Social care setting

Community care services for adults and children (alternatively known as home care services or domiciliary care services)

Overview of the setting

Platform 1 Being an accountable professional criteria can and should be demonstrated in all of the settings:

1.1 | 1.2 | 1.3 | 1.4 | 1.5 | 1.6 | 1.7 | 1.8 | 1.9 | 1.10 | 1.11 | 1.12 | 1.13 | 1.14 | 1.15 | 1.16 | 1.17 | 1.18 | 1.19 | 1.20

Community care services provide care and support to individuals of any age in their own homes. The people who use these services are likely to have health and social care needs that they can't meet themselves. These may include physical disability, mental ill health, dementia, sensory loss, learning disability, people recovering from illness, and palliative care/end of life care. The people you support may or may not have loved ones who provide informal care, and there's a need for additional support to assist them to remain living independently in their own home. Community care services provide care tailored to the needs of each situation and they work with the people they support and that person's family, carers, and other professionals to deliver this. The overarching goal is to enable people to remain in their homes as far as possible and to live enriched, fulfilled lives. Services are offered at all times of day and night and include:

- personal care
- medication assistance
- meal preparation
- companionship
- overnight care
- end of life care
- domestic assistance
- short term respite care
- rehabilitation support
- support with social interaction in the community.

As a learning environment we offer an introduction to compassionate, person-centred care and person-centred approaches to care and support that are holistic and rights-based. Community home care environments allow the student to consider what care and nursing requirements are needed to support individuals to remain within their own home and maintain their independence, and how this can link to being a nurse in a community setting. When working in the acute sector and discharging patients home it gives the student nurse a greater understanding of the requirements needed to safely ensure an effective hospital discharge to reduce re-admissions into hospital. It will encourage the student nurse to develop their critical thinking, problem solving through assessment and evaluation, and work with the people they support, helping them identify their outcomes. Nursing students will also achieve a greater understanding of how the domiciliary/community care services work with and alongside other professional teams such as GPs, district nursing services, occupational health, physiotherapy, pharmacists, and various specialist nursing teams.

Working with the people we support, their family members, adult social care providers, and community nurses we work as full partners in the care of the people we support through personalised care and support planning, to help them recover from or manage ill health, stay well, or support and maintain their independence.

As a community care provider, we work closely with the hospital discharge teams, continuing health teams, and adult care teams. It's vital that we have open and effective communication and information on discharge as this will assist in the seamless transition of the people we support from hospital back to their own home environment and avoid unnecessary re-admission.

We assist and care for people with complex needs such as multiple sclerosis, motor neurone disease, chronic obstructive pulmonary disease and various other respiratory issues, brain injury, stroke, cancer, dementia, cardiovascular disease, elderly needs, and frailty. We also support people with mental health needs, including people with depression and people who self-harm.

As a community care provider, we support individuals at home who are terminally ill and require end of life care and support. We provide sensitive care for people who are in the final weeks or months of life. Their wishes at this stage of their care are incredibly personal and we ensure those needs are respected and provided with dignity enabling their end of life decisions to be upheld during this difficult time. We work closely with the district nursing teams and palliative care services to ensure effective pain management throughout all stages of end of life care.

We support the family members in their understanding of these changes which may cause some distress and provide them with any supportive information they may require.

Hello, my name is… Albert

I live on my own following the sudden death of my wife. I'm very close to my daughter, grandchildren and great grandchildren. I've worked all my life, including as ground crew for the RA, as a delivery man and as a tanker driver for 30 years. I was always a very active man prior to having a stroke a few years ago which has left me with some right-sided weakness and balance problems leaving me at risk of falling.

Support that I receive includes assistance with my personal care needs and encouragement to participate in my care routine to maintain my independence. This includes cleaning and management of my gastrostomy tube site, monitoring of urine output, observation of my skin integrity, support in maintaining a healthy diet, mobility support, support with communication, management of my medication, and facilitation of social activities and a safe home environment. I have also received support in enabling me to make my own end of life decisions.

Clinical skills employed in this social care environment

- complex clinical care
- rehabilitation
- application of infection prevention and control
- risk assessments (environmental, moving and handling, medication)
- multi-disciplinary teams sharing information
- catheterisation
- percutaneous gastrostomy tube care
- stoma care
- use of SBAR communication tool to relay clinical information
- knock-on effects of poor discharge
- understanding frailty
- understanding falls risk
- monitoring of various conditions i.e. diabetes management using blood glucose meter
- effective discharge planning from hospital/sharing information, working with multi-disciplinary teams including home care agencies to reduce re-admissions
- ongoing monitoring using tools including MUST and the Waterlow score.

All the people supported by home care services have a holistic, person-centred needs assessment. Care planning and risk assessments are undertaken and regularly reviewed when the needs of the individual change.

All staff are trained and have experience in catheter care and gastrostomy tube feeding, and care and assist people using continuous positive airway pressure.

Staff are trained to relay all clinical information of any changes in the people they support to the relevant people, for example, urinary infections, changes in skin integrity, raised blood glucose, increased falls, or reduced appetites.

We work closely with specialist nurses, speech and language therapy teams, physiotherapists, and occupational therapists, and have extended training to safely ensure the people we support receive the appropriate care and know when to seek further assistance and advice.

As a community care provider, we work closely with the hospital discharge teams, continuing health teams, and adult care teams. It's vital that we have open and effective communication and information on discharge. This will assist in the seamless transition of the people we support from hospital back to their own home environment and avoid unnecessary re-admission.
Changes to medication or monitoring of their clinical needs can also be addressed.

Risk assessments and care plans will require updating as well as ensuring the correct equipment and aids are in situ if required.

Staff wear appropriate personal protective equipment and have rigorous infection control training.

People likely to be working during a normal shift

- care co-ordinators
- team leaders
- community support staff
- registered manager.

Many will be professionals who are not part of the regulated workforce.

Multi-disciplinary opportunities to work with registered nurses from different fields, allied health, and other professionals

Community nursing/district nurses

Community nursing/district nurses provide wound care management/tissue viability checks, continence management, diabetes care, and venepuncture.

GP services

GP services include GP home visits to assess various medical conditions and instruct on medication changes.

Social workers

Social workers provide care assessment and review of services.

Occupational therapists

Speech and language therapists carry out assessments and reviews of people they support who have swallowing difficulties following such conditions as a stroke, multiple sclerosis, brain injury, cancer, and motor neurone disease.

Physiotherapists

Physiotherapists provide physiotherapy assessments to improve mobility of people they support.

Specialist nurses

Specialist nurses support people with complex needs such as gastrostomy tube care, epilepsy management, diabetes management, stoma care, respiratory care and palliative care. Training is provided by specialist nurses for staff.

Pharmacists

Pharmacists liaise with home care services regarding medication issues and issuing various medication aids.

Community psychiatric nurses

Community psychiatric nurses work with the people we support who have mental health issues to effectively manage these patients in the community. Also, links with crisis teams.

What can be achieved here?

This setting can offer the opportunity to experience activity that links to the following NMC proficiencies, click on the proficiency to be taken to the full criteria:

Promoting health and preventing ill health

2.1 | 2.2 | 2.3 | 2.4 | 2.7 | 2.8 | 2.9 | 2.10 | 2.12

Assessing needs and planning care

3.3 | 3.4 | 3.6 | 3.7 | 3.8 | 3.9 | 3.10 | 3.11 | 3.12 | 3.13 | 3.14 | 3.15 | 3.16

Leading and managing nursing care and working in teams

4.1 | 4.2 | 4.3 | 4.4 | 4.5 | 4.6 | 4.7 | 4.8 | 4.9 | 4.10 | 4.11 | 4.13 | 4.15 | 4.16

Providing and evaluating care

5.1 | 5.2 | 5.4 | 5.6 | 5.7 | 5.8 | 5.9 | 5.10 | 5.11

Leading and managing nursing care and working in teams

6.1 | 6.2 | 6.3 | 6.5 | 6.6 | 6.8 | 6.9 | 6.10 | 6.11 | 6.12

Leading and managing nursing care and working in teams

7.1 | 7.2 | 7.3 | 7.4 | 7.5 | 7.6 | 7.7 | 7.8 | 7.9 | 7.10 | 7.11 | 7.12 | 7.13

Communication and relationship management skills

1.1 | 1.2 | 1.3 | 1.4 | 1.5 | 1.6 | 1.7 | 1.8 | 1.9 | 1.10 | 1.11 | 1.12 | 2.1 | 2.2 | 2.3 | 2.4 | 2.5 | 2.6
2.7 | 2.8 | 2.9 | 3.1 | 3.2 | 3.3 | 3.4 | 3.5 | 3.6 | 3.7 | 3.8 | 3.9 | 4.1.1 | 4.1.2 | 4.1.3 | 4.1.4 | 4.1.5 | 4.2.1
4.2.2 | 4.2.3 | 4.2.4 | 4.2.5 | 4.2.6

Nursing procedures

1.1.1 | 1.1.2 | 1.1.3 | 1.1.4 | 1.1.5 | 1.1.6 | 1.2.1 | 1.2.2 | 1.2.3 | 2.1 | 2.6 | 2.10 | 2.11 | 2.12 | 2.13 | 2.14 | 2.15 | 2.16
2.17 | 3.1 | 3.2 | 3.3 | 3.4 | 3.5 | 3.6 | 4.1 | 4.2 | 4.3 | 4.4 | 4.5 | 4.8 | 5.1 | 5.2 | 5.3 | 5.4 | 5.5
5.7 | 5.8 | 6.1 | 6.2 | 6.4 | 7.1 | 7.2 | 7.3 | 7.4 | 8.1 | 8.5 | 9.1 | 9.2 | 9.4 | 9.5 | 9.6 | 9.7 | 9.8
10.1 | 10.2 | 10.3 | 10.4 | 10.5 | 11.1 | 11.2 | 11.3 | 11.6 | 11.8 | 11.10 | 11.11