AN EVALUATION OF THE ROLE, THEORY, AND PRACTICE OF THE
OCCUPATION OF HOMEMAKER

by

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ABSTRACT

A homemaker is an individual who is employed by a homemaking agency for the purpose of providing in-home service to specific clients. These client services involve housekeeping and/or personal care assistance. Until now little research has been done in the area of homemaking as an occupation. Therefore, this study is intended to provide research background for present and future work concerning the homemakers in the areas of their role change, theory, and practice. Using the data base obtained from supervisor case notes of homemaker clients in the years 1976 and 1980, this study attempted to look at the role changes that occurred and the discrepancy that existed between the practice of homemakers in an agency and the practice its homemakers were taught within the classroom.

The sample data was derived from one hundred client files each from 1976 and from 1980. The individual files were randomly selected from the files of a large metropolitan homemaker agency within the province of British Columbia. The corresponding curriculum that was used in this study is the Homemaker Program of the Vancouver Community College, Vancouver, B.C., as taught in 1980. Methodology for this research included statistical analyses of the client file data and use of the Provus Discrepancy Evaluation Model, in which the actual practice of the homemaker and the formal curriculum of homemaker training were compared.

Findings of the research are that the client of 1980 appeared to be older, was representative of a numerically

smaller household, and depended on others for referral to the homemaker agency. Cross-tabulations of the years (1976 and 1980) with a variety of health and demographic indicators display statistically significant increase in 1980 of clients who had psychological and medical-surgical problems. However, child-care related problems for these clients decreased significantly in 1980.

The category of homemaker practice, meaning the duties that the homemaker was indicated as having been required to perform in the client's home, also showed areas of significant statistical change. Cross-tabulations of these years indicate that personal care and housekeeping practice had increased significantly by 1980. Homemaker practice related to assistance with child care in the home decreased in 1980.

A discrepancy analysis between the practice of the homemaker in the client's home and their corresponding curriculum of the homemaker training program indicated congruency for eight of the eleven practice categories. The areas of discrepancy were: 1) replace Home Care nurse (temporarily); 2) assist with the administration of medications; and 3) monitor state of health.

The homemaker organization is a service oriented group in which rapid role changes are occurring, accompanied by the evidence of some apparent discrepancies between curricular theory and actual practice.

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Chapter I

PROBLEM AREA

Introduction

Societal understandings about health and health services have undergone radical changes within the past one hundred years. Prior to the nineteenth century, the state of health and treatment of disease was very much person oriented. The sick were usually cared for in their homes, attended by family and community members. Sickness, aging, and death were commonly experienced phenomena that occurred within the lifespan of individuals; and as such were understood as being aspects of life over which the individual had little or no control.

The advent of the germ theory in the nineteenth century created a dramatic change in the belief structures concerning health and disease. What occurred was a refocusing of attitudes onto the disease process and away from the individual. There was a diminishing interest by the medical profession in the non-biological aspects of illness.

As professionals within health service settings became more skilled and institutionally oriented, the power and mystique surrounding the helper increased. A professional body of knowledge that encompassed the cause, effect, and treatment of the infirmed was developed. Specializations within the field of the helping professions increased. The knowledge about the area of health care and social service assistance became more complex

as the demand for these services increased.

More recently, health service structures have begun to show additional signs of change. Interest has increased in the concept of treating the whole person as well as the disease process. Alternative choices for the care of the elderly, the chronically ill, and the dependent individual have appeared. Boarding homes, residential care facilities, health care oriented apartment complexes have in many cases replaced and supplemented the asylums, orphanages, and large hospital complexes of the past. This may be due to the realization that long term, institutionally based care is not optimal care for certain clients and the belief that home or community situated care may be more cost beneficial to the taxpayer.

The homemaker organization is a social service, health care oriented association that was created within the professional mode of client assistance in the early nineteen hundreds. It is a service that has rapidly increased in response to the demand for alternative modes of assistance for the elderly, the chronically ill, and the dependent individual. Homemakers have consistently, since their beginnings as an occupational group in the nineteen thirties, provided service to the client in the areas of housekeeping and personal care assistance. However, as the shift toward the alternative choice of home and community based settings for certain individuals has increased, the role and practice of the homemaker appears to have changed.

There have been few studies published that are related to the homemaker. Therefore, the writer attempted to create a study of the homemaker that is both quantitative and qualitative

in nature in order to provide a multiple perspective of this unique occupation.

Specifically the study looked at the degree of congruency or discrepancy that exists between the theory (the formal curriculum that is taught to the homemaker) and the actual practice of the homemaker in the home of the client. The study also involved a limited analysis of the role change of the homemaker in British Columbia since the nineteen thirties with a particular focus on the changes that appear to have occurred between 1976 and 1980.

History of the Homemaker Organization

Berger and Luckman (1966) contend that an institution cannot be adequately understood unless there is an understanding of the historical process in which it was produced. Our contemporary understanding of the homemaker is therefore grounded within the changes that have occurred in health and social service assistance of the past century, as well as the more specific and regionally defined changes of the past five years within the province of British Columbia.

Historical, documentary accounts of the origins and development of the homemakers organization within British Columbia exist in a limited form that is not easily researchable. There are few published articles or unpublished studies related to homemakers. The historical information that does exist is usually found in the form of primary or secondary sources, with the majority of documents being situated in the

files of homemaker agencies or governmental bodies associated with the purchasing of homemaker service.

The writer, having been given file access to a homemaker agency, selected newspaper clippings, brochures, minutes from agency meetings, and limited correspondence as the basis for reconstructing some of the historical beginnings and development of the homemaker service in British Columbia.

The earliest correspondence in the agency files concerned a summary of minutes that were recorded during the first committee meeting on the visiting homemaker in Vancouver, January, 1938. In this document the homemaker is described as being primarily a mother substitute.

A brochure describing the role of the community homemaker (undated), also found in the agency files, refers to its historical beginnings in British Columbia as being the establishment in 1938 of a homemaker service by the Family Services of Greater Vancouver. The brochure goes on to state that by 1966 the B.C. government expanded homemaker service to persons of all ages and families of any size with fees being set by a predetermined means test. The homemaker was described as someone who provided both household assistance and personal care to clients in their home.

A newspaper article from The Vancouver Sun, February 14, 1973 portrayed the homemaker as being sent into the client's home in certain situations when there is illness. This article stated emphatically, however, that the homemaker never administered medication. Homemaker training was described as including a first aid and a home nursing course. The Vancouver

Vocational Institute was sited as being the source of homemaker curriculum for the early seventies with the program shifting to the Vancouver Community College by the middle seventies.

The creation of The Division of Long Term Care in the British Columbia Ministry of Health by a provincial legislative act in the year 1978 appeared to have a major impact on the growth and development of the occupation of homemaking. Following the department's creation, the number of homemaker agencies increased by a factor of ten from 1970 to 1980.

In a document sent to homemaker agencies in 1978, the British Columbia Ministry of Health, in its Introduction to the Program of Long Term Care, January 1, 1978, described the philosophy of long term care in the following manner. The ministry stated that there had been a long standing interest in creating a provincially based program of long term care. The key element of such a program was the belief that individuals would want to stay in their homes for as long as practical and desirable and that support should be provided for those needing this special assistance. In addition to the home care support that was to be made available for those assessed as being in need of this service, institutional care at the personal, intermediate, and extended care levels was also to be made available. The objectives of the Long Term Care program outlined and stressed the importance of maintaining independence and optimal health levels for the client.

Newspaper articles such as the one that appeared in The Province (Vancouver) on January 5, 1978, at the beginning of the Long Term Care program, emphasized the importance of keeping

individuals in home settings whenever possible. This article from The Province also stressed the government's point of view that homemaker services were assumed to be a positive factor in reducing the demand and the cost of more extensive and costly levels of care.

By 1979, however, there was an occasional article appearing in these collections of newspaper clippings that seemed to raise a new issue related to the accelerating development of homemaker services. That issue centred around the increasing complexity of care being required by the client. On June 11, 1979, a Colonist (Victoria) reporter quoted the president of a community social service association in British Columbia as voicing concerns that the level of service the homemakers were expected to provide for the client seemed to be increasing in complexity. The number of clients were observed to be steadily increasing, as were the hours of service required.

The occupation of homemaking services by the nineteen eighties appeared to have shifted from its initial focus of a primary concern with short-term, family oriented crises to include a new and much more complex dimension of the client whose needs were frequently long term and chronic in nature. This client often required complicated personal care assistance in addition to housekeeping services.

These particular facets of homemaker role change and the training and practice of homemakers will be examined further in the research presentation and analysis chapters.

Development of the Homemaker Curriculum

The records of the homemaker agency that has been the focus of research for this thesis indicated that approximately fifty five percent of its homemakers completed the Vancouver Community College Homemaker Training Program. Homemaker training for the remaining homemakers consisted primarily of brief orientation sessions and an on-going in-service program that was taught by agency supervisors and available to all of the agency's homemakers.

There have never been any compulsory educational requirements in British Columbia for the homemaker who is employed by a homemaking agency. This specific situation and the problems that it represents will be further addressed in the recommendations chapter of this thesis. Since the Vancouver Community College curriculum represents the formal curriculum that has been taught to a majority of homemakers from the agency researched, it was chosen as being the most appropriate training program to use as the basis for a discrepancy evaluation concerning the teaching and practice of the particular group of homemakers under study. There are other forms of homemaker curricula that have been taught and developed within the province of British Columbia. However, it is not the purpose of this thesis to comment on these programs but to look specifically at the curriculum that constitutes the major educational component for the formal training of the homemakers from the agency that has been the focus of this thesis.

The document, Development of the Vancouver City College Homemaker Program - Report of Phase III, published in 1978,

indicates close historical ties between family service organizations and the early growth and educational development of the Homemaker Program in British Columbia. In 1964 Family Services Centers met with representatives of the Vancouver Vocational Institute, requesting that a "Housekeeping Training Program" be developed. An advisory committee was formed and a pilot training program was developed and situated at the Vancouver Vocational Institute. Subsequently, a housekeeping program to train Indian women was also developed and funded by the Department of Indian Affairs. In 1965, the provincial government approved the Trained Family Aide Program. This was a program that centred around topics such as: food preparation, housecleaning, home nursing, and human behaviour needs.

In 1966 there was a push to develop specific, formal training programs for the homemakers employed by the Family Service Centers. The document cited above states that within this period a specific program other than the Trained Family Aide Program was needed. This program was the Trained Homemaker Program, consisting of six weeks of training and including topics with a broader base of theory than that provided by the Family Aide Program.

In 1969 the program was extended to eight weeks in order to meet what appeared to be the more complex needs of the client. Vancouver Community College records also state that in 1975, as personal care needs of the client intensified, the program, then taught by V.C.C., was extended to a period of twelve weeks. A subsequently revised curriculum reflecting the changing needs of the homemaker and client was put into place in 1978. By 1980

the homemaker program had been extended to a thirteen week course for those enrolled in the full-time day sessions. Evening sessions were also offered, consisting of one session a week for approximately one year.

Additional documents and discussions between the writer and the Vancouver Community College curriculum developers in 1980 indicate that the curriculum is experiencing an on-going review with revisions especially reflecting the important role of Long Term Care in the area of homemaker services. These revisions also appear to reflect the rapidly changing nature of the homemaker's role and the increasing demands that are being placed on homemaker agencies and the curriculum developers in terms of providing both housekeeping and health care assistance to the client.

Chapter II

LITERATURE REVIEW

Introduction

A search of the literature related to the topic of the homemakers reveals that there is little research material available. The literature that does exist can be divided into two areas:

- 1) studies that are primarily descriptive in nature, in which the contemporary role or the futuristic role of the homemaker was delineated;
- 2) studies related to the cost-effectiveness of homemaker services.

There does not appear to be any published research that is concerned with the analysis of congruency or discrepancy between the theory and the practice of the homemaker. The lack of research within this particular area is an issue that will be addressed in subsequent chapters. The research studies that do exist are useful for the purpose of delineating some of the observations and concerns that other researchers have noted.

There is literature on the topic of homemaking as an occupation available from both American and Canadian sources. Numerically, there are more American articles available. However, the Canadian literature appears to be much more applicable to the study of the homemaker with in the context of

British Columbia because the provision of social and medical services differs in the two countries.

Literature from the United States

The articles from the United States were written primarily during the sixties and seventies and were principally descriptive in nature. These descriptive studies portray the role of the homemaker as being one that is grounded within the context of the family. In these studies the homemaker was often described as being a mother substitute or mother helper. The homemaker was frequently referred to as being an individual who was utilized in short-term crisis situations. The studies, "Analysis of Tasks in Three Home Related Occupations" (Shipley, 1967) and "Supervision of the Paraprofessional" (Ripple, 1973), both describe a homemaker as being essentially a mature individual who helps or replaces the mother in family settings. She was seen as being a person who was trained to perform household duties in order to assist with the normalization of family life during periods of stress. Another study from this period refers to the homemaker as an individual who could combine both the skills of homemaking and home nursing (Lewis and Scheuren, 1975). The homemaker in the Lewis and Scheuren study was also described as being unlicensed and nonprofessional. The homemaker was someone, who would, when the occasion demanded, be prepared to give both personal care assistance and assistance with housekeeping duties to the client.

The literature from the United States also contains some studies that were concerned with the cost-effectiveness of homemaker services. One of these studies, which assessed the utility of homemaker service as an alternative to a variety of more expensive and complex forms of institutional care, found that homemaker service could be generally described as being more cost-effective than any of the out-of-home alternatives surveyed (Robinson, 1974).

Canadian Literature

The Canadian literature related to the homemaker consists of three research studies. These Canadian studies also address the descriptive aspects of the homemaker and the issue of the cost-effectiveness of homemaker service to the client. The first of these studies, "Visiting Homemaker Service in Canada: Report of a Survey with Recommendations", sponsored by the Canadian Council on Social Development (1971), described the homemaker as someone who provided an organized community service. She was responsible for assisting or replacing the mother in family settings. This report also outlined the costs of service. It stated that there was no simple formula based on financial statistics by which costs and benefits to clients could be assessed. This same report also addressed the training of the homemaker. The findings were that the training or lack of training for homemakers varied widely across Canada. In its recommendations the council presented as its first priority for

action that homemaker service be recognized as being a public utility, one that is available and accessible to the whole community. The study also stressed the importance of on-going evaluation of homemaker training programs.

The remaining two Canadian studies were researched within the lower mainland of British Columbia. In a study entitled: Report on Homemakers and Related Services in Greater Vancouver (Mercer, 1974), homemaker service was described as providing assistance or mother replacement in family settings and as giving help to the chronic or convalescent adult. This report described the typical client in the period of the early seventies as requiring assistance in short-term, stress related situations. Personal care involved only 19% of all services surveyed.

The last of the Canadian literature to be reviewed was a study prepared by the Social Planning and Review Council of British Columbia (S.P.A.R.C.) in 1977. This report, Homemaker Service for Elderly Persons in B.C., surfaced just prior to the legislative actions of the British Columbia government in 1978 when the program of Long Term Care was created. The S.P.A.R.C. report addressed the need for priorities in community care for senior citizens. The major recommendation was that homemaker service for the elderly should be universally provided on the basis of a health/social needs assessment and that it should be available under a form of comprehensive care. The S.P.A.R.C. study also stated that public financing of in-home care was less expensive than was the financing of comparable institutional care and that it was almost always more satisfactory to the

client.

The Canadian literature indicates the stage that was being set for the enactment of legislation regarding Long Term Care financing of homemakers; a legislative action that was to affect both the homemakers and their clients.

Chapter III

CONCEPTUAL FRAMEWORK

Framework Design

The conceptual framework for this paper was designed with a sociological base of inquiry. The primary foundation is the writings of Berger and Luckman (1966) in the area of the sociology of knowledge. Secondarily, the writings of MacIntyre (1977) concerning conflicting perspectives of health care and social services has been chosen to augment the writings of Berger and Luckman. These two modes of inquiry were also chosen as being complimentary to one another, and of particular value in researching the complex factors that influence the homemaker.

Sociology of Knowledge Approach

The sociology of knowledge approach, as postulated by Berger and Luckman (1966), is a useful framework against which the role change and the educational issues of the homemaker organization can be viewed. Berger and Luckman, in their particular field of sociological inquiry, look at the question of how knowledge comes to be socially established as reality. For the purposes of homemaker research this approach entails a historical understanding of what society in the past has understood the homemaker to be, what were her roles, and what

was her perceived function within society. Adjunctive to her role and function, what was she taught about homemaking, and what was the scope and limitations of that body of knowledge that we refer to as being homemaker curriculum. Specifically, Berger and Luckman refer to such a group as the homemakers as being representative of an institutional concept. The institutional concept is that the homemakers are a group which has been set aside for some specific purpose. Their existence as a group is recognized by the society of which they are a part. There is an implied body of knowledge that is associated with their role and function and an implied external control over what they can and cannot do as they provide homemaker service to the client. Berger and Luckman also state that the more conduct itself is institutionalized, or seen and accepted as being part of commonplace activities within our lives, then the more predictable and controlled the activity of groups such as the homemakers should become.

Homemaker Roles

In terms of the roles that homemakers play and how these roles may have changed over the years, Berger and Luckman (1966) contend that all institutionalized conduct, such as that of homemaking, involves the concept of a role. The role of an individual is part of the controlling character of institutionalization. If the role and role stability of the individual is indeed crucial as a control factor, then problems will arise in situations in which the individual's role is

rapidly changing. The findings of this thesis study indicate that the role of the homemaker in 1980 is not congruent with her role in 1976. Given the rapidly increasing complexity of client needs, the role of the homemaker may continue to change.

The institutional constraints that are placed on the homemaker also appear to define her role of service to the client. Berger and Luckman state that institutions control human conduct by establishing predefined patterns of conduct which channel it in one direction as against the many other directions that theoretically would be possible. The homemaker is directed by the homemaker agency as to certain prescribed duties that she is to provide for specific clients. She may be further limited in her patterns of conduct by the educational training she has or has not received.

Ideally, the role, theory, and practice of a body such as the homemakers should mesh together within a generalized pattern of congruency. However, in the case of the homemakers as outlined in this thesis, there appears to have been rapid role change and corresponding areas of discrepancy between theory (training) and actual practice. When this occurs, both the homemaker's understandings of who she is and what services she should be giving to the client may be distorted. The understandings of society at large as to the role of the homemaker may also be poorly defined.

Conflicting Perspectives in Health Care and Social Services

A second viewpoint from which the role and function of the

homemaker can be understood is derived from the sociological writings of Sally MacIntyre. One particular study (MacIntyre, 1977) outlines a duality of concepts within the area of health care and social service. In her studies MacIntyre used the issue of old age as a social problem as the basis of research. She pointed out, though, that her research is of relevance not only to the problem of old age, but also to health and social service problems of chronicity and dependency in general. She stated that in England there appears to have been tension between the organizational and the humanitarian perspective within the last century and a half. In the humanitarian perspective old age (as well as chronicity and dependency in general), is seen as being problematic because it encompasses suffering and observable costs for the individual. The action component concerns the question of how best to prevent these problems of old age, chronicity, and dependency by reducing the costs to the individual experiencing them. The organizational perspective sees old age, chronicity, and dependency as a social problem because there is a burden of dependency that is placed primarily on the productive members of society. The action component here involves a consideration of how best to reduce the social costs that are placed on the community by these individuals who require health care and social assistance.

It will be argued in this thesis that both the humanitarian and the organizational perspective are operative within the area of the homemakers. These two concepts are particularly useful in determining some of the complex factors that influence not only the homemaker, the client, and society in general.

Chapter IV

METHODOLOGY

Overview

Instrumentation for the research was chosen with the specific intent of analyzing the role change of the homemaker over a defined period of time and the discrepancy that might exist between the curricular theory and the actual practice of homemakers in the client's home.

For the purpose of comparison, one hundred client files each from 1976 and from 1980 were randomly selected. These years were chosen so that the role and practice of the homemaker could be assessed prior to and following the introduction of the Long Term Care legislation in 1978. Content analysis of this file data was used to reduce the information contained within these client files to the form of manageable units. After the data gathering was completed, content reduction of this data to mutually exclusive units of information was then employed. The prepared categories of information obtained from the 1976 and 1980 client files were then statistically compared using the Statistical Package for the Social Studies program (S.P.S.S.).

The next step in the methodology design was to compare the practice categories obtained with the 1980 curriculum of the homemaker training program. The Provus Discrepancy Model (Provus, 1971) was used in this instance. The Provus Model is an evaluative tool that allows for the analysis of congruence

and/or discrepancy between curricular theory and practice. The curricular theory was that of the 1980 homemaker training program as taught by the Vancouver Community College; a program that corresponds to the training received by a majority of the homemakers within the agency researched for this thesis.

The final methodology to be employed was that of focussed interviews consisting of data from representative field supervisors within the agency being studied. The interviews served to expand the information available from all sources, regarding the role and training of the homemaker.

These methods were selected not only for their ability to provide tools for analyzing some of the underlying conceptual questions about the homemakers but also with the purpose in mind of creating a multi-dimensional view of the homemaker's role, theory, and practice within the specified period of time.

Content Analysis

In this thesis content analysis as described by Holsti (1969) was used specifically for the purpose of reducing the amount of descriptive material related to the practice of homemakers and biodemographic characteristics about the client to the form of manageable units. Content analysis provided a technique whereby inferences about homemaker practice data obtained from the client's case notes could be objectively and systematically identified, and the specific characteristics of this material extracted for analysis.

The writer initially formulated a series of biodemographic

and homemaker practice areas of interest that were expected to be found within the client file information. These were: the client's age; sex; area of city residing in; method of referral; the number in the family unit of the client; the reason(s) why assistance was required by the homemaker; and the areas of practice the homemaker was recorded as having performed in the client's home. Careful construction of these categories was seen as being an important preliminary step in meeting both the theoretical requirements of the problem at hand, as well as the recognized canons of category construction. Additionally, a precise operational definition of categories was decided upon in order that the coding could proceed with acceptable levels of reliability, as has been suggested by Holsti and other writers in the field of content analysis (Holsti, 1969). The writer also chose the use of content analysis for this particular task of information analysis because all content analysis is based upon the comparative mode (Holsti, 1969). By reducing information to mutually exclusive units, the homemaker case note data could be easily tabulated and cross referenced.

Another concern of the writer was within the area of objective as opposed to subjective information gathering. These particular client files were compiled by field supervisors, who entered specific data at the time of client processing and during the months or years the client's file was active. Using the content analysis method of retrieving information about client characteristics and homemaker practice, it was possible in this instance to make use of an unobtrusive research technique (Webb et al. , 1966). Information written at the time

in which there is ongoing interaction between a field supervisor, a homemaker, and a client provides a unique data vignette. Webb and Salancik(1965) described this kind of documentary evidence as being far superior to the recall of events; the palest ink of these documents reveals more of the past than would be possible in volumes of verbal recollections. The method of content analysis further eliminated the possible contamination of data that might have occurred with the use of other forms of data gathering; forms in which interaction between the researcher and the subject generating and recording information could affect the nature of the response (Holsti, 1969).

The biodemographic information was retrieved without difficulty and recorded in the form of mutually exclusive units. The category of client diagnosis (or the reason why the client requested assistance from the homemaker agency) was retrieved in a similar manner. However, the area of homemaker practice required much more exhaustive analysis before the writer was able to reduce the extensive client notes to manageable units. The ultimate goal for this more complex area of analysis was to determine what the communication was about. This goal of reduction of practice notation to mutually exclusive categories was obtained after many readings and re-readings of client files in order to determine how many times and with what variation certain homemaker practice categories appeared for each client. As Holsti (1969) has noted in his research in the field of content analysis, the theme, the single assertion about the subject being investigated, is often the most useful unit of

content analysis.

Once the content analysis was completed, and these specific categories recorded, the next phase was the statistical analysis of the client case note data.

Statistical Package for the Social Sciences

The Statistical Package for the Social Sciences was chosen for use in the statistical analysis of the data generated from the client files. The S.P.S.S. is an integrated system of computer programs that has been designed specifically for the analysis of social science data. It contains procedures that are especially useful for obtaining descriptive statistics, simple frequency distributions, and cross tabulations.

The Provus Discrepancy Model

A central question for this evaluative thesis is the extent of congruency or discrepancy between the curriculum of the formal training program for the homemakers being researched and the areas of practice in which she is typically engaged within the home of the client. The Provus Discrepancy Model of Evaluation (Provus, 1971) was chosen as an appropriate tool by which these areas of congruency and/or discrepancy could be clearly identified and analyzed. Provus states that an underlying interest in evaluation is derived from a basic desire to provide optimal educational programs and that within this

framework of seeking optimal programs there should always be an underlying skepticism about the present program. He goes on to suggest that we evaluate on the assumption that a problem (a discrepancy) exists, that a solution can be found, and that evaluation will aid in the solution process. He further describes the evaluation of any institution as involving two major steps: 1) the adequate defining of the standards that must be followed; and 2) a comparison of the actual performance of the institution with those standards. In the Provus model there are five stages:

Stage I: Design of the Program

Stage II: Program Instillation and Congruence Testing

Stage III: Delineation of Interim Products

Stage IV: Terminal Products

Stage V: Cost Effectiveness of the Program.

The fifth stage of this model has been deleted from the analysis on the grounds that it represents a phase of research that is not central to the issue of congruency and/or discrepancy being pursued within this particular study.

Within the parameters of this thesis Stages I through IV have been used as follows: Stage I analyzed the terminal goal(s) and the interim objective(s) of the Vancouver Community College Homemaker Training Program (1980 curriculum guide). Stage II matched the homemaker practice data that was originally derived from the client case notes with the curriculum guide's goals and objectives. Stage III was employed to analyze assumed relationships between processes and the interim products. Specifically, what competencies the homemaker student should be

able to practice within certain curriculum areas were examined in this stage. Stage III was also the stage at which the product was measured. For example, what minimum number of hours appear in the student guidelines concerning student learning activities. In Stage IV there were evaluative conclusions reached as to whether or not the combination of interim product sets appeared to have met the major terminal goal or objective. In Stage IV, the final stage used for this analysis, the specific practice category of the homemaker being assessed either matched the format of the curriculum guide, or a discrepancy was noted. It should be noted that only the practice areas retrieved from the 1980 statistical analysis were used for congruence/discrepancy evaluation.

Interviews

The final mode of instrumentation was that of brief, focused interviews with four field supervisors who were representatively chosen from the agency where the client data was generated. The purpose of these interviews was primarily to gather additional information related to the role and training of the homemaker.

Homemaker supervisors within the agency were representatively selected from the areas of the greater Vancouver area in which the agency being studied is located. A form of focussed interview technique was used. Specifically, the supervisors were asked questions that related to the role, theory and practice of the homemakers within their particular

agency. The three questions were: 1) What do you consider to be the role of the homemaker as she assists her clients? 2) Is there any area of discrepancy between what the homemakers in this agency have been trained to do, and what she may actually be required to do in the home of the client? 3) Does the present homemaker training program meet the needs of the homemakers within this agency in their assistance to the client?

The data from the interviews was then content analyzed so that patterns of response to the questions could be studied. The patterns of responses provided information as to how the supervisors viewed the homemakers within this particular agency.

The overall intent of these brief interviews was that of providing another viewpoint from which this complex area of homemaker theory and practice could be seen.

Summary

The methods of research were: a statistical analysis of client file data; a Provus Discrepancy analysis of the practice and theory of the homemakers studied; and structured interviews with representative homemaker supervisors. The results of the statistical and the discrepancy analyses will be discussed and presented in detailed, tabular form in the next chapter. The findings of the interviews will also be presented in Chapter VI and will provide additional information about the supervisors' understandings of the role, theory, and practice of the homemaker that was not obtained from an analysis of the client files.

Chapter V

RESULTS

Introduction

This research study concerning the role, training, and practice of the homemaker has involved the necessity of comparing and analyzing a variety of factors that are contained within the overall concept of the homemaker.

Overall, the findings of this research study present a composite picture of a specific group of homemakers and their clients in which there has been significant change. The role and practice of the homemaker appears to have undergone observable alterations. The curricular theory does not in every instance appear to match the actual practice of the homemaker. However, the data analysis does indicate more congruency than discrepancy.

Specifically, the statistical analysis reveals the typical homemaker client in 1980 as being older than her 1976 counterpart. This client of 1980 is also representative of a smaller family unit; resides primarily in the city of Vancouver; is more apt to be referred by Long Term Care; has a significantly higher percentage of psychiatric and medical problems; but requires less assistance with child care in the home.

In terms of theory and practice the curriculum of the homemaker training program that was completed by a significant

percentage of homemakers in the agency surveyed proved to be primarily congruent with the exception of three out of the eleven categories tabulated. The areas of practice and theory discrepancy occurred in the categories of: monitoring the state of health of the client, assisting the client with medication, and replacing Home Care nurses on a temporary basis. These three areas of discrepancy are explicitly excluded from the V.C.C. curriculum of 1980, and the premise for their exclusion will be addressed in the concluding chapter.

This chapter contains a detailed presentation of both the statistical analysis of the client files as well as an evaluation of the theory and practice of the homemaker. Because the statistical tables that follow contain three separate analyses of data, a guide to these tables has been provided for the reader. A written summary of both the statistical tables and the evaluation data are included in this chapter.

Guide to the Statistical Tables

Cross-tabulations were done between the years 1976, 1980, and the following variables that were obtained from the homemaker client case notes: sex of client, age, number in family unit, area of residence, method of referral; combined practice categories of total personal care, total child care, total housekeeping; combined diagnosis categories of total psychiatric problems, total medical problems, and total child care needs.

For each of these variables three research questions were

tested that required separate analysis of the data. In the first instance the writer was interested in determining any degree of difference that might have existed between the 1976 and 1980 client data. The second research area of analysis looked at similar differentiations between 1976 and 1980 data that did not include Long Term Care clients. In the third area of analysis the writer compared 1980 Long Term Care clients with 1980 non-Long Term Care clients. In all three areas of research interest the question was that of ascertaining what patterns of change might occur. In the case of the Long Term Care variable, the intent was also to discover, if possible, the extent to which the Long Term Care client might differ from other clients who had not been categorized as belonging to Long Term Care.

TABLE I
Cross Tabulation of Sex and Year

	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
Male	11	(11.1)	19	(19.0)	8	(20.5)	11	(18.0)
Female	87	(87.9)	79	(79.0)	31	(79.5)	48	(78.7)
Couple	1	(1.0)	2	(2.0)	0	(0.0)	2	(3.3)
Total	99		100		39		61	

Significance Tests

1976 vs. 1980 $\chi^2 = 2.847$ (df = 2; P = 0.241).
 1976 vs. 1980(not LTC)¹ $\chi^2 = 2.729$ (df = 2; P = 0.255).
 1980(LTC) vs. 1980(not LTC) $\chi^2 = 1.358$ (df = 2; P = 0.507).

¹ Long term care

Table II
Cross Tabulation of Age and Year

	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
<u>years</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
10 - 19	0	(0.0)	1	(1.2)	0	(0.0)	1	(2.0)
20 - 29	23	(25.0)	8	(9.4)	0	(0.0)	8	(16.3)
30 - 39	19	(20.7)	6	(7.1)	0	(0.0)	6	(12.2)
40 - 49	3	(3.3)	4	(4.7)	0	(0.0)	4	(8.2)
50 - 59	8	(8.7)	7	(8.2)	3	(8.3)	4	(8.2)
60 - 69	9	(9.8)	20	(23.5)	10	(27.8)	10	(20.4)
70 - 79	17	(18.5)	16	(18.8)	6	(16.7)	10	(20.4)
80 - 89	9	(9.8)	22	(25.9)	17	(47.2)	5	(10.2)
90 - 99	4	(4.3)	1	(1.2)	0	(0.0)	1	(2.0)
Total	92		85		36		49	

Significance Tests

1976 vs. 1980 Kendall's Tau C = 0.281; (P = 0.001).

1976 vs. 1980(not LTC) Kendall's Tau C = 0.077; (P = 0.414).

1980(LTC) vs. 1980(not LTC) Kendall's Tau C = -0.512; (P = 0.000).

Table IIICross Tabulation of Number in Family Unit and Year

	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
<u>no.</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
1	41	(41.4)	46	(46.5)	26	(68.4)	20	(32.8)
2	15	(15.2)	29	(29.3)	11	(28.9)	18	(29.5)
3	22	(22.2)	10	(10.1)	1	(2.6)	9	(14.8)
4	7	(7.1)	8	(8.1)	0	(0.0)	8	(13.1)
5	6	(6.1)	2	(2.0)	0	(0.0)	2	(3.3)
6	7	(7.1)	1	(1.0)	0	(0.0)	1	(1.6)
7	1	(1.0)	3	(3.0)	0	(0.0)	3	(4.9)
Total	99		99		38		61	

Significance Tests

1976 vs. 1980 Kendall's Tau C = -0.135; (P = 0.087).
 1976 vs. 1980(not LTC) Kendall's Tau C = 0.026; (P = 0.777).
 1980(LTC) vs. 1980(not LTC) Kendall's Tau C = 0.439; (P = 0.000).

Table IV

Cross Tabulation of Area of Residence and Year

<u>Area Code</u>	<u>Area Where Living</u>							
	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
1	4	(4.1)	8	(8.2)	3	(7.9)	5	(8.5)
2	10	(10.2)	2	(2.1)	1	(2.6)	1	(1.7)
3	4	(4.1)	2	(2.1)	0	(0.0)	2	(3.4)
4	4	(4.1)	6	(6.2)	2	(5.3)	4	(6.8)
5	0	(0.0)	6	(6.2)	1	(2.6)	5	(8.5)
6	2	(2.0)	1	(1.0)	0	(0.0)	1	(1.7)
7	2	(2.0)	3	(3.1)	1	(2.6)	2	(3.4)
8	7	(7.1)	7	(7.2)	2	(5.3)	5	(8.5)
9	2	(2.0)	3	(3.1)	1	(2.6)	2	(3.4)
10	2	(2.0)	2	(2.1)	1	(2.6)	1	(1.7)
11	11	(11.2)	16	(16.5)	9	(23.7)	7	(11.9)
12	3	(3.1)	5	(5.2)	4	(10.5)	1	(1.7)
13	2	(2.0)	2	(2.1)	1	(2.6)	1	(1.7)
14	3	(3.1)	2	(2.1)	0	(0.0)	2	(3.4)
15	2	(2.0)	2	(2.1)	1	(2.6)	1	(1.7)
16	2	(2.0)	0	(0.0)	0	(0.0)	0	(0.0)
17	0	(0.0)	1	(1.0)	0	(0.0)	1	(1.7)
18	8	(8.2)	5	(5.2)	4	(10.5)	1	(1.7)

Table IV (Continued)

Cross Tabulation of Area of Residence and Year(continued)

<u>Area Code</u>	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
19	1	(1.0)	3	(3.1)	1	(2.6)	2	(3.4)
20	5	(5.1)	3	(3.1)	2	(5.3)	1	(1.7)
21	3	(3.1)	2	(2.1)	0	(0.0)	2	(3.4)
22	0	(0.0)	1	(1.0)	0	(0.0)	1	(1.7)
23	10	(10.2)	13	(13.4)	3	(7.9)	10	(16.9)
24	10	(10.2)	1	(1.0)	1	(2.6)	0	(0.0)
25	1	(1.0)	1	(1.0)	0	(0.0)	1	(1.7)
Total	98		97		38		59	

Significance Tests

1976	vs. 1980	$\chi^2 = 30.24$ (df = 24; P = 0.177).
1976	vs. 1980(not LTC)	$\chi^2 = 31.82$ (df = 24; P = 0.132).
1980(LTC)	vs. 1980(not LTC)	$\chi^2 = 21.53$ (df = 23; P = 0.549).

Table IV (Continued)Biodemographic DataArea Where Living (Continued)

Area Codes: 1 = Hastings/Sunrise	14 = Oakridge
2 = Renfrew/Collingwood	15 = Marpole
3 = Killarney	16 = Shaughnessy
4 = Grandview/Woodlands	17 = Kerrisdale
5 = Kensington/Cedar Cottage	18 = Kitsilano
6 = Victoria/Fraserview	19 = Arbutus Ridge
7 = Strathcona	20 = Dunbar/Southlands
8 = Mt. Pleasant	21 = West Pt. Grey
9 = Riley Park	22 = Univ. End. Lands
10 = Sunset	23 = Burnaby
11 = West End	24 = Richmond
12 = Fairview	25 = N. Vanc./W. Vanc.
13 = South Cambie	

Table VCross Tabulation of Method of Referral and Year

	<u>Method of Referral</u>					
	<u>1976</u>		<u>1980</u>		<u>1980(not LTC)</u>	
	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
Long Term Care (LTC)	0	(0.0)	39	(43.3)	-	
Client/Relative of Client	39	(39.8)	3	(3.3)	3	(5.9)
Medical Staff	23	(23.5)	19	(21.1)	19	(37.3)
Social Service Agency	36	(36.7)	29	(32.2)	29	(56.9)
Total	98		90		51	

Significance Tests

1976 vs. 1980 $\chi^2 = 70.78$ (df = 3; P = 0.000).

1976 vs. 1980(not LTC) $\chi^2 = 19.06$ (df = 2; P = 0.000).

TABLE VICross Tabulation of Combined Personal Care Practice and Year

<u>Client received</u> <u>Personal Care</u>	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
No	87	(87.0)	58	(58.0)	17	(43.6)	41	(67.2)
Yes	13	(13.0)	42	(42.0)	22	(56.4)	20	(32.8)
Total	100		100		39		61	

Significance Tests

1976 vs. 1980 $\chi^2 = 21.09$ (df = 1; P = 0.000).
 1976 vs. 1980(not LTC) $\chi^2 = 9.103$ (df = 1; P = 0.003).
 1980(LTC) vs. 1980(not LTC) $\chi^2 = 5.450$ (df = 1; P = 0.020).

Table VIICross Tabulation of Combined Child Care Practice and Year

<u>Client received</u> <u>Child Care</u>	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
No	55	(55.0)	81	(81.0)	39	(100.)	42	(68.9)
Yes	45	(45.0)	19	(19.0)	0	(0.0)	19	(31.1)
Total	100		100		39		61	

Significance Tests

1976 vs. 1980 $\chi^2 = 15.53$ (df = 1; P = 0.000).
 1976 vs. 1980(not LTC) $\chi^2 = 3.036$ (df = 1; P = 0.082).
 1980(LTC) vs. 1980(not LTC) $\chi^2 = 15.00$ (df = 1; P = 0.000).

Table VIIICross Tabulation of Combined Housekeeping Practice and Year

<u>Client received</u> <u>Housekeeping</u>	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
No	7	(7.0)	3	(3.0)	3	(7.7)	0	(0.0)
Yes	93	(93.0)	97	(97.0)	36	(92.3)	61	(100.)
Total	100		100		39		61	

Significance Tests

1976 vs. 1980 $\chi^2 = 1.684$ (df = 1; P = 0.194).
 1976 vs. 1980(not LTC) $\chi^2 = 4.464$ (df = 1; P = 0.035).
 1980(LTC) vs. 1980(not LTC) $\chi^2 = 4.837$ (df = 1; P = 0.028).

TABLE IXCross Tabulation of Combined Psychiatric Problems and Year

<u>Client indicated</u>	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
<u>Psychiatric Problems</u>								
	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
No	92	(92.0)	80	(80.0)	36	(92.3)	44	(72.1)
Yes	8	(8.0)	20	(20.0)	3	(7.7)	17	(27.9)
Total	100		100		39		61	

Significance Tests

1976 vs. 1980 $\chi^2 = 5.980$ (df = 1; P = 0.015).
 1976 vs. 1980(not LTC) $\chi^2 = 11.40$ (df = 1; P = 0.001).
 1980(LTC) vs. 1980(not LTC) $\chi^2 = 6.053$ (df = 1; P = 0.014).

Table XCross Tabulation of Combined Medical Problems and Year

<u>Client indicated</u>	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
<u>Medical Problems</u>								
	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
No	35	(35.0)	20	(20.0)	2	(5.1)	18	(29.5)
Yes	65	(65.0)	80	(80.0)	37	(94.9)	43	(70.5)
Total	100		100		39		61	

Significance Tests

1976 vs. 1980 $\chi^2 = 5.643$ (df = 1; P = 0.018).

1976 vs. 1980(not LTC) $\chi^2 = 0.517$ (df = 1; P = 0.472).

1980(LTC) vs. 1980(not LTC) $\chi^2 = 8.838$ (df = 1; P = 0.003).

Table XICross Tabulation of Child Care Problems and Year

<u>Client indicated</u>	<u>1976</u>		<u>1980</u>		<u>1980(LTC)</u>		<u>1980(not LTC)</u>	
<u>Child Care Problems</u>								
	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>	<u>f</u>	<u>%</u>
No	72	(72.0)	94	(94.0)	39	(100.)	55	(90.2)
Yes	28	(28.0)	6	(6.0)	0	(0.0)	6	(9.8)
Total	100		100		39		61	

Significance Tests

1976	vs. 1980	$\chi^2 = 17.15$ (df = 1; P = 0.000).
1976	vs. 1980(not LTC)	$\chi^2 = 7.504$ (df = 1; P = 0.006).
1980(LTC)	vs. 1980(not LTC)	$\chi^2 = 4.081$ (df = 1; P = 0.043).

Summary of the Statistical Data

The statistical tables were constructed to reflect the following: biodemographic profiles of typical clients; the reasons they received homemaker service; and what kinds of homemaker assistance were provided to these clients.

The homemaker practice and client diagnosis categories were studied in both individual and combined data analysis. The individual categories of post-partum depression, psychiatric problem (undifferentiated), stress, alcoholism, schizophrenia, and suicidal thought disturbance were all combined to create the category of total psychiatric diagnosis. The individual categories of physical handicap, arthritis, at home with undifferentiated illness, diabetes, cardiovascular disease, senility, lung disease, and cancer were all combined to create the category of total medical diagnoses. The individual categories of sick child with parent working, parentless home, and new baby were combined to create the total child care needs diagnostic category.

In the second area of category groupings, individual categories of undifferentiated personal care, ambulate, change dressings, help dress, help bathe, monitor health, assist with medication, and replace Home Care nurse became the total category of personal care practice. Care for children existed both as an individual as well as a total practice category. Individual categories of home care (undifferentiated), clean, do laundry, prepare meals, and shop were combined for the total practice category of housekeeping practice. Individual sub-categories were tabulated for the years 1976 and 1980. The

combined categories were tabulated for 1976 vs. 1980 (total); 1976 vs. 1980 (excluding all LTC clients); and 1980 (LTC clients) vs. 1980 (non-LTC clients). The decision to combine the individual categories into combined, tabulated categories was based on the finding that most of the individual categories were not statistically significant, and in some cases were overlapping.

Individual Categories of Practice

The individual categories of the overall practice category displayed the following trends. Areas in which there was an increase in particular services being received by clients were: assistance with undifferentiated personal care; replacing the home care nurse temporarily; cleaning; preparing meals; and shopping. Decreases occurred in the areas of: assisting with dressing changes; caring for children; doing laundry; and housekeeping (undifferentiated). New categories were created in 1980 that did not exist in 1976. These were: monitoring the client's health status (e.g. noted changes in vital signs); assisting with medications (e.g. giving pre-poured medication to the client); helping to ambulate; dress; and bathe.

Individual Categories of Diagnosis

In the area of individual client diagnosis, the area that refers specifically to the problems the client experienced as a precursor to needing homemaker assistance, the following trends were observed. Increases occurred in 1980 within the client diagnostic categories of: undifferentiated psychiatric problems;

alcoholism; physical handicap; at home with undiagnosed illness; diabetic condition; cardiovascular disease; and cancer.

Decreases occurred in the areas of: stress syndrome; arthritis; senility; lung disease; sick child with parent working; parentless home; and new baby.

The individual categories, while displaying interesting trends in practice and diagnosis, cannot be construed as being statistically significant. Given the diverse spread of categories, a decision was made to combine the individual subsets of diagnosis and practice into the more statistically accurate groupings of: total personal care practice, total child care practice, total housekeeping practice, total psychiatric diagnosis, total medical diagnosis, and total child care needs diagnosis. These specific, individual categories do not appear as such within the tabular form of the preceding statistical tables.

Quantitative Statements Concerning Tables I - XI

Table I - Sex of Client

The homemaker clients in this study were shown to be predominately female in both years; 87.9 % in 1976; 79.0 % in 1980.

Table II - Age of Client

The client of 1980 also increased in age with a significant increase occurring in those 80-90 years: 9.8% in 1976 compared to 25.9% in 1980. 47.2% of the LTC clients were aged 80 - 90 years. There was a corresponding decrease in 1980 of clients under the age of forty.

Table III - Number in Family Unit

The client of 1980 represented a smaller family unit. LTC clients were especially representative of decreased family units, with 68.4% living alone.

Table IV - Area of Residence

The majority of clients in both years were City of Vancouver residents. By 1980 there was a rise in client residency in the West End; increasing from 11.2% in 1976 to 16.5% in 1980.

Table V - Method of Referral

It is important to note that the Long Term Care (LTC) division of the Ministry of Health did not exist in 1976. By

1980, following the creation of this LTC division in 1978, 43.3% of all clients to this homemaker agency were being referred by LTC. In 1976, 39.8% of all clients were referred by the client or the client's relative; by 1980 this referral mode had decreased to only 3.3%.

Tables VI through VIII - Combined Practice Categories

When the above individual categories were combined for overall analysis, the following picture of homemaker practice appeared. Total personal care practice increased from 13.0% in 1976 to 42.0% in 1980. In 1980 56.4% of those receiving personal care assistance were LTC clients. Total child care practice decreased from 45.0% in 1976 to 19.0% in 1980, with no LTC clients receiving this service. Total housekeeping practice displayed no significant differentiation in the percentage of clients receiving this service in either year, with 93.0% of the clients in 1976 receiving housekeeping assistance, 97.0% in 1980. 92.3% clients received housekeeping service were LTC clients; 100% of the non-LTC clients had help with their housework.

Tables IX through XI - Combined Diagnosis Categories

The combined category of diagnoses presents the following information about the homemaker client. Total psychiatric diagnoses increased from 8.0% of the clients in 1976 to 20.0% in 1980. In 1980 there were 27.9% of the non-LTC clients in this category, as opposed to 7.7% in the same year. Total medical diagnoses increased from 65.0% in 1976 to 80.0% in 1980. A

higher percentage of LTC clients had a medical diagnosis problem, with 94.9% of all LTC clients having a medical diagnosis as opposed to 70.5% of the non-LTC clients. In total child care problems a decrease occurred with 28.0% of 1976 clients in this category, while 6.0% had this problem in 1980.

The Provus Discrepancy Model Applied to Homemakers

The Provus Discrepancy Model (see Table XII) presents a detailed, multi-stage analysis of the level of congruency or discrepancy that appears to exist between what the homemaker in this agency practiced and the theory that a majority of these homemakers had been taught. The curriculum of the V.C.C. program that was used in the discrepancy evaluation contains a series of seven tracks of teaching and student activities. They are: Track A (Orientation to Employment Market), Track B (Orientation to Occupational Role and Function), Track C (Protection in the Home), Track D (Nutrition), Track E (Growth and Development), Track F (Communications), and Track G (Health).

In preparing the data for this discrepancy evaluation phase, the total curriculum of the program was analyzed for comparative purposes with the statistical practice categories. The writer's intent was to determine where and to what extent a particular homemaker practice appeared to have been taught within the homemaker training program, 1980 format. In all categories it was possible to ascertain these curricular details, with the exception of the Homemaker Practice Category

7.0: Care for Children, Stage III, subset, student guidelines as to hours of teaching/activity specifically related to this practice alone. This category presented a uniquely difficult area for researching all the possible tracks and their sub specialities of teaching and activity that could be related to this practice category. The reason for this difficulty arose from the fact that child care training is subsumed under the tracks of C, D, E, F, and G. Subsequently, this one subset of Stage III does not indicate the amount of actual teaching/practice time allotted in the curriculum outline for the homemaker course. It is, however, obvious that Stages I through Stage IV indicate extensive congruence in this area of practice.

The overall results of the Provus Discrepancy Model indicate that a significant degree of congruence occurred between the theory and the practice of the homemaker group. The areas of discrepancy, as noted within the Provus model, and the apparent reasons for their exclusion from the V.C.C. homemaker curriculum will be addressed in detail in the concluding chapter.

Table XIIHomemaker Practice Category 1.0 Ambulate ClientStage I

Terminal Goal:

Track G. "Assist children and adults to maintain their activities of daily living."

- Interim Objectives:
- G. I. "Demonstrate acceptance of the homemaker's role in relation to supervising health personnel and responsibilities appropriate to the homemakers in the delivery of health care."
 - G. II. "Assist children and ambulatory adults with a stabilized care plan to meet their needs for personal care under the prescription and supervision of the health care team."
 - G. II. 3.0 "Assist infants, children and adults to maintain the level of exercise and activity prescribed to meet individual needs."

Stage II

Homemaker practice indicates 5% of the clients in 1980 received service.
 V.C.C. Curriculum indicates Terminal Goal G. and Interim Objectives G.I., G.II., G.II.3.0 related to Practice Category 1.0.

Stage III

V.C.C. Curriculum indicates student will be able to assist client in the following areas (examples given):

- "Transferring a client from the bed to various sitting positions in a chair, wheelchair, toilet, tub, or chair."
- "Assist a client to walk with mechanical aids, such as, canes, crutches, walkers, or without aids."

Students Guidelines indicate a minimum of 60 minutes independent activity, 30 minutes whole group activity, and a home assignment related to ambulation.

Stage IV

Data indicates
congruence in
practice category.

Table XII (continued)Homemaker Practice Category 2.0 Help DressStage I

- Terminal Goal: Track G. "Assist children and adults to maintain their activities of daily living."
- Interim Objectives: G. I. "Demonstrate acceptance of the homemaker's role in relation to supervising health personnel and responsibilities appropriate to the homemakers in the delivery of health care."
- G. II. "Assist children and ambulatory adults with a stabilized care plan to meet their needs for personal care under the prescription and supervision of the health care team."
- G. II. 1.2 "Provide the assistance required by the infant, the child, the temporarily incapacitated adult and the elderly person who has moderate limitations in carrying out personal hygiene."

Stage II

- Homemaker practice data indicates 4% of the clients in 1980 received service.
- V.C.C. Curriculum indicates terminal goal G.; interim objectives G.I., G.II., G.II.1.2 related to practice category 2.0.

Stage III

- V.C.C. Curriculum indicates student will be able to assist client in the following areas (examples given):
- "Providing neat, clean clothing and bedding."
- Students Guidelines indicate a minimum of 60 minutes group activity, including filmstrip and resource sheet for students related to personal care in long-term illnesses.

Stage IV

Data indicates
congruence in
practice category.

Table XII (continued)Homemaker Practice Category 3.0 Help BatheStage I

- Terminal goal: Track G. "Assist children and adults to maintain their activities of daily living."
- Interim Objectives: G. I. "Demonstrate acceptance of the homemaker's role in relation to supervising health personnel and responsibilities appropriate to the homemakers in the delivery of health care."
- G. II. "Assist children and ambulatory adults with a stabilized care plan to meet their needs for personal care under the prescription and supervision of the health care team."
- G. II. 1.2.1 "Provide the assistance required by the infant, the child, the temporarily incapacitated adult and the elderly person who has moderate limitations in meeting needs for bathing and eye care."

Stage II

- Homemaker practice data indicates 19% of the clients in 1980 received service.
- V.C.C. Curriculum indicates terminal goal G., interim objectives G.I., G.II., G.II.1.2.1 related to practice category 3.0.

Stage III

- V.C.C. Curriculum indicates student will be able to assist client in the following areas (examples given):
- "Providing assistance with bed baths, baby baths, showers and tub baths."
- Student Guidelines indicate a minimum of 4 hours group/individual activities, post-testing; use of film strip and resource sheets related to bathing assistance.

Stage IV

Data indicates
congruence in
practice category.

Table XII (continued)Homemaker Practice Category 4.0 Monitor Health StateStage I

Terminal Goal: No terminal goal/interim objective
Interim Objective: related to practice category.

Stage II

Homemaker practice data indicates 7%
of the clients in 1980 received
service.

V.C.C. Curriculum indicates no
terminal goal/interim objective
related to practice category.

Stage III

V.C.C. Curriculum
indicates no
interim products
related to
practice.

Stage IV

Data indicates lack
of congruence in
practice category.

Table XII (continued)Homemaker Practice Category 5.0 Assist With MedicationStage I

Terminal Goal: No terminal goal/interim objective
Interim Objective: related to practice category.

Stage II

Homemaker practice data indicates 2%
of the clients in 1980 received
service.

V.C.C. Curriculum indicates no
terminal goal/interim objective
related to practice category.

Stage III

V.C.C. Curriculum
indicates no
interim products
related to
practice.

Stage IV

Data indicates lack
of congruence in
practice category.

Table XII (continued)Homemaker Practice Category 6.0 Replace Homecare NurseTemporarilyStage I

Terminal Goal: No terminal goal/interim objective
Interim Objective: related to practice category.

Stage II

Homemaker practice data indicates 4%
of the clients in 1980 received
service.

V.C.C. Curriculum indicates no
terminal goal/interim objective
related to practice category.

Stage III

V.C.C. Curriculum
indicates no
interim products
related to
practice.

Stage IV

Data indicates lack
of congruence in
practice category.

Table XII (continued)Homemaker Practice Category 7.0 Care for ChildrenStage I

- Terminal Goal: Track E. "Work with children and adults at various states of growth and development."
 Track G. "Assist children and adults to maintain their activities of daily living."
- Interim Objectives: E. I. "Understand the common cultural, emotional, and biological needs of an individual arising from his age (stage of growth and development), life style and family situation."
 E. II. "Demonstrate a helping response to given individuals and families consistent with their basic human needs and special needs for growth and development."
 G. I. "Demonstrate acceptance of the homemaker's role in relation to supervising health personnel and responsibilities appropriate to the homemakers in the delivery of health care."
 G. II. "Assist children and ambulatory adults with a stabilized care plan to meet their needs for personal care under the prescription and supervision of the health care team."
 G. II. 1.0 "Assist in maintaining healthy function of the skin and mucuous membranes ..."
 G. II. 2.0 "Assist in providing conditions which promote rest and sleep for infants, children and adults."
 G. II. 3.0 "Assist infants, children and adults to maintain the level of exercise and activity prescribed to meet individual needs."
 G. II. 4.0 "Assist an individual to meet his normal needs for elimination from bowel, bladder, skin and lungs."

- G. II. 5.0 "Assist infants, children and moderately incapacitated adults with feeding."
- G. II. 6.0 "Assist in supporting an individual and a family to meet their needs for security in approved and/or prescribed ways."
- G. III. "Promote independence in her clients regarding activities of daily living."

Stage II

Homemaker practice data indicates 19% of the clients in 1980 received service.

V.C.C. Curriculum indicates Terminal Goals E and G; and Interim Objectives E.I., E.II., G.I., G.II., G.II.1.0, G.II.2.0, G.II.3.0, G.II.4.0, G.II.5.0, G.II.6.0, and G.III. related to Practice Category 8.0.

Stage III

V.C.C. Curriculum indicates student will be able to assist client in the following areas (examples given):

"Performing the specific skills of baby baths, bathing a child confined to bed, diapering an infant, bottle feeding infants, providing feeding required by infants and toddlers."

Student Guidelines indicate extensive individual/group activities, filmstrips and discussion related to care for children.

Practice Category 7.0 is an example of an integrated category, involving Track C (Protection in the Home), Track D (Nutrition), Track E (Growth and Development), Track F (Communication), and Track G (Health).

Stage IV

Data indicates congruence in practice category.

Table XII (continued)Homemaker Practice Categories 8.0 Clean and 9.0 Do LaundryStage I

Terminal Goal:	Track C. "Meet needs for protection in the home."
Interim Objectives:	C. V. "Know approved methods for controlling common hazards to sanitation in the home." C. VI. 1.0 "Know basic principles underlying home cleaning and maintenance." C. VI. 1.2 "Describe the major principles involved in home cleaning." C. VI. 2.0 "List common procedures involved in a home cleaning plan." C. VI. 3.0 "Know the basics of laundering." C. VI. 4.0 "Do laundry." C. VI. 5.0 "Use, clean, and maintain a refrigerator-freezer." C. VI. 6.0 "Use, clean, and maintain a kitchen range." C. VI. 7.0 "Use, clean, and maintain a dishwasher." C. VI. 8.0 "Provide floor care." C. VI. 9.0 "Provide rug and carpet care." C. VI. 10.0 "Care for walls and woodwork." C. VI. 11.0 "Care for furniture, windows, and mirrors." C. VI. 12.0 "Use, clean, and maintain cleaning tools." C. VI. 13.0 "Clean the bathroom." C. VI. 14.0 "Use, clean, and maintain cleaning tools." C. VI. 15.0 "Given a specific family and home situation, use a home cleaning and maintenance plan."

Stage II

Homemaker practice data indicates 52% of the clients in 1980 received service in Practice 8.0; and 27% received service in Practice 9.0.

V.C.C. Curriculum indicates Terminal Goal C. and Interim Objectives C.V. and C.VI.1.0 to C.VI.15.0 are related to Practice Categories 8.0 and 9.0.

Stage III

V.C.C. Curriculum indicates student will be able to assist client in the following areas (examples given):

"Do laundry and clean."
Student guidelines indicate a minimum of 56 hours and 30 minutes of independent/group activity, post-testing, and field assignments.

Stage IV

Data indicates congruence in practice categories.

Table XII (continued)

Homemaker Practice Category 10.0 Prepare Meals and 11.0 Shop for
Groceries

Stage I

- Terminal Goal: Track D. "Meet needs for nutrition in the home."
- Interim Objectives: D. I. "Identify basic nutritional needs of an individual and a family."
 D. II. Identify the major influences which affect how an individual and/or family meets their nutritional needs.
 D. III. "Outline meal plans to meet the nutritional needs of an individual or family in given field situations."
 D. IV. "Demonstrate approved ways of meeting nutritional needs of a individual or family."
 D. V. "Evaluate the continuing effectiveness of the nutritional plan for an individual and/or family."
 D. VI. "Demonstrate a personal committment to the pursuit of adequate nutrition for herself and her clients."

Stage II

Homemaker practice data indicates 28% of the clients in 1980 received service in practice category 10.0; and 32% received service in practice category 11.0.

V.C.C. Curriculum indicates Terminal Goal D. and Interim Objectives D.I. to D.VI. are related to Practice Categories 10.0 and 11.0.

Stage III

V.C.C. Curriculum indicates student will be able to assist client in the following areas (examples given):

"Organize and implement daily and weekly meal plans."

"Purchase food according to a food plan."

"Prepare food for client consumption."

Student guidelines indicate a minimum of 33 hours of independent activities, whole group and small group activities, films, lectures and discussions.

Stage IV

Data indicates congruence in practice categories.

Limitations of the Study

It has been the intent of the writer to describe with some detail the role, theory and practice of a particular homemaker group from the lower mainland of British Columbia. The research boundaries within this thesis were deliberately limited in order to describe with some depth and precision a specific body of homemakers. As a result, it may not be possible to generalize the results of this thesis.

The evaluative mode was chosen as a way of providing in detail the homemaker's theory and practice. The sociological underpinning that provides a contextual framework for this thesis is presented as an essential foundation on which our understandings of the homemaker's role, theory, and practice can be based.

In further outlining the limitations of this thesis the writer wishes to point out certain areas of the theory and practice data that have been accepted as untested. For example, there may be additional areas of discrepancy involving the exact number of hours that actually go into the overall process of homemaker training. Furthermore, the client files indicate only nominal areas of practice. The exact measurement of the actual hours of all practice within a given client's home has yet to be determined. The limitations of this thesis are provided in order to clarify as well as to suggest further research in this area. A participant observer mode of inquiry could be most useful in illuminating these questions.

This chapter has presented all the data analyses except the interview findings. The interview findings are included with

the overall discussion of the homemaker role, theory, and practice that will appear in Chapter VI.

Chapter VI

DISCUSSION AND RECOMMENDATIONS

Change and Its Implications

Whereas, the client in 1980 differs significantly from her 1976 counterpart, it cannot be argued that this change is solely due to the creation of Long Term Care in 1978. Clients with personal care needs in 1980 who were not associated with LTC increased significantly. The same is true for non-LTC clients in 1980 who experienced psychiatric as well as medical problems. Viewed as a whole, the homemaker situation appears to display a number of inherent problems. The inferences that can be drawn from the research are related specifically to the role, theory, and practice of the homemaker as it affected both the LTC and the non-LTC client.

The overall findings in this area were that the role of the homemaker has changed significantly between 1976 and 1980. The homemaker appears to have been placed in a situation in which increasing demands are being placed on her capacity to meet the rapidly changing needs of her client. Not only is her client older, having a notable degree of medical and psychiatric problems that often necessitate a myriad array of complex health care services, but this same client is part of smaller family unit and may be more socially isolated than was her 1976 counterpart.

Role of the Homemaker as the "Good Samaritan"

One of the more intriguing aspects of the homemaker role is that of the homemaker as the "Good Samaritan" in her relationship with the client. The interviews conducted with the homemaker supervisors and the various notations that appear on sample client files appear to affirm this phenomena as occurring with some regularity. The Position Paper of the V.C.C. Homemaker Program in its response to the Personal Assistance Guidelines of the homemaker agencies within B.C. also contains references that can be construed as being related to this helping mode of the homemaker.

In the majority of the two hundred client case files that were read for the purpose of data analysis in this study, the homemaker appeared to be performing services for the client that could be described as housekeeping duties. For example, in the agency files she would frequently be described as being involved in: "helping Mrs. ---- do the weekly shopping"; "may need to also prepare a light lunch on some days". The areas in which there appears to be a problem for the homemaker, the homemaker agency, the V.C.C. homemaker program training division, and other concerned homemaker-oriented bodies appear to follow with some precision the exact outline of discrepancy that were found in the Provus analysis. These areas of concern fall into a broad category that could be referred as special health care assistance and are the practice categories of: monitoring the state of health of the client; assisting the client with medication; and replacing Home Care nurses on a temporary basis. These same practice areas also constitute service categories in

which the homemaker may be involved with the client in a situation where the "Good Samaritan" principle is operative.

This particular situation and the concerns created by these homemaker practices are found to be an often repeated theme in the interviews with the supervisors of the homemakers of this agency. For example, one of the supervisors in her comments regarding the role of the homemaker replied: "...sometimes homemakers are involved in basic nursing areas (that) she shouldn't be in....she doesn't have nursing training. Sometimes she has to take over for the Home Care Nurse because there aren't enough of these nurses to go around. Problems arise in a crisis in certain situations. They (the homemakers) are the only people who can help."

Another supervisor summarized the role as being: "...in certain situations the homemaker takes over because there's no one else there to do it....". And another supervisor voiced concern over the giving of medications: "...the homemaker shouldn't be doing this...we need more Home Care nurses."

The theme of the homemaker as the Good Samaritan and the concerns raised about this role are succinctly delineated in the V.C.C. position paper regarding the personal assistance guidelines of homemaker agencies (June, 1980). This paper states: "The history of homemaking in British Columbia tends to give rise to a view of the homemaker as a kindly mother surrogate or family friend. These kinds of attributes are commendable in the performance of some homemaking tasks, but it must be clearly understood that in the eyes of the law the homemaker does not have the freedom to perform many acts which a

family member could do with impunity."

In terms of the contemporary role of the homemaker and the far reaching consequences of this expanding role, the executive director of the agency researched for this study, summed up her feelings in an annual report to the homemaker association members as follows: "The Board of Directors is very aware of the expanding role of the homemaker in the health care field and the implications of this. In many cases it would be difficult to define the difference between a homemaker and a practical nurse." In many cases this does indeed appear to be the role situation of the homemaker. Furthermore, given the probable increasing demands for complexity of homecare assistance, the homemaker's role may continue its metamorphic development from that of housekeeping to the emerging role of the health care assistant in the home.

Interpretation of Theory and Practice of the Homemaker

As previously stated, the three areas of theory/practice discrepancy noted in this study involve the homemaker's assistance to certain clients in temporarily replacing the Home Care nurse, administering medications, and monitoring health states. An example of the homemaker as Home Care nurse substitute can be illustrated by a handicapped client with extensive decubitus ulcers who required a bed bath. Home Care had been requested, but was not available. The homemaker was not trained to replace the Home Care nurse, but did so. In the second area, certain clients's charts indicated difficulty with

self-administration of medication, and the homemaker was requested to assist them. In the area of monitoring health states a typical example was that of a client with cardiovascular problems who required monitoring of pulse rate related to medication usage. These three areas of practice are clearly outside the confines of the formal V.C.C. homemaker program.

In an attempt to further explain this phenomena of discrepancy, homemaker supervisor interviews, documents from the V.C.C. program, and the homemaker agencies were analyzed.

Interviews with homemaker supervisors explored not only their interpretation of the homemaker role, but also their concerns about the congruence and discrepancy of homemaker practice and theory. In this area of theory and practice a majority of the supervisors prefaced their remarks by stating an awareness that in certain situations the homemaker may be providing services that do not match the theory taught by the V.C.C. program. However, in these instances, the supervisors frequently referred back to their statements regarding the "Good Samaritan" role of the homemaker. Only one of the four supervisors felt that the homemaker should receive formal training in these specific areas of discrepancy. For the majority, the feeling was that the present curriculum of the homemaker training program was more than adequate and that the homemaker should avoid taking on the role of a practical nurse or nurse's aide. An expansion of the service and client use of the Home Care nurse was seen as being the solution to the problem of homemaker practice that at times may be nursing

rather than housekeeping.

Other groups have also displayed concerns about the practice/theory discrepancy that exists in certain areas of homemaker service. One of the central groups voicing its concerns is the community college in which the homemaker program was developed. As was the case with the role of the homemaker, the position paper of this institution regarding the personal assistance guidelines for the homemaker outlined some rather detailed concerns regarding this situation.

One of the more critical areas of concern involves that of the homemaker's assisting the client with medications. The V.C.C. position paper clearly states that: "The homemaker should not administer medications in any circumstances." (V.C.C. Position Paper, page 6). This paper goes on to state that: "It appears that homemaker agencies are attempting to respond to meet client needs for medication treatment in the current system which does not provide adequate supervision by appropriate nursing professionals. The answer is not to provide service by putting the homemaker in legal jeopardy." (V.C.C. Position Paper, page 7). This position of the homemaker program officials does not appear to concur with the Community Homemaker Services Association of British Columbia Guidelines that were drafted in 1979, and in use in 1980, in which on page 2 the following guidelines are given concerning medication administration: "Medication is never to be administered by the homemaker until such time as she has received authorization to do so from her supervisor....Only oral medication may be given by a homemaker, and if there is any other possible option for

the administration of medication, the homemaker should not be involved." Here again, the "Good Samaritan" principle appears to be operational even within these guidelines.

Pursuing this area of discrepancy into the specific agency being investigated, concerns over homemaker involvement in certain areas of personal care assistance surfaced many times during 1980. Typical of these discussions was a Board of Directors meeting of June 1980 in which certain board members had expressed their concerns regarding the legal implications of homemakers being involved with the administration of medication to the client. These minutes also reflect a concern felt by the Board about the need for clarification by the provincial government as to who should authorize or take responsibility for such a critical service to the client.

Four months later, the Board minutes of October 14 reveal that the agency's executive director had been appointed to an interdisciplinary committee for the purpose of studying the on-going problem of personal care assistance by the homemaker.

One month later, a memo to Board members on November 7 displays further concerns with this area of practice. Referring to the 1978 Guidelines issued by the Ministry of Health, the agency's director expressed concern about the ambiguity and lack of direction within the area of personal care. The memo discussed at length the Ministry Guidelines that listed activities the homemaker could provide when certain conditions had been met. For example, certain duties could be carried out "when the Homemaker Agency Supervisor is assured that the homemaker has adequate skills and training to perform the tasks

required to meet the individual needs of the client. (Note there are no guidelines as to 'adequate training')." And on the matter of medication specifically, this same Board memo expresses concern about the fact that: "The second section of the Guidelines is prefaced with: 'Assistance with the following personal functions can be undertaken if appropriate and only after individual instruction and direction from an appropriate professional involved with the individual receiving care' (Note: There is no definition of 'appropriate professional'). The list of activities include: Assistance with oral medication if homemaker has been given written order....". The overall area of personal care assistance to the client appeared to create ongoing problems for the agency and its homemakers.

Conclusions

It would appear that the homemaker, the agencies, the training programs, the Ministry of Health that purchases homemaker services, and last, but not least, the homemaker clients themselves are placed within an enigmatic situation. There is no simple, clear cut solution to the problem that now exists.

Viewing this complex situation of the homemaker's role, theory, and practice from a Berger and Luckman point of view, the ownership of knowledge related especially to the area of personal care assistance, and also the corresponding control of that knowledge, appears to not be clearly established for all parties concerned (Berger and Luckman, 1966).

At the same time, with the dispersement of health and social service assistance to clients in home settings and away from the more rigidly controlled, institutional settings, such as hospitals, there may have occurred a corresponding loosening of previous areas of knowledge and practice control. That is to say that the nurse's aide, for example, within most hospital settings appears to have a rather well defined role. In most hospital settings there is a well defined and concisely executed control over the training program and the corresponding practice that this individual is expected to perform within the institution. For the homemaker within the research milieu of this study, these demarkations and control boundaries do not appear to have been established with the same precision as that of the aide in institutional settings. It would then appear that the dispersal of certain clients with health care needs into home rather than institutional settings carries with it specific problems as well as advantages, both to the client and the taxpayer.

In the long run it may well be that the delicate balance of health care and social service assistance, documented by MacIntyre in her review of the British system of the seventies, will continue to create a sense of on-going tension between what is best for the homemaker client within the home setting as opposed to what is best for the taxpayers of the province.

The third issue that appears to be intertwined with this complex situation is the possibility that home care assistance may in many situations not be the best solution for many clients. There appears to have been, especially during the

seventies, an understanding that home care was the ultimate answer to the problem of health and social service assistance to the chronically ill, the elderly, and the dependent individual. While this form of assistance is both cost beneficial and medically effective for some clients, it cannot be assumed that it is suitable for all. Given the paucity of any research related to the multiplicity of factors that must be considered in assessing this form of assistance, its widespread use must be questioned.

The final issue that appears to be a continual problem for those involved in the homecare service area is the question of who is ultimately in control of this entity we refer to as homemakers. At present, without the existence of some form of licensure of the homemakers, their control boundaries are very ill defined. The levels of training of the homemakers vary widely throughout the province. Some of these homemakers have been trained by the community college homemaker programs. Others have only minimal on the job training. The client, it appears, has no assurance of uniformity of training. Indeed, the practice discrepancies that appear within this closely defined research area may be much more extensive for other agencies and their homemakers. This contemporary state of discrepancy will continue to exist until such time that there is some clearly established, uniform guidelines for all agencies, all training programs, and all homemakers practicing in the province.

Recommendations

Having studied the research findings related to the homemaker, the writer makes the following recommendations concerning the occupation of homemaking as it exists within the Province of British Columbia.

1) It is recommended that the Ministry of Health, in consultation with all homemaker agencies and all homemaker training programs throughout the province, should establish clear-cut guidelines for the role and practice of the homemaker that will be uniform in their useage by homemakers and strictly enforced throughout the province. Additionally, that the Ministry of Health in the Province of British Columbia should assume the ultimate legal liability in the area of homemaker practice. Finally, within this area of homemaker practice there should be very close supervision of agencies and homemakers for the purpose of assuring optimal, safe levels of service to all clients.

2) It is recommended that a process of licensing the homemaker be instituted. This act of licensing homemakers throughout the province would serve to assure the client that a homemaker, employed by any given agency within the province, would in fact have received adequate homemaker training and would possess the proper qualifications needed to meet specific client needs.

3) In the area of training, it is recommended that the provincial and/or the federal government provide adequate educational funding assistance for homemakers already practicing who have not received formal training in homemaking.

Furthermore, these homemakers should be encouraged to upgrade their training levels by sustained support and encouragement of not only their agency employers but also by the provincial government that is the ultimate purchaser of their service.

4) It is also recommended that the community colleges currently involved in the training of homemakers expand their educational expertise to make available in-service programs for all homemaker agencies within the province.

5) The final recommendation is that there be expanded and accelerated research within the broad area of homemaker concerns. Given the rapidly changing dimensions of the homemaker's role and practice, it is imperative that decisions related to these areas, and indeed to the whole of homemaking as an occupational entity, be assisted by means of on-going research and development.

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Appendix

The following material is provided as an example of how the content analysis coding was performed on the client files. Included is an actual client file that was chosen from a current 1981 client list. All confidential material and identifying characteristics have been removed for the purpose of assuring confidentiality to the client, the agency, and all other parties involved.

Content Analysis of a Client File Related to Categories Researched Within This Thesis

Age : 81 (husband) 76 (wife).

Sex : Male and Female (Couple).

Number in Family Unit : 2.

Area of Residence : 18.

Referral Mode : Medical Staff.

Client Diagnosis Category : Medical Problems.

Homemaker Practice Categories :

Cleaning, Laundry, Meal Preparation = Combined
Housekeeping.

Probus Evaluation Categories = 8.0 Clean; 9.0 Do Laundry,
and 10.0 Prepare Meals.

ENQUIRY FOR HOMEMAKER SERVICE

83

DATE 4/8/81
January 31 1980
 BIRTHDAY
 BUS. PHONE: _____

CLIENT'S SURNAME _____ HUSBAND _____ BIRTHDAY _____
 WIFE _____ BIRTHDAY _____
 ADDRESS _____ HOME PHONE: _____

Single () Married (☒) Sep. () Wid. () Div. ()

CHILDREN:	NAME	BIRTHDATE	SCHOOL
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Others in the home: _____

DATE SERVICE REQUIRED _____ RES/NON-RES. 4 hrs (PM) 3x per week
 HOURS OF WORK DAYS OF WORK DURATION?

DOCTOR _____ PHONE No. _____ SPECIALIST _____ PHONE No. _____

REFERRED BY: _____

REASONS FOR SERVICE: -

Husband due for discharge on Friday at St Paul's Botk
 at automobile accident.

Wife discharged tomorrow. hurt spine, collar
 at neck.