THE UNIVERSITY OF MANITOBA
SCHOOL OF SOCIAL WORK

# AN ANALYSIS OF DATA COLLECTED DURING THE EVALUATION OF THE HOME HELP PILOT PROJECT

## Some factors which may account for the additional service needs of the clientele

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by

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TABLE OF CONTENTS

| | Page |
|---|---|
| ACKNOWLEDGEMENT . . . . . . . . . . . . . . . . . . . . . . . . | ii |
| LIST OF TABLES . . . . . . . . . . . . . . . . . . . . . . . . | iv |
| ABSTRACT . . . . . . . . . . . . . . . . . . . . . . . . . | v |
| CHAPTERS | |
| I. Introduction . . . . . . . . . . . . . . . . . . . | 1 |
| II. Background of the Study . . . . . . . . . . . . | 8 |
| III. Method . . . . . . . . . . . . . . . . . . . . . . | 18 |
| IV. Presentation and Analysis of Date . . . . . | 23 |
| V. Conclusions . . . . . . . . . . . . . . . . . . . | 38 |
| BIBLIOGRAPHY . . . . . . . . . . . . . . . . . . . . . . . . | 43 |
| APPENDIX A: The evaluation of the Home Help Pilot Project . . . . . . . . . . . . . . . . . . . | 45 |
| APPENDIX B: The Interview Schedule . . . . . . . . . . | 56 |
| APPENDIX C: A comparison of Groups "A" and "B" on the basis of selected factors . . . . . . | 63 |

LIST OF TABLES


| TABLE | | Page |
|---|---|---|
| 1. | Number of Patients in Each Group and Category | 23 |
| 2. | Suggestions from Group B of Ways in which Service Could Be More Helpful | 24 |
| 3. | A Comparison of Suggestions for More Helpful Service on the Basis of Length of Service | 25 |
| 4. | Service Provided in Days per Week | 26 |
| 5. | Service Provided in Hours per Day | 26 |

ABSTRACT

This report is concerned with the isolation of some of the factors which may account for the need for additional service on the part of a segment of the clientele of the Home Help Service of the Victorian Order of Nurses. The data analyzed was collected during the evaluation of the Home Help Pilot Project in June, 1968. The sample group was classified on the basic of the need for additional service and the length of time service had been provided. The group with additional service needs was analyzed in relation to length of service, marital status, and family structure; and then compared to the group which found service satisfactory.

The conclusions were that there were differences in the service needs of clients which could be related to the factors studied, and that the clientele had a wide range of service needs - not simply a need for part-time household assistance. The chonically ill patients who were receiving long-term service were most likely to require additional service.

# CHAPTER I

## INTRODUCTION

The provision of household help to person's with health problems is not new. New York's Family Service Bureau provided "visiting cleaners" for sick mothers in 1903, and Montefiore Hospital established a Home Care Department in 1957.[1] However, public acceptance of a general need for this type of service has been slow. It is only during the last decade that there has been real recognition that urbanization has affected the traditional provision of support from family and neighborhood; and that "Homemaker Services must be offered as a basic social service."[2]

Home Care, in particular, is seen as an emerging need due to such factors as the increased life span and the consequent rise in the numbers of people with chronic illness. New Medical concepts of effective treatment and the pressure on expensive institutional facilities have necessitated a consideration of alternative ways of providing care.

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[1] Homemaker Services in the United States, Report of the 1959 Conference, The United States Department of Health

[2] Loc. cit., p. 23

Underlying these practical concerns is the belief that there are inherent advantages in maintaining individuals in their own home and community; and that society has a responsibility to provide supports to families who are physically, emotionally, and economically burdened by the care of an ill or disabled member.[3]

The traditional pattern of providing this service on the North American continent has been through voluntary agencies. However, in recent years, there are some instances of public funds being directed into programs. The United States Social Security Act provides grants to states which establish Home Care programs. The province of Ontario, in 1958, introduced legislation which makes possible subsidized services for individuals who "are not in a financial position to pay for services themselves;"[4] the Manitoba Social Allowance Program provides for payment of homemakers for recipients; and the Preventive Social Services program in Alberta enables Municipalities to establish this type of service with an 80% subsidy from the province.

In Europe, where Home Help Services and Home Care programs have been in operation for a longer period of time, they are generally fully or partially subsidized by

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[3]Encyclopaedia of Social Work. p. 150.

[4]Gardner, D.C., Paper presented at the Ontario Welfare Council Conference on Homemaker Service, Toronto, 1959, p. 7.

public funds. Britain, Sweden, and Finland finance services with joint Federal-Municipal participation. Nationally financed services are provided in Denmark, France, and Norway; and a few European nations such as Switzerland, Germany, Italy, and Israel have privately financed services.[5]

Much of the recent concern about the need for this type of service has been generated as a result of increased knowledge and understanding of the effects of stress on individual and family functioning, and a recognition of the implications of a health problem in terms of social, emotional, and economic functioning.

Frances Upham defines health as a "state of positive physical and emotional well-being which permits the individual to utilize his full potential for social living,"[6] and points out that a condition of health is achieved as a result of favourable life influences and conditions. When one considers the impact of illness, disability, and old age on the individual, the dynamics seem very similar. All these conditions constitute a threat to self-image and feelings of competence and independence. They are a source of

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[5] Homemaker Services in the United States - Report of the 1959 Conference, U.S. Department of Health, Education and Welfare, pp. 188 - 189.

[6] Upham, Frances, A Dynamic Approach to Illness, Family Service Association of America, New York, 1949, p. 7.

stress since they represent an attack on the person,[7,8] and demand an adaptation to impaired functioning.

Although individuals react and adapt differentially, according to their ego strengths, level of maturity, and the amount of support that is provided by the social environment; there is an initial response of anxiety, and a reactivation of repressed fears and conflicts which seems to be universal. This universal response has been observed to result in a period of defensive, regressive behavior.[9,10] Although a few individuals find pleasure and satisfaction in prolonged regression to a dependent role; for most the experience is frustrating and anxiety provoking. Indications are that the mature person returns to his usual level of functioning as health returns, if his needs for security and reassurance are met, and he is not overprotected.[11, 12] Similarly, a return to healthy equilibrium is hindered by inadequate care and failure to meet emotional needs.[13]

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[7]Loc. cit., p. 15

[8]Babcock, Charlotte, "Inner Stress in Illness and Disability", in Ego-Oriented Casework, Family Service Association of America, New York, 1963, p. 46.

[9]Upham, Frances, Loc. cit., p. 15

[10]Babcock, Charlotte, Loc. cit. p. 46

[11]Upham, Frances, Loc. cit., p. 19

[12]Towle, Charlotte, Common Human Needs, National Association of Social Workers, Inc., New York, 1965, p. 95.

[13]Babcock, Charlotte, Loc. cit., p. 50

In our society, with its valuation of self-reliance and independence, the role of "sick" or "helped" person is a deviant one; and the individual is not expected to fulfill normal responsibilities to others, or to care for himself, and loses avenues for accomplishment and reward. This tends to reinforce regression and dependency.[14]

The role transition involved in adapting to limited capacities, because it involves discontinuity, is usually characterized by confusion, anxiety, and stress which must be dealt with. It presents problems from an interactional point of view if the change is abrupt and sudden, or if there are opposing behavioral expectations, differing concepts of the degree of disability, or problems realistically perceiving the dependency requirements of the condition.[15]

The presence of an ill or disabled member in the family network affects the role balance, task performance, and relationship patterns. Under normal circumstances, families give and receive emotional satisfaction, share family tasks and responsibilities, and, ideally, complement and enrich each other. The disturbance of the functioning balance affects all members, since a reorganization of family task performance is necessary, and the usual sources of

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[14]Thomas, Edwin, Behavioral Sciences for Social Workers, The Free Press, New York, 1967. pp. 61 - 63.

[15]Thomas, Edwin, Loc. Cit., p. 67.

satisfaction may be disrupted. Increased demands on healthy members may result in family anxiety and tension, a decrease in relationship satisfactions, and conscious or unconscious hostility towards the ill or disabled individual.

It is recognized that a negative family environment will not promote a return to healthy functioning; and that, if home care is to be effective, timely and appropriate service must be provided to assure constructive family interaction.[16]

Social work knowledge of family interaction, and the need to relieve stress, to assess and promote the development of family strengths is relevant to an evaluation of this kind of a service. Inadequate service can have destructive impact on other individuals in the role network of the patient, and a decision to provide Home Help Service should be based on an evaluation of the total situation -- including the family's willingness and ability to provide care in the home. There must be assurance that services are provided in a way that makes reality more satisfying, is ego-strengthening for the individual, and is supportive of healthy family interaction.

Exploration for previous research, prior to the evaluation of the Home Help Service, disclosed that this

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[16]Upham, Frances, Loc. cit., pp. 21 - 24.

study appeared to be the first of its kind on the North American continent. Most studies carried out in Canada have been community surveys designed to establish the need for this type of service.

Community studies in Toronto in 1959;[17] Saskatoon in 1966;[18] and Montreal in 1967;[19] affirmed the need for extending this type of service. The affirmation of need was based on an evaluation of the quantity and quality of service being provided in each community in comparison with population data, and European estimates of probable service requirements.

To the best of our knowledge, there is no documentation of previous attempts to evaluate provision of this type of service in relation to the needs of the clientele.

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[17]Gardner, D.C., Loc. cit.

[18]Report of the Homemaker Study Committee - Saskatoon Welfare Council, 1966.

[19]Organized Help in the Home - A Plan for Action in the Montreal Area, The Montreal Council of Social Agencies, 1967.

## CHAPTER II

## BACKGROUND OF THE STUDY

In May, 1960, the Age and Opportunity Bureau requested that the Community Welfare Planning Council of Greater Winnipeg study the need for Homemaker Services. A Study Committee was appointed in October, 1960 which included representatives from the Family Bureau of Greater Winnipeg, the Victorian Order of Nurses, the City of Winnipeg Health Department, the Provincial Departments of Health and Welfare, and the Children's Aid Society of Winnipeg.

The Committee proceeded by doing a statistical survey of the need for Homemaker Services in which fourteen health and welfare organizations participated; and corroborated the findings by briefs and submissions from eighteen health and welfare organizations.

In addition to reviewing local provision of services both currently and in historical perspective, the committee studied provision of similar services nationally and internationally. It was observed that many social factors such as increased life span, mobility, and changing family relationship patterns made it necessary to provide organized services -- particularly in urban centres; and

that a particular need existed for household assistance to enable aged, ill, and disabled persons to remain in their own homes.

The first report, in November, 1961 differentiated two basic types of service:

(a) Homemaker Service: the purpose of which is to maintain the integrity of homes with children. The homemaker in this service is expected to assume responsibility for the management of the home.

(b) Home Help Service: the purpose of which is to provide assistance with household routines, (usuually part-time) personal care, and social contact for the elderly, convalescent, or disabled person.

The committee referred to the Report of the 1959 National Conference of Homemaker Services of the United States of America which documented the damaging social consequences of a lack of adequate service. It was felt that consequences such as unnecessary institutionalization of the ill and aged, absence from school or foster home placements of children, loss of employment, and family indebtedness due to the cost of hiring domestic staff privately were just as applicable to the urban community of Winnipeg.

The committee concluded that, in Winnipeg, the most

urgent need existed for emergency and part-time help; and recommended that the Family Bureau concentrate its attention on Homemaker Service and that a separate Home Help Service be established under the sponsorship of an existing agency.

Preliminary plans for the proposed service were developed and approved. In September, 1965 a three year pilot project was launched providing Home Help Services under the auspices of the Victorian Order of Nurses and financed by grants from the Province of Manitoba, the Winnipeg Foundation, and the Rotary Club of Winnipeg. The plan stipulated that the service be evaluated at the end of the third year, before the service was established on a permanent basis. This evaluation was carried out in June, 1968.

The final report of the Community Welfare Planning Council[20] recommends the establishment of a continuing study committee in Homemaker Services to explore the development of expanded services and to determine the best method of administration.

Two alternatives seem most feasible and have been recommended for consideration. One alternative is that all services be administered by a Central Homemaker Bureau; the

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[20]Home Help Service and Meals Delivery Service for Greater Winnipeg - Summary Report of a Three Year Pilot Project Community Welfare Planning Council, Winnipeg, Man., 1969.

other, that a central information service be established if services continue to be provided by several problem-oriented agencies.

The report differentiates between four levels of service which could be provided: homemaking, home help, companion service, and household cleaning.

Regardless of the administrative alternative chosen, more refined knowledge about the recipients of this particular service and their needs would make it possible to make more knowledgeable decisions at intake regarding such matters as the leve of service required.

Rationale

The overall plan for the study included an evaluation of the administration of the program; an evaluation of the effect of the service on patients and families served by the program; and an estimate of the unmet need for service in the community.

The particular aspect of the study which is the focus of this paper is the evaluation of the effect of the service on patients and families served by the program. This part of the study was carried out by the School of Home Economics of the University of Manitoba in June, 1968. The necessary data was collected by interviewing a sample of homemakers employed by the agency, and

patients receiving the service. It was concluded that the goals of the project had been realized; and that the service was helpful and supportive to those who used it -- in fact, that patients could not have been cared for at home without the service. The stated goals of the service are as follows:

1. To enable the ill to remain at home in order to promote independence in an environment favorable to recovery.
2. To lessen the physical, emotional, and economic burdens for families.
3. To reduce the length of the hospital stay, and to hasten convalescence.
4. To keep the employable adult at work.[21]

It appeared that useful knowledge for future planning might be obtained by carrying out a finer analyses of the data collected -- particularly with regard to those persons who expressed a need for more help than was provided by the Home Help Service.

Although only one of the forty-two patients interviewed expressed serious dissatisfaction with the service; twenty-three patients, (54.7% of the sample) made concrete suggestions of ways in which the service could be more helpful. This would seem to be an indication of some degree

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[21]Home Help Report, Victorian Order of Nurses, 1965.

of unmet need among the recipients of service.

One of the specific objectives of the Pilot Project was to "Explore the need for, and assist in the expansion of Homemaker and Home Help Service in the community';[22] and one criteria for the provision of service was the assurance that Home Help Service will meet the patients' needs."[23] In view of these factors, a closer examination of the segment of the sample group expressing unmet need seems relevant at this time.

There is no question that, within the framework of its policy and philosophy, and the limitations of its available staff and funds; the Home Help Agency has provided a necessary and useful service to its clientele. However, it is recognized that it is not sufficient for agency to operate efficiently and meet its own specific goals. Unless agency goals and purpose are logically related to existing community needs, the agency is not meeting its social responsibility. An examination of agency functioning should include an analyses of the impact of its efforts on those who use it, an assessment of the contribution of the agency to overall community planning, and a study of client needs in order to evaluate the program in the light of what is really needed in the

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22 Home Help Report, Loc. cit.

23 Home Help Report, Loc. cit.

community.[24]

At a time when Homemaker Service is being examined by the community (a part of the Social Service Audit of Greater Winnipeg), it seems important to give serious consideration to the clients' view of service, and to examine the ways in which recipients of service feel it could be provided more helpfully. Although the clients' view of service is only one of the considerations involved in planning future services, it is an essential one if services are to be effective in a preventive and rehaiblitative sense and not simply ameliorative. The suggestions from clients for more helpful service should enable those responsible for planning to view service from the perspective of utilization as well as that of provision.

A number of factors related to the provision of service from a problem-orientation tend to mitigate its effectiveness. There is a tendency, due to a lack of alternate resources, to accommodate the needs of the client to the service as it is provided; rather than to provide the service in a way which meets the existing needs. The establishment of eligibility criteria often makes the service unavailable to individuals who need it, but do not meet all the criteria.

In some instances, areas of responsibility overlap, and it is difficult to determine which agency should be

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[24]Reid, Ella W., Social Welfare Administration, Columbia University Press, New York, 1961, pp. 11 - 14

providing service. One result of this situation may be that the total needs of an individual or family fail to receive the necessary consideration due to the particular philosophy and orientation of each agency. It is also possible that an individual can be considered ineligible for any agency's service from an administrative point of view; on the assumption that the necessary supervisory knowledge and skill is lodged with another agency.

In his discussion of the general topic of service organization in urban communities, Alfred Kahn emphasizes the need to distinguish between case services which are assigned diagnostically, and social utilities which should be available on the basis of need.[25] In a modern urban community, where traditional forms of support are no longer adequate; it seems apparent that the need for household help at certain periods of the life cycle will be common to most citizens -- and that provision of this type of service should be made from this perspective. It is possible that an examination of unmet need in this clientele may reveal whether or not this is a result of administering service from a problem orientation.

There are indications of a need for a broader, more flexible approach to the provision of this type of service. Agencies such as Care Services have made limited use of the

[25] Kahn, Alfred, "Organizing Services in a Complex Urban Community," The Kahn Institute, Toronto, 1967, pp. 6 - 9.

Home Help Service because it does not meet the needs of its clientele (all of whom are aged and ill or handicapped), and have found it necessary to establish their own service. The report of the Home Help Service indicates that Hospital Home Care Departments are making the most extensive use of the service. During the project period, 75% of their seven hundred referrals were accepted for service, compared with only 25% of the four hundred family referrals, 34% of the fifty referrals from private physicians. While this fact would support the fulfillment of one of the project purposes -- that of relieving pressure on hospital beds -- one wonders what this indicates in relation to general community need for varying levels of household help.

Focus of the Study

For all of the foregoing reasons, it was decided to do a finer analyses of the data collected during the evaluation of the Home Help Service in order to examine the following questions:

1. What are the additional needs expressed by the members of the sample group?
2. Are there differences in the needs expressed by patients receiving long term service as opposed to clients receiving short term service.
3. Would an analyses on the basis of marital status

and family structure, yield information regarding differential service needs?

4. Can any comparisons be drawn between the group which finds present service satisfactory, and the group which expresses some degree of unmet need.

# CHAPTER III

## METHOD

The original study was carried out between May and July of 1968. A 25% random sample of the 201 individuals who received service between February 1, 1968 and April 30, 1968 was selected from the billing records of the Home Help Service. Out of the sample of fifty, twenty-eight patients were actually interviewed -- seven were deceased at the time of the study, one had left the city, and, in fourteen cases, it was necessary to interview members of the immediate family because of language or illness barriers.

A pre-test was carried out before the interview schedule was finalized, using five patients from the original population. This was valuable in assessing the probable difficulties with the wording of the questions and the interview situation. It was found necessary to arrange interviews when the home helper would not be in the home, and appointments were made by telephone.

It had been agreed that patients would be prepared for the evaluation interview by the district nurse who would interpret the purpose of the study in terms of information collection for improving future service. Unfortu-

nately, this interpretation did not take place in most instances -- only one patient acknowledged that she had been expecting the interview. This may have limited the expression of negative factors in relation to the service.

Statistical data regarding such factors as age, sex, marital status, income, source of income, nature of illness, etc. was obtained from Home Help Service files and recorded on a face sheet prior to the interviews. (See Appendix A)

The interviews were carried out using a schedule, responses were tabulated numerically, and compiled into a report which was presented to the Victorian Order of Nurses on September 13, 1968. (See Appendix B)

In order to carry out the present study and analyze the data related to unmet client need, it was decided to differentiate the sample grouping using question #22 of the interview schedule. "Are there ways the service could be/have been more helpful to you?" It was assumed that a positive reply would be an indication that some degree of unmet need existed. On this basis, the sample group was divided into two categories:

<u>Group A</u>: The nineteen patients who stated that their needs were adequately met by the service as it currently operates.

Group B: The twenty-three patients who expressed concrete suggestions for making the service more helpful.

Each group was further classified, on the basis of the length of time Home Help Service had been provided in the following manner:

Short-term service was defined as service provided for a period of three months or less.

Long-term service was defined as service provided for a period of more than three months.

In order to examine the date in relation to each of the questions posed, responses to the relevant questions on the schedule were tabulated as follows:

Question #1 - "What are the additional needs expressed by the members of the sample group?" The responses of Group B to question #22, part (b) (See Appendix A) were tabulated and examined.

Question #2 - "Are there differences between the needs of those receiving long-term service, and those receiving short-term service?"

The responses of Group B to question #22 part (b) were retabulated on the basis of length of service, and the expressed needs of the two categories were compared.

Because of the predominance of requests for more hours of service, it was decided to tabulate the responses to Question #4 of the schedule in order to examine the

actual service received by each of the groups and categories; and to attempt to assess whether a valid need for increased service does exist.

Question #3 - "Would an analyses on the basis of marital status and family structure yield information regarding differential service needs?"

Group B was first broken down into five categories - (1) Married couples with dependent children, (2) Married couples, (3) Widows or Widowers, (4) Single persons, and (5) Sole parents with dependent children. The following factors from the face sheet data were tabulated: Age of patient, amount of income, type of illness, length of time in receipt of Home Help Service, amount of service received. In addition, the responses to questions #10, 12, 13, 16, 17, 20 and 22 (See Appendix A) were tabulated and examined.

Question #4 - "Can any comparisons be drawn between the group who find service satisfactory and the group who express some degree of unmet work?"

Using the initial groupings of unmet need and length of service, information in relation to the following factors was tabulated: Age of patient, sex of patient, marital status of patient, amount of income, source of income, category of illness, duration of illness, leiving arrangement, family members in Greater Winnipeg, length of residence in Greater Winnipeg, and length of residence in

neighborhood. Groups A and B were compared in order to determine whether differing needs can be accounted for by any of the preceding factors.

## CHAPTER IV

## PRESENTATION AND ANALYSIS OF DATA

Table I

NUMBER OF PATIENTS IN EACH GROUP AND CATEGORY

| | Short term | Long term | Total | Percentage of Total |
|---|---|---|---|---|
| Group A | 10 | 9 | 19 | 45.3 |
| Group B | 9 | 14 | 23 | 54.7 |

Total number of patients interviewd = 42

It should be noted that twenty-three (54.7%) of the total sample of forty-two patients interviewd fell into Group B. The fact that 60.8% of the population of Group B is made up of long-term patients; compared with 47.3% of Group A, suggests that there is a relationship between unmet need and the length of time patients receive service.

## Additional Service Needs

Table 2

SUGGESTIONS FROM GROUP B OF WAYS IN WHICH SERVICE COULD BE MORE HELPFUL

| Suggestion | Number |
|---|---|
| **A. Suggestions related to service administration** | |
| Increased hours of service | 8 |
| Continuity of homemakers | 6 |
| More convenient hours of service | 4 |
| Evening and week-end service | 2 |
| Notification when home-helper not available | 2 |
| Regularized time for service provision | 1 |
| More realistic evaluation of ability to pay | 1 |
| Continuation of service when mother hospitalized | 1 |
| More sensitive intake interview | 1 |
| **B. Suggestions related to functioning of home helpers** | |
| More consistent calibre of home-helpers | 4 |
| More competent home-helpers | 3 |
| Willingness to do heavy cleaning | 3 |
| Better understanding of the needs of the convalescent | 1 |

The majority of the suggestions for more helpful service centred around the amount of service provided, and the quality of the work performed. This suggests that, within the clientele of the service, a group exists which needs more than the "auxiliary, part-time assistance" which was originally defined as the type of service provision to be made by the Home Help Service.

Over one-third of the respondents requested more hours of service; almost one-half were concerned with competence; and a quarter with continuity of home-helpers. Perhaps because their basic problem is one of health, these

individuals have been provided with Home Help Service when their needs might be better met by homemaker service.

## Additional Service Needs and Length of Service

Table 3

A COMPARISON OF SUGGESTION FOR MORE HELPFUL SERVICE ON THE BASIS OF LENGTH OF SERVICE

| Suggestions from short term patients | # from Table 2 | Comparative total from Table 2 |
|---|---|---|
| More competent home-helpers | 3 | 3 |
| Continuity of home-helpers | 2 | 6 |
| Willingness to do heavy cleaning | 2 | 3 |

| Suggestions from long-term patients | # from Table 2 | Comparative total from Table 2 |
|---|---|---|
| More hours of service | 7 | 8 |
| Continuity of home-helpers | 4 | 6 |
| More convenient hours of service | 3 | 4 |
| More consistent calibre of home-helper | 3 | 4 |

The short-term patients seemed most concerned with the quality of the help provided -- all requests for more competent home-helpers came from this group, and two-thirds of the requests for heavy cleaning. Only two of the six requests for continuity came from the short-term group, which suggests that social and relationship needs are not paramount.

The long-term patients were most concerned with the

amount of service, more convenient hours of service, continuity and more consistent calibre of home-helper.

Continuing contact with a particular home-helper probably results in the development of personal relationships which make competence factors less important for long-term patients. However, the most striking difference between the two groups is the expressed need for more hours of service on the part of the long-term patients.

## Actual Service Provided

Table 4

Service Provided in DAYS PER WEEK

| | 1 day/week | | 2 days/week | | 3 days/week | | 4 days/week | | 5 days/week | |
|---|---|---|---|---|---|---|---|---|---|---|
| GROUP | # of patients | %age | # of patients | %age | # of patients | %age | # of patients | %age | # of patients | %age |
| A | 7 | 36.8 | 4 | 21 | 2 | 10.5 | 2 | 10.5 | 3 | 15.7 |
| B | 5 | 21.7 | 4 | 17.3 | 5 | 21.7 | - | - | 9 | 39.1 |

Table 5

Service Provided in HOURS PER DAY

| | 3 hrs/day | | 4 hrs/day | | 5 hrs./day | | 6 hrs/day | | 8 hrs/day | | 9hrs/day | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GROUP | # of patients | % | # of patient | % | # of patients | % | # of patients | % | # of patients | % | # of patients | % |
| A | 1 | 5.5 | 7 | 36.8 | 2 | 11 | 6 | 31.6 | 2 | 11 | 1 | 5.5 |
| B | 2 | 8.7 | 12 | 52.2 | 3 | 13 | 4 | 17.4 | 2 | 8.7 | - | - |

There would appear to be a valid basis for the request for more hours of service from the members of Group B. Although the largest percentage (39.1%) received daily service; 83.9% of the service was provided for 3 - 5 hours per day, and only 8.7% of the group received full time service. On the other hand, Group A. received the largest percentage of its service once a week; and 46.7% of the service was provided 6 - 9 hours per day, 16.5% of the group receiving full-time service.

In Group B, two-thirds of the patients receiving daily or weekly service are long term; whereas only half the comparable members of Group A are long-term.

It may be that, due to financial considerations and service priorities, the number of hours per day is decreased as service is established on a long-term basis. However, since 73.9% of the patients in Group B are chronically ill (See Appendix C(f)), their service needs are not likely to decrease with the passage of time, and ability to cope may not increase as it does in the case of the acutely ill or convalescent patient.

<u>Additional Service Needs and Marital Status and Family Structure</u>

A. <u>Married Couples with Dependent Children</u> (4)

In all four cases, Home Help Service was necessary due to the illness of the family homemaker. Three of the four mothers had been chronically ill for more than a year, and two were totally incapacitated. These latter two fami-

seemed to have the greatest need for more helpful service; since substitute mothering and homemaking was required in addition to personal care for the invalid. Family income was average ($6,000. and $7,200.), and both families found it difficult to contribute the partial payment assessed by the agency.

Service was being provided for 5 - 6 hours per day, and the fact that these mothers were alone in the home for part of the day was a concern to the absent members of the family. There appeared to be an underlying assumption that family members can care for the patient whenever their time is not taken up with employment or educational roles. Service was not provided during the hours when children and adolescents were out of school or when the spouse was not fulfilling job responsibilities, and was withdrawn during the husband's annual vacation. One could speculate about the general social development of children who are expected to devote a large part of their "free" time to the care of an invalid parent and the assumption of household duties. In one of these cases, the family had terminated service and a seventeen year old daughter was caring for the home and her mother full-time rather than completing her education.

In all cases, when not fulfilling their employement responsibilities, husbands were carrying additional responsi-

bilities, for the care of their wives, the management of their homes, and parenting. Although the provision of service enabled these men to continue their employment, it provided them with limited relief from financial burdens and family responsibilities, and little opportunity for meeting their personal needs.

Married Couples (7)

All of the patients in this group were over sixty years of age, and four of the seven had been chronically ill for over a year. Although in four cases service was required due to the illness of the family homemaker, only one case involved a total homemaking role. Most of the service provided was part-time (only two patients received service five days per week), and involved light housekeeping, personal care of patients, or sitter-relief for a spouse.

The unmet need in this group was varied, and it is difficult to make broad generalizations. The concern expressed most often was related to the competence and calibre of the home-helpers; next often, a need for more hours of service. Since only two of these couples had adult children living in Winnipeg, and three had no relatives at all; they were, to a considerable degree, dependent on this service to meet their needs. Netiher the patient nor the spouse, due to old age, were able to carry extra role responsibilities in an adequate manner.

Two of the wives were totally incapacitated, and the husband's felt that the amount of service provided was inadequate for their needs. In both cases the service met the wife's need for personal care and supervision in her hsuband's absence, but provided little relief for the husband from household duties and patient care. During the study period, service was terminated in both these homes. In one case, the wife was hospitalized; and, in the other, the husband located a live-in homemaker in order to obtain some evening and weekend relief.

Six of the couples in the group, with incomes ranging from $3,000. - $11,000., paid for their services in full and felt they could afford to do so. One couple, with an income in the $2,000. - $3,000. range, found it difficult to pay the partial fee assessed by the service.

The provision of service seemed to be focussed pri-arily on the needs of the patient, and did not take into account the needs of both members of the family.

Widows and Widowers (7)

The age range in this group was from seventy-four to eighty-nine, all patients were chronically ill and six of the seven were living with adult children (three of these children were employed full-time, and Home Help provided substitute care and supervision), two were living alone, and one in a Senior Citizens Housing Development. In four cases, service provision permitted the patient to either

remain out of hospital or be discharged from hospital.

The tasks performed by home-helpers were light housekeeping and meal preparation (6), and personal care and supervision of the patient (7); and service was part-time.

The needs of patients living with employed adult children were least adequately met. There were three requests for more hours of service; since in these cases, patients were alone in the home for part of the day. One patient was bed-ridden, another was senile and forgetful, and their children worried about these unsupervised hours. Two family members pointed out that they were not always notified when a home helper was not available, and had no way of knowing that the parent would be alone all day.

Three of the four requests from Group B for continuity of home-helpers came from this category, and two of the three requests for a more consistent calibre of Home-Helper. This is in line with our knowledge of the very aged person who tends to be upset by change, and is often not sufficiently aggressive and competent to direct the activities of a household helper.

Single Persons (2)

The two single women in Group B were over seventy-five years of age and living alone. In one case service was necessary due to chronic illness; and in the other, to the general deterioration of old age.

The chronically ill patient was receiving six hours of service per day, mostly devoted to light housekeeping, meal preparation, and personal care. Service was terminated due to the lack of continuity in Home Helpers, and her need for service in the evenings - she was placed in a foster home.

The elderly woman received service once a week for a general cleaning of her apartment, shopping, and supervised outings. She found the amount of service provided was insufficient to accomplish the tasks with which she was no longer able to cope.

In the case of the chronically ill patient, the Home Help Service probably could not meet her needs in an independent living arrangment, unless they could provide her with a live-in homemaker. However, it seems feasible to gradually increase the service to the aged patient who is able to live independently but becomes progressively unable to cope with her own housekeeping.

Sole Parents (2)

Both of these women were under forty, had been chronically ill for several years, and service was necessarry due to their inability to carry a homemaker role. In one case, service was full-time; and involved total homemaking, care of children, and personal care of the patient. The family had been receiving service for two and a half years, and the patient felt that there was a need for a more

consistent calibre of home-helpers. The present homehelper was very competent, but there had been occasions when this was not so. This mother also pointed out the need for assistance with heavy chores. However, this need would necessitate the employment of male workers, which might be better handled in some other way.

The second sole-parent was receiving part-time service (one day a week for four hours) for assistance with light housework and laundry. She felt she needed more hours of service, more help with heavy cleaning, and shopping. Since the patient had no relatives in the city of Winnipeg, she had no other source of assistance and felt she had a valid need for increased service.

## A Comparison of Group A and Group B on the Basis of Some Selected Factors

The detailed tabulation of the factors considered is in Appendix C.

There was no evidence of obvious differences between the two groups in relation to the following factors: Age, sex, source of income, and relatives in Greater Winnipeg.

The most striking difference between the two groups was noted in examining the data related to the category and duration of illness. The chronically ill were more highly concentrated in Group B (73.9%), and few members of this group had terminal conditions or general disability due to old age. About half of Group A (52.6%) were chronically ill and the remainder were either acutely ill or affected

by old age.

Group A was fairly evenly split between the three time categories, with the lowest proportion (26.3%) in the one to five year duration category. Group B, however, had the highest proportion of its members in this category (47.8%) -- almost double the comparable percentage in Group B.

It would appear that chronic illness is an important factor in relation to service needs, and that the adjustment period for patients and family members is a lengthy one. Physical, emotional, and financial resources are probably reduced under prolonged stress; resulting in a need for increased support from outside the family.

Some differences were apparent in relation to other factors such as marital status, amount of income, length of residence, and living arrangement.

The percentage of patients in family categories was 8.3% higher in Group B than in Group A, and Group B had both of the separated women with dependent children in the sample. Group A had a slight predominance of single and widowed patients.

The largest grouping (43.3%) of the members of Group B had incomes over $3,000. per year (double the percentage of Group A in that income category. In Group A, the largest concentration of members (42.1%)) was in the

lowest income range -- mostly Old Age Pensioners.

It was not possible to correlate the income factor with others, to determine why the higher income levels were in need of additional service. However, there was an expectation of some payment for service from those patients in the income ranges above Social allowance levels; and patients may havelimited service in order to reduce the costs -- or the agency may have limited service due to a lack of resources for subsidizing service to this group.

Both groups were largely composed of long-term residents of this city, with a higher percentage of Group A (84.2 vs. 69.5) having over twenty years residence. There were some differences in mobility within the city, however, and Group A appeared to be most mobile. Approximately two-thirds of Group B had lived in the same neighborhood for more than twenty years.

Their additional service needs might be related to an attempt to maintain functioning in a living situation no longer in line with their capacities. It may also be that they were the few remaining "old-timers" in their neighborhoods, and no longer had friends and neighbors who might be a source of support and assistance.

Although the largest percentage of Group A were living alone (10% higher than Group B), half of them were in Senior Citizens Housing which provided a form of support

and assistance. The most significant difference in relation to living arrangement appeared to be among those living with adult children. Group B had over three times Group A's percentage in this category. (17.3% v. 5.3%) The adult children were attempting to care for an ill parent in addition to their own family or employment responsibilities, and the need for additional service was probably related to a need for more relief from the excessive load of responsibility.

Although some of the factors appear to be clearly related to additional service needs; in relation to most of the factors, the groups are quite similar. It is likely that a constellation of factors, rather than a single one, accounts for the need for more service.

Reuben Hill[26] suggests that level of need in subjectively defined, and that an objective evaluation of resources is not as significant as the attitude of individuals and families regarding hardship. If individual and family funntioning is to be improved, a professional evaluation is necessary to ensure that services are provided to meet the client's defined level of need.

It would appear that members of this client group

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[26]Hill, Reuben, "Generic Features of Families Under Stress", in Crisis Intervention: Selected Readings, Family Service Association of America, New York, 1965, p. 51.

are in need of a professional assessment of their total situation and functioning, since their additional needs cannot be completely accounted for by objective factors.

# CHAPTER V

## CONCLUSIONS

The original plan for Home Help Service was that it would provide "assistance with household routines and personal care services"[27] when such provision would enable convalescent, aged, ill, or disabled persons to remain at home.[28] Since the Family Bureau was to continue to provide and develop homemaker services to the community when home management and the care of children was involved; this division of responsibility implied that Home Help would serve a clientele with a limited range of service needs.

It would appear, however, that during the Pilot Project, service has been provided on the basis of the existence of a health problem, and the clientele has become one with a much broader range of service needs than was originally planned or anticipated. The level of service required ranges all the way from total homemaking and substitute mothering to patient "sitting".

About three-quarters of the sample group were

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[27]Victorian Order of Nurses, Winnipeg Branch, Home Help Service Project, p. 3.

[28]The Evaluation of the Home Help Project, Appendix C, p.3.

living with at least one family member.[29] This fact about the clientele indicates that a thorough evaluation of individual and family strengths and weaknesses, interaction, and functioning is essential, in order to determine the level of service which will not only promote patient recovery, but will also enable other family members to meet their personal needs, and prevent dysfunctional effects.

The evaluation results verify that certain types of family structure are more vulnerable to dysfunctional effects than others. Families with children need service provision which recognizes and supports the need of the children for a family atmosphere conducive to sound development. It seems apparent that the inability of a wife to carry homemaking and parenting responsibilities for an extended period of time necessitates the assumption of an excessive task-load by her spouse -- particularly if he is carrying an employment role, or suffering from some reduction in capacity to function himself. In cases where a patient is living with adult children, their family and employment responsibilities involve a drain on their personal resources. These responsibilities are liable to be neglected or ineffectively handled if insufficient assistance is provided to enable them to care for their parents. Sole parents are also in need of additional service since they

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[29]The Evaluation of the Home Help Project, Appendix C, p.3.

lack the support and assistance of a spouse, particularly if there is an absence of extended family members to fill this gap.

The analyses of the evaluation data indicates that the needs of the acutely ill and those suffering from general disability due to old age are, on the whole, met by this service; however, the majority of the chronically ill (63%) need a variety of additional services. As Home Help service is provided over an extended period of time, the need for more than light housekeeping assistance will probably develop; since the majority of the patients are women.[30] Income levels are too low to permit families to hire heavy cleaning help privately[31], and the requests for more competent home-helpers suggest that this service need is not adequately met for some clients. It appears that the amount of service tends to be decreased as time goes on, in spite of the expressed need for more hours of service on the part of long-term patients.

Perhaps the lack of an adequate financial base for the provision of this service (particularly for self-supporting patients whose service is not subsidized by public agencies) makes it necessary to spread available resources so thinly that client needs are inadequately met.

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[30]The Evaluation of the Home Help Pilot Project (Appendiz C), p. 2.

[31]Ibid., p. 3.

Although this philosophy of resource allocation may be satisfactory for a temporary period, and may assure the provision of some service to a larger group of clients; it is unlikely to meet the needs of patients and families on a long-term basis.

Some planning experts feel that the most satisfactory way of meeting the cost of Home Care Services is through a Health Insurance program which assures the provision of an adequate level of service on the basis of need rather than financial considerations. The exploration of publicly fin-anced Home Help service as an aspect of Health Insurance seems legitimate, since the alternative to Home Care is the use of more costly institutional space. The benefits of maintaining patients in the community will be reduced un-less the plan is a feasible one for the patient and all the individuals affected by his condition.

Some of the criteria for effective service pro-vision have not always been met -- e.g. that provision of service will contribute to an appropriate solution to a family's problems;[32] and that Home Care only be planned when the family members are willing and able to provide the necessary patient care.[33] Unless Home Help is provided at an adequate rather than a minimum level, the program will

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[32]Homemaker Services in the United States, p. 24.

[33]Upham, Francies, Loc. cit., pp. 176 - 177.

not realize its potential as a rehabilitative and preventive service - particularly if it fails to meet the clients' expressed level of need.

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# THE EVALUATION OF THE HOME HELP PILOT PROJECT

September 13, 1968

## Assessment of the Effect on the Families and Individuals Served

In order to study the effect of the Home Help Service on the families served, the School of Home Economics at the University of Manitoba was asked to carry out a small research project. During the months of June, 1968, a sample of home helpers and patients was interviewed. An analysis of the findings follows:

### The Sample:

#### A) The Patients

A 25 per cent random sample was chosen from a list of persons receiving service between the dates of February 1, 1968, and April 30, 1968. The sample was selected from the billing records using a table of random numbers. Because of the high mortality rate of the patients, it was not feasible to draw from those served at an earlier time period. Of the 201 patients, 50 were selected for the Study. Forty-two of these were actually interviewed, seven were deceased, and one had moved out of the city. In 14 cases,members of the immediate family were interviewed rather than the patient, because of language or illness barriers.

#### B) The Home Helpers

A 25 per cent random sample of home helpers was chosen, using the list of all those receiving a pay cheque during the period February 1, 1968, to April 30, 1968. A table of random numbers was used to select 25 home helpers from the list of 101 names of this group, 22 were interviewed as three were out of the city during the time of the Study.

### The Pretest:

The interview schedule was not finalized until a pretest was completed. Five patients and four home helpers, similar to the sample group but not included in it, were used. Format and wording of many questions was changed, as well as additional information collected. In some patient's homes, the home helper was present during the interview. This was found to provide some difficulties and reticence on the part of the patient to divulge information. It was decided to set up a timetable so that the home helpers would be interviewed in their own homes, and the patients would be interviewed at a time when the home helper was not there. The pretest was found to be very valuable in assessing probable difficulties and misunderstandings.

### The Procedure:

The interviewer was assured that the visiting nurse would warn the family that the study was taking place, but this was not found to be the case. In only one instance was advance preparation noted and the interviewer felt that she would have had a better reception if this was the general rule. All interviews took place in the home of the persons being interviewed, and appointments were generally made by telephone.

### Results:

#### a) The Patients:

The sample group of patients was similar to those reported in the second report 1966-67. Men accounted for 15 per cent of the patients in that report,

while this sample had 14 percent male to 86 percent female patients. Patients accepted for service were also similar in their type of illness to those in the second report. The specific illnesses and conditions were of such a variety that no trends or patterns could be delineated. Arthritis and cardiovascular conditions appeared somewhat more often than others.

Table 1

Patients accepted for service by category of illness

| Illness Category all patients | Second report n = 304 | | Sample n = 50 | |
|---|---|---|---|---|
| | n | % | n | % |
| Chronic illness | 174 | 58 | 28 | 56 |
| Acute illness | 70 | 23 | 10 | 20 |
| Terminal illness | 41 | 13 | 3 | 6 |
| Mental illness | 15 | 5 | 2 | 4 |
| General disability due to old age | 4 | 1 | 5 | 10 |
| Pregnancy | - | - | 2 | 4 |

The age range was fairly similar to that reported for the total group of patients in the second report.

Table 2

Patients accepted for service by age

| Age | Second Report n = 30¢ | | Sample n = 50 | |
|---|---|---|---|---|
| | n | % | n | % |
| 0 - 19 | - | - | - | - |
| 20 - 29 | 18 | 6 | 3 | 6 |
| 30 - 39 | 19 | 6 | 3 | 6 |
| 40 - 49 | 26 | 9 | 5 | 10 |
| 50 - 59 | 39 | 13 | 3 | 6 |
| 60 - 69 | 39 | 13 | 10 | 20 |
| 70 - 79 | 93 | 3 | 12 | 24 |
| 80 - 89 | 57 | 19 | 13 | 26 |
| 90 - 99 | 13 | 4 | 1 | 2 |

Other data which were collected for the patient group included information on income. Most often mentioned as sources of income were government or private pensions. Sixty per cent of the patients mentioned only one source of income, 26 per cent had two sources, eight per cent had three or more sources while six per cent had no response to the question. Most patients for whom income data was available reported incomes under $5,000, with the largest group being under $2,000 annual income.

Table 3

Source of Income

| Source | Number * |
|---|---|
| Wages | 9 |
| Private pension | 12 |
| Government pension (O.A.P. and/or disability) | 26 |
| Public assistance | 9 |
| Savings/investments | 5 |
| Insurance policy | 1 |
| Other (rent) | 6 |
| No response | 3 |

Table 4

Amount of Income

| Income in dollars | n = 50 | |
|---|---|---|
| | n | % |
| Not available | 12 | 24 |
| 0 - 999 | 2 | 4 |
| 1000 - 1999 | 17 | 34 |
| 2000 - 2999 | 4 | 8 |
| 3000 - 3999 | 7 | 14 |
| 4000 - 4999 | 3 | 6 |
| 5000 and over | 5 | 10 |

The largest group of patients was married, with over one-half presently living with a spouse, and about one-third were widowed. About three-quarters of all those surveyed were living with at least one other family member.

* number exceeds 50 because some patients gave more than one source of income.

Table 5

Marital Status

| Marital Status | n = 50 | |
|---|---|---|
| | n | % |
| Married | 26 | 52 |
| Single | 6 | 12 |
| Widowed | 16 | 32 |
| Divorced | 0 | 0 |
| Separated | 2 | 4 |

Table 6

Persons in Household

| Number of persons in the Household | n = 50 | |
|---|---|---|
| | n | % |
| Patient alone | 13 | 26 |
| Patient and one family member | 20 | 40 |
| Patient and more than one family member | 17 | 34 |

The patients surveyed had been on service for widely varying periods of time, as can be seen in Table 7. This should indicate that their opinions would represent a broad range of the advantages and disadvantages of the service, for these time periods. Of these families, one half were presently on the service and one half had terminated service. The reasons for terminating are illustrated in Table 8.

Table 7

Length of Time Using the Home Help Service

| Length of Service | n = 50 | |
|---|---|---|
| | n | % |
| Under 30 days | 11 | 22 |
| 31 - 120 days | 12 | 24 |
| 121 - 365 days | 11 | 22 |
| 366 - 4 years | 13 | 26 |
| over 5 years | 2 | 4 |
| no response | 1 | 2 |

Table 8

Reasons for Terminating Home Help Service

| Reason Given | n = 25 | |
|---|---|---|
| | n | % |
| Patient institutionalized | 8 | 32 |
| Death | 6 | 24 |
| Not needed | 5 | 20 |
| Refused service | 2 | 8 |
| Private homemaker employed | 2 | 8 |
| Relative assumed duties | 1 | 4 |
| Foster home | 1 | 4 |

Referrals for the patient group as shown on their records came predominately from the large hospitals in the metropolitan area, with VON also being mentioned frequently. The group had a history of prior care by a myriad of private and public institutions, individuals, and themselves with the hospitals again making the greatest contribution. Referrals, as seen by the patients themselves, are from a different group of agencies and individuals than those mentioned on their records. The family doctor and the home care department were most frequently reported. Other services in the homes were evident, with VON or other nursing care as almost universal. Meals on Wheels, Red Cross equipment, CARS services, physiotherapy and social workers most frequently mentioned. Only two patients said they had no other services in their home, in addition to Home Help.

The sample group was most often living in their own homes, in which some of them rented suites. Over eighty percent of the patients lived in this type of accommodation, or in their own suite.

Table 9

Type of Accommodation of Patients

| Type of Accommodation | n = 50 | |
|---|---|---|
| | n | % |
| Own home | 30 | 60 |
| Suite | 11 | 22 |
| Housing unit | 4 | 8 |
| Rooms (1 or 2) | 3 | 6 |
| With relatives | 2 | 4 |

The person responsible for care of the patient was in all cases, either the patient himself or a close relative. Overy forty percent had a spouse who was responsible, while thirty percent were dependent upon a child.

Table 10

Person Responsible for Patient's Care *

| Person responsible for care | n = 42<br>n |
|---|---|
| Patient himself | 11 |
| Spouse | 18 |
| Child | 13 |
| Sister or brother | 1 |
| Parent | 1 |
| Other relative | 1 |

The sample was divided equally as to those who had received service immediately after being released from hospital, and those who had the service in their homes at a later date. The amount of service received was most often less than five hours and for one day per week.

Table 11

Amount of Service Received by Sample n = 42

| Hours → / Days per week ↓ | 0 - 4 | 5 - 6 | 7 - 8 |
|---|---|---|---|
| No response 2 | | | |
| One | 8 | 3 | - |
| Two | 3 | 2 | - |
| Three | 6 | 1 | - |
| Four | - | 1 | 1 |
| Five | 3 | 5 | 4 |

The sample group was predominately long time residents of the Winnipeg urban area, with over three-quarters of them living over 21 years in the area, and only four residing less than six years. They were also not geographically mobile within the city with one-half stating they hadn't moved from the area in their lifetime. Only six patients had relocated during the past five years. About eighty percent had relatives in the metropolitan area, and undoubtedly they were one of the main comforts of continued residence in the area.

* number exceeds 42 because some patients gave more than 1 name.

When asked how they managed before receiving home help, the largest number of replies indicated that they had managed alone. It is interesting to note that two patients reported children being kept out of school to care for them, and four mentioned a state of neglect present before initiation of service.

Table 12

Care of Patient before Home Help Service

| Type of Care | n = 42<br>n * |
|---|---|
| Managed on own | 22 |
| Spouse and family | 12 |
| Private homemaker | 5 |
| Neglect | 4 |
| Neighbours | 3 |
| Children kept out of school | 2 |
| Other relatives | 2 |
| Other agency | 1 |
| Institution | 1 |
| No answer | 1 |

* Number exceeds 42 because some patients gave more than 1 answer

The tasks done by the homemakers ranged from one to nine different jobs. The high degree of satisfaction was noted by most patients, although this is taken with some reservation because most patients were very anxious for the service to continue and were concerned with giving the "right" answers to the interviewer. One patient told of eight homemakers, and classified three as very satisfactory, three as satisfactory and two as unsatisfactory. The criticism was that they "mostly smoked and drank coffee". The range of tasks, and patient satisfaction with them, is recorded below.

Table 13

Quality and Range of Housekeeping Tasks

| Task | very satisfied | satisfied | dissatisfied |
|---|---|---|---|
| Laundry | 17 | 2 | 1 |
| Ironing | 14 | 3 | 1 |
| Tidy home | 22 | 4 | 3 |
| Make beds | 13 | 1 | - |
| Vacuum/dust | 25 | 4 | 3 |
| Heavy cleaning | 15 | 5 | 2 |
| Meal preparation | 17 | 2 | 1 |
| Baking | 5 | - | - |
| Mending | 6 | 1 | - |

Even more satisfaction was expressed in the way homemakers were able to care for their patients personal needs. In no case was anyone dissatisfied with these services, although more time was thought necessary for appropriate care in some instances. A broad range of services were provided, from cutting toenails and lighting cigarettes to feeding and dressing. The companionship of the homemaker was often mentioned, although many patients appeared to take this for granted.

Table 14

Personal needs tasks done by Home Helper

| Task | | very satisfied | satisfied | dissatisfied |
|---|---|---|---|---|
| Washing, dressing, care of hair | | 14 | - | - |
| Bathroom help | | 9 | 1 | - |
| Shopping and errands | | 8 | 1 | - |
| Feeding patient | | 5 | - | - |
| Company and supervision | | 6 | 1 | - |
| Making patient comfortable | | 6 | - | - |
| Rubs and packs | | 2 | - | - |
| Lights cigarettes | | 2 | - | - |
| Misc. (exercises, helps into chair, etc.) | | 8 | - | - |
| No response | 3 | | | |
| Not applicable | 10 | | | |

For some patients, special activities seemed important and again, they were highly satisfied with the results. This often affected the rest of the family more than the patient, but seemed to bring him some relief in that he felt his illness was not such a havy burden on the family. A daughter returning to work, and children returning to school are examples of the benefits of the service as seen by the patients. When asked if the service enabled a relative to go to work, nine patients answered in the affirmative. For all others, the question was not applicable.

Table 15

Extra tasks done by Home Helper

| Tasks | | very satisfied | satisfied | dissatisfied |
|---|---|---|---|---|
| Relief from patient care | | 10 | 1 | - |
| Patient able to get out of bed | | 9 | 1 | - |
| Social outings for patient | | 5 | 1 | - |
| Watched children | | 2 | - | - |
| No response | 4 | | | |
| Not applicable | 12 | | | |

In asking whether other activities were desired, 70 percent said "no". Of the group which wished more types of services, these seemed limited only by time. If the homemaker had been able to spend more hours in the home, baking, mending, laundry and shopping could have been expanded. Some patients expected work done which would be more suitable for male labour, such as cutting grass, removing storm windows, heavy cleaning and walking the patient.

In order to see where the services were most needed, with a view to perhaps different emphases in training sessions, patients were asked their opinions. The housekeeping tasks far out weighed the personal needs and companionship tasks in the patient's estimation. Because better housekeeping is a more tangible benefit of the service, many patients overlooked other vital functions of the homemaker. Also, it is probably easier to talk about housekeeping than one's personal needs and weaknesses.

Table 16

Area where most help needed by patient

| Task | |
|---|---|
| Laundry (includes ironing) | 10 |
| General cleaning | 17 |
| Heavy cleaning | 10 |
| Meal preparation | 10 |
| Sitting with patient | 9 |
| Personal patient care | 9 |
| Shopping and errands | 2 |
| Care of children | 1 |
| No response | 2 |

Attempts were made to assess some of the factors involved in payments and charges for the service. Of the sample, sixty per cent did not pay for the service. Fourteen percent paid part of the cost, and 26 percent paid the total cost of the service. Most of the patients did not know who paid for their service, although several mentioned home care and the VON. Only five patients admitted that they could not afford the charges for which they were billed.

The value of such a service in keeping persons out of institutions can be seen from the following table. Patients were asked what other arrangements they would have had to make if no service existed, and their replies follow.

Table 17

Arrangements made if Home Help Service not available

| Alternate arrangement | n |
|---|---|
| Institution | 20 |
| Private homemaker | 9 |
| "Just manage" | 7 |
| Don't know -- can't contemplate | 6 |
| Couldn't manage, neglect | 7 |
| Friends and relatives | 2 |
| Child kept from school | 1 |
| Welfare | 1 |

Patients were asked what age of homemaker they would most desire, and one-third mentioned that age was not as important as the homemaker's personality, health, ability and attitude. Over one-half were satisfied with the age of their present homemaker, and of those who felt that it was important, fifteen percent would have preferred a younger woman. Most patients estimated the age of their homemaker as in the 46-60 year range. "They're so good" and "marvellous" were comments to describe the homemakers, and one patient commented that they should be paid higher wages.

No objections to the presence of a home helper were expressed by the family members or patients interviewed; they were grateful for the service.

Table 18

Benefits for other Family Members

| Benefit | n |
|---|---|
| Relief from worry | 14 |
| Less demand on relatives | 14 |
| Relief from extra work | 13 |
| Maintains home | 10 |
| Miscellaneous | 2 |
| Not applicable | 7 |

Of the patients whose service had been interrupted, most had to "let things go" until it was resumed. Other alternatives were that the spouse stayed home, relatives helped, or that certain activities were left undone. Some mentioned that they had not always been informed when the service had been withdrawn, and that it was a worry to themselves and relatives to be left alone. No one felt that the service had been withdrawn too soon.

The sample group was asked if the service could be more helpful. Almost two-thirds said that it could not be. From the other group, a list of complaints was compiled, and these are arranged in order of frequency.

1. Longer hours needed.
2. Fewer changes in homemakers.
3. Person responsible for the patient was not notified if homemaker did not arrive.
4. Occasional relief needed weekends and evenings.
5. Service at a more helpful time.
6. More realistic evaluation of family's ability to pay.
7. Homemaker should visit with patient before placement.
8. Service at a more regular time.
9. Patient should not be discharged from hospital until a homemaker is available.
10. Occasional help with heavy cleaning.
11. More specific instructions for homemakers from office.
12. Outings for wheelchair patients.
13. Investigation was unpleasant.
14. Man to do odd jobs (storm windows).
15. Other complaints re extra services wished.

All but one patient would recommend the home help service. The dissenter felt that the administrative costs were too high. The reasons most often mentioned for recommending it were satisfaction with the service, financial reasons, and the personal interest shown.

Discussion: The Home Help Service appears to be meeting the needs of both patients and their families as an auxiliary service for health care. The goals of the project, as stated in the project proposal, pages 4 and 5 have been met for the most part, by the service. The overwhelmingly positive responses to the questions asked of patients and families indicate the great need for the service, and its success.

Patients expressed a high degree of satisfaction with the Home Helpers and their job performance, especially in the area of personal care. The patients indicated, though, that the housekeeping role was the most needed area of concern, whereas the Home Helpers felt that the companionship and patient care side of the coin was most beneficial.

The goal of enabling family members to return to work is being well met by the service. In all cases where this was applicable, patients reported that relatives had been able to return to employment. Important too is the fact that some children were able to return to school on a more regular basis when service was brought into the home.

The effect of the service in keeping patients out of institutions is also illustrated by the findings. Table 17 shows that most felt they would have to return to a hospital if service was withdrawn. Since one-quarter of the patients lived alone, the value of the service in providing their only help can be seen.

Charges for the service did not appear to be a great problem, probably because many patients did not pay for the entire amount themselves. Since privately hired help of a similar nature is more expensive, the service provides reasonably priced care.

Two-thirds of the sample interviewed felt that the service "couldn't be better" but some of the disadvantages mentioned are listed in the report. Many of these are already being implemented, such as weekend service and longer hours. Some are probably a result of individual idiosyncracies. The main criticism, which

APPENDIX B

INTERVIEW GUIDE

Name ______________________________ Age __________

Address ______________________________ Sex __________

Marital Status: M _____ S _______ W _______ D _______ Sep. ___

Referred by ____________________ Prior Care ___________
(Name & Type of Facility)

Family Income: Amount per annum _______ _______ 0- 999
Source of income _______ _______ 1000-1999
_______ 2000-2999
_______ 3000-3999
_______ 4000-4999
_______ 5000&Over

Length of service given by program ______________________

Type of illness of patient receiving service ____________

Duration of illness of patient receiving service: Days_____

Months_____ Years____

Living accommodation: Type of accommodation_______________

No. of family member in home _______

Person responsible for patient and/or management of home __
______________
(relationship)

Other Services Provided in home:
__________________________ (Indicate type of service
__________________________
__________________________
__________________________

Current Service: Yes _______ No __________
If no, what is current plan:____________________________

PATIENT/FAMILY QUESTIONNAIRE

Hello ________________________________, I'm from the University. The V.O.N. has asked us to visit with some of the people who have used their Home Help Service, and see how helpful it has been; and whether there are any ways that it could be changed to be more helpful.

I have some questions to ask you. Your opinions will be kept confidential, and may help to improve the service where it seems necessary and is possible.

1. Are you use the home help service now?

   Yes ____ No ____

2. How long (did you use)
   (have you used) the service?

   ______________________________________________

3. Did the service begin when you came home from the hospital? ____ Yes ____ No

4. How often do you have a home helper?

   ______________________________________________

5. Have you lived in Winnipeg long?

   Yes ____ No ____ How long? ________________

6. Have you always lived in this neighbourhood? Comment.

   ______________________________________________

   ______________________________________________

7. Have you relatives living in the Greater Winnipeg area?

   Yes ____ No ____ Comment.

   ______________________________________________

   ______________________________________________

8. Do you have relatives living elsewhere?

   Yes ____ No ____ Comment.

   ______________________________________________

   ______________________________________________

9. How did you come to use this service?

____ Recommended by family doctor

____ Recommended by Home Care Department

____ Requested by patient or family

____ Recommended by friend or neighbour

____ Transfer from other Agency Homemaker Service

Other ________________________________________

________________________________________

10. Why was the service necessary?

____ Illness of family homemaker

____ Relief from care of ill person in the home

____ Unable to afford cost of private help

____ To keep patient out of institutions

____ Need for help to supplement work of other family members

____ General deterioration re old age

Other ________________________________________

________________________________________

11. How did you manage your housekeeping before a home helper was placed in your home?

____ Was able to manage by myself

____ Spouse and other family members carried on

____ H omemaker hired privately

____ Homemaker from another social agency

____ Housekeeping was neglected

Other ________________________________________

________________________________________

________________________________________

Now I'd like to talk to you about the things the homemaker actually did when she was in your home and could you tell me whether you were satisfied with the way she did it.

12. a) For instance, what housekeeping tasks did she carry out?

____ Laundry ___ light ___ regular __ Very satisfied __ Satisfied __ Dissatisfied

____ Tidy your home __ Very satisfied __ Satisfied __ Dissatisfied

____ Make beds __ Very satisfied __ Satisfied __ Dissatisfied

____ Vacuum and dust __ Very satisfied __ Satisfied __ Dissatisfied

____ Heavy cleaning __ Very satisfied __ Satisfied __ Dissatisfied

____ Meal preparation __ Very satisfied __ Satisfied __ Dissatisfied

____ Baking __ Very satisfied __ Satisfied __ Dissatisfied

____ Mending __ Very satisfied __ Satisfied __ Dissatisfied

Other ____________________________________________

____________________________________________

b) What about helping with your personal needs:

____ Wash, dress, do hair __ Very satisfied __ Satisfied __ Dissatisfied

____ Help to bathroom __ Very satisfied __ satisfied __ Dissatisfied

____ Feeding patient __ Very satisfied __ Satisfied __ Dissatisfied

____ Shopping & errands __ Very satisfied __ Satisfied __ Dissatisfied

Other ____________________________________________

____________________________________________

c) Did she make it possible for you to carry on extra activities?

____ Relief from patient care __ Very satisfied __ Satisfied __ Dissatisfied

____ Enable patient to be out of bed __ Very satisfied __ Satisifed __ Dissatisfied

____ Take patient out of home for social outings

__ Very satisfied __ Satisfied __ Dissatisfied

Other ____________________________________________

____________________________________________

13. Are there other activities you would have liked a home helper to carry out?

Yes ____ No ____

(If yes) What would these be?

________________________________________

________________________________________

________________________________________

14. Where (do (need
(did you feel you (needed the most help?

____ Laundering and ironing

____ General cleaning

____ Heavy cleaning

____ Sitting with patient

____ Meal preparation

____ Shopping and errands

____ Personal care of patient

Other ________________________________________

________________________________________

15. Did the Home Help Service enable a relative to continue or go to work who otherwise would have had to stay at home?

Yes ____ No ____ Not applicable ____

16. (Do
(Did you pay for this service?

Yes ____ No ____

(If yes) ____ in full Who pays the other part? ____ Family

____ in part ____ V.O.N.

____ Home Care

____ Don't know

(If no) Who paid? ____ Don't know

____ Home Care

____ V.O.N.

17. (If yes to 16) Did you feel you could afford to pay what was charged?

Yes ____ No ____ N/A ____ Don't know ____

18. What arrangements would you have made if there was no Home Help Service?

____ Placement in institution

____ Would have to manage without the service

____ Hire a homemaker privately

____ Have to depend on friends and relatives

Other ________________________________________

________________________________________

19. How (do<br>(did you feel about the age of your home helper? Would you prefer someone

____ older; ____ younger; ____ right age.

How old (was<br>(is she? ____ under 25

____ 26 - 45

____ 46 - 60

____ +60

20. (Did (assisted<br>(Do you feel the service (assists other members of your family?

Yes ____ No ____ Don't know ____

(If yes) In what way?

____ Relief from worry

____ Relief from extra work

____ Maintains a comfortable home for the family

____ Relief from extra expenses

____ Less demand on relative's time

Other ________________________________________

________________________________________

(If no) Did any members of the family object to the use of the Home Help Service?

Yes ____ No ____ Comment. ________________________________________

________________________________________

21. a) (If on current service):

Has the service been interrupted or withdrawn while you have used it?

Yes ____ No ____

(If yes) How did you manage without service?

______________________________________________

______________________________________________

______________________________________________

b) (If service is terminated)

Did you feel service was withdrawn too soon?

Yes ____ No ____

(If yes) Why did you feel you needed further service?

______________________________________________

______________________________________________

______________________________________________

How did you manage?

______________________________________________

______________________________________________

22. Are there ways that the service could be more helpful to you?

______________________________________________

______________________________________________

______________________________________________

23. Would you recommend the Home Help Service to other members of your family or to friends?

Yes ____ No ____ Don't know ____

Why?

____ Satisfied with the service

____ Personal interest of home helpers

____ Financial reasons - couldn't afford service at community rates.

APPENDIX C

A COMPARISON OF GROUP "A" AND GROUP "B" ON THE BASIS OF SOME SELECTED FACTORS

| SELECTED FACTORS | | GROUP A | | GROUP B | |
|---|---|---|---|---|---|
| | | Number | % of Group | Number | % of Group |
| Age | 0-40 | 3 | 15.7 | 3 | 13 |
| | 41-50 | 2 | 10.5 | 3 | 13 |
| | 51-65 | 3 | 15.7 | 4 | 17.3 |
| | 66-80 | 5 | 26.3 | 7 | 30.4 |
| | Over 80 | 6 | 31.5 | 6 | 26 |
| Sex | Male | 3 | 15.7 | 4 | 17.3 |
| | Female | 16 | 84.2 | 19 | 82.6 |
| Marital Status- | Single | 3 | 15.7 | 2 | 8.7 |
| | Married | 9 | 47.3 | 12 | 52.1 |
| | Widowed | 7 | 36.8 | 7 | 30.4 |
| | Separated | - | - | 2 | 8.7 |
| Annual INcome | -Unknown | 4 | 21 | 4 | 17.3 |
| | 0-1999 | 8 | 42.1 | 8 | 34.2 |
| | 2000-2999 | 3 | 15.7 | 1 | 4.3 |
| | 3000 & over | 4 | 21 | 10 | 43.3 |
| Source of Income | Old age pension | 9 | 47.3 | 8 | 34.2 |
| | Other Pension | 4 | 21 | 7 | 30.3 |
| | Wages | 3 | 15.7 | 5 | 21.7 |
| | Public Assistance | 3 | 15.7 | 3 | 13 |
| Illness Category | Acute | 5 | 26.3 | 4 | 17.3 |
| | Chronic | 10 | 52.6 | 17 | 73.9 |
| | Terminal | 1 | 5.3 | 1 | 4.3 |
| | Old age | 3 | 15.7 | 1 | 4.3 |

| SELECTED FACTORS | GROUP A | | GROUP B | |
|---|---|---|---|---|
| | Number | % of Group | Number | % of Group |
| Duration of Illness Unknown | 2 | 10.5 | 6 | 26 |
| 0-1 yr. | 6 | 31.5 | 1 | 4.3 |
| 1 yr. 1 day-5 yr. | 5 | 26.3 | 11 | 47.8 |
| over 5 yr. | 6 | 31.5 | 5 | 21.7 |
| Relatives in Greater Wpg. Yes | 16 | 84.2 | 18 | 78.2 |
| No | 3 | 15.7 | 4 | 17.3 |
| No response | - | - | 1 | 4.3 |
| Category of Relative | | | | |
| Parents | 3 | 13.6 | 3 | 11.5 |
| Adult Children | 9 | 40.9 | 10 | 38.6 |
| Siblings | 6 | 27.2 | 9 | 34.6 |
| Extended Family | 4 | 18.1 | 4 | 17.3 |
| Length of residence in Greater Wpg. 0-5 yrs. | 2 | 10.5 | 2 | 8.7 |
| 6 - 20 yr. | 1 | 5.3 | 5 | 21.7 |
| Over 20 " | 16 | 84.2 | 16 | 69.5 |
| Length of Residence in Neighborhood** 0-5 yrs. | 6 | 31.5 | 5 | 21.7 |
| 6-20 yrs. | 6 | 31.6 | 6 | 26 |
| Over 20 yrs. | 7 | 36.8 | 11 | 47.8 |
| Living Arrangement Alone | 6* | 31.5 | 5 | 21.7 |
| Spouse | 5 | 26.3 | 7 | 30.4 |
| Parent | 1 | 5.3 | - | - |
| Spouse & Dpdt. Chdn. | 3 | 15.7 | 4 | 17.3 |
| Spouse & Adult " | 1 | 5.3 | 1 | 4.3 |
| Adult " | 1 | 5.3 | 4 | 17.3 |
| Dpdt. " | 1 | 5.3 | 2 | 8.7 |
| Sibling | - | - | - | - |
| Boarder | 1 | 5.3 | - | - |

* half of this group are in Senior Citizens Housing
**One no response in Group B.