Nursing care in patients with dependency-related skin injuries in the community: a scoping review

Abstract

Purpose: Dependency-related skin injuries (DRSI) occur in people who need a high level of support to carry out day-to-day activities. Owing to the ageing population, the number of people at risk of DRSI is increasing. Most wound care is performed by nurses in the community. This scoping review aimed to identify the extent of literature on nursing care for patients with or at risk of developing DRSI living in their own home. **Materials and methods:** A scoping review was conducted. **Results:** A total of 28 studies met the inclusion criteria and four main themes emerged: features of the community setting; wound types, causes and management; prevention strategies around aetiology and holistic care; care management and local wound care. **Conclusion:** Although most wounds occur in and are treated in the community, there is a paucity of research on wounds in this setting. The care of patients with DRSI in the community is complex and prevention according to the individual aetiology of each lesion is the key factor in wound care.

■ Community nursing ■ dependency-related skin injuries ■ home nursing ■ moisture-associated skin damage ■ pressure ulcer ■ skin tear

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Dependence is a state in which people, because they lack or have lost physical, psychological or intellectual autonomy, require significant assistance or help in carrying out their usual day-to-day activities (Council of Europe, 1998). In Europe, there is a demographic trend towards an ageing population, which leads to a growing prevalence of long-term conditions and wounds. This results in increased reliance on care, which coincides with a reduction in hospital beds and rising healthcare costs. More cost-efficient ways of organising healthcare are being developed, including providing care for patients in their own homes (Probst et al, 2014).

The way in which people interact with the environment, because of their dependence, can lead to skin lesions. These lesions are often called pressure injuries (PI), because this is the main causal mechanism (Torra et al, 2017). However, a more comprehensive theoretical framework for classification was created in 2014, and injuries in this group of people are now classified as DRSI (García-Fernández et al, 2014) and include injuries from pressure, friction and a range of forces, moisture-associated skin damage and skin tears. This new designation and classification make it possible to understand the relationships between different causal elements (pressure, friction, shear stress and moisture) and facilitates identifying interventions for prevention and treatment.

These lesions appear in patients with some type of dependence, regardless of age, disease process or disease status. These people are unable to care for themselves and depend on a third person for this, such as a professional or family caregiver.

Although these lesions generally appear in patients who are immobile, incontinent or confined to bed, they can also be observed in children or those who are temporarily dependent while undergoing diagnostic or treatment procedures (García-Fernández et al, 2014).

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DRSI are a major worldwide public health problem in terms of: prevalence (Demarré et al, 2015); mortality (Nolasco et al, 2003; Takahashi et al, 2008); impact on patients and caregivers (Baharestani, 1994; García-Sánchez et al, 2019a); quality of life (Langemo, 2005); economic effects (Torra-Bou et al, 2017); ethical and legal aspects (Soldevilla Agreda and Navarro Rodríguez, 2006; Cuculic et al, 2015; Seyhan, 2018), and patient safety (Torra-Bou et al, 2016).

The latest prevalence study carried out by the Spanish Pressure Ulcer and Chronic Wounds Advisory Panel in 2017 found that in people receiving care at home from healthcare services, the prevalence of DRSI was 6.11%. By type of injuries, these were: PI: 4.79%; moisture: 1.39%; friction: 1.81%; combined injuries: 1.05%; and skin tears: 1.05%. Injuries occurred in the patient's home in 83.3% of cases; only 16.7% were of no socomial origin (García-Fernández et al, 2019b).

Although studies quantifying this are scarce, wounds constitute a major cost to health services in terms of practitioner time, length of hospital stay, costs of additional treatments and tests, and loss of productivity and legal costs; this varies in the literature and accounts approximately for 0.4%–5.2% of total health expenditure in some Western countries (Demarré et al, 2015; Torra-Bou et al, 2017).

Wound care in the home

An estimated 70–90% of wound care in Europe is conducted within the community and at least 50% of the workload of primary care nurses is spent on this (Probst et al, 2014).

Many dependent patients receive care at home because they are unable to attend primary care centres. The development of home-care programmes has been a consequence of the increase in life expectancy, changes to traditional family structures, fewer hospital stays and a shortage of nursing homes and social and health centres, together with the desire of older adults to continue living in the community (Gené Badia et al, 2011).

Home-based community care is influenced by how well primary care in each country is developed, and there are many differences in the models between countries. The same is true of the community nurse role (Torra-Bou, 2021).

Practitioners in all clinical settings who care for individuals with PI must be acutely aware of and sensitive to their impact and issues surrounding the patients' health-related quality of life (QoL). These effects are significant, ongoing and unique to each individual, and appropriate care is required. Education for practitioners so they can provide care that is individualised and customised to patients' needs and their QoL goals is mandatory (Langemo, 2005).

Review aim

This review is socially relevant given the progressive increase in life expectancy in the population, and thus in dependency, and meeting consequent needs is a priority for clinical practice (Gorecki et al, 2014). Additionally, this review is relevant to the nursing discipline as it is the nursing profession that is responsible for wound care (Pancorbo-Hidalgo, 2021).

Furthermore, as the European Wound Management Association (EWMA) (Probst et al, 2014) states, there is a paucity of research focusing on home wound care from a clinical perspective, as well as a lack of guidelines and recommendations on providing the best care to patients with wounds and their families in the home-care setting.

To consider the above issues, the review question was: 'What is known from the existing literature about the provision of nursing care to patients with or at risk of developing DRSI in the community setting?'

This scoping review aimed to identify the extent of the literature regarding nursing care of patients with or at risk of developing DRSI in the community.

Methods

The methodology for this scoping review was based on the framework outlined by Arksey and O'Malley (2005). This was selected as the purpose of the review was to identify knowledge gaps, scope a body of literature and clarify concepts rather than provide evidence to inform practice (Munn et al, 2018).

The review included the following five key phases: identifying the research question; identifying relevant studies; study selection; extracting and charting the data; and collating, summarising and reporting the results.

The optional consultation with professionals, patients and families was not conducted. No critical appraisal was carried out; while Arksey and O'Malley (2005) have stated that quality assessment does not form part of a scoping review, they acknowledge this is a limitation of the method.

The core concept examined in the scoping review was the care of patients with DRSI by community nurses, focusing on elements such as the need for care and interventions. The participants were adults (aged ≥18 years old); paediatric patients were excluded as dependency is more prevalent in adults.

Papers about wounds that addressed DRSI but did not focus on other types of lesions, such as diabetic foot ulcers or leg wounds, were included in the review.

For the purpose of this review, the authors defined care in the community setting as that provided by nurses to patients with DRSI living at home (cared for both at home and in primary health centres), as the pathway for patients is often dictated by their mobility and other circumstances that can change during an episode of care, and as the organisation of care is heterogeneous between countries.

Hospitals, residential care homes and other settings were excluded as people in those settings are not receiving care at home. Studies where the care was provided by professionals other than nurses were excluded. No geographic location limitation was set.

Search strategy

The search strategy aimed to find all types of studies published. A literature search was conducted using the following databases: PubMed, CINAHL, SCOPUS, World of Science, Google Scholar, Cuiden, Dialnet, SciELO and the Cochrane Library.

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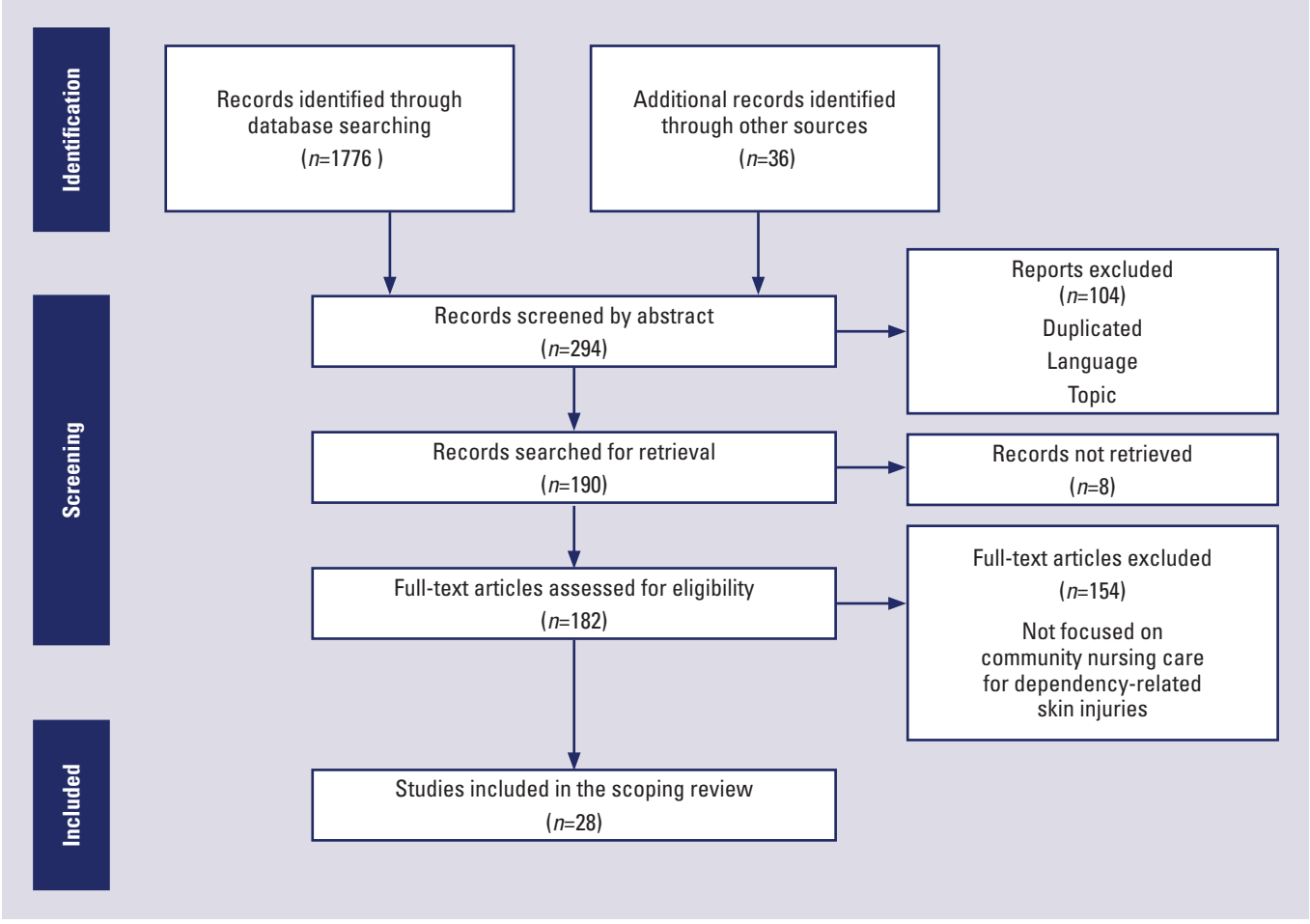


Figure 1: PRISMA flow diagram showing study selection (Page et al, 2021)

The following key words and MeSH terms were used: care, caring, prevention and control, wounds and injuries, risk, pressure ulcer, incontinence-associated dermatitis, moisture-associated skin damage, skin tear, skin ulcer, nursing, autonomous nursing practice, home health nursing, domiciliary care, domiciliary attention, community nursing, ambulatory care nursing, primary health care, community health nursing and primary care nursing. The search strategy was adapted for each included database.

Only articles published in English and Spanish within the past 10 years were considered because of the broad scope of the review question and to find literature that referred to the latest framework (García-Fernández et al, 2014) and changes in the demographic profile and aging of society (McGraw, 2019).

All papers retrieved were manually screened for title and relevance and were organised using a Microsoft Excel spreadsheet. They were manually screened by abstract, and those selected were imported into the Mendeley bibliography manager for full article retrieval and duplicate removal.

The authors developed a form to check relevance and extract study characteristics, such as publication year, publication type, title, authors, objectives, setting, participants, methods, intervention, variables and results. All sources were reviewed by at least two authors.

Results

The search period ran from January 2021 to September 2021. It ended when all the articles found in each database had been screened according to the strategy mentioned above.

After 1776 articles had been screened by title, 294 were selected for abstract screening. A total of 104 articles were excluded after checking for duplicates, languages different from English or Spanish, and for covering topics not addressing adult patients, DRSI or community care. The full texts of the remaining 190 sources were searched for retrieval, and eight were not found.

After screening the 182 retrieved articles, 154 were eliminated for one or more of the following reasons: they did not discuss DRSI or associated risk/did not include DRSI; they did not focus on the adult population; they did not discuss or involve nursing care; and the setting was not set in the community or did not include community settings. Ultimately, 28 articles were selected and included in the final analysis. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses diagram (*Figure 1*) (Page et al, 2021) summarises this process.

The articles included in the scoping review were categorised by year of publication, authors, context, wound type, topic, country of origin and research method (*Table 1*). All sources in

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the final analysis addressed the three elements of the research question: nursing care of patients with DRSI; nurses' care; and community.

Community nursing and wound care

Some reviewed articles covered the specifics of care provided to patients with wounds in the home, and why they differed from care provided in other settings.

In most cases in the community, a nurse is invited to a patient's home. If the patient refuses the care offered, this makes the situation difficult for the nurse, and such incidents can lead to compromised care and the nurse opting to offer some care rather than none (Lumbers, 2019). As guests, community nurses seek equal relationships with patients, and conversations with them about behavioural changes can be difficult (McGraw, 2019).

Although community nurses are invited to patients' homes, they should remain qualified professionals who lead all treatment discussions. Scheduling time to discuss any concerns can help improve patient compliance. Understanding and addressing pain, social isolation and other concerns can help improve mental health, which supports healing outcomes (Lumbers, 2019). The development of interpersonal relationships enhances therapeutic care and can directly affect the quality of care (Probst et al, 2014).

The review also highlights that wound care in primary care settings can be complex if patients have been discharged early from hospital and have comorbidities (Lumbers, 2019). In addition, GPs' lack of knowledge regarding wound care can inhibit good cooperation (Aune and Struksnes, 2019).

Furthermore, when nurses encountered hard-to-heal wounds, they reported that taking care of such patients was often physically and emotionally difficult. Problems with the availability of dressings in the home-care sector were also reported (Probst, 2014).

Home wound care professionals should have levels of education and competency that enable them to work independently in the following areas: assessing complex wounds and wound healing; implementing wound management based on best practice and evidence; selecting the best products available; supporting patient independence and involvement in decision-making; educating patients and informal caregivers in self-care and wound prevention; documenting wound healing, symptoms and management; ensuring continuity of care in all circumstances and conditions; using consultations and various applications of e-health; and engaging in continuing professional development to maintain knowledge and skills (Probst et al, 2014).

As community nurses often work alone, it is imperative they have access to support to guide clinical decision making, for example, through expert or specialist nurses, guidelines, protocols, wound care forums, care pathways and care plans (Lumbers, 2019).

Role of the wound care specialist

In this literature review, the topic of the role of wound care specialists commonly arose. Wound specialist positions between countries vary; for example, there are wound, ostomy and continence-certified nurses in the US, tissue viability nurses in the UK and advanced practice nurses (APN) in wound care in Spain. Some studies (Bliss et al, 2013; Westra et al, 2013; Jiménez García et al, 2020) showed that in settings where specialist nurses were involved, the incidence of wounds was lower. Specialist nurses usually manage the most complicated wounds and these have a high rate of healing and improvement. APNs also reduce costs for patients and systems as well as referrals to hospitals and play an important role in coordination.

In home care, wound-care specialists serve as consultants, using their expertise to establish a comprehensive plan of care for patients with wounds and collaborating with other team members. They organise joint visits to educate staff; give recommendations that are evidence based and in line with best practice in wound care; obtain and use products that are both high quality and cost-effective; and provide education to patients, families and new staff (Appleby, 2011).

Community patient

Some studies in the US, Canada and the UK cited by the EWMA document (Probst et al, 2014) show that 25–35% of individuals with wounds in the community are cared for in their own homes. Significant human and economic costs are generated through the heavy use of health services and provision of pressure-redistributing equipment (Jackson et al, 2017a).

One study found that patients with pressure ulcers and their caregivers preferred home over long-term institutional care for the treatment of these injuries (García-Sánchez et al, 2019b).

Home care involves some challenges because some patients attempt to dictate their care when they are at home, disagree with clinical decisions and refuse to accept the prescribed care. Discrepancies exist between hospital and community nursing. In an acute setting, if a patient refuses care, as long as they have the mental capacity to make a decision, they can sign the paperwork and discharge themselves (Lumbers, 2019).

Healthcare professionals need to include patients and their informal caregivers in their care by providing information and advising them on how to manage a wound at home, where to obtain dressings, how to choose a dressing and how to cope with wound-related symptoms (Probst et al, 2014). It is essential that nurses establish a trusting relationship, provide fully informed explanations of procedures and obtain patients' consent (Lumbers, 2019).

Patients must be repeatedly reassured that, while different nurses may perform the care, the plan of care is recorded in great detail in their notes and consistency is ensured (Lumbers, 2019).

A study on the shared decision-making process (García-Sánchez et al, 2019c) showed that the facilitators for home care of pressure ulcers included primary care professionals' attitudes (closeness, trust and being open-minded to the opinions of patients and family members) and personal motivation (positive feelings associated with the implications in decision-making). García-Sánchez et al (2019c) also identified barriers to the process as limitations related to participants' personal factors (advanced age, disabling pathology and low

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educational level); and the health system, such as the influence of a paternalistic model of care.

Wound types, causes and management

Pressure injury

García-Sánchez et al (2019b) found that patients considered PI to be unavoidable, often associated with age, severity of illness, treatments that they had received or a lack of knowledge on behalf of the primary caregivers.

A study involving nurses on the root causes of PI at home (McGraw, 2019) identified reasons related to:

- Patient characteristics such as physical, sensory and cognitive capacity, motivation and attitude, as well as health knowledge/ literacy
- Provider characteristics, such as deficits in health knowledge/ literacy, and weak caregiving skills attributed to limited education and training
- The nature of home healthcare tasks, such as barriers to nurses inspecting skin integrity (for example, pressure areas in intimate anatomical locations needed to be checked) and engaging patients in difficult conversations pertaining to behaviour change
- Physical environment: space in and layout of the home posed problems in providing pressure-reducing support devices
- The social and community environment, including functions of the domestic space, maintenance of order and cleanliness
- Medical devices and new technology: power outages and pressure-relieving equipment needing maintenance
- The external environment, including economic pressures, limits on the number and frequency of home-care visits and payments for medical devices.

Skin tears

The prevalence of skin tears in older adults living at home and/or receiving home care is unknown and may be much higher than it is in residential settings (Holmes et al, 2013). The implementation of prevention protocols and training is fundamental to the management of skin tears in the community (Vanzi and Toma, 2017), especially in the care of older adults, infants or dependent persons (Stephen-Haynes and Carville, 2011).

A number of risk factors have been reported (Stephen-Haynes and Carville, 2011): older age; sex (women are at greater risk); history of previous skin tears; dry and fragile skin; medications that thin the skin, such as steroids; ecchymoses; impaired mobility or vision; poor nutrition and hydration; cognitive or sensory impairment; comorbidities that compromise vascularity and skin status, including chronic heart disease, renal failure and cerebral vascular accident; and dependence on others for showering, dressing or transferring.

Interventions for skin-tear prevention found in the literature (Vanzi and Toma, 2017; Brennan-Cook and Turner, 2019) include: creating a safe environment by ensuring adequate lighting and removing potential sources of injury (such as unnecessary equipment); handling patients gently to decrease shear, friction, trauma or any forceful movement or pull that can cause tearing; following bathing guidelines to promote skin integrity and hydration; assessing nutritional status and seeking dietetic advice to ensure adequate nutrition and hydration, which affect tissue viability and decrease the risk of falls; and dressing patients properly to provide an additional protective barrier to blunt trauma.

Moisture-associated skin damage

Practitioners should recognise the differences between incontinence-associated dermatitis skin tears and PI. If an area of wetness is associated with incontinence, the home-care professional should shift the focus of teaching to good continence care (Brennan-Cook and Turner, 2019).

As the cause of moisture-associated skin damage is overexposure of the skin to moisture, the main preventive measure is avoiding excessive contact of the skin with moisture (Voegli, 2013).

Prevention and treatment require regular assessment and a skincare regimen that protects the skin from excessive wetness, controlling the source of excessive moisture and treating secondary infections (Voegli, 2013).

Holistic care

The EWMA document (Probst et al, 2014) states that the cornerstone of managing patients with wounds in the community is holistic assessment. This encompasses the patient's physical, psychological, social, spiritual and economic needs; their personal resources and empowerment; the living context of the patient and family; living habits and possible risks of the wound not healing or ulcer recurrence; signs and symptoms in and around the wound; efficient use of resources: practitioner knowledge and skills; wound-care products and technology; and the patient's personal and family environment.

Prevention

All personal and professional caregivers should be well-versed in prevention and basic management strategies, and teach patients about them (Vanzi and Toma, 2017).

A study on older people's skincare provides recommendations for practice. Practitioners should properly assess all skin surfaces, not just what is readily visible (Brennan-Cook and Turner, 2019). Home-care professionals should also ask about dryness, rashes, itching, redness or swelling and recommend skincare products. Health conditions common in older adults, such as diabetes and malnutrition, which can aggravate dry skin should also be assessed. Practitioners should recommend healthy bathing habits and measures for preventing xerosis. The importance of using sun protection in all sun-exposed areas should be emphasised. Long sleeves, elbow pads and leg coverings serve as additional barriers to protect thin, fragile skin. Teaching the patient and caregiver best practices for positioning, turning and shifting body weight can prevent unnecessary stress and injuries (Brennan-Cook and Turner, 2019).

Nutrition

Some of the articles included in this review emphasised the importance of adequate nutrition (Sancho, 2012; Mahoney, 2014; Probst et al, 2014). This is essential to support wound healing; poor nutrition can affect the healing potential of a wound as energy and

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proteins are needed to fuel new tissue growth (Mahoney, 2014).

In residential care and acute settings, monitoring and assessing patients with wounds or at risk of developing a wound are readily achievable. However, in the home setting, where health professionals may visit only once a week, the assessment of nutritional status is more problematic (Probst et al, 2014).

Sancho et al (2012) have recommended personalised nutritional interventions for home-care patients, especially those with a greater degree of physical dependence or cognitive impairment, to improve their quality of life and reduce the possibility of pressure ulcers and therefore, the risk of being hospitalised or institutionalised.

While nurses may be the first people to assess the nutritional status of a patient, it is important to refer those at risk of poor wound healing because of nutritional deficiencies to a dietitian for a more comprehensive assessment and development of a nutrition plan (Probst et al, 2014).

Quality of life

The impact of wounds on individuals living in their own home is significant. Consistent themes of isolation, ability to maintain a restricted home role, pain and discomfort have been reported in research on patients with wounds (Probst et al, 2014).

Gorecki et al's (2013) research deepened the understanding of health-related QoL related to pressure ulcers. A patient-reported outcome tool, the pressure ulcer quality of life (PU-QOL) instrument, was developed to measure QoL based on the following components: symptoms: pain and discomfort (pain frequency, severity and bother), exudate (bother), and odour (bother); physical functioning: mobility (movement, sitting, walking and transferring), daily activities (washing, dressing, housework, general activities and dependence), general malaise (loss of appetite, fatigue, feeling unwell and tired) and sleep (disturbed); psychological wellbeing: mood (feeling down, depressed, irritated and frustrated), anxiety and worry (feeling fear, concern, surprise/shock and helpless), self-efficacy and dependence (confidence, self-esteem and reliance), and appearance and self-consciousness (physical appearance and embarrassment); and social functioning: social isolation (feeling left out, cut off or lonely) and participation (social activities with family, friends, groups and hobbies/leisure).

The PU-QOL can be used for intervention research where improvement and/or deterioration in health-related QoL are measured, promoting patient-physician communication, informing changes in treatment, facilitating priority setting and care management decisions in patients and PI care, and evaluating the care provided from the patient's perspective (Gorecki et al, 2013).

Pain

Pain has consistently emerged as the main concern regarding the impact of DRSI on patients. It is the main symptom for the detection, treatment and control of PI (García-Sánchez et al, 2019d). Pain can be a useful clinical predictor of pressure damage, particularly during the early stages of pressure ulcer development (McGinnis et al, 2014).

In the first study that reported the prevalence of pain associated with PI in a UK community population, this was found to be 75.6%, and all patients reported pain at a PI site. Both inflammatory and neuropathic pain were identified but neuropathic pain was dominant (McGinnis et al, 2014).

Pain occurs in particular during dressing changes or other types of wound care. PI pain can be debilitating, reducing an individual's ability to participate in physical and social activities, and consequently compromising psychological wellbeing (Gorecki et al, 2011).

Jackson et al (2017b) have suggested that both the assessment and subsequent management of pain are not well managed in this patient group.

To achieve the best possible outcomes important to patients and ensure more effective pressure ulcer pain management, improved communication about pain between the patient and practitioners across disciplines, pain assessment by health professionals, interventions to control or reduce pressure ulcer pain, taking patient-centred concerns into account and systemic barriers need to be considered when managing pressure ulcers (Gorecki et al, 2011).

Care management

Communication

Communication among health professionals is a key factor in promoting best practices in wound care (Probst et al, 2014), especially during discharge or transition processes, which can be a time of heightened vulnerability that is exacerbated by poor communication and changes to prescribed care (Jackson et al, 2017a).

A study from the perspective of patient safety (González et al, 2017) analysed the PI in the home setting and found some problems related to communication issues, including the patient at risk not being referred to home-care services after discharge from hospital. It also identified problems in communication between professionals, including the referring nurse not being clearly identified and unwritten communication being used for referral between practitioners (González et al, 2017).

Novy and Woith (2020) analysed the impact of standardised electronic communication during transitions from acute settings to the community and found that using such a system to improve communication can aid in ensuring that accurate information is immediately available to nurses in the home-care setting. The transition is also facilitated by APNs and the use of instruments, such as scales, to measure healing.

Another issue is communication between patients and nurses. Reliance on community services makes it more difficult for patients to make unplanned calls to their nursing team. Doing this is not always straightforward, and patients are often left to deal with a third party (Jackson et al, 2017a).

Continuity of care

A particular problem experienced by people living with PI in the community is the continuity of care between services and between care workers and health professionals (Jackson et al, 2017a).

A study on nursing quality indicators related to processes showed that continuity (episodes in which at least 50% of the consultations were provided by the same professional) and nursing follow-ups (care episodes in which at least 75% of the consultations

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Table 1. Summary of results included in the scoping review

Authors (year)	Context	Wound type	Topic	Country	Methods
Appleby (2011)	Home care	All types	Wound specialist	US	Case report
Gorecki et al (2011)	Any setting	Pressure injuries	Pain	UK	Mixed methods
Stephen-Haynes and Carville (2011)	Any setting	Skin tears	Overview	UK	Review
Sancho et al (2012)	Home care	Pressure injuries	Nutrition	Spain	Quantitative
Bliss et al (2013)	Home care	All types	Wound specialist	US	Quantitative
Gorecki et al (2013)	Acute and community	Pressure injuries	Quality of life patient-reported outcome measure	UK	Mixed methods
Holmes et al (2013)	Community	Skin tears	Care and management	US	Case study
Voegeli (2013)	Community	Moisture-associated skin damage	Overview	UK	Review
Westra et al (2013)	Home	All types	Wound specialist	US	Quantitative
Dale and Emmons (2014)	Home care	Pressure injuries	Palliative wound care	US	Case study
Mahoney (2014)	Community	All types	Fundamentals of evidence-based wound care	UK	Review paper
McGinnis et al (2014)	Community	Pressure injuries	Prevalence of pain	UK	Quantitative
Probst et al (2014)	Community	All wound types	Home care—wound care overview	Europe	Review
González et al (2017)	Home care	Pressure injuries	Patient safety	Spain	Quantitative

were with a registered nurse) were associated with improved outcomes. These indicators are directly related to the way care is organised and can guide management in improving both nursing service performance and patient outcomes (Dufour et al, 2020).

Mahoney (2014) summarises wound care in the community provided by nurses, which includes assessing the type and size of the wound, its location, the types of tissue involved and wound symptoms (such as pain, swelling and odour) and the wound edges, as well as basic skin assessment.

In cases of doubt or if the community nurse is unsure about the aetiology of the wound, referral to a specialist is advised. The nurse should assess factors that can affect healing: those that are internal to the patient, for example comorbidities such as diabetes, ischaemia, neuropathy, rheumatoid disease and other systemic problems; and those that are external, such as unrelieved pressure on the patient's heel and being able to identify the impact of ageing and poor nutrition (Mahoney, 2014).

Basic steps in wound care include debridement, dressing choice, application and removal (requiring pain and exudate management), wound cleansing, lavage and wound infection management (Mahoney, 2014).

Asepsis

One concern raised in this review was asepsis in community setting (Palmer, 2019). In community settings, wound care generally requires clean rather than aseptic techniques.

The use of alcohol gel is essential, and handwashing is necessary for visibly soiled hands that have been in contact with body fluids. Health professionals' hands are a main factor in bacterial contamination. If hands are kept as clean as possible, the chance of bacterial transmission is low. In addition, personal protective equipment should be used.

Skin tears management

For skin tears management, some issues must be considered in addition to the basic care discussed above.

All articles in this review related to skin tears (Bianchi, 2012; Vanzi and Toma, 2017; Brennan-Cook and Turner, 2019) provided instructions for their management. These included classification using a recognised tool, such as the Skin Tear Audit Research system, control of bleeding, cleansing the skin tears to remove any residual haematoma, approximating the skin flap by gently easing it back into place using a dampened cotton bud or gloved finger and encouraging moist wound healing by applying a dressing. The

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Table 1. Summary of results included in the scoping review (cont.)

Jackson et al (2017a)	Community patients	Pressure injuries	Pressure-redistributing devices Health service provision	UK	Mixed methods
Jackson et al (2017b)	Community care	Pressure injuries	Pain	UK	Mixed methods
Vanzi and Toma (2017)	Home	Skin tears	Prevention and management	Italy	Review
Aune and Struksnes (2019)	Home care	All types	Hard-to-heal wounds	Norway	Qualitative
Bianchi (2019)	Any setting	Skin tears	Preventing, assessing and managing	UK	Review
Brennan-Cook, Turner (2019)	Home care	All types	Prevention	US	Review paper
García-Sánchez et al (2019b)	Home care	Pressure injuries	Carer and patient perspectives	Spain	Qualitative
García-Sánchez et al (2019c)	Home care	Pressure injuries	Carer and patient perspectives, plus shared-decision making	Spain	Qualitative
Novy and Woith (2020)	Community	Pressure injuries	Transition from acute care to the community	US	Quantitative
McGraw (2019)	Community	Pressure injuries	Causes of injuries	UK	Qualitative
Palmer (2019)	Community	All types	Asepsis	UK	Review paper
Dufour et al (2020)	Primary health care	All types	Nursing quality indicator validation	Canada	Quantitative
Jímenez García et al (2020)	Community	All type	Advanced practice nurses	Spain	Quantitative

use of adhesive strips was recommended. If possible, the dressing should be left in place for several days to avoid disturbing the flap; if an opaque dressing is used, the practitioner should mark an arrow to indicate the preferred direction of removal and record this in the notes. Dressings should be held in place with stocking-like products (for example a tubular bandage), and a pain assessment should be carried out.

If a skin tear is extensive or associated with a full-thickness injury, significant bleeding or haematoma formation, a surgical review may be required. If the injury is on the lower leg, practitioners should refer to local leg ulcer guidelines.

Moisture-associated skin injuries

Regardless of the cause of excessive moisture, interventions should involve the adoption of a structured skincare regimen to cleanse and protect the skin, methods to keep the skin dry by wicking away excessive moisture, controlling the source of the excessive moisture and treating any secondary infections (Voegli, 2013).

Palliative wound care

One approach that emerged from the review (Dale and Emmons, 2014) was a palliative wound-care protocol. Palliative wound care is generally understood to be that provided without the goal of complete wound healing. It is not exclusive to end-of-life care; the principles of palliative care can be applied across the lifespan with a focus on symptom management and without excluding the possibility of healing as the endpoint.

People with wounds often have those that do not heal or are burdened with numerous symptoms that affect their QoL. In these cases, the home-care nurse must understand the concepts of palliative wound care to alleviate symptoms with the goal of improving QoL. To determine goals and appropriate interventions to achieve them, the first questions to ask are: what bothers you most about the injury? What symptom or symptoms have the greatest effect on your daily well-being?

Implications for practice and research

It is not the goal of a scoping review to provide evidence-based recommendations for practice; however, some ideas may be useful to bear in mind when caring for patients with DRSI in the community. Community care in the home has some features that distinguish it from other contexts, such as hospitals or residential care. As care takes place in the patient's environment,

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Key points

- Aetiological factors of dependency-related skin injury (DRSI) include pressure, friction, shear and moisture. Dependency is on the rise as life expectancy has increased, so more people are risk for DRSI
- Care of patients with DRSI in the community is complex and multifaceted, and understanding its key components can improve healthcare outcomes
- Quality of life should be prioritised when dealing with dependency-related skin lesions, and this can involve taking a palliative approach
- Some elements of healthcare system organisation can be improved when it comes to DRSI, such as communication and the discharge process.

CPD reflective questions

- What healthcare organisational factors could be improved in the care of patients with wounds?
- Why is caring for patients in their homes considered complex?
- What is the most important factor to consider when caring for dependent patients in terms of wounds?

an individualised approach is necessary to obtain good results.

Prevention and a holistic approach are recommended, with a special focus on QoL and assessing and treating pain.
Wound specialists, if available, should be contacted in case of doubt regarding community nursing when wounds are not healing or proving hard to heal. Aspects of care management aspects that affect patient outcomes, such as maintaining continuity of care and ensuring effective communication, should be considered.

Because research in this field is scarce, the authors do not recommend carrying out a systematic review on the same topic; primary research in this area may be more appropriate.

A gap in knowledge was identified from the results of the scoping review. Separate areas covered by the different studies; however, an examination of the phenomenon as a whole, using a biopsychosocial and spiritual model, is lacking. A situation-specific theory could be useful in guiding the care of these patients in the community.

Limitations

This review included articles published in any language but the search was conducted using only English and Spanish terms; therefore, some relevant studies might have been excluded.
A literature search was carried out for each type of wound category. This limited the uniformity of the criteria.

Conclusion

The following aspects of nursing care stood out from the analysis of the results.

The setting in which community nursing occurs determines its complexity. Patients with wounds are usually treated at home. They prefer being at home to being treated in long-term care institutions. Home care presents some difficulties owing to the more symmetrical relationship in this setting, where agreement on the patient's plan of care can require more effort and time than in an acute unit. In this context, good professional attitudes and skills are essential. Nurses are usually invited to a patient's home, and attempts made to form a relationship of equals.

Care can be complex owing to the early discharge of patients, GPs' lack of knowledge in relation to wound care and the fact that community nurses often work alone and are confronted with hard-to-heal wounds that are physically and emotionally difficult to manage. This makes it important to use a wound specialist who has been proven to be effective in managing these patients.

Prevention remains the most important intervention in the field of wound care. A holistic approach to the patient is necessary, which includes: performing a complete assessment of all areas of the skin; addressing all comorbidities and nutritional status; and providing health education to the patient and caregiver on sun protection, protection of areas at risk of skin tears, postural changes, avoidance of friction and moisture, and pressure relief. Additionally, this involves creating a safe environment to reduce the risk of falls.

Holistic care is the cornerstone of the approach for patients with wounds in the community; a comprehensive assessment, including the physical, physiological, social, spiritual and economic aspects should be performed. The literature has highlighted the importance of nutrition and at-risk patients should be referred to a dietitian.

Wounds greatly reduce patients' QoL. Physical, social and psychological function are affected by symptoms such as pain, oozing and odours. Therefore, the use of scales to measure impairment is recommended.

Pain emerges as the issue that most impacts patients with DRSI. This is the main symptom and it must be detected and treated.

Regarding care management, the literature review shows that communication between health professionals is key to promoting best practice in the care of patients with wounds. Communication issues include problems with the recruitment of at-risk patients at hospital discharge and the use of unwritten communication for referrals between professionals. Transitions can be standardised through the involvement of APNs/wound specialists and the use of instruments, such as scales, to measure healing. Nurse-patient communication issues include that patients need to be able to make unplanned communications with nurses. Another major care management challenge is continuity of care. In addition, when patients are cared for by the same professionals, especially nurses, their outcomes are better.

Regarding local wound care, the basic concepts are as follows: correct assessment of the wound and patient in general to reach a correct aetiologic diagnosis and referral to a specialist in case of doubts. An aetiological approach should be taken by eliminating the cause, pressure relief, moisture and friction management, a proper approach to skin tears, flap management and the use of appropriate dressings. The basic steps of local

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healing include debridement, dressing choice, cleansing, lavage and infection management.

Maintenance of asepsis is important in the community, and a clean rather than a sterile approach is taken. The use of alcohol gels and handwashing are essential.

Finally, a palliative approach to the care of patients with wounds must be considered. This is not exclusive to those at the end of life but consists of symptom management, without excluding the possibility of an eventual cure. **CWC**

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Promote independence and activity in older people

Julie I Swann

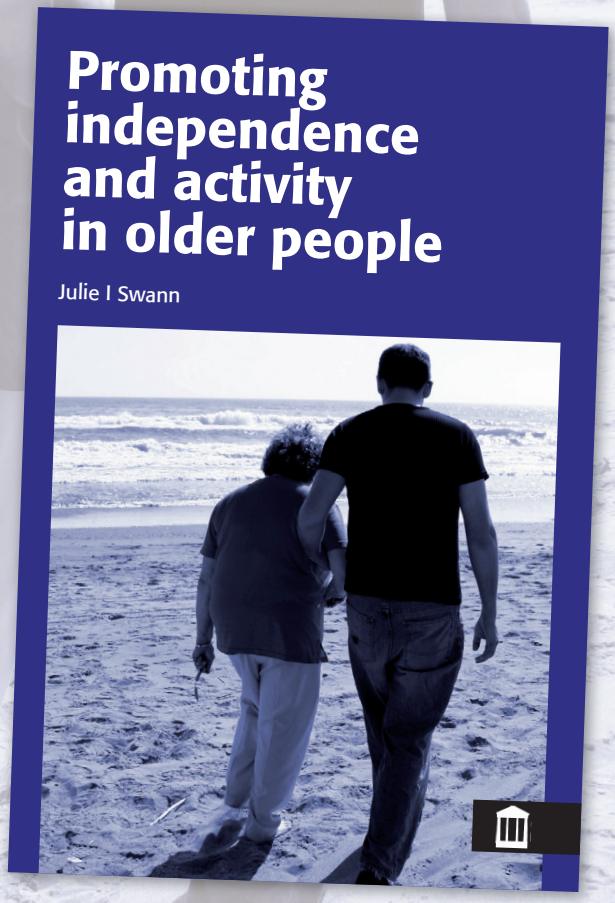
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