A REPORT ON THE DEVELOPMENT AND EVALUATION OF A TELEVISION PROGRAM ENTITLED NO PLACE LIKE HOME-A LOOK AT HOME CARE: A PUBLIC INFORMATION PROGRAM

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A REPORT ON THE DEVELOPMENT AND EVALUATION OF A TELEVISION PROGRAM ENTITLED NO PLACE LIKE HOME--A LOOK AT HOME CARE, A PUBLIC INFORMATION PROGRAM

by

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ABSTRACT

Hospital-based home care is a practise that has become prevalent in North America within the last fifteen years, stemming from the belief that hospital personnel should be responsible for patient care beyond the confines of the hospital building. An outgrowth of this philosophy has been the establishment, in many hospitals, of personnel whose responsibility is to assess patients upon admission and to plan immediately for discharge. It is maintained that discharge planning can reduce the length of stay for many individuals and that full recovery can be achieved at home. Essential to home care are the services of a number of community-based agencies whose efforts can be coordinated by the hospital's referral nurse. Such agencies meet a variety of needs, including nursing care, physiotherapy, socialization, and basic homemaking.

At St. Clare's Mercy Hospital in St. John's, Newfoundland, attempts were being made to achieve optimum utilization of the community's home care services. The referral personnel, however, due to heavy workload and constraints of time, were unable to review thoroughly the cases of all potential patients for home care. One solution was to have the patients or members of their

families take the initiative. Unfortunately, a large majority of individuals knew little about home care, and were certainly unaware of the varied services available. Consequently, many of the services were being underutilized.

As a solution to the problem, a television program was developed, its broad objective being to increase the number of referrals to home care by broadening the knowledge base of the public. The program was designed to provide a basic overview of home care, as well as descriptions of the community agencies available to residents of Newfoundland and Labrador. Through implementation of such a program, patients and family members were encouraged to contact the referral nurse or any member of the health team to obtain a personal assessment for a home care option.

The program was produced following thorough analyses of needs, intended audiences, and a delineation of tasks and objectives. Formative evaluation was conducted following completion of the script and the feedback resulted in a number of alterations. Following production and post-production, the completed program was summatively evaluated through implementation of three techniques.

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CHAPTER I

INTRODUCTION

Historical Development of Home Care Services

The provision of care and assistance at home for the chronically ill, the disabled, or the aged is probably the oldest form of care, predating the use of hospitals and other institutions by many centuries. Indeed, the home was the chief site of all health care until quite recently. It was not until the 1940's, in fact, that medical specialization and the development of expensive and elaborate technologies led to a rapid growth in hospital facilities throughout North America and a greater dependence upon institutional care (Shapiro, 1979).

Throughout the 1950's and early 1960's, the hospital was considered the ultimate and, often, the only agent which could serve the needs of patients with acute illnesses. For the physically and mentally disabled, and for the aged, other types of institutions were established. To some authorities in the field of health services, however, it gradually became apparent that the institutional setting was not always the most appropriate for many patients. According to some critics, the hospital environment was artificial, isolating individuals from the familial,

kinship and community ties which could often prove contributory to their physiological and physical recovery (Litman, 1966; Shapiro, 1979). Others pointed to the tremendous cost of hospitalization, noting that home care could provide comparable and adequate service at about one-tenth of the cost incurred in an institution (McCarthy, 1976).

Although such criticisms were in no way intended to undermine the high level of sophisticated technology and personnel available in hospitals, overdependence upon such facilities was leading to a phenomenon called "over-institutionalization". Indeed, concern over this problem continues. As Duggan (1979) wrote:

> This overuse of institutions . . . fosters the needless dependence of persons who do not really require the high level of services provided in these facilities, particularly if these institutions are weak in the provision of rehabilitative services. It also denies these people the freedom to live at home among family, friends and familiar surroundings, and it fails to take into account the importance of these familiar people and surroundings in the process of healing [and] rehabilitating (Duggan, 1979, p. 1).

In the United States, the development of home care services received its chief impetus in 1966 with the introduction of Medicare. Prior to that year, only one hundred out of a sample of seven thousand hospitals had established coordinated home health activities; by 1969, however, fifteen hundred home care programs had been instituted (Gee, 1972). This tremendous growth was confirmed by yet another study,

conducted in 1969, which showed that 65 percent of the hospital-administered home care programs then in existence had been established since 1965, the median length of operation being 3.65 years (Richter & Gonnerman, 1972).

In Canada, the development and refinement of home care services did not become a major concern until the seventies. In 1969, the "Federal-Provincial Task Force on the Cost of Health Services in Canada" gave somewhat limited acknowledgement to home care by perceiving it primarily as a way to shorten hospitalization periods (Shapiro, 1979). There was, however, little consideration given to the social and psychological benefits of home care, and there seemed to be no commitment to the provision of facilities which allowed for the treatment and maintenance of people requiring chronic or long-term care at home (Shapiro, 1979). During the early 1970's, some provinces did fund and deliver various home care programs, usually through grants to private agencies, budget allocations to hospitals, or by serving those eligible for Social Assistance. The latter two options proved most popular since much of the cost was assumed by the Federal Government. Unfortunately, such practices severely limited the growth of a comprehensive system of home care since:

> . . . the structure, organization and target populations of many home care programs were influenced more by their capacity to recoup federal dollars than by specific needs of the population requiring service. (Shapiro, 1979, p. 2)

Although the number of home care facilities continued to increase during the 1970's, there seemed to be little uniformity in objectives, funding or eligibility criteria (Shapiro, 1979). What seemed most inappropriate to proponents of home care, however, was that the concept was not being developed to its fullest potential. There seemed to be little practical application of the social and psychological implications inherent in home care and far too limited a delivery for the many individuals who required such a service. Recognizing these deficiencies, the Department of National Health and Welfare funded, in 1978, the preparation of a comprehensive report on home care in Canada. Prepared by Evelyn Shapiro, Assistant Professor of Social and Preventive Medicine at the University of Manitoba, the 220-page document was entitled, Home Care: A Comprehensive Overview, and contained an exhaustive analysis of the philosophy and objectives of home care, its level of operation in Canada, as well as an extensive list of recommendations for improvements, organization and delivery (Shapiro, 1979).

In essence, Shapiro's report criticizes early concepts of home care, charging that they have been narrowly applied to a limited target population based upon physician-directed models. Such definitions have fostered the belief that home care is only to be utilized by the chronically ill. In its broadest application, however, home care must

not only serve medical needs, but the social, psychological and basic homemaking requirements of all individuals who cannot meet such needs unassisted (Shapiro, 1979). As Sangster (1973) states, home care should be a

> coordinated community health service providing nursing, physiotherapy, occupational therapy, and homemaking services where applicable in the case of patients in their own home (Sangster, 1973, p. 91).

Philosophy of Home Care

The philosophy of home care is a very basic one, arising from the importance cultural tradition places upon familial, kinship and community ties. It is perceived that home care helps maintain and enhance individual relationships with the community, family, and neighbours, thus transcending the artificiality of institutional environments (Shapiro, 1979).

Central to the concept is the family unit. As Litman (1966) points out, most patients seek comfort and encouragement from their families and, in fact, seem to respond more favourably to treatment when they have re-entered the family unit. It has further been demonstrated that families not only define whether a person is sick and subsequently decide where or to whom his care should be entrusted (Pratt, 1973), but that most families are willing to assume the responsibility of care (Sussman, 1959; Litman, 1966).

Succinctly, then, the philosophy of home care is to provide for the needs of the ill, disabled, or aged in the company of family members and friends and within the familiar environment of home and community.

The Objectives of Home Care

In its 1975 report, the Federal-Provincial working Group on Home Care cited five major objectives that form the basis for the planning and implementation of a home care program. These are:

1) to make more effective use of institutional beds by preventing admission and shortening length of stay;

2) to promote and support greater personal and family responsibility for health;

3) to assist in planning and arranging for continuity of health care prior to and after home care;

4) to relieve excess strain on family members and, in so doing, prevent the breakdown of a desirable living arrangement and/or the health of the person(s) providing care;

5) to provide services and support to assist persons in meeting their health-related needs in the home where this is the most appropriate place for care.

(Shapiro, 1979, p. 15)

Home care can provide for a variety of needs. Shapiro (1979), for example, delineates three broad categories:

1) Basic needs--defined as those which are necessary to the basic maintenance of the person. These include: total or partial assistance in such tasks as preparing food, taking medication, keeping house, bathing, grooming, etc.

2) Supportive needs--defined as those which help the individual cope with the indirect effects of the illness. These include personal attention, company, reassurance, redefinition of responsibilities, and the maintenance of maximum functional capacity.

3) Remedial or therapeutic needs--defined as those which require professional intervention and treatment. These include, when appropriate, medical and nursing care, rehabilitation, vocational retraining, financial assistance, and personal or family counselling.

(Shapiro, 1979, p. 21)

Although the satisfaction of patient needs constitutes the essential objective of home care, the needs of the family are also an important consideration. As Duggan (1979) maintains, an effective program should not neglect the tremendous responsibility assumed by the family. It is necessary to ensure that assistance is provided to help alleviate the possible burden of caring for a disabled member. Such assistance may be provided in a number of ways:

1) Respite care; the provision of helpers who can care for patients while family members take short or extended vacations.

2) Assistance in completing any renovations necessary for the maintenance and mobility of the physically disabled.

3) The allocation of allowances for families who care for the elderly.

(Duggan, 1979, pp. 57-62)

It becomes obvious that the objectives of home care cover a broad range of needs, and it is believed that through

public education and the establishment of community care programs, great potential exists for improving the quality of care (Vanhooran, 1978).

The Organization of Home Care

If the multiple objectives of home care are to be achieved, it seems apparent that a comprehensive and co-ordinated method of organization must be established.

There are probably as many different agencies supplying some form of home care as there are individual needs. Indeed, if one considers the basic, supportive, and remedial needs to be met, the necessity of a complex organizational structure composed of a variety of professional, paraprofessional, and non-professional personnel becomes apparent. Shapiro (1979) identifies the chief types of personnel who should constitute a comprehensive and well-organized program of home care; besides the medical professional, these are:

1) Homemakers, whose basic function is to look after the basic needs which individuals would normally carry out themselves, or which family members carry out. In most cases, this includes the performance of housekeeping tasks and the provision of some personal care.

2) Paraprofessionals, such as Licensed Practical Nurses, Orderlies, and Nurses' Aides. These individuals would require some formal specialized technical training which equips them to look after the routine tasks required for health maintenance and personal hygiene.

> 3) Volunteers, or ordinary citizens who can make weekly visits, daily telephone reassurance, or deliver meals. Such individuals can not only provide surveillance of the health and social status of the patient, but can help the apathetic become interested in hobbies or other pursuits which may aid in psychological recovery.
>
> (Shapiro, 1979)

With such a diversity of personnel comprising home care, it has been recognized that a central organization to coordinate the delivery of services is a necessity (Duggan, 1979). Although the hospital may seem the logical agent to achieve this, many proponents of home care feel that hospitals represent a restricted view of the concept, since they are prompted mainly by the desire to free beds as quickly as possible, and are essentially oriented towards illness and crisis situations (Shapiro, 1979). If the non-medical components of home care are to be utilized, the best alternative for a coordinating body seems to be a community-based organization which can act as liaison for all potential services, from the homemaker to the medical professional. According to Shapiro (1979), these multi-disciplinary home care organizations can most logically be monitored and maintained through a central agency of the provincial government, such as the Department of Health and Social Services.

Home Care in Canada

During recent years, many provinces of Canada have instituted some sort of provincial home care organization.

In 1974, the province of Manitoba pioneered such implementation when the Working Group on Home Care delivered a report recommending a provincial organization which would provide a comprehensive program of home care services, totally integrated with the operations of the health department (Shapiro, 1979). This use of a provincially-controlled program has a number of advantages:

a) those responsible for coordinating the program also have the authority to do so;

b) one integrated home care program can be offered in the context of all other provincial programs;

c) continuity of care is most simply assured, with a minimum of jurisdictional confusion and barriers;

d) the costs of delivering the organized home care services can most efficiently be budgeted, accounted, controlled, and shared;

e) monitoring the home care program by means of uniform data collection, administration of uniform program standards, and by means of systematized program evaluation, is most easily done by this organizational structure; and

f) not least, the seeker and user of home care services has, presumably, the least possibility for confusion or for getting lost in a maze of services that come from and require multiple referrals.

(Shapiro, 1979, pp. 63-64)

Since its inception in 1974, the Manitoba Home Care Program has continued to be the most highly developed system of its kind in Canada, offering the full range of professional, paraprofessional, and nonprofessional services to all citizens who require such assistance. The following is a

brief overview of the personnel and services which constitute the Manitoba model:

SERVICES		PERSONNEL PROVIDING SERVICE
<u>Household Maintenance</u>		
Meal Preparation		Homemakers (as appropriate)
Cleaning		
Laundry		
<u>Personal Care and Hygiene</u>		
Assistance in:	Bathing Grooming Feeding Dressing	Homemaker/and/or/aide/ orderly
<u>Health Maintenance Services</u>		
Health Teaching		Public Health Nurse/ Registered Nurse
Surveillance		Public Health Nurse/ Registered Nurse/Licensed Practical Nurse
Drugs Care		Registered Nurse/Licensed Practical Nurse/Homemaker
Diet Care		Homemaker/Home Helper
Physical Exercises		Physiotherapist/Homemaker/ Aide
Activation		Occupational Therapist/ Homemaker/Aide
Supervision/Social Relief		Sitter Attendant
Foot Care		Registered Nurse/Licensed Practical Nurse

SERVICES	PERSONNEL PROVIDING SERVICE
Health Treatment	
Treatment Procedures	Medical Doctor/Public Health Nurse/Registered Nurse
Drug Therapy	Public Health Nurse/ Registered Nurse
Diet Therapy	Home Economist/Public Health Nurse
Physiotherapy	Physiotherapist
Speech Therapy	Speech Therapist/Public Health Nurse
Occupational Therapy	Occupational Therapist
Information and Referral Counselling	
Income Maintenance	
Financial Counselling	
Resource Counselling	
Legal Counselling	
Personal and Family Social Services	
Personal Counselling	Social Worker
Health Counselling	Public Health Nurse
Mental Health Services	
Facility Services	
Day Hospital	
Hospital Short-Term Relief Care	
Personal Care Home Day Care	

SERVICES	PERSONNEL PROVIDING SERVICE
Volunteer Services	
Daily Hello	Provided by volunteers
Friendly Visiting	
Transportation	
Shopping	
Snow Shovelling	
Meals-on-Wheels	
Surveillance	
Equipment Services	
Home Care Equipment	Home Care Equipment Pool

(Duggan, 1979, pp. 96-98).

Since the implementation of the Manitoba model, the provinces of Saskatchewan, Quebec, British Columbia, Alberta, and New Brunswick have commenced their own initiatives. With the exception of New Brunswick, which provides services only in three select areas, all of the above provinces are attempting to deliver the full realm of services, where appropriate, to all citizens, through centrally-administered government organizations (Shapiro, 1979).

Home Care in Newfoundland and Labrador

Newfoundland lacks a major coordinating agency at the provincial level. There has been, however, considerable

activity in recent years to achieve higher standards of home care throughout the province. Since early 1979, the "Home Support Services Action Committee," a St. John's group made up of medical professionals and home care specialists, has been meeting to determine needs and to establish liaison with the provincial government. The most substantial document of the state of home care in the province was contained in a report prepared in 1979 by William J. Duggan for the "Community Services Council," an organization committed to the coordination of existing social services in St. John's (Duggan, 1979). Although Duggan's report was restricted to the St. John's metropolitan area, his observations and recommendations had some applicability to the entire province.

In assessing the state of home care in the province, Duggan (1979) noted that Newfoundland has emphasized the delivery of service via institutions, but has failed to develop community-based programs to the extent they are needed. One striking example has been the failure to provide adequate community care for seniors, a fact confirmed by Rowe (1977), who found that up to 44 percent of the individuals in the province's homes for the elderly were there "without sufficient cause; and could be managed at home if sufficient community care were available."

In a province such as Newfoundland and Labrador, with sparsely distributed population and much geographic

isolation, it is not surprising to find that most of the home care services are situated in or near the larger centres. Although the Public Health Nursing Service theoretically covers the entire province, it is frequently unavailable to many rural areas; also, one should recall that nursing is but one of the components of comprehensive home care. The majority of services and the greatest variety are located within the St. John's Metropolitan area, with fewer services in all other regions.

Although other areas of the province can avail of some of the services provided by provincial divisions of national societies, one suspects that they are operational only in larger communities, such as Corner Brook or Gander. Indeed, according to Spurrell (1980), the services available outside the capital city are as follows:

Public Health Nursing Services

International Grenfell Association - Northern Peninsula

Victorian Order of Nurses - Corner Brook
Conception Bay South

Home Care Programs - Carbonear
Corner Brook
Gander
Grand Falls
Springdale
Baie d'Espoir
Goose Bay

(Spurrell, 1980, p. 17)

Although home support services are centred in specific areas, a significant number of organizations exist

to warrant some sort of coordination, ideally through an agency of the provincial government. In his report on Home Support Services for St. John's, William Duggan (1979) claims to have identified problems common to most Newfoundland communities. From his extensive list of recommendations, he cites three as being most important. They are:

> 1) The establishment of a joint community-government committee to work for the development of home support services.
>
> 2) The creation of a comprehensive home support program to coordinate the efficient and economical delivery of services to persons in their own homes.
>
> 3) The establishment of a service to recruit volunteer workers and match them with individuals in need of certain home support services.
>
> (Duggan, 1979, p. 5)

Hospital-Based Home Care

In much of the formal discussion of home care, a community-based system seems to be the most favourably received alternative (Shapiro, 1979; Duggan, 1979), with coordination offered through departments of the provincial government. This is not to suggest, however, that hospitals should take no role in delivering home support to those who need it. Indeed, in provinces where there is no government coordination, the hospital may become the sole organization referring patients to home care. Although

the hospital is basically oriented towards illness and crisis situations, it must logically take a leading role in home care referrals as Vanhooren (1978) suggests:

> Hospitals . . . have a clientele who have recognized a problem as a patient and made a commitment of time and effort . . . these patients are receptive to medical intervention and community care programs (Vanhooren, 1978, p. 24).

On a more philosophical level, the view is generally being accepted that hospitals must assume responsibilities for patient care even after discharge. As Falcone (1979) states, the responsibility of hospital personnel extends beyond the alleviation of the immediate problems for which patients were hospitalized:

> Preparation for discharge involved a great deal more than repacking a suitcase and calling a relative for a ride (Falcone, 1979, p. 24).

In more practical terms, the involvement of hospitals in home care referral may hold many advantages. The reduction of patient stay periods is an oft-cited result which has ample justification:

> Movement should whenever possible be towards a place of pleasure and independence . . . therefore, people should be in hospital as little as possible (Sutherland, 1979, p. 11).

There is little doubt that hospitals involved in home care referral have reduced patient stay periods. As one physician noted, home care not only results in shortened stay periods, but may, in fact, prevent certain admissions from ever occurring (Sangster, 1973). In a comparison of Framingham

Union Hospital in Maryland with peers in its geographic area, it was found that Framingham had achieved an average length of stay of 5.9 days, compared with 8.6 days in other institutions. The result was that Framingham was able to handle 47 admissions per bed per year, while other hospitals could accommodate only thirty (Wymelenberg, 1978).

Yet another practical benefit derived from hospital-based home care is related to cost-effectiveness. According to Duggan (1979), the provision of services at home costs approximately $10.95 per patient per day, while hospital care costs over $150.00 per patient per day.

In order to achieve optimum use of home support services and to ensure ease of transition between the hospital and home setting, a great deal of coordination is necessary, involving:

> the person being transferred, his family or other supporters, and members of the health care team in both care settings (Habeeb & McLaughlin, 1979, p. 1443).

In many hospitals, a patient-care coordinator or referral nurse is included on staff to make early assessments of patients and to ensure that those who can benefit from care at home receive the appropriate range of services as soon as possible (Edwards, 1978). Such a process involves constant consultation with many departments and staff members; including physicians, nurses, social workers, rehabilitation personnel, nutritionists, chaplains, volunteers, and teachers (American Hospital Association,

1974). The process utilized is most often referred to as "discharge planning" and involves thorough assessments of patient needs, family and environmental situations, and delivery of services. The essential basis to discharge planning is that the institution provide a

> centralized, coordinated program . . . to ensure that each patient has a planned program for needed continuing care and/or follow-up (American Hospital Association, 1974, p. 1).

Discharge Planning at St. Clare's Mercy Hospital, St. John's, Newfoundland

In 1974, St. Clare's Mercy Hospital established a referral system to "meet the post-hospitalization needs of selected patients by utilizing the existing community service agencies, particularly the Victorian Order of Nurses, the Department of Health's physiotherapy and speech therapy services, Jack and Jill homemaking service, and the St. John's Home Care Program" (Spurrell, 1980). Essentially, the referral system seeks to eliminate the crisis discharge situation and decrease patient length of stay when appropriate. This is achieved through early discharge planning which quickly and thoroughly identifies those patients and families who require further care, counselling, health teaching and supervision following hospitalization (Spurrell, 1980).

As with most hospital discharge planning systems in North America, an interdisciplinary approach is stressed, coordinated by the referral nurse but involving such

personnel as physicians, nurses on patient care units, physiotherapists, social workers, and dietitians. Prior to admission to St. Clare's, all patients are sent a brochure outlining the services available through the St. John's Home Care Program. Upon admission, a notification calling attention to the St. John's program is placed upon the charts of all patients who live within the boundaries of the St. John's Home Care Program. Immediately following admission, discharge planning is commenced, and mainly constitutes seven steps:

1) Identification of patients requiring Discharge Planning through a bi-weekly screening system.

2) Identification of needs, including an assessment of household composition, family abilities to cope, and such patient-related factors as physical functioning, clinical status, psychological status, and mental competence.

3) Placing of a notification on the patient's chart when the patient has reached the 50 percent point in the average length of stay.

4) Selection of the appropriate agency to deliver services.

5) Consultation with the attending physician who must complete a medical referral and provide written prescriptions for medication. In addition to information provided by the physician, reports must be provided by the nurse giving patient care and, when appropriate, by other professionals such as physiotherapists, occupational therapists, social workers, and dieticians.

6) Interviews with patient and family.

7) Contact made with appropriate agencies by the referral nurse.

(Spurrell, 1980)

The Problem

For St. Clare's Mercy Hospital, the problem related to home care is a very basic one. Although an organized system exists for the delivery of home care services, optimum effectiveness has not been attained, mainly because there are too few personnel to coordinate the complex procedures which characterize discharge planning and home care referral. According to the Referral Department, home care services are underutilized and many patients who could benefit from such support are never identified.

CHAPTER II

NEEDS ASSESSMENT

Statement of Needs

According to the Referral Department of St. Clare's Hospital, the underutilization of home care is largely a result of the general public's limited knowledge of the scope of available home support services and of the steps which may be taken to avail of such services. To overcome this lack of knowledge, it would be necessary to implement some procedure for informing patients and their families of the scope and accessibility of home care.[1]

To analyse more specifically and to confirm the stated need, the developer conducted a study at St. Clare's Hospital (see Appendix A). The questionnaire was administered orally by student nurses to 25 hospital patients, on a one-to-one basis. There were two sections to the instrument, the first consisting of questions and requiring simple one- or two-word responses, and the second allowing for more detailed explanation of certain questions in the first part. From the "free responses" of Part Two, the developer was able to determine the accuracy of individual perceptions

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[1]Personal communication from Geri Spurrell, June 15, 1980.

of certain concepts. For example, a subject might state in Part One that he or she knew what home care involves; whereas in the free response, he or she might indicate an incorrect or a limited perception of the concept. In other words, Part Two was used as a means of validating Part One.

Subjects with "limited" knowledge were those who knew of one minor aspect of a concept, but lacked a thorough understanding of the multiple components. To be more specific, those with limited knowledge defined home care as nothing more than a nursing service, and believed that the only method for obtaining help was through the family physician; the homemaker was seen as one who only cooks meals, and the referral nurse was described as one who arranges for a public health nurse to visit the home.

As shown in Table 1, very few of the respondents possessed an adequate knowledge of the scope of available home care services. Indeed, only 12 percent of the sample were able to present a description of home care which encompassed its diverse components. The services offered by professionals such as physiotherapists, social workers, homemakers, and others were not familiar to many in the sample.

With such a large majority lacking knowledge of the diverse services available through home care, it may not be surprising to find that 44 percent of the sample

TABLE 1

Assessment of the Public's Knowledge About Home Care

	Questionnaire Items	Responses		
		Adequate Knowledge	Very limited Knowledge	No Knowledge
General Concept of Home Care	5a, 5b	12%	56%	32%
Homemaking	7a, 7b	16%	4%	80%
Referral Nurse	6a, 6b	4%	4%	92%
Method for Obtaining Help	8a, 8b	12%	24%	64%

Note: Questionnaire items 1, 2, 3, 4, and 10 were used for another purpose unrelated to the developer's study.

indicated that they would prefer to be cared for in hospital rather than at home, and felt that home care was not possible for them during their episode of illness. Of those who discounted home care as a personal possibility, only 5 percent actually knew what home care could provide.

As one might expect, the lack of knowledge about the general concept of home care is magnified when one considers more specific aspects, such as the roles played by hospital personnel in the delivery of home care services to patients. Indeed, only 4 percent of the sample were familiar with the duties of a referral nurse, and only 12 percent had knowledge of how to request home care during hospitalization.

The data suggest a need for the production of an informational package which would describe the general concept of home care, with particular attention focused on the various professional services which are available to residents of Newfoundland and Labrador. In addition, a discussion is needed of the role of the hospital in home care, including specific descriptions of the duties of the referral nurse and other professionals in the discharge planning process. Such a program would not only broaden perception of the scope of home care, but would provide more practical information on how the hospital patient may request an assessment for home care.

Alternative Solutions

In the development of a project such as this one, the developer may consider one of three available alternatives. Firstly, he may search for, procure, and adopt existing materials as the basis for instruction. Secondly, he may adapt existing materials, altering their structure or method of presentation to suit his purposes, or by incorporating them into a package which includes some original material. Finally, a completely original package may be used, produced as a self-contained unit and designed to meet the specific needs of the target audience.

Of these alternatives, the first two are the most desirable since the commitment of time and finances is likely to be considerably less than that required for the complete development, production, and evaluation of an original package. In order to determine which course is to be ultimately followed, the developer must first examine any existing materials related to the problem and assess their applicability.

Survey of Existing Materials

The developer conducted a search of all existing materials related to home care, and found only two that were readily available in Newfoundland and Labrador. These were a slide/tape presentation produced by Geri Spurrell, referral nurse at St. Clare's Mercy Hospital,

and a 16 mm. film produced by the American Hospital Association. Following is a discussion of each production and an analysis of applicability:

1) "People in Crisis: An Introduction to Discharge Planning," 16 mm. Colour. 28 minutes. American Hospital Association, 1979.

This is an excellent production, available on a loan basis from the Newfoundland Hospital Association. The presentation technique comprises an on-camera narrator who allows the viewer to look in on various patients and professionals within the hospital. Through a series of mini-dramatizations, one learns of the hospital's engagement in patient education, counselling, and discharge planning.

This film was designed specifically for health professionals and, as a result, considerable time is devoted to intricacies and technicalities of discharge planning. Since the film was shot entirely within a hospital, there is virtually no mention of the services which comprise care at home; indeed, such was not the intent of the film. Although there is much information for the health professional who wishes to learn about discharge planning and hospital-based education programs, there is little to offer the patient who wishes to learn of the home care services available in Newfoundland and Labrador, or elsewhere, for that matter.

It is, perhaps, interesting to note that there is absolutely no mention of a referral nurse. To be sure, the multidisciplinary nature of discharge planning is thoroughly described; but central coordination through a referral department is not discussed. Although it may be that the hospital used in the film did not have such a department, the absence of such information greatly reduced the applicability of the film as a solution to the problem defined.

2) "The Nurse's Role in Discharge Planning," Sound/Slide, 35 slides, St. Clare's Mercy Hospital, St. John's, Newfoundland.

This program is well produced, but similar in content to the film described above. Intended for the instruction of health professionals, it utilizes a great deal of technical language which makes it unsuitable for dissemination to the general public.

Decision to Produce Materials

Since the existing materials seemed to be produced for the information of health professionals and, therefore, did not present a detailed view of the home care services available to the public, the decision was made to produce an original information package. Such a package would present, in simple 'layman's' terms, an overview of home care, as well as a practical guide to the attainment of appropriate services.

CHAPTER III

LEARNER ANALYSIS

Primary Audience

The primary audience could be comprised of any individual, with no clear demarcations of age, sex, social status, or educational background. There are, however, certain characteristics which do prevail among those who are found to require home care.

As one would expect, the need for home care services seems to increase with age. Robinson and Caso (1975), for example, analyzed the discharge summaries of nearly 4,000 individuals in Massachusetts home care, and found that 77.2 percent were over 60 years of age, while only 4 percent were under 20. In Canada, similar studies of home care recipients have yielded almost identical results (Shapiro, 1979).

Besides identifying a major age group which requires home care, researchers have also discovered that women use the service far more than men. In the study conducted by Robinson and Caso (1975), it was found that 68 percent of home care patients were female; similarly, a 1976 study conducted by Donna Angus in Alberta revealed that 70 percent of the sample was female (Shapiro, 1979). Indeed, as Mitch

and Kaczala (1968) have indicated, female patients seem to outnumber males by two-and-a-half to one.

Although it seems possible to deduce that the majority of home care recipients are elderly and female, it is more difficult to categorize in terms of illnesses or disabilities. To be sure, a vast majority of potential users seem to be suffering from chronic illness (Mitch & Kaczala, 1968). Following their studies conducted in 1966 and 1967, Mitch and Kaczala (1968) delineated the 10 most common diagnostic categories among their sample of 593 individuals:

1) diseases of the heart and circulatory system - 189

2) accidents - 96

3) vascular lesions affecting the central nervous system - 90

4) diabetes mellitus - 70

5) malignant neoplasms - 51

6) selected respiratory diseases - 26

7) cirrhosis of the liver - 19

8) cataracts - 16

9) arthritis - 14

10) anemia - 11

(Mitch & Kaczala, 1968, p. 36)

In her description of the medical problems which could be dealt with in a home care setting, Spurrell (1980) has outlined the following nursing requirements of patients:

1) Diet supervision and/or instruction

2) General nursing care: taking vital signs, observation of symptoms

3) Range of motion exercises

4) Foley catheter care (includes catheterization and irrigations)

5) Teaching and supervision of medications

6) Dressing changes

7) Progressive ambulation

8) All phases of diabetic care (urine testing, reactions, etc.)

9) Equipment ordered for home nursing care of patients (i.e., hospital beds, geriatric chairs, bedpans, etc.)

10) Terminal cancer care

11) Transfer techniques

12) Teaching and supervising of family member (e.g., changing tube)

13) Evaluation of home situation and environment

14) Supportive care, especially for terminally ill patients: medical, psychiatric, chronics and geriatrics)

15) Bowel and bladder training

16) Rehabilitation

17) Decubitus care

18) Injections given by nurse

19) Wound irrigations or cleansing

20) Bed positioning

21) Colostomy care (includes teaching irrigations, skin care)

22) Skin care (includes supervision of family giving care)

23) Use of walker or cane

24) Teaching sterilization of home equipment

25) Care of deaf

26) Temporary breast prosthesis

27) Perineal irrigations

28) Care and use of oxygen in home

29) Sitz baths

30) Regulating insulin

31) Friendly visitor for isolated patients

32) Care and safety of blind person

33) Maximist nebulizer

34) Suprapubic catheter care

35) Paraplegic care

36) Teaching and supervision of postural drainage

37) Gastrostomy care and feelings

38) Elevation of head of bed

39) Speech therapy (therapist with Department of Health)

40) Transportation

41) Follow-up for suspicious chest x-ray film

42) Heat application

43) Deep breathing exercises

44) Prevention of contractures

45) Nephrostomy care

46) Laryngectomy care

47) Intake and output

48) Activities of daily living

49) Crutch walking

50) Evaluation of bladder control

51) Strict bed rest

52) Ileostomy care (changing appliance, skin care, and care of appliance)

53) Family planning

54) Tuberculosis contact; follow-up in home

55) Tracheostomy care (changing and caring for inner and outer cannula)

56) Suctioning (teaching patient how to suction himself)

(Spurrell, 1980, pp. 23-24)

These are, of course, only nursing services and say nothing of the social, psychological, and basic home-making requirements an individual might have.

Although such categorizations possibly represent the most frequently occurring disabilities, it is virtually impossible, and certainly impractical, to attempt to list all possible illnesses or disabilities which may cause the individual to require health care at home. It is equally difficult to attempt categorization in terms of educational background, social status, and other such factors. One can only assume that potential clients may be either rich or poor, may range in educational experience from illiteracy to a post-graduate degree, and may reside in either urban or rural environments.

Regardless of the many differences, however, there may be one prevailing attitude that exists almost universally among the ill or disabled. In most cases, institutionalization is not an appealing method of dealing with their health problems. Although the technological benefits of hospital are undeniable in many cases, it should still be obvious that most individuals would rather receive quality care at home, if appropriate, where they can maintain and enhance their relationships with their families, friends and neighbours, and remain integral citizens of the community.

Tertiary Audiences

Although the instructional package was designed primarily for hospital patients who may benefit from home care, there are other groups who may utilize the materials. As has been indicated previously, the patient's family is an extremely important group in the home care scheme, since it plays a vital supportive role during the course of an individual's rehabilitation by providing comfort and encouragement (Litman, 1966). Indeed, it is likely that the family unit actually defines whether a person is sick and, subsequently, decides where and to whom this person's care should be entrusted (Pratt, 1973). Although family members may not be able to provide professional health care themselves, there seems little doubt that most families

wish to assist in alleviating the illness of kin (Sussman, 1959) and would like to ensure that adequate care is provided, in the home if possible. One may assume, therefore, that family members could derive great benefit from knowing which home care services are available and how these services may be obtained. This is particularly important in cases where the ill or disabled are mentally or physically unable to learn of home care themselves or to request referral; consequently, the family must provide the chief impetus.

Yet another secondary group to be considered are health professionals themselves. Although most of these are doubtless aware of home care, it may be that some may not have thorough knowledge of the services provided by other professionals. Although more experienced specialists may be totally familiar with the home care program, one may wish to consider those who are training for careers in health care, such as student nurses, physiotherapists, social workers, and others.

CHAPTER IV

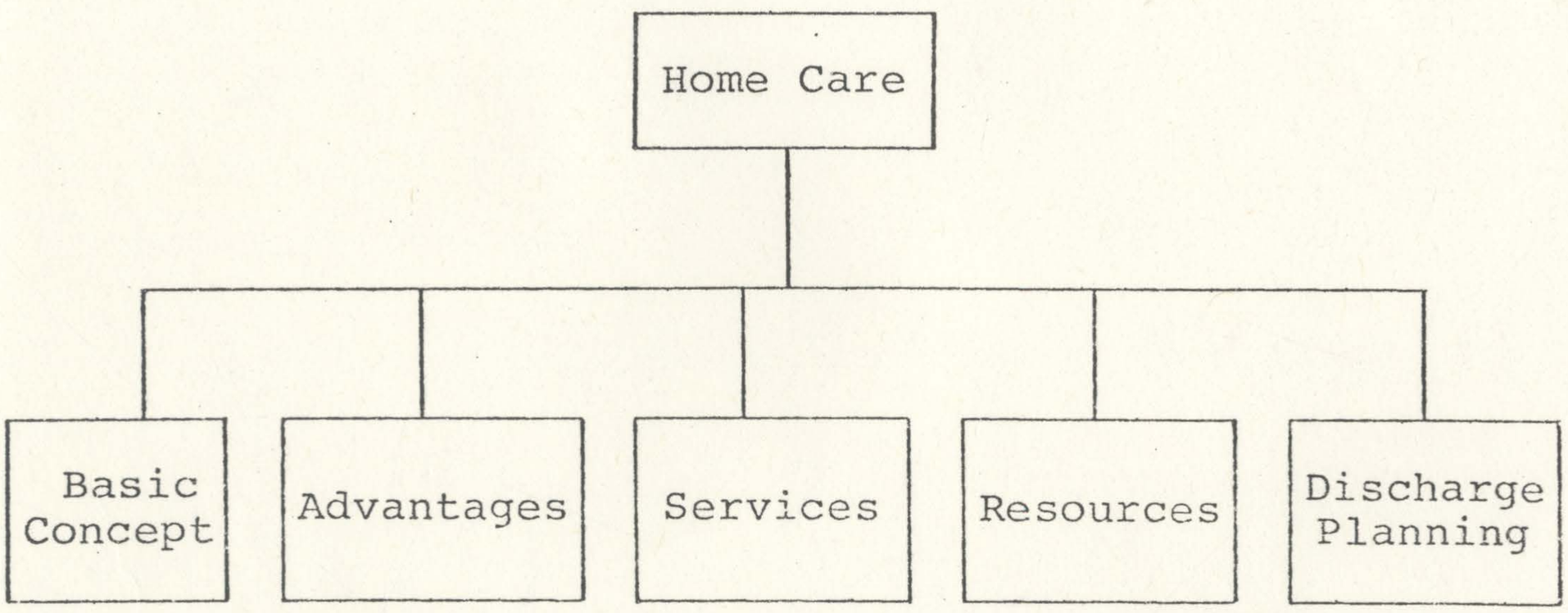
TASK ANALYSIS

Task Analysis

In preparation for the development of the instructional package, it was necessary to delineate precisely what information would be included and to arrange this content in a sequential manner. The format utilized to describe the content is the following task analysis. Presented first is an overall diagram of all the major tasks, followed by more detailed descriptions of the components of each task.

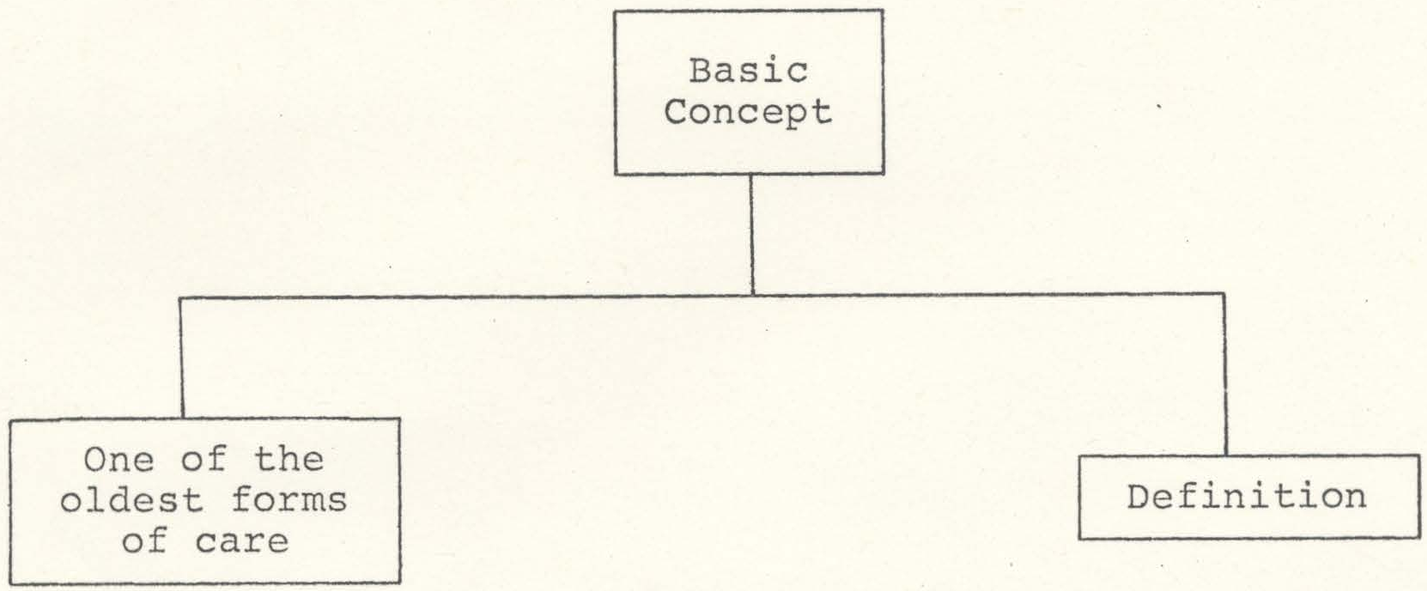
HOME CARE

Task Analysis (1)



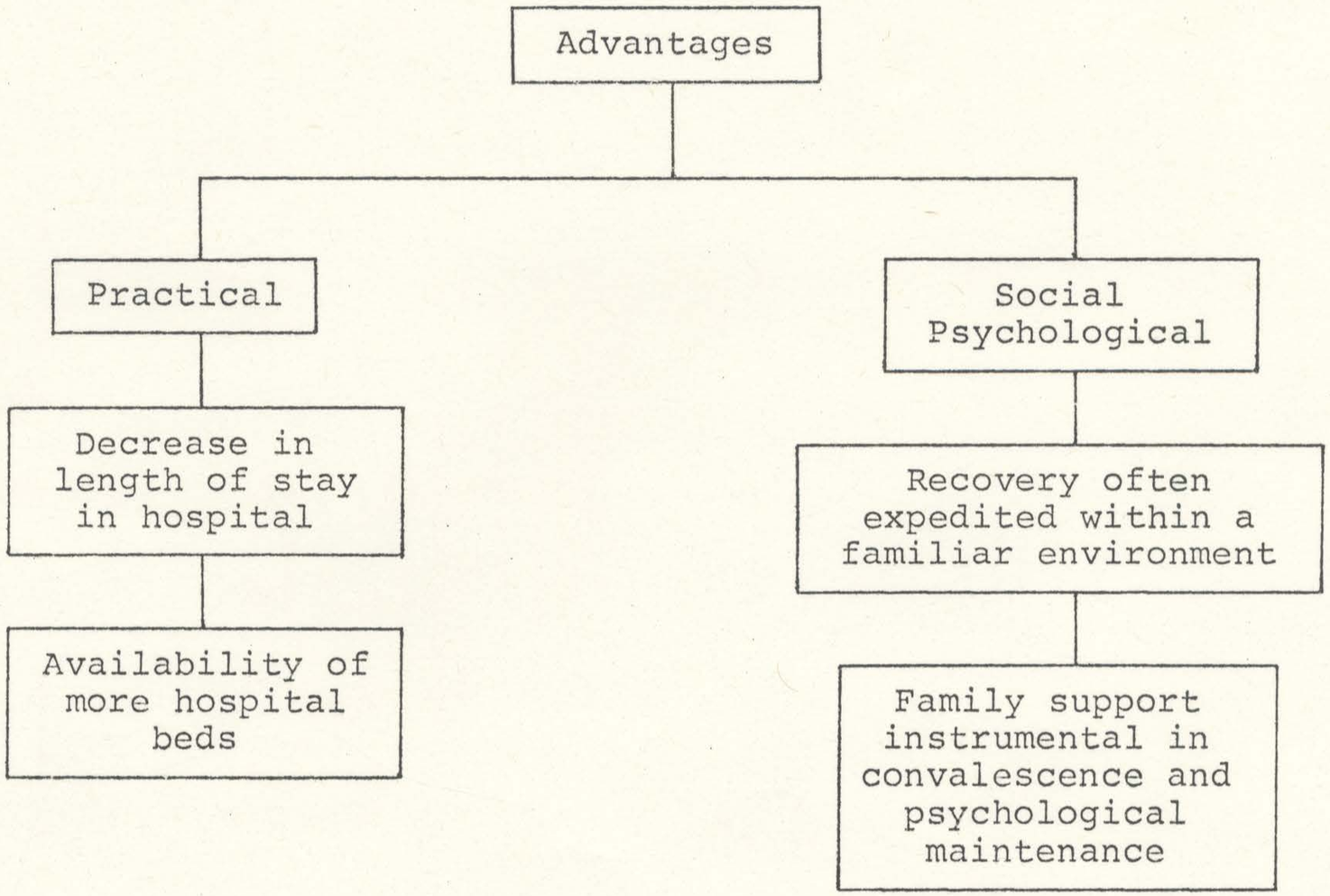
HOME CARE

Task Analysis (2)



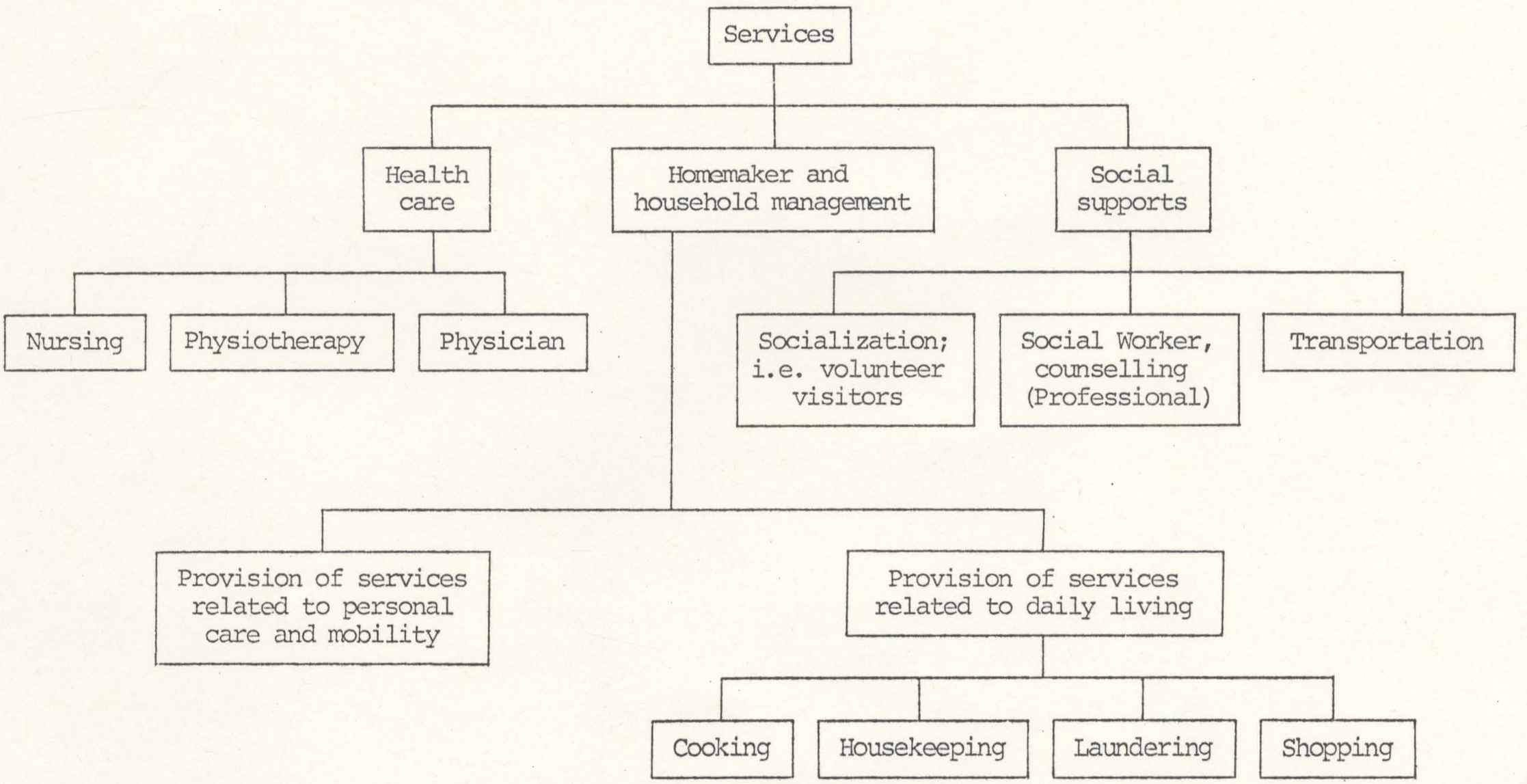
HOME CARE

Task Analysis (3)



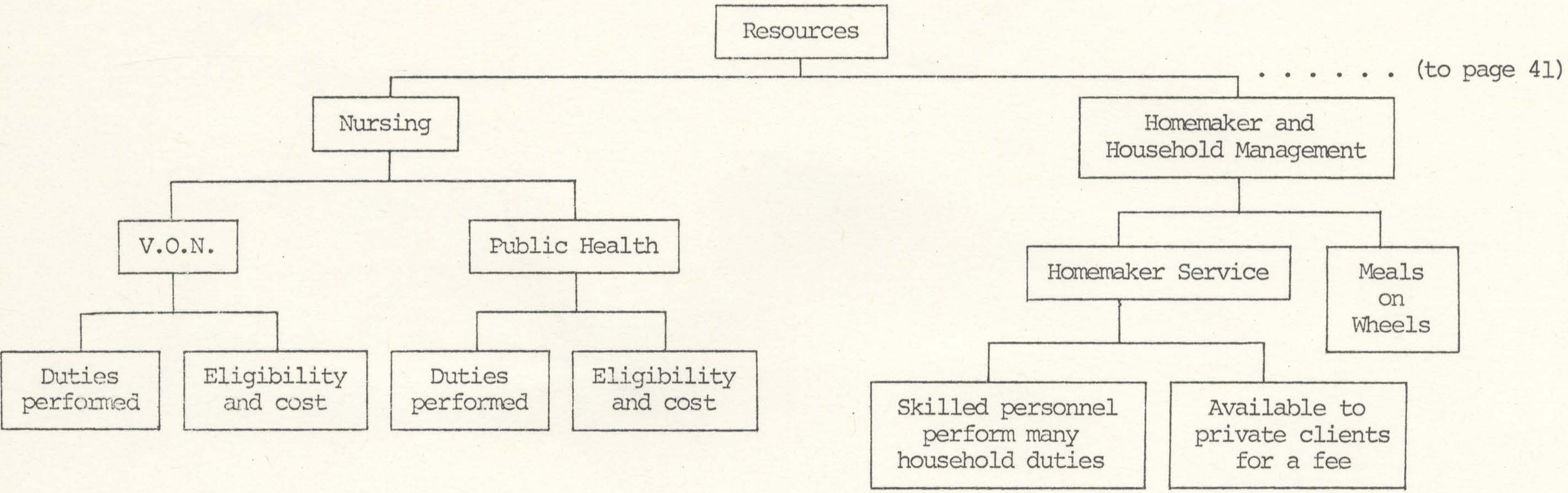
HOME CARE

Task Analysis (4)



HOME CARE

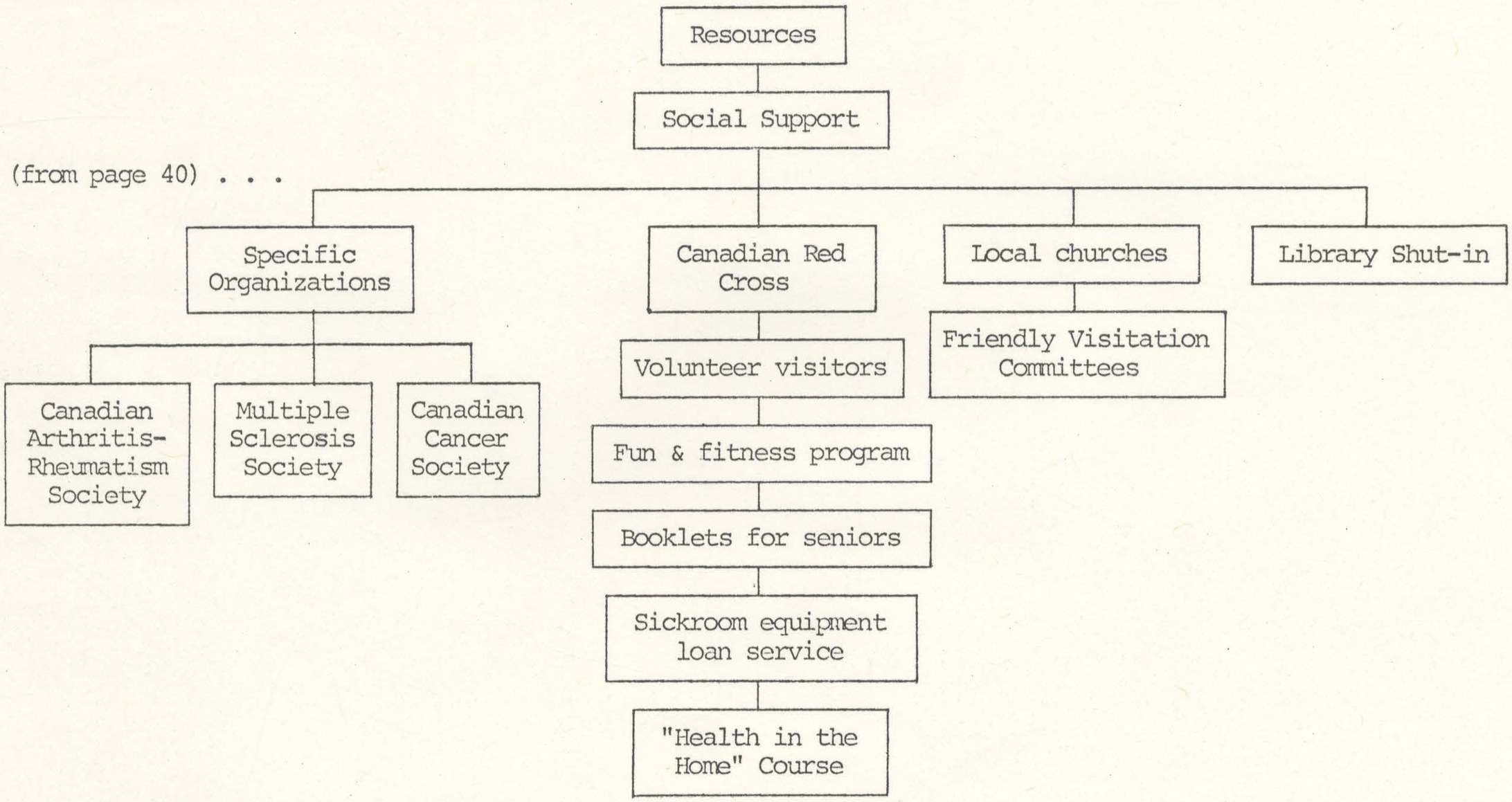
Task Analysis (5)



HOME CARE

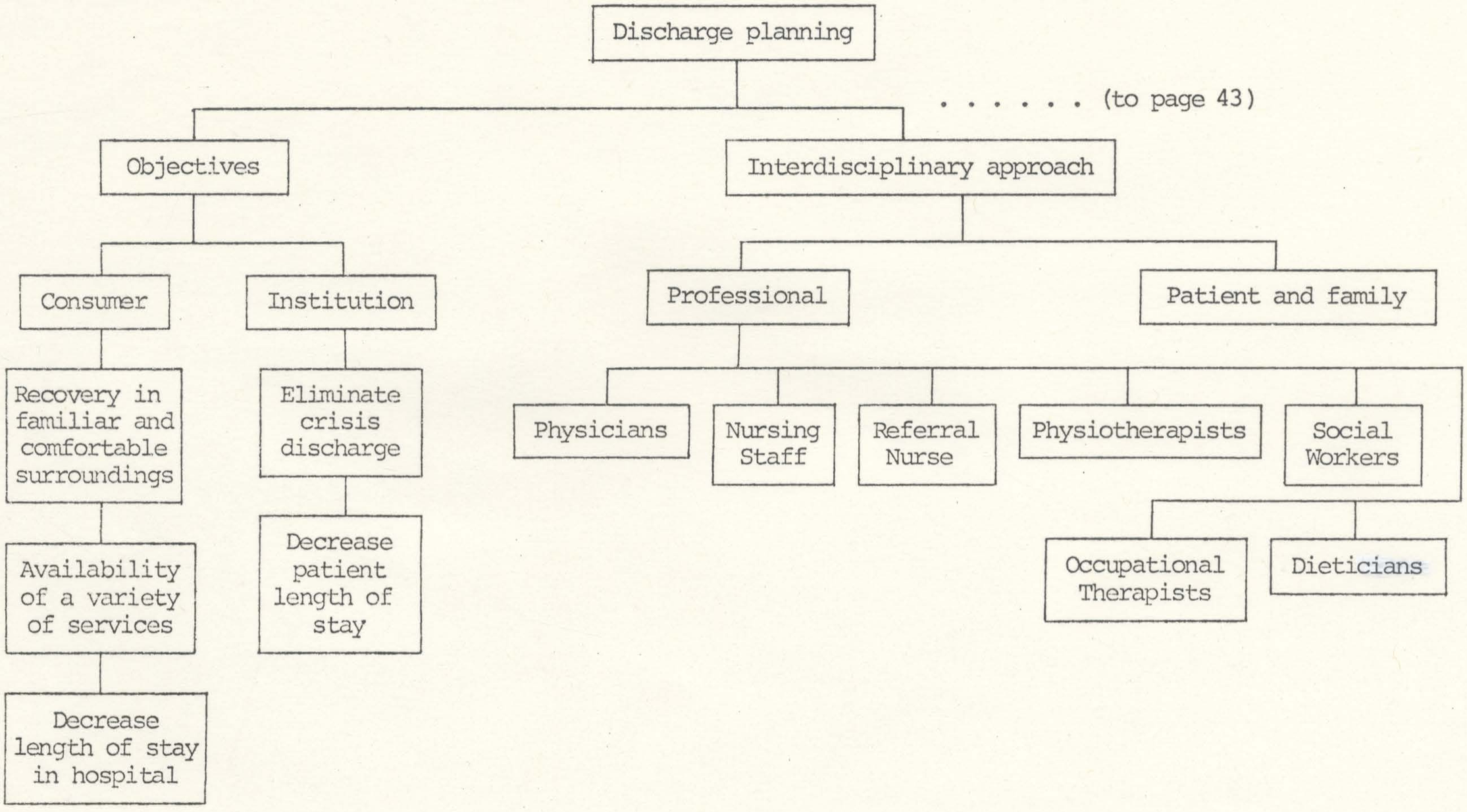
Task Analysis (6)

(from page 40) . . .

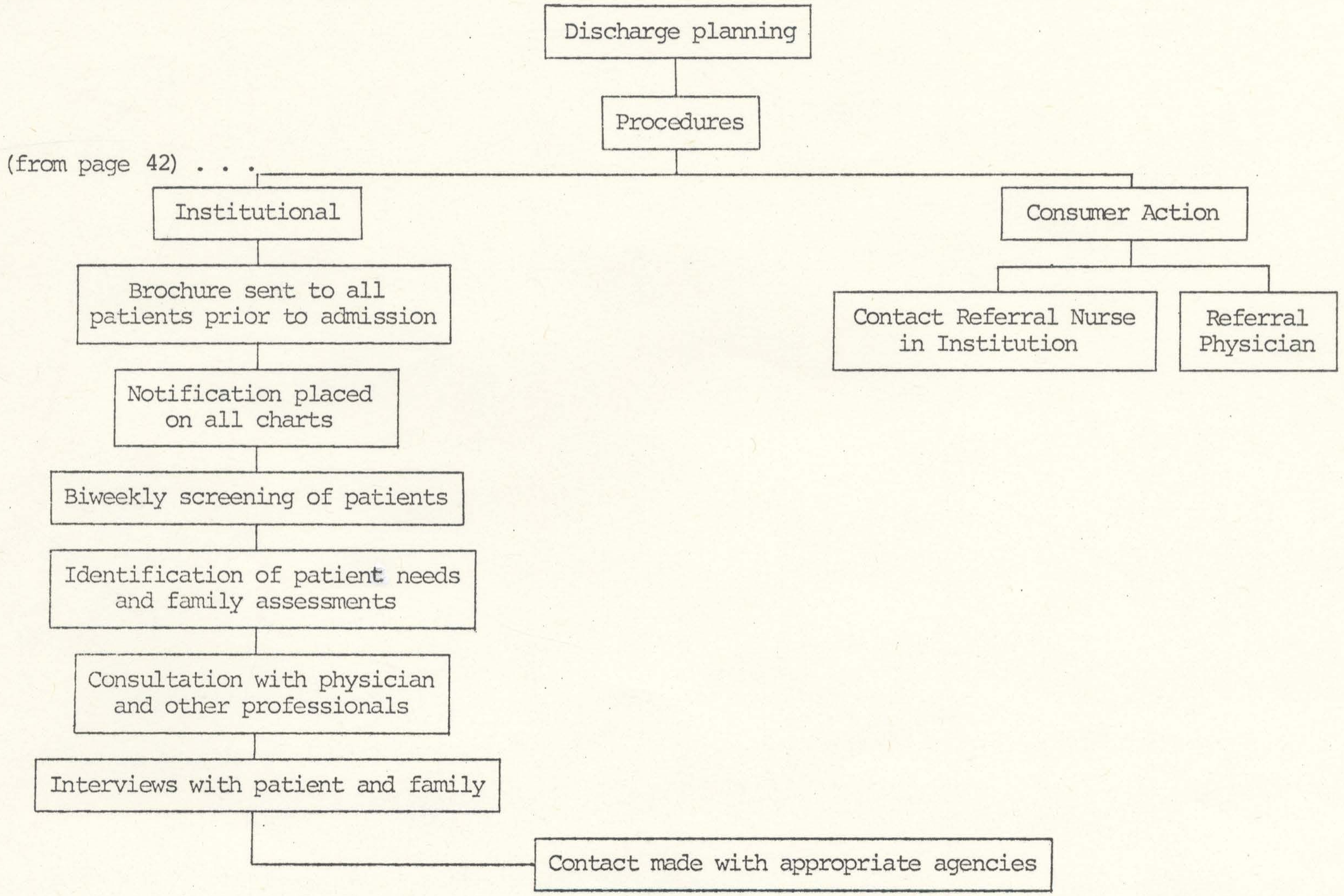


HOME CARE

Task Analysis (6)



Task Analysis (7)



Behavioral Objectives

Derived directly from the task analysis are the behavioral objectives of the program. The objectives are designed to detail specific learning outcomes and should, therefore, serve as the basis for the design of the testing instrument to be used in the summative evaluation. Indeed, as Mager (1962) points out, the behavioral objectives should be precise enough to allow a person unfamiliar with the instructional development project, to design a valid evaluation instrument.

As indicated from the survey cited in the Needs Assessment, one may assume that the intended audience knows little about home care, with the majority familiar only with the availability of nursing services, and very few familiar with the roles of the referral nurse and hospital in the delivery of home care.

From a practical, long-range perspective, it was hoped that increased knowledge of home care would generate interest among patients and family members and that such interest would result in greater numbers of individuals requesting further information from the referral nurse and/or requesting assessments for referrals. Such goals, however, were general aims of the program and could only be discerned subtly and over an extended period. There were, however, a number of immediate and specific objectives

which could be readily discerned. The objectives of the package are described below.

Objectives

Having viewed the presentation, all members of the audience will demonstrate:

1) an understanding that home care is the provision of various services for the care of the sick, disabled, or elderly at home.

2) an insight into the advantages of home care, by being able to cite one of the following benefits:

   a. it allows people to be cared for in familiar and comfortable surroundings

   b. it frees hospital beds for others who need them

3) a knowledge that there is a wide range of services which constitute home care, by being able to identify three of the following available services (if not by name, then by description):

   a. nursing

   b. homemaking

   c. social work

   d. physiotherapy

   e. occupational therapy

   f. volunteer visitation

   g. library loans

   h. delivery of cooked meals

4) an understanding that the referral nurse in hospital-based home care tries to find out

which patients can benefit from home care, contacts the agencies which provide services, and arranges for the delivery of appropriate services for each patient.

5) an understanding that the multi-disciplinary nature of hospital-based home care means that the referral nurse, in order to assess patient needs, relies on the advice of other professionals (i.e., doctors, nurses, social workers, etc.) as well as family members and patients themselves.

6) an understanding that in order to request a referral to home care, one may contact the hospital referral nurse, or any member of the health team.

CHAPTER V

RATIONALE FOR CHOICE OF MEDIA

An investigation of the literature related to instructional media readily reveals the existence of a number of classification systems or taxonomies which attempt to delineate the appropriateness of different media formats to specific situations. One of the first models to be developed was Dale's Cone of Experience (Dale, 1954), which classified various media in terms of proximity to reality.

Perhaps one of the best-known taxonomies is that proposed by Briggs (1970) who developed a matrix which attempted to match learner characteristics with task and media characteristics. Yet another approach to classification was to suggest a model which grouped media with regard to the quantity of stimuli transmitted by each medium (Heidt, 1978).

Although such taxonomies attempt to relate the applicability of various media to certain theories of learning, it seems obvious that the criteria for classification varies considerably from model to model, and as Meredith (1965) noted, "the idea that there is any one objective 'natural' classification is somewhat absurd"

(p. 379). Indeed, such considerations have led Heidt (1978) to conclude that:

> a single, comprehensive media taxonomy which is suited to all occasions cannot exist, that one has rather to aim at the development of a number of equally valid classification systems for different purposes and for different theoretical approaches (Heidt, 1978, p. 36).

Although the assessments such as those of Meredith and Heidt may be valid, they are, nonetheless, assessments of a purely theoretical approach to media selection. In many cases of instructional development, and certainly in this case, the rationale for choice of media has much of its basis in a number of practical considerations. Indeed, the governing factor was that the organization requesting the package was the Medical Television facility of St. Clare's Mercy Hospital in St. John's, Newfoundland.

Independent of this aspect, however, there remain a number of additional factors which support the choice of television as the ideal medium. In choosing media, one must be constantly aware of the intended audience. For hospital patients, the primary target group, television possesses many advantages. Information can be explicitly presented in a format which is familiar to virtually all individuals, regardless of age, sex, or, more significantly perhaps, educational background. Since there is no necessity to utilize print in television, information can be effectively disseminated even to illiterate members of the

audience. As Brown, Lewis and Harcleroad (1969) point out:

> television is capable of helping to overcome learning barriers for many persons . . . by presenting ideas, helping mold attitudes . . . and providing information in ways which demand neither high verbal proficiency nor physical presence at the scene of action (Brown, Lewis, & Harcleroad, 1969, p. 297).

In terms of physical delivery to hospital patients, television's advantages are undeniable. Many patients have private television sets at their bedsides, and in an institution such as St. Clare's Hospital, broadcast is possible over a closed-circuit channel. Such broadcasts may also be received in lounge areas or seminar rooms. Consequently, a single broadcast can simultaneously reach many people in many locations. Such ease of delivery would not be possible with other audio-visual formats, such as sound/slide or sound/filmstrip packages.

Of all media, the television program can possibly receive much wider dissemination than any other form--an important factor when one considers that the secondary audience comprises the families of patients and, in effect, the general public. Although the commercial networks have not been traditionally accessible to such programming, the increase in community and university cable channels has meant tremendous possibilities for broadcast to a wide general audience.

In terms of cost-effectiveness, television was, indeed, a viable production alternative. Much of the

necessary hardware for shooting and editing was available through the facilities of Medical Television, Avalon Cablevision, and Memorial University's Educational Television Center. In effect, the only expenses incurred were for videotape, payment of a narrator, and incidental expenses, such as graphics supplies and 35 mm. film.

Although television has obvious practical advantages, at least in the context of this project, it is encouraging to note that the medium has also received strong philosophical support from theorists such as those discussed earlier in this chapter. As early as 1954, when commercial television was in its infancy, Edgar Dale noted that the medium may, indeed, be easier to understand than direct experience, since a deliberate order is imposed on the material. Concomitant with this is what Dale (1954) calls the "impact of immediacy":

> . . . television is as close as any mechanical device can get to the direct experience. . . . The unique value of . . . film and television . . . lies in their sensory concreteness, their realism, their emphasis upon persons and personality, their ability to dramatize, to highlight, to clarify (Dale, 1954, p. 201).

Since the publication of Dale's work, a great deal of research has been conducted into the effectiveness of television. To be sure, not all results have been favourable, for many researchers have attempted to demonstrate that commercial television creates a number of evils, ranging from the destruction of family life (Price, 1978) to an

increase in violent behavior (Skornia, 1977), to the perpetuation of extreme passivity (Gotz, 1975).

Despite the alleged evils of commercial television, there has been considerable acceptance of the medium as an effective "instructional" device. Indeed, it has been evident from research findings that television instruction is as effective as, and in many cases superior to, conventional methodology:

TABLE 2

Comparison of Growth with Pupils Taught Conventionally and by Television

	Taught Conventionally		Taught by Television	
Ability level, Grade 6 Science	Average I.Q.	Achievement growth	Average I.Q.	Achievement growth
111 - 140	117	12 months	118	15 months
90 - 110	100	11 months	100	14 months
57 - 89	80	6 months	83	13 months

(Chu & Schramm, 1967, p. 5)

The analyses of Chu and Schramm were of a very basic and uninspired version of instructional television. As Florence Levinsohn (1977) writes:

> the legacy of instructional television is a singularly uninspired one. There has been very little imagination used in the production of programs. . . . (p. 302).

In recent years, however, with the prevalence of more dynamic techniques in the production of instructional television, it has been found that a tremendous amount of assimilation can result from creative programming such as "Sesame Street" (Mukerji, 1976; Moore, 1977).

Although not all studies have yielded positive results (see Cohen, 1974; Anderson, Levin & Lorch, 1977), the instructional potential of television has been recognized by many media specialists. Brown, Lewis, and Harcleroad (1969), for example, cite a number of advantages, including the ease of wide dissemination, the capability of achieving social improvements and developments, and the ability to capitalize upon immediacy. More recently, Gerlach, Ely, and Melnick (1980) have listed 11 major advantages of television; some of these are:

1) television offers a means for providing a common base of experience for all who see a given program at the same time;

2) it brings to the classroom people, places, and events that could not be seen otherwise;

3) a television signal can originate from one source and can be distributed to several areas at the same time; and

4) television can instantly magnify small objects so that all can see them at the same time.

It should be noted, however, that Gerlach, Ely, and Melnick (1980) indicate some limitations of the medium, such as its small screen size for large groups, the prevalence of programs

which merely present teachers talking, and the difficulties of scheduling broadcast television. Such criticisms are minor, however, and in the context of this project, do not apply. Therefore, the limitations do little to negate the importance of television as a viable and effective medium for imparting information to a large, general audience.

CHAPTER VI

DEVELOPMENT PROCEDURES AND FORMATIVE EVALUATION

The television program was designed within the framework of an established instructional development plan. Once the initial planning procedures of needs assessment, audience analysis, and task analysis had been completed, the production phases began, including scripting, taping, and evaluation.

Throughout all phases of pre-production, the developer was in constant consultation with various professionals in the health care field. The two individuals most involved in planning were Geri Spurrell, R.N., referral nurse at St. Clare's Mercy Hospital, and Diana Carl, Ed.D., Director of Medical Television at St. Clare's. Following completion of the task analysis and objectives, both these professionals met with the developer to ensure that the necessary content was included and to determine how well the stated objectives reflected the demonstrated need. During this meeting, only minor changes were suggested. Spurrell, the content advisor, clarified certain aspects relative to social support in home care and also recommended that there be no special mention of the St. John's Home Care program, nor of any organization based only in the

city, since it was possible that a unit with a broad, province-wide applicability be developed. Both recommendations were accepted.

During the writing of the script, the developer consulted several other professionals who possessed specific areas of expertise. Both Joyce Dawson, Head of the Department of Social Work, St. Clare's Hospital, and Sister Mary Manning, Director of Patient Education, emphasized the wide educational levels of patients and suggested a simple, direct, and personalized approach. It was suggested by Sister Manning that the technical aspects of home care administration and of discharge planning be minimized or even avoided.

In attempting to achieve concise, yet accurate, descriptions of the separate professional services, a number of individuals were consulted. Joyce Dawson discussed the role of the social worker, and Madelaine Marrie, Occupational Therapist at St. Clare's, made the developer aware of the distinctions between her profession and that of the physiotherapist. Information on homemaking was derived from the Jack and Jill Homemaker Service of St. John's; the Canadian Red Cross supplied a tremendous amount of literature on its involvement in community-based home care.

After completion of the first draft of the script, a meeting was held with Diana Carl, the learning and media specialist, and with Geri Spurrell, the content expert.

Carl indicated that she felt the script was well-thought-out, concise, and showed potential for holding the audience's attention. She also stated that the task and audience elements seemed well represented. There were, however, a number of changes suggested. In the content area, it was recommended that the developer more thoroughly investigate the role of the Occupational Therapist to ensure that it was being represented correctly. In terms of presentation technique, Carl suggested that the dreary music in the initial hospital scene be deleted, since it may have created a negative reaction to hospitals. It was also suggested that the shift to cartoons near the end of the script seemed to interfere with the flow of messages; therefore, these caricatures were to be deleted, or the format introduced much earlier in the program.

In the analysis of content, Spurrell stated that the developer had apparently assimilated a great deal on home care and had incorporated sufficient information in the program. There were, however, a number of areas that required clarification:

1) the 'professional' nature of social counselling required greater emphasis

2) the objectives of discharge planning were different for the institution than for the individual, and these differences should have been included

3) there was a need for greater distinction between the health professional's role and the patient's role in the referral process

4) it was also recommended that any references to specific organizations unique to St. John's be deleted, since such localization would severely limit general applicability of the program.

The production of effective instructional materials requires that a structured developmental process be followed. Most development plans are similar and generally are comprised of four basic stages, as is depicted in Figure 1. The model suggests that a number of important factors must be investigated before materials are actually produced and evaluated. Also shown is the importance of data acquired through evaluation procedures, and how the resulting feedback affects production. So far in this report, the 'needs assessment' has been described. Following is a discussion of the subsequent analyses, and of the production, evaluation, and dissemination of the instructional package.

In view of the formative evaluation, a number of changes were introduced before production commenced:

1) It was decided to delete any references to organizations unique to St. John's.

2) The music planned for the exterior shot of the hospital was to be replaced with actual street and traffic noise.

3) The cartoon sequence near the end of the script, originally intended to review the various services in a humourous fashion, were replaced with repeated sequences from earlier portions of the program, seen in the memory of the central character.

4) To maintain continuity, it was decided to delete visual displays of the crests of certain organizations providing social

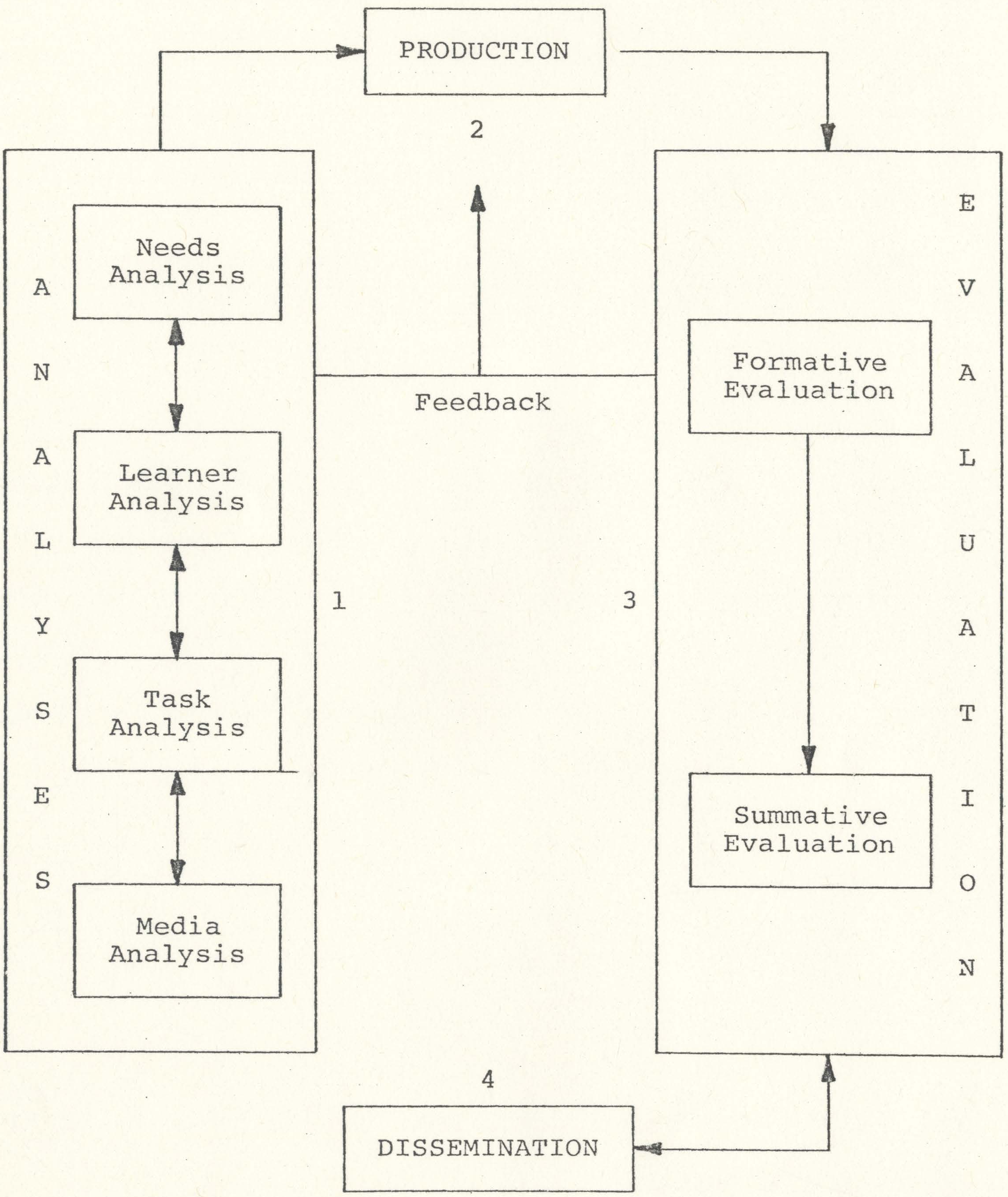


Figure 1. Instructional Development Model

support to individuals. The original scene was to open with an elderly lady alone in her room, then break to the crests as the organizations are listed, and finally return to the original shot. It was felt that insertion of the crests would be disjointed and interrupt continuity. As an alternative, the original scene would be held, with changes in camera position and angle to maintain interest.

5) The professional nature of social counselling was to be depicted, and the distinct roles of health professionals and patients in the discharge planning process were to be more clearly identified.

The program was produced on three-quarter inch colour videocassette, using the studio cameras of Medical Television, and colour portable units made available by the School for the Deaf and Avalon Cablevision in St. John's. Editing was completed at the Educational Television Centre, Memorial University of Newfoundland.

CHAPTER VII

SUMMATIVE EVALUATION

Procedure

Evaluation of the program consisted of three separate methodologies. To determine the effectiveness of the cognitive elements, a questionnaire was administered to two groups of hospital patients, with six subjects in each group. Because of the physical and mental difficulties inherent in hospitalization, it was necessary to choose subjects who were mobile or, at least, were able to respond intelligibly to the survey. The twelve individuals chosen were assigned randomly to each group, thus achieving partial randomization. The experimental design, expressed in the terminology devised by Campbell and Stanley (1963), is represented as follows:

R X O

R O

The experimental group viewed the program and each member was subsequently interviewed by a student nurse relative to the content. The evaluative instrument (see Appendix B) allowed each subject to respond fully to the questions, and their comments were recorded by the nurses. The control group was administered the same instrument in the same

manner but did not view the program before completion of the questionnaire. It is important to note that the subjects were not assembled into physical groups either to view the program or to complete the evaluation. The program was viewed privately either from bed or in a patient lounge, and the evaluation was conducted in similar circumstances.

To supplement the data gleaned from the above procedure, feedback was also obtained from health professionals involved in home care throughout the province. There were two separate groups involved. The first group, comprising 11 members of the St. John's Home Care Program, viewed the program collectively. After viewing, each professional was given a list of the program's objectives and was asked to assess the realization of each objective by completing a simple five-point semantic differential scale (see Appendix C).

A second group of professionals was composed of members of the Newfoundland Hospital Association, who were attending the organization's annual convention in St. John's. These individuals, representing hospitals throughout Newfoundland and Labrador, were invited to view the program and, subsequently, to record their impressions in writing, delineating what they considered to be the most positive and most negative elements. Of course, such an informal procedure cannot be analyzed statistically but can provide valuable insight into individual impressions, thus helping

to reveal specific strengths and weaknesses of the project.

Results

In the questionnaire administered to hospital patients, there were five questions which dealt with cognitive elements, with a total possible score of six points.

TABLE 3

Raw and Mean Scores on Home Care Questionnaire Administered to Hospital Patients

Subjects	Group 1: Control	Subjects	Group 2: Experimental
1	1	1	2
2	1	2	6
3	1	3	5
4	1	4	4
5	1	5	6
6	0	6	6
Mean	0.8	Mean	4.8

Note: Maximum score = 6

A sixth item on the questionnaire has not been discussed. It was included to test the hypothesis that patients who viewed the program would have more favourable attitudes toward home care than those who had not seen the program. It was also hypothesized that subjects who could obtain help from family members would be less inclined to accept the applicability of home care, whether they saw the program or not. Since this question employed a five-point semantic differential scale, it required an analysis different from that of the other five questions. Also, since the sixth question did not deal with cognitive elements, as did the other five, it was decided to analyse it separately (see Table 4).

Although the two subjects who lacked family support saw great benefit in home care, the other ten were not consistent in their attitudes. In order to establish a correlation between attitudes and family situations, a much larger sample is required, as well as the gathering of data on the extent of home care required by each subject, since these factors may have considerable bearing on perceptions. For the same reasons, the second function of the sixth question, to determine if those who viewed the program felt more positive than the others towards what home care had to offer, yielded inconclusive results.

The second questionnaire, administered to 11 home care professionals, required each individual to record his

TABLE 4

Scores on the Five-Point Scale Measuring Attitudes Towards the Personal Applicability of Home Care

Group 1: Control			Group 2: Experimental		
Subjects	Personal Value of Home Care	Family Help	Subjects	Personal Value of Home Care	Family Help
1	1	Yes	1	4	No
2	2	Yes	2	4	Yes
3	5	Yes	3	5	Yes
4	4	Yes	4	4	No
5	1	Yes	5	1	Yes
6	3	Yes	6	1	Yes

or her assessment of how well each objective was realized in the program. A five-point differential scale was utilized. The results are summarized in Table 5.

In the final evaluation procedure, 15 health care professionals were asked to indicate what they felt were the most negative and positive aspects of the program. In all, there were 19 favourable comments, while only six negative criticisms were recorded.

On the negative side, two individuals were disturbed that the patient had not been informed of home care prior to admission to hospital. Another criticism centered on the absence of the clergy in the health care team. The remaining criticisms seemed to be of an aspect of presentation, specifically the scene where the hospital patient is waiting idly in his room. The following comment is typical:

> I thought the 'waiting . . . waiting' went a bit too long. This plus the paper planes gave a melodramatic feel to the presentations.

In general, however, the reaction seemed favourable, as indicated by the following selected comments:

> This film is very good. What I like about it is the information it gives. Most everyone who becomes sick or unable to care for themselves don't really have much idea of how someone can help them stay at home.
>
> Good presentation of the services available, was active, showed services being provided. The entry scene was quite effective in capturing my attention. . . . Very pleasant,

TABLE 5

Total Scores on Home Care Questionnaire Administered to Home Care Professionals

	Subjects											
	1	2	3	4	5	6	7	8	9	10	11	Totals
Objective 1	4	5	4	5	5	5	4	5	5	5	4	51
Objective 2	4	5	4	5	5	5	4	5	5	5	4	51
Objective 3	5	5	5	5	5	5	4	4	5	5	4	52
Objective 4	4	5	5	5	4	5	4	4	5	5	4	50
TOTALS	17	20	18	20	19	20	16	18	20	20	16	204

Note: Total score for each objective = 55

soothing voice of the narrator. . . . Good review of material presented just when I was trying to remember them. Very good explanation of how the patient can apply.

I found the whole program followed a logical flow that people would follow in their own minds when asking what home care was about. You didn't bring up too much so that people were not overwhelmed with information, but you certainly gave enough to be useful.

Message clear, concise, and well presented. I have no major criticisms.

Analysis of Results and Conclusion

An analysis of the data from the first evaluation procedure seems to indicate that the program achieved results in the proper direction, that those patients who viewed the production had much more knowledge of home care than those who had not seen it.

The extremely small sample severely curtails the achievement of complete reliability from the data collected. The reasons for such a small sample are related to the nature of the hospitalization. In an institution of this type, the prime concern of administrators and health specialists is the well-being of the patient. This basic philosophy naturally serves to undermine the administration of surveys and questionnaires to patients, for such procedures are intrusions into an established routine that seeks to be of optimum benefit to the chronically ill.

Another limitation lies with the patients themselves. Many individuals, especially those of low educational background, were reluctant to answer questions about the program, even when asked by student nurses. Other patients were either too heavily sedated or simply too ill to respond in the interview situation. Therefore, in the wards where patients were most likely to benefit from home care, it was possible to find only 12 who were willing or eligible to respond to the questionnaire.

The results of the questionnaire given to home care specialists clearly indicate that the program was well received and that they considered it successful in meeting its objectives. Each objective could be allotted a total possible of 55 points. The average total score for each objective was 51 points. On each questionnaire, the four objectives together could be given a total score of 20; the average was 18.5. Overall, the program received a total score of 204, out of a possible 220--a clear indication of highly favourable reception by home care experts.

The opinions of these home care specialists were similar to those of members of the Newfoundland Hospital Association, whose informal assessments were indeed favourable. Although some people expressed concern that the patient had not been informed of home care prior to

hospitalization, it is the opinion of many home care specialists that this is often the case, an opinion corroborated by the lack of knowledge about home care among those subjects who had not seen the videotape.

The "waiting" episode, criticized by two people, was considered necessary to impart the feeling of idleness and boredom experienced by the patient. Admittedly, the sequence might have been too long, but this was caused by a technical problem beyond the producer's control. In order to successfully complete the dissolves in this scene, it was necessary to do so in the studio during taping. This required the main character to move from one scene into the next as the switcher dissolved from one camera to the other. The availability of editing facilities capable of completing dissolves in post-production would have made it possible to shorten this sequence, but, unfortunately, such facilities were unavailable.

Summary

Although the evaluation by hospital patients suffers the limitation of a small sample, it does, nevertheless, yield results in the proper direction, indicating that the program succeeds in achieving its objectives. This assessment seems to have been substantiated by the opinions of a large number of home care and health specialists throughout the province.

CHAPTER VIII

CONCLUSION, RECOMMENDATIONS, IMPLEMENTATION

The program, entitled No Place Like Home--A Look At Home Care, seems to be successful in presenting an overview of the various services which constitute home care, of the duties of the referral nurse, and of the place of discharge planning in hospital-based home care.

There are a number of channels through which the program can be disseminated to a wide audience, to family members and health specialists, as well as to patients requiring home care.

At St. Clare's Mercy Hospital, a closed-circuit television system allows broadcast to private monitors situated in patients' rooms and to television receivers located in lounge areas. Through this channel, a large portion of the primary audience may be reached. Although many hospitals do not have a broadcast facility such as St. Clare's, it is still possible to present the videotape to groups of patients. For this purpose, nothing more is needed than a monitor and playback unit. Indeed, two hospitals--Grace General and the Health Sciences Complex in St. John's--have already used the program in this manner.

With the availability of community cable networks, dissemination to a wide general audience is possible. In

fact, the program has already been broadcast on several occasions over the St. John's community channel, making it possible for family members and prospective patients to learn of home care.

Although the program was originally designed to meet a specific need at a particular hospital, there is no reason why the concepts presented cannot apply provincially. It is hoped that other hospitals and community cable channels throughout the Province might use the program in an effective manner, thus giving it the widest dissemination possible in Newfoundland and Labrador.

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APPENDICES

APPENDIX A

INSTRUMENT USED TO DETERMINE THE NEEDS

QUESTIONNAIRE--HOME CARE

PART I

1. How many times have you (or this relative) been admitted to hospital in the past five years?

_____

2. What is the reason for this admission to hospital?

_____

3. Would you prefer to be cared for in your own home if possible?

Yes _____ No _____

4. In your opinion, is home care possible for you (or this relative) during this episode of ill health?

Yes _____ No _____

5a. Do you know what home care is? Yes _____ No _____

6a. Do you know what a referral nurse does?

Yes _____ No _____

7a. Do you know what a homemaking service provides?

Yes _____ No _____

8a. Do you have any idea how you would go about getting someone to help at home during this episode of ill health?

Yes _____ No _____

9. If you could get help at home, what would you need, in your opinion?

(cont'd.)

a. Visiting nurse _____

b. Visiting physiotherapist _____

c. Help with meals _____

d. Help with housekeeping _____

e. Help with activities of daily living (bathing, eating, dressing, etc.) _____

f. Someone to visit, for some companionship _____

QUESTIONNAIRE--HOME CARE

PART II

Should any of the individuals surveyed answer "Yes" to questions 5 to 9, it is important that you have them explain their answers, and that their responses be recorded below:

5b. HOME CARE _____

_____

_____

_____

6b. REFERRAL NURSE _____

_____

_____

_____

7b. HOMEMAKING SERVICE _____

_____

_____

_____

8b. How would you go about obtaining Home Care?

_____

_____

_____

_____

APPENDIX B

INSTRUMENT USED IN THE FORMATIVE EVALUATION BY TWO GROUPS OF HOSPITAL PATIENTS

QUESTIONNAIRE--HOME CARE

Note to interviewers: In some cases you may have to further explain or simplify questions. Please record patient responses as accurately as possible.

1. a. Do you know of any services available to people who need care at home?

   Yes _____ No _____

   b. (If the patient answers "yes", please ask:) Would you please list or describe some services available through home care?

_____

_____

_____

_____

   Yes - 1; No - 0

2. Can you name one advantage or benefit of home care?

_____

_____

_____

_____

   Yes - 1; No - 0

3. a. Do you know what a referral nurse in a hospital does?

   Yes _____ No _____

   b. If yes, explain.

_____

(cont'd.)

_____

_____

_____

Yes - 1; No - 0

4. Can you think of some people a referral nurse might talk to in doing her job?

_____

_____

_____

Yes - 1; No - 0

5. If you wanted to find out about home care, who is the best person in hospital to contact?

_____

_____

_____

Don't know - 0; nurse, doctor, physiotherapist, etc. - 1; referral nurse - 2

6. a. Do you have friends or relatives at home who can take care of you?

Yes _____ No _____

b. Do you think home care has anything to offer you?

Nothing at all	Very little	No opinion	Some services	A great deal
1	2	3	4	5

Sex ___ Ambulatory ___ Viewed in Room ___
Age ___ Non-Ambulatory ___ Viewed in Lounge ___

APPENDIX C

INSTRUMENT ADMINISTERED TO

HOME CARE PROFESSIONALS

QUESTIONNAIRE--HOME CARE

Your impressions of the program No Place Like Home--A Look at Home Care would be greatly appreciated.

Below are the objectives of the program. After viewing, would you kindly indicate your opinion of how well each objective was realized.

Objective 1: To show that home care is the provision of a wide range of services for the care of the sick, disabled, or elderly at home:

This objective was realized: (Please circle the appropriate digit).

Not at all	Poorly	No opinion	Well	Very well
1	2	3	4	5

Objective 2: To describe the role of the hospital referral nurse in home care:

Not at all	Poorly	No opinion	Well	Very well
1	2	3	4	5

Objective 3: To show that home care is multi-disciplinary in nature, and that the referral nurse, in order to assess patient needs, relies on the advice of other professionals, as well as family members and patients themselves:

Not at all	Poorly	No opinion	Well	Very well
1	2	3	4	5

Objective 4: To show that the patient in hospital may request more information on home care by contacting the hospital referral nurse, or any member of the health team:

Not at all	Poorly	No opinion	Well	Very well
1	2	3	4	5

APPENDIX D

SCRIPT:

NO PLACE LIKE HOME--A LOOK AT HOME CARE

NO PLACE LIKE HOME--A LOOK AT HOME CARE

1. Doctor and patient in doctor's office following examination.	1. Narrator: That day in the doctor's office, the examination results were unexpected, to say the least. The doctor's words would ring in John's ears for weeks to come.
2. CU Patient.	2. Doctor's Voice Over: I'm going to have you admitted to hospital as soon as possible. . . .
3. MS Patient with suitcase entering hospital.	3. Doctor's Voice Over:. . . it may take a few days before you can be admitted . . . beds are scarce, you see. . . .
4. LS of surgery	4. Doctor's Voice Over:. . . the surgery is nothing to worry about; pretty routine stuff . . . be over before you know it. . . .
5. MS Nurse propping patient up in bed.	5. Doctor's Voice Over: . . . Then, it's just a matter of recovery . . . you'll need to get your strength back. . . . It takes a bit of waiting. . . .
6. DISSOLVE TO: Patient thumbing idly through magazine.	6. Doctor's Voice Over: (reverb) . . . a bit of waiting . . .
7. Patient looking out window, obviously bored . . .	7. Same as # 6.
8. Patient crossing off 21st day on a calendar.	8. Same as # 7, but fading.

9. Patient idly throwing paper airplanes at his waste basket.	9. (Silence for a couple of seconds, then): Narrator: Very few of us enjoy the thought of spending time in hospital. Sure, the people are friendly, the place is clean. . . .
10. Continue various angles of previous scene	10. . . . and you can get all the material you need for that important paper work. (CU paper airplane entering basket)
11. Nurse enters room with chart and gear. Patient throws last airplane and folds arms. Nurse places thermometer in his mouth and checks pulse.	11. And, of course, it's encouraging to know that there's always someone around when you need them.
12. CU patient with thermometer in mouth, thoughtful.	12. . . . But, in spite of it all, you can't help but wish there was some way all of this could be done at home.
13. Fade to black.	13. Music up. (4 sec.)
14. Title (super over typical surburban street).	14. Music.
15. MS of homes.	15. Narrator: Most of us would rather be home than anywhere alse. . . .
16. Shot of different houses.	16. The surroundings are familiar and we feel comfortable there . . .
17. MS people in neighbourhood . . . children playing, etc.	17. . . . in the company of family and friends we see every day.
18. CU faces.	18. But when illness occurs, or accidents happen, anyone becomes a candidate for hospital.

19. Low angle hospital.	19. Although most people dislike the idea of going to hospital, it is, nonetheless, quite often a necessity.
20. Hospital entrance.	20. . . . without a doubt hospitals provide the very best in advanced technology, equipment that is so cumbersome and expensive that very few of us could ever hope to have it at home.
21. Interior hospital, lots of equipment and personnel.	21.
22. MS pros using machinery.	22. Advanced technology, however, is only part of what we find in a hospital. There are also many highly skilled people who help us through the most critical phases of our illnesses.
23. Cut to: Patient 1 being treated.	23. Yet, when we are in hospital, most of us have one thought: When can I go home?
24. MS ext. Homes (older)	24. Actually, before there were hospitals, most sicknesses and disabilities were treated at home. . . .
25. Zoom in on older home.	25. Indeed, home care predates the use of hospitals by many centuries. . . .
26. Photo: early hospital.	26. Naturally, in many cases, the quality of care available in modern hospitals is far superior to that which was available for many years at home.
27. Patient 2, in bed at home, talking to a family member.	27. But, today, there are many instances where quality care can be provided in the home. . . .

28. Pan of community.	28. And in many communities, there are organizations committed to looking after a variety of needs. . . .
29. Volunteer helping older person.	29. . . . within familiar and comfortable surroundings.
30. Hold # 29.	30. It is likely that no two persons will have exactly the same needs. Therefore, we do not all require the same services.
31. Nurse, examining patient.	31. For some, a certain amount of professional health care is needed in the home. This may be provided by a physician, but more likely, these duties will be performed by a nurse. . . .
32. Nurse begins to change dressing.	32. Maybe you've just had an operation and need dressings changed . . .
33. Nurse helping patient use syringe.	33. . . . or you may need regular monitoring of blood pressure. (Insert live sound). For those who require nursing care, there are two organizations which provide such services in the home.
34. CU nurse in # 33.	34. The Provincial Department of Health has a staff of Public Health Nurses whose assistance is available throughout the province.
35. VON car drives up, stops.	35. Another organization which offers nursing care in many larger communities is the Victorian Order of Nurses.

36. VON nurse gets out of car, approaches house.	36. They do charge a small fee for their services, but no one is ever denied assistance because of inabilities to pay.
37. Older person eating a "Meal-on-Wheels" (neat trick!).	37. Besides nursing services, the VON also maintains a "Meals-on-Wheels" program, which provides delivery of cooked meals to persons unable to cook for themselves.
38. Physio in home with Patient 3.	38. Another person who can provide professional health care in the home is the physiotherapist.
39. As in # 38.	39. If you are recovering from an accident, or a stroke, you may require visits from a physiotherapist, to assist you in regaining mobility, and to help you attain as much use as possible of limbs and muscles.
40. MS occupational therapist instruction person in wheelchair.	40. Often working closely with the physiotherapist is the occupational therapist, who can help people learn the use of wheelchairs and other mobility aids around their homes.
41. CU OT evaluation form.	41. The occupational therapist is able to make a thorough assessment of each room in your house and . . .
42. MS OT measuring bathroom door.	42. . . . can recognize the need for changes in your home that will make it easier for you to get around.

43. Patient 4 in bed. Dolly back to show someone propping up patient. Homemaker picks up laundry and leaves.

43. Nursing and other health care services are not the only needs that people have. Those recovering from illness or surgery, and many senior citizens may need assistance in completing homemaking tasks . . .

44. MS homemaker enters kitchen with laundry and fills washer.

44. The work provided by homemakers is a vital part of home care services and goes a long way to making family members and patients feel comfortable. There may be several organizations that offer homemaking services.

45. MS Jack and Jill Building, or vehicle, or homemaker.

45. Some larger communities may have private homemakers whose assistance is available for a fee.

46. MS someone (Patient 5) alone in room, looking out window (subdued lighting).

46. But besides someone to help look after our health and someone to help out around the house, it's sometimes "nice" just to have someone to talk to or help us keep in touch with friends.

47. Hold # 46.

47. For those who live alone, contact with other people provides great reassurance . . . and, believe it or not, there are many people who are willing to keep in touch.

48. Hold # 47.

48. Quite often, local branches of national organizations may provide such a service. The Canadian Arthritie and Rheumatism Society, the Multiple Sclerosis Society, and the Canadian Cancer Society, all have

a staff of volunteers who will keep close contact with patients who are members of that organization.

49. Red Cross Building.

49. The Canadian Red Cross is another group which has a large recruitment of volunteer visitors. Besides this, however, a variety of home support services are provided.

50. CU Booklet.

50. A series of booklets for seniors offers tips on financing and the preparation of nourishing meals. Also offered is a course on "Health in the Home," of interest to patients and families.

51. CU Fun and Fitness Activity Booklet.

51. There is a Fun and Fitness program geared for senior citizens and offering a variety of activities that groups may enjoy.

52. CU Booklet.

52. Yet another service of the Red Cross is the sick-room equipment loan service. Anyone who is recommended by a doctor or other professional may obtain anything from a hospital bed to a commode for use in the home.

53. MS visitor with patient in a home.

53. Besides the national health and safety organizations, there may be others who are willing to offer a helping hand. In almost any community, local churches have visitation committees, whose members are happy to share moments with a friend.

54. Bus--senior citizens getting on.	54. In some communities, transportation may be available to those who need it. Many bus companies, for example, provide reduced rates for senior citizens.
55. London's mini-bus.	55. And there may be organizations which provide transportation for certain individuals with particular needs.
56. Patient reading.	56. Even the local library may take a hand in home care. For those who enjoy the company of a good book, some libraries operate a service which provides the delivery of books to homes.
57. Social Worker in home with patient.	57. There may be times, of course, when you need to keep in touch with someone who can provide more than friendship. For example, you may need to discuss an important personal problem with someone and obtain expert advice. Professional social workers are often available and willing to visit homes and provide counselling.
58. Patient and Social Worker.	58. (Live sound).
59. Our first patient still in hospital.	59. By now, the patient in hospital may be asking: "How do I get hold of these home care services?"
60. Interior hospital corridor.	60. Today, most hospitals recognize the value of home care and are committed to providing care for their patients.

61. Interior Hospital Home Care Door Referral	61. In fact, many hospitals have a Home Care, or Referral department, whose staff works to provide home care services to those who need them.
62. Referral Nurse	62. Geri Spurrell, Referral Nurse, explains the advantages of home care.
63. MS Referral Nurse walking down corridor.	63. In many modern hospitals, the Referral Nurse uses a system called "discharge planning," which helps identify patients who can benefit from home care.
64. Hold # 63.	64. At St. Clare's Mercy Hospital in St. John's, Nfld., a set procedure for discharge planning has been established.
65. CU Brochure, hands leafing through.	65. Before a patient is admitted to hospital, he or she receives a brochure explaining how the local home care program works (outlining the services which are available).
66. CU Notification being clipped on chart.	66. After admission to hospital, a home care notification is placed on the chart of every patient.
67. MS R.N. glancing through chart.	67. Twice a week, the Referral Nurse examines charts to try and find out who can benefit from care at home.
68. Hold # 67.	68. The Referral Nurse tries to discover each and every need a patient might have.

69.	Referral Nurse talking to Staff Nurse about chart.	69. To do this, she relies on the advice of a great many people . . . the nursing staff . . .
70.	Photo: Doctor.	70. the doctor . . .
71.	Photo: Physiotherapist.	71. the physiotherapist . . .
72.	Photo: Social worker.	72. the social worker . . .
73.	Photo: Occupational therapist. Photo: Dietitian.	73. the occupational therapist . . . the dietitian.
74.	Pull back to show collage of all photos. (May also use live footage for scenes 70-73, and show the entire group in conference with the Referral Nurse for Scene 74).	74. All these people are able to give insight into the needs of each patient.
75.	Patient in bed, looks up as Referral Nurse enters.	75. And, of course, there is the patient . . .
76.	CU Referral Nurse talking. CU Patient reaction MS Two-shot	76. The Referral Nurse is eager to talk with patients, to learn what their needs are.
77.	Family entering Referral Nurse's office. Sit down.	77. Also of great interest to the Referral Nurse are the needs and interests of the patient's family.
78.	MLS Entire group (family and Referral Nurse).	78. She realizes that caring for someone at home may at first be a difficult experience for some families.
79.	MS Family.	79. She tries to find out how the family feels about home care . . .
80.	MCS Nurse explaining.	80. and she tries to reassure them that there are many people who are glad to come to the home, to help out or to provide relief.

81. Referral Nurse glancing through patient file; picks up phone.	81. Once a patient's needs have been determined, the Referral Nurse contacts the various agencies who will be providing service at home.
82. Referral Nurse on phone.	82. In many provinces, home care services are co-ordinated by a central agency, which make it possible to provide a wide range of services over a wide area.
83. Referral Nurse hangs up, looks up another number, and dials again.	83. In Newfoundland and Labrador, the services offered are designed to meet the needs in your area. (Pause)
84. Out first patient gazing out window.	84. So, now you know something about home care. You know that there are many types of help you can get right in the comfort of your own home.
85. MS Nurse.	85. There are nursing and health services provided by such groups as the Department of Health or the VON.
86. MS Physiotherapist.	86. There are physiotherapists and occupational therapists who visit homes and help with therapy.
87. MS Homemaker.	87. Homemaking can be provided, to help patients take care of housework, cooking, shopping.
88. MS Visitor and patient.	88. And there are many people who are glad just to come for a visit, to help break up a long day.

89. MS Nurse.	89. It may be that you only require one of these services . . .
90. LS Health Professionals Conference.	90. . . . or you may need all. (Long Pause)
91. CU First patient, thinking.	91. So, how do you find out more about home care? How do you know you qualify?
92. DISSOLVE TO Scene 1 (blurred edges)	92. Had you known, that day in the doctor's office, you could have asked him, and perhaps avoided going to hospital at all.
93. Patient sitting in chair.	93. Too late for that.
94. CU Patient . . . idea!	94. But wait, don't forget that there's a Referral Nurse in most hospitals.
95. Referral Nurse checking charts (blurred edges).	95. Remember, she's the one who finds out which patients can use home care.
96. MLS Back view of patient in pyjamas, searching corridors.	96. Of course, you don't have to go find the Referral Nurse yourself . . .
97. Patient passes nurse, who stares at him curiously.	97. Any member of the hospital staff would be glad to have someone from the Referral Department come talk to you.
98. Patient finally finds Home Care door, knocks, enters.	98. But, however you do it, why not ask about Home Care. There might be something in it for you.
99. Credits.	99. Bring up music.

APPENDIX E

TELEVISION PROGRAM:

NO PLACE LIKE HOME--A LOOK AT HOME CARE

(under separate cover)
(Film & Tapes)