Nutritionists aid staff members of an organized home care team in recognizing and interpreting the importance of diet in the care of patients with long-term illness.

The Nutritionist in Organized Home Care

MILDRED KAUFMAN, M.S., and MARIAN S. BRYAN, M.S.

THE NUTRITIONAL NEEDS of the chronically ill too often are considered only when a therapeutic diet is required. Nutrition service is commonly believed adequate if diet instructions have been given in the hospital or if the physician has provided the patient with a diet list.

Thoughtful observers will quickly recognize that this approach ignores the dynamic role of nutrition in the patient's improvement, rehabilitation, or recovery. Even the most clearly written diet instruction sheet is not effective in motivating patients to change or improve the eating habits of a lifetime. The nutritionist in organized home care plans gives other team members stimulation and guidance in developing the knowledge, skills, and techniques to recognize nutritional needs and to assist patients and their families in achieving and maintaining an appropriate diet.

Nutritionists, as an integral part of organized home care programs, have a valuable contribution to make in the treatment of patients with long-term illness.

Organized Home Care

Organized home care programs have developed in a number of communities as an answer to the mounting problem of providing comprehensive care to patients with long-term illness (*1*). These programs coordinate the various skills of the medical care team and bring them to the patient at home. The trained workers who provide the skilled services also teach family members to perform some of the simpler procedures needed for care of the patient. Through this plan, the patient receives the professional care and supervision he requires while remaining a part of his family and enjoying the comfort and security of his own home. The family continues to provide such basic essentials as food, shelter, laundry, clothing, and other necessities (*2*).

As specifically defined, "Organized home care provides coordinated medical and related services to selected patients at home through a formally structured group comprising at least a family physician, a public health nurse, and a social caseworker assisted by clerical service. For satisfactory functioning, patients must be formally referred and there must be an initial evaluation, monthly review of records, and a final discharge conference. There must be ready access to inpatient facilities." This definition was agreed upon at the Roanoke conference on organized home care which was sponsored by the Public Health Service in June 1958.

Organized home care programs now in operation are administered by hospitals or such agencies as visiting nurse associations and local

Both the authors are nutrition consultants, Miss Kaufman with the Chronic Disease Branch, Division of Special Health Services, Public Health Service, Washington, D.C., and Miss Bryan with the Visiting Nurse Society of Philadelphia, Pa.

health or welfare departments. Administration and services vary with the agency from which the program operates. Regardless of the administration or agency, the services should be planned around the care needs of the patients. The above definition, as well as a review of the existing programs, indicates that the minimum services considered essential are medical, nursing, and social services, and provision of drugs and supplies. Services considered desirable are physical and occupational therapy, homemaking, health education, and nutrition (*3*).

Nutrition Needs in Long-Term Illness

In considering the needs of patients, optimal nutrition is emphasized as one of the most important environmental factors affecting health. However, nutrition is one area which professional workers might easily overlook if their attention is not directed to it, since the family of the home care patient assumes the responsibility for planning, preparing, and serving his meals.

The kind and quantity of food that will meet his individual needs are essential for each patient. An inadequate diet must be improved to provide an optimal level of nutrients. Special needs require increases above normal nutrient requirements, to help fight infection, or to heal wounds, decubiti, and fractures, or to aid recovery from an anemia. Reducing the obese patient and bringing the underweight up to normal weight often are essential steps in rehabilitation. Correction of constipation through diet can reduce the use of medication and the need for routine enemas. Diabetes, cardiac disease, gastrointestinal disorders, liver or gall bladder disease, or other medical conditions require modified diets, and chewing or swallowing difficulties require changes in the consistency of food.

Whether a therapeutic diet or improvement in the nutritional quality of the diet is ordered, the patient and his family almost inevitably need and desire some guidance in their meal planning. Often there is need for improvement of the nutritional value of the entire family diet.

Because good nutrition can contribute to the vigor, well-being, and therapy of the patient, dietary guidance should be an essential part of a well-organized home care plan.

Role of the Nutritionist

The role of the nutrition consultant in the Philadelphia Home Care Plan illustrates how nutrition services can be integrated into an organized home care program. Administered by the Visiting Nurse Society of Philadelphia, this program is a special service within the agency (*4*). For many years the society has employed a full-time nutrition consultant to help the nurses plan for the nutritional needs of their patients and to participate in student and staff inservice education. When the plan was organized in 1949, it was recognized that the nutrition consultant should be a member of the team and that part of her time should be devoted to home care activities.

The team includes the patient's physician, medical consultant to the plan, nurse coordinator, staff nurse, social worker, physical therapist, occupational therapist, occupational health consultant, as well as the nutrition consultant. At team conferences, candidates are evaluated for admission and plans are made for the care, treatment, and rehabilitation of the patient. At this time, the patient's needs and the contributions of various services are coordinated. The patient's progress is reevaluated periodically at subsequent meetings.

The nutrition consultant interprets to the team the dietary goals desirable for the patient. Dietary guidance is thus coordinated with the other home care services, placing nutrition in its proper perspective. With conference planning, followed by consultation, it is possible for team members who work directly with the patient to integrate nutrition advice into patient contacts and so strengthen diet teaching.

A consultant seldom has direct contact with the patient. She is dependent upon others for background and insight concerning the patient and his home situation. The reports of various team members frequently identify factors motivating family behavior, which must be considered in planning for any workable diet regimen. Time is saved and duplication of effort is avoided by early recognition

at the team conference that nutrition is an important aspect of the total plan for care.

Whether or not giving direct service to patients is the most effective use of the nutritionist's time is a decision to be made within the home care program. Factors affecting this decision might be the number, interest, and preparation of other staff workers to do dietary teaching.

To function as a team member, a well-planned orientation for the nutritionist is vital. She should fully understand the philosophy and objectives of the home care program and how to plan for the nutritional needs of patients in their own homes. It is essential that she work closely with the other team members, and to do so, she should feel comfortable as part of the group and appreciate what each of her coworkers is trying to do. In turn, the nutritionist should make sure that all workers understand her function and the importance of good nutrition to the patient. In achieving these goals, the nutritionist should be active in in-service staff education and have assurance of the support of the program administrator.

Case History

The story of a 27-year-old patient shows how this program operates and how the nutritionist contributes. For this discussion, the patient is called Jane Green.

Jane was admitted to the Philadelphia Home Care Plan in November 1957, after a year of treatment in a large city hospital. Her illness had been diagnosed as Pott's disease, with paraplegia.

As a basis for the first team conference at admission, the patient's physician submitted a medical referral form which reviewed her physical condition and gave orders for nursing care, physical and occupational therapy, and a 2,500 calorie diet with 125 grams of protein. Jane's public assistance visitor was included in the initial conference.

Workers who had visited Jane for evaluation described her as intelligent and cooperative but discouraged because she was bedfast. She complained of weakness and fatigue to each of them. Jane's mother, with whom she lived, took care of the home and meal preparation.

The team concluded that getting about in a wheelchair would be a minimum goal for Jane, but she might achieve ambulation with braces and a return to some gainful employment. It was felt that the patient's poor nutrition contributed to her chronic state of fatigue, an obstacle in achieving the maximum goal. The patient was quoted as stating that she had "a poor appetite," "ate poorly in the hospital," and "could not eat much at home." The physician had told Jane to "eat more protein." Mrs. Green thought this meant expensive cuts of meat and complained that she was unable to afford the diet ordered.

As a result of the conference, the public assistance worker obtained from the physician a request for an additional financial allowance for the prescribed diet. The nutrition consultant suggested that the nurse ask the patient to keep a food-intake record as a more objective criterion in evaluating Jane's current diet. Questions about food habits and home conditions identified areas for the staff nurse to investigate before dietary guidance could be planned.

Shortly after this conference, the nutritionist and nurse met to discuss Jane's diet. Jane's food-intake record showed that she was eating only two meals a day and small servings of selected foods. She was eating much less than the 2,500 calories and the 125 grams of protein prescribed, and her food intake failed to meet recommended dietary allowances for other nutrients (*5*).

Since the prescribed diet did not appear immediately practical, as Jane could not eat large quantities of food, a phone call was made to Jane's physician to inform him of dietary findings. He recognized the problem but, because of the nature of Jane's illness, stressed her need for the prescribed protein intake, optimal levels of other nutrients, and calories to provide gradual weight gain of 10 pounds. He urged that an acceptable diet be planned for Jane, working toward the diet prescription gradually, and asked for reports of progress.

Together the nurse and nutrition consultant prepared a diet plan for Jane considering the diet prescription, her appetite and food preferences, and her mother's limited cooking skill. The plan suggested amounts of specific food

groups to provide about 2,000 calories. A supplemental list specified foods which could be added gradually to bring the diet up to prescribed levels as Jane's appetite increased. Jane had agreed to cooperate, stating that she was anxious to do anything that would contribute to her well-being. Written copies of the diet plan were given to the patient, sent to the physician, and kept in the records of the nurse and nutrition consultant. At the request of Mrs. Green, simple recipes were supplied for the foods listed on the diet, particularly some using nonfat dry milk which the family received as a surplus food commodity.

Reevaluation of the patient's food intake at 2 and 4 months following the initial diet instruction showed considerable improvement. Nurse's notes on successive visits showed that Jane was eating three meals a day regularly and was using an increased amount and variety of foods. However, she still needed more foods rich in vitamins A and C. Jane made a real effort, but constant support and encouragement were required to help her continue with the diet. She said that she was enjoying her food more at home. Mrs. Green had tried some of the recipes the nurse had given to her, and she catered more to Jane's taste than would be possible in the hospital. At the end of 4 months, Jane had gained 6 pounds; she was feeling better and was not as weak and tired as she had been.

Diet plans for Jane had been discussed with her physical and occupational therapists, and they were asked to lend encouragement. The physical therapist reported after 4 months that Jane expressed concern about gaining too much weight. She had explained to Jane that as her food intake was increasing her physical activity was also increasing; that her weight gain so far was satisfactory but when she reached the desired weight, the calorie intake would be modified.

Nine months later at the final evaluation conference, it was reported that Jane was walking with braces, getting around the house, and going outside. Employment possibilities outside the home were being explored with the help of the occupational health consultant. Everyone expressed pleasure with the patient's progress and agreed that improved nutrition was a prime factor in achievement of the treatment goals for this patient.

Use of Nutrition Services

As has been stated, in the Philadelphia program the nutrition consultant attends all of the team planning and evaluation conferences. Individual consultations to give dietary guidance for the patient are held at the request of the nurse or other team member. Requests were made for nutrition consultation on behalf of 95 (49 percent) of the 194 patients admitted from June 1, 1957, to May 31, 1958 (see table).

It will be noted that nutrition consultation was not requested for every patient. Some patients or their families were unable to accept any dietary modification. A few patients died shortly after admission. And in a number of instances, it was felt that an experienced staff nurse had sufficient background to provide suitable dietary guidance without consultation.

With a changing caseload, the demands for nutrition consultation vary from week to week. The nutrition consultant has a flexible schedule and can devote more or less time to home care as needed. She estimates that in an average week she devotes about 6 to 8 hours to individual and team conferences on behalf of patients receiving home care.

Other Patterns

The Philadelphia Home Care Plan has been used to illustrate how a nutritionist in one organized program provides dietary guidance for its patients. It is emphasized, however, that the nutritionist should tailor her service to the individual program and offer to serve in the way that will be most effective for the patients and staff.

Some hospital-based programs utilize the services of their own hospital dietary department. This can be developed in a dietary department which has a well-trained staff with an active patient education program. If the dietitian has initiated diet teaching in the hospital or clinic, she then can follow progress and offer continuing guidance by working with the staff members who visit the patient at home. Since dietary problems of patients at home are

Nutrition consultation in the Philadelphia Home Care Plan, June 1, 1957–May 31, 1958

Diagnostic classification	Patients admitted	Patients for whom nutrition consultation was provided	
		Number	Percent of patients admitted
Cerebral vascular accident	99	44	44. 4
Neurological disorders	26	11	42. 3
Arthritis	25	16	64. 0
Cancer	7	4	57. 1
Fracture	20	7	35. 0
Heart and other circulatory disorders	5	2	40, 0
Diabetes	8	7	87. 5
Tuberculosis	2	2	100. 0
Other	2	2	100. 0
Total	194	95	49. 0

somewhat different from those of hospital patients, the hospital dietitian, working in a home care program and as a member of the home care team, must be oriented by observation and experience to the type of patients cared for by the program and the kinds of homes in which they live. Information concerning diet should be shared with the staff of any of the community agencies who may be providing related services to patients receiving home care.

A number of medical schools have organized home care programs which are used for the training of students. In such programs, a nutritionist can present a dietary teaching program as part of professional education. She can participate actively in team planning and evaluation conferences and, when working directly with patients and their families, demonstrate dietary teaching methods to the students.

In programs that cannot budget a full-time staff nutritionist, it has been possible to "borrow" these services from another health agency. A nutritionist in a cooperating private agency, in the local or State health department, or on the dietary staff in a cooperating hospital is a possibility. With a limited budget, it also might be possible to employ, on a part-time basis, a qualified nutritionist or dietitian living in the community. When utilizing nutrition service from another agency or on a part-time basis, realistic arrangements must be made to provide continuing service and sufficient time for full participation in conferences.

Conclusion

Nutrition services in an organized home care program may be provided effectively in a number of ways, but the main objective is to help each patient achieve and maintain the diet which best meets his needs, with the least difficulty for him and his family. This objective can be accomplished when the diet teaching plan considers the patient's social, emotional, and financial situation as well as his physical problems; when diet is the concern of all workers attending the patient; and when changing dietary needs are a part of the comprehensive plan for care.

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