2. Clinical investigations are required to identify medical and occupational factors whch either support or contra-indicate the use of this seating concept in the treatment and management of low back problems.
3. Long term investigations of back pain, comfort and acceptability are required.
4. The prototype chair needs to be evaluated in comparison with conventional, well designed workplaces in order to clarify the reasons underlying the results reported above.

CONCLUSIONS

Users' reactions to the prototype chair suggest that it is of value in reducing the incidence of sedentary low back pain and that it is perceived by many as an acceptable and appropriate item of office furniture.

This supports the view that further research and development is required in order to gain a fuller understanding of the effects of the chair on musculoskeletal and physiological strain and sitting posture.

The sitting concept described above merits the close attention of researchers and practitioners in the fields of back pain and furniture design.

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Suggestions for a Training Programme for Home-helpers for the Aged and Disabled

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INTRODUCTION

The general improvement in health status and the continuous increase in life expectancy have caused a considerable growth of the aged population. Health and welfare organisations throughout the world are faced with the imminent problem of providing adequate care for this large population at risk, for as people grow older they accumulate various losses in most aspects of life, making them increasingly dependent on the support of family and society.[1]

The current concept of care for the aged is to enable people to remain part of their family and community for as long as possible before being confined to insitututional care. This concept, combined with the ever increasing cost of hospital treatment, has given rise to the development of community health and welfare services. Nurses, social workers, physiotherapists and others were diverted from the hospitals to the community to provide the elderly population with expert care in the various professions. The common objective of the multidisciplinary teams was to enable the elderly to retain or regain their functional effectiveness in everyday life.[2,3]

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REVIEW OF THE LITERATURE

During the last two decades several community programmes in the U.K., the Netherlands, Scandinavia and U.S.A., have been described in the literature. Some projects have been scientifically evaluated and some important conclusions have been reached.

In general it has been found that the elderly population can, and does benefit from measures of primary and tertiary prevention in the community,[4,5] and that there is a need for regular reaching-out in the form of individual home visits and group instruction for the aged. On the other hand, several problems have been identified:

1. The existing funds and professional staff are usually insufficient to meet the ever growing needs of the elderly population in terms of health and social services.
2. The multiplicity of organisations, agencies and professionals causes confusion, contradictory instructions and overlapping of services on the one hand, and 'falling between the chairs' on the other.[6]
3. The cost effectiveness, though better than hospital care, has not been proven in many cases.[7]
4. The communication systems between the different professionals working in the community and between them and their supervisors 'off the field' are often very cumbersome. The multiplicatory record-keeping is superfluous at its best, and totally ineffectual at its worst.[6]
5. Most important of all, the main brunt of the day to day care of the handicapped elderly patient, continues to be shouldered by the family, usually the spouse.[8,9] Several studies have shown the immense burden this continuous care entails, and the detrimental results in the deterioration in the general health of the care giver.[9,10,11]

THE SUGGESTED PATTERN OF CARE

It has been found that the daily care of the elderly and disabled is usually of a practical nature, not requiring the expert professional in every aspect. Indeed, it has been shown that the professionals tend to prescribe more hours of care in their own speciality than the patient or their family thought they needed.[10]

It is therefore suggested to train home helpers who will have a broad scope of non-specific skills and who will be able to supply adequate care to the population in need, aiming to promote physical and social well-being. The expert professionals in the various fields will be available in a consultory capacity to perform the preliminary assessment and support the home helper by guidance and instruction as needed.[7]

GENERAL OBJECTIVE OF THE TRAINING COURSE

The course is designed to provide the trainee with an opportunity to acquire basic knowledge, appropriate attitudes and practical skills to deal effectively with a wide variety of common situations in the different stages of physical, mental and social incapacity.

PROCEDURE

It is suggested that the training programme be executed in three stages:

Stage I — Planning and Policy Determination
Stage II — Recruitment and Training
Stage III — Evaluation and Continuing Education

Stage I: Planning and Policy Determination

It is proposed that a committee be formed consisting of senior educators in public health nursing, social work, physiotherapy and occupational therapy. This group would work out a detailed job description for the home helpers and discuss and decide upon the following issues:

1. What are the needs of the homebound elderly and their families in terms of personal care and basic physical and social functions?
2. Which of these needs could be supplied by a suitably trained lay-person and which by an expert professional only?
3. What routine procedures can be delegated to non-professionals?
4. How should these procedures be taught, at what level?
5. How much time should be allocated to such a training course.
6. How should the knowledge, attitudes and skills be evaluated, and at what stage of the training?
7. How should the supervision and on-going education be organised after termination of the initial training?
8. What support systems should be organised for the home helpers?

During discussion several other questions might arise. It would be unwise to embark on the training course before the various professions have reached mutual agreement on the conceptual issue.

Stage II: Recruitment and Training

It is suggested that candidates for the home helper training course should be women between 18-55 years of age, with a minimum of ten years of schooling. The younger trainees would be able to use their training in coping more effectively with their own family problems — or they might progress to more specialised training in one of the professions. Thus even if this younger group leaves the service, the training would not be wasted. This has been shown by several reports published by the various professions.[13] The older trainees would benefit by the course as this new job opportunity creates a new interest in life for these more mature and experienced women, supplying meaningful employment after their children are out of the house. It has been shown that this age group is a valuable asset to the work force which is not often utilised.

It would be desirable that the trainees be chosen from a variety of cultural backgrounds so as to be able to supply the various needs of the community in terms of different languages and customs.

A standard questionnaire should be filled out and the applicants must be interviewed by a panel of com-

munity workers to determine their suitability for the job.

The training course should emphasise the practical nature of the home helper's role and should therefore consist mainly of demonstrations and practical sessions. The theory taught should be concise and relevant to the job description decided upon and should increase the understanding of the procedures taught.

As to the detailed contents of the programme, only a general outline of the educational objectives will be stated here — the specific objectives, teaching methods, level of instruction and time allocated, will be determined by the planning committee.

At the end of the course the trainee will possess the necessary knowledge, attitudes and skills in order to:

1. Supply emotional support in crisis situations;
2. Help maintain and promote social function of the elderly individual within the family and the community;
3. Supply personal care such as washing, dressing, feeding, etc.;
4. Prepare meals according to dietary prescription;
5. Maintain and promote mobility and ambulation;
6. Supply basic chiropodal care;
7. Maintain respiratory, circulatory and excretory function;
8. Supply skin care and prevent pressure sores;
9. Assist in basic errands such as shopping, pharmacy, bank, etc.;
10. Keep adequate records, present and retrieve information.

Stage III: Evaluation and Continuing Education

The exact method of evaluation should be determined during the planning stage. It is easily understood that regular written or oral examinations are not sufficient to establish whether the trainee is competent in her job. One possible method of evaluation is to compile a list of practical skills which the trainee is supposed to be able to perform at the end of the course. Competency in direct patient care should be demonstrated in the presence of a professional, at the predetermined level of performance.

It is extremely important that the group of home-helpers trained at one time, have a structured programme of regular study meetings — this will enable ongoing regular education and group problem solving and will also serve as a support system.

It is recommended that after two or three courses have been given and a trial period of approximately two years has passed, a scientific study be designed to determine whether this new semiprofessional home helper is effective in solving the problem of providing care for the population in need.

CONCLUSIONS

The above is a preliminary proposal to train semiprofessional home helpers to take upon themselves the day to day care of the homebound elderly in the community. At a time when the helping professions are considering the reinstatement of lower level educational programmes in order to increase the number of non-academic practice workers, it seems that **one** person suitably trained by all the professions and having access to an expert for guidance if, and when, necessary, could supply most of the needs of the elderly population. This concept must be accepted by members of all the helping professions, and requires them to go through the soul searching process of determining which part of their expertise is but routine procedure and can easily be taught to others. Indeed, the nursing profession has already accepted the idea that some of their skills can be delegated to the patient themselves or to their families. Nurses have been teaching patients and others to inject insulin, to take blood pressure and to perform catheterisations. This excellent example can and should be followed by the other professions.

By delegating most of the routine procedures to others, the professionals will have more time and opportunity to develop the higher levels of their professionalism. Instead of spending most of their time providing routine care, the professionals would improve their assessment techniques, develop their teaching skills, and become involved in clinical research. Thus their expert services would extend to an ever widening sphere of professional activities.

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