ORIGINAL ARTICLE

https://doi.org/10.30886/estima.v17.737_IN

Epidemiological profile of patients with chronic wounds treated by the "Better at Home Program"

Perfil epidemiológico dos pacientes com feridas crônicas atendidos pelo "Programa Melhor em Casa"

Perfil epidemiológico de pacientes con heridas crónicas tratados por el "Programa Mejor en Casa"

Jacqueline de Almeida Gonçalves Sachett[1,2], Christielle da Silva Montenegro[1]

ORCID IDs

Sachett JAG https://orcid.org/0000-0001-5723-9977
Montenegro CS https://orcid.org/0000-0003-3474-8992

HOW TO CITE

Sachett JAG, Montenegro CS. Epidemiological profile of patients with chronic wounds treated by the "Better at Home Program". ESTIMA, Braz. J. Enterostomal Ther., 17: e2019. https://doi.org/10.30886/estima.v17.737_IN

ABSTRACT

Objective: To define the epidemiological profile of patients with chronic wounds treated by the Multidisciplinary Home Care Team (EMAD) of Rio Branco, state of Acre. **Methods:** This is an exploratory, field study, in which users were enrolled in the Better at Home Program from January to May 2018. The sample of this study was composed of all active patients in the list attended by EMAD in the period comprised from the first visit of the researchers until the moment of exhaustion of the patients for the data collection. All patients of EMAD with wounds were included, totaling the sample of 100 patients. **Results:** One hundred patients answered a self-administered questionnaire. It was shown that 54% of the participants were men, with age greater than 51 years and mean age of 50 years [standard deviation (SD) = 19.81]. Sixty percent were brown, 36% singles, 52% had income between one and two minimum wages, 34% had incomplete elementary education, and 35% were retired. Of those selected, 80% live in their properties, 70% of which is masonry, water is piped in 74% of the places, and 100% has electricity. About 38% had hypertension, and 31% were diabetic, being the most prevalent diseases. Families were the main responsible for patients' access to home care (45%). Lower limb injuries were the most prevalent (38%). It was possible to observe a low level of schooling and income in these patients, besides the majority presence of chronic noncommunicable diseases, as well as the importance of families in the search for specialized treatment. **Conclusion:** For the quicker rehabilitation of the patients, a holistic view is necessary, relating all areas of health and using the interdisciplinary knowledge so that greater treatment effectiveness occurs.

DESCRIPTORS: Wound healing. Multidisciplinary team. Epidemiological profile. Stomatherapy.

1.Universidade do Estado do Amazonas – Escola Superior de Ciências da Saúde – Programa de Pós-Graduação – Manaus/AM – Brazil.
2.Fundação de Dermatologia Tropical e Venereologia "Alfredo da Matta" – Diretoria de Ensino e Pesquisa – Departamento de Ensino e Pesquisa – Manaus/AM – Brazil.

Correspondence author: jac.sachett@gmail.com

Received: Mar. 26 2019 | **Accepted:** Jun.14 2019

RESUMO

Objetivo: Definir o perfil epidemiológico dos pacientes com feridas crônicas atendidos pela Equipe Multidisciplinar de Atenção Domiciliar (EMAD) de Rio Branco, estado do Acre. **Métodos:** Trata-se de um estudo exploratório, de campo, no qual foram acompanhados usuários contemplados pelo programa Melhor em Casa de janeiro a maio de 2018. A amostra deste estudo foi composta por todos os pacientes ativos na lista de atendidos pela EMAD no período que compreendeu desde a primeira visita dos pesquisadores até o momento de esgotamento dos pacientes para a coleta de dados. Incluíram-se todos os pacientes da EMAD com feridas, totalizando a amostra de 100 pacientes. **Resultados:** Cem pacientes responderam a um questionário autoaplicado. Mostrou-se que 54% dos participantes eram do sexo masculino, com faixa etária maior que 51 anos e média de idade de 50 anos [desvio-padrão (DP) = 19,81]. Sessenta por cento eram pardos, 36% solteiros, 52% tinham renda entre um e dois salários mínimos, 34% apresentaram ensino fundamental incompleto e 35% eram aposentados. Dentre os selecionados, 80% vivem em imóveis próprios, sendo esses 70% de alvenaria, a água é encanada em 74% dos locais e 100% têm energia elétrica. Sobre sua saúde, 38% tinham hipertensão arterial e 31% eram diabéticos, sendo essas as doenças mais prevalentes. As famílias foram as maiores responsáveis pelo acesso dos pacientes à atenção domiciliar (45%). As lesões de membros inferiores foram as mais prevalentes (38%). Foi possível observar perfil de baixa escolaridade e renda nesses pacientes, além da presença majoritária de doenças crônicas não transmissíveis, bem como a importância das famílias na busca de tratamento especializado. **Conclusão:** Para a reabilitação mais rápida dos pacientes, é necessária uma visão holística, relacionando todas as áreas da saúde e utilizando o conhecimento interdisciplinar para que ocorra maior efetividade do tratamento.

DESCRITORES: Cicatrização de feridas. Equipe multiprofissional. Perfil epidemiológico. Estomaterapia.

RESUMEN

Objetivo: Definir el perfil epidemiológico de los pacientes con heridas crónicas tratados por el Equipo multidisciplinario de Atención Domiciliaria (EMAD) de Rio Branco, estado de Acre. **Métodos:** Este es un estudio de campo exploratorio, en el que los usuarios contemplados por el "Programa Mejor en Casa"fueron seguidos de enero a mayo de 2018. La muestra de este estudio estaba compuesta por todos los pacientes activos en la lista de ayudados por EMAD en el período que varió desde la primera visita de los investigadores hasta el momento del agotamiento de los pacientes para la recolección de datos. Se incluyeron todos los pacientes da EMAD con herida, un total de 100 pacientes. **Resultados:** Cien pacientes respondieron un cuestionario autoadministrado.Se demostró que el 54% de los participantes eran hombres, mayores de 51 años y una edad promedio de 50 años [desviación estándar (DE) = 19.81]. Sesenta por ciento eran marrones, 36% solteros, 52% tenían ingresos entre uno y dos salarios mínimos, 34% tenían educación primaria incompleta y el 35% estaban jubilados. Entre los seleccionados, 80% vive en sus propias propiedades, siendo 70% de albañilería, el agua se canaliza en el 74% de los lugares y el 100% tiene electricidad. Sobre su salud, 38% tenía hipertensión y el 31% eran diabéticos, siendo estas las enfermedades más prevalentes. Las familias fueron las más responsables del acceso de los pacientes a la atención domiciliaria (45%). Las lesiones de las extremidades inferiores fueron las más frecuentes (38%). Fue posible observar un bajo perfil de educación e ingresos en estos pacientes, además de la presencia mayoritaria de enfermedades crónicas no transmisibles, así como la importancia de las familias en la búsqueda de tratamiento especializado. **Conclusión:** Para una rehabilitación más rápida de los pacientes, se necesita una visión holística, relacionando todas las áreas de la salud y utilizando el conocimiento interdisciplinario para una mayor efectividad del tratamiento.

DESCRIPTORES: Cicatrización de heridas. Equipo multiprofesional. Perfil epidemiológico. Estomaterapia.

INTRODUCTION

There is a recent trend in Brazilian health for the decentralization of health services. The attention that had previously been hospital-centric, unicausing, based on the biological and curative view, ended up resulting in onerous health for the population[1] by the lack of the look to the individual as a whole, concentrating efforts on the disease itself. This decentralization also shows the psychological aspects, in addition to the financial ones, in which the sick person goes beyond their physical aggravation, but it is inserted in a social and familiar context[2].

This holistic view of the individual brings the family as the primary source of beliefs and types of health-related behaviors and directly interferes with how the individual manifests its symptoms. Thus, the family sinus becomes a resource of help and support to the patient, and the professional inserted in this family context and directly interfering in the life of these people can obtain better results from the clinical point of view[1]. It is also considered, in this conjuncture, the territory, lifestyle, health promotion, and its basis[1]. According to Dias and Nunes[2], clinical experience shows that families influence and are influenced by the health of their elements and that primary health care can contribute to improving the health of both the family and the sick person.

Moreover, it is in this family context and the decentralization of health that comes from Home Care (HC). This type of care has been growing in Brazil

since 1990, following a worldwide trend stemming from its potential for alleviating the excessive burden of the public health system, mainly hospital, thus providing greater efficiency and effectiveness of health care[3]. Thus, many individuals are discharged and returned to their homes to reestablish themselves with their families, so that, in addition to meeting their psychic needs, they can reduce public spending on hospitalization, reserving this place expressly for acute events, leaving the chronic diseases are treated extra-hospital[1].

In an attempt to expand home care, it is highlighted the creation of the Better at Home Program - Hospital Safety in the Comfort of Your Home, initiated by the Brazilian Federal Government[3]. According to the Ministry of Health[4], this is a service indicated for people who have temporary or permanent difficulties to leave their homes to reach a health unit or for people who are in situations in which this type of care is more appropriate for their treatment. This program is protected by ordinances nº 2527/2011 and 2959/2011, which conceptualize HC in the context of the Unified Health System (UHS) and enable health establishment covered by the HC service[3].

The Better at Home care is done by multiprofessional teams composed mainly of nurses, nursing technicians, doctors, physiotherapists or social workers, but other professionals, such as a speech-language therapist, nutritionists, dentists, psychologists, occupational therapists, and pharmacists, are also qualified to form the support teams. Patients enrolled in this program are those who require weekly or more frequent visits, and that each team may consist of up to 60 concurrent patients[4].

The Brazilian government points out several benefits for the implementation of this program, which includes humanized care, family recovery, better recovery of diseases, reduction of contamination and infection risks, as well as vacating hospital beds, providing better care and regularization of hospital urgency services4. Also, professionals may face complex and controversial cultural and social universes, and it is in this peculiarity of HC that the possibility of "interaction, overcoming prejudices, an invention of solutions and rescue of networks of solidarity"[3].

As part of the Better at Home Program in Rio Branco, state of Acre, the Multiprofessional Home Care Team (EMAD) serves patients who have wounds of more significant physical weakness. These assisted wounds are defined as the loss of cutaneous cover, not only of the skin, but also of the subcutaneous tissues, muscles and bones and, as regards etiology, can be caused by trauma, surgical complications, diabetes, necrosis, ischemia or venous insufficiencies, such as venous ulcers and pressure and post-radiation injuries[5]. These bring constant challenge to EMAD, not only for the nursing area, but for the care offered by all professionals, for testing the interdisciplinarity of the areas, the relationship and knowledge of the team in choosing the most appropriate conduct for each patient , that is, by promoting the constant search for the newest techniques, equipment and materials for the treatment of injuries. In addition, the human factor stands out because the HC inserts the professionals in the family environment, causing them to experience and place hope in the course of their evolution until their rehabilitation and cure.

In addition to the care of the body, the importance of establishing links with patients, caregivers, and family members, understood by the staff as necessary for successful actions, is emphasized. For this, EMAD uses music therapy, birthday celebrations, recreational activities with children with disabilities, among other activities[6].

In this sense, considering the importance of home care and the challenges generated in the treatment of wounds, the focus of the present study emerges, which aims to define the epidemiological profile of active patients with skin lesions attended by EMAD, aiming to serve as a foundation for the professionals of the area, especially with regard to the materials used in the recovery and healing process of these lesions.

METHODS

This is an exploratory, field study, in which the services provided by EMAD accompanied users benefiting from the Better at Home Program.

EMAD was created in 2015, regulated by Ordinance nº 963, dated May 27, 2013, and redefined by Ordinance nº 825, of April 25, 2016, to take UHS care to patients who need HC[6]. In 2018, the team was composed of a doctor, nurse, nutritionist, physiotherapist, nursing technicians, administrative technicians, and drivers, as

well as its extension in the primary health unit Gentil Perdome, which only works with dressings. EMAD serves patients with skin lesions, residents of Rio Branco, who can not go to a health facility, totaling 214 patients from January to November, 2018[6].

The sample of this study was composed of all active patients in the list of patients attended by EMAD from January to May of 2018. This period comprised from the first visit of the researchers until the time of exhaustion of the patients for the data collection. All patients of EMAD with wounds were included, totaling the sample of 100 patients. Data were collected through a questionnaire applied by the researcher, which included questions related to sociodemographic aspects (gender, age, profession, address) and issues related to the theme, such as classification of wounds as etiology, evolution, complexity, tissue involvement, thickness, presence or absence of infection, which were evaluated at the time of the interview. This questionnaire was applied at pre-scheduled times after accepting the Informed Consent Term.

After being approved by the Ethics Council of the State University of Amazonas, with an opinion nº 3.149.001, the participants received detailed information about the objectives, methods, benefits, risks, and importance of the research, is also informed that they could withdraw their consent at any time without no kind of embarrassment or coercion.

Data were recorded and stored in a spreadsheet and typed in the Excel 2013 program. Descriptive statistical analysis was performed from the continuous and categorical quantitative variables of the population involved, using the EPI INFO 7 program with the presentation of frequencies, averages, and standard deviation (SD).

RESULTS

Among the participants, 54% were men, 44% women, and 2% reported belonging to other sexual groups. Regarding the age group, patients were predominant with 51 years or more, being 52 % of the participants, followed by 41% of individuals with ages between 21 and 50 years and 7% between 0 and 20 years. The mean age of participants was 50 years (SD = 19.81) (Table 1).

Table 1. Number and proportion of users with wounds attended by the Multiprofessional Home Care Team, according to sociodemographic variables, in Rio Branco, state of Acre, 2018.

Sociodemographic data	n (100)	%
Age group		
0-20	7	7
21-50	41	41
51 or more	52	52
Gender		
Male	54	54
Female	44	44
Others	2	2
Marital status		
Married	34	34
Divorced	5	5
Single	36	36
Widower	10	10
Stable union	15	15
Schooling		
Illiterate	13	13
Elementary school	40	40
High school	38	38
High education	9	9
Race/color		
White	31	31
Brown	60	60
Black	9	9
Work		
Retired	35	35
Signed portfolio	16	16
No signed portfolio	15	15
Student	10	10
Unemployed	8	8
On leave	6	6
Housewife	6	6
Pensioner	3	3
Others	1	1
Family income in MWs		
< 1	22	22
1 to 2	52	52
2 to 3	12	12
3 to 4	4	4
> 4	4	4
> 5	1	1
No fixed income	5	5

...continue

Table 1. Continuation...

Habitation conditions		
Own	80	80
Rented	9	9
Others	11	11
Type of residence		
Masonry	70	70
Wood	17	17
Mixed	13	13
Water		
Piped	74	74
Well	26	26
Power		
Eletrical	100	100

MW = Minimum Wage.

60% of the patients were brown, 31% considered themselves white, and 9% declared themselves black. Regarding marital status, 36% were single, 34% married, 15% with a stable union, 10% were widowers, and 5% were divorced. When questioned about their income, 52% reported earning between one and two minimum wages (MWs), 22% earned less than one MW, and 12% received two to three MWs. The prevalence of people with incomes lower than two MWs can be justified due to the linkage of the program with UHS and with the public hospital of Rio Branco. Thus, the purpose of free assistance and accessibility are being met.

As for education, 34% had incomplete elementary education, 24% had completed high school, 14% had not completed high school, 13% were illiterate, 6% had completed elementary education. Of the current work situation, 35% of the participants reported being retired, 16% worked with a formal contract, and 15% worked, but did not have a formal contract.

Regarding habitation conditions, 80% live in their places, 9% of the properties are rented, and 11% are in other situations. These residences are 70% masonry, 17% wood, and 13% mixed. Water is piped in 74% of sites, and 26% comes from wells. Finally, 100% of the participants have electricity in their homes. The houses of the participants match their urban location, most of which have access to the necessary resources for decent housing.

About its current state of health, diabetes was present in 31% of patients. Another disease that was highlighted in this public was hypertension, present in 38% of patients, which is also a risk factor for complications in the treatment of chronic wounds.

Smoking habits were reported in 10% and alcohol consumption in 16% of the participants (Table 2).

Table 2. Number and proportion of users with wounds attended by the Multiprofessional Home Care Team, according to comorbidities and habits of life, in Rio Branco, state of Acre, 2018.

Características	n (100)	%
Pathologies*		
Systemic arterial hypertension	38	38
Diabetes	31	31
Cardiopathy	10	10
Nephropathy	2	2
Others	19	19
Habits*	**n (100)**	**%**
Ethicism	16	16
Smoking	10	10

*It was considered more than one option for the patient with an affirmative response to different comorbidities and/or lifestyle habits.

Regarding the conditions of access to HC, 45% of the participants came from a spontaneous patient or family demand, which reinforces the point that the family can be a crucial ally of health professionals for the adequate recovery of a patient[2]. EMAD provided 100% of the patients in necessity of services in psychology and social services, 91% with visits from the nursing team (nurse and nurse technician, 9% of visits were made only by nursing technicians), 89% had medical attention and 75% received visits and assistance from a nutritionist (Table 3).

In the analysis of wound location data, 19% were present in the foot area, 19% below the knee, 18% in the sacrococcygeal region, 7% in the ischium, 6% in the heel, 6% in the trochanteric region, 2% in the ankle and 43% presented in other regions of the body (Table 4).

Concerning wound time, 41% of the participants had them for less than one year, and 39% had less than one month, with secretion present in 82% of the patients. Healing is expected to occur slowly due to pre-existing conditions such as pressure, diabetes, poor circulation, precarious nutritional status, immunodeficiency, and factors such as infection and the presence of necrotic tissue[7].

Table 3. Number and proportion of users with wounds attended by the Multiprofessional Home Care Team (EMAD), according to the type of access to home care services (HC) in Rio Branco, state of Acre, 2018.

Access features	n (100)	%
First access to HC		
Spontaneous patient/family demand	45	45
Health care network services	40	40
Others	10	10
Did not answer	5	5
Which EMAD professionals received/receives care		
Psychologist	100	100
Social worker	100	100
Nurse	91	91
Doctor	89	89
Nutritionist	75	75
Nursing Technician	9	9

Table 4. Number and proportion of users with wounds attended by the Multiprofessional Home Care Team, according to the characteristics of the wounds, in Rio Branco, state of Acre, 2018.

Wounds features	n (100)	%
Location		
Below the knee	19	19
Foot	19	19
Sacrococcygeal region	18	18
Ischial region	7	7
Heel	6	6
Trochanteric region	6	6
Ankle	2	2
Others	43	43
Wound time		
< 1 month	39	39
< 1 year	41	41
Between 1 and 5 years	4	4
> 5 years	16	16
Secretion		
Yes	82	82
No	18	18
Use of alternative treatment to treat the wound		
Yes	30	30
No	63	63
Did not answer	7	7

DISCUSSION

The higher number of men with injuries may be a consequence of greater risk exposure in the type of activity that develops, which can be justified with the more significant occurrence of auto accidents in men, which often results in chronic wounds. According to data from Insurance Company Lider8, responsible for the payment of Insurance Personal Injury caused by Motor Vehicles (DPVAT), men represented 75% of the total number of people involved in accidents from January to October 2018, while only 25% were women.

According to Chibante et al.9, the more advanced age is related to the higher susceptibility to lesions, due to changes in the physiological systems resulting from nutritional, metabolic, vascular and immunological modifications that affect the function and appearance of the skin, such as: reduction of epidermal thickness; reduction of dermal elasticity by decreasing the number of fibroblasts, which modifies the collagen and elastin fibers; and reduction of blood vessels and nerve fibers10. The speed and intensity at almost all stages of healing are decreased in the elderly affected by lesions, resulting in lower inflammatory responses, reduced circulation, increased capillary fragility, and epithelialization time9.

Low schooling and income were predominant in this study, which is consistent with the reality of the patients found in the UHS because it is a public service. According to Vicava10, in their analysis of regional and social inequalities in health, there is a higher rate of hospitalizations among individuals with lower levels of schooling when compared to individuals with higher levels of education. About income, it should be noted that people with higher earnings adhere in more significant numbers to health insurance plans or insurance, usually related to the employment relationship, thus shaping the profile of lower socioeconomic status of WHO10 patients.

The information about the work activity becomes worrying when observing that only 51% of these patients have fixed income, like formal work or some benefit; thus, the others are dependent and are not currently able to look for some occupation, falling to the families to sustain them until their rehabilitation, which may not occur early as desired.

The educational level has a close relation with the level of health of the people, with income and the professional category, economic variables that have positive effects on health11. Besides, the level of education is of fundamental importance for HC, as it

directly interferes with self-care, reflecting the ability to understand the instructions of the team. Patients and their families need to learn to control factors that can interfere with their healing process, such as diet and blood pressure, especially for individuals with hypertension, diabetes for glycemia, and mechanisms that cause tissue damage the adaptation of the language used with the patient and its family, according to the reality of that home, in order to obtain more effective results12,13.

Diabetes mellitus (DM) was expressive as a comorbidity in patients and had several chronic complications, among which the emergence of nephropathies, retinopathies, neuropathies and vasculopathies, the latter two being the main ones responsible for the appearance of lower limb wounds and foot12. The excess of glucose in the bloodstream of the patient with diabetes causes the reduction of serum nitric oxide concentration, promoting endothelial dysfunction, which causes an ischemic-peripheral microenvironment that reduces the rate of angiogenesis, besides promoting the reduction of the response of the factors growth12. Therefore, DM was expected to be present among the main pathologies of this sample.

In addition to DM, hypertension has also been reported. This causes microvascular changes because the blood vessels tend to increase the thickness of your wall, which reduces your lumen. Thus, it decreases the peripheral blood flow, reducing the supply of oxygen and nutrients to the wound, as well as decreasing collagen deposition and inhibiting the phagocytic action, consequently causing a delay in healing12. Other disorders mentioned were: heart disease, nephropathy, Alzheimer's disease, arthritis, arthrosis, cerebrovascular accident, cancer, peripheral obstructive arterial disease, depression, malnutrition, and autoimmune diseases.

Other behavioral factors, such as smoking, were found in participants. Smoking is significantly harmful in patients with wounds because it promotes peripheral vasoconstriction, which also reduces the thickness of blood vessels and impairs the supply of nutrients and local oxygen. Nicotine, the main component of the cigarette, impedes the transport of oxygen in the red blood cells, which, besides damaging the neoangiogenesis and the multiplication of fibroblasts in the wounds, provides a favorable microenvironment for the growth of bacteria, increasing the risk of infection[12].

About home care, EMAD attended all patients with a necessity for services in psychology and social service. The presence of professional psychologists in the multiprofessional team, for example, is of paramount importance in order to meet the emotional and psychosocial demands of these patients[14]. Nutrition, besides promoting energetic and protein substratum for healing, still offers the vitamins used as cofactors by several enzymes in the healing process. Severely ill patients may have a greater loss of vitamins, which can lead to their deficiency and delay in the healing process[15].

Most of the lesions found in these patients were located in the lower limbs. Chavaglia[13], in his study about the profile of patients with chronic wounds, also detected that most of the lesions were in the lower limbs. The causes of chronic lower limb wounds may be due to venous insufficiency, arterial insufficiency, neuropathy, lymphedema, rheumatoid arthritis, trauma, osteomyelitis, sickle cell anemia, vasculitis, cutaneous tumors (basocell and spinocell carcinoma) and chronic infectious diseases.

According to the American Diabetes Society[16], at least half of all amputations occurred in people with diabetes and occasioned by ulcers in the infected diabetic foot. Thus, knowledge and correct handling of the wound are paramount to decrease this risk.

Prevention of complications, such as amputations, especially in cases of neuropathy, should be addressed at all levels of health care. In primary care, adequate sorting and wound classification may be predictors of referral to specialized care, targeted education, or the use of tailored therapeutic footwear. Infection associated with peripheral arterial disease contributes to the risk of amputation; thus, the professional nursing needs more attention in case of lesion secretion, as it provides a humid environment that facilitates the installation of an infectious process[16].

In addition, the therapy adopted for the treatment of chronic wounds is a factor that directly influences healing time[13], notably when we observed that 30% of patients reported using alternative methods to treat their wounds, which can often be based on empirical care, recommendations from friends or relatives, lead to inadequate therapeutic approaches, insecurity, and attrition, prolonging healing[13]; possibly this fact may contribute to worsening and delayed wound healing. The

wounds on the feet of men tend to have worse complications than those of women. Therefore, the health professional needs attention in the care at the feet of men, since these are more sloppy and can compromise more these injuries[17].

As a limitation of this study, there was, mainly, transportation to the patient's home. Thus, access to the patients' residence was difficult. There was also difficulty in providing information from the health team and patients and caregivers. Researchers used their resources to perform home visits and also a differentiated language with patients and caregivers in order to be able to collect as much information as possible.

CONCLUSION

The accomplishment of this study provided the vision of the epidemiological profile of the people with wounds attended by the Better at Home program through EMAD. Of these, the profile of patients with more than 51 years of age, single, with income between one and two MWs was shown. Regarding its educational aspect, the majority had incomplete elementary education, was retired and lived in their property with basic sanitation. Regarding its current state of health, the presence of arterial hypertension and diabetes were highlighted, being these the most prevalent diseases. The families were the main responsible for patients' access to HC. Lower limb injuries were the most prevalent, being most common in the foot and below the knee.

It is concluded that, for the quicker rehabilitation of patients, a holistic view is needed, in which the wound itself is considered, but the family, socioeconomic situation, habits and underlying diseases, relating all areas of health and using the interdisciplinary knowledge so that greater effectiveness of the treatment occurs.

This type of study is of fundamental importance to provide health professionals with scientific material of reference to their practices and behaviors. Actions directed to the specific profile of this population can lead to a reduction in healing time and recovery of patients. It is also worth mentioning the necessity for more studies of the type, and with larger samples, to serve as a basis for public health promotion policies appropriate to the reality and necessity of the patients.

AUTHORS CONTRIBUTION

Conceptualization, Sachett JAG and Montenegro CS; Methodology, Sachett JAG; Investigation, Montenegro CS; Writing - First version Sachett JAG and Montenegro CS; Writing - Review & Editing, Sachett JAG; Supervision Sachett JAG.

REFERENCES

1. Silva KL, Sena RR, Seixas CT, Feuerwerker LCM, Merhy EE. Atenção domiciliar como mudança do modelo tecnoassistencial. Rev Saude Publica. 2010;44(1):166-76. https://doi.org/10.1590/S0034-89102010000100018

2. Dias MB, Nunes P. A política nacional de atenção domiciliar no Brasil: potencialidades, desafios e a valorização necessária da atenção primária à saúde. J Manag Prim Heal Care. 2015;6(1):1-7.

3. Andrade A, Brito M, Silva K, Randow R, Montenegro L. Singularidades do trabalho na atenção domiciliar: imprimindo uma nova lógica em saúde. Rev Pesqui Cuid Fundam. 2013;5(1):3383-93. https://doi.org/10.9789/2175-5361.2013v5n1p3383

4. Ministério da Saúde (BR). Melhor em casa. [Internet]. Brasília, DF: MS. 2019 [cited dia mês ano]. Available at: http://www.saude.gov.br/acoes-e-programas/melhor-em-casa-servico-de-atencao-domiciliar/melhor-em-casa

5. Lagos SDEF, Uratani SS, Gomes FV. Revisão bibliográfica sobre úlcera de pressão: uma proposta para intervenção de enfermagem. Rev Uningá. 2017;3(1):137-46.

6. Prefeitura Municipal de Rio Branco. Relatório Gerencial: EMAD Equipe Multiprofissional de Atendimento Domiciliar. 2018.

7. Medeiros ABA, Frazão CMFQ, Fernandes MICD, Andriola IC, Lopes MVO, Lira ALBC. Associação dos fatores socioeconômicos e clínicos e o resultado integridade tissular em pacientes com úlceras. Rev Gaúcha Enferm. 2016;37(1):1-9. https://doi.org/1590/1983-1447.2016.01.54105

8. Seguradora Líder. Boletim estatístico. Seguradora Líder-DPVAT. Rio de Janeiro: Seguradora Líder; 2018.

9. Chibante C. Perfil de clientes hospitalizados com lesões cutâneas. Rev Cub Enferm. 2015;31(4):1-13.

10. Vicava F. Desigualdades regionais e sociais em saúde segundo inquéritos domiciliares (Brasil, 1998-2013). Cien Saude Colet. 2018;23:1-6.

11. Oliveira MF, Viana BJF, Matozinhos FP, Silva MMS, Pinto DM, Moreira AD, et al. Feridas em membros inferiores em diabéticos e não diabéticos: estudo de sobrevida. Rev Gaúcha Enferm. 2019;40:e20180016. https://doi.org/10.1590/1983-1447.2019.20180016

12. Braz RM, Squizatto RH, Rafaldini BP, Poletti NAA, Lopes ADO,

13. Almeida DB de. Perfil dos usuários atendidos em ambulatório de cuidado com feridas. Cogitare Enferm. 2017;22(1):1-9. https://doi.org/10.5380/ce.v22i1.48472

14. Chavaglia SRR, Ohl RIB, Ferreira LA, Santiago VR, Abdanur AF, Soares AS. Caracterização de pacientes com lesão cutânea em unidades de internação médica e cirúrgica. Rev enferm UFPE. 2015;9(1):183-92. https://doi.org/10.5205/reuol.6817-60679-1-ED.0901201526

15. Coutinho ALS, Pena LAS, Rodrigues SP, Severino ALRL, Viana ESM. A atuação do psicólogo na estratégia de saúde da família. Rev Científica Univiçosa. 2015;7(1):13-9.

16. Mendes DC, Santos BCO, Oliveira LB, Sabino LF. A importância da nutrição no processo de cicatrização de feridas. Revista Científica Univiçosa. 2017;9(1):68-75.

17. Boulton AJM, Armstrong DG, Kirsner RS, Attinger EC, Lavery LA, Lipsky BA, et al. Diagnosis and management of diabetic foot complications [Internet]. American Diabetes Association. 2018 [cited 3 Jun 2019]. https://doi.org/10.2337/db20182-1

18. Jarl G, Alnemo J, Tranberg R, Lundqvist LO. Gender differences in attitudes and attributes of people using therapeutic shoes for diabetic foot complications. J Foot Ankle Res. 2019;12(21):1-7. https://doi.org/10.1186/s13047-019-0327-0