Home Nursing Care Program on an Indian Reservation

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LONG BEFORE HOSPITALS EXISTED, the sick were cared for in the home. The family assumed the main responsibility for providing the care needed. Not until late in the history of medicine did the hospital take over this role. The sick were transferred from their homes to the hospital because, for one reason or another, this seemed seemed more suitable. Once the patient was moved (to the hospital) the family relinquished its responsibility. It was either one or the other; there was no sharing (*1*).

In recent years the trend has been toward a return to home care, and the American Hospital Association (AHA) has encouraged hospitals to participate in organizing and coordinating such programs (*2*). The modern concept of hospital-based home care began with a program set up in January 1947 by Dr. Michael Bluestone at Montefiore Hospital in New York City. With this program, he hoped to discharge certain patients earlier than would otherwise be expected and to totally eliminate the need for hospitalization of certain other patients.

The number of organized home care programs has grown rapidly, in many respects as a result of the successful Montefiore project. According

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to a 1970 AHA survey (*3*), 263 home care programs were being administered by hospitals; however, this number was only about 10 percent of the total number of home health agencies that were meeting Medicare standards.

Basic to home care programs is the premise that, for certain patients, the familiar surroundings of their homes are more therapeutic than the hospital's regimented atmosphere. Several recognized advantages of home care are (*a*) more appropriate means of care than hospitalization, (*b*) good followup so that gains made by the patient in the hospital will be maintained or exceeded at home, (*c*) freeing of hospital beds for patients in greater need, (*d*) better continuity of care, and (*e*) it is less costly than inpatient care.. Additionally, the patient's care becomes a responsibility shared by the hospital and the family. This shift can prove to be meaningful for the hospital, the family, and the patient.

Home care is not applicable to all patients. Its suitability depends on the limits of the home care program, the patient, his medical condition, his family, and his home situation. Good criteria for the selection of patients are therefore essential to the success of a home care program.

Home care can work for several types of patients: the short-term, convalescent patient; the patient with chronic illness; the terminally ill patient; and the patient temporarily unable to come for outpatient care. Levels of care in the home care program can range from minimal to intensive, depending on the needs of the patient and the limits of the program.

In September 1973, a home nursing care program was organized as a 6-month pilot project at the Public Health Service Indian Hospital in San Carlos, Ariz. One of its main objectives was to study the need for such a program in this particular community. A request by the San Carlos Apache Tribal Health Committee for an increase in the provision of direct nursing services in the home prompted the beginning of the program.

The San Carlos Apache Reservation occupies 2,854 square miles of southwestern Arizona. Its population has been estimated at about 6,000, most of whom live in San Carlos and Bylas, the two major communities. Most of the Apache people are bilingual, and the majority dress in modern attire. Unfortunately, much of the Apache culture has been lost, or at least it is not readily apparent to non-Apaches. Some customs, ceremonies, and old beliefs persist, however, especially among the elderly. For example, Apache families are still predominantly matriarchal.

Many members of the tribe are not self-supporting and must depend heavily on government funds. Employment on the reservation is severely limited by the relative lack of private enterprise. Off-reservation employment is available, but many obstacles exist to prevent the Apache from taking advantage of such opportunities. Although housing has been improved in recent years, many homes still are without plumbing. Most families have their own vehicle or access to one—a necessity, since there is no public transportation. For one reason or another, however, many people must rely on walking as their chief mode of transportation.

Health care is provided by the Public Health Service. A 36-bed hospital in San Carlos offers inpatient and outpatient services; when necessary, patients are referred to the Phoenix Indian Medical Center. In addition to a nursing staff of 27 and a medical staff of 6, the San Carlos hospital has a community health medic, a pediatric nurse associate, a medical social worker, a psychologist, and a part-time physical therapist. Community health nursing is also offered; its staff consists of one licensed practical nurse, two registered nurses, and two community health nurse trainees (RNs), all of whom are employed by the Public Health Service.

Design of the Project

The home nursing care (HNC) project was considered an appropriate means of attempting to improve health services and better meet the needs of the San Carlos Apache for several reasons:

1. Many of the hospital's patients with long-term diseases require extended hospitalization or transfer to a nursing home. Since the only nursing home in the area is approximately 40 miles from the reservation, far from relatives and friends, and long hospitalizations are often psychologically traumatic, nursing care and supervision in the home would be far more suitable for a large portion of these patients.

2. Many patients, especially those with chronic conditions, are hospitalized repeatedly for the same condition. Better followup, with an increase in the supervised involvement of the patient and

his family, might help to prevent rehospitalization.

3. Some outpatients require daily care for a short time—for example, patients in need of special care for a wound. Transportation difficulties sometimes cause patients to miss clinic visits and this could necessitate hospitalization for some of them. This situation could be alleviated by treating these patients at home.

4. Frequently, the hospital's inpatient census is near capacity. Reducing unnecessary hospitalizations would free beds for other patients in need, an important consideration in a small hospital.

5. Continuity of care between hospital and home needs to be improved. The home nursing care project could further this objective, at least among the patients it serves.

As a registered nurse on the staff who was interested in caring for patients in their homes, I was selected to head the HNC project. Guidelines were established to help organize it.

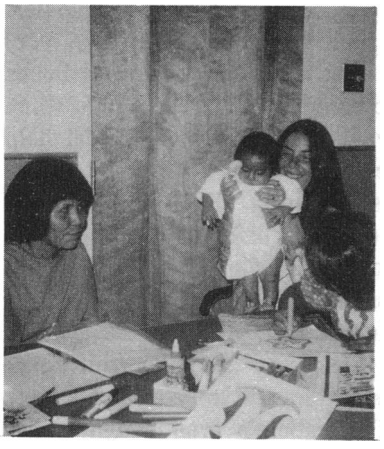
The stated purpose of the HNC program was to "offer professional nursing care in the home of certain individuals as an alternative to hospital or nursing home care, thus recognizing and utilizing the home as a therapeutic agent." Objectives were formulated in relation to the needs mentioned previously. In addition, the program was to strive to deliver "organized and comprehensive health care under the supervision and leadership of a professional nurse." There was to be input from all members of the health team as indicated by the needs of each patient. Therefore, even though the official staff was from the nursing department, the services of other departments, such as the medical social worker, the psychologist, and the physical therapist, were available and utilized. Community health aides, employed by the tribe, were also a part of the HNC's health team; among these aides was a newly organized group of five homemakers.

In selecting patients for the program, several criteria were to be considered. With the resources available, could the care needed be provided in the patient's home? Because of the experimental nature of the program, staff and working time were limited. The staff consisted of the registered nurse coordinator and a licensed practical nurse. Both were assigned to HNC part time—an average of 2 days a week for the coordinator, less time for the practical nurse. Therefore, we had to consider whether we could adapt the hospital service to the home and whether we would be able to visit the patient as often as necessary.

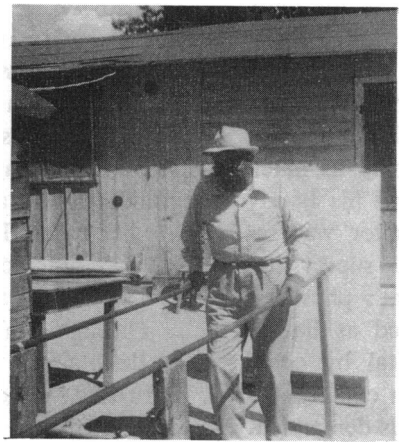
Social eligibility was the most important criterion. The patient's feelings about going home were assessed. How much did it mean to him? As Silver noted (*4*):

> Separated from the warmth of the home, dependent, a patient will tend to worry more about his family, their financial needs, the crumbling of family solidarity. The feeling of belonging, of contributing, begins to disappear. For many patients, particularly long-term patients, hospital sights, smells, sounds, discipline, are not conductive to affection, to allaying fear, or the feeling of helpless despair.

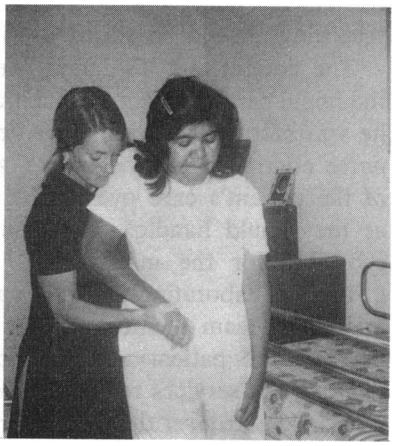
The emotional status of the patient (left) has greatly improved since she has been involved in more activities, such as volunteer work



Stroke patient practices on parallel bars constructed by his son



Physical therapist works with hemiplegic patient at home



The hospital "sights, smells . . ." are even more foreign to the Apache; many patients are anxious to go home as soon as they begin to feel better.

In addition to the patient's emotions, the family's response was taken into account. Were family members able to offer the patient supplementary care? Field and Schless have said that successful home care depends not only on the services the program is able to offer, but "on the capacity of the patient and his family to make constructive use of the services" (*5*). With our staffing limitations, this factor was especially important. If he had no family, the patient had to be responsible for his own supplementary care. We anticipated problems in this area because there were many patients requiring close followup who had no family members to help them and who were unreliable in caring for themselves. All criteria were flexible, however; their application depended on the individual patient and his needs.

Having determined the guidelines, our next step was to identify eligible patients. Referrals were made directly to the registered nurse coordinator, who made the final decision in the selection of patients. After an initial discussion with the referring person, the coordinator began to determine the patient's medical and social suitability for HNC. The home situation was explored first, and the program was then explained to the patient —preferably while he was still in the hospital.

When a patient was accepted for the program, his health needs were discussed with pertinent team members, and a goal-oriented care plan was written. A chart containing his medical and social profiles was set up for day-to-day recording. In keeping with the hospital's system of POMR (problem oriented medical records), a copy of the patient's list of problems was transferred from his hospital file. Periodic summaries of the daily recordings would be added to his hospital chart.

The patient and his family were prepared for the home care program as much as possible while he was still in the hospital. After discharge, the nurse continued to teach them, turning as much of the patient's care over to him and his family as they could handle. The coordinator was responsible for the management and supervision of care, collaborating with the patient's physician and other team members. She acted as liaison between the patient and the hospital by coordinating the services required. Team conferences were held whenever the patient's needs demanded. They were not scheduled regularly, however.

In the project's first 6 months, 17 patients were admitted. Most of these were patients with long-term diseases; they were considered "high risk," because they had been hospitalized several times for the same condition. A few patients were seen for a short period, mostly for care of wounds. They were then discharged with referral to community health nursing, when indicated, for periodic followup. The diagnoses were as follows:

Principal condition	*Number of patients*	*Average age (years)*
Chronic ulcers	2	62
Cardiac disease	1	27
Multiple problems	5	72
Hemiplegia	1	28
Diabetes	1	42
Psychiatric problem	1	36
Rehabilitation after cardiovascular arrest	2	58
Tuberculosis	1	46
Wounds, short-term care	3	61

Although it is too early to draw valid conclusions about the group of patients, it should be noted that only one high-risk patient needed to be rehospitalized. He had expressive aphasia and was unable or unwilling to cooperate with his family or the nurse. Rehospitalization of another patient was prevented on three separate occasions when ulcer breakdown was observed and treated early at home.

Case Studies

The following case studies illustrate how the home nursing care program has helped to improve health care in the community.

Case 1. A 66-year-old woman is being followed in the program because of multiple problems which include renal disease, chronic foot ulcers, and anemia. She left the hospital against medical advice because she "needed to go home." She is highly respected by the community, very independent, and mistrustful of modern medicine. She was known to come to the hospital only when she was seriously ill, after refusing medical help in the early stages of an illness. An 18-year-old granddaughter assumes most of the responsibility for her care. The patient lives in a small shack with 11 other people, including her daughter and son-in-law; all are unemployed.

Through health teaching, visits on the average of three times a week, and careful nurturing of a trusting relationship, several improvements have been achieved. The patient's granddaughter has

been providing good daily care of the ulcers, although we have had difficulty with the patient occasionally because she wanted to leave the dressings off. The HNC staff has worked closely with her physician and the laboratory, and blood studies have been performed to help monitor her renal disease status and anemia. Her medication is altered as necessary. Although she refuses to be rehospitalized for a thorough re-evaluation of her problems, she does go to the outpatient clinic for periodic checkups. We have been working also with the medical social worker and various community agencies to improve her social situation. Although management of her health conditions is far from ideal, it is now continuous rather than sporadic.

Case 2. A 27-year-old woman with rheumatic heart disease underwent mitral valve replacement in July 1973, and she was subsequently discharged on a regimen of anticoagulant medication. She did not take the medication as prescribed, and shortly after discharge she was again admitted to the hospital because of a mild cardiovascular accident. After this hospitalization, she experienced episodes of bleeding because of continued poor followup and errors in taking her medication.

The patient was reluctant to come to the outpatient clinic because if she had to be rehospitalized, her son would have no one to care for him. At this point, she was referred to the home nursing care program, and it was stressed that her cooperation was essential. She was given instructions in self-care for her condition, with emphasis on the importance of taking her medication as prescribed. Prothrombin time and hematocrit studies were done weekly, and her habits of medication were supervised. Her condition is now well controlled by the anticoagulant medication, and she is more reliable in self-care.

Case 3. A 79-year-old woman came to the clinic with an infected wound. Hospitalization was not necessary, but the wound required close observation and daily care. The patient had difficulty arranging for transportation and getting a babysitter each day for her grandson, and she was referred to the coordinator of the HNC program. At this time, the program's patient census was such that daily care for her wound was feasible. After a week, her wound was sufficiently healed for her to assume responsibility for the remaining care. She had to come to the clinic only three times. The program saved her considerable inconvenience and demonstrated to her the hospital's interest in her problems.

Achievements and Problems

The HNC program's most notable contribution has been the improvement in the health care of patients with long-term diseases. It has also increased the involvement of both patient and family in the patient's health care. Their understanding of the medical problem and of what they can do to help has decreased the number of crises that occurred because of lack of knowledge. Continuity of care has been greatly improved. In addition, it has been demonstrated to patients that the hospital staff does not merely wish patients to get well so they they can be discharged; they want patients to remain well. Communication and cooperation have increased between the hospital staff and the patient at home.

The lack of time and staff to help all patients who could benefit from the program has been a major concern. It was especially difficult to follow patients living in Bylas, which is 25 miles away. Staffing problems in the nursing department of the hospital have made it difficult for the program to expand, even to the point of designating definite days for home care visits. Also, data on the home care patients were not incorporated into the hospital's system of collecting statistics.

Patient selection was poor at times, resulting in unsuccessful home care. As we expected, these failures were with patients who had no reliable person to give them supplementary care and who would not cooperate with home care staff. Inadequate preparation of the patient and the family before the patient left the hospital also caused some failures.

Answers to questionnaires testing the reponse of both hospital personnel and the community to the program provided further insights, both positive and negative. Staff members were asked whether they were aware of the program and its purpose, what their general feelings were about it, and whether they knew of any instance in which the program had proved beneficial regarding their particular aspect of patient care. Persons engaged in the program—notably the medical, social service, and physical therapy staffs—believed that the program was valuable and had improved health services to the community. All the physicians felt comfortable working through the pro-

gram, and each knew at least one patient who had benefited from it. The physicians considered the nurse coordinator to be especially effective as a liaison between them and the patient who needed close followup at home. She could keep the physician informed about the patient's status by building on a relationship started in the hospital to communicate with the patient at home. Thus, the physicians felt that they could maintain control even after the patient was discharged.

On the negative side, many hospital staff members did not really understand the HNC program. This reaction was particularly true of the nursing staff; many felt that there was not enough feedback. The following questions were raised. Would the program do as well with another coordinator if the present one should leave? Didn't the HNC program really belong in community health nursing, which is responsible for all services provided outside the hospital?

The patients and their families were also asked how they felt about the HNC program. Did they think it helped them and, if so, how? Did it change their feelings about the hospital personnel? Did they like being involved in their own or in their family member's care? They responded with enthusiasm and appreciation for home nursing care. Significantly, the majority said that the program made it easier for them to communicate with the hospital personnel, especially their physicians. Although they frequently knew when a health problem required attention, they lacked transportation to the hospital. They believed that the hospital cared about what happened to them or "they wouldn't have sent a nurse to check on me." The families enjoyed being involved in the patient's care, and they thought that the program helped them to take better care of the famliy member.

Future Plans

The registered nurse coordinator will continue to be based in the hospital. Even with the unique relationship between the hospital and community health services in the Indian Health Service's service units, it was felt that a HNC program based outside the hospital would not be as effective in coordinating services and providing for continuity of care.

More attention will be given to periodic inservice education of community health nursing and hospital staff concerning the program. The coordinator will work closely with the community health nurses in organizing and delivering care. This coordination will allow for better coverage of Bylas, since a community health nurse is assigned to that area. The community health recordkeeping system will be used for day-to-day charting, allowing for the collection of statistical data on the home care patients. Periodic summaries will be added to the patients' hospital charts, as was done previously. Patient care conferences with the community nursing staff will be held weekly in the hospital. These conferences will serve several purposes: (*a*) keep the coordinator and the staff up to date on the patients' status, (*b*) improve the quality of care by increasing input on the patients' status, (*c*) improve feedback to the hospital personnel, and (*4*) improve the relationship between the hospital staff and the community health nurses. A policy and procedures manual, which emphasizes selection of patients, will be written to improve the structuring of the program.

Most of these measures are being implemented at this time and, as a result, the program is operating more effectively. The part-time status of the HNC program continues to be its major weakness, forcing the exclusion of many patients requiring daily care who would otherwise be excellent candidates for home nursing care.

Home nursing care offers the San Carlos hospital, the community health staff, and the tribal health staff a means of working together to achieve the most appropriate use of health facilities and resources. The possibilities for improvement of comprehensive health care services to the San Carlos Apache are tremendous. What the home nursing care program needs now is recognition of its worth and approval of its reorganization as a full-time program.

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