social development

Department:
Social Development
**REPUBLIC OF SOUTH AFRICA**

# Final Report

# Audit of Residential Facilities

**UMHLABA**

**DEVELOPMENT SERVICES**

**April 2010**

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# EXECUTIVE SUMMARY

The Department of Social Development is responsible for the development and administration of the legislation which impacts on social development services to older persons and residential facilities is one of them. The government has a responsibility to ensure that its senior citizens are in environments that maintains or improves the physical, social and psychological well-being of individuals who, for a variety of reasons, are not fully able to care for themselves.

The purpose of this Audit was to identify the services provided and determine the quality of these services whilst also identifying the management systems which are used to run these facilities. The aim is to provide a national baseline study of the current status of residential facilities, focusing primarily on where government interventions should be focused to improve the quality of life of older persons within these institutions.

Umhlaba Development Services was appointed as the service provider by the Department of Social Development, with the task of auditing the residential facilities for older persons in South Africa. The report will provide the reader with a review and analysis of 405 homes across the country in terms of the following: medical services, social / recreational and outreach services, policies and procedures, management and governance, staff and volunteers, as well as an overview of the building and facilities. The report provides a quantitative analysis of these areas as well as some anecdotal views of all stakeholders.

The following documents formed the basis of this study, namely the Older Persons Act, SA Policy on Older Persons as well as the Guidelines for Frail Care and the National Norms and Standards regarding acceptable levels of services to older persons and service standards for residential facilities. These norms and standards prescribe the acceptable levels of services that should be provided to older persons and in terms of which services must be monitored and evaluated. Therefore, any person who provides a service to older persons must comply with the norms and standards. It is important to note that across the provinces only 61% of management and 26% of staff knew about the new norms and standards. The lack of knowledge of these norms and standards was also reflected in the current practices in many of the homes.

There were often big differences of opinion between the views of board and management and that of the staff. In some instances it was clear that this was as a result of a lack of communication between management and staff, in others, it related to grievances that staff had

towards their conditions of employment (low salaries and bad working conditions). This made it difficult for the audit team to assess in a 2-day visit, with limited access to people, the real situations in these homes. At times we were able to verify information through studying various documents but, often this did not give a clear sense of what the actual practice was in a home. It was also very clear in many instances that the homes were 'prepared' for the audit, the place was cleaned, the residents were groomed and very often the different teams were briefed in a particular way.

The distribution of old age residential facilities is disproportionate in the wealthier provinces of Gauteng and the Western Cape, with a distinct lack of facilities in poorer provinces such as Limpopo, Eastern Cape and Free State. Owing to out-migration and urbanisation amongst younger persons, older persons are disproportionately represented in the most rural and poorest provinces of the country. At the same time the audit found that the majority of facilities (79%) are concentrated in metropolitan formal areas or small urban formal areas. Only 5% are in informal or squatter areas while 16% are in rural areas.

The audit found that the key service providers that run large proportions of these facilities are bigger NGOs and in some outlying areas smaller FBOs or CBOs. In addition to providing frail care accommodation and assisted living facilities, such organisations homes provide home help and meals on wheels and they facilitate support groups and luncheon clubs. The bigger NGOs usually have a number of homes affiliated to them.

The findings of this study demonstrated that the majority of homes were not in a position to comply with the norms and standards in its current form. Most of the homes were of the view that they would require a huge financial investment in order to comply with the letter as noted in the norms and standards.

Based on the findings of the study an attempt was made to identify those homes that required urgent intervention. This was arrived at by observations of the fieldworkers where they were asked to rate their visual impression of each facility – does it leave a good impression or is it in a state of neglect and in need of maintenance and repair, as well as other issues such as whether the home offered 24 hour care and support, did a doctor or nurse visit the facility, did the facility have a policy to deal with abuse, did the facility have emergency procedures and finally how the staff rated the facility.

While Government has taken a strong policy lead to ensure the positive integration of older persons within society, support for them within their families, their access to proper community-based services, their protection from abuse, and promoting their general quality of life, at the same time there are numerous challenges that exist to turn government policy into reality in the lives of older persons. A number of recommendations are made as to what the priorities should be for service delivery organisations within a context of sound policy but limited capacity and resources.

These are recommendations that need to be addressed at a strategic level, but which will in turn, apply to, and impact on, the effective functioning of individual homes. In terms of the Guidelines and National Norms and Standards it is clear that the homes across the country are at different levels of meeting these standards.

It is recommended that in terms of:

1. The *relationship between the Department of Social Development and the Homes* is vital for the continued quality service delivery. The Home fulfils an important role in bringing welfare services to older persons and the state plays a key role in providing an environment that is conducive for the Home to carry out its work. This clearly indicates the desirability of close cooperation between them for the success of the programme. Both parties should meet and discuss ways in which the DSD could perhaps play a more significant role.

   - Where a more positive relationship exists between the Province or region and the homes, this supportive relationship needs to be maintained and the partnership further strengthened.
   - However, in the main the relationship (and communication) between the Department and the homes must improve and the homes seen as partners in this process of caring for older persons

2. *Roles, responsibilities and capacity of different players within DSD*: The Department at all levels must have their respective roles and responsibilities clarified so that there is no blurring, overlap and duplication of activities adding unnecessary anxieties to home managers. For this to happen the Department must streamline and adopt a more coordinated approach to its own operations more effectively

- The M&E role of the Department (wherever this responsibility lays) must be implemented on a continuous and consistent basis.
- The capacity of provincial and regional staff of DSD must be developed so that they are confident in performing their tasks
- The problem areas identified in this audit must be addressed and homes must be provided with more mentoring and support by the DSD in order to build the capacity of the homes (this is also a key issue in sustainability)

3. While attempts have been made by some homes to change their racial profiles, in many homes cultural and social norms and high fees have been used as a reason to exclude people of different racial groups. The focus on t*ransformation* is crucial; however the importance and focus which is to provide proper care for older persons must not be lost. Therefore:

- The issue of transformation in relation to providing an effective service for all older persons must become a priority for the DSD to ensure that homes address transformation with more than just lip-service.
- Homes that have given the impression that they have transformed but have kept black residents separate from white residents must be addressed as a matter of urgency
- Good practice models of transformation need to be shared with homes; many fear the unknown so if they know that it has worked in another home they might feel less resistant to the change
- Many of the homes that are resistant to change are controlled by 'mother bodies'. These bodies act as a pool of resources and personnel yet they also often also hamper transformation initiatives. The Department needs to conduct a more thorough study into their practices and address their resistance
- Diversity awareness should be done with home management and staff so that they are sensitised to different cultural and religious practices
- At the same time instead of enforcing compliance with punitive measures, DSD must embark on a process of assisting homes with transformation by helping them to develop a transformation strategy. Business Plans must include a plan for transformation with clear indicators by which to measure the progress made by homes
- Transformation is not only about racial integration of homes but also on all the other principles inherent in the Transformation Guidelines such as the composition of the

Board, management and staff, and transfer of skills from established organisations to emerging organisations. A few homes have started 'twinning' with sub-economic homes in their areas but others have felt that they do not want to appear as imposing their help onto homes that need it. Instead they believe that the Department should facilitate this process through their own needs assessment of a home and introduce the home that will assist, so that it is seen as a formal agreement and as part of their capacity building programme.

- Government must look at supporting black people who apply to white homes and cannot afford to pay with the pension and government subsidy. There could be a sliding scale developed to accommodate different categories of older persons in need of subsidised accommodation.

- While there is clearly difficulty in finding suitable, skilled individuals, a more stringent policy should be put in place targeted at Management levels with the primary aim of monitoring the recruitment of management and senior level staff as well as the structure of the 'mother bodies'

4. The challenge remains *intersectoral collaboration amongst government departments* which could in turn promote optimum utilisation of resources.

- The shortage of nursing staff could be addressed with the Department of Health to explore the possibility of these posts being subsidised or co-funded as the medical component forms the core of services provided to older persons.

- For many homes, transport is problematic especially when residents need to go to hospital. DSD should facilitate discussion between homes, the Department of Health and Hospitals in an attempt to find a solution.

5. In terms of *governance* boards need to be trained in order to understand their role in relation to good governance. In addition, they need to distinguish their role from that of management

- The Board should develop a policy of rotation and changing Board members within a specified time period

- In addition there must be a succession plan for Board members who leave and those who might be interested in joining.

6. **With regard to *management capacity,* *a*** management training programme must be developed for all home managers that focuses on the management of people, performance management, as well as aspects such as conflict management, building a cohesive team, and understanding diversity management which is crucial for real transformation

    - There must be a properly implemented performance management system in place with regular assessments of staff undertaken
    - Caring management is important in this environment as it impacts on the ability of staff to do their jobs effectively and with pride. Staff management conflicts need to be addressed.
    - Staff retention policies and procedures need to be developed which can include counselling and stress management support
    - The staff and management in all the homes must be familiarised with the norms and standards as well as the rights of older persons

7. ***Staff capacity:*** There is a problem of the shortage of staff, that needs to be addressed but this has financial implications

    - There is a need to build the capacity of staff through regular training programmes. This would allow staff to be updated with the most recent practices in the care for older persons
    - A capacity building programme should also look at issues such as assertiveness training, diversity awareness, self-esteem and other life skills

8. ***Funding policies*** should be re-addressed as many of the less affluent homes are struggling to maintain health care standards.

    - At the same time funding programmes such as an outreach programme, etc needs to be seriously considered as opposed to funding people
    - At the same time the Department could assist home managers and fund-raisers in exploring a sustainability strategy that addresses various options that include not only financial sustainability but also human resources and skills transfer
    - Implementing some of the norms and standards requires funding which the Department must consider, particularly in the homes that are less resourced and under-developed.

9. ***Multiple usages of facilities:*** For the sake of the safety of the residents, the patients as well as the staff Government should look at separate facilities (or sections of the same facility) to accommodate patients with Alzheimer's, dementia and mental illnesses.

- These require specialised forms of care as well and trained specialist staff to provide optimum care

10. The ***volunteer*** component at the Homes should be increased, both to enhance the medical services and recreational activities as well as for fundraising activities.
- There should be a better strategy to recruit, train and place support volunteers especially in black areas where volunteers are more lacking

11. The situation with homes where their ***basic service delivery needs*** are been ignored or where services such as water and electricity are intermittent, needs to be addressed as a matter of urgency.
- Discussions between the DSD at the highest level and its counterpart in local government regarding the regular interruptions in the supply of electricity and water need to take place urgently.

12. ***Homes that require support for basic infrastructure***: A special fund should also be created for homes that fall into specific sub-economic categories. Extra money should come from this fund and be given to homes as repairs for major breakages and faulty equipment is expensive and many homes simply cannot afford it.
- It might be possible for the Department to intervene and request assistance from the Department of Housing or Public Works for some assistance

13. ***Outreach Community Programmes:*** There are possibilities for homes to extend its outreach services. This would require additional finances as well as personnel. The DSD should consider subsidising such outreach programmes as it is in line with the Departments' vision of preventative intervention.
- The DSD should also subsidise home based care as the requirements are often similar to frail care. This will also put less of a burden on the homes while still allowing them to be active in their communities.

14. **Sharing, Learning and Networking:**  There is a need to move away from a competitive individualistic service to cooperative and collective approaches that facilitate skills transfer and service integration, which would also contribute to sustainability as well as meet the transformation imperative.

- A network or forum could also be used to connect homes with one another. In this way white homes could form a support process for black homes.
- At the same time homes could link up and do bulk buying or joint training programmes as well as 'job shadowing' to exchange ideas about proper cooking methods, diets and hygiene. These would help to pool resources and be less expensive to one organisation.

15. **Appropriate Model of Care**

It is difficult to propose a model of care when the majority of homes do not comply with the minimum standards according to the norms and standards. Homes were unanimous that if they were to comply with the norms and standards that they would require a considerable boost of funding from government. This needs to be further interrogated.

# WORKING DEFINITIONS

**Applicant** refers to a person or organisation that is applying to provide a service or operate a residential facility in terms of the Act, and includes a person applying for registration as a caregiver

**Assets** are any immovable or movable property owned by the service provider or operator and bought with Government funds

**Basic needs** means necessities which must be met in order to ensure an older person's survival and includes, shelter, food, water, access to health care services and access to social security

**Resident** refers to an older person residing in a residential facility

**Restraint** is the use of physical force or medication to impede the movement of the body or limbs of an older person

**Service provider** means a person who is providing a service in terms of the Act.

**Financial year** is the period beginning on 1 April of one year and ending on 31 March of the following year

**Abuse** means a single or repeated act, or lack of action occurring within any relationship where there is an expectation of trust, that causes harm or distress to an older person, including physical, psychological, financial, material or sexual harm or neglect

**Care** means provision of physical, psychological, social or material assistance to an older person and includes services aimed at promoting the quality of life and general well-being of an older person

**Caregiver** means any person who provides care to an older person

**Community-based care and support services** mean development, care and support services provided within a community, aimed at promoting and maintaining the independent functioning of older persons in a community, and include home-based care for frail older persons within the community

**Day care** means a service within a residential home or a community-based facility which provides social, recreational and health related activities in a protective setting to individuals who cannot be left alone during the day, due to health care and other social needs

**Director-General** means the Director-General of the Department of Social Development

**Domestic assistance** means the provision of domestic services to an older person living outside a facility, in order to enable the older person to maintain his or her present level of independent living

**DQ98** is a tool used to assess the level of frailty for applicants in a residential facility

**Facility** means a building or other structure used for the purpose of providing accommodation, shelter, community-based care and support services to older persons, including a private residential home in which older persons are accommodated

**Frail older person** means an older person in need of 24 hour care and/or whose physical or mental condition renders him or her incapable of caring for himself or herself

**Grant-in-aid** means a grant paid to or on behalf of any older or persons with disabilities who is in such a physical or mental condition that he or she requires regular attendance by any person

**Home-based care** means the provision of health and personal care services rendered by formal and informal care givers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health, including care towards a dignified death

**Manager** means the person responsible for the day to day management of a facility or service

**Mental condition** for the purposes of this document would be mental illness or mental disorder, which affect older persons due to old age, e.g. Dementia or Alzheimer's disease

**Minister** means the Minister of Social Development

**Older person** means a person who, in the case of a male, is 65 years of age or older and, in the case of a female, is 60 years of age or older

**Older person in need of care and protection** means an older person referred to in section 24(5) of the South African Policy for older Persons

**Operator** means a person who operates a residential facility

**Organisation** any group or association of persons, any institution, federation, society, movement, trust or fund, incorporated or unincorporated, and whether or not it has been

established or registered in accordance with any law, who care for support or assist with the needs of older persons

**Police official** means a member as defined in section 1 of the South African Police Service Act, 1995 (Act No. 68 of 1995), or a member of a municipal police service established under section 64A of that Act

**Recipient of social assistance** means a person receiving a grant under the Social Assistance Act, 1992 (Act No. 59 of 1992)

**Rehabilitation** means a process where older persons are provided with tools to enable them to reach and maintain their optimal physical, sensory, intellectual, psychiatric and/or social functional levels, and includes measures to restore and/or provide functions, or compensate for the loss or absence of a function or for a functional limitation, but excludes medical care

**Representative** means a family member, lawyer, friend or member of the general public authorised to represent the interests of an older person

**Residential facility** means a building or other structure used primarily for the purposes of providing accommodation and of providing a 24-hour service to older persons

**Respite care** means a service offered specifically to a frail older person and to a caregiver and which is aimed at the provision of temporary care and relief

**Service** means any activity or programme designed to meet the needs of an older person

**Service centre** is a multi-purpose centre or a community centre for older persons. A residential facility may serve as a service centre and an outreach home based care service to the housebound

**Shelter** means any facility or premises maintained or used for the reception, protection and temporary care of an older person in need of care and protection

**Social worker** means any person registered as a social worker under section 17 of the Social Service Professions Act, 1978 (Act No. 110 of 1978)

**Welfare organisation** means an organisation which renders services to older persons for non profitable purposes and includes any company or other association of persons established for a public purpose and the income and property of which are not distributable to its members or

office-bearers except as reasonable compensation for services rendered, and includes a nonprofit organisation established in terms of the Nonprofit Organisations Act, 1997 (Act No. 71 of 1997)

# CHAPTER 1    INTRODUCTION TO THE STUDY

## 1.1  Background

The Department of Social Development is responsible for the development and administration of the legislation which impacts on social development services to older persons and residential facilities is one of them. The government has a responsibility to ensure that its senior citizens are in environments that maintains or improves the physical, social and psychological well-being of individuals who, for a variety of reasons, are not fully able to care for themselves.

The Department has realized the need to revisit facilities that are home to some of the elderly people with an aim to review the systems adopted to run these facilities and explore the quality of services provided to the elderly.  The purpose of this Audit is to identify the services provided and determine the quality of these services whilst also identifying the management systems which are used to run these facilities.  The aim is to provide a national baseline study of the current status of residential facilities, focusing primarily on where government interventions should be focused to improve the quality of life of older persons within these establishments.

Umhlaba Development Services was appointed as the service provider by the Department of Social Development, with the task of auditing the residential facilities for older persons in South Africa.  The report will provide the reader with a review and analysis of 426 homes across the country in terms of the following: medical services, social / recreational and outreach services, policies and procedures, management and governance, staff and volunteers, as well as an overview of the building and facilities. The report provides a quantitative analysis of these areas as well as some anecdotal views of all stakeholders.

## 1.2 Objective of the Study

The main objective of the study was to conduct an audit to assess and analyse the quality of services in 426 residential facilities (in the end it was 405 as some homes have become private while others refused to be audited) in respect of the relevant norms and standards in order that the DSD may review, plan and implement appropriate management systems for the facilities.

## 1.3 Process Followed

A number of other processes were followed, which are listed below:

i. **Literature review**: A review of current legislation, policies, norms and standards was undertaken as well as a review of studies completed with regard to older persons

ii. **Developing tools for the audit**: These included a set of questionnaires for Board and management, staff and volunteers, residents, and where possible family members and community members. These tools were discussed and reviewed by a Reference Group in the Department after which it was finalised and accepted

iii. **Training and appointment of fieldworkers**: Three teams were trained to conduct the field work over the duration of the audit process. The first team was made up of twelve (12) fieldworkers from Gauteng. This team conducted the audit in Gauteng, Mpumalanga, North West, Free State, Limpopo, and the Northern Cape. The second team was also made up of nine (9) fieldworkers and these fieldworkers were based in KwaZulu Natal. This team conducted the audit in KwaZulu Natal and Eastern Cape. The third team conducted the audit in the outlying areas of the Western Cape and consisted of seven (7) fieldworkers.

iv. **Database:** Once the lists were received from the Department or provincial coordinator, follow up was done with each home to verify the identifying and contact details. This will ensure that there is an updated list of all homes that have been visited.

v. **Appointments made with homes**: This was a challenging process as it involved making telephonic contact with each home, agreeing on 2 consecutive days for the audit in each home, faxing a letter to confirm the dates as well as the requirements for the 2-day visit. In a number of homes, especially in outlying areas, discussions with family and community members did not take place either because the homes were a long distance away from where families lived or because there was no contact with the older person. Community members and volunteers were often part of the same group, and would consist of the local priests, a few NGOs and people who provided some service to the homes on a voluntary basis.

vi. **Verification of Audit**: Once the visits were completed, the field worker returned all the completed questionnaires as well as other documentation received such as attendance registers, staff and resident registers. The following process was then followed:

### a. Checking and Verification of Questionnaires

The Project Manager did the 1st quality check once they have returned from the field. The Project Manager did an initial checking to ensure the following:

- That all relevant questionnaires have been completed
- That all required staff lists, board members lists, attendance registers for group discussions and residents lists are submitted for each home
- That a narrative report is submitted for each home

The Project Manager would then submit all the above (with the exception of the narrative report) to the data management team. Once received the data team did a 2nd quality check of the data as follows:

- Recording of the home against the provincial lists and allocation lists provided
- Checking of the questionnaires to ensure that they have been correctly and entirely completed
- Any queries were raised by means of a Query Tracking Sheet. This recorded any inconsistencies in the questionnaires and was referred back to the fieldworker to correct
- Once this was returned to the data team, it was checked again and recorded as such
- The questionnaires were then captured in coded format for later data analysis

As a further quality check a verification exercise was conducted. This was done by choosing a random sample of homes from each province, ensuring that each fieldworker is represented. A telephone call was made to the main respondent of the home, usually the manager where a series of questions were asked. This includes:

- Confirming the name of the respondent
- Confirming the name and address of the home
- Confirming the fieldworker who conducted the visit
- Confirming the way in which data was collected, e.g. Did they conduct group sessions, did they conduct document scanning, etc
- Enquiring as to how the respondent felt about the Audit
- Enquiring as the conduct and professionalism of the fieldworker

This was recorded and submitted to the Project Manager on a regular basis.

b. **Data analysis**: Once the data was captured from the questionnaires, the data was sent to a data management specialist who collated and analysed the data on a provincial basis, using SPSS as the statistical programme. The provincial data was combined to produce the data for the national report.

c. **Reporting**

After conducting the two day audit with each home, the fieldworker produced a report. This is a report in which the field worker collates the information in the 5 questionnaires (management and board, staff and volunteers, residents, family and community members) to describe what was happening in the home. It drew a few conclusions and makes some recommendations where this is necessary. The reports were checked by the Project management team, sent back to the fieldworkers for additional information where necessary, and then produced as a final report. This was done for each home.

Provincial reports were written based on the provincial data as well as an attempt to draw out some provincial trends, while the national data was used to draw out some national trends.

## 1.4 Limitations of the Study

i. There was a discrepancy across all groups with regard to the conditions in the home such as the availability of services, policies and procedures and overall management and governance issues. Often Board and management indicated one answer and staff would say something different. In some instances it was clear that this was as a result of a lack of communication between management and staff, in others, it related to grievances that staff had towards their conditions of employment (low salaries and bad working conditions). This made it difficult for the audit team to assess in a 2-day visit, with limited access to people, to know what the reality was. At times we were able to verify information through studying various documents but, often this did not give a clear sense of what the actual practice was in a home.

ii. It was also very clear in many instances that the homes were 'prepared' for the audit, the place was cleaned, the residents were groomed and very often the different teams were briefed in a particular way that they would all give the same responses, which

under normal circumstances would be very unlikely that everyone would say the same thing.

# CHAPTER 2     OVERALL CONTEXT OF OLDER PERSONS

## 2.1   Introduction

This chapter outlines the overall context of older persons highlighting some international trends with regard to ageing. It also provides a brief overview of ageing in South Africa addressing mainly the demographic trends as well as the legislative context that should provide the enabling environment for older persons.

## 2.2   Defining Aged

At the moment, there is no United Nations standard numerical criterion, but the UN agreed cut off is 60+ years to refer to the older population. Realistically, if a definition in Africa is to be developed, it should be either 50 or 55 years of age, but even this is somewhat arbitrary and introduces additional problems of data comparability across nations. The more traditional African definitions of an elder or 'elderly' person correlate with the chronological ages of 50 to 65 years, depending on the setting, the region and the country. Lacking an accepted and acceptable definition, in many instances the age at which a person became eligible for statutory and occupational retirement pensions has become the default definition. The ages of 60 and 65 years are often used, despite its arbitrary nature, for which the origins and surrounding debates can be followed from the end of the 1800's through the mid 1900's. (Thane, 1978 & 1989; Roebuck 1979)

## 2.3   The World's ageing Population

Population ageing refers to a rising share of older people living in our societies and this will be accompanied by a shrinking population overall.  This phenomenon is mostly prevalent in Europe. A European comparative analysis shows that the challenge and extent of the population ageing is different for each country even within the European region.  Spain, for example is absorbing a much quicker rise in the share of older people than most of the other European countries such as Great Britain.  Table 1 shows figures on ageing in the world's regions and in a few specific countries.

The Population Reference Bureau estimates that in 2008 older persons comprise seven percent of the world's population. In Europe, the regional average proportion of older persons is 16 percent and is highest in Monaco at 22% (6600 older persons). In Asia, Japan is estimated to have 28 million older persons comprising 22 percent of the country's population. South Africa is estimated to have 1.9 million older persons. In other words, 86 percent of all older persons in Southern African reside in South Africa.

## 2.4   Ageing in South Africa

### 2.4.1   Demographic Trends

Sandra Marais and Ilse Eigelaar-Meets (2007) make reference to numerous studies conducted by Joubert and Bradshaw which provide a useful overview of the situation of older persons in South Africa. The authors indicate that South Africa has one of the most rapidly ageing populations in Africa, with a particular increase in the 64-70 year age category (May, 2003). In the year 2000 South Africa had the second highest number of older persons on the African continent, being only surpassed by the older population of Nigeria (5.24 million). The 2001 Census found that 7.3% of the total population in South Africa were 60 years or older which is higher than the proportions of almost all other African nations in 2000 and noticeably higher than

| Country | Mid -Year Population Estimate Mid 2008 in Millions | Proportion of Population aged 65+ | Estimated Population 65+ in Millions |
|---|---|---|---|
| **World** | **6705** | **7** | **469.4** |
| More Developed Countries | 1227 | 16 | 196.3 |
| Less Developed Countries | 5479 | 6 | 328.7 |
| Sub-Saharan Africa | 809 | 3 | 24.3 |
| Southern Africa | 55 | 4 | 2.2 |
| **Africa** | **967** | **3** | **29.0** |
| Lesotho | 1.8 | 5 | 0.1 |
| Reunion | 1.3 | 7 | 0.1 |
| Mauritius | 0.8 | 7 | 0.1 |
| South Africa | 48.3 | 4 | 1.9 |
| **Americas** | **915** | **9** | **82.4** |
| Canada | 33.3 | 14 | 4.7 |
| **Asia** | **4052** | **7** | **283.6** |
| Japan | 127.7 | 22 | 28.1 |
| **Europe** | **736** | **16** | **117.8** |
| Monaco | 0.03 | 22 | 0.007 |
| Italy | 59.9 | 20 | 12.0 |

the 5.1% for the African continent as a whole (Joubert & Bradshaw, 2006).

Table 1: **TABLE 1: POPULATION AGEING – WORLD FIGURES Source:** Population Reference Bureau (2008)
It is expected that despite the demographic impact of the AIDS epidemic, the South African population is to continue ageing over the next two decades with more than one person in ten being 60 years or older by 2025 [Figure 1] (Joubert & Bradshaw, 2006; Joubert, et.al., 2004; Joubert and Bradshaw, 2004). Furthermore, although the proportion of the older population will increase moderately over the projected period, the increase in the absolute size for the time period 1985 to 2025 is 112%, i.e. from 2.47 million to 5.23 million (a doubling in numbers over the course of 40 years). Figure 2 shows that the total number of older persons is expected to increase more rapidly over the next two decades than over the past two decades.



Figure 1: Population ageing in South Africa, 1985-2025 (percentage)
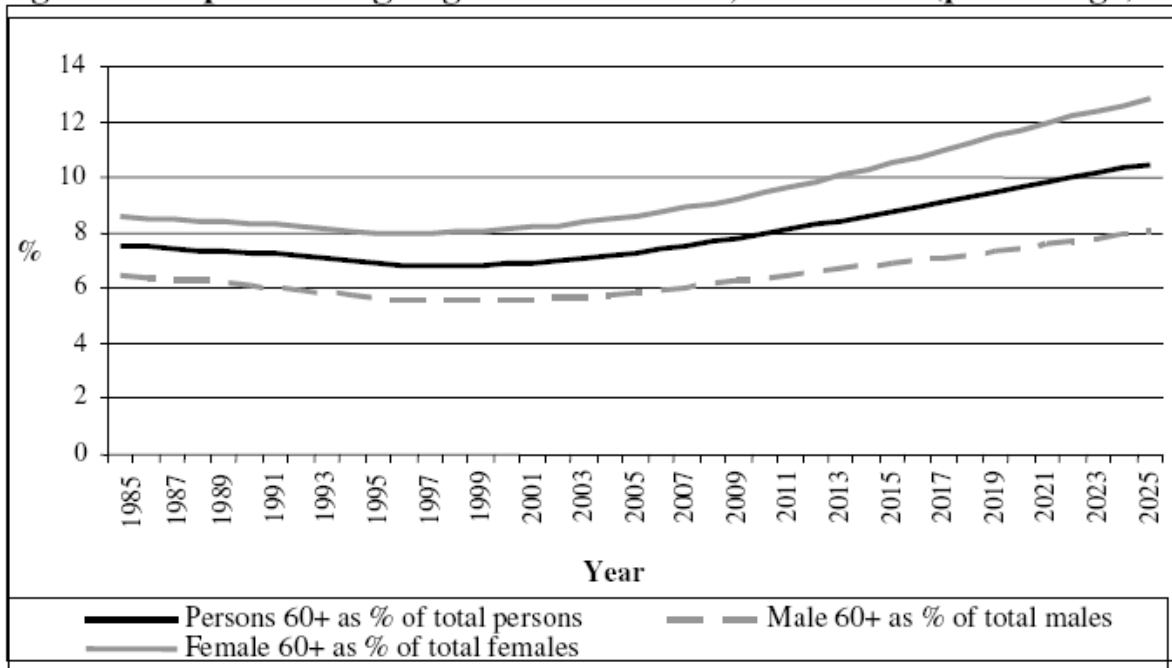
Source: ASSA2002, Joubert & Bradshaw, 2006

## Figure 2: Population ageing in South Africa, 1985-2025 (numbers)
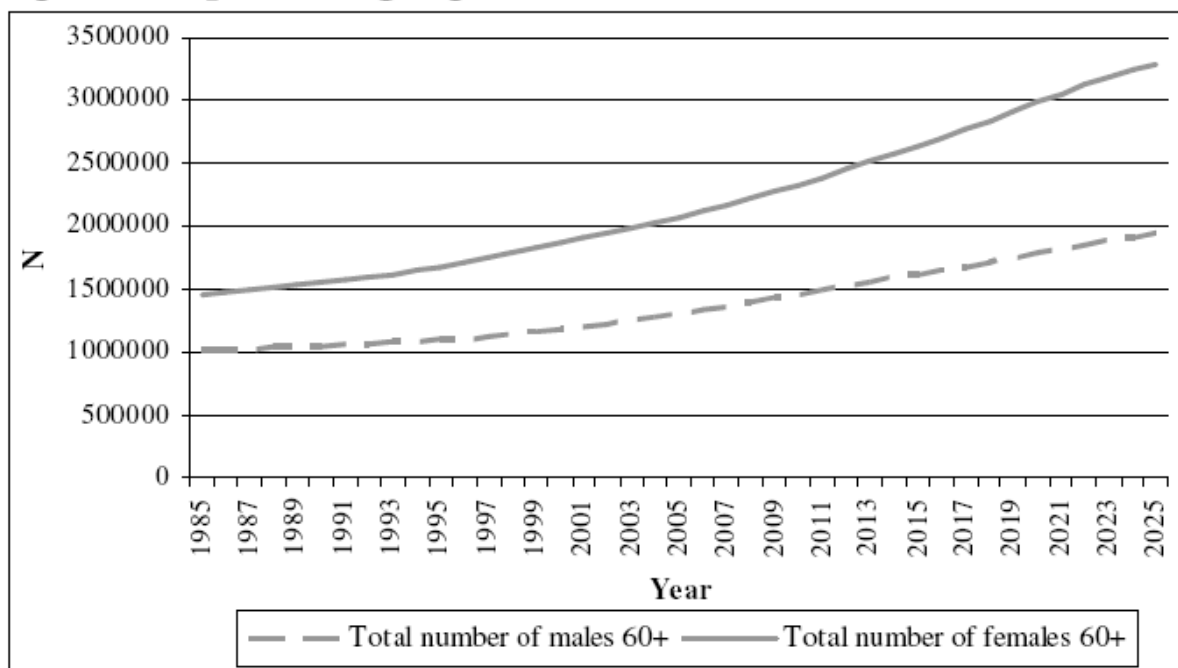


Source: ASSA2002, Joubert & Bradshaw, 2006

### 2.4.2 Proportion of women versus men

The proportion of older persons in South Africa varies considerably between the nine provinces as a reflection of migratory patterns, the impact of chronic diseases such as AIDS and other causes of differentials in age structure. More than six out of ten older persons in South Africa are females, who tend to live longer than males and are thus more likely to be widowed and to be living alone than older males. The female proportion of older persons among the population aged 85 years or over is also higher than males (Department of Social Development, 2005).

The graph below indicates the proportion of men to women in all the facilities that were audited.

**Average number of women vs men**

Men ▪ Women

| Province | Men | Women |
|---|---|---|
| Eastern Cape | 15 | 48 |
| Free State | 13 | 49 |
| Gauteng | 37 | 87 |
| KZN | 24 | 47 |
| Limpopo | 13 | 65 |
| Mpumalanga | 17 | 46 |
| Northern Cape | 11 | 32 |
| North West | 15 | 49 |
| Western Cape | 24 | 62 |
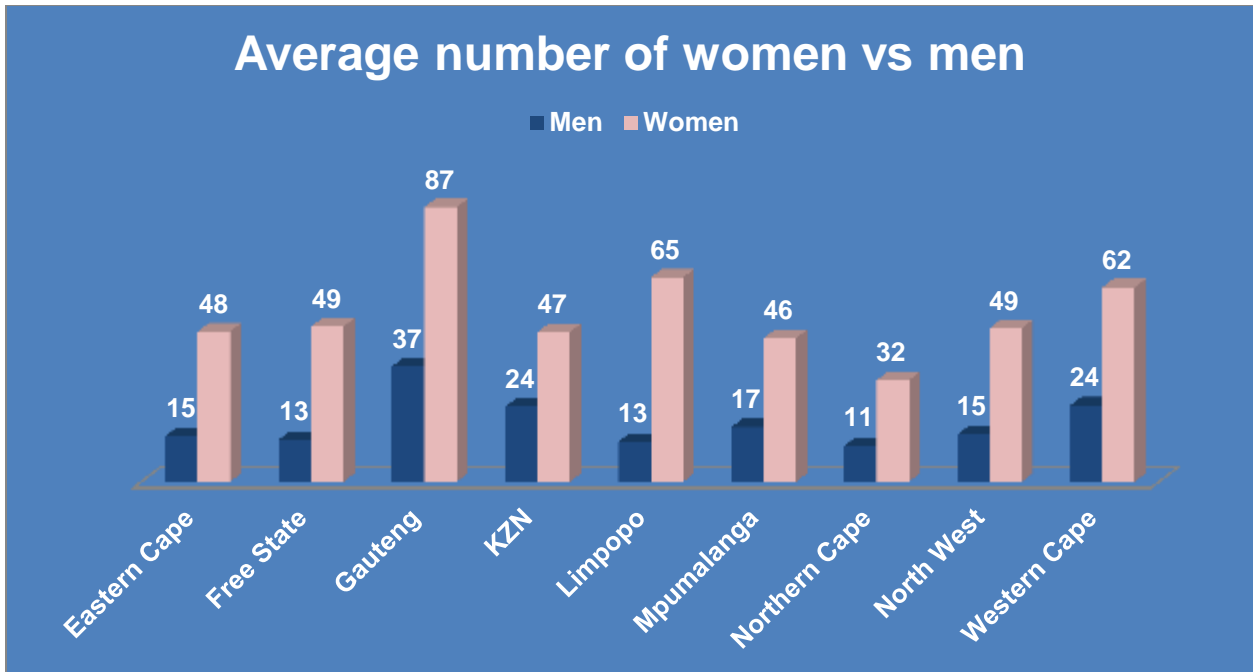
### 2.4.3 Location of homes

Figure 3 shows the distribution of the elderly population within the country across the nine provinces. The Eastern Cape is shown as the province with the largest elderly population (9.2%) in proportion to the total population in the province, following the Northern Cape (8.24%) and the Western Cape with the third largest elderly population (7.8%).

**Figure 3: Percentage of people 60+ as percentage of total population per province**



| Province | % |
|---|---|
| Eastern Cape | 9.18 |
| Free State | 7.31 |
| Gauteng | 6.16 |
| Kwa Zulu-Natal | 6.92 |
| Limpopo | 7.74 |
| Mpumalanga | 6.28 |
| Northern Cape | 8.24 |
| North West | 7.34 |
| Western Cape | 7.80 |
| South Africa | 7.30 |
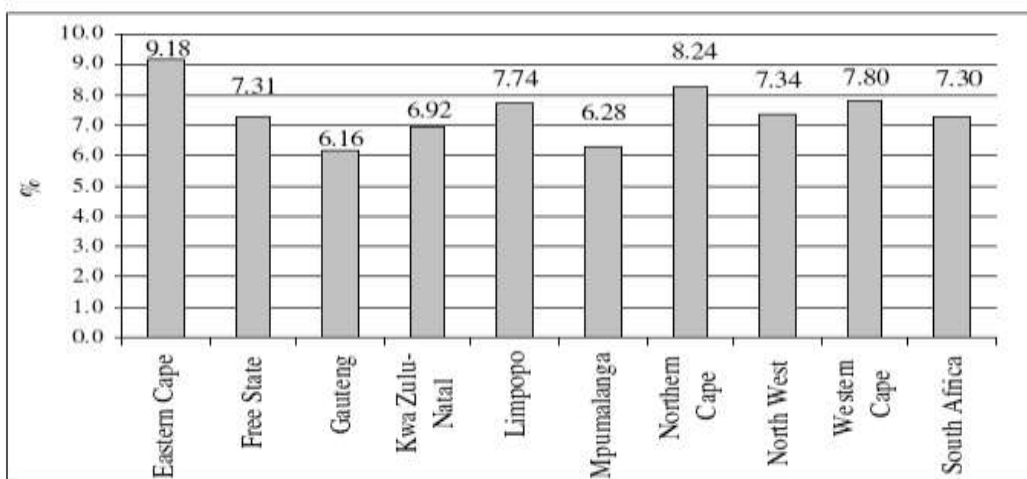
Source: Stats SA, Census 2001 (persons weighted)

Africans comprise 67, 7% of the population of older persons and mostly reside in rural areas. Whites comprise 22, 5% of older persons, which is more than double their proportion in the general population. This is probably attributable to longer life expectancy and lower fertility. Apart from Africans, older persons in other population groups mostly reside in urban areas.

In terms of the overall distribution of older person in South Africa the distribution of old age residential facilities is disproportionate in the wealthier provinces of Gauteng and the Western Cape, with a distinct lack of facilities in poorer provinces such as Limpopo, Eastern Cape and Free State. Owing to out-migration and urbanisation amongst younger persons, older persons are disproportionately represented in the most rural and the poorest provinces of the country.  At the same time the audit found that the majority of facilities (79%) are concentrated in metropolitan formal areas or small urban formal areas.  Only 5% are in informal or squatter areas while 16% are in rural areas.

### 2.4.4 Homes in proportion to the Population

A study conducted by FEM Research Consultants in the Western Cape is indicative of the situation in the rest of the country, where the number of homes for older persons is disproportionate to the population in the province.
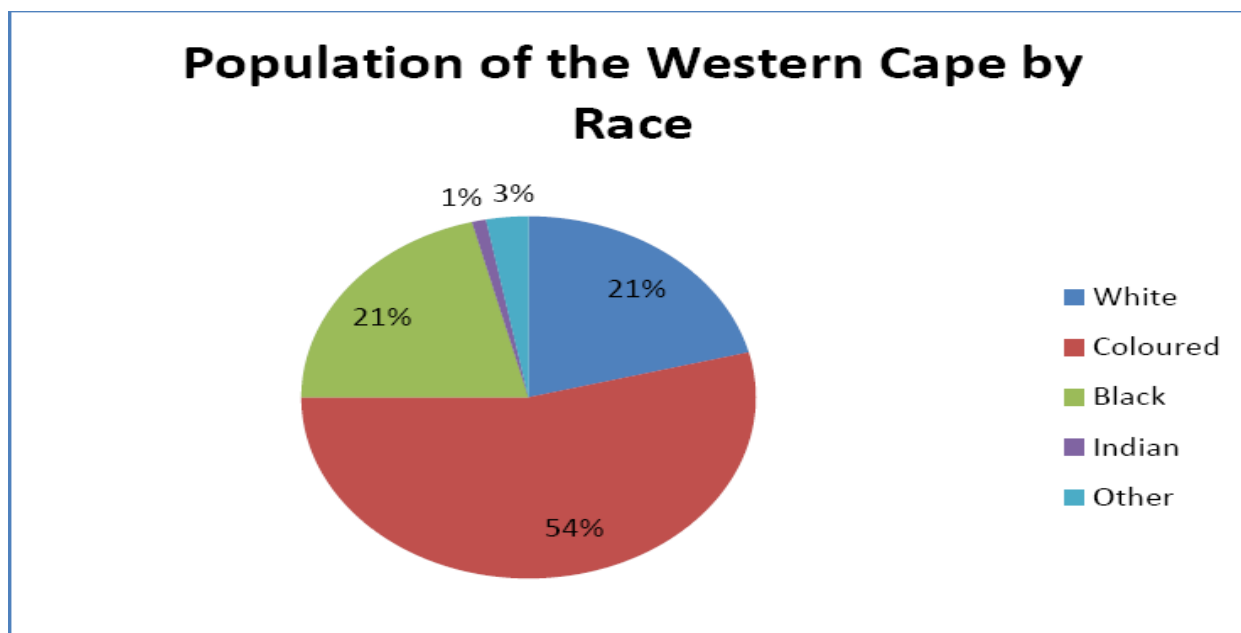
**Racial Demographic in HFA**
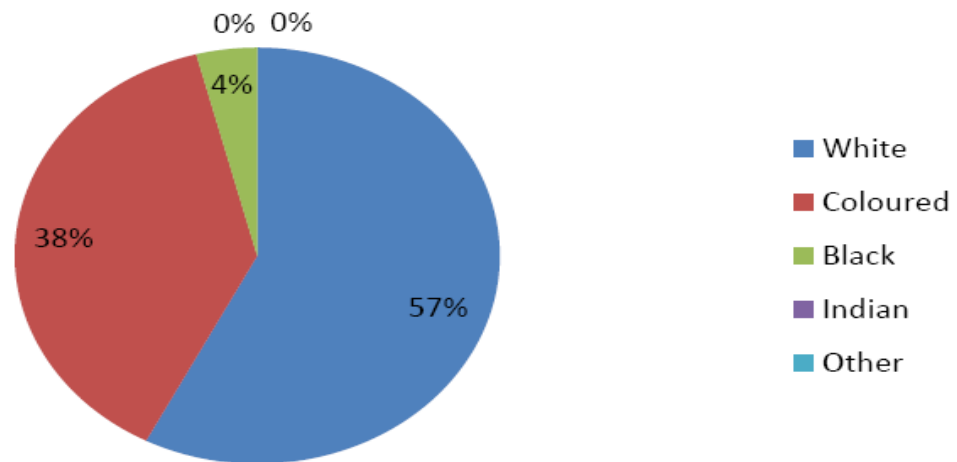


The study shows that the "…racial proportions in Homes for the Aged (HFA) do not match the racial proportions of the Western Capes population. The coloured demographic of the Western Cape is 54% of the total population, yet HFA are only 38% coloured. Likewise the black demographic of the Western Cape is 21% of the total population, yet HFA are 4% black. Whereas social norms and cultural factors may account for these mismatched racial proportions, a disparity of this level should not be occurring. As South Africa's demographic continues to change the transformation of HFA will be of paramount importance…"

In support of the above, the graph below indicates where most of the homes are currently located, which is in turn, indicative of the population they largely still serve.

## Where homes are situated
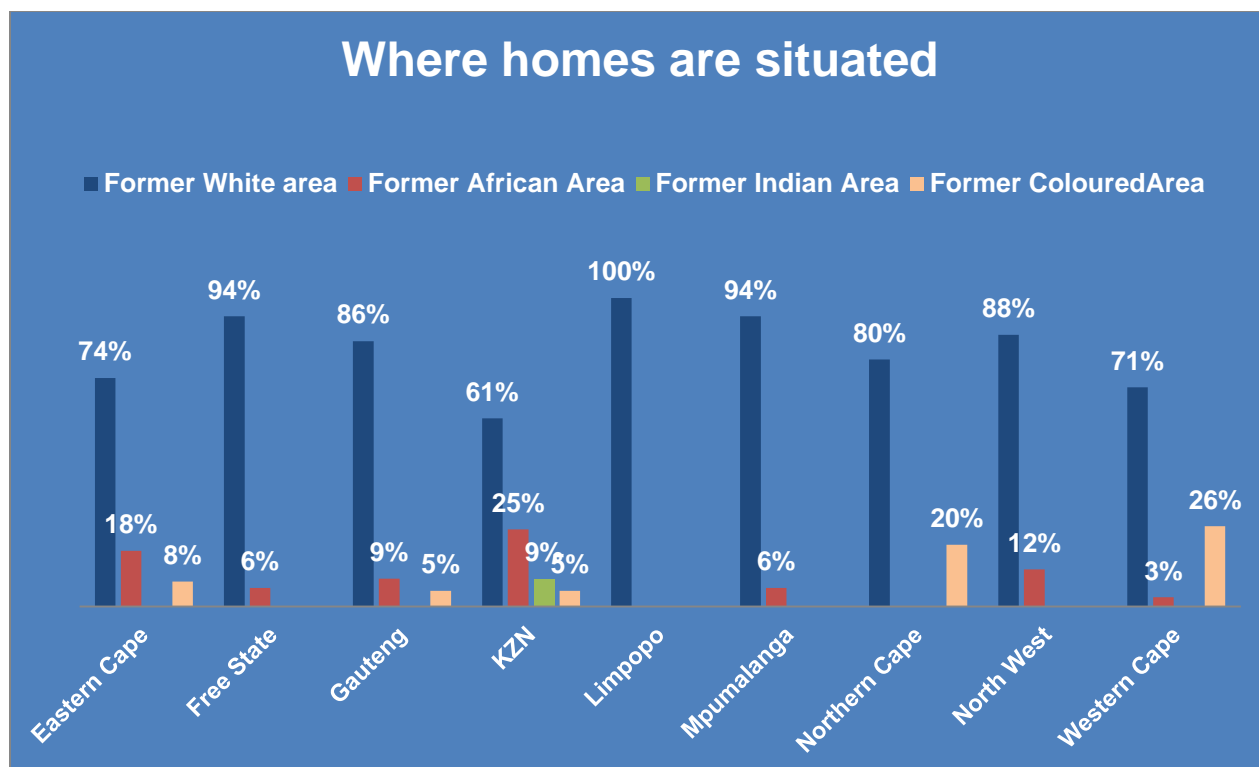
**2.4.5 Management of the homes**

The audit found that the key Service Providers that run large proportions of these facilities are bigger NGOs and in some outlying areas smaller FBOs or CBOs. In addition to providing frail care accommodation and assisted living facilities, such organisations homes provide home help and meals on wheels and they facilitate support groups and luncheon clubs. The bigger NGOs usually have a number of homes affiliated to them. Some of these NGOs are presented in the table below:

### SPREAD OF NGO'S MANAGING FACILITIES

| NGO | NUMBER OF HOMES | PERCENTAGE |
|---|---|---|
| Self Managed | 170 | 41.98% |
| ACVV | 50 | 12.35% |
| BADISA | 40 | 9.88 |
| SAVF | 32 | 7.90% |
| NGMD | 13 | 3.21% |
| SKDB | 11 | 2.72 |
| Methodist Homes for the Aged | 9 | 2.22% |
| Residentia Foundation | 7 | 1.73% |
| **Other\*\*** | **73** | **18.02%** |

***\*\*This refers to NGO's which managed between 2 and 6 homes each***

## 2.5 Legislative Context for Older Persons

The *South African Older Persons Act, 2006* effectively addresses the plight of older persons by establishing a framework and an enabling environment aimed at the empowerment, protection of older persons, promoting and maintaining their dignity, independence, participation, rights, well-being, safety and security.  The Act encompasses the main pillars of the Madrid Plan of Action to which South Africa is a signatory.  The foundation of the Act is the Constitution that establishes a society based on democratic values, social justice and fundamental human rights and seeks to improve the quality of life of all citizens and to free the potential of each person.  The Bill of Rights as set out in the Constitution, acknowledges that every citizen has inherent dignity and the right to have their dignity respected and protected.  The State therefore has a duty to create an enabling environment in which the rights in the Bill of Rights must be respected, protected and fulfilled. The Act therefore consolidates and strengthens existing laws relating to older persons to facilitate accessible, equitable and affordable services to older persons and to empower older persons to continue to live meaningfully and constructively in a society that recognises them as important sources of knowledge, wisdom and expertise.

Turok (2006) notes that these basic rights have now been laid down in law which means that all government departments and organisations serving the elderly will be obliged to observe and respect these rights. Most important issues emphasised in the Act are access to community based care and support services within a supportive environment, the regulation of residential facilities for older people, and protection against abuse, ill treatment and neglect. In order to address and follow through with these issues, an integrated South African Plan of Action on Ageing has been developed by the Department of Social Development since they are a lead department in the provision of services to older persons.

The purpose of the *Plan of Action on Ageing* is to facilitate intersectoral collaboration amongst government departments and to define roles and responsibilities of government departments and civil society in the provision of services to older people. The aim is for older people to remain independent, active and contributing citizens in the community for as long as possible. This will hopefully ensure that older people are treated in a dignified and respectful manner by service providers, family members and members of the wider communities in which they live.

While the *guideline for frail care services* adopts firstly a developmental approach towards ageing as well as the new approach to ageing which requires that frail older persons remain in the community for as long as possible, the Department acknowledged that there will always be those older persons who will need residential care due to circumstances. Therefore, the 2% of older persons in public and private residential facilities (old age homes), and frail care units in retirement villages are covered in this guidelines (as well as the 3% of frail persons in the community that will benefit from day care and home-based care services. The primary purpose for developing a guideline is to ensure that quality services to frail older persons living in frail care facilities and communities are accessible, affordable, comprehensive and equitable.

In compliance with the Act, in 2008, the Department produced a revised document on the *national norms and standards* for the acceptable level of service that must be provided to older persons. These norms and standards prescribe the acceptable levels of services that should be provided to older persons and in terms of which services must be monitored and evaluated. Any person who provides a service to older persons must comply with the norms and standards.

It is against this backdrop that the next section presents the findings of the national audit.

# CHAPTER 3    FINDINGS OF THE STUDY

## 3.1 Introduction

These findings will be assessed against the Older Persons Act, SA Policy on Older Persons as well as the Guidelines for Frail Care and the National Norms and Standards regarding acceptable levels of services to older persons and service standards for residential facilities. It is important to note that across the provinces only 61% of management and 26% of staff knew about the new norms and standards. The lack of knowledge of these norms and standards was also reflected in the current practices in many of the homes.
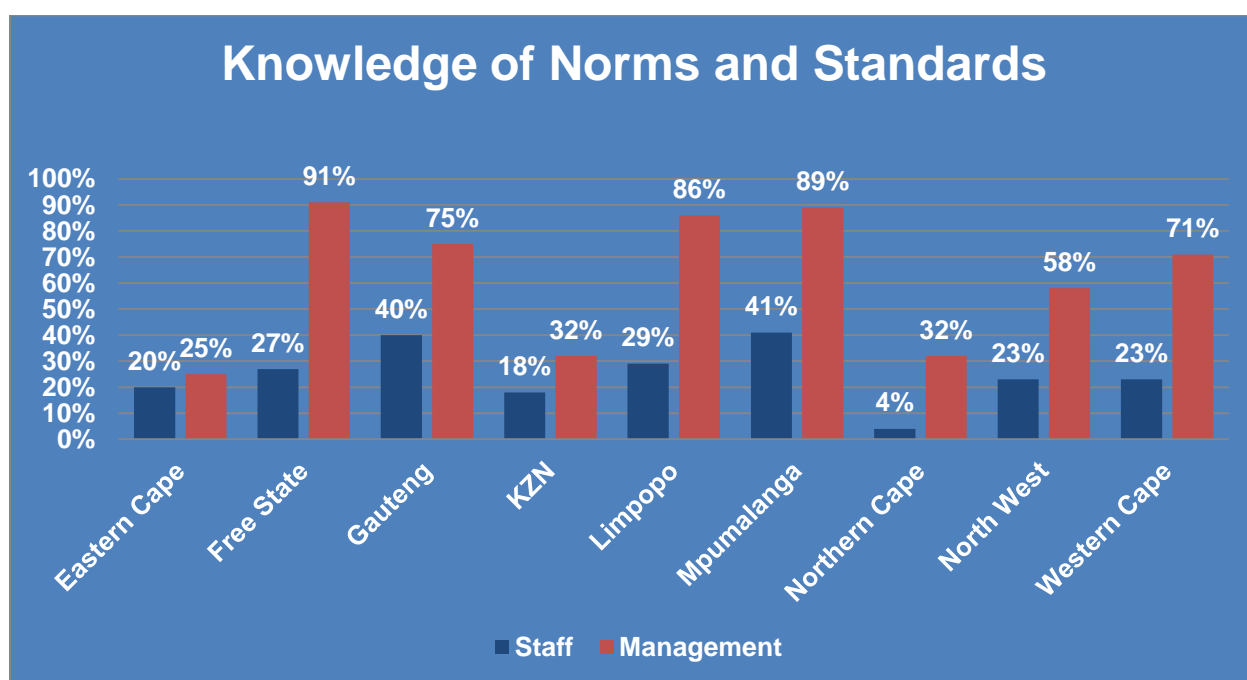


Four hundred and five (405) homes were audited in total. A few homes that were subsidised by the Department refused to be part of the audit; in addition, some homes that were on the original database had become private and were no longer receiving a subsidy and were excluded as a result.

The breakdown of these homes is as follows:

| Province | Number of residential facilities |
|---|---|
| Eastern Cape | 49 |
| Free State | 33 |
| Gauteng | 85 |
| Kwa Zulu Natal | 44 |
| Limpopo | 7 |
| Mpumalanga | 18 |
| North West | 26 |
| Northern Cape | 25 |
| Western Cape | 117 |
| **Total number of homes audited** | **405** |

## 3.2 Findings

### 3.2.1 Medical Services in frail care facilities

*The Older Persons Act and the National Norms and Standards for acceptable levels of services for Older Persons states that the following services should be provided at residential facilities (important to note that the Act says might provide instead of must provide)*

"***24hour care and support services to frail older persons*** *who need special attention, care and supervision services to older persons who are suffering from dementia and related diseases and rehabilitation services".*

It is important to note though that this information relates to those residents that were not on a private medical aid and were therefore not able to access medical services as they needed it. This is one of the most distinctive features of the medical care that is afforded to those with private medical aid as opposed to those who are dependent on state hospitals. In most of the homes it was reported that a District Surgeon previously visited the home to attend to the medical needs of the residents but that this service was stopped by the Department of Health. However in some Provinces a District Surgeon still visited some of the homes in that province so it appears

that the decision for terminating this service or reducing its frequency might rest at the provincial Department of Health rather than as a mandate from the National level.

> "*In relation to **care and supervision services to older persons with dementia and related diseases** the norms and standards states that basic care protocols and programmes should be in place.*

While most of the homes (88%) offered care and supervision services to older persons who are suffering from Alzheimer's and dementia from anecdotal evidence most homes were of the opinion that they were not suitably equipped to deal with these residents. This is both from an infrastructure point of view by not having a separate section to accommodate them as well as not having sufficient and appropriately qualified staff to deal with residents who suffer from Alzheimer's and dementia.
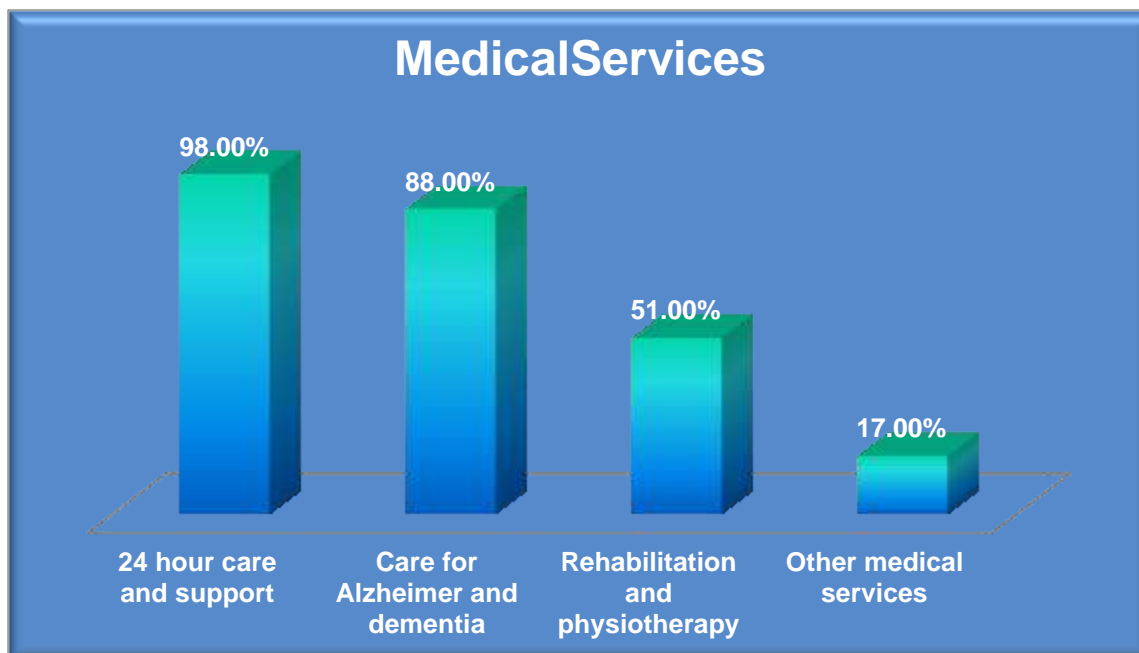


> *With regard to **rehabilitation services** the norms and standards states that physiotherapy and occupational services should be provided when applicable, and that **assistive devices** should be provided.*

Just over a half (51%) of homes offer physiotherapy and occupational therapy to residents who might have had a stroke, an onset of a disability and other physical or mental conditions that need a rehabilitation programme. More homes in Mpumalanga (72%) and the Free State (70%) offered these services while in the Eastern Cape only 31% and Kwa Zulu Natal only 34% of homes provided this service.

In terms of mobility aids and assistive devices such as walking sticks or wheelchairs, being available 81% indicated that they had enough while 18% indicated that they had these devices available but that it was not sufficient. At least 4 homes indicated that they did not have assistive devices available.
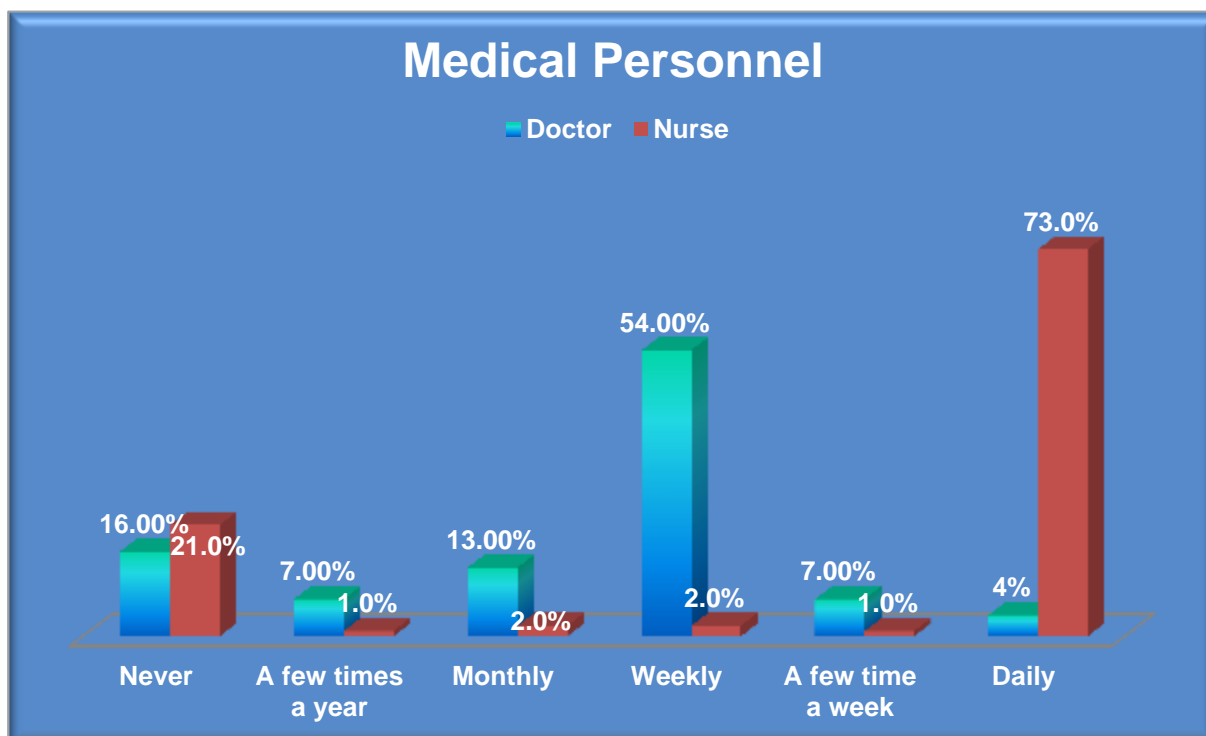


While 98% of the homes indicated that they provided 24-hour care and support to frail persons, this did differ from home to home. In at least 16% (65) homes a doctor never visited, while in 4% (16) homes a doctor was available on a daily basis.

*The norms and standards provides some formula to work out how many staff are required to take care of each person in a frail care facility. For example 30 frail residents would require approximately = 13 staff units as follows:*

*33% nursing sister = 4 (50 % can be replaced with staff nurses)*

*66% nursing assistants = 9    (50% can be replaced with care givers)*

It was quite alarming therefore, that in at least 21% of homes they never had access to a nurse, with some provinces much higher such as Eastern Cape (49%), Free State (33%) and North West Province (65%). This means that these homes probably rely on nursing assistants and caregivers.

*Public hospital services:*

In the majority of homes the residents had to access medical services such as a doctor, medicines, a physiotherapist and occupational therapist at their nearest hospital. While in 81% of homes there was a hospital available within a 1-10km radius, in some provinces the hospitals were more than 50km away from the home. In the Free State out of 33 homes, 11 were more than 50km away from the home making access to medical care very difficult. The lack of transport was a problem in many of the homes so in the case where homes did not have appropriate transport for the residents, they relied on family members who were easy to access, or on an ambulance from the Department of Health that was very unreliable. In almost all the homes they indicated that even where an ambulance fetched the resident, they would not return then to the home when they were discharged.

Information received from all respondents across the provinces, there were numerous complaints received by older persons who are forced to use the services of government hospitals. They are reportedly not treated with dignity and respect; have to wait for many hours to be assisted. Many complained that they waited long hours and often returned from a full day at the hospital without having been attended to by a doctor, or receiving medication.

In the SA Policy for Older Persons it notes that *"…A Ministerial Committee was appointed in 2000 to investigate the neglect, ill-treatment and abuse of older persons. It found services for the elderly in hospitals and clinics to be less than adequate and heard many complaints about the attitude of staff to older patients, the shortage of medicines and assistive devices, the lack of transport and long out-patient waiting times…"*

It is therefore very concerning that since 2000 the situation for older persons using the public health system remains the same and in some cases might have worsened. Since this provision of frail care for those in need of twenty-four hour care is official policy the division of responsibility between Social Development and Health Departments needs to be clarified. The Policy states

that "…*The Department of Health, through partnerships should provide free transport to state-held facilities with community-based organisations and service centres. Community Health Centres (CHCs) should provide Primary Health Care Services. Hospitals should render secondary services, including specialist geriatric services, to older persons at a specific user fee. Specialist geriatric services should be provided for in-patients (diagnostic and therapeutic care) and outpatients (referral, continuity and condition specific care). Tertiary centres for older persons should provide additional care for complex or rare conditions. Laboratory services, radiography services and other diagnostic support services should be provided at district hospitals…*"

**Medical services offered to the Community**
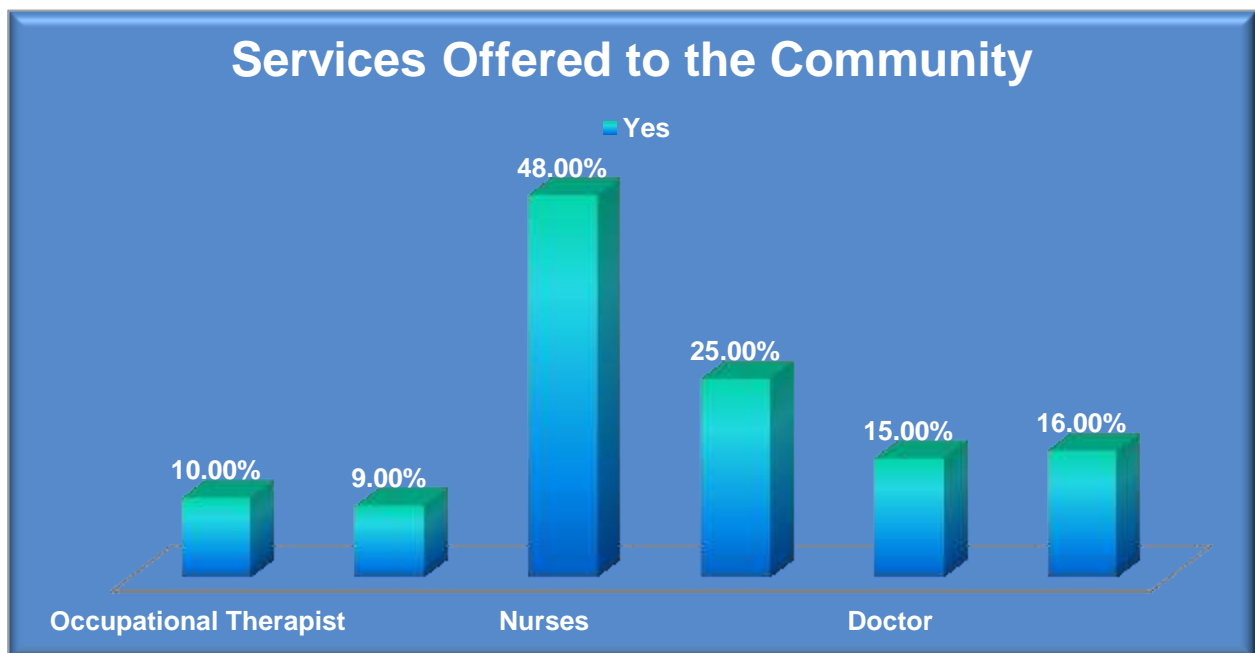


Given the lack of adequate medical care and resources for the residents it is not surprising that in only about 10% of the homes (40) are medical services offered to the neighbouring community; within this the majority (48%) is the provision of nurses to the community.

## 3.2.2 Social, Recreational and Outreach Services

*Social work services:*

> *The norms and standards states that there should be "…a program for Counseling services to residents and family members who need these services..."*

The graph below indicates that only 41% (165) of the homes had a social worker so although 77% indicated that counselling was available to residents very often the counselling was provided by the local church leaders. It was argued that this was not professional counseling but in the absence of a social worker, they seem to rely on the local religious leaders to provide counselling and emotional support.
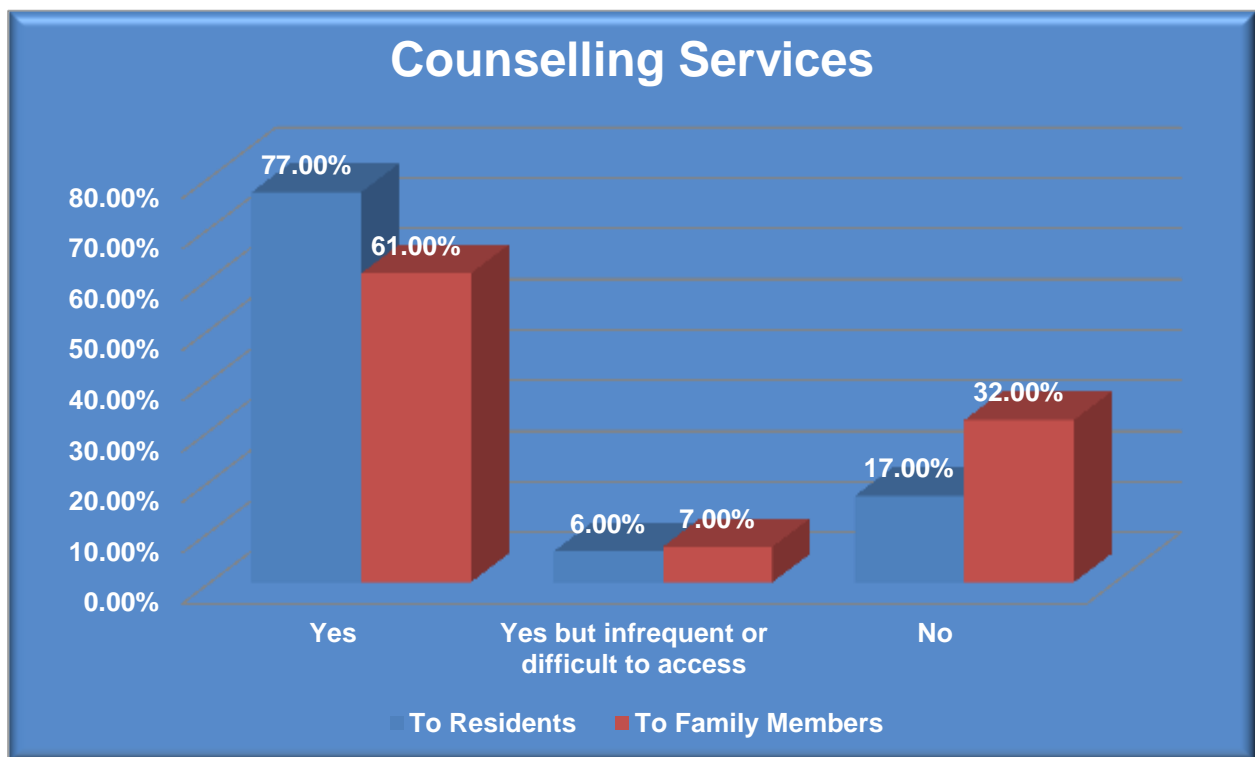


The meeting with the key informants in the Directorate Partnerships and Finance in Gauteng (changed to Institutional Capacity Building and Support) indicated that they "…fund the NGOs for a certain amount of social work posts so that they could service the homes…Where these homes are not part of a 'mother body' individual homes are provided with a social worker internally (20%) and for the community (80%)…" This issue is quite serious as a number of homes reported that its residents have suffered from a history of abuse and violence in their homes and communities and as a result are suffering from the effects thereof.

### Cultural and recreational activities:

> *It is further noted in the norms and standards that regular programmes appropriate for the needs and limitations for the persons being cared for must be implemented, that all persons should be out of bed at least twice a day and appropriately dressed and finally that they should participate in organised activities, including but not limited to reading, radio and TV, religious and cultural activities.*

Although all homes provided some form of social, religious, cultural and recreational activities, many focused on religious activities. This was especially the case where homes had a strong affiliation to a particular church. Activities such as guided exercises (64%), guided reading and cultural activities (73%), entertainment and recreation (73%) and religious and spiritual activities (74%). Some of the more popular activities include: games (i.e. dominoes, cards, puzzles, and bingo), exercises, arts and craft, TV, radio, sing-along events, reading, outings and church based activities (i.e. prayer meetings, bible study)

Many homes argued that they did not offer much recreational programmes because the frequency and intensity of it depends on the level of frailty in the home. While this is indeed the case a home in the North West Province provided a good practice model for social, cultural and recreational programmes in which the Recreation Officer provided a range of activities involving frail residents as well. If these activities could not be done in the recreation room it was taken to the wards so that frail residents could participate even from their beds.

### Outreach services:

> *The norms and standards state that "…older persons should maintain their independence through the provisioning of day care services, home care services and short-term residential placement and care services…"*

**Outreach Services Provided**
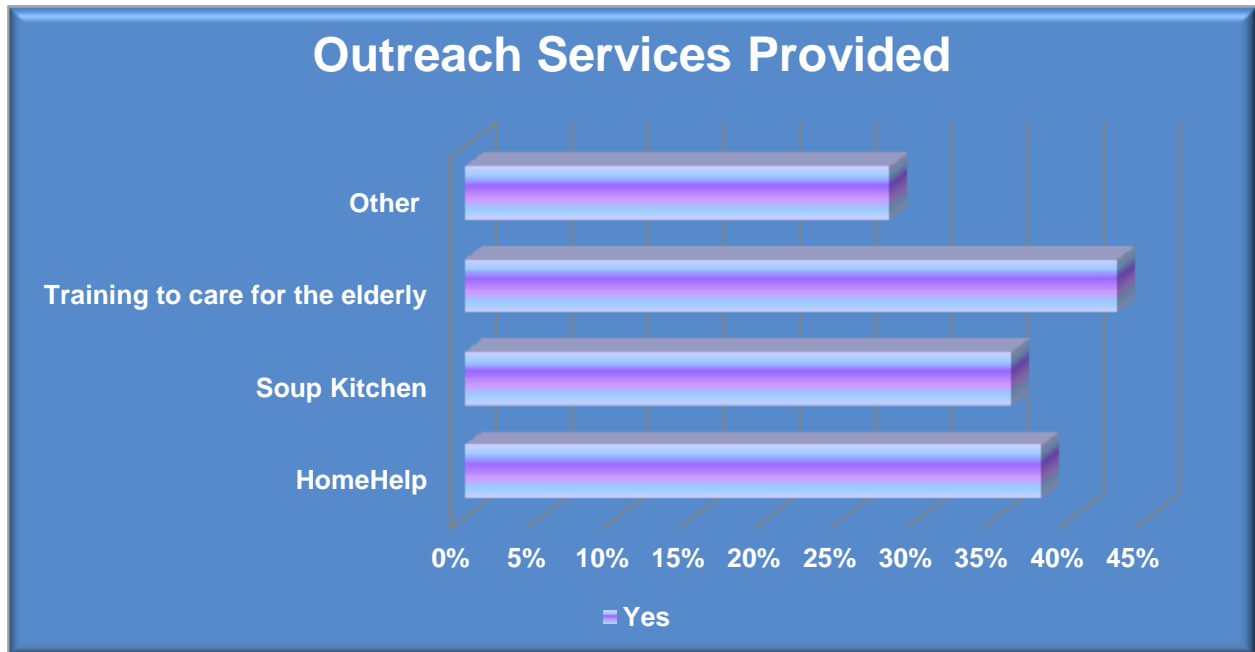
A number of homes provide some form of outreach to neighbouring impoverished communities. At least 38% of the homes (153) provided home help services, 36% (145 homes) provided a soup kitchen and 43% (174 homes) provided training to care for the elderly. These programmes are generally provided by the homes themselves while the guidelines state that "…Programmes should be offered in conjunction with relevant departments, to train, develop and support home-based carers and the families of frail older persons in the surrounding community…"

*In terms of the guidelines facilities should offer at least one outreach programme which is needed in the neighbouring community.*

### Subsidised beds and respite services

*The norms and standards states that "…there should be provision of beds for the temporary accommodation of older persons at risk and that respite care should be available as per the need for such services…"*

With regard to providing subsidised beds to other older persons in the community in case of an emergency, 45% of the homes did not provide this facility while 55% of the homes provided subsidised beds either all of the time or at certain times only. The guidelines indicate that at least

one bed should be set aside for short-term care of abused older persons or older persons at risk. These beds should be subsidised.

*The guidelines indicate that short-term respite care for a maximum of one month per person or home-based care should be available for the relief of family carers or in case of an acute condition.*

Just over 62% homes (250) provided respite care to caregivers of older persons in the community who need a temporary break from their task of caring for an older person. This means however that at least 36% (145 homes) do not provide this service to caregivers in the community.

### 3.2.3 Policies and Procedures

*The norms and standards reflect a number of policies and procedures that are required in order to assist the homes in having a standardised approach to admissions, statutory requirements, code of conduct for staff and caregivers to mention but a few*

The majority of the homes operated with a number of policies and procedures in place. These were verified during the 2-day audit. In some instances there were homes that had very few policies in place. In addition, there were sometimes big differences between management's knowledge of the existence of polices and those of the staff. Often these policies were verified during the audit process which meant that there were definitely policies in place but staff were not informed about it, or lacked sufficient knowledge about the policies.

## Responses on policies from management and staff

■ Management ■ Staff

| | Are there admission criteria | Are there formal assessment tools for admission | Is there a constitution | Is there a code of conduct for staff |
|---|---|---|---|---|
| Management | 97% | 97% | 98% | 95% |
| Staff | 90% | 88% | 69% | 92% |
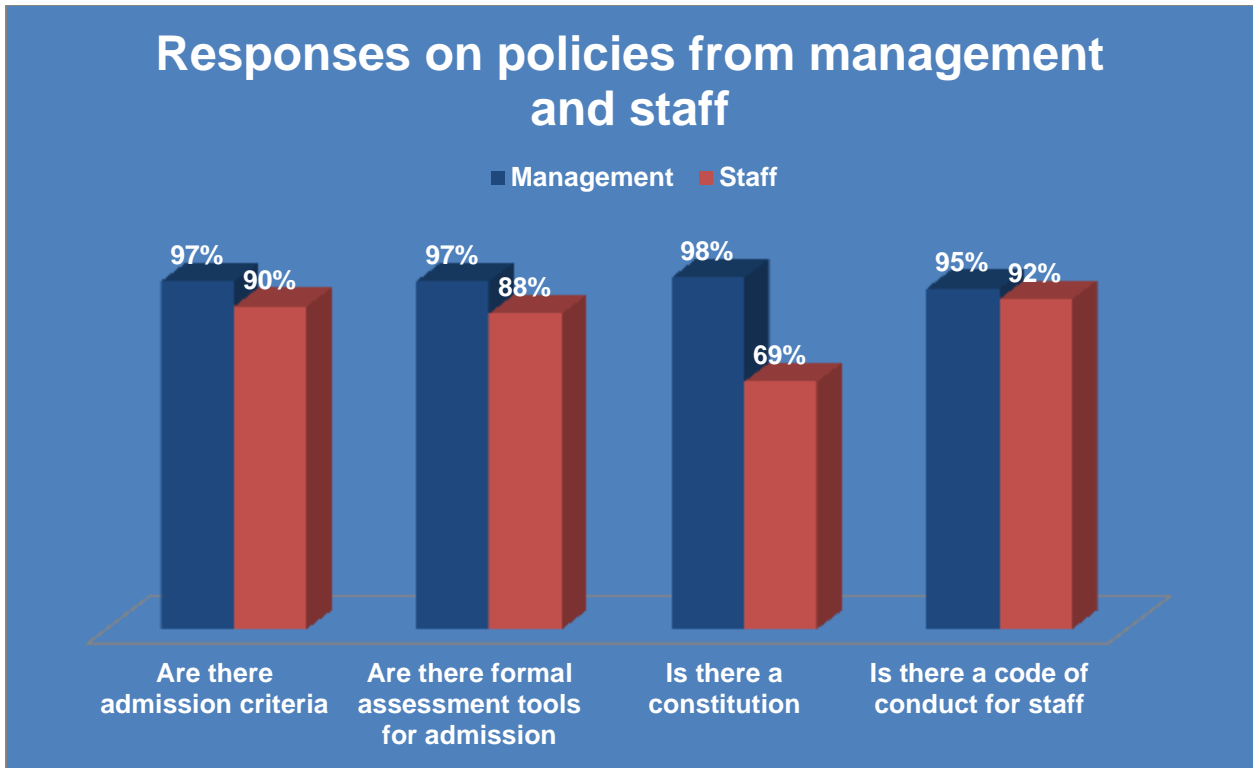
i. **Admission** – There are formal assessment tools used for admission, which included a doctor's certificate and a financial statement of the applicant. Most of the homes use the DQ98 Departmental assessment form. Although most of the homes had a service level agreement signed with the Department a number of homes (36) did not have these agreements signed as part of their renewal with the Department. This created a lot of anxiety amongst the homes as they were not sure what this means for them.

*The guidelines note that the homes should have a transformation plan to ensure the facility, its board, staff and residents are representative of the community they serve.*

ii. **Non-discrimination** – None of the homes had a written transformation plan and in most of the homes the status quo has remained with very little attempts at transformation.

All the homes said that their admission criteria were based on non-discrimination. While it was clear that internal policies and procedures including the Constitution were in line with the principles of the Constitution of the Republic of South Africa, and therefore non-discriminatory, the practice in many of the homes was very different. Where homes had given the appearance of having transformed, the following key issues were picked up in homes across the country:

a. Although there were a few homes which had residents of different race groups, this was a very small minority and most homes did not have residents of other race groups in the homes

b. In at least 10 homes there was a physical separation between white and black residents, and there was evidence to show that the residents were not receiving the same quality and standard of service. In these homes they were either put into separate buildings, in separate sections of the same building, or they did not eat together or share the same accommodation.

c. In some homes family members indicated that if the home became integrated they would remove the relatives from the home

d. There was very little sensitivity displayed (and knowledge) of different religious and cultural habits and practices of residents including home language and food preferences.

e. Some homes that had only white residents indicated that when black families brought their relatives to see the place they never returned their applications "…probably because they feel out of place in an environment where there are only white people…" It is clear though that in spite of the reality of cultural and social norms, some homes have been effective in implementing transformation initiatives, while others have not. This disparity may indicate that certain homes with very low levels of transformation would use culture as a major factor for unequal racial proportions.

f. It is also largely because the homes have not made much effort to demonstrate their commitment to transformation so everything in the environment from management to senior staff to residents is mainly white. It is understandable that to place an older person of a different racial and cultural background in an environment that is alienating, can be quite traumatic.

**Capacity vs Total at Present vs Waiting List**

Legend:
- **Total home capacity** (dark blue bars)
- **Total residents at present** (red bars)
- **% of homes with a Waiting List** (green line)

Categories: Eastern Cape, Free State, Gauteng, KZN, Limpopo, Mpumalanga, Northern Cape, North West, Western Cape
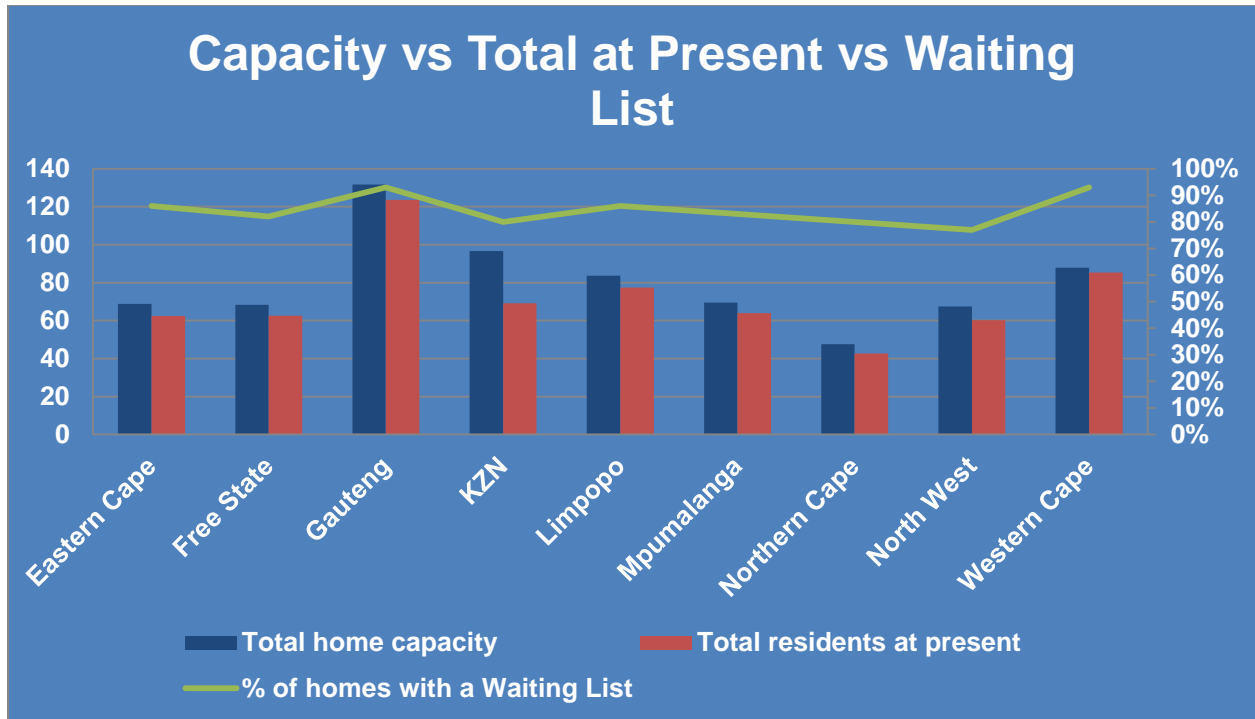
It was interesting to note that while all the homes were below their allowed capacity at the same time they all had waiting list of people that needed to be admitted. In general, the waiting period for admission to a home was less than a year in the majority of cases (89%) while in 2% of cases, it was between three to five years and more than five years respectively.

iii. *Visitation* – In all homes there were procedures for friends and families to access the facilities, and in general these procedures were followed. Proper supervision of visits takes place in most homes (83%) although in 17% (69 homes) proper supervision of visits did not take place, leaving the older person open to harassment and abuse.

**Abuse Incidents Management**
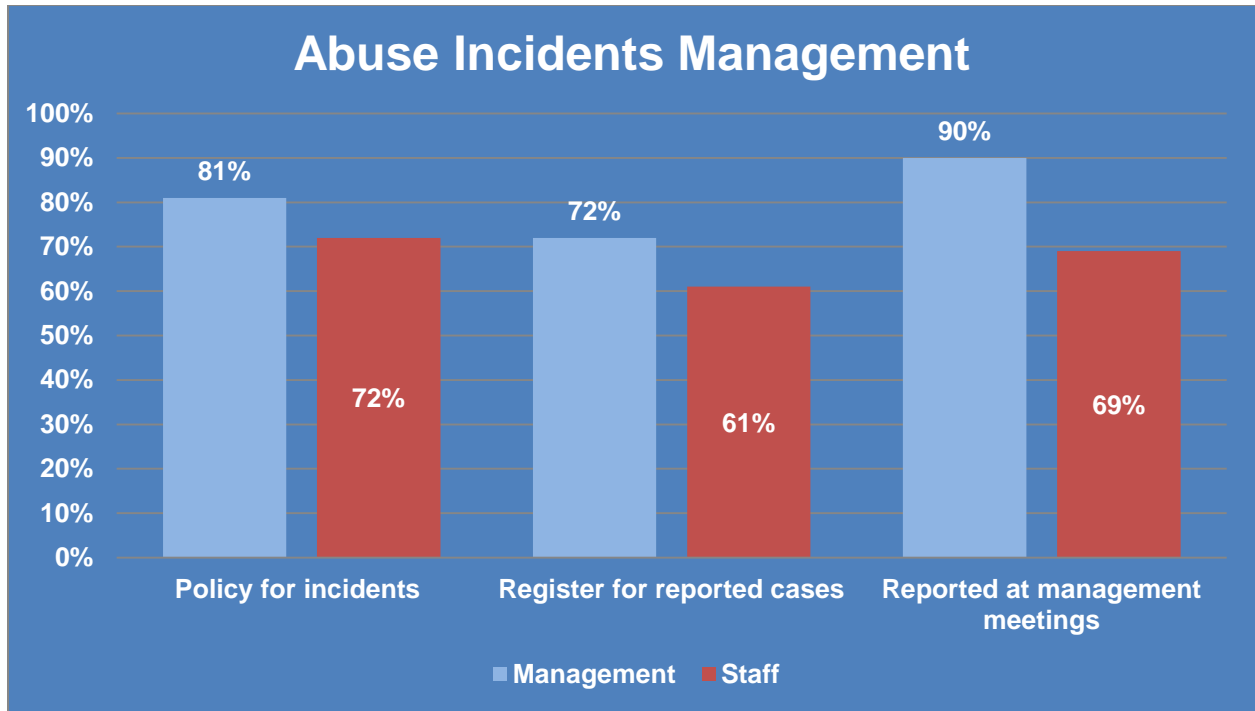
iv. *Abuse Incidents Management*

> The norms and standards highlights the protection of older persons against abuse, neglect, ill-treatment and exploitation…there should be a policy on addressing issues of abuse in the home, a register on abuse and staff and caregivers should be trained on the policy

Particularly as the issue of abuse of older persons is rife and much attention has been received in the media with regard to this, it was noted that over 70 homes (19%) did not have a policy in place to address incidents of abuse. At the same time 113 homes (28%) did not have a register for reported cases of abuse.

Moreover, staff in a number of homes (72%) did not know about the policy to address incidents of abuse, and in 61% of the homes did not know whether there was a register to report cases of abuse. Likewise, in only 36% of the homes nationally (145 homes) did the residents know about this register, meaning that in 259 homes the residents did not know one of their basic rights in terms of being able to report incidents of abuse.

Once an abuse has been reported, it is equally concerning that staff in 31% of the homes (125) did not know that cases of abuse were reported at management meetings.

The guidelines state clearly that there must be a "…written complaint and grievance procedure, which is visible and accessible to residents and the public, and includes a complaint register that is presented to management meetings..."

### 3.2.4 Governance and Management



**Structures Operational in Facilities**

- Manager or Director: 93.00%
- Management board: 94.00%
- Financial Officer: 93.00%
- Representative residents committee: 65.00%
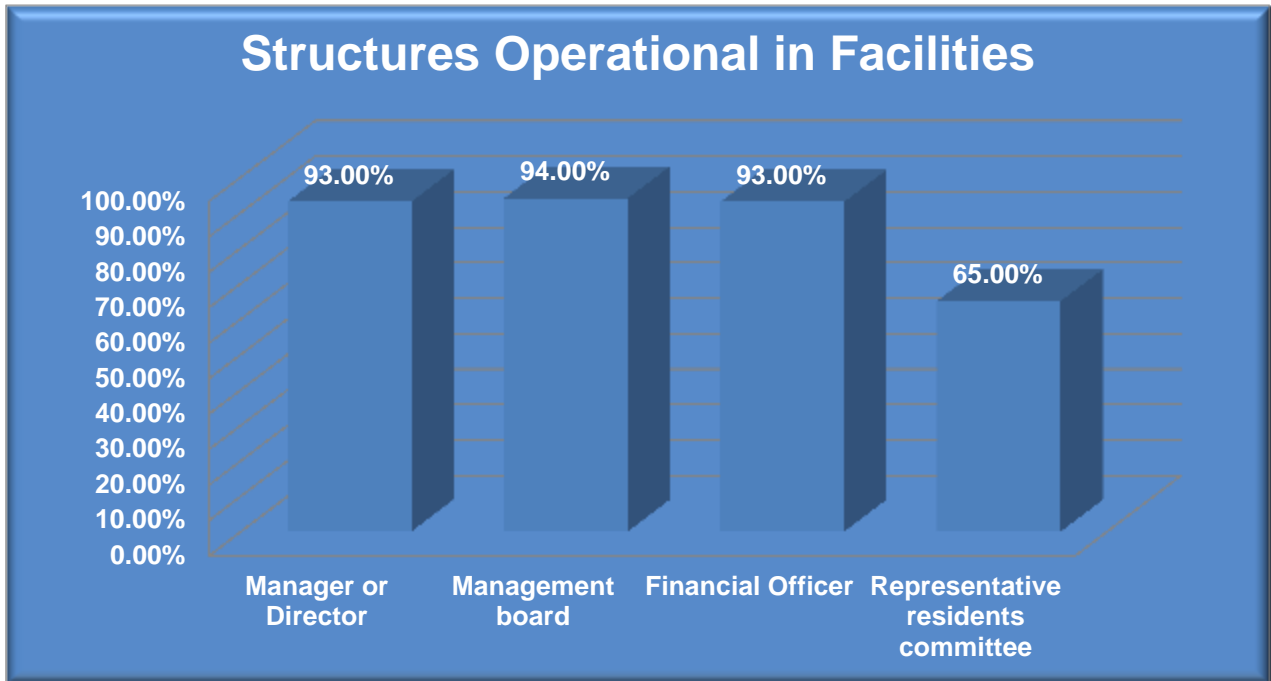
The following structures / officials exist in most of the homes:

i. **Board of Management** – Most of the homes (94%) have a board which was responsible for overall governance of the home.



**Board Length of Term**

- No specified length of term: 23%
- More than five years: 4%
- Three to Five Years: 11%
- One to Three Years: 62%
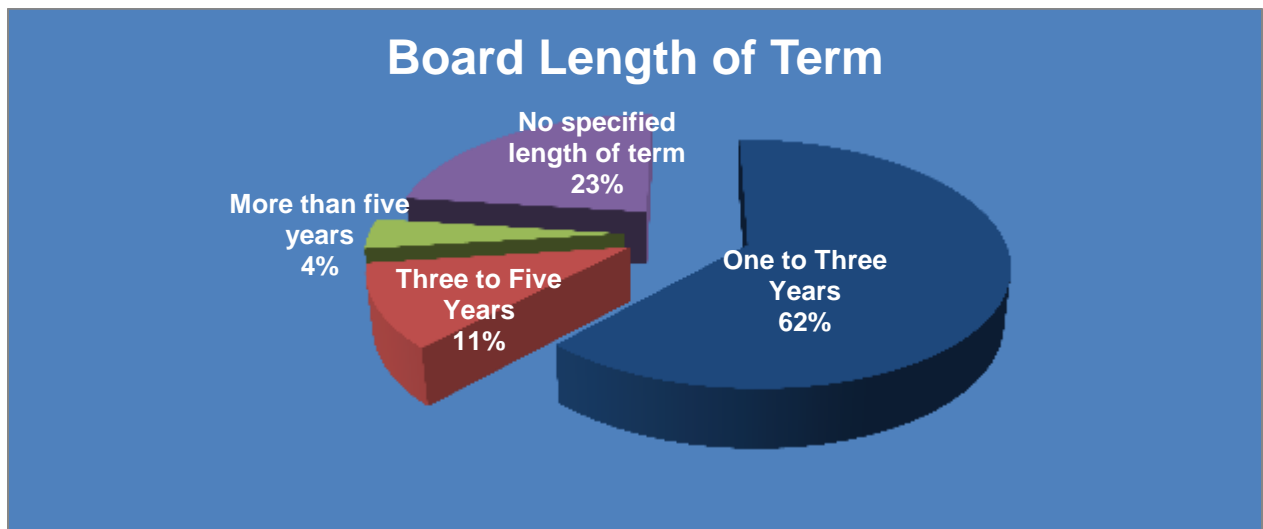
While in the majority of homes (62%) the Board serves for between 1 and 3 years and 3 to 5 years (11%) there were some homes where board members serve for more than 5 years (4%) and for an unspecified length of term (23%). In terms of good governance, it is important that board members are rotated on a regular basis and not serve for more than 2 terms at a time. While this is difficult to achieve as homes often complain that it is difficult to find people committed to serve on the Board, at the same time these homes become 'more vulnerable' to issues of territoriality, blurring of roles as well as a lack of new ideas been generated at the level of the Board.

ii.    ***Director / Manager*** – 93% of homes (376) had a Director or Manager responsible for the day to day operations. In the majority of cases one could easily define the role of the Manager / Director as:

- Day to day management of the facility
- Staff management
- Fundraising
- Community liaison and networking
- Monitoring and Evaluation

It is of concern that in 28 homes nationally there was not a Manager to see to the day to day management; again this makes an organisation vulnerable and at risk if there is not one assigned person responsible for performing this function. In general, the Director / Manager reports to the Board.

iii.    ***Finance Officer*** – Ninety-three percent of the homes (375) had someone who took responsibility for managing the financial records of the home.

> The guidelines suggest that there is a "…*designated financial manager who is responsible for the implementation of a financial strategy, written policies and procedures and an internal and external audit system and … that the financial manager has to comply with PFMA and NPO…*"

### iv. Residents committee

*The norms and standards indicate that there should be an effective residents committee, that regular monthly meetings with proper agendas and minutes and regular reports to the residents should be given. It also notes that members of the residents committee are well equipped for their tasks.*

In only 65% of the homes (263) indicated that they had a Residents Committee that represented the residents and their families. Residents in only 54% of these homes confirmed the existence of a Resident's Committee. A reason for this could be that the Committee is not communicating with all, and therefore not representing the needs of the residents. Alternatively that they have been selected by a few people in management and peers so that the homes can account for a Residents Committee but that they do not serve the purpose of such a Committee. In one home the Director attends the Committee meetings which were seen as defeating the purpose for which it was set up, and therefore, her presence is intimidating to the Committee. In most of the homes where these committees exist, it was not very organised with some of them meeting on a monthly basis and others meeting twice a year.

v. **Role of the Board versus that of Management** – The following responses reflect that the role of the Board and that of management was not always clearly defined or understood.
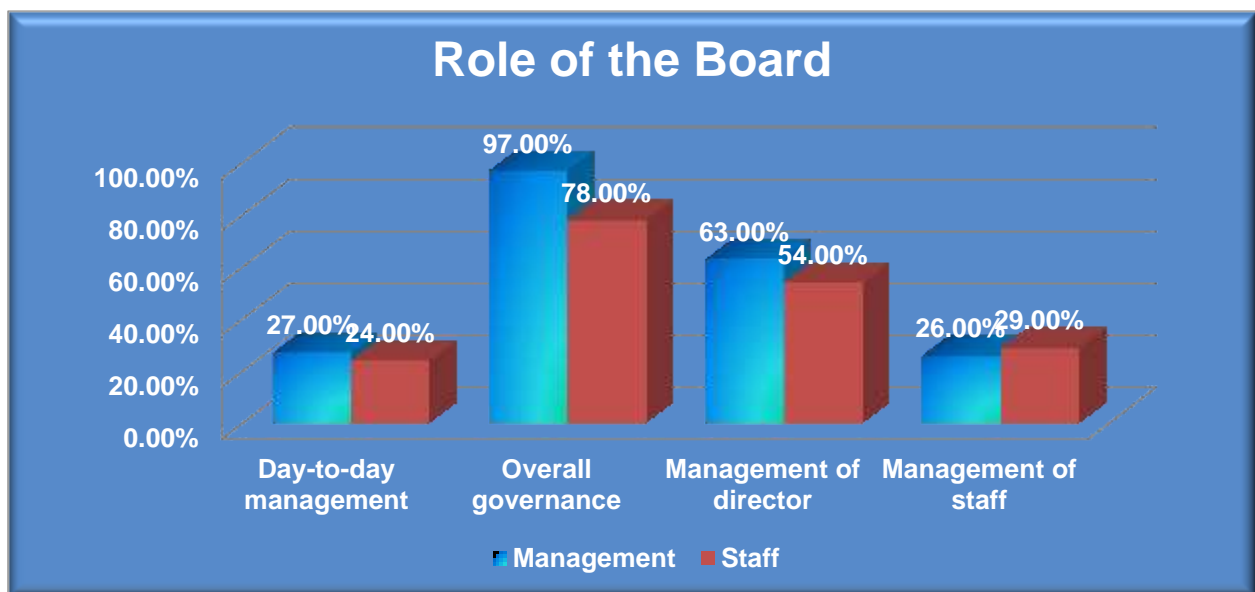
The graph indicates that staff for example in 24% of the homes saw the role of the Board as day-to-day management while in 29% of the homes they saw the Board as being responsible for the management of staff. This blurring of roles is usually the cause of many problems in organisations and also creates division between management and staff.

The management of the homes was rated as follows by management, staff and residents:



In general, the majority of board and management rated the management of the homes as either excellent (55%) or good (41%). However, in over half of the homes staff rated the management of the homes lower with 36% rating it as excellent and 40% as good. Staff in 24% of the homes rated the management of these homes as fair (16% - 65 homes) to poor (8% - 32 homes). In many of these homes the relationship between staff and management was poor. This issue will be further elaborated under the section on Institutional Issues.

### 3.2.5 Staff and Volunteers

Staff members at a residential facility form a very important component for an efficient and effective service. Coupled with qualifications and experience, is personal characteristics, attitude and the devotion to duty. These attributes ensure good quality service for older persons. At the same time when staff conditions are not conducive to their well-being one often finds that they become unhappy and as a result do not give the home the best that they can. Having said this,

however, in many homes the residents particularly commended the nursing staff and caregivers for their care and commitment.

The discrepancies between the views of management and staff were more seriously highlighted in this section where in the majority of homes their views were responses were contradicted by staff.  Some examples are demonstrated in the graph below:
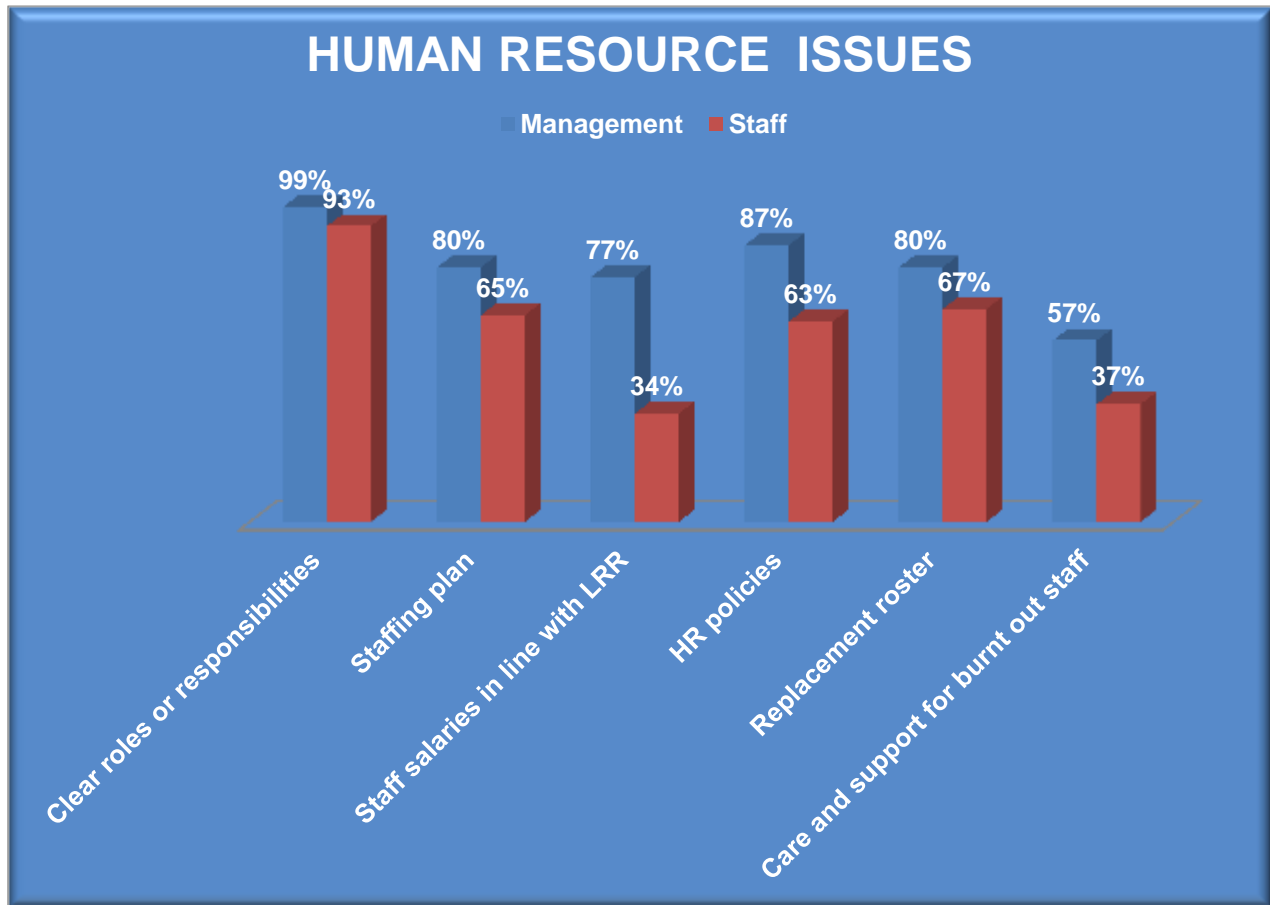


i.       ***Clear roles and responsibilities*** – Although the staff in 93% of the homes (376) indicated that they had job descriptions with clear roles and responsibilities, it was acknowledged by both management and staff that the lack of funding meant that there were fewer staff to do all the work, and often staff had to do more than what their job descriptions defined. The shortage of staff in one province *"…it was particularly noted that the shortage of nurses and care workers compelled staff to start washing residents from around 2am every day…"*

ii. **Staffing plan** – The Guidelines states that there must be a staffing plan identifying the number, categories, desired qualifications, experience, remuneration bands and benefits of staff. While in 80% of the homes management indicated that there was a staffing plan, staff in only 65% of these homes knew of a staffing plan.

iii. **Salaries** – This was a hugely contested issue within the homes. While management in 77% of the homes indicated that salaries were in line with Labour Relations, staff in only 34% of the homes agreed with this. Anecdotal evidence from staff meetings clearly indicated staff unhappiness about salaries with allegations I some homes of racism and discrimination for the same job positions and no salary increases for staff in some homes for many years. An example is where someone who has worked in a home for the past 20 years still earns R1 000 per month.

iv. **HR Policies** – While the majority of homes (87%) had an array of HR policies in place it was clear that in only 67% of these homes did staff know about these policies. These include policies for recruitment, selection and appointment of staff, screening of all prospective staff (for criminal and abuse records, qualifications, etc.), and an induction programme for all new employees.

v. **Replacement roster** – Staff were of the view in 67% of the homes that there was often not a replacement roster when staff were ill or had a family emergency and that the work was distributed amongst other staff. Management in 80% of the homes indicated that they brought in replacement staff when a staff member could not attend to their work duties due to illness or family emergencies.

vi. **Care and support for burnt out staff**: While the Guidelines indicate that there must be a care and support plan for burnt-out staff, in 57% of the homes management indicated that they did have a plan, even though it was not written while staff in only 37% of the homes indicated that such a practice existed.

In one province, management indicated that they ensured the well-being of their staff by insisting that they take their leave and through staff outings and team building activities.

vii.  **Outsourced staff** – A number of homes are now using outsourced staff to fill key functions within the homes, most notably, staff nurses, nursing assistants and domestic staff. The issue with using outsourced staff is that the agencies do not provide these staff with any benefits. Many argue that the rights of these workers are compromised through these agencies and the homes do not need to take any responsibilities for the appointment, payment, and management of the staff. If they are not happy with a staff member the agency would simply replace them.

viii.  **Use of Volunteers** – In the more rural areas there was more community involvement and fund-raising efforts, particularly from the Afrikaans churches and the local farmers. In the urban areas it seems that community interaction was around fundraising whereas in smaller towns community interaction was more obvious and the community volunteered more of their time in helping with nail care, taking old people shopping, and so forth. It was particularly noted that volunteerism in these communities should not be under-played particularly as white Afrikaans churches and farming communities provide lots of support to homes as part of their voluntary or charitable work.

ix.  **Staff Performance Assessments and Staff in-service training** – Monitoring staff performance is a key component of any well functioning organisation. Again management indicated in more instances that staff performance assessments were done while staff on the other hand, indicated in much less homes that these took place. In Mpumalanga and Northern Cape the differences between management and staff on the issue of performance assessments was in as many as 30% of the home. Only in Limpopo did staff and management agree on this issue, although this could be indicative of the fact that there are only 7 homes in this province, although the differences between the views of management and staff in relation to staff in-service training in Limpopo is particularly high as can be seen from the graph below.

*The Guidelines makes reference to regular supervision sessions between management and staff including accurate staff records, and annual staff assessments*

**Are there staff records and Performance Assessments**

Eastern Cape: Management 69%, Staff 58%
Free State: Management 88%, Staff 61%
Gauteng: Management 77%, Staff 67%
KZN: Management 66%, Staff 55%
Limpopo: Management 71%, Staff 71%
Mpumalanga: Management 100%, Staff 71%
Northern Cape: Management 72%, Staff 40%
North West: Management 77%, Staff 65%
Western Cape: Management 89%, Staff 78%

■ Management ■ Staff
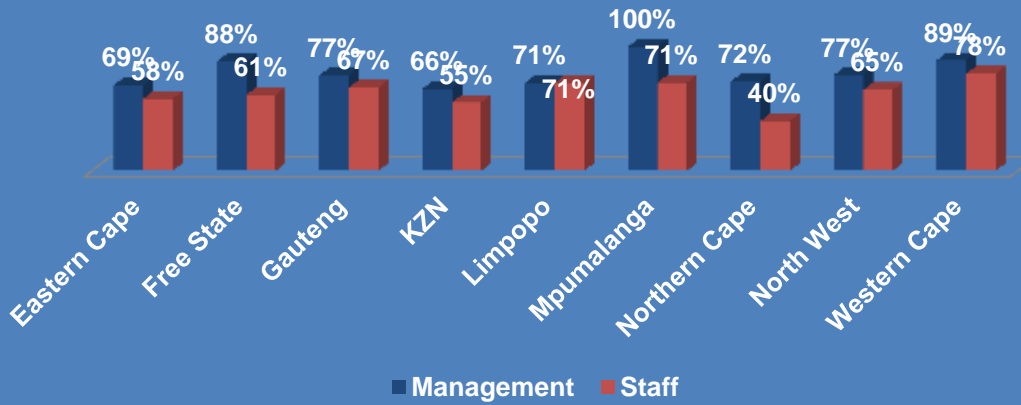
It can also be assumed that in many instances staff performance assessments are not done because according to many staff they have not received any salary increments for many years.

x. ***Staff in-service training*** – was provided by 18 homes (72%), although in only 7 homes did staff indicate that there was in-service training for them. Staff assessments were done in 18 homes (72%). According to staff responses in only 10 homes (as opposed to 18) were staff assessments done.  In only 10 homes (40%), is care and support provided for burnt-out staff, although staff in only 2 homes (8%) indicated this to be the case. In only 13 homes (52%) there is a replacement roster when someone is ill or has a family emergency.



**Is there in service training**

Eastern Cape: Management 78%, Staff 54%
Free State: Management 100%, Staff 82%
Gauteng: Management 86%, Staff 68%
KZN: Management 80%, Staff 68%
Limpopo: Management 100%, Staff 57%
Mpumalanga: Management 94%, Staff 82%
Northern Cape: Management 72%, Staff 28%
North West: Management 92%, Staff 85%
Western Cape: Management 97%, Staff 72%

■ Management ■ Staff
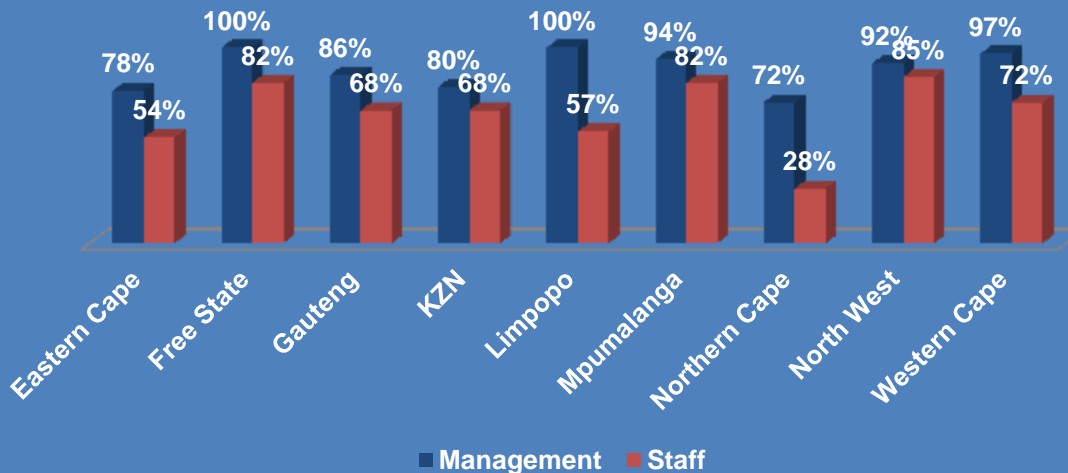
## 3.2.6 Buildings and Facilities

*The norms and standards as well as the guidelines refer to necessary requirements such as a maximum of 4 beds per room, that each resident has a bed with mattress, chair and private, safe and lockable cupboard, that there is an individualised care plan for each older person for whom direct care is provided, a document on the rights of residents as well as a folder or file for each resident with relevant personal and medical information*

### Individual Care

| Category | Percentage |
| --- | --- |
| Each resident has chair and personal area | 92.00% |
| Each resident has bed with mattress | 100.00% |
| No more than 4 residents per room | 85.00% |
| Document on rights of residents | 84.00% |
| Folder on each resident | 100.00% |
| Social and physical care plan for each resident | 86.00% |
| Safe storage area for personal belongings | 94.00% |
| Burial scheme | 85.00% |
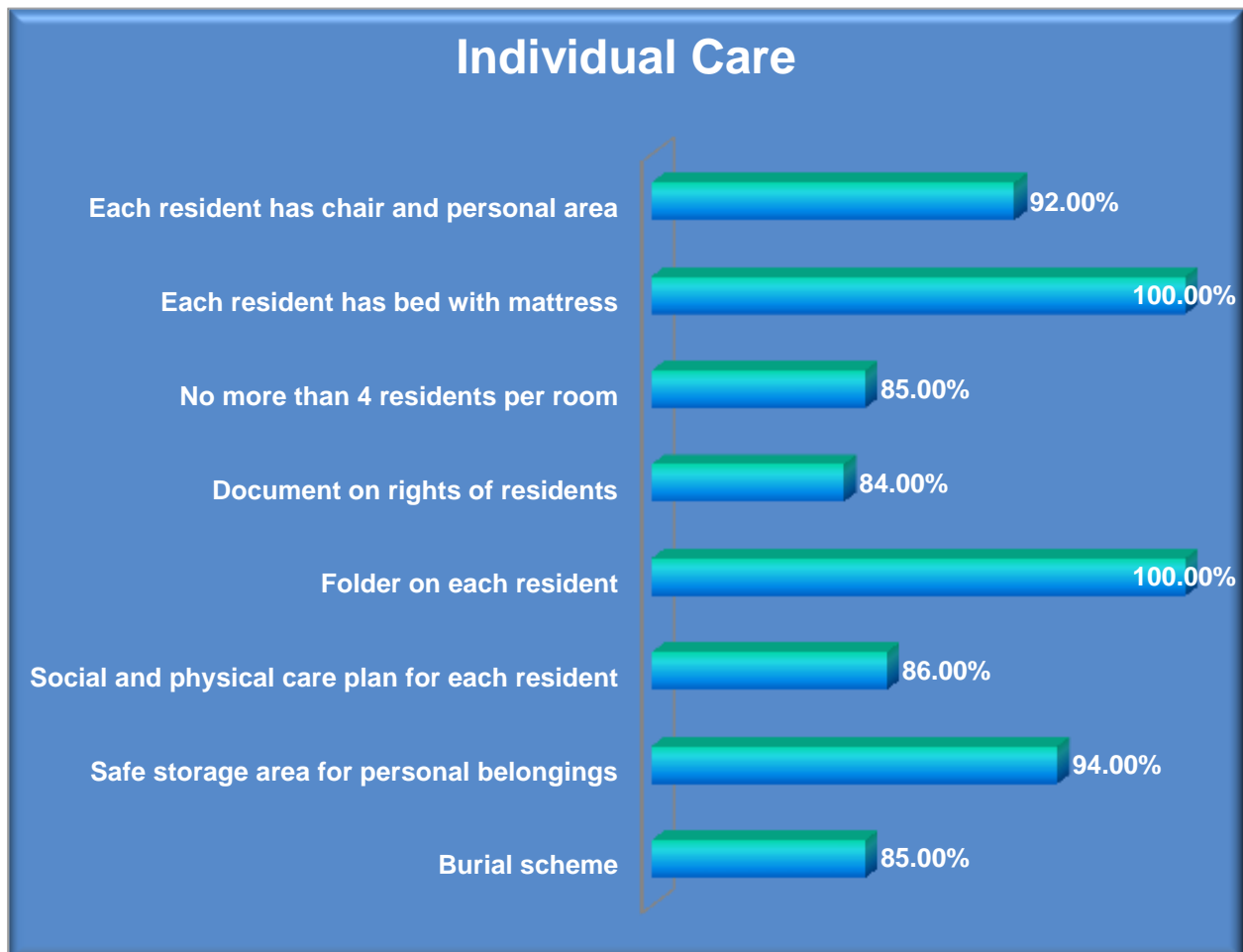
i. ***Individual care*** – All the homes kept a folder on each resident

- 86% of the homes had a social and physical care plan for each resident with relevant personal and medical information (in line with the guidelines).
- In 85% of the homes there were no more than 4 residents in a room
- In all the homes the residents had their own bed with a mattress

- In 92% of the homes the residents did not have their own chair and personal space.
- In 94% of the homes they had their own storage place for their personal belongings.
- A burial scheme existed in 85% of the homes.
- 84% of the homes had a document on the rights of residents and many had not heard of this document.

ii.    ***State of the facilities***

## State of Facilities

| Facility | Percentage |
|---|---|
| Separate recreational space | 94.00% |
| Separate dining area | 97.00% |
| Sufficient clean toilets | 96.00% |
| Food preparation area is hygienic | 99.00% |
| Dining area is clean | 99.00% |
| Separate men and women sleeping and ablution areas | 85.00% |
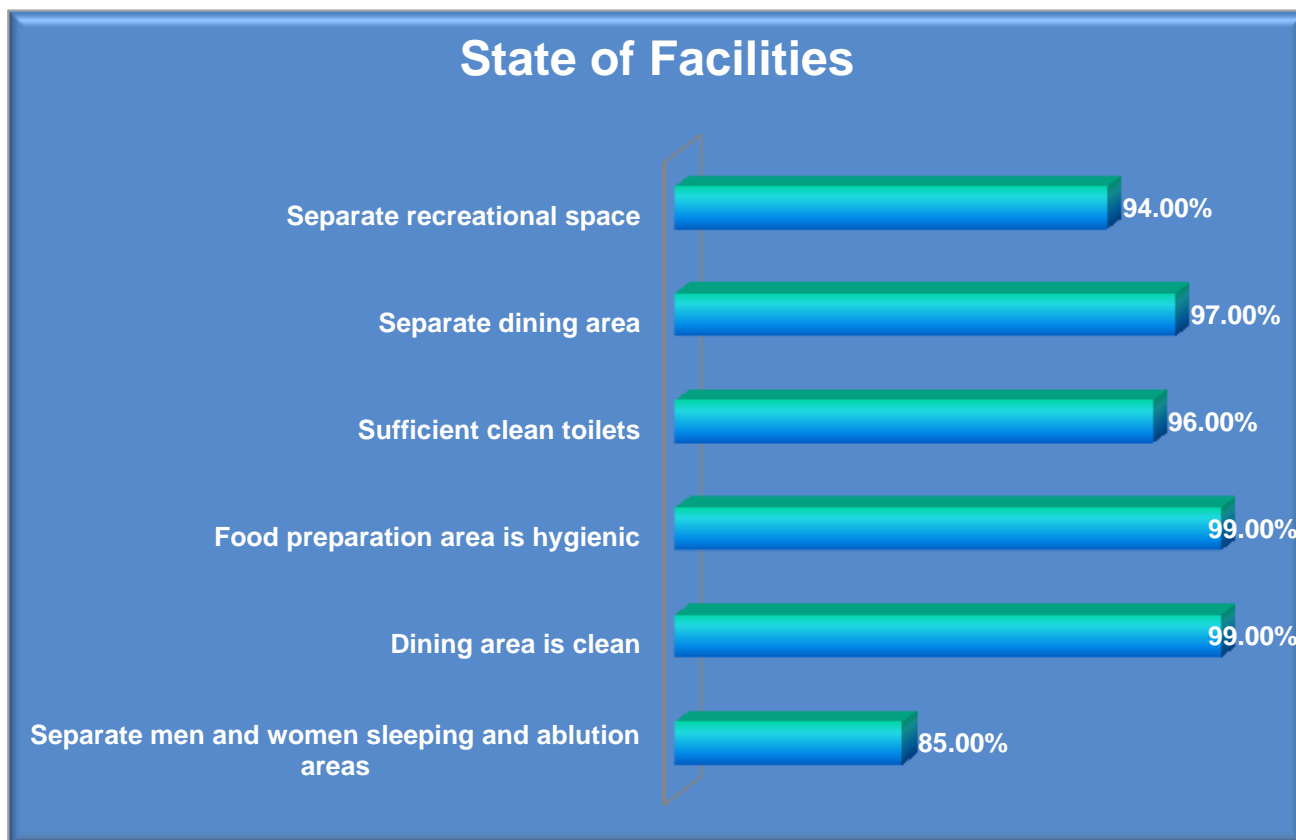
- In 85% of the homes the sleeping and ablution facilities for men and women was separate.
- In all homes there was some separate space for recreation and dining although in the majority of homes there was a separate dining area and a separate area for recreation.
- 98% of the homes had an adequate number of toilets, baths and showers

- In a number of homes the toilets were not clean, and many did not non-slip flooring.
- In many homes the doors were not sufficiently wide enough to accommodate wheelchairs, beds, trolleys and tri-pods.
- In some homes which were multi story buildings there were no lifts.
-  Many homes did not have closed Circuit TV cameras for the frail care section.
- Many homes had no 2-way communication feature.

iii.    ***Health and Safety***
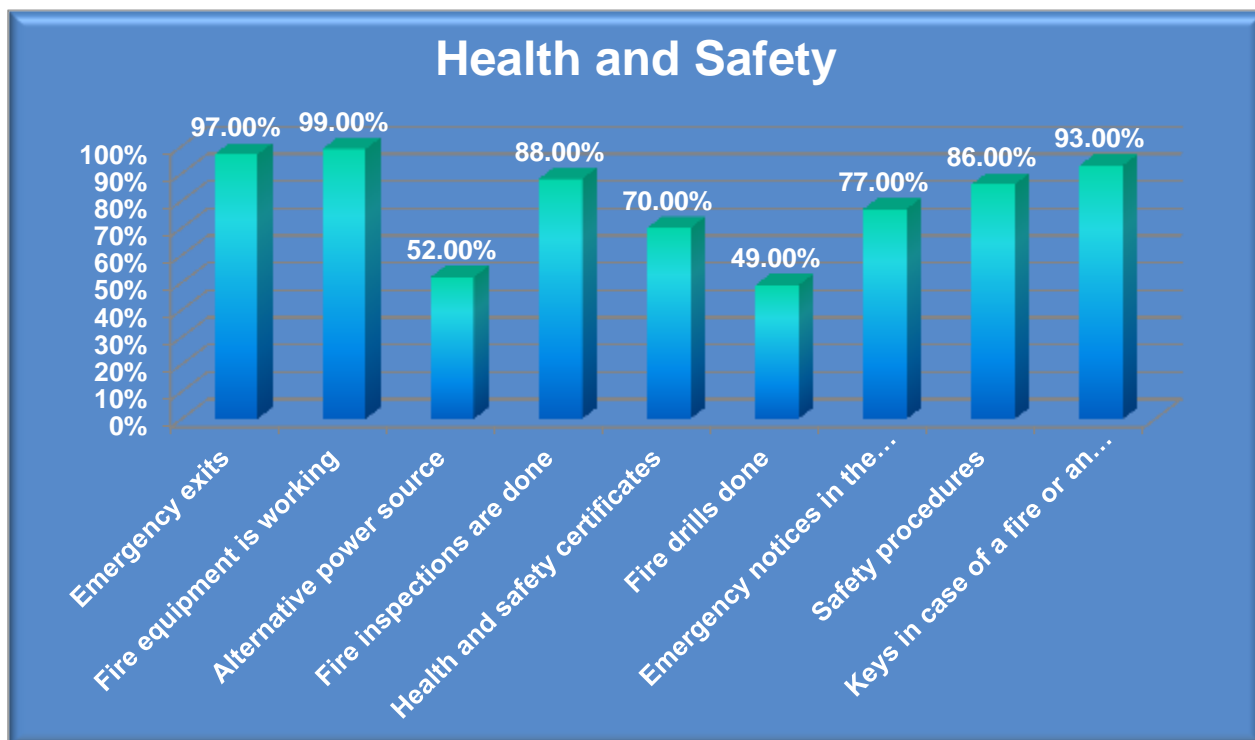


Some homes had elaborate safety procedures in place (one home had a Safety Committee that looked specifically addressed issues of safety in the home).

- It is the 14% of homes (57) that do not have safety procedures that are of concern. Give the recent fires at some old age homes and the lack of preparedness for this, the issue of safety especially in the case of fires becomes a big issue.
- The graph indicates the seriousness of the situation where:
  o    In 12% of the homes (48) fire inspections are not done
  o    30% (121) do not have the necessary health and safety certificates and
  o    In 51% (206) homes fire drills are not done

- In addition, emergency exits were often not accessible by wheelchair, trolleys and tri-pods
- In 48% of the homes (194) there is no alternate power source which means that in the case of a power outage, the residents would not be able to attend to basic needs such as preparing food or having hot water and they would use candles in their rooms which is a serious fire hazard.

*The guidelines indicate that homes should have proper emergency exits, fire equipment and that it must be regularly maintained, alternative power sources should be available in the event of an electricity failure. In addition, a resident safety protocol must be in place to ensure the day-to-day safety of staff and residents and a plan for fire and other emergencies including a designated staff member or team responsible for implementation of emergency plan.*

# CHAPTER 4    KEY INSTITUTIONAL ISSUES

While the previous chapter was based on the quantitative information derived from the completed questionnaires, this chapter is based on the perceptions and experiences of different stakeholders as experienced by them within the home environment and therefore, impacting on them, hence it serves as anecdotal evidence.   It is also based on the observations and perceptions derived by fieldworkers during their 2-day visits as well as some of the information being derived from interviews with key informants from the DSD in a few provinces and at national level.

## 4.1 Role of the Department of Social Development

The following information on the role of the Department at different levels (national and provincial as well as interdepartmental) was extracted from interviews with key informants in the Department.

### a.  National level:

- To develop over-arching policies to improve the lives of older persons

- To provide strategic direction to the Provinces

- To interact and engage with Provinces on a regular basis to share information

- To build capacity of Provincial coordinators

### b.  Provincial level:

In some provinces the Provincial Coordinator interpreted their role as:

i.    Develop policy guidelines around legislation

ii.   Providing guidance in terms of policies, legislation and programmes

iii.  Building capacity of the board and management with regard to implementing changes in policies

iv.   Undertake visits to homes to monitor compliance with the norms and standards as well as monitoring integration / transformation

v.   In some provinces, the coordinators are involved in the screening of applicants

vi.   In Gauteng Regional officials do on-site monitoring on a quarterly basis. There is a DQA (Development Quality Assurance) team which includes a nursing sister from the Department of Health as well as an official from the Department that is responsible for the Home, the M&E department as well as person from the Older Persons Unit. This team would go into a home for 3-4days and conduct a proper 'audit' of the situation in the home. While this visit is supposed to be done once a year in Gauteng it was said that the Department does not have the capacity to visit 85 homes for this amount of time within a 1-year cycle. The attention has therefore been on the previously disadvantaged communities to assist these homes in order to bring them up to standard and to visit other homes only where there are areas of concern.  Included in this process is monitoring the OD plan to see how the homes are implementing this.

vii.   The meeting with the key informants in the Directorate Partnerships and Finance in Gauteng (changed to Institutional Capacity Building and Support) indicated that their key responsibilities included:

a.   Training to the mother bodies to building the capacity of the Boards around financing requirements

b.   Development and implementation of systems

**c.  Regional / District Officers:**

i.   In provinces where there are district coordinators, they have the more direct contact with the homes and the mother bodies monitoring function is largely carried out by them. They in turn report to their respective managers and meet with the Provincial Coordinator on a quarterly basis

ii.   In the Western Cape there is also the M&E unit that does monitoring across all programmes and they also have their own District Officers that undertakes this function.

The following summarises the findings from these interviews as well as interviews with the management of all the homes:

***Duplication and blurring of roles***: In the entire M&E system, it is apparent that there is overlap and duplication of some roles and responsibilities, placing unnecessary hardships on homes that need to keep their focus of ensuring that they manage their homes effectively and deliver a good service to the residents. It seems that a more streamlined and coordinated approach might go a long way to reducing the burden on both the Department as well as the homes.

***Relationship with DSD***: The relationship with the DSD was frequently not very productive and common complaints were as follows:

- The dearth of research studies commissioned by the Department which places undue pressure on homes, while at the same time very little feedback is given to them

- Lack of communication between the Department and the Homes

- Lack of support from the Department in implementing policy, a few homes gave positive feedback while the majority did not

- There has been a general difficulty in getting support of any kind from a social worker. Apart from the counselling and monitoring role of the social worker admissions screenings are now a pre-requisite for all incoming residents and a departmental requirement, indicating that accessibility to social workers is important

- It seemed apparent that there was a good relationship in certain provinces between the DSD and the homes, for example, in some parts of the Western Cape while in the smaller provinces the relationship with the DSD was different.

- Many homes were of the view that the DSD lacked the skills to really add value to their engagement with them and as a result the DSD resorted to a more bullying attitude with the attitude of an 'inspector', to which the homes then retaliated sometimes not in a positive way. In one home everyone was so anxious during the audit and it was explained that this anxiety is as a result of a previous audit experience with officials from the Department. Apparently it was "…an extremely unpleasant experience which, in the words of the Manager, 'resembled a witch hunt' with many derogatory statements being made by officials to management and staff. This experience left the team and residents traumatized with much work needing to be done restore their confidence…"

- The delays in payment of the subsidies often leave homes with serious cash flow problems creating further tensions

## 4.2 Governance

***Composition*:** Through the audit it was very apparent that board structures were still largely white. In a few homes where there were black[1] members they were firstly one or two members amongst largely white members and were very silent with limited participation in the meetings.

Some homes have indicated that they have made an effort to recruit black people to the board. In black homes the boards were mainly from the same race groups, although it is less likely that white people would go to a home in a previously disadvantaged area. In terms of mobility it would usually be black families moving into previously white-designated areas.

Hence, in terms of transformation, the majority of Boards still reflect the dominant area in which they are based, and for which they were previously started. This is also as a result of many of the NGOs working in this sector having a historically white Afrikaans background with strong affiliations to the Afrikaans churches.  It governs issues such as accountability, strategic leadership as well as policy development within organisations.

On this issue FEM Research Consultants in the Western Cape that noted "…Transformation initiatives as they allow for the incorporation of 'fresh' individuals into the governing board. In this regard stagnation may occur in HFA without succession plans. If transformation on the governing board is to take place succession plans and maximum terms of tenure must become part of HFA legislature. Whereas there have been strides towards redressing racial imbalances on HFA governing boards, a increased effort needs to be made before HFA can be truly classified as representative..."

*Role:* In many of the white homes the Board almost plays a de facto management role and it is difficult to say if the Board is effective or if management is doing a good job, at times it was all so enmeshed that staff thought that the Board's role was to manage staff.

The present scenario in some homes is that Managers work in the shadows of the Board with Board members taking on too many managerial responsibilities. There is a need for management to develop the necessary managerial skills and be given the authority to make decisions in consultation with the Board and to know that there is support and confidence from the Board with

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[1] Black refers to Africa, coloured and Indian

regards to the Mangers carrying out their responsibilities; yet at the same time being accountable to the Board.

*Skills:* In general terms the Board members of the white homes were more skilled and brought their years of opportunities and experience to be used to the advantage of the home. In many of these homes board members served on specific committees that utilised their experience in an appropriate way. This was less obvious in black homes where Board members might not have had the appropriate level of skills or experience to oversee the work of the Manager and provide the strategic leadership and governance to the home. The other reality is that more white people are able to offer their services voluntarily as they are less in need of being 'compensated' for the contributions that they make. Many skilled Black people on the other hand, are still building their careers and either not that available or either serving on too many Boards because of the demand for their skills and those that are available might not have had the necessary exposure and experience in serving on Boards.

*Term of Office*: In terms of good governance there is a very undesirable practice in many homes where Board members remain on for an 'unspecified period', which often translates into over 10 to 15 years, and even more in some cases. There are common problems of founding member syndrome where those who initiated the home remain on the board forever, of territoriality and of not allowing new blood and fresh ideas onto the Board.

## 4.3 Management Capacity in Homes

**Composition**: As with the composition of the Board most management and senior levels of staff were white, while in homes in black areas, it was predominantly the same race group of the area in which it is located.

**Skills**: The competence of the Manager is crucial in the homes as this is in turn impacts on critical aspects of service delivery.  The management capacity in many homes was lacking as homes did not always appoint the right person to do this job. One often assumes that someone who is good at their job (being a nurse, matron, social worker) will in turn make a good manager. However, none of these disciplines prepares people to manage effectively, although one could argue that social work training does provide a sound basis for dealing with people.

The homes that fall under the umbrella of larger NGOs such as the ACVV or the SAVF are generally better managed because of the support structure that the "mother body" provides. It was clear that many independent homes have a need for such assistance especially if their boards are unable to provide this support.

In a few black-run homes, the managers did not have the capacity to manage the homes properly and in some there were allegations of mismanagement and fraud. This points to both the lack of capacity of Boards to provide the necessary oversight but in some cases also the lack of management capacity, understanding and experience in these homes about transparent and accountable management.

*Role*: the management of staff is generally a difficult aspect and many homes report some type of difficulty around staff relations. The lack of management experience often meant that managers did not fully grasp the opportunities to address issues such as effective people-management, conflict management and building a cohesive team. Most managers were not aware of diversity-related issues or if they were, this was not demonstrated. The result was in at least 80% of the homes there were big differences between management and black staff.  As indicated earlier the black were largely silent in the group discussions but many requested separate meetings with the fieldworkers, and in cases where they were able to accommodate this request, staff complained about unfair treatment and salary differentials between people involved in the same job. In many homes the racial dynamics amongst staff was very obvious. White staff was very amiable and complementary of management, and their interactions were more with management than with their co-workers.

There seemed to be a lack of proper and effective communication between staff and management in a more general sense, and this was clear from staff in many homes not being aware of policies and procedures that existed in the homes. This was also obvious as DSD indicated that they provided training to the management of the 'mother bodies' who in turn should pass the information on to other managers and staff in the homes, often this did not seem to have happened and the information was filed away.

What made the situation in the majority of homes while management and senior staff were mainly white, the majority of junior staff, caregivers, nursing assistants and domestic staff were probably between 95-100% black. On querying this issue the answer was often "…we are unable to attract good black staff…" However, this practice served to entrench existing perceptions of racism and unequal treatment.  In only one home in the Eastern Cape there was a manager and

some senior staff that were black. Staff was unhappy that the DSD did not see this and complained that the homes produce transformation reports for the DSD where it will reflect that there is many black staff in a home but what they don't see is that the majority of them are at the lowest levels.

## 4.4 Staffing

The required nurse to patient ratio is unfeasible and becoming increasingly difficult to fulfil. In addition professional staff is also being absorbed by the private sector and homes cannot afford to replace these lost skills. Staff indicated that they are over-worked and underpaid. Many homes to not provide a forum for staff to debrief which means that these feelings are internalised and present itself in burn-out, depression, lethargy, low work ethic and poor morale. The absence of communication channels (such as a workers committee or something similar) probably contributes to the type of cold war or stand-off that exists.

On the other hand, there are homes that provide valuable models of care and support focusing on regular debriefing, team building, employee of the month programmes, wilderness trails; these are inclusive of all staff. The attitude of staff in these homes is markedly different from homes that do not provide some form of care and support for staff.

Caregivers play a crucial role in many homes, and are often not trained but have the compassion to care for older persons. However, their role is often undermined, they are unappreciated, poorly paid and not considered as an important component in the home as the professional staff. One home reported the following:

"…*The success of this home can in part be attributed to the acknowledgment of the centrality of the caregiver and their praxis that their human resources are the most important asset. Knowledge, skills, attitudes and motivation of the caregivers are crucial. A key component of the Home therefore is the focus on capacity building of all staff and, according to the staff development manager, self awareness, self esteem and the development of interpersonal skills form an integral part of all aspects of training and development. In the words of the deputy director, 'We have a high standard of care and it comes down to the fact that if you look at these caregivers, their own lives are full of hardships and yet we expect them to deliver the care to a group of vulnerable old people in a kind and compassionate way. Now if we don't actually*

*nurture, train and replenish them in some way how can we possibly expect them to deliver that kind of care…"*

It is also clear that some homes do not provide adequate specialised training for those staff responsible for providing more specialised care such as Alzheimer's and dementia.

## 4.5 Sustainability / Funding

For many homes, the government funding is proving insufficient. At present, funding for HFA is based solely on pension and subsidy rates and only for frail care residents. A number of homes that have very few frail residents receive a small percentage of their funding from the government subsidies and would consider becoming private. There is a concern if this happens as the government loses an important resource that should be used to address the needs of older persons choosing the option of going into an old age home.

The majority of homes are finding it difficult to deliver a suitable level of care, and in terms of meeting the national norms and standards many are unable to fully fulfil the requirements without receiving additional financial support. Hence all homes do the best they can while operating in a difficult funding environment.

Some homes have tried to raise funds from other sources such as the Lottery, National Development Agency and corporate donors but most of the homes do not seem to do this. There was also a reliance especially on white Afrikaans churches to receive donations from church members for the homes or to support the homes in their fund-raising activities. The sustainability of these homes therefore becomes questionable in the long-term and as a result more and more homes are charging rates that far exceed the monthly pension and subsidy. This means that they have a justifiable reason to ensure their continued existence while at the same time excluding many who cannot afford the exorbitant rates.

The capacity of many of the homes must also be developed as part of a sustainability strategy especially with those homes that are in previously disadvantaged areas. This capacity building should focus on building the management and staff capacity to enhance their service delivery and overall management of the home, to provide support in developing the necessary systems, policies and procedures, provide other OD support needed and to offer mentoring to the homes.

## 4.6 Intersectoral Collaboration

The study by FEM Research consultants found that on average, nurses working in homes for older persons receive three times less than those working directly for the Department of Health. Yet many residents in homes require a similar level of care to those in hospital. Furthermore it is often the case that residents are moved from hospital directly to a home. A 'burden' is thus transferred from hospital care to home care. Yet, there is an almost total lack of intersectoral collaboration and cooperation between these two key departments providing services to older persons. The responsibility for the lack of adequate medical care and support for older persons who do not have private medical aid should rest with the Department of Health.

## 4.7 Multiple use of old-age homes

Homes are falling short with the subsidy grant for older persons; therefore a pattern that arises due to gaps in policy is that frail care centres are admitting psychiatric patients with good intention to make up for the short fall in finances. In addition, many homes that offer care and support to Alzheimer's and dementia patients are often ill equipped to deal with these conditions. A few homes have taken in disabled people of all ages as well as psychiatric patients, and often the residents with mental illnesses are mixed with others

This negatively impacts on residents because psychiatric patient's moods affect older people in frail care, as was witnessed during the fieldwork.  It also presents a danger to the residents and the staff who are not equipped to deal with psychotic or aggressive patients.

## 4.8 Basic Service Delivery

Homes in especially poorer rural and outlying areas experience the added challenges of not having access to basic services such as water supply. This was quite prominent in Limpopo and the Free State, where there was not a constant supply of drinking water so homes that are able to have to purchase huge water tanks to store water because this basic service is either lacking or not reliable. In one home in the North West they spent a month without water and no access to a water tank and only survived this ordeal through the generosity of a farmer that assisted the home.

## 4.9 Transformation

While the issue of transformation, or the lack thereof, is addressed in some sections of this report, a few additional issues need to be addressed. The Transformation Guidelines indicates that the critical elements of transformation in relation to governance are as follows:

- Management structures that reflect the demographic profile of the region and the province they serve
- There needs to be a balance between demographics and effective management
- Demographic profiles of communities to be reflected in management structures of organisations (skills transfer, capacity building, transparent processes etc.)

If one were to take the above literally, it is easy to assume that transformation is happening especially as many communities have remained intact since 1994 with few areas reflecting changes in the demographic profile of the community. Hence, on the surface it would appear that these homes are transforming as they reflect the demographic profiles of the communities in which they are based and which they still largely serve.

It was also clear that some homes used cost as a way to exclude different groups of people. The Guidelines notes that "…the same quality and standard of service is provided to all, irrespective of race, gender and ability to pay…" While this implies that a home cannot refuse someone who cannot afford the prescribed fees, in practice homes do not accept those who cannot afford the fees. Although some white families also battled to pay the monthly fees, sometimes as much as R8 000 – R15 000 per month, they were still however able to afford it, probably at the expense of other priorities. Many indicated that they had no option but to pay it because they couldn't take care of their relative.

As the social construct of black families start to change and they continue to choose the option of institutional care for their frail residents, the urgency to address transformation at various levels in the homes must be addressed. Rather than using the reasons of culture and social norms as an excuse to exclude people there has to be some incentive for homes to embrace diversity and to be held accountable for transformation. While transformation is not going to be easy there has to be an intention, a plan and an effective monitoring system to ensure that while there is consideration for the "more advantaged" older people who might not be able to easily adjust, so too should we be mindful of those pensioners who are adversely affected by a continuation of the system.

In terms of the Transformation Charter it is important that other elements be considered and acted on as well, such as:

- Ensuring the equitable distribution of services and resources between rural and urban areas
- Ensuring the sustainability of emerging and disadvantaged non-profit organisations.
- The development of more community based services
- Ensuring the transfer of skills from established organisations to emerging organisations
- Building the management and financial capacity of emerging organisations
- Improving the infrastructure and resource base of historically marginalised non-profit organisations and communities
- Moving away from a competitive individualistic service to cooperative and collective approaches that facilitate skills transfer and service integration

## 10. Models of Care

A "model of care" broadly defines the way the welfare of older persons, is delivered, and includes an integrated approach that includes their health, welfare and social well being. It aims to ensure older persons get the right care, at the right time, by the right team and in the right place.

South Africa, as with other countries in the world, has an ageing population, which means that the proportion of older persons in the country is increasing.  This South African reality calls for a concerted effort towards strengthening the capacity of older persons to play a more meaningful role in society, to enjoy active ageing, healthy and independent living, by creating an enabling environment for them.

The Guidelines for frail care clearly defines a model of care that is on par with international good practice where a developmental approach towards ageing as well as the new approach to ageing which requires that frail older persons remain in the community for as long as possible were taken into consideration. This guideline also reflects the needs and addresses the realities of older persons in the community.

At the same time with changing circumstances within the family structure, the Department is aware that there will always be those older persons who will need residential care due to circumstances. Therefore, the 2% target group in frail care facilities is accommodated in the

guideline as is the 3% of frail older persons in the community who will from Day Care services and Home Based Care Services.  Hence the proposed model of care in South Africa is:

1. **Community Based Care And Support Services**:

There are two types of models for service delivery in a community, viz. Day Care and Home Based Care Services. This guideline provides a framework for the development of an integrated system of community based care and support.  This model refers to frail care services provided by a service centre or a frail care facility to frail older persons who live within the community. Older persons are taken to and from their homes daily.

In **Day Care** older persons are provided with a variety of services covering the promotion and maintenance of independent living and active ageing, i.e. promotion of a healthy life-style, physical exercises, prevention of continuous dependency, continuous care, i.e. hygiene, grooming, prevention of isolation / socialisation programmes, laundry, transport services, outreach programme for the home-bound older persons, provision of nutritious meals, provision of safety and security, respite care, provision of assistive devices and an information centre for the community. In addition, this model provides training of volunteer care workers and care-givers at home, and provisioning and monitoring of services rendered by community carers.

The **Home Based Care Model** is a programme on the continuum of care level of service delivery targeting the housebound older persons as a result of frailty. Services include: basic home nursing, management of pressure areas and dressing of bed sores, tidying up of the frail person's room, training of family members with regard to caring for the frail older persons, doing shopping for basic needs of the person, counselling, laundry especially on items such as bandages, night dresses, bed linen if the family cannot do it, help with basic activities of living that may not have been mentioned, advice and support to clients and families.

2. **Residential Facility**

This is an institution that offers a 24-hour frail care service to frail older persons. These individuals have been declared "frail" in terms of the DQ98. Residential services include 24-hour frail care services to older persons, outreach services that are needed in the community where the residential facility is and / or a neighbouring community, training of volunteer caregivers who will serve frail older persons, care and supervision services to older persons who are suffering

from Alzheimer's disease, dementia and related diseases, rehabilitation services to older persons who had stroke, an onset of a disability and other physical or mental conditions that need a rehabilitation programme, information dissemination and education to family members of residents, older persons and the community on Alzheimer's Disease, dementia, stroke, sugar diabetes other diseases that affect older persons including other issues on ageing, ccounselling services to residents and family members who need such services, respite care services for caregivers and older persons who reside in the community, a subsidised open bed for emergencies and sport and recreational activities.

There is no reason to change this approach; however the challenge is to ensure that this model is being implemented. The audit found that many homes did not know about the guidelines (norms and standards) and if they knew about it, they claimed not to be in a position to implement it without funding from government.

# CHAPTER 5      RATING OF OLD AGE HOMES

At a meeting held with the Department of Social Development on the findings of the Audit, it was requested that Umhlaba provide the department with a list of homes; that through the audit process, were deemed in most need of urgent intervention.

This report sets out to identify these homes, as well as the methodology used for this.

## 5.1 Methodology

In the course of the field work data was collected that reflected the state of the home in many facets of its functioning.  When the request to rate the homes to reflect those in most need of some intervention, Umhlaba identified the following fields held within the data as key to establishing where the homes needed help. These fields were:-

1.  An assessment by the field worker where they were asked; *Condition rating (What is the visual impression of this particular facility – does it leave a good impression or is it in a state of neglect and in need of maintenance and repairs?)*
2.  The above was also cross referenced against any comments made about the condition of the home?
3.  Did the home offer 24 hour care and support?
4.  Did a Doctor visit the facility?
5.  Did a Nurse visit the facility?
6.  Did the facility have a policy to deal with Abuse?
7.  Did the facility have Emergency Procedures?
8.  How did the staff rate the facility?

The data base was then sorted to reflect the responses of the abovementioned questioned and sorted accordingly.  Once the home of most need emerged; a scan of the hard copy data and reports was done to ensure that there was consistency between this and the supporting data.

This process was followed in each province. It was Umhlaba's intention to ensure that by following the process provincially no homes would "fall between the cracks".

The rationale for using the question on the staff rating was that even where the homes seemed to be in excellent physical condition and functioning very well; if the staff rated the management of

the home as *very poor*, Umhlaba suggests that this may be cause for concern.  Very unhappy staff members could potentially aim these frustrations at the residents. In addition, staff members may find themselves exploited for which some intervention by the department would be recommended.  While this process provides a list of these homes, it would need to be followed up with amore in depth questionnaire to these homes, to ascertain where specifically an intervention would need to be aimed.

## 5.2 Results

KwaZulu Natal

In KZN the above process yielded the following results:



**Homes Requiring Intervention**

| Home | Condition | 24 hour care | Doctor | Nurse | Abuse Policy | Emergency Procedures | Staff Rating |
|------|-----------|--------------|--------|-------|--------------|----------------------|--------------|
| Resthaven Home | Very Poor | Yes | Weekly | Daily | Yes | Yes | **Poor** |
| Ekuphumuleni Old Aged Home | Poor | Yes | Never | Never | No | No | **Good** |
| Entokozweni Old Aged Home | Poor | Yes | Never | Never | No | No | **Excellent** |
| Emuseni Centre For the Aged | Poor | Yes | Monthly | Monthly | Yes | Yes | **Good** |

**Homes with a poor staff rating**

- Umlazi Christian Centre

Limpopo



There are no homes in Limpopo that require urgent attention according to the rating method used. All homes appear to be in good condition and staff did not reflect any poor comments during the audit.

North West Province
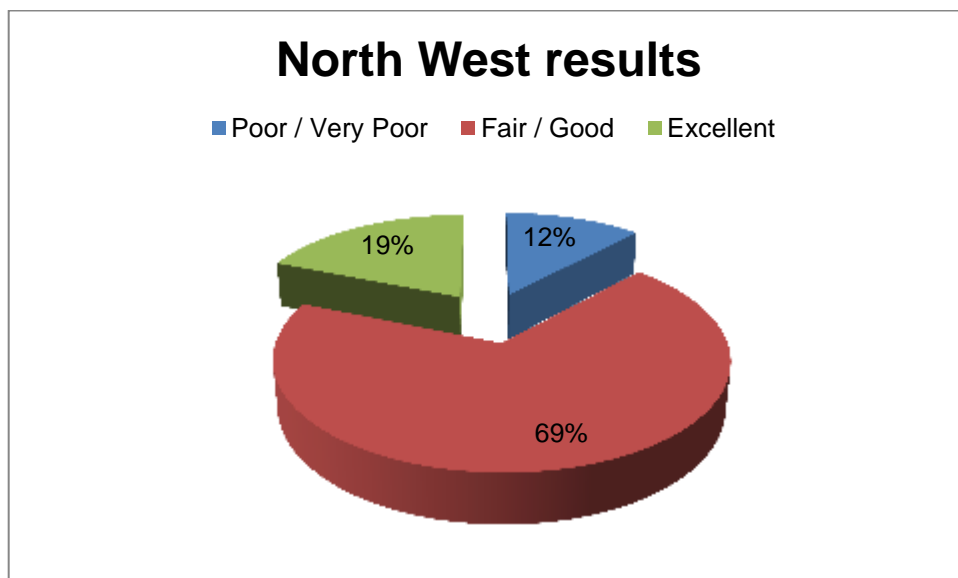
**Home Requiring Intervention**

| Home | Condition | 24 hour care | Doctor | Nurse | Abuse Policy | Emergency Procedures | Staff Rating |
|------|-----------|--------------|--------|-------|--------------|----------------------|--------------|
| Lapa La Botlhe Aged Care Centre | Poor | Yes | Never | Never | No | No | **Fair** |

**Homes with a poor staff rating**

- Huis Louis Swanepoel
- Rotarus Home for Senior Citizens

Mpumalanga
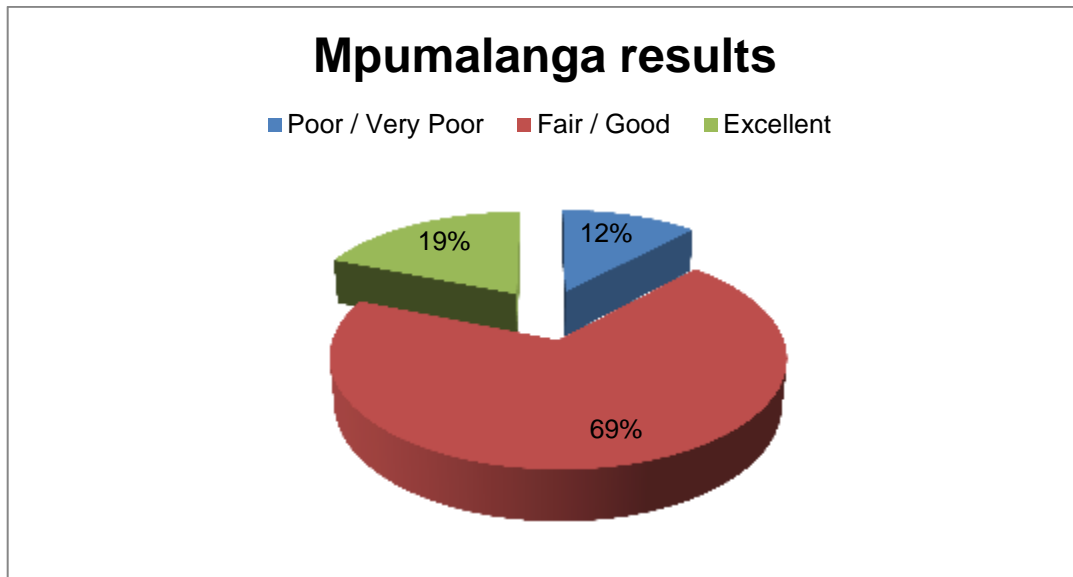


There are no homes in Mpumalanga that where a rating of *poor* was recorded for the condition of the home. However some remarks were noted that suggested some infrastructural problems and these homes were noted as:-

- Standerton Association for the Aged
- SAVF Hendrina Tehuis

In addition 1 home reflected a *poor* staff rating being:

- *Rusoord Old Aged Home*

Northern Cape
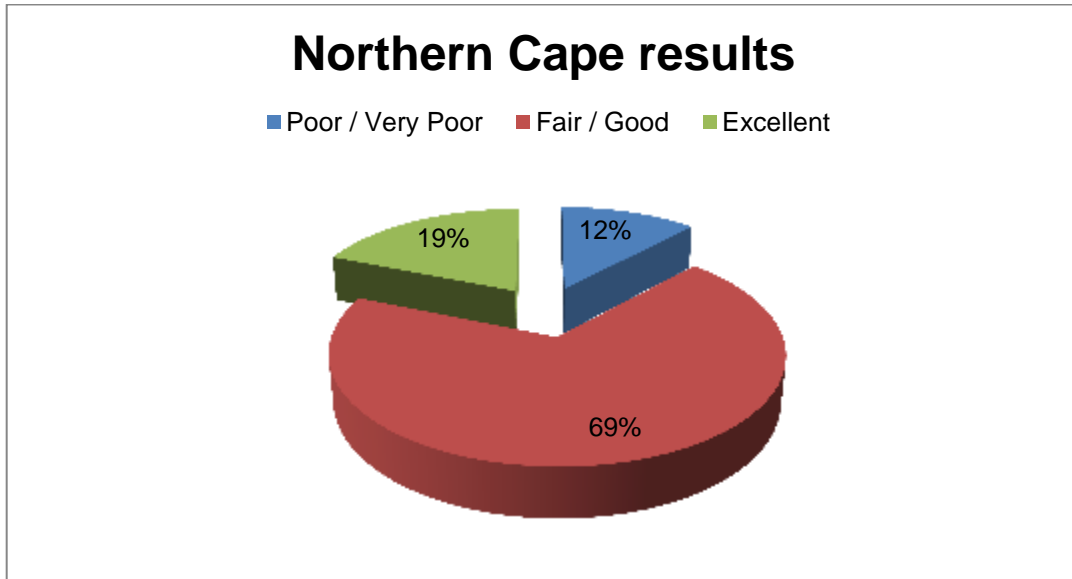


## Homes Requiring Intervention

| Home | Condition | 24 hour care | Doctor | Nurse | Abuse Policy | Emergency Procedures | Staff Rating |
|------|-----------|--------------|--------|-------|--------------|----------------------|--------------|
| Emmanuel Tehuis | Very Poor | No | Few times a year | Few times per week | No | Yes | **Good** |
| Resthaven Old Age Home | Poor | Yes | Few times a year | Daily | Yes | Yes | **Fair** |
| Huis Daneel | Poor | Yes | Weekly | Daily | No | Yes | **Good** |
| Johenco | Poor | Yes | Weekly | Daily | No | No | **Good** |
| Loxton Tuiste vir Bejaaardes | Poor | No | Weekly | Daily | Yes | Yes | **Excellent** |

## Homes with a poor staff rating

- Huis Danie van Huysteen
- Frieda Kempen Tehuis
- Huis Frank du Toit
- Huis Spes Bona

<u>Free State</u>

## Free State Results

**■ Poor / Very Poor   ■ Fair / Good   ■ Excellent**



19%   12%

69%

**Homes Requiring Intervention**

| Home | Condition | 24 hour care | Doctor | Nurse | Abuse Policy | Emergency Procedures | Staff Rating |
|------|-----------|--------------|--------|-------|--------------|----------------------|--------------|
| Boikhuco | Poor | Yes | Never | Daily | Yes | Yes | **<u>Poor</u>** |
| Mmabahloki Clara House | Poor | Yes | Few times per year | Daily | Yes | Yes | **<u>Poor</u>** |
| Reddersrus Old Aged Home | Poor | Yes | Monthly | Daily | Yes | Yes | **Excellent** |
| Huis Onze Rust | Poor | Yes | Monthly | Daily | Yes | Yes | **Good** |
| Huis Kosmos | Poor | Yes | Weekly | Daily | Yes | Yes | **Fair** |

There are no additional homes with a *poor staff rating* to those listed above.

Gauteng

## Gauteng Results



**Homes Requiring Intervention**

| Home | Condition | 24 hour care | Doctor | Nurse | Abuse Policy | Emergency Procedures | Staff Rating |
|---|---|---|---|---|---|---|---|
| SAVF Millenium Centre | Very Poor | Yes | Few times per year | Daily | Yes | Yes | **Excellent** |
| Daveyton Society For the Aged | Poor | Yes | Never | Daily | Yes | Yes | **Poor** |
| Mohlakeng Old Aged Home | Poor | Yes | Few times per year | Few times per year | Yes | Yes | **Fair** |
| Ephraim Zulu Senior Citizen Home | Poor | Yes | Monthly | Daily | No | No | **Fair** |
| Itlhokomeleng Old Aged Home | Poor | Yes | Monthly | Daily | Yes | Yes | **Fair** |
| Pieter Wessels Frail Care | Poor | Yes | Weekly | Daily | Yes | Yes | **Poor** |
| Frederic Place | Poor | Yes | Weekly | Daily | No | Yes | **Excellent** |

**Homes with a poor staff rating**

In addition to the two listed above, the following are homes that received a *poor* rating from staff:-

- SAVF Huis Silwersig
- Moreglans Tehuis
- Lodewyk P.Spies Home

- Vosloorus Society Care of the Aged
- Luipaardsvlei
- Vriendskap Tuiste
- Queen Alexandra
- Heidelberg Society For the Aged

Eastern Cape



**Eastern Cape Results**

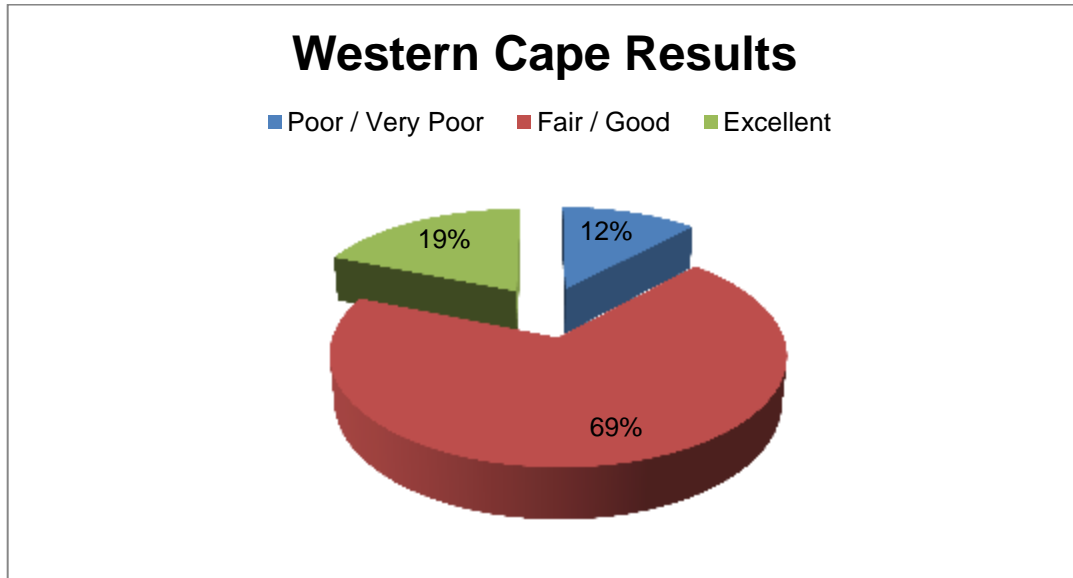Poor / Very Poor — 12%
Fair / Good — 69%
Excellent — 19%

**Homes Requiring Intervention**

| Home | Condition | 24 hour care | Doctor | Nurse | Abuse Policy | Emergency Procedures | Staff Rating |
|---|---|---|---|---|---|---|---|
| Rowell Old Aged Home | Very Poor | Yes | Monthly | Daily | No | No | **Poor** |
| The Salvation Army | Very Poor | No | Never | Never | Yes | Yes | **Excellent** |
| Ekuphumleni Old Aged Home | Poor | Yes | Never | Never | No | No | **Fair** |
| Kings Home | Fair (Poor Structure) | Yes | Never | Daily | Yes | Yes | **Fair** |
| Empilweni Home For the Aged | Fair (Poor Structure) | Yes | Few times per year | Daily | No | No | **Good** |
| Gelvan Park Frail Care Centre | Fair (Poor Structure) | Yes | Few times per week | Never | Never | Never | **Fair** |

**Homes with a poor staff rating**

In addition to the 1 listed above, the following home received a *poor* rating from staff:

- Parsonage Street Home

Western Cape



**Homes Requiring Intervention**

| Home | Condition | 24 hour care | Doctor | Nurse | Abuse Policy | Emergency Procedures | Staff Rating |
|---|---|---|---|---|---|---|---|
| Coronation Memorial | Very Poor | Yes | Weekly | Daily | Yes | Yes | **Good** |
| CPOA Place Arcadia | Poor | Yes | Never | Daily | Yes | Yes | **Excellent** |
| Lingelihle Old Age Home | Poor | Yes | Never | Daily | No | No | **Good** |
| Ekuphumuleni Frail and Aged | Poor | Yes | Monthly | Daily | Yes | Yes | **<u>Poor</u>** |
| House Sencit Resthaven | Poor | Yes | Weekly | Never | No | No | **<u>Poor</u>** |
| AGS Sarepta Tuiste vir Bejaardes | Poor | Yes | Weekly | Daily | Yes | Yes | **Good** |
| CPOA: Erica Place | Poor | Yes | Weekly | Daily | Yes | Yes | **Fair** |
| Rusthof Tehuis | Poor | Yes | Weekly | Daily | Yes | Yes | **Fair** |
| Huis Luckoff | Poor | Yes | Weekly | Daily | Yes | Yes | **<u>Poor</u>** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Beaconvale Home for the Aged | Poor | Yes | | | | | | **Fair** |
| | | | Weekly | Daily | Yes | Yes | | |
| Benevolent Park | Fair (Poor Structure) | Yes | Monthly | Daily | Yes | Yes | | **Good** |
| Vermont Centre | Fair | Yes | Few time per week | Daily | Yes | Yes | | **Excellent** |
| Joseph Matwa | Fair | No | Never | Few time per week | Yes | Yes | | **Good** |
| Beth Rogelim - Salvation Army | Fair | No | Monthly | Few time per week | No | No | | **Good** |

In addition to those listed above, the following homes also received a *poor* rating from staff:

- Huis Wittekruin
- Helen Bellinghof
- AGS Kuilsriver Tehuis vir Bejaardes
- Ysterplaat
- Kensington Home for the Aged
- Parkhaven Home for the Aged
- Hesperos Old Age Home
- Rusoord

# CHAPTER 6    RECOMMENDATIONS

While Government has taken a strong policy lead to ensure the positive integration of older persons within society, support for them within their families, their access to proper community-based services, their protection from abuse, and promoting their general quality of life, at the same time there are numerous challenges that exist to turn government policy into reality in the lives of older persons.  A number of recommendations are made as to what the priorities should be for service delivery organisations within a context of sound policy but limited capacity and resources.

Health is not only a vital asset but also a fundamental right. It is defined as a "complete state of physical, mental and social well-being" (World Health Organisation). Health thus has implications that extend far beyond medicine and a health care system. It includes a temporal, socio-economic and political perspective as well as biological, behavioural and psychosocial processes that operate from conception to old age. All have potent influences on health outcomes and chronic disease risks. Most illnesses and diseases require not only medical solutions but also political and social interventions. In the context of South Africa, older persons should be eligible for Primary Health Care (PHC) services at no cost to themselves.

These are recommendations that need to be addressed at a strategic level, but which will in turn, apply to, and impact on, the effective functioning of individual homes.  In terms of the Guidelines and National Norms and Standards it is clear that the homes across the country are at different levels of meeting these standards.

It is recommended that in terms of:

## 1. Department of Social Development
- The relationship between the Provincial office of the Department of Social Development and the Homes is vital for the continued quality service delivery. The Home fulfils an important role in bringing welfare services to older persons and the state plays a key role in providing an environment that is conducive for the Home to carry out its work. This clearly indicates the desirability of close cooperation between them for the success of the programme. Both parties should meet and discuss ways in which the DSD could perhaps play a more significant role.

- Where a more positive relationship exists between the Province or region and the homes, this supportive relationship needs to be maintained and the partnership further strengthened.

- However, in the main the relationship (and communication) between the Department and the homes must improve and the homes seen as partners in this process of caring for older persons

- The Department at all levels must have their respective roles and responsibilities clarified so that there is no blurring, overlap and duplication of activities adding unnecessary anxieties to home managers. For this to happen the Department must streamline and adopt a more coordinated approach to its own operations more effectively

- The M&E role of the Department (wherever this responsibility lays) must be implemented on a continuous and consistent basis.

- The capacity of provincial and regional staff of DSD must be developed so that they are confident in performing their tasks

- The problem areas identified in this audit must be addressed and homes must be provided with more mentoring and support by the DSD in order to build the capacity of the homes (this is also a key issue in sustainability)

## 2. Transformation

While attempts have been made by some homes to change their racial profiles, in many homes cultural and social norms and high fees have been used as a reason to exclude people of different racial groups. The focus on transformation is crucial; however the importance and focus which is to provide proper care for older persons must not be lost. Therefore:

- The issue of transformation in relation to providing an effective service for all older persons must become a priority for the DSD to ensure that homes address transformation with more than just lip-service.

- Homes that have given the impression that they have transformed but have kept black residents separate from white residents must be addressed as a matter of urgency

- Good practice models of transformation need to be shared with homes; many fear the unknown so if they know that it has worked in another home they might feel less resistant to the change

- Many of the homes that are resistant to change are controlled by 'mother bodies'. These bodies act as a pool of resources and personnel yet they also often also hamper transformation initiatives. The Department needs to conduct a more thorough study into their practices and address their resistance

- Diversity awareness should be done with home management and staff so that they are sensitised to different cultural and religious practices

- At the same time instead of enforcing compliance with punitive measures, DSD must embark on a process of assisting homes with transformation by helping them to develop a transformation strategy. Business Plans must include a plan for transformation with clear indicators by which to measure the progress made by homes

- Transformation is not only about racial integration of homes but also on all the other principles inherent in the Transformation Guidelines such as the composition of the Board, management and staff, and transfer of skills from established organisations to emerging organisations. A few homes have started 'twinning' with sub-economic homes in their areas but others have felt that they do not want to appear as imposing their help onto homes that need it. Instead they believe that the Department should facilitate this process through their own needs assessment of a home and introduce the home that will assist, so that it is seen as a formal agreement and as part of their capacity building programme.

- Government must look at supporting black people who apply to white homes and cannot afford to pay with the pension and government subsidy. There could be a sliding scale developed to accommodate different categories of older persons in need of subsidised accommodation.

- While there is clearly difficulty in finding suitable, skilled individuals, a more stringent policy should be put in place targeted at Management levels with the primary aim of monitoring the recruitment of management and senior level staff as well as the structure of the 'mother bodies'

### 3. *Intersectoral collaboration*
- The challenge remains the collaboration of government departments with a view to ensure mainstreaming of older persons in all programmes as well as the integration of services. This will promote optimum utilisation of resources.

- The shortage of nursing staff could be addressed with the Department of Health to explore the possibility of these posts being subsidised or co-funded as the medical component forms the core of services provided to older persons.
- For many homes, transport is problematic especially when residents need to go to hospital. DSD should facilitate discussion between homes, the Department of Health and Hospitals in an attempt to find a solution.

### 4. Governance
- Boards need to be trained in order to understand their role in relation to good governance. In addition, they need to distinguish their role from that of management
- The Board should develop a policy of rotation and changing Board members within a specified time period
- In addition there must be a succession plan for Board members who leave and those who might be interested in joining.

### 5. Management capacity
- A management training programme must be developed for all home managers that focuses on the management of people, performance management, as well as aspects such as conflict management, building a cohesive team, and understanding diversity management which is crucial for real transformation
- There must be a properly implemented performance management system in place with regular assessments of staff undertaken
- Caring management is important in this environment as it impacts on the ability of staff to do their jobs effectively and with pride. Staff management conflicts need to be addressed.
- Staff retention policies and procedures need to be developed which can include counselling and stress management support
- The staff and management in all the homes must be familiarised with the norms and standards as well as the rights of older persons

### 6. Staff capacity
- There is a problem of the shortage of staff, that needs to be addressed but this has financial implications
- There is a need to build the capacity of staff through regular training programmes. This would allow staff to be updated with the most recent practices in the care for older persons

- A capacity building programme should also look at issues such as assertiveness training, diversity awareness, self-esteem and other life skills

### 7. Sustainability / Funding

- It is recommended that funding policies should be re-addressed as many of the less affluent homes are struggling to maintain health care standards.

- At the same time funding programmes such as an outreach programme, etc needs to be seriously considered as opposed to funding people

- At the same time the Department could assist home managers and fund-raisers in exploring a sustainability strategy that addresses various options that include not only financial sustainability but also human resources and skills transfer

- Implementing some of the norms and standards requires funding which the Department must consider, particularly in the homes that are less resourced and under-developed.

### 8. Multiple use of facilities

- For the sake of the safety of the residents, the patients as well as the staff Government should look at separate facilities (or sections of the same facility) to accommodate patients with Alzheimer's, dementia and mental illnesses. These require specialised forms of care as well and trained specialist staff required to provide optimum care

### 9. Volunteers

- The volunteer component at the Homes should be increased, both to enhance the medical services and recreational activities as well as for fundraising activities. There should be a better strategy to recruit, train and place support volunteers especially in black areas where volunteers are more lacking

### 10. Basic Service Delivery

- The situation with homes where their basic service delivery needs are been ignored or where it is only intermittent needs to be addressed as a matter of urgency. Discussions between the DSD at the highest level and its counterpart in local government regarding the regular interruptions in the supply of electricity and water need to take place urgently.

- NGOs should also be lobbying government around this issue

### 11. Homes that require support for basic infrastructure

- A special fund should also be created for homes that fall into specific sub-economic categories. Extra money should come from this fund and be given to homes as repairs for

major breakages and faulty equipment is expensive and many homes simply cannot afford it.

- It might be possible for the Department to intervene and request assistance from the Department of Housing or Public Works for some assistance

### 12. Outreach Community Programmes

- There are possibilities for homes to extend its outreach services. This would require additional finances as well as personnel. The DSD should consider subsidising such outreach programmes as it is in line with the Departments' vision of preventative intervention.

- The DSD should also subsidise home based care as the requirements are often similar to frail care. This will also put less of a burden on the homes while still allowing them to be active in their communities.

### 13. Sharing, Learning and Networking

- There is a need to move away from a competitive individualistic service to cooperative and collective approaches that facilitate skills transfer and service integration, which would also contribute to sustainability as well as meet the transformation imperative.

- A network or forum could also be used to connect homes with one another. In this way white homes could form a support process for black homes.

- At the same time homes could link up and do bulk buying or joint training programmes as well as 'job shadowing' to exchange ideas about proper cooking methods, diets and hygiene. These would help to pool resources and be less expensive to one organisation.

### 14. Appropriate Model of Care

It is difficult to propose a model of care when the majority of homes do not comply with the minimum standards according to the norms and standards. Homes were unanimous that if they were to comply with the norms and standards that they would require a considerable boost of funding from government. This needs to be further interrogated.

# APPENDICES

### a. Documents referenced

1. Department of Social Development (2006)   Older Persons Act, 2006 (Act No. 13 of 2006)
2. Department Of Social Development (2008) Older Persons Act, 2006 Regulations Pertaining To The Older Persons Act, 2006 (Act No. 13 Of 2006).
3. Department Of Social Development: South African Plan of Action on Ageing, 2007
4. Department Of Social Development: Guidelines for Frail Care for older Persons
5. Department Of Social Development: Final Draft Regulations 2008 older persons act, 2006 regulations pertaining to the Older Persons Act, 2006 (act no. 13 of 2006)
6. Department of Social Development: National Norms and Standards regarding acceptable levels of services to older persons and service standards for residential facilities
7. Department of Social Development: Guidelines for transformation
8. Department of Social Development: Transformation charter
9. FEM Research Consultants: Impact Assessment (to assess levels of transformation in 15 homes across the Western Cape), commissioned by Western Cape Department of Social Development
10. Gauteng Department of Social Development: Transformation Indicators
11. Gauteng Department of Social Development, Partnerships and Financing Directorate: Social Services Program Costing Models
12. Marais, Sandra and Eigelaar-Meets, Ilse: The social wellbeing of older persons in the Western Cape: An overview research commissioned by: Directorate Research and Population Development, Western-Cape Department of Social Development, 2007
13. Population Reference Bureau (2008): World Population Data Sheet: Downloaded from http://www.prb.org/pdf08/08WPDS_Eng.pdf
14. Statistics South Africa: General Household Survey, 2005.
15. Turok M.: New bill in parliament seeks to enshrine rights of elderly in law. Cape, Argus, March 21: 8, 2006.
16. Vusi Madonsela, Director General Department of Social Development, South Africa, Paper presented at the White House Conference on Aging

**b. Meetings / Interviews with:**

1. Dorothy Thuli Mahlangu: National Director Care and Services to Older Persons, National Department of Social Development

2. Jabulile Mohlouwa: Promotion of Rights, Directorate Care and Services to Older Persons, National Department of Social Development

3. Jubilee Matlou: Principal Social Worker, Directorate Care and Services to Older Persons, National Department of Social Development

4. Nono Yende: Deputy Director Partnerships and Financing Directorate (now called Institutional Capacity building and Support)

5. Lindiwe Molubi: Assistant Director Partnerships and Financing Directorate (now called Institutional Capacity building and Support)

6. Debbie Fortuin: Provincial Coordinator Directorate Social Policy Formulation Western Cape Department of Social Development

7. Henry Tebbutt: Older Persons Programme, Western Cape Department of Social Development

8. Khanyisela Mathebula: Acting Director Social Welfare Services Mpumalanga Department of Social Development

9. Lea Deputy Director for Older Persons and Disability, Gauteng Department of Social Development (Telephonic)

**c. Two-day (2) visit to residential facilities**

Visits to 405 residential facilities around the country to conduct the audit

### d. __Homes that were not audited__

| Province | Home | Description |
|---|---|---|
| GP | Deutsche Alterheim | Refused Audit |
| GP | Methodist Home | No Longer Receives Subsidy |
| KZN | Anerley Haven | Refused Audit |
| EC | Munro Kirk | Duplicated on Dept list |
| EC | Salvation Army | Not an Old Age Home |
| EC | Lorraine Residential | Not subsidised |
| EC | Algoa Frail Care Center | Not Subsidised |
| NC | Acasia | No Longer Receives Subsidy |
| NW | Sonop Old Aged Home | Had to obtain approval from regional leadership of DSD – referred to the Department |
| WC | CPOA Avondrust | No Longer Receives Subsidy |
| WC | Huis Martina | Refused Audit |
| WC | Ravenzitcht | Refused Audit |
| WC | St Johannes Heim | Refused Audit |
| WC | Uitsig Tehuis | Refused Audit |