

NURSING CARE PRACTICES IN PRIMARY HEALTH CARE: ELDERLY PEOPLE'S SKIN CARE MANAGEMENT*

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ABSTRACT

Objective: to identify care practices used by nurses who work at the Family Health Strategy program to prevent and treat friction and pressure injuries in elderly people living in the community and perform the corresponding nursing diagnosis.

Methods: qualitative and descriptive study carried out with 25 Family Health Strategy nurses, linked to the Municipal Health Secretariat of São José, Santa Catarina, Brazil. A semi-structured questionnaire was applied between March and May 2018 to collect data, which were submitted to thematic content analysis.

Results: four different categories related to nursing practices for elderly people's skin care emerged: tools for clinical evaluation of elderly people's skin; evaluation of risk of injuries in elderly people; injury staging; and treatment of the injuries in elderly people.

Conclusion: the need for higher institutional investment in continuing education actions oriented toward nursing professionals was observed, so good care practices can be implemented in preventing, staging, and handling the injuries under discussion.

DESCRIPTORS: Community Health Nursing; Geriatric Nursing; Nursing Care; Skin; Wounds and Injuries.


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PRÁTICAS DE CUIDADOS DO ENFERMEIRO NA ATENÇÃO PRIMÁRIA À SAÚDE: GESTÃO DO CUIDADO DA PELE DO IDOSO

RESUMO

Objetivo: identificar práticas de cuidado empregadas pelos Enfermeiros da Estratégia Saúde da Família para prevenção, diagnóstico de enfermagem e tratamento de lesão por fricção e lesão por pressão em idosos na comunidade.

Método: estudo qualitativo descritivo com 25 enfermeiros da Estratégia Saúde da Família, lotados no âmbito da Secretaria Municipal de São José/Santa Catarina. Para coleta de dados, aplicou-se questionário semiestruturado entre março e maio de 2018. Os dados foram submetidos à Análise Temática de Conteúdo.

Resultados: emergiram quatro categorias distintas relacionadas às práticas do enfermeiro para cuidado da pele do idoso: Ferramentas para avaliação clínica da pele do idoso; Avaliação do risco para as lesões em idosos; Estadiamento das lesões; e Tratamento das lesões em idosos.

Conclusão: observou-se a necessidade de maior investimento institucional em ações de educação permanente aos profissionais de Enfermagem, para que sejam efetivadas boas práticas de cuidado na prevenção, estadiamento e manejo das lesões estudadas.

DESCRITORES: Enfermagem em Saúde Comunitária; Enfermagem Geriátrica; Cuidados de Enfermagem; Pele; Ferimentos e Lesões.

PRÁCTICAS DE ENFERMERÍA EN ATENCIÓN PRIMARIA DE SALUD: GESTIÓN DEL CUIDADO DÉRMICO DEL ANCIANO

RESUMEN

Objetivo: Identificar prácticas de atención utilizados por enfermeros de Estrategia Salud de la Familia en prevención, diagnóstico de enfermería y tratamiento de lesión por fricción y por presión en ancianos.

Método: Estudio cualitativo, descriptivo, con 25 enfermeros de Estrategia Salud de la Familia, actuantes en el ámbito de la Secretaría Municipal de São José/Santa Catarina. Datos recolectados mediante cuestionario semiestructurado, entre marzo y mayo de 2018, posteriormente sometidos a análisis temático de contenido.

Resultados: Surgieron cuatro categorías en relación a las prácticas del enfermero para cuidar la piel del anciano: Herramientas de evaluación clínica de la piel del anciano; Evaluación del riesgo de lesiones en ancianos; Estadificación de las lesiones; y Tratamiento de las lesiones en ancianos.

Conclusión: Se observó necesidad de mayor inversión institucional en capacitación continuada a profesionales de enfermería, para que sean aplicadas las buenas prácticas de atención en prevención, estadificación y manejo de las lesiones estudiadas.

DESCRIPTORES: Enfermería en Salud Comunitaria; Enfermería Geriátrica; Atención de Enfermería; Piel; Heridas y Traumatismos.

INTRODUCTION

The increase in the elderly population is considered a worldwide event. Consequently, health services must be ready to meet the specificities of the demands inherent in this age group. Skin alterations such as skin dryness, peeling, thinning, and elasticity reduction are common in this population and considered intrinsic to the aging process. Together with these conditions, and under the influence of external factors, such as pressure, friction, and shear, this population has higher chances of developing skin injuries, including friction injuries (FI) and pressure injuries (PI)⁽¹⁻²⁾.

Friction injuries occur when there is skin tear resulting from trauma (friction, bruising, or shear) capable of causing a separation of the tissue constitutive elements (epidermis, dermis, or both). Pressure injuries involve superficial or deep tissue damage, caused by intense or prolonged pressure and/or shear, which in most cases happens in areas of bony prominences, whether they are medical or not^(1,3).

In this context, it is considered that nursing care practices must be based on the thorough evaluation of elderly people's skin to make it possible to carry out nursing diagnosis by performing a physical exam and then interventions capable of treating or preventing complications inherent in the alteration or loss of skin integrity in people of this age group⁽⁴⁻⁵⁾.

It is important to emphasize that, in the primary health care performed by applying the Family Health Strategy (FHS), nursing work is centered in a participatory approach and grounded on care comprehensiveness, which allows multiple possibilities to cope with the complications experienced by the elderly population, including skin-related ones. Consequently, given the care complexity, primary health care is an essential scenario for nurses to ground preventive practices, given that their insertion in the community makes them able to better recognize the health demands of this age group, which allows these professionals to identify and schedule actions oriented toward keeping elderly people's skin integrity⁽⁶⁻⁷⁾.

The objective of the present study was to identify care practices used by FHS nurses to prevent and treat FI and PI in elderly people living in the community and perform the corresponding nursing diagnosis.

METHOD

A qualitative and descriptive study was carried out with FHS nurses in the municipality of São José, Santa Catarina, Brazil, which has 23 Basic Health Units and 44 FHS teams in its care network. Its estimated population is 242,927 people, of whom 19,843 are 60 years old or older⁽⁸⁾.

Nurses who worked at the FHS program allocated in the sphere of the institution previously mentioned, whose population was 44 professionals according to the Department of Informatics of the Brazilian Unified Health System (DATASUS)⁽⁹⁾, were invited to make up the sample. The inclusion criteria were being a public servant, whether tenured or hired, working in the municipality for more than three months, and being a member of a FHS team. The professionals who were on vacation, maternity leave, or bonus leave, or were undergoing a health treatment, or were going through any other kind of leave were excluded.

The participants were invited during a nursing committee, during which the study purposes were explained. Afterwards, individual contact was carried out to schedule the interviews. There were 25 nurses fit to make up the sample according to the inclusion criteria,

to whom a semi-structured questionnaire was applied and with whom data were collected from March to May 2018, until the researchers noticed that information saturation had been reached⁽¹⁰⁾. Data collection was carried out at Basic Health Units and/or the Municipal Health Secretariat, with the interviews lasting 25 minutes on average.

Data obtained during the interviews were transcribed by using the Google Forms® platform, which allowed the researchers to submit the gathered information to descriptive analysis. Data were also submitted to thematic content analysis⁽¹¹⁾.

The study proposal was approved by the Human Research Ethics Committee at the Federal University of Santa Catarina as per consolidated report no. 2,697,902.

RESULTS

The sample of the present study was 25 nurses, of whom 22 (88%) were women. The participants' age ranged from 26 to 56 years, with length of time working in primary health care between less than six months and 16 years. Eleven professionals (44%) had been working at the place for one to five years. Regarding level of education, 13 (52%) had a lato sensu graduate course, 11 (44%) had complete higher education, and one had a master's degree.

Four categories emerged from the results: tools for clinical evaluation; evaluation of risk of developing FI and PI; instruments for nursing diagnosis; and treatment, as the following items show in further detail.

Category 1 – Tools for the clinical evaluation of elderly people's skin: nursing practices in primary health care

Discrepancies and a lack of standardization of the tools used in the institution were found in the accounts. The professionals mentioned that they used the following instruments:

Protocol for PI prevention designed by the Brazilian Ministry of Health. (N2)

Braden Scale (evaluation of the level of sensory perception, skin moisture, physical activity, nutrition, friction, and shear). (N5)

For skin evaluation, I have been using RYB [red-yellow-black wound classification system] and Measure. (N11)

I use the Braden Scale. We are also used to applying the Norton Scale. (N17)

It is noteworthy that one of the interviewees emphasized the relevance of skin clinical evaluation when an FI was detected:

[...] Whether in primary care or the hospital setting, when we detect the presence of FI, especially in elderly people [...] I use the STAR [Skin Tear Audit Research] standardization, which helps me classify the injury category/staging, for instance. (N25)

[...] The Braden Scale can be used [...] the risk of developing PI is also based on lifestyle, smoking or not smoking, among other aspects. (N25)

Category 2 – Assessment of risk of FI and PI in elderly people: nursing actions and care to prevent these injuries in primary health care

When trying to understand how the risk of FI and PI in elderly people is assessed

by nurses in primary health care, the researchers observed that the application of tools validated for this purpose is little explored.

I evaluate the lack of change in position when the patient is lying down, inadequate conditions of the mattress, inadequate body hygiene, skin moisture, nutrition. (N1)

Actually, I carry out the assessment according to theoretical knowledge. (N4)

I do not use scales or protocols. (N5)

I take into account the external and internal conditions that contribute to the development of these injuries, although the scales are considered reliable instruments. I cannot adjust them to reality. (N10)

Empirical evaluation, according to my experience [...]. (N12)

[...] by applying anamnesis and by taking into consideration the risk factors for the development of the injuries. (N16)

[...] evaluation of skin, nutritional status, hydration, immunological disorders, deficiencies, housing status, and economic situation so we can identify the best conduct to be carried out by the team. (N17)

I perform the evaluation by checking skin color, skin moisture, the patient's capacity to significantly react to discomfort-related pressure, I consider whether the patient is bedridden or not, their mobility, their nutrition. (N20)

When scales were used, it was noticed that the application of tools to stratify the risk of developing PI prevailed:

[...] I take into account the skin type, the clothes the patient wears, and last I use the Braden Scale for PI. (N19)

Some nurses reported that they do not apply tools for risk assessment because of work process issues:

I do not use them in my daily routine because of the high demand in the unit and lack of time. (N5)

No, because we still do not have a dressing protocol. (N15)

No, given that there is a high demand in the unit and consequently little time to evaluate all the elderly people during home visits. (N22)

There is no protocol for this age group in the municipality. (N13)

Data suggested that the definition of a care plan to prevent FI and PI seemed to be based on the risk factor shown by the elderly person. Consequently, a tendency to the proposition of a care plan more focused on preventing PI in detriment of FI was observed, with the following preventive care procedures being applied:

Change in the decubitus position, the positioning of the patient in bed, hydration, nutrition, skin care, observing changes in the skin. (N5)

Keeping the patient dry and hydrated and their skin clean, diet and hydration; repositioning; use of a proper mattress, cushions, and squabs when the patient use their feet for support in the sitting position; when he or she is lying down, the headboard must have a 30° slope at most; bedridden patients require the use of a moving lining, protection for the calcaneus, and keeping upper and lower limbs protected. (N7)

Use of a proper mattress (pyramidal); change in the decubitus position; hydration; adequate

nutrition, with vitamins and proteins; covering according to the aspect of the injury. (N15)

Improving the diet, change in the decubitus position every two hours, skin moisturization, friction reduction, removing edges and unevenness in the bed sheet and the mattress, using a pneumatic mattress if possible. (N18)

Regarding FI prevention, the observed practices were:

[...] using soap with balanced pH; using warm water to wash the injury; reducing shower time; applying moisturizer cream on the skin, but not on the injuries; following a balanced diet. (N15)

Additionally, when risk factors related to FI were observed, the following care practices to prevent the problem were cited:

[...] avoiding using sponges on the skin when showering; avoiding using adhesive medications and/or products; applying moisturizers; using warm water when showering; keeping nails trimmed; increasing water intake. (N19)

Category 3 – Instruments for nursing diagnosis: application of classification systems for FI and PI by nurses in primary health care

When asked about the use of classification or nursing diagnosis systems for FI and PI, the participants showed that they were little familiar with the application of instruments:

I do not use them, because there is none [...]. (N12)

I carry out the classification according to the injury etiology, but I use no system. (N16)

I do not use systems, I have no knowledge of them. (N23)

The application of a specific nomenclature for PI staging in the examined setting was observed. It was also noticed that FI staging is still incipient.

Classification by stage, according to the NPUAP [National Pressure Ulcer Advisory Panel]. (N7)

National Pressure Ulcer Advisory Panel. The injuries are classified as follows: Stage 1; Stage 2; Stage 3; Stage 4; deep tissue injury; unstable PI; medical device-related PI; and mucosal membrane PI. (N10)

Regarding FI specifically, only one nurse mentioned:

Concerning skin tear [...] I use STAR for the staging nomenclature. (N25)

Other professionals cited the use of a classification system for PI staging, but they did not specify the origin of the applied system:

For staging, I use the classification of PI in stages 1, 2, 3, and 4. (N10)

The PI classification has four stages (1, 2, 3, and 4), which I and my FHS work team do use to classify the injuries. (N25)

Category 4 – Treatment and care plan for FI and PI in elderly people: practices used by nurses in primary health care

Analysis of the nurses' approach to the treatment confirmed that they applied practices oriented toward the general aspects to handle skin injuries. When the practices were specified, their target was almost always PI:

According to the injury evaluation intended to identify signs of infection. If there is necrosis, it is necessary to consider debridement (in this case, we have to refer the patient). Cleaning the injury and the skin around it every time the dressing is changed. Skin nutrition. Adequate coverage to keep the injury protected. Guidance on preventive measures. (N4)

Skin inspection; keeping the patient dry and hydrated; clean skin; diet and hydration; repositioning; use of a proper mattress, cushions, and squabs when the patient use their feet for support in the sitting position; when he or she is lying down, the headboard must have a 30° slope at most; bedridden patients require the use of a moving lining, protection for the calcaneus, and keeping upper and lower limbs protected. (N7)

For PI, use of squabs to relieve pressure in the area; use of products that help the healing process; changes in the decubitus position; use of dressings, cleaning of the affected area, and evaluation of the wound bed. (N10)

The care procedures related to FI were cited by two nurses.

I carry out a care plan for the injury treatment, execution of the dressings, approximation of the edges (if there are remnants in an FI); atraumatic removal of dressings; use of products to help healing. (N19)

I carry out interventions and care procedures based on the injury type, [...] standardizing the care to PI and skin tear is not feasible, given that the skin will be in different forms depending on the injury level, requiring distinct treatments [...] sometimes, it is pertinent to use hydrogel depending on the aspect of the injury, as well as foams, silver foams, alginate, among other products. (N25)

DISCUSSION

The sociodemographic profile of the sample was characterized by female professionals, which reinforces the historical fact that nursing is an activity carried out mostly by women⁽¹²⁾.

Regarding the knowledge of the tools to perform nursing practices to manage FI and PI, the findings showed the absence of institutional standardization, suggesting the need to ground nursing actions and care on evidence-based practice to guarantee high-quality assistance to elderly people⁽¹³⁾. Researchers in the area⁽¹⁴⁾ have emphasized that the qualification of nurses' practice in primary health care must be substantiated on the consolidation of care protocols, which provide scientific knowledge, supporting professionals in their decision-making.

It is relevant to add that, regardless of the presence or absence of these tools, elderly people's skin evaluation must occur concomitantly to the nursing process, initiated with anamnesis⁽⁴⁾. In the present study, the nurses referred to the tools as being used with that purpose but, instead of being linked specifically to skin clinical evaluation, they were related to risk stratification, staging, or injury characterization, as illustrated by the Braden Scale, the STAR classification, and the RYB system⁽¹⁵⁻¹⁷⁾.

Factors such as work overload also seem to interfere with the use of these resources in clinical practice, suggesting that adjustments in the number of nurses to the work process be discussed⁽¹⁴⁾.

It was observed that the risk stratification for FI and PI was little systematized. However, it should be stressed that, in the occasions in which care was carried out by applying a scale, consistency in using the Braden Scale was noticed, similarly to the result described in a study that evaluated sociodemographic and clinical variables and the application of the Waterlow and Braden Scales and indicated that the latter proved to be a more effective screening method⁽¹⁸⁾.

Analysis of the accounts addressing FI showed that, although there are tools for risk classification, there was a lack of knowledge of the participants of the present study regarding their use. It is possible that this finding can be explained by the fact that this subject is still incipiently discussed in Brazil, despite the publication of international studies in the area since the 1990s, according to the literature⁽¹⁶⁾.

Corroborating the incipiency of the topic in Brazil, a study⁽¹⁹⁾ suggested the application of the Skin Tear Risk Assessment Pathway, a tool designed after the achievement of a consensus by specialists that has the objective of stratifying the risks for the occurrence of FI. However, this instrument has not yet been validated to be used in Brazil.

Regarding preventive practices, it was observed that the actions related to PI corroborated what is described in the literature, including repositioning, care concerning nutritional aspects, protection of the calcaneus, and use of a specific type of mattress⁽²⁰⁻²¹⁾. The participants pointed out repositioning as a practice to prevent PI. Although this was not mentioned by the interviewees, some studies, in addition to having indicated that the 30° tilt must be adopted, have included the possibility of adjusting the angle up to 45° when obesity is confirmed and have indicated a new repositioning in less than three hours⁽²²⁻²³⁾.

The use of moisturizers was also mentioned as an effective intervention to prevent PI. According to the NPUAP, the European Pressure Ulcer Advisory Panel, and the Pan Pacific Pressure Injury Alliance⁽²⁴⁾, the use of emollients to hydrate the skin must be considered, given that it reduces the risks of damage to the organ.

Analysis of the care procedures related to FI mentioned by the participants of the present study showed that their conduct is in agreement with the set of procedures suggested by the International Skin Tear Advisory Panel, with the following caveats: application of moisturizers at least twice a day, adoption of adhesive silicone products, use of clothes with long leaves, and attention regarding abrupt touch in elderly people's skin^(1,6,25).

It was noteworthy that skin hydration and use of warm water during showers were mentioned often by the interviewees. These are important care procedures, because they belong to the set of actions necessary to keep skin integrity and, consequently, prevent FI⁽²⁶⁾.

The use of nursing diagnosis specifically related to FI and PI was not found. However, the adoption of instruments that help elucidate them was observed.

Regarding PI, the literature indicates that NPUAP has had a classification system since 1989, which went through updates repeatedly, with the most recent one published in 2016⁽³⁾. This system currently classifies PI into stages that range from 1 to 4⁽³⁾. Some interviewed nurses reported that they classified PI based on stages, without informing the used system. Possibly, these professionals referred to the procedures proposed by the NPUAP⁽²⁷⁾, given the similarity with the previously mentioned nomenclature.

Although FI are considered an incipiently discussed subject in Brazil, there are records in the literature indicating that the approach to these injuries has been discussed since 1990, when the Classification System for Skin Tears was proposed by Payne and Martin⁽²⁸⁾.

The findings showed that care practices such as moisture control, repositioning, position tilting, hydration, lifting of the calcaneus, use of squabs, among others, are commonly applied by nurses in the examined context. It is inferred that, although the need to apply them during treatment cannot be excluded, the literature points out that these practices are interventions related to PI prevention^(23,27).

Regarding topical therapy, the relevance of using coverages for the treatment was mentioned. However, the participants did not refer to specific technologies except for debridement, which was cited as an alternative to be applied in cases involving tissue necrosis. It is important to add that this technique was pointed out in a study as a possibility

in the treatment of PI, as described by the authors⁽²⁹⁾, but does not seem to be effective when applied in isolation. Regarding the care to treat FI, mentioned by a small fraction of the participants, the referred procedures are compatible with what is proposed in the literature⁽³⁰⁾, which suggests topical therapy as a coverage as long as there are viable skin remnants, liable to realignment.

Regarding the atraumatic removal of the dressing, this measure has been more associated with the prevention than the treatment of the injuries. However, when faced with the need to use this type of material, nurses must prefer tapes that show low adhesion⁽³⁰⁾.

The fact that one of the interviewees mentioned that care standardization must be avoided because the decision-making related to the treatment results directly from the characteristics of the injury was noteworthy.

Depending on the injury classification, the treatment may vary, and some possibilities are silicone foam coverages, calcium alginate, hydrofiber, ionic silver, methylene blue, 2-octyl cyanoacrylate glue, among other technologies^(6,30).

The fact that the investigation examined a limited group of nursing professionals may be a limitation of the present study. It is suggested that future studies be carried out in different regions, offering the possibility of comparing the findings and showing the practices applied by professionals in a macrosenario.

CONCLUSION

The absence of institutional protocols to carry out care to people with the injuries under discussion seemed to influence the actions of the nurses. It was found that divergences regarding the performed care practices were common and that the selection of tools to manage risks and handle FI and PI, when present, was random.

The results indicated that, between the two types of injuries analyzed, nurses showed greater knowledge of PI, especially concerning risk stratification and practices to prevent this problem. This finding certainly is a consequence of the publication of seminal studies by Brazilian researchers on stratification of risks for developing PI by applying the previously mentioned scale.

It was observed that the interviewed nurses were little familiar with FI, possibly because the discussions about this subject in Brazil gained prominence in the past few years only. The results stressed the need for institutional investment in continuing education actions oriented toward these professionals, as well as the design of local tools to systematize care, leading to good practices to prevent, stage, and handle these injuries, given the impact they have on users and health services.

The authors believe that the results of the present study will encourage the scientific community to ponder over the offered care to treat these injuries, envisaging the proposition and incorporation of new technologies capable of constantly help nurses carry out an accurate evaluation of elderly people's skin, an effective risk management, and a scientifically based treatment of both types of injuries.

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