Identify differences in care to prevent pressure ulcers

Richard Buckland

When I moved from acute care to become the tissue viability nurse for a primary care trust, it was immediately apparent how different both settings are. After 16 years experience of one acute trust (including five years as its TVN) my move to primary care has given me the opportunity to see the other side of the patients' healthcare journey. It has also made me realise that more needs to be done to recognise and accept the differences between the two modes of care, particularly when considering equipment provision for pressure ulcer prevention and tissue viability.

Having written the pressure ulcer prevention policy for both an acute and community organisation, using the NICE guidelines, it is obvious that current research, evidence and knowledge are centred on secondary care settings and do not easily transfer to the community. This is evident in the guidance on repositioning and skin assessment. In hospital, nurses are available 24 hours a day, seven days a week and so it is possible to carry out frequent skin assessment, patients can be easily repositioned and care plans can be easily amended. In the community it is social care staff who deliver the majority of personal care such as washing and dressing and this is the perfect time for skin assessments and for preventive care to be planned, but this can only happen if these carers have adequate training to recognise early warning signs of skin damage and they have the ability to refer the patient to district nurses for further assessment. Even then, nursing staff can only visit patients a maximum of four times a day so preventive care, such as repositioning, depends on the availability of relatives and the provision of appropriate equipment.

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There are many people in the community who defy our current knowledge about pressure ulcers. People do not always develop pressure damage despite having all the recognised risk elements such as very poor nutrition, incontinence, multiple comorbidities and complete immobility. Despite having an increasing population of dependent older people in the community, many with no family to help them, pressure ulcer incidence is between 1–2% in district nursing caseloads in my area — which is far lower than the reported levels in hospital settings.

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Having worked in both areas it has occurred to me that there are less 'recommended' preventive measures being delivered in the community than in hospital, so it should follow that there are more patients with pressure damage. So why is this not the reality? Is the difference in the people? In hospital the role of 'patient' is easily adopted and this brings different expectations. Patients are acutely ill and as such are visitors to the healthcare domain. At home the patient is more in charge of their own destiny and invite healthcare into their domain.

Is the difference in the staff? Community staff will often have known their patients for several years and have built up a relationship with them and their family whereas acute care is geared to treating the acute episode of illness with a minimal stay and maximum throughput which means that preventive care can become less important.

Equipment needs are different in each setting yet until recently there has been little development of products focused on community needs. There is relatively little research undertaken in community settings — the majority is based in the acute sector and therefore its relevance to the community is questionable.

A problem shared by both settings is that nursing itself does not seem to value the task of washing and dressing (so-called 'basic care'). As a qualified nurse I spend this time assessing the patient, not just washing them. In hospital the majority of personal care is undertaken by healthcare assistants whereas in the community it is classed as social care and undertaken by social care agencies. This means that qualified staff in both settings are missing this opportunity to adequately assess patients as well as noting the different needs of the separate patient populations.

Pressure ulcer prevention is not simple or 'basic'; no 'one size fits all' and we actually know very little about it. We need to start recognising and examining the differences between the two care settings, the different patient risk profiles and the needs of both patients, staff and the organisations who provide the care if we are to start to really widen our knowledge of pressure ulcer prevention. WUK