

Care in the community: are we taking the easy option?



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While presenting at the Eliminating Avoidable Pressure Ulcer Conference in Bristol in October, I found myself saying something I had said many times before, but had the sudden realisation that I had just been making excuses. At the time, I was lecturing about pressure ulcer prevention in the community, watching the wry smiles from all the community staff as I talked about the difficulties of regular turning/repositioning in a patient's own home.

We all seem to have accepted the vagaries of maximum frequencies of visits by social care and the mainly limited care provided between 10pm and 8am. But how come? We would not accept this in a hospital, so why do we accept it in community? I know ... it's not the same, and the issue is undoubtedly much more complex, plus there are many other aspects to consider; nevertheless, pressure ulcer prevention is pressure ulcer prevention. If a patient in hospital at risk of pressure ulcers (using any scoring method) can expect a certain level of care, doesn't a patient in the community deserve the same? Please don't assume this is an attack on the quality of care in the community or the knowledge and skills of clinicians in the community — it is not — I simply want to ask some questions with regards to the systems and processes within which community care is embedded.

There is a huge focus on provision of care to patients in the community, demonstrated in campaigns such as *Care Closer to Home* (Department of Health (DH), 2008), *Prevention of Admission and Management of Long Term Conditions* (DH, 2013a). However, is this feasible and safe if we don't do the same things for these patients that we deem necessary in a hospital setting? How relevant or useful is a Surface, Keep moving, Incontinence, Nutrition (SKIN) Care Bundle if there is no one to follow its guidance, let alone fill it in? Can we ask a patient's relative to do this? Is it still a legal document? What if there isn't a family member or carer available? Who provides

that overnight turn for the patient? Do we even know how many patients in the community have pressure ulcers? There have been only a handful of prevalence studies that include community patients compared to the multitude in acute care, primarily because 'it's too difficult'. Does that mean we should not do it? I don't think so.

Many of you will have encountered patients with terrible pressure damage — previously frail and wheelchair-bound patients who may have only had contact with their GP perhaps, who may have not been aware of pressure ulcers developing. Why wouldn't we expect a GP to check for pressure ulcers? How can we reach these patients? Again it seems it is on the 'too difficult' list — but is this because we try to solve these problems individually rather than united?

Why is it that in the community if you want pressure ulcer prevention equipment 'now' (or even just today) additional charges are frequently incurred? Why, in some organisations, is equipment under the auspices of social care while in others it is under health? Shouldn't there be some joined-up working here (DH, 2013b)?

These big changes need strategic input, they need a larger driver, we need to start to raise them as a priority. We have new guidance both from National Institute for Health and Care Excellence (NICE, 2014) and the National Pressure Ulcer Advisory Panel (NPUAP, 2014). Let's start to use that as a lever. Why shouldn't patients get turned in the community? If a 2-hourly (for the sake of argument) visit is not appropriate — how else can we achieve this? Where are the manufacturers? What other mechanisms or devices can they provide at a reasonable cost to assist community healthcare professionals?

This needs some joined-up thinking and working, we need to move from 'too hard to do' to 'what a fantastic challenge'. Let's make some noise and see if we can help our community colleagues but, more importantly, all of those patients in community care.

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