DOI: 10.35279/jewma201905.03

Taking Care of an Individual's Needs at Home: Experiences of a Community Care Nursing Group

In Italy, home care is guaranteed in a variety of ways. This article reports community care experiences in Italy and documents how a group of professionals were able to adapt their roles as service providers to those of leaders, taking into account different patient needs.


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Conflicts of interest: None

ABSTRACT

In Italy, home care is guaranteed in a variety of ways. This article reports community care experiences in the foothills of Bergamo (Lombardy) and documents how a group of professionals were able to adapt their roles as service providers to those of leaders, taking into account different patient needs.

BACKGROUND

The reasons behind the constant increases in the use of health care services are found in four contexts that have changed the structure of care today (Fig. 1).

Ageing increases the demand for health care and social services, and numerous pathologies require the involvement of different professionals and a complex, articulated approach to care. Chronic diseases (at least one chronic disease is present in 38% of the population) are partly related to ageing, which obliges us to strengthen community care management for both their prevention and treatment that can be adapted to the demands of concomitant acute diseases and progressive disabilities. As 23 million people utilize 70% of the few family and NHS resources available , this contributes to the lack of self-sufficiency of fragile populations, further depleting the resources of the NHS, which in turn has suffered from the recent recession.

Within this scenario, we reviewed the governance of the production and supply of community care services, with the objective to transfer services to teams to guarantee fair access and treatment, in line with established care objectives. The territory in which this improvement process originated is shown in Figure 2, in the foothills of Bergamo.

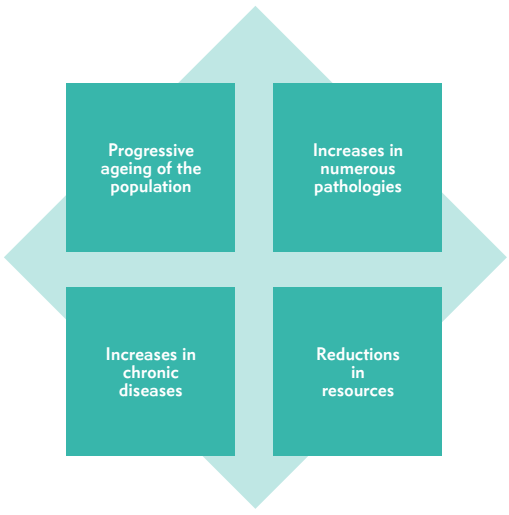


Figure 1. The four contexts of community care.

Figure 2. Regions of competency in Bergamo Santia.

In this context, it is increasingly necessary to underline the importance of a holistic approach that starts with "family medicine," where the activities of individual professionals are focused on the patient and his or her needs (Fig. 3). This approach harmonizes the community with the hospital and favours the integration of primary care with both intermediate and hospital care, especially in the context of low-intensity care.

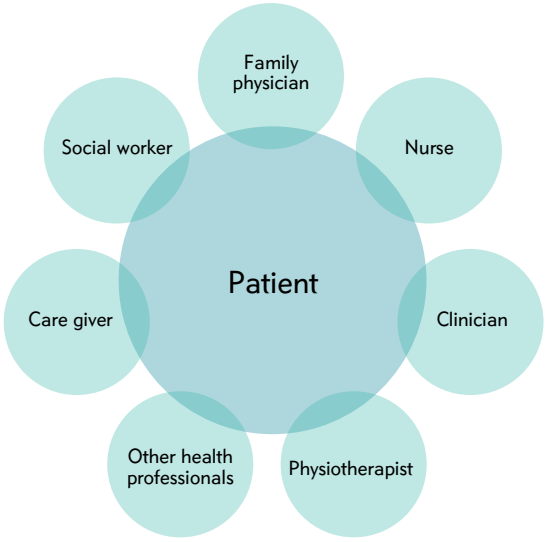


Figure 3. Family medicine practitioners.

OBJECTIVES

The primary objectives of this process were to identify the problem and possible solutions and to train operators to provide the best possible solution, considering the recommendations of specialists in the territory.

The rule contained in Law No. 189 of 2012 suggests the following important goals:

- Distribution of community care
- Care of fragile patients
- Performance guarantee in the presence of f inancial difficulties

We describe our community care experiences with particular attention to patients who have skin ulcers.

The lack of homogeneity of approaches linked to individual professionals has led to the need for training courses that take into account the best knowledge, practices, and evidence regarding wound management considering the recommendations from third-level treatment centres for the care of difficult wounds, diabetic foot care management, and treatment of dermatological diseases.

MATERIALS AND METHODS

The process was divided into three phases:

1. Knowledge phase

2. In-depth training phase

3. Management change phase

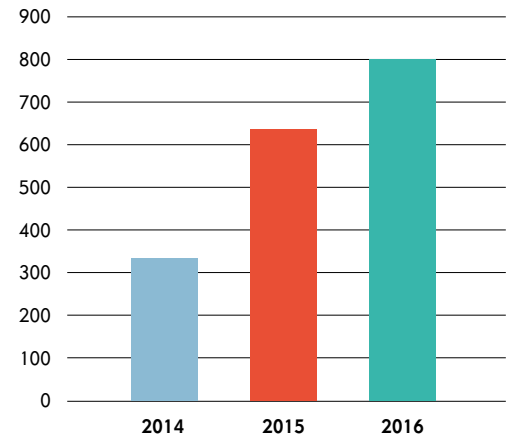
The first step, which involved the statistical analysis of the patients (Graph 1), nursing activities (Graph 2), and treatments for wounds (Graph 3) from 2014–2016, allowed an evaluation of the impact of the organizational and managerial structure of care on the treatment of patients with ulcers (Graphs 4–6).

This step led to an assessment of the most appropriate way to respond to the identified changes. The answer was to create an approach for the analysis of experiences obtained by individual nursing professionals, a direct comparison of the patients who were treated, and an in-depth study of the medical devices used. A training course was implemented to improve and consolidate knowledge about wound management issues, involving local providers. The course focused on diseases and complications for the generation and implementation of appropriate, shared treatment approaches. This process has also led to a review of the products in use and their more careful use.

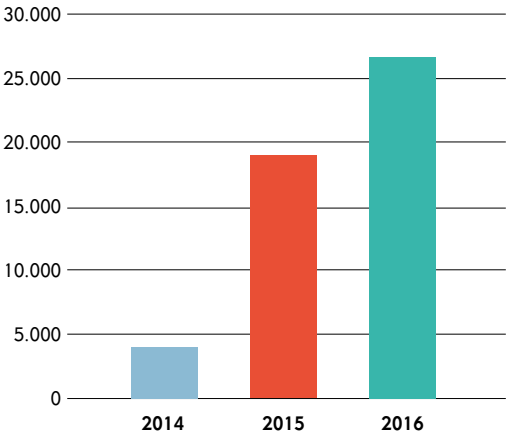
The last step involved the implementation of management changes, the drafting of a shared care protocol, and the execution of care approaches, considering that the health care and social needs are still in the implementation phase; thus, no results are available today.

RESULTS

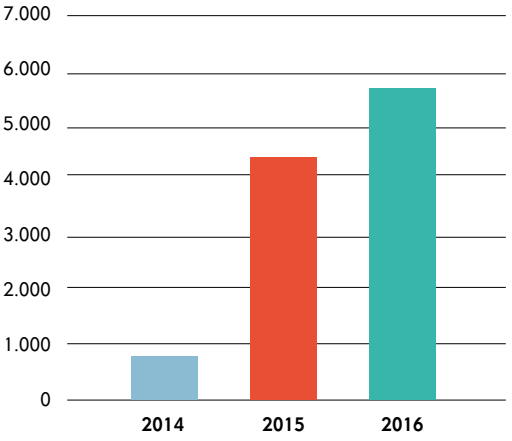
The data, including 6,000 initial services that grew from 2014 to 2017 to more than 90,000 in the last year, show how wound care has become an important part of provider workload, exceeding 21,000 services among the different types of wounds treated (Graphs 7 and 8). In this scenario, although the absolute numbers differed, the percentages of workload dedicated to the treatment of skin wounds has remained stable, that is, 20 ± 4.5%. This means, in terms of working time for the nurse who goes to the home, 51.2% of the time available to him to carry out all the activities entrusted to him. The costs incurred for treatment and the results achieved after implementation of the approach have grown but are consistent when compared to the treatment plan applied, thanks to the use of a shared protocol and the availability of professionals in advanced levels of care.



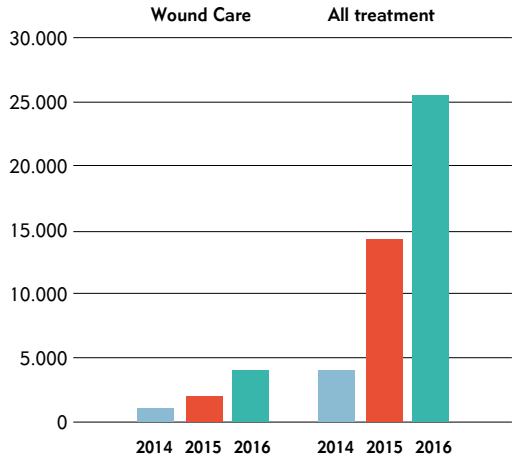
Graph 1. Number of patients treated in the 3-year period, 2014-2016.



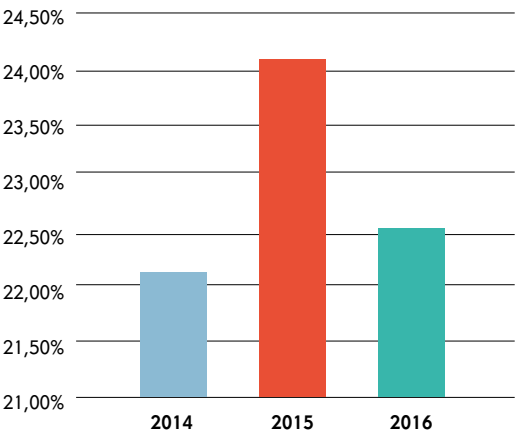
Graph 2. Number of nursing activities provided in the 3-year period.



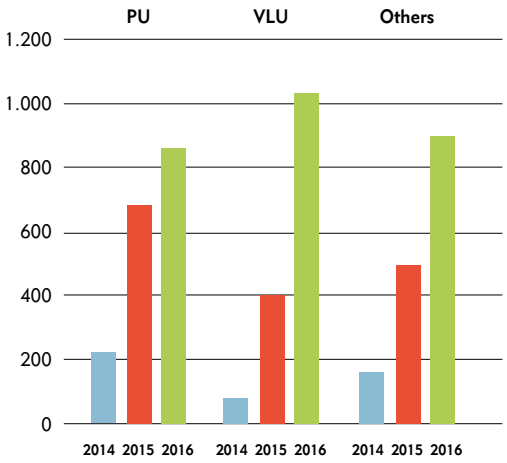
Graph 3. Number of treatments for wounds of different aetiologies.



Graph 4. Impact of wound care compared to all treatments provided.



Graph 5. Wound care services as a percentage of total activities.



Graph 6a. Types of ulcers prevalent in men.

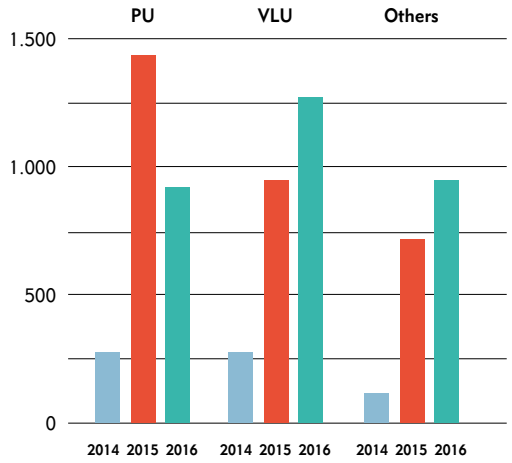
CONCLUSIONS

The approach used to implement care plans has made it possible to offer a therapeutic response in line with good clinical practice. The comparison between the professionals and the clinical results achieved have improved the availability of medical devices, which ensures a significant ▶

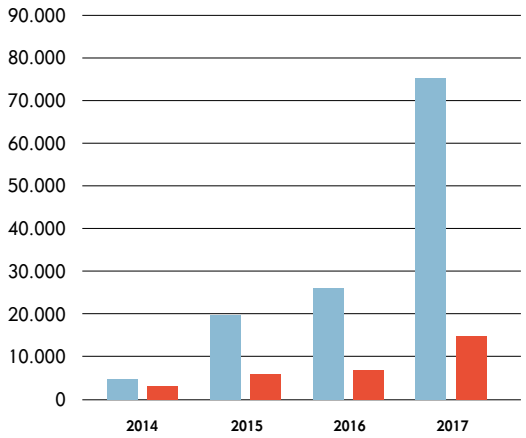
increase in both treatment times and satisfaction of users and professionals. The costs incurred for patient treatment have increased annually because of the complexity of available materials, even though they were partly borne by the providers. In fact, we found ourselves providing services at higher costs than what were reimbursed, allowing us to provide high quality care, which included patient comfort, in line with both quality standards recognised by the regional health system and best clinical practices. The effectiveness of the approaches undertaken remains unknown. The 2018 data are not yet available, particularly for changes linked to the shift in job function. Additionally, the clinical results demonstrated improved patient recovery related to the care objectives. ■

REFERENCES:

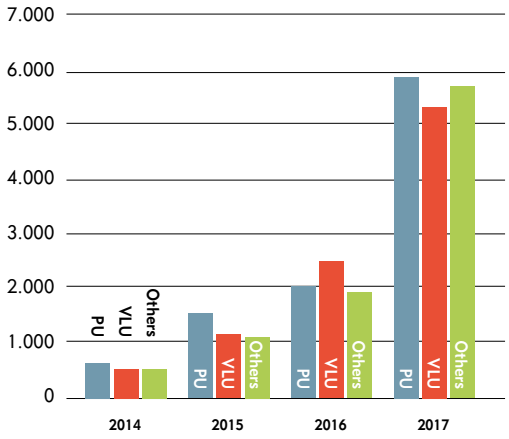
1. Bergamo Sanità s.c.s ONLUS: It consists of a multidisciplinary nursing team that deals with home care and provides social and health services on behalf of the NHS
2. Source Fondazione ISTUD, 2013



Graph 6b. Types of ulcers prevalent in women.



Graph 7. Treatments provided during the 4-year period, 2014-2017; total treatments/care activities (grey), treatment for ulcers (red) .



Graph 8. Types of ulcers and number of services provided during the 4-year period, 2014-2017.