

## The daily practice in home help services in the Netherlands: instrument development

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### Abstract

Many developments have taken place in home help services which have made further professionalization necessary. For this reason, a national study has been planned in the Netherlands to obtain a representative picture of the work of home helps and to examine overloading aspects of their workload. Five instruments were developed for this purpose and a pilot study was carried out to establish the reliability and content validity of the main instrument: a registration form to record the activities that home helps perform. Twenty-five home helps participated in the pilot study. An observer monitored them during their home visits for a period of 1 week. Both the observer and the home help recorded the activities that were carried out independently on the registration form. The reliability of the registration form was assessed by inter-rater-reliability. The validity of this instrument was estimated by the content validity. The results show that the registration form is, in general, a reliable instrument. There is a high level of agreement between home helps and observers in the four main categories: 94% for the household and the caring activities, 98% for the psycho-social or supporting activities and 96% for the reporting activities. The content validity of the form is adequate and only a few items will be added to the final version of the form.

**Keywords:** home help services, instrument development, professionalization, the Netherlands

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### Introduction

In the last decade, important developments and changes have occurred in health care and in particular in home care. These developments have made further professionalization of home help services necessary. In order to contribute to this professionalization, research in this area has to be carried out. Currently there is no information available on home help services, task differences between the various types of home help, discrepancies between home help care assessed, allocated and provided, and workload. A national study on home help services in the Netherlands is planned, to obtain a representative picture of the daily practice of home helps and to examine possible overloading aspects of their jobs. In Ireland, a similar study was carried out to establish baseline data on the nature and

components of home help services, the profile and requirements of current service recipients, the impact of the service on the life of service recipients and possible gaps in existing provision (National Council for the Elderly 1994). The home helps were asked what they were able to do and a job profile, that tested the specific tasks of home helps, was used. Additionally, a questionnaire was used to ask the home help clients what tasks they could do for themselves and how difficult they found them. If they were not able to carry out these specific tasks, they were asked who did (including the home help).

Before the national representative study started, a pilot study was conducted in order to develop the measurement instruments. In this paper, the results of the pilot are reported. Five measurement instruments

were developed: an individual client plan for information about assessed and allocated home help care; an interview scheme for home care organizers about criteria used to assess the need for home help care; a registration form to record the activities that home helps carry out; a weekly report for the non-client based activities; and a questionnaire to measure the pressure of working in home help services. The pilot study was meant to establish the reliability and validity of the most important instrument. The main question in the pilot study was whether the reliability and content validity of the instrument was sufficient to warrant its use in the main study. Reliability stands for the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure. Validity is the degree to which an instrument measures what it is intended to measure. Before we report on the methods of the pilot study, a short overview of the organization of home help services in the Netherlands is given.

### Home help services in the Netherlands

Home help services are defined as help of a domestic and caring nature, occasionally supplemented by help of a personal and supporting nature, offered to all inhabitants of the Netherlands who are in need of domestic help because of illness or recovery, old age, handicap, death, psycho-social, and personal problems that threaten the maintenance of the household. The home help service's objectives are to support families and individuals in need and enable them to live as independently as possible (van den Heuvel & Gerritsen 1991). In the Netherlands, home help services are provided either by organizations for home help services (foundations) or by home care organizations (integrated organizations for home help services and community nursing). In January 1995, 41 home care organizations had already been integrated, and the process of integration is continuing. The remaining 60 home help organizations provide home help services only. Five years earlier, in 1990, the umbrella organizations for home help services and community nursing had already merged to form the National Association for Home Care (LVT). Home help care can be divided into four main categories: household activities, caring activities, psycho-social or supporting activities and activities in the area of consultation and cooperation, including reporting activities (Werkgroep SOGW 1990). A large variety of workers are employed in home help services: home helps A, who are restricted to housework; caring helps B, who do the housekeeping and give some personal care; home carers C, who are mainly involved in providing personal care and some housework; home carers D,

who mostly carry out caring and psycho-social or supporting tasks, and specialized home carers E, who support households with multiple complex problems. In addition, there are 'alpha-helps', who were introduced in 1973, as a way of providing cheaper help. The alpha-helps are not employed by the organizations, but in formal terms, the client is the direct employer of the alpha-help. Most organizations operate as an intermediary between the client and the alpha-help. In 1993, approximately 45 000 alpha-helps were active in the Netherlands. This is an increase of 50% in 1 year, as the number of alpha-helps in 1992 was estimated at 30 000 (Hornman 1994). In addition to the alpha-helps, there are about 110 000 home helps and home help organizers working in the Netherlands. However, most of these people are part-time, because there were only 40 500 full time equivalents (see Table 1). Up to June 1993, home help care was provided by alpha-helps, home helps, home carers and specialized home carers. The FTEs in Table 1 are based on these former categories (De Lange & Spaan 1994). In June 1993, the new job descriptions based on a job evaluation were introduced: home help A, caring help B, home carer C, home carer D and specialized home carer E (Abvakabo 1994).

Three-quarters of the home helps (77%) do not have specific qualifications. This means that, of home carers and to a lesser degree home helps, only 23% have received training (Hornman 1994). Recently, home help organizations have started in-service training for their home helps, mainly for home helps A and B.

## Methods

### Instrument

Home helps spend the majority of their working time on client-based activities. Therefore, the most important instrument tested in the pilot was the registration form. On this form, home helps collect these activities. For this purpose, a self-registration form was developed based on a theoretical model for the care provided by home help services (Arts *et al.* 1994). This

**Table 1** Staff of home help services by category in 1993, in full time equivalents

Alpha-helps	4.700
Home helps	20.500
Home carers	9.000
Specialized home carers	900
Home help organizers	3.300
Other	2.000
<b>TOTAL FTEs</b>	<b>40.500</b>

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integrated model is founded on the theories of Orem (self-care), Zuidberg (analysis-scheme of households), de Vos (theory of household activities) and their corresponding concepts, and will be used as a framework to carry out research on the daily practice of home helps (Zuidberg 1978, de Vos 1987, Orem 1991). Existing task profiles and classifications and existing assessment forms have been investigated thoroughly for a realistic classification of the activities, as used on the registration form (Werkgroep SOGW 1990, Abvakabo 1992, Stichting Thuiszorg Hilversum, 's-Graveland & Loosdrecht 1992, Verheij *et al.* 1993, Abvakabo 1994). The registration form represents virtually all activities that home help services may provide. It also has the option to distinguish between taking activities over from the client and assisting the client with activities. On the registration form this can be scored as '1' or '2', respectively. Furthermore, the home helps recorded both the time spent on the four main categories and the travelling time between clients on the registration form.

### Sample

Eight home care organizations were contacted to take part in this pilot study. Three organizations, who were either very occupied with the integrating process or already involved in a research project, declined to participate. Therefore, five organizations for home help services, from different parts of the country, rural and urban organizations, traditional home help services and integrated with community nursing, took part in the pilot study. Five different types of home help, based on the former categories, were examined in this pilot study: alpha-help, home help A, caring help B, home carer C and specialized home carer E. The participating organizations were asked to select five home helps, one of every type of home help. Consequently, a total of 25 home helps took part in the pilot study, of whom 24 were female. The mean age of the home helps was 41 years, with a range from 22 to 58 years. Their average period of employment in the home help services was 8 years and 8 months, with a range from 7 months to 21 years.

### Procedure

During an induction meeting, the purpose of the study was explained to the 25 participating home helps. For a 1-week period, each home help was monitored by one of the two observers during all her home visits, unless the client, the home help or the organization refused the presence of an observer during the home visit. After every home visit, both the home help and the

observer independently recorded the activities that were carried out on separate registration forms.

During the registration period, the 25 home helps made 223 home visits. In 29% of the home visits ( $n = 64$ ) the home help was not observed for practical reasons. For example, the client, home help or organization refused the observer's presence in 25 of the non-monitored home visits (39%). In another 39%, the observers had simultaneous duties, like monitoring two home helps with the same working hours and preparing and holding instruction meetings during the registration period. Almost half of the non-monitored 64 home visits (46%) were carried out by specialized home carers E, 28% by home carers C, and the remaining 26% by caring helps B, home helps A and by alpha helps (17, 6 and 3%, respectively). Therefore, the home helps were monitored during 159 home visits. The registration forms, of the home helps and observers, respectively, were used for the analyses.

Chi-square analysis was used to compare the activities recorded by the home helps during the 159 observed home visits and the activities recorded during the 64 non-observed home visits. The results showed that 101 of the 111 activities (91%) were not significantly different. The 10 activities (9%) that were significantly different at a nominal 5% level, are presented in Table 2; given the number of comparisons made, Chi-square values in excess of 9.55 corresponds to a 10% overall significance level.

The household activities were performed less frequently in the non-observed home visits, while the psycho-social or supporting activities were carried out more frequently in the non-observed home visits. This outcome was somewhat expected, because the specialized home carers E, who mainly perform psycho-social and supporting activities and occasionally household activities, made almost half of the non-observed home visits.

### Analyses

The reliability of the registration form was assessed by inter-rater-reliability: the respondent and the observer simultaneously and independently recorded the activities carried out (Polit & Hungler 1987). The level of agreement, i.e. the similarity between the frequencies scored by the home helps and the frequencies scored by the observer expressed in percentages, was computed for every activity, subcategory and main category. When the frequencies are equal, the level of agreement is 100%. Two different agreement percentages were calculated: a percentage based on the frequencies scored without taking into account the distinction between the score 1 and 2 of the registration form (column 3 in Tables 3, 4, 5 and 6) and a percent-

Activities	Monitored visits <i>n</i> = 159 (%)	Non-monitored visits <i>n</i> = 64 (%)	$\chi^2$	<i>P</i> -value
<b>Household activities</b>				
Doing the dishes or putting them away	29	16	4.29	0.04
Making the beds	33	19	4.69	0.03
Cleaning the kitchen	26	13	4.69	0.03
<b>Psycho-social or supporting activities</b>				
<i>Topics of conversation</i>				
Loneliness	8	20	7.47	0.00
Parent-child relationship	6	19	9.16	0.00
<i>Dealing with problems</i>				
Seek for solution	11	23	5.31	0.02
Encourage the client for certain behaviour	11	33	15.79	0.00
Observing the client for mental changes	19	44	14.68	0.00
Observing the client for social changes	7	38	32.25	0.00
Supporting/guiding children	6	16	5.81	0.02

**Table 2** Significant differences in activities recorded during 159 monitored home visits and 64 non-monitored home visits, using Chi-square analysis

**Table 3** Frequency of household activities carried out (columns 1 and 2) and the level of agreement between the home help and observer regardless of the value 1 or 2 (column 3) and when taking into account the value 1 and 2 (column 4), expressed as percentages (*n* = 159 home visits)

Household activities	Frequency home helps (%)	Frequency observers (%)	Overall agreement (%)	Adjusted for amount of support agreement (%)
	79	79	94	72
<i>Daily household activities</i>				
Tidying up the room	19	19	89	86
Vacuuming	40	42	99	99
Doing the dishes or putting them away	29	30	91	89
Making the beds	33	26	89	88
Dusting	36	39	92	89
Scrubbing the floors	19	27	89	88
<i>Cleaning bathroom or toilet or kitchen</i>				
Cleaning the toilet	36	36	95	94
Cleaning the kitchen	26	28	91	90
Cleaning the bathroom	33	33	98	98
<i>Periodical household activities</i>				
Changing the beds	13	14	97	97
Wiping the windows	16	17	96	96
Changing or taken out garbage can	9	13	93	92
<i>Taking care of linen, clothing and footwear</i>				
Doing the laundry or hanging it out or taking it in	15	18	94	92
Ironing or folding up or putting away the laundry	12	13	96	96
<i>Preparing meals or drinks</i>				
Preparing drinks	37	42	82	72
Setting or clearing the table	8	14	92	89
Preparing breakfast or lunch	13	14	97	96
Cooking (freezing)	7	7	97	96
<i>Grocery shopping</i>				
Daily grocery shopping	13	14	98	96
	11	12	95	94

**Table 4** Frequency of caring activities carried out (columns 1 and 2) and the level of agreement between the home help and observer regardless of the value 1 or 2 (column 3) and when taking into account the value 1 and 2 (column 4), expressed in percentages ( $n = 159$  home visits)

	Frequency home helps (%)	Frequency observers (%)	Overall agreement (%)	Adjusted for amount of support agreement (%)
Household activities	52	52	94	82
<i>Simple personal care</i>	40	45	89	67
Putting on or taking off shoes or socks	26	27	86	81
Getting (un)dressed	21	28	93	88
Helping in or out bed	11	9	92	
Hair or nail care	10	13	96	94
<i>Complex personal care</i>	42	43	98	77
Putting on or taking off supported stockings	21	21	98	97
Washing or bathing or showering the client	23	23	97	92
Skin care or preventing bed sores	12	15	96	94
Putting on or taking off incontinence material	6	6	98	97
Setting out medicine	6	4	95	95
Administering medicine	8	8	96	94

age based on the frequencies which accounted for the distinction between the scores 1 or 2. The distinction between scores 1 and 2 can not be made for the psycho-social or supporting and reporting activities and this agreement percentage (column 4) is therefore lacking in Tables 5 and 6.

The validity of the registration form was estimated by the content validity, which means the degree to which the items of the registration form adequately represented the universe of content, i.e. the daily work of home helps (Polit & Hungler 1987).

## Results

### Reliability of the registration form

Activities that were recorded in fewer than 5% of the home visits, which were included in the analyses, are not presented in the Tables 3, 4, 5 and 6.

#### *Household activities*

Household activities were performed in 79% of the home visits. Table 3 shows that the level of agreement between home helps and observers concerning this main category is high (94%). The highest level of agreement is achieved for the subcategory 'grocery shopping' (98%) and the lowest level of agreement for the subcategory 'preparing meals/drinks' (87%). 'Vacuuming' is most frequently carried out (40%) and has a high level of agreement (99%).

#### *Caring activities (Table 4)*

This main category has also a high level of agreement (94%). In 52% of the home visits, caring activities were carried out. The most common activity according to the home helps, is 'putting on and taking off socks and shoes' (26%). According to the observers, on the other hand, the most common activity is 'getting the client (un)dressed' (28%). The subcategory 'complex personal care' (98%) had a higher level of agreement than the subcategory 'simple personal care' (89%), with and without the distinction between the scores 1 and 2.

#### *Psycho-social or supporting activities*

The majority of the 'psycho-social or supporting activities' (Table 5) scored less frequently than activities in the other main categories, but the level of agreement was also high (98%). Social activities, like chatting with the clients and inquiring about their health should be distinguished from 'real' psycho-social or supporting activities, like talking about (emotional) problems and managing these problems. Consequently, the frequency-percentage of this main category (98%) is mostly a result of the frequency of 'social activities' (94%). The frequencies of the remaining subcategories were substantially lower, e.g. 'dealing with problems' (51–67%). The other subcategories also yielded lower levels of agreement. The 'topics of conversation' subcategory, for example, had an agreement level of 63% between respondent and observer, with considerable differences between the frequencies of the home helps

Supporting activities	Frequency home helps (%)	Frequency observers (%)	Overall agreement (%)
	98	100	98
<i>Social activities</i>	94	99	95
Have a chat with the client	93	99	95
Inquire about the client's condition	67	67	74
Inform about what has to be done	25	25	86
<i>Topics of conversation</i>	35	59	63
Provided home (help) care	18	35	68
Acceptation of disease or handicap	8	14	84
Loneliness	8	16	91
Parent-child relationship	6	17	85
<i>Dealing with problems</i>	51	67	74
Listen	47	66	70
Express sympathy	33	33	70
Seek for solution	11	13	86
Give advice	9	9	89
Encourage the client for certain behaviour	11	11	86
<i>Health promotion and education</i>	16	11	86
Inform about education	11	6	91
Inform about nature of disease or illness	8	4	92
<i>Encouraging the client to realise certain goals</i>	13	27	79
Nutrition or diet	8	9	91
<i>Observing the client for ...</i>	37	48	71
Physical changes	31	31	75
Mental changes	19	1	79
Social changes	7	16	84
<i>Informal care</i>	13	6	89
Discuss the client's situation	6	4	93
Provide emotional care	6	3	93
<i>Special activities</i>	9	18	80
Making the house cosy	9	18	81
<i>Children</i>	9	10	99
Play with children	8	8	97
Support or guide children	6	6	96
Educate children	5	3	97

**Table 5** Frequency of psycho-social or supporting activities carried out (columns 1 and 2) and the level of agreement between the home help and observer regardless of the value 1 or 2 (column 3), expressed in percentages ( $n = 159$  home visits).

(35%) and the observers (59%). Apparently there was a lack of clarity about the topics.

#### Activities regarding reporting

The home helps recorded reporting activities (Table 6) in approximately 30% of the home visits. Consistent with the other main categories, this main category had a high level of agreement (96%). The activity with the highest frequency of reporting is use of a communication notebook (26%). This is a notebook, which is used by the client and can also be used by other professional care providers and family members of the client for comments and observations. 'Reporting about the client's health problems' was scored more often by the

home helps than by the observers (10 and 2%, respectively). An explanation for this might be that the home helps reported this, and also scored it, after the home visit and thus out of the sight of the observer.

We have also examined whether the levels of agreement are similar for the various types of home help. The overall level of agreement and the level of agreement for the main categories and of the majority of the subcategories were good for all types of home help (85% or higher). Agreement percentages of lower than 85% are presented in Table 7. Three household subcategories had a moderate level of agreement (82-84%) recorded by the caring helps B, home carers C and specialized home carers E. Two psycho-social or supporting subcategories were recorded less reliably by

Reporting activities	Frequency home helps (%)	Frequency observers (%)	Overall agreement (%)
	30	27	96
<i>Reporting in a communication notebook</i>	26	25	98
To colleagues	24	24	97
To informal care	15	16	97
<i>Reporting about the client's health problem(s)</i>	10	2	90
To colleagues	6	1	92
To informal care	9	1	92

**Table 6** Frequency of reporting activities carried out (columns 1 and 2) and the level of agreement between the home help and observer regardless of the value 1 or 2 (column 3), expressed as percentages ( $n = 159$  home visits)

caring helps B and specialized home carers E (70-82% agreement). Five other subcategories of the 'psycho-social or supporting activities' had a low level of agreement for almost all the types of home helps (41-85%). Apparently, not the different types of home help, but the activities themselves were recorded less reliably. Table 7 shows that, in general, there are no major differences in the reliability of recording between the types of home help.

Although the majority of the items at the registration form were recorded reliably, there are a few items that are less reliable: 17 items have a difference in frequency between the home help and the observer of 5% or more. This can partly be explained by a low face validity of certain items. 'Vacuuming', for example, is a more distinct activity than 'listening'. Two of the 17 activities, 'making the beds' and 'observing the client for mental changes', were overestimated by the home helps. A probable explanation for the first mentioned activity is that the home helps actually were asked to change the beds and because they automatically made the beds, they recorded these activities

separately on the registration form. The observers on the other hand, only recorded 'changing the beds', because they assumed that this included making the beds. The second activity is an example of an 'invisible' activity. It is very difficult for the observers to see or determine if the home help observed the client for possible mental changes. In these situations, the home help only recorded this activity, which led to an overestimation compared with the observers. In contrast, 'observing the client for social changes' is an activity that is overestimated by the observers (16 vs 7% by the home helps). The observers interpreted certain actions, mainly questions enquiring indirectly about the client's social life, wrongly as being 'social observations'. The remaining 15 activities were underestimated by the home helps. There are two types of underestimation. First, the home help records the same activity under a different item than the observer. This has to do with concept definition. An example of this is 'scrubbing the floor'. When the kitchen is cleaned, the floor will usually be scrubbed too. The home helps did not score 'scrub-

**Table 7** The level of agreement between home help and observer for the five types of home help, expressed as percentages ( $n = 159$  home visits)

	Total $n = 159$	Ah $n = 8$	A $n = 27$	B $n = 37$	C $n = 70$	E $n = 17$
<i>Household activities</i>						
Cleaning bathroom or toilet or kitchen		100	100	95	96	82
Periodical household activities		100	85	84	96	88
Preparing meals/drinks		88	89	87	84	100
<i>Psycho-social or supporting activities</i>						
Health promotion and education		88	89	73	91	88
Informal care		100	100	70	96	82
Topics of conversation		63	63	65	64	53
Dealing with problems		63	70	73	73	88
Encourage client to realise certain goals		100	85	76	77	71
Observing the client for changes		100	78	65	76	41
Special activities		63	85	89	83	47

**Table 8** Distribution of the travelling time between clients, the duration of a home visit, time spent on the main categories recorded by home helps and observers, in minutes with *P*-values (*n* = 159 home visits)

	Home helps (median)			Observers (median)			P-value
	25%	50%	75%	25%	50%	75%	
Travelling time between clients	5	5	10	5	5	10	0.88
Duration of home visits	30	85	180	30	85	180	0.25
Time spent on household activities	5	45	120	5	60	135	0.11
Time spent on caring activities	0	0	15	0	0	15	0.59
Time spent on supporting activities	10	23	45	10	30	45	0.15
Time spent on reporting activities	0	0	5	0	0	2	0.56

bing the floor' separately, but only scored 'cleaning the kitchen'. The observers on the other hand, scored both 'cleaning the kitchen' and 'scrubbing the floor'. This has led to an underestimation by the home helps. The second type is when a certain activity is scored by the observer and not by the home help. This can be illustrated by the activity 'set or clear the table'. Many clients receive 'meals-on-wheels' (a warm meal delivered by a nearby home for elderly people). When a home help is providing care at that time, he or she usually puts cutlery and a plate on the table. This is a quick and simple action, which could easily be missed by the home help when filling in the registration form. The observer, recording the activities directly, may not miss it and this can lead to an underestimation by the home helps. There are a number of activities where this could also apply. 'Making the house cosy' for example, which was recorded more frequently by the observers too. A few supporting activities, topics of conversation to be more precise, were also affected by this type of underestimation. For the home helps, talking about the client's loneliness and the client's acceptance of his or her disease is so natural that they do not record it. The observers, on the contrary, did record these activities.

In addition to recording the various activities, the time spent on them was recorded by home helps and observers. Medians and lower and upper quartiles were used to describe the distribution of the travelling time between clients, the duration of a home visit and the time spent on the four main categories of work (see Table 8). The distribution of these times was not normal. To test whether these distributions are the same for the home helps and the observers, the Wilcoxon signed-ranks test was used. The results confirm the assumption, with levels of significance between 0.11 and 0.88, that the distributions of the travelling time between clients, the duration of a home visit and the time spent on the four main categories are similar for the home helps and the observers.

At the end of the reliability study we considered the likelihood of a learning effect having taken place. This can occur when information is collected over a long period of time and the possibility of the instrument used becoming more reliable over such a period must be examined. In the pilot study, the home helps and observers recorded for 5 consecutive days. Analysis of variance, with the reliability scores of the main categories as dependent variables and the 5 recording days as independent variables, produced no significant differences. There is, therefore, no learning effect when recording for 5 consecutive days. If there had been any significant differences, this would have meant that the results were distributed unequally among home helps with large and small employment contracts.

#### Content validity of the registration form

Remarks and comments were made by a few home helps. The content of these remarks was similar and mainly centred around the fact that the registration form was clear and conveniently arranged, but was not comprehensive enough. For example, one home help said that it was 'not possible to make a distinction between household activities on the first floor and the same activities on the second floor. However, when developing the registration form, it was never intended to make this distinction. According to the home helps, the registration form also lacked a few activities; mainly those activities that are rarely carried out (twice or three times a year). However, such activities could be recorded in the subcategory 'miscellaneous'. It is intended that activities that were scored more than 10 times during the pilot study will be added to a new version of the registration form. A few examples are washing the curtains, taking care of pets or plants, taking children to school or picking them up and getting clients ready for a day-centre. The other activities can be recorded as 'miscellaneous' or are



covered by activities already included. Finally, one respondent had difficulties recording the psychosocial or supporting activities.

## Discussion

This pilot study was meant to estimate the reliability and validity of the primary instrument in order to achieve the general aim of the main study, i.e. to obtain a representative picture of the daily practice of home help services. The reason for this study is that in the last decade, important developments and changes have occurred in both health care and home care. Home help services are confronted with an increased demand for home care. Firstly because of the ageing of the population, and secondly because of the policy of substitution of home care for hospital care. This increasing demand for home care, together with the savings on the health care budget, have caused long waiting lists for home help services. In December 1992 in the Netherlands, almost 1300 households were waiting to be assessed for need for home help services and approximately 12 500 households, which had already been assessed positively, were waiting to receive home help care (Groenewegen *et al.* 1993). Waiting lists are quite common in many countries of the European Union, for example home help services in Belgium, Portugal and Spain are experiencing the same problem. According to experts in these countries, the waiting lists are caused by financial problems, i.e. budgets are too low while the demand for home help services is increasing. Only in Denmark, Finland, Germany, Luxembourg, Sweden and the United Kingdom are no waiting lists reported. In the United Kingdom, people receive care if either the local authority or the individual are prepared to pay for it. Otherwise it is refused until further application (Familiehulp 1991, Holstein *et al.* 1991, Hutten & Kerkstra 1996). Another problem is a shortage of personnel, which will become an even bigger problem in the near future. In the year 2000 it is expected that there will be a shortage of approximately 7500 home helps in the Netherlands (van Tits & Groot 1991, van Tits & Vermeulen 1992). This will increase the already long waiting lists for home help services. Shortage of personnel is also a problem in many other countries in Europe, e.g. Belgium, Denmark, France, Germany, Greece, Ireland, Italy and Portugal. According to experts in these countries this type of employment is not considered attractive, because it has a low status, it is poorly paid and the training is considered to be inadequate (Familiehulp 1991, Hutten & Kerkstra 1996). Furthermore, research has shown that absenteeism due to illness among home helps is very high (almost 10% in 1993) (Hornman 1994). Finally, a development that

involves a lot of extra time and work, is the integration, at a regional level, of organizations for home help services and community nursing.

These developments have made further professionalization of the home help services necessary. In order to contribute to this, research in this area is required. Research is planned in the Netherlands because information regarding home help services, workload, task differences between the various types of home help, and discrepancies between assessed, allocated and actual home help care is not available. A pilot study was carried out to establish the reliability and content validity of the registration form used to record the activities that home helps carry out.

The results of the pilot study showed that the registration form is clear and conveniently set out. Shortcomings are restricted to the occasional occurrence of an activity not being cited. Consequently, the self-registration form appears to be a reliable and valid instrument for measuring the work of home helps. Nevertheless, a few activities will be added to the form, like washing the curtains, taking care of pets or plants, taking children to school or picking them up and getting clients ready for the day-centre. The new form will also have a better layout. The type of underestimation where home helps do not record certain activities while the observers do, also occurred in a comparable study by Kerkstra & de Wit (1987) among community nurses and in a study of Sluijs (1988) on patient education by physiotherapists. Sluijs mentioned the most obvious explanation,

... that physiotherapists consider educating the patient, as such, a natural part of their work that they do not regard it specifically as patient education (and therefore also do not record it as such).

She also refers to forgetting certain activities or considering them unimportant. Similar explanations possibly can be applied to this study too. However, this does not alter the fact that this type of underestimation prevents a reliable and valid representation to a certain extent. For the benefit of the main study, we will try to minimize the effect of this type of underestimation by clustering. An attempt is made by clustering some items in the subcategory 'topics of conversation'. To keep the other type of underestimation, due to concept definition, as low as possible too, this should be taken into consideration at induction meetings. The items that could possibly cause confusion of concept, have to be clarified during the instruction and again in the handbook. All the above mentioned findings were used to adjust or improve the registration form.

In summary, the main measurement instrument appeared to be reliable and valid for use in the main

study, by all types of home help. This main study, involving a representative sample of 16 organizations for home help services and 500 home helps, was started in March 1995 with the adjusted and improved instrument.

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