Excellence A Framework for Professional Nursing Practice in Long-Term Care. *Research in Gerontological Nursing*, 1(3):217 – 228.

Maas, M.L., Specht, J.P., Buckwalter, K.C., Gittler, J. & Bechen, K. 2008. Nursing Home Staffing and Training Recommendations for Promoting Older Adults' Quality of Care and Life. Part 1. Deficits in the Quality of Care Due to Understaffing and Undertraining. *Research in Gerontological Nursing*, 1(2):123 – 133.

Majerovitz, S.D., Mollott, R.J. & Rudder, C. 2009. We're on the Same Side: Improving Communication Between Nursing Home and Family. *Health Communication*, 24(1):12 – 20.

Molony, S.L. 2010. The Meaning of Home. A Qualitative Methasynthesis. *Research in Gerontological Nursing*, 3(4):291 – 307.

Mueller, C. & Savik, K. 2010. Identifying and Validating the Components of Nursing Practice Models for Long-Term Care Facilities. *Research in Gerontological Nursing*, 3(4):270 – 281.

Muller, M. 2009. *Nursing Dynamics*. 4th edition. Sandton: Heinemann.

Muller, M. Bezuidenhout, M. & Jooste, K. 2011. *Healthcare Service Management*. 2nd edition. Cape Town: Juta.

Nakrem, S., Vinsnes, A.G., Harkless, G.E., Paulsen, B. & Seim, A. 2009. Nursing sensitive quality indicators for nursing home care: International review of literature, policy and practice. *International Journal of Nursing Studies*, 46(6):848 – 857.

Provincial Government of the Western Cape. 2014. Department of Social Development. [Online]. Available: <http://westerncape.gov.za/dept/social-development/facility>. [2014. February 13].

Rantz, M.J., Zwygart-Stauffacher, M. & Flesner, M. 2005. Advances in Measuring Quality of Care in Nursing Homes: A New Tool for Providers, Consumers, Regulators and Researchers. *Journal of Nursing Care Quality*, 20(4):293 – 296.

Redfern, S.J. & Ross, F.M. 2006. *Nursing older people*. 4th edition. Philadelphia: Elsevier Churchill Livingstone.

Republic of South Africa. 1978. *Nursing Act 50 of 1978*. Pretoria: Government Printer.

Republic of South Africa. 1996. *Constitution of the Republic of South Africa, No 108 of 1996*. Pretoria: Government Printer.

Republic of South Africa. 2003. *National Health Act 61 of 2003*. Pretoria: Government Printer.

Republic of South Africa. 2005. *Nursing Act 33 of 2005*. Pretoria: Government Printer.

Republic of South Africa. 2006. *Older Persons Act 13 of 2006*. Pretoria: Government Printer.

Republic of South Africa. 2010. *Regulations regarding older persons, Regulation 260 of 2010*. Pretoria: Government Printer.

Scott-Cawiezell, J., Schenkman, M., Moore, L., Vojir, C., Connolly, R.P., Pratt, M. & Palmer, L. 2004. Exploring Nursing Home Staff's Perceptions of

Communication and Leadership to Facilitate Quality Improvement. *Journal of Nursing Care Quality*, 19(3):242 – 252.

Stelfox, H.T. & Straus, S.E. 2013. Measuring quality of care: considering measurement frameworks and needs assessment to guide quality indicator development. *Journal of Clinical Epidemiology*, 66(12):1320-1327.

Spilsbury, K., Hewitt, C., Stirk, L. & Bowman, C. 2011. The relationship between nurse staffing and quality of nursing homes: A systematic review. *International Journal of Nursing Studies*, 48(6):732 – 750.

South African Nursing Council. 1984. *Regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act, 1978 Regulation 2598, as amended*. Pretoria: Government printer.

Statistics South Africa. 2012. *Statistical release (Revised) P0301.4 Census 2011*. [Online]. Available: http://www.statssa.gov.za/Publications/P03014/afdb/P0301.4_2011.pdf. [2015, February 21].

Van Malderen, L., Mets, T. & Gorus, E. 2013. Interventions to enhance the Quality of Life of older people in residential long-term care: A systematic review. *Ageing Research Reviews*, 12(1):141 – 150.

Wagner, C., Ikkink, K.K., Van der Wal, G., Spreeuwenberg, P., De Bakker, D.H. & Groenewegen, P.P. 2006. Quality management systems and clinical outcomes in Dutch nursing homes. *Health Policy*, 75(2):230 – 240.

Whittaker, S., Shaw, C., Spieker, N. & Linegar, A. 2011. *Quality standards for healthcare establishments in South Africa*. [Online]. Available: http://www.cohsasa.co.za/files/publications_pdf. [2014, September, 16].

World Health Organization. 2015. *Health Statistics Information Systems*. [Online]. Available: <http://www.who.int/healthinfo/survey/ageingdefnolder/en>. [2015, February 21].

Yoder-Wise, P.S. 2014. *Leading and Managing in Nursing*. 5th edition. Missouri: Elsevier.

ANNEXURE A – Ethics approval from the Health Research Ethics Committee 1 of Stellenbosch University



UNIVERSITEIT-SELLENBOSCH-UNIVERSITY
jou kennisvenoot • your knowledge partner

Approval Notice New Application

18-Jul-2014
Ellis, Susanna SLHM

Ethics Reference #: S14/05/115

Title: An investigation into resident satisfaction following the implementation of a quality assurance programme at a home for the elderly.

Dear Mrs. Susanna Ellis,

The New Application received on 27-May-2014, was reviewed by members of Health Research Ethics Committee 1 via Expedited review procedures on 15-Jul-2014 and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: 15-Jul-2014 -15-Jul-2015

Please remember to use your **protocol number** (S14/05/115) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note a template of the progress report is obtainable on www.sun.ac.za/ids and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/ids

If you have any questions or need further assistance, please contact the HREC office at 0219389657.

Included Documents:

Protocol
Investigator CV (Stellenberg)
Investigator declaration (Ellis)

Investigator CV (Ellis)
Questionnaire
Division checklist
Consent form
HREC New application form
Investigator declaration (Stellenberg)
HREC general checklist
Protocol Synopsis

Sincerely,



Franklin Weber
HREC Coordinator
Health Research Ethics Committee 1

ANNEXURE B- Permission letter from the George and Annie Starck Homes



UNIVERSITEIT-STELLENBOSCH-UNIVERSITY
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**Division of Nursing
Faculty of Medicine and Health Sciences
PO Box 19063
Tygerberg
7505
31 July 2014**

**The Manager
George and Annie Starck Homes
PO Box 119
Bellville
7535**

Re: Permission to conduct research

Dear Mrs Bastiaanse

I am doing a Master's degree in Nursing and herewith ask permission to do research at your facility.

**The title of the study is “An investigation into resident satisfaction following the implementation of a quality assurance programme at a home for the elderly”
The George and Annie Starck Home has been selected since a quality assurance programme has been implemented at this facility. The researcher is interested in the outcome of the programme in terms of resident satisfaction.**

The data will be collected by means of a questionnaire, available in both Afrikaans and English. The researcher will explain the procedure to the residents, consent will be obtained and participation will be voluntary. All information will be kept confidential.

Ethics approval for this study has been obtained from the Health Research Ethics Committee of Stellenbosch University, Faculty of Medicine and Health Sciences. The reference no is S14/05/115. My supervisor is Dr E.L. Stellenberg.

Your favourable consideration in this regard will be much appreciated

**Kind regards
Susan Ellis**

(082 412 4188)



Fakulteit Geneeskunde en Gesondheidswetenskappe
Faculty of Medicine and Health Sciences



Verpleging • Nursing

Afdeling van Inter-dissiplinêre Gesondheidswetenskappe • A Division in Interdisciplinary Health Sciences

Verbind tot Optimale Gesondheid • Committed to Optimal Health

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Tel: +27 (0) 21 9389036 • Faks/Fax: +27 (0) 21 9389854

THE GEORGE AND ANNIE STARCK HOMES

Established under the will of the late George Henry Starck

Frans Conradie Drive
P O Box 119
7535 Bellville



(021) 948-1844
(021) 949-0305
Email: gash@starckhomes.co.za
Website: www.starckhomes.co.za

Ms Susan Ellis
Division of Nursing
Faculty of Medicine and Health Sciences
P O Box 19063
TYGERBERG
7505

13 August 2014

Dear Ms Ellis

Re: **PERMISSION TO CONDUCT RESEARCH**

I wish to refer to your letter dated 31 July 2014 requesting permission to conduct a study into resident satisfaction following the implementation of a quality assurance programme at the homes.

Your application was discussed at our Management Committee Meeting held on 12 August 2014. We feel honoured that you have singled us out for this study and permission for you to go ahead has been granted by our Management Committee.

We would be very interested to know what the outcome of your study is. We therefore request, if at all possible, that you share this information with the management of the homes.

We wish you all the best in the completion of your master's degree.

Kind regards

Simone Bastiaanse
GENERAL MANAGER

ANNEXURE C – Information letter to staff and residents at the George and Annie Starck Homes

THE GEORGE AND ANNIE STARCK HOMES

TO: ALL RESIDENTS
ALL HOUSEMOTHERS
Sr PEARCE - MARYPORT

13 August 2014

SUBJECT: STUDY INTO RESIDENTS' SATISFACTION

Sr Susan Ellis a previous employee of the Homes has been granted permission to do a study into resident satisfaction following the implementation of a quality assurance programme at the homes.

Sr Ellis is currently doing her master's degree in nursing and this will form part of her thesis.

The data will be collected by means of a questionnaire. The procedure will be explained by Sr Ellis to residents partaking in the study. **Participation will be anonymous and entirely voluntary.** All information will be kept confidential.

On 19 August 2014 a Pilot study will be carried out in the dining room at Maryport from 08:30 onwards. For this she will require one volunteer from each house. Please could the housemother let us know by Monday morning 18 August who the volunteer in their house will be.

The actual study will be carried out as per attached schedule. On the particular date Sr Ellis will visit each house where she will conduct the main study.

Ethics approval for this study has been obtained from the Health Research Ethics Committee of Stellenbosch University, Faculty of Medicine and Health Sciences.

Your favourable consideration for participation will be appreciated.



SO BASTIAANSE
General Manager

ANNEXURE D –Participant information leaflet and consent form (English & Afrikaans)

TITLE OF THE RESEARCH PROJECT:

An investigation into resident satisfaction following the implementation of a quality assurance programme at a home for the elderly

REFERENCE NUMBER: S14/05/115

PRINCIPAL INVESTIGATOR: SLHM Ellis

ADDRESS: Division of Nursing

Faculty of Medicine and Health Sciences

PO Box 1963

Francie van Zijl Drive

Tygerberg

7500

CONTACT NUMBER: 021 938 9826 or 082 412 4188

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied and that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** 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 do agree to take part.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

This study will be conducted at the George and Annie Starck homes where a quality assurance programme was implemented.

All residents who are living in the various houses will be invited to participate in the study. Residents from Mary Port, the unit for frail care, who are able to take part in

the study, will be invited to do so. The aim is to include as many of the 152 residents as possible.

The researcher would like to determine your satisfaction about the living conditions, environment, services and care you receive at the George and Annie Starck homes. The researcher is interested in your opinion about any improvements you may wish to contribute to. This information will assist in determining the success of the programme and how the programme may be improved.

You will be given a questionnaire to complete, but you need not have to write your name anywhere on the document. It will be anonymous. The information will be confidential and will be kept by the researcher. Together with a statistician the information will be analysed and the results will be published in the thesis the researcher is currently busy with.

Why have you been invited to participate?

Since you have been living at the George and Annie Starck homes for more than six months you are invited to participate in the study. The researcher is of the opinion that you may give valuable information as to how your daily needs are being taken care of and how happy you are about living at George and Annie Starck homes.

What will your responsibilities be?

You will be required to fill in the questionnaire provided by the researcher. There is no time limit to complete the questions. You may ask the researcher for assistance if you do not understand a question. You do not have to write your name anywhere on the document. After completing the questionnaire it may be placed into the envelope provided by the researcher.

Will you benefit from taking part in this research?

You may not benefit immediately from this research, but the information may be used to maintain and improve the quality of the services and care you receive at the George and Annie Starck Homes.

You may thus benefit from this research in the long term.

Are there in risks involved in your taking part in this research?

There are no anticipated risks involved by you participating in this research. In the event that you may feel emotionally disturbed by answering any of the questions and need support, an appointment may be arranged with the social worker. Alternatively, an appointment may be scheduled with the district surgeon who visits the facility weekly.

If you do not agree to take part, what will happen then?

Participation in this research is completely voluntary. If you do not wish to participate you will not be compromised in any way.

Who will have access to the questionnaires?

The collected information will be treated as confidential. It will be kept by the researcher in a locked cupboard. Only the researcher, the supervisor and the statistician will have access to the questionnaires. The information will be published in the form of a thesis, but the identity of the participants will remain anonymous.

Will you be paid to take part in this study and are there any costs involved?

You will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

You can contact the researcher, Ms Ellis at 082 412 4188 if you have any further queries or encounter any problems.

You can contact Dr Stellenberg, the supervisor of the researcher at 021 938 9826 if you have any concerns or problems that have not been adequately addressed by the researcher

You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by the researcher.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I agree to take part in a research study entitled: **An investigation into resident satisfaction following the implementation of a quality assurance programme at a home for the elderly**

I declare that:

- I have read or had read to me 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 pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*)
2014.

.....
Signature of participant

.....
Signature of witness

Declaration by investigator

I (*name*) 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, as discussed above
- I did not use an interpreter.

Signed at (*place*) on (*date*)
2014

.....
Signature of investigator

.....
Signature of witness

DEELNEMERINLIGTINGSBLAD EN -TOESTEMMINGSVORM

TITEL VAN DIE NAVORSINGSPROJEK:

'n Onderzoek aangaande inwoner-tevredenheid na die implementering van 'n gehalteversekeringsprogram by 'n tehuis vir bejaardes

VERWYSINGSNOMMER: S14/05/115

HOOFNAVORSER: SLHM Ellis

ADRES: Verpleegkunde Divisie

Mediese en Gesondheidswetenskappe Fakulteit

Posbus 1963

Francie van Zijl Rylaan

Tygerberg

7500

KONTAKNOMMER: 021 938 9826 of 082412 4188

U word genooi om deel te neem aan 'n navorsingsprojek. Lees asseblief hierdie inligtingsblad op u tyd deur aangesien die besonderhede van die navorsingsprojek daarin verduidelik word. Indien daar enige deel van die navorsingsprojek is wat u nie ten volle verstaan nie, is u welkom om die navorser daarvoor uit te vra. Dit is baie belangrik dat u ten volle moet verstaan wat die navorsingsprojek behels en hoe u daarby betrokke kan wees. U deelname is ook **volkome vrywillig** en dit staan u vry om deelname te weier. U sal op geen wyse hoegenaamd negatief beïnvloed word indien u sou weier om deel te neem nie. U mag ook te eniger tyd aan die navorsingsprojek onttrek, selfs al het u ingestem om deel te neem.

Hierdie navorsingsprojek is deur die Gesondheidsnavorsingsetiekkomitee (GNEK) van die Universiteit Stellenbosch **goedgekeur en sal uitgevoer word volgens die etiese riglyne en beginsels van die Internasionale Verklaring van Helsinki en die Etiese Riglyne vir Navorsing van die Mediese Navorsingsraad (MNR).**

Wat behels hierdie navorsingsprojek?

Hierdie studie sal by die George en Annie Starck Homes, waar 'n gehalteversekerings-program geïmplementeer was, gedoen word.

Al die inwoners wat in die verskillende huise woon sal uitgenooi word om aan die studie deel te neem. Inwoners van die versorgingseenheid Mary Port, wat in staat is

om aan die studie deel te neem, sal ook uitgenooi word. Die doelwit is om soveel moontlik van die 152 inwoners in te sluit.

Die navorser wil graag u tevredenheid met die verblyf-omstandighede, omgewing, dienste en sorg wat u by die George en Annie Starck Homes ontvang, bepaal. Die navorser is geïnteresseerd in u opinie rakende enige verbeteringe waartoe u graag 'n bydrae sal wil maak. Hierdie inligting sal help om die sukses van die program te bepaal asook hoedanig die program verbeter kan word.

Daar sal aan u 'n vraelys gegee word om te voltooi, maar dit is nie nodig om u naam op enige plek op die dokument te skryf nie. Dit sal anoniem wees. Die inligting is konfidentiële en sal deur die navorser gehou word. Die inligting sal saam met 'n statistikus ontleed word en die resultate sal in die tesis waarmee die navorser tans besig is, gepubliseer word.

Waarom is u genooi om deel te neem?

U word uitgenooi om aan die studie deel te neem aangesien u al vir meer as ses maande by die George en Annie Starck Homes woon. Dit is die opinie van die navorser dat u waardevolle inligting kan verskaf oor hoe daar in u daaglikse behoeftes voorsien word en hoe gelukkig u met u inwoning by die George en Annie Starck Homes is.

Wat sal u verantwoordelikhede wees?

Daar sal van u verwag word om 'n vraelys in te vul wat deur die navorser aan u gegee sal word. Daar is nie 'n tydsbeperking op die voltooiing van die vrae nie. U mag die navorser vra vir hulp indien u nie 'n vraag verstaan nie. Dit is nie nodig om u naam op die dokument te skryf nie. Na voltooiing van die vraelys kan dit in die koevert geplaas word wat die navorser aan u gegee het.

Sal u voordeel trek deur deel te neem aan hierdie navorsingsprojek?

U mag moontlik nie onmiddellik voordeel trek deur die navorsing nie, maar die inligting kan gebruik word om die gehalte van die dienste en sorg wat u by die George en Annie Starck Homes ontvang, te behou en verbeter. U mag dus in die lang termyn voordeel trek uit die navorsing.

Is daar enige risiko's verbonde aan u deelname aan hierdie navorsingsprojek?

Geen risiko's, wat verband hou met u deelname aan hierdie navorsingsprojek, word voorsien nie. Ingeval u dalk emosioneel ontstig sou voel deurdat u enige van die vrae beantwoord het en ondersteuning benodig, kan 'n afspraak met die maatskaplike werker gereël word. Alternatiewelik kan 'n afspraak ook met die distriksgeneesheer, wat die fasiliteit weekliks besoek, gereël word.

Wat sal gebeur indien u nie instem om deel te neem nie?

Deelname aan hierdie navorsingsprojek is geheel en al vrywillig. Indien u besluit om nie deel te neem nie, sal u op geen manier benadeel word nie.

Wie sal toegang hê tot die vraelyste?

Die inligting wat versamel word, sal as vertroulik hanteer word. Dit sal deur die navorser in 'n toesluit-kabinet bewaar word. Slegs die navorser, die studieleier en die statistikus sal toegang hê tot die vraelyste. Die inligting sal in die vorm van 'n tesis gepubliseer word, maar die identiteit van die deelnemers sal anoniem bly.

Sal u betaal word vir deelname aan die navorsingsprojek en is daar enige koste verbonde aan deelname?

U sal nie betaal word vir deelname aan die navorsingsprojek nie. Indien u sou deelneem, sal daar geen kostes verbonde aan wees nie.

Is daar enigiets anders wat u moet weet of doen?

U kan die navorser, Mev. Ellis, kontak by 082 412 4188 indien u enige verdere vrae het, of enige probleme ondervind.

U kan die navorser se studieleier, Dr Stellenberg, kontak by 021 938 9826 indien u enige bekommernisse of klagte het wat nie bevredigend deur die navorser hanteer is nie.

U kan die **Gesondheidsnavorsingsetiek administrasie** kontak by 021-938 9207 indien u enige bekommernis of klagte het wat nie bevredigend deur die navorser hanteer is nie.

U sal 'n afskrif van hierdie inligtings- en toestemmingsvorm ontvang vir u eie rekords.

Verklaring deur deelnemer

Met die ondertekening van hierdie dokument onderneem ek,, om deel te neem aan 'n navorsingsprojek getiteld: **'n Onderzoek aangaande inwoner-tevredenheid na die implementering van 'n gehalteversekeringsprogram by 'n tehuis vir bejaardes**

Ek verklaar dat:

- Ek hierdie inligtings- en toestemmingsvorm gelees het of aan my laat voorlees het en dat dit in 'n taal geskryf is waarin ek vaardig en gemaklik mee is.
- Ek geleentheid gehad het om vrae te stel en dat al my vrae bevredigend beantwoord is.
- Ek verstaan dat deelname aan hierdie navorsingsprojek **vrywillig** is en dat daar geen druk op my geplaas is om deel te neem nie.

- Ek te eniger tyd aan die navorsingsprojek mag onttrek en dat ek nie op enige wyse daardeur benadeel sal word nie.
- Ek gevra mag word om van die navorsingsprojek te onttrek voordat dit afgehandel is indien die studiedokter of navorser van oordeel is dat dit in my beste belang is, of indien ek nie die ooreengekome navorsingsplan volg nie.

Geteken te (*plek*) op (*datum*)
2014.

.....
Handtekening van deelnemer

.....
Handtekening van getuie

Verklaring deur navorser

Ek (*naam*) verklaar dat:

- Ek die inligting in hierdie dokument verduidelik het aan
.....
- Ek hom/haar aangemoedig het om vrae te vra en voldoende tyd gebruik het om dit te beantwoord.
- Ek tevrede is dat hy/sy al die aspekte van die navorsingsprojek soos hierbo bespreek, voldoende verstaan.
- Ek nie 'n tolk gebruik het nie.

Geteken te (*plek*) op (*datum*)
2014.

.....
Handtekening van navorser

.....
Handtekening van getuie

ANNEXURE E – Data collection instrument (Questionnaire)

Questionnaire to investigate resident satisfaction following the implementation of a quality assurance programme at a home for the elderly

The purpose of the programme was to improve the well-being and safety of the residents living at the home for the elderly where it was implemented.

Instructions

- Do not write your name anywhere on the questionnaire.
- The information you provide is considered confidential and will be treated as such.
- There is no time limit to complete the questions.
- Use the pen provided and indicate your choice by making a tick in the applicable box.
- Please tell the researcher if you need help to complete the questionnaire or if you are uncertain about any of the questions.

A. Demographic information – tell us about yourself

1. Tick off whether you are:

Male

Female

2. Write down your age in the block provided.

--

3. Write down how many years you have been living at the George and Annie Starck Homes in the block provided.

--

B. Standards of care – tell us about your living at the George and Annie Starck Homes

B1. Structure standards

1.1. The gardens are kept neat and tidy.

Strongly agree	Agree	Disagree	Strongly disagree

1.2. I can easily walk in the gardens, even if I have to use a walking aid.

Strongly agree	Agree	Disagree	Strongly disagree

1.3. There are dedicated areas to relax outside the buildings.

Strongly agree	Agree	Disagree	Strongly disagree

1.4. The exterior structures of the buildings are kept in a good condition.

Strongly agree	Agree	Disagree	Strongly disagree

1.5. The buildings are easy to access even if I use a walking aid / wheelchair.

Strongly agree	Agree	Disagree	Strongly disagree

1.6. The interior of the buildings are attractive and homely.

Strongly agree	Agree	Disagree	Strongly disagree

1.7. I can easily move around inside the buildings.

Strongly agree	Agree	Disagree	Strongly disagree

1.8. The distance between my room and the bathroom is acceptable.

Strongly agree	Agree	Disagree	Strongly disagree

1.9. The facilities in the bathroom meet my needs.

Strongly agree	Agree	Disagree	Strongly disagree

1.10. My room is comfortable and homely.

Strongly agree	Agree	Disagree	Strongly disagree

1.11. There is a place where I can relax apart from my room.

Strongly agree	Agree	Disagree	Strongly disagree

1.12. The nursing staff is available when I need them.

Strongly agree	Agree	Disagree	Strongly disagree

1.13. The same menu is not served daily by the homes.

Strongly agree	Agree	Disagree	Strongly disagree

1.14. The food is tasty.

Strongly agree	Agree	Disagree	Strongly disagree

1.15. There is a variety of activities offered by the home.

Strongly agree	Agree	Disagree	Strongly disagree

1.16. It is possible for me to attend the activities being offered by the home.

Strongly agree	Agree	Disagree	Strongly disagree

B2. Process standards

2.1. There are no bad odours in the passages.

Strongly agree	Agree	Disagree	Strongly disagree

2.2. The rooms are kept clean.

Strongly agree	Agree	Disagree	Strongly disagree

2.3. The noise levels are acceptable during the night.

Strongly agree	Agree	Disagree	Strongly disagree

2.4. I know what to do in the event of a fire.

Strongly agree	Agree	Disagree	Strongly disagree

2.5. There is a procedure in place to safeguard my money and other valuables.

Strongly agree	Agree	Disagree	Strongly disagree

2.6. The meals are served on time.

Strongly agree	Agree	Disagree	Strongly disagree

2.7. The amount of food served during meals is acceptable.

Strongly agree	Agree	Disagree	Strongly disagree

2.8. If I need a special diet, it can be arranged with the kitchen.

Strongly agree	Agree	Disagree	Strongly disagree

2.9. I am satisfied with the way my laundry is dealt with.

Strongly agree	Agree	Disagree	Strongly disagree

2.10. I know whom to report to when I do not feel well.

Strongly agree	Agree	Disagree	Strongly disagree

2.11. The staff is friendly towards me.

Strongly agree	Agree	Disagree	Strongly disagree

2.12. My privacy is being respected.

Strongly agree	Agree	Disagree	Strongly disagree

2.13. My concerns about my health are being taken care of.

Strongly agree	Agree	Disagree	Strongly disagree

2.14. I have an input in decisions about my health care.

Strongly agree	Agree	Disagree	Strongly disagree

2.15. The manager listens to my complaints.

Strongly agree	Agree	Disagree	Strongly disagree

2.16. If I feel unhappy, I know whom to talk to.

Strongly agree	Agree	Disagree	Strongly disagree

2.17. The home keeps me informed of new developments.

Strongly agree	Agree	Disagree	Strongly disagree

2.18. There is an opportunity for me to give input into the management of the facility.

Strongly agree	Agree	Disagree	Strongly disagree

2.19. I know how to ask for help during the night.

Strongly agree	Agree	Disagree	Strongly disagree

2.20. When I press the call bell, it is promptly answered by the staff.

Strongly agree	Agree	Disagree	Strongly disagree

2.21. My family may visit me at any time.

Strongly agree	Agree	Disagree	Strongly disagree

B3. Outcome standards

3.1. I feel safe at night.

Strongly agree	Agree	Disagree	Strongly disagree

3.2. I can walk in the garden during the day without being afraid.

Strongly agree	Agree	Disagree	Strongly disagree

3.3. I feel my property is safe in my room.

Strongly agree	Agree	Disagree	Strongly disagree

3.4. I would prefer to live at another home for the elderly.

Strongly agree	Agree	Disagree	Strongly disagree

3.5. I am satisfied with the nursing care I receive.

Strongly agree	Agree	Disagree	Strongly disagree

3.6. I feel my needs are being taken care of.

Strongly agree	Agree	Disagree	Strongly disagree

3.7. I would recommend living at the George and Annie Starck homes to my friends.

Strongly agree	Agree	Disagree	Strongly disagree

3.8. I feel that my dignity as a human-being is being protected by the staff.

Strongly agree	Agree	Disagree	Strongly disagree

3.9. I feel comfortable when my family visits me.

Strongly agree	Agree	Disagree	Strongly disagree

C. Improvements

Please answer the following questions in the space provided.

4.1. In your opinion, what have been the best improvement at the George and Annie Starck Homes since you have come to live here?

.....

4.2. Which aspect of the George and Annie Starck Homes do you like most?

.....

4.3. Which aspect of the George and Annie Starck Homes do you like least?

.....

4.4. Any suggestions of further improvements that you would like to see being implemented at the George and Annie Starck Homes?

.....

Thank you for completing the questionnaire

ANNEXURE F – Confirmation of language correctness



3 Beroma Crescent
Beroma
Bellville 7530

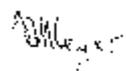
12 August 2015

TO WHOM IT MAY CONCERN

This letter serves to confirm that the undersigned

ILLONA ALTHAEA MEYER

has proof-read and edited the document contained herein for language correctness.

 (Ms IA Meyer)

SIGNED

FOR: Ellis, Susanna Louisa Hendrina Maria

TITLE: AN INVESTIGATION INTO RESIDENT SATISFACTION FOLLOWING THE IMPLEMENTATION OF A QUALITY ASSURANCE PROGRAMME AT A HOME FOR THE ELDERLY

ANNEXURE G – Quality assurance programme

THE GEORGE AND ANNIE STARCK HOMES

Established under the will of the late George Henry Starck

Frans Conradie Drive
P O Box 119
7535 Bellville



(021) 948-1844
(021) 949-0305
Email: gash@starckhomes.co.za
Website: www.starckhomes.co.za

Quality Assurance programme

George and Annie Starck Homes

Vision: To become known as a place of excellence in serving the elderly in need of care.

Mission: To provide high quality and cost-effective care, while maintaining the dignity of the vulnerable residents in our care

Aim:

To improve the physical and social well-being of the residents living at the George and Annie Starck homes.

Target groups:

- All residents of the respective houses receiving assisted living as well as all the residents of the frail care unit receiving moderate to full care.
- All staff involved in caring for the residents
- Management of George and Annie Starck homes

Standard: Care and treatment provided according to nursing protocols	
Objective: Provide safe and effective nursing care according to best practice to improve clinical outcomes	
Indicators :	Actions
1. Pressure ulcers	1.1 Identify residents at risk to develop pressure ulcers according to guideline.
	1.2 Do baseline assessment and record the findings.
	1.3 Implement preventative measures according to specific care plan for prevention of pressure ulcers.

	1.4 Evaluate effectiveness of care plan and adjust accordingly.
	1.5 Monitor the incidence of pressure ulcers and report as adverse events at monthly Board meetings.
2. Patient falls	2.1 Identify residents with a high risk for falls according to guideline.
	2.2 Implement preventative measures according to specific care plans for prevention of resident falls.
	2.3 Evaluate effectiveness of care plan and adjust accordingly.
	2.4 Do daily environmental rounds to identify risks that could result in resident falls.
	2.5 Investigate all resident falls in order to identify root causes and develop strategies to prevent resident falls
	2.6 Monitor the incidence of resident falls and report as adverse events at monthly Board meetings.
3. Urinary tract infections	3.1 Identify residents with a risk for developing urinary tract infections according to guideline.
	3.2 Implement preventative measures according to specific care plan for prevention of urinary tract infections.
	3.3 Evaluate effectiveness of care plan and adjust accordingly.
	3.4 Monitor the incidence of urinary tract infections and report as adverse events at monthly Board meetings.
4. Wound infections	4.1 Identify residents with a risk for developing wound infections according to guidelines.
	4.2 Do baseline assessments and record the findings.
	4.3 Implement preventative measures according to specific care plan for prevention of wound infections.
	4.4 Evaluate the effectiveness of care plans and adjust accordingly.

	4.5 Monitor the incidence of wound infections and report as adverse events at monthly Board meetings.
5. Scabies - infections	5.1 Monitor all bedridden and confused residents for early identification of scabies infection.
	5.2 Investigate all complaints of itchiness from residents.
	5.3 Follow protocol for treatment of all confirmed cases of scabies infections.
	5.4 Follow protocol for prophylactic treatment of all suspected cases of scabies infections.
	5.5 Monitor the incidence of scabies infections and report as adverse events at monthly Board meetings.
Standard: Safety of residents monitored according to relevant protocols	
Objective: Provide a safe environment according to best practice to prevent negative incidents	
Indicators :	Actions
1. External environment	1.1 Identify external environmental risks and report to management.
	1.2 Investigate the risk and advise the Board of possible solutions.
	1.3 Implement plan according to guidelines and permission from the Board.
	1.4 Evaluate effectiveness of plan and give feedback to the Board.
2. Internal environment	2.1 Identify internal environmental risks and report to management.
	2.2 Investigate the risk and advise the Board of possible solutions.
	2.3 Implement plan according to guidelines and permission from the Board.

	2.4 Evaluate effectiveness of plan and give feedback to the Board.
3. Fire safety	3.1 Orientate all new staff and residents to fire safety.
	3.2 Fire safety protocol to be communicated to all staff and residents every second month – use the rotation programme compiled by nursing manager and submit a written report to the manager.
	3.3 Fire-fighting alarms and equipment to be tested monthly according to protocol – management to arrange the tests and to communicate with all senior staff.
	3.4 Monthly fire and evacuation drills with the residents.
	3.5 Revise fire safety protocol yearly.
4. Personal safety of residents	4.1 All staff, visitors and suppliers to adhere strictly to access control policy at the main gate
	4.2 All staff to adhere strictly to locking of outside-doors policy at all times
	4.3 Surveillance camera system in frail-care –nursing manager to monitor and report any system faults or any incidents.
	4.5 All negative incidences to be investigated by management, reported on and feedback given to relevant persons.
	4.6 All call bells to be tested daily by staff. Any problems to be reported to the registered professional nurse on duty who will arrange for repairs.
5. Protection of residents valuables and money	5.1 All new residents to be orientated to the policy and procedure for safekeeping of money and other personal valuables.
	5.2 All resident rooms in the houses to have lockable cupboards.
	5.3 All single rooms in frail care to have lockable cupboards.
	5.4 Pocket money system available for the frail, confused and bedridden residents.

	5.5 Facility for safe keeping of other valuables and documents available at the main office as well as in the frail-care unit.
	5.6 All negative incidences to be investigated by management, reported on and feedback given to relevant persons.
Standard: Establish effective communication between staff, residents and their families according to relevant protocols	
Objective: Promote open communication and flow of information between staff, residents and their families to improve care	
Indicators :	Actions
1. Meetings	1.1 Monthly Board meetings to be held as scheduled by management.
	1.2 Each house to be visited by Management and Board members during the year as per pre-planned programme working on a rotation basis to provide opportunities for open communication with residents.
	1.3 Three-monthly staff meetings to be held between management and senior nursing staff, as well as between management and the house parents.
	1.4 Other meetings to be scheduled as per the need of staff, residents or their families.
2. Reports	2.1 Daily report to be compiled by the registered professional nurse about the residents in frail care as per protocol and sent to main office.
	2.2 Weekly report to be compiled by the house mother of each house about the welfare of residents of the particular house as per protocol and sent to the nurse manager.
	2.3 Monthly report to be compiled by the house mother of each house about individual residents of the particular house as per protocol and sent to the nurse manager.
	2.4 Monthly report to be compiled by the nursing manager

	about adverse events and clinical indicators as per protocol and sent to management.
Standard: Acceptable food services provided to all residents	
Objective: Promote acceptable food services to all residents to meet their daily dietary needs	
Indicators :	Actions
1. Menu	1.1 A five-weekly menu is set by the dietician of the contracted catering providers, submitted to management for approval and circulated to the houses. A winter and a summer menu is further provided
	1.1 Provision is made for special dietary requests as per protocol.
	1.3 Special menus for special occasions and festive calendar days during the year.
	1.4 Menu to be revised twice a year.
2. Monitoring of the food services	2.1 Food provided to residents to be monitored daily by the housemothers. In the frail-care unit, this will be the responsibility of the registered professional nurse on duty.
	2.2 Weekly reports to be submitted to management from each house and the frail-care unit. A final report to be compiled and submitted to the catering providers about any problems including all the complaints received from the residents.
	2.3 Nursing manager to visit the kitchen daily and meet with the supervisor of catering provider and evaluate whether there are any problem being experienced on the particular day.
Standard: Effective cleaning services provided to all residents	
Objective: Promote effective cleaning services to all residents to enhance a therapeutic and safe environment	
Indicators :	Actions

<p>1. Cleaning of rooms in the houses and the frail-care unit.</p>	<p>1.1 All toilets to be cleaned three times a day. Bathrooms and corridors to be cleaned daily and in between as needed by the contracted service provider. Housemothers to oversee the process and report any problems to the nursing manager. Registered professional nurse to oversee the process in the frail-care unit and report any problems to the nursing manager. Deep cleaning as per protocol.</p>
	<p>1.2 All other rooms cleaned daily by the contracted service provider. Housemothers to oversee the process and report any problems to the nursing manager. Registered professional nurse to oversee the process in the frail-care unit and report any problems to the nursing manager. Deep cleaning as per protocol.</p>
<p>2. Odour control</p>	<p>2.1 All staff to investigate and address any bad odours immediately.</p>
	<p>2.2 Functionality of odour control devices to be monitored daily.</p>
	<p>2.3 Ensure that odour control devices are changed monthly by the contracted company.</p>
<p>3. Pest control</p>	<p>3.1 Regular pest control services to be arranged by management.</p>
	<p>3.2 No open food to be kept in resident rooms.</p>
	<p>3.3 All staff and residents to report any pests immediately to management.</p>
<p>4. Laundry</p>	<p>2.1 All soiled linen and clothes to be managed by nursing staff as per protocol. Thereafter to be sent to laundry for regular cleaning.</p>
	<p>2.2 All infected linen and clothes to be managed by nursing staff as per protocol. Thereafter to be sent to laundry for regular cleaning.</p>
	<p>2.3 All other dirty linen and clothes to be sent to laundry for regular cleaning.</p>
	<p>2.4 Housemothers to oversee that bed linen be changed at least weekly and that residents send their dirty clothes to the laundry as per schedule. Housemothers also to ensure all laundry are clearly marked before sending it to the laundry.</p>
	<p>2.5 Nursing staff to oversee that bed linen of the residents in</p>

	the frail-care unit be changed at least weekly or more often if needed. Nurses to ensure all clothes of frail-care residents are clearly marked before sending it to the laundry.
	2.6 Nursing manager to visit laundry services daily. Any problems to be reported to nursing manager.
Standard: Variety of activities and social interaction provided to all residents	
Objective: Promote a variety of activities and social interaction to all residents in order to add value to their lives	
Indicators :	Actions
1. Library and reading corner	1.1 Improve access to library in the main building, including assisting residents who would like to visit the library.
	1.2 Provide weekly library services to residents in frail-care unit.
	1.3 Provide the latest edition of two main newspapers in the reading corner of main building.
2. Games and exercise	2.1 Improve access to snooker table and dart board in games room of main building.
	2.2 Weekly carpet bowls in main building as per schedule.
	2.3 Weekly board games in dining room of frail-care unit as per schedule.
	2.4 Bi-weekly exercise programme for residents as arranged with the physiotherapist. Staff to assist residents to attend the sessions.
3. Chapel services and spiritual activities	3.1 Weekly chapel services by the various denominations as per pre-planned schedule based on the needs of the residents and availability of designated persons.
	3.2 Provide assistance to residents who would like to attend the chapel services as per schedule.
	3.3 Schedule of weekly services to be provided to the houses and frail-care unit to be displayed on the notice boards.
	3.4 Sing-alongs and other spiritual services arranged by the various denominations as per pre-planned schedule based on

	the needs of the residents and availability of designated persons.
4 Other activities	4.1 Weekly transport to one of the nearby shopping centres for residents who are still mobile, but who cannot drive any more.
	4.2 Interaction with other homes for the elderly to be arranged by management.
	4.3 Monthly excursion to be arranged by management.
	4.4 Yearly Christmas events for residents.
5 Report	5.1 Social worker to submit a monthly report to the Board about the social interaction and activities.

Next review: 2016

Signature:.....

Nursing Service Manager

External Audit: 2014

Signature: 

Nursing Service Manager

Implementation: 2009

Signature: 

Nursing Service Manager