

Social networks of patients with chronic skin lesions: nursing care

Redes sociais de portadores de lesão cutânea crônica: o cuidado de enfermagem
Redes sociales de portadores de lesión cutánea crónica: el cuidado de la enfermería

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ABSTRACT

Objective: To describe the social networks of patients with chronic skin damages. **Method:** A qualitative study conducted through semi-structured interviews with nine subjects with chronic skin lesions from June 2016 to March 2017; we used the theoretical-methodological framework of Lia Sanicola's Social Network. **Results:** The analysis of the relational maps revealed that the primary network was formed mainly by relatives and neighbors; its characteristics, such as: reduced size, low density and few exchanges/relationships, configures fragility in these links. The secondary network was essentially described by health services, and the nurse was cited as a linker in the therapeutic process. **Final considerations:** Faced with the fragility of the links and social isolation, the primary health care professionals are fundamental foundations for the construction of networks of social support and care for patients with chronic skin lesions.

Descriptors: Leg Ulcer; Chronic Disease; Nursing Care; Social network; Primary Health Care.

RESUMO

Objetivo: Descrever as redes sociais de portadores de lesão cutânea crônica. **Método:** Estudo qualitativo realizado através de entrevistas semiestruturadas com nove sujeitos portadores de lesões cutâneas crônicas no período de junho de 2016 a março de 2017; utilizou-se o referencial teórico metodológico de Rede Social de Lia Sanicola. **Resultados:** A análise dos mapas relacionais revelou que a rede primária era formada principalmente por familiares e vizinhos; suas características, como: tamanho reduzido, baixa densidade e poucas trocas/relacionamentos, configura fragilidade nesses vínculos. A rede secundária foi descrita essencialmente por serviços de saúde, e a enfermeira foi citada como formadora de vínculo no processo terapêutico. **Considerações finais:** Diante da fragilidade dos vínculos e do isolamento social, os profissionais da atenção primária à saúde são alicerces fundamentais para a construção de redes de apoio social e cuidado ao portador de lesão cutânea crônica.

Descritores: Úlcera da Perna; Doença Crônica; Cuidado de Enfermagem; Rede Social; Atenção Primária à Saúde.

RESUMEN

Objetivo: Describir las redes sociales de portadores de lesión cutánea crónica. **Método:** Estudio cualitativo realizado a través de entrevistas semiestructuras con nueve sujetos portadores de lesiones cutáneas crónicas en el período de junio 2016 a marzo 2017; se utilizó el referencial teórico metodológico de Red Social de Lia Sanicola. **Resultados:** El análisis de los mapas relacionales reveló que la red primaria estaba formada principalmente por familiares y vecinos; sus características, como: tamaño reducido, baja densidad y pocos intercambios/relaciones, configuran fragilidad en esos vínculos. La red secundaria fue descrita esencialmente por servicios de salud y la enfermera fue citada como formadora de vínculo en el proceso terapéutico.

Consideraciones finales: Ante la fragilidad de los vínculos y del aislamiento social, los profesionales de la atención primaria a la salud son bases fundamentales para la construcción de redes de apoyo social y cuidado al portador de lesión cutánea crónica.

Descriptor: Úlcera de la Pierna; Enfermedad Crónica; Cuidado de Enfermería; Red Social; Atención Primaria a la Salud.

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INTRODUCTION

Among the most frequent skin problems in the daily life of health care services, chronic skin lesions are prominent, which are classified as those lesions that exceed 6 weeks or more to heal⁽¹⁾. With high rates of incidence and prevalence in the population, skin lesions cause great losses in the lives of individuals and their families, especially due to the psychological, social and economic repercussions that affect their lives, modifying social relations and burdening the public system⁽¹⁻²⁾. Because of this scenario, chronic lesions are considered a public health problem.

In Brazil, skin lesions affect the Brazilian population in general, regardless of age, gender or ethnicity. In this way, health professionals must be prepared to perform adequate care for these patients. In Primary Care (PC), the care of the nurse is essential to the care, since it performs several actions, such as: listening, welcoming, nursing consultation, among other assistance and management activities, having as a north the resolution of the health problems faced by the population. However, this care is often focused on a biologic model, not valuing the sociocultural factors involved in the health/disease process⁽³⁻⁶⁾.

In order to provide comprehensive care for patients with chronic skin lesions, the nurse must take into account, in addition to the biological factors, the biopsychosocial factors that may be affected, both in the sick person and in their social network, since the effects of this lesion are multifaceted and reach the family nucleus as well. In this way, increasing the risk of aggravation of the problems of physical and emotional health, being necessary the identification of all the subjects affected by the chronicity of the lesion to promote the quality of life of the patients and the people involved in their social network⁽⁷⁾.

Living with any kind of lesion interferes in social relationships, in the workplace and even in family life. Consequently, people become vulnerable or more susceptible to various situations such as: unemployment, prejudice, social shame and even social isolation, resulting in undesirable effects for life projects. These situations interfere in the state of balance, in the self-image, in the self-esteem, becoming a relevant phenomenon for nursing care⁽⁸⁾.

In order to plan health care, in the last years, the importance of the aspects linked to the network and social support that the bearer and the family seek in daily life has been recognized and considered. Thus, when stable, active and reliable social networks generate health, they have a condition of help, accelerate the process of rehabilitation and healing, and increase survival⁽⁹⁾. The social network is a group of people, organizations or social institutions that are connected by some kind of relationship, where the person can receive emotional, material, service or information⁽¹⁰⁾.

Social networks can be differentiated by the types of exchanges, being they can be primary or secondary⁽¹⁰⁾. The primaries are those in which group together some people known and united by bonds of kinship, neighborhood, friendship and work, where they circulate reciprocity and trust⁽¹⁰⁻¹¹⁾. The family is a central link of the primary networks, because it is in this network that one learns to live in relation, being recognized

as the point of attachment for the construction of human and social capital. The secondary social network, in turn, differs according to established relationships, being it: formal, informal, third sector, market and mixed⁽¹⁰⁾.

Regarding the identification of the support network of patients with chronic lesion, as an important part of care, there is a shortage of publications, some studies⁽⁵⁻⁷⁾ found only address issues related to the feelings of the chronic lesion, social isolation and impacts on quality of life, psychological and economic, highlighting a knowledge gap regarding this theme of recognition of social networks of support in the treatment of chronic skin lesions.

Given the characteristic of prolonged length of treatment of chronic cutaneous lesions, the social network becomes the main support and support of the patient during this period. The nurse in the PC needs to plan care actions for the users and their network. To do so, it is necessary to identify this network to subsidize the assistance of the nurse, since its action is permeated by educational, preventive and curative activities of the treatment and its adherence by the patients and their families.

OBJECTIVE

To answer the following question: How are social networks of chronic skin lesions formed? To describe the social networks of patients with chronic skin lesions.

METHOD

Ethical aspects

The study was part of the "Integrated research on work organization and integrality in services: new technologies in care for the user with skin damage in the health care network in the state of Rio Grande do Sul", approved by the Research Ethics Committee of the Universidade Federal do Rio Grande do Sul and Municipal Secretary of Porto Alegre; complying with Resolution 466/12, where the participants were aware of the objectives of the study and signed the FCCT at the time of the interview.

Type of study and theoretical-referential

This is a study with a qualitative approach, based on the theoretical-methodological framework of Lia Sanicola's Social Network, seeking the structural and functional dimension related to the individuals and the relationships they establish in networks⁽¹⁰⁾. The use of the social network referential points to both the enhancement of qualitative research actions and innovation in the processes of health intervention, and the appropriation of this referential by researchers in the field of health, including professionals in the area of nursing, constitutes an important subsidy for the understanding of the effectiveness of their actions in the professional daily life, as well as favors a more comprehensive view on the social context experienced by the individual⁽¹²⁾.

Study scenario

It was constituted by a Family Health Unit (FHU), belonging to the Municipality of Porto Alegre/Rio Grande do Sul,

Brazil. This FHU has 2,747 households, consists of two Family Health teams composed of the following professionals: two general practitioners, two nurses, five nursing technicians and seven community health agents.

The place was chosen for convenience, due to the professional proximity of one of the researchers with the service and for being one of the places that caused the emergence of the restlessness about the theme of the study.

Data source

The study participants were patients with chronic skin lesions, attended at the FHU (nine users), and the sample closure was defined by the convergences of the speeches⁽¹³⁾. Inclusion criteria were: the presence of a chronic skin lesion (of venous, arterial, pressure and indeterminate cause), being a resident of the area and being followed up at the referred FHU; and the criterion of exclusion: to have some cognitive limitation. There was no refusal to participate in the survey.

Collection and organization of data

The relationships and connections with the social network can be understood through the elaboration of a map of this network, providing a broader understanding of the relationships existing in each node⁽¹⁰⁻¹²⁾. Thus, data generation occurred in the period from June 2016 to March 2017, through the semi-structured interview. This research technique initially had questions about socio-demographic characteristics that included: age, race, sex, marital status, religion, profession, and a brief characterization of the cutaneous lesion (type of lesion and time of injury). Open questions were asked about the relational context with the primary network (about people present in the participants' lives, proximity, description of relationships established and type of links, about the help received and involvement of people with the situation of caring for the lesion). With regard to the secondary network, the questionnaire was questioned about the presence of labor ties, institutions that attended or where they received some benefit, identifying the position they occupied with respect to the person studied, as well as the health services accessed for established bond and aid received.

The construction of the social network map was carried out jointly by the user and researcher at the time of the interview, individually, in the health service or at the home of the participants, by prior appointment. The interviews were recorded and transcribed in their entirety, with an average time of 40 minutes. After the transcription and preliminary analysis, the researcher validated the map of the social network with the participants. The letter M followed by numeral was adopted to guarantee anonymity of the participants.

Data analysis

Based on the interviews and joint construction, using geometric figures representing the members of the various types of social network, data were presented in illustrative maps with the primary and secondary social networks, describing the relationships between the members of the network and subsidizing the importance of nursing care for the user with chronic skin lesion.

The methodological framework⁽¹⁰⁾ used indicates that the social network structure presents some important indicators that allow us to understand how the connections are established in the relational context of the people that compose it. In order to explore the network from a structural point of view and map construction, we considered some indicators such as: amplitude, density, intensity, proximity/distance, physical proximity, frequency and length.

- **Amplitude:** Amplitude: refers to the number of people present and allows to state if a network is small (less than nine members), average (ten to thirty) or large (with more than thirty), that is, it indicates the number of individuals with whom the person maintains a personal contact.
- **Density:** Density: this is the interconnection between the people who are part of the network. The number of people you know allows you to see how many loops there are among members of a network and to identify the nodes, which are the highest density points in the network.
- **Intensity:** indicates the balance of exchange in the relationship between two people. It makes it possible to check whether you are exchanging much or little and whether what is exchanged is material, affective or informative. By observing the intensity of the links, the researcher is in a position to ask some questions, but above all to circulate the information among the members of the network as they become more active and aware.
- **Proximity/distance:** allows the thinking on the affective distance and reveals the degrees of intimacy that can be of extreme proximity; of familiarity; spare; of coldness; and of rupture (separation).
- **Physical proximity:** refers to the physical space inhabited by members of the network, which may be on the same perimeter or shifted miles. Indicates how far these people are located (in the same house, in the same building or community, or yet another city, state or country) in relation to a certain dimension.
- **Frequency:** manifests the systematicity with which the bond is established. The frequency can be delimited as: every day; two to three times a week; once a week; three to six months; about once a year.
- **Length:** indicates how long people in the network know each other.

At the end of the analysis, a typical consolidated map of the patient with chronic skin lesion was drawn.

RESULTS

As to the characterization of the participants, a predominance of males was observed. Of the nine individuals interviewed, five were males and the age group was between 37 and 79 years of age, with a mean age of 56 years, with a predominance of the population over 60 years old (77%). Seven self-reported white individuals and two black self-reported individuals were interviewed. In the screen study, the average age of users living with the skin lesion was 7.6 years, the patient with the longest period with the lesion was 30 years ago and the one with the least time,

1 year. The referred comorbidities were: Systemic Arterial Hypertension - SAH (7); Diabetes Mellitus - DM (6); Vascular Insufficiency (6); Diabetic Neuropathy (5).

The map of the primary social network of individuals with chronic skin lesions shows a small amplitude network, followed by a mean, with a predominance of few relationships among the members of the network, that is, low density. It is noteworthy that this network was composed almost entirely by relatives and relatives, being sister, children and wife the most cited. The family nucleus was responsible for performing the care with the wound, but fragility in the affective bonds was observed. Although most participants referred to the presence of a strong link in their primary network, these relationships were permeated by conflicting, fragile, and even broken links.

With regard to the formal secondary social network, this was essentially constituted by health services that provided care. Only two interviewees cited the figure of the religious entity as part of its secondary network of third sector. They were listed: Basic Health Unit, public hospital institutions, specialty outpatient clinic, prompt care and private health clinics. As to the secondary market network, only one chronic lesion had an employment relationship. We observed in this study the limitation of the secondary network, which refers to the social isolation factor created by the long-term lesion and all the characteristics that surround it.

The relationship between the health professional and the individual studied was characterized as strong, especially in the figure of the nurse of the Health Unit, as described in the speeches:

I went to the post office to get material to make a dressing, but I was wrong. I found the nurse here and she said, "No, I'm not going to give material, I have to see the dressing." And it was the best thing, it was an angel. From then on I started to do the dressings here all day and, as she was changing, and now I'm much better here, I can even wear sandals. (M6)

From the first moment I came in here, they helped me [...] the nurse who takes care of me is a great person, a strong relationship. (M1)

I did the treatment as best I could, if the treatment was effective in the 8 months, that's fine, now if I did not, you had to wait, because they did not treat you before. It is not that assisted thing like here. Thank God I come here every day and do my dressing, I'm well received, I'm well treated, it's a different place, honey. So who took care of me this whole time is you, the nurses here are so caring for me ... (M3)

However, there were speeches that characterized broken links with professionals of other services of greater complexity, as explicit in the statements below:

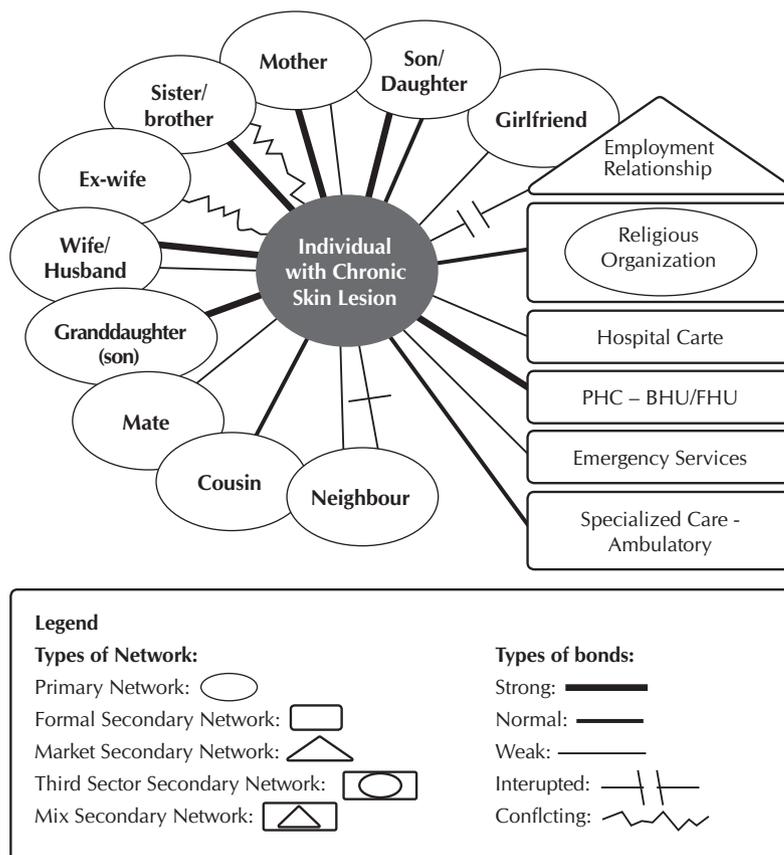
I asked for help to the doctor, he was in a lot of pain, and he said: "There is no cure, my

child, you can put what you want up there, this is a waste of time." - Shouting like that, he said: You know what's going to happen? You're going to lose your legs, it's rotten, but today or tomorrow you're going to be crippled! "It was horrible; I will never forget ... People, my daughter, do not putrefy! ... (M2)

The first time I went to the hospital I had it there and it was crowded, oh, oh!, no vacancy, no vacancy. My son, nervous, said: "And privately, do you have any private rooms? I'm not asking how much it costs, I will pay. "Then I said: My son, you know, a place that we are going to be well attended to is in the health post, okay, so get in the car. Then, at the station I got out of the car with him, and with my sister, I really liked it, I was well taken care of ... (M2)

And when I did the amputation and I was hospitalized I saw that I was in a room that I forgot. I saw in the bandages, the nurses did not like to do much, they wanted to leave for the afternoon group ... And I was afraid of the girls of the afternoon. It was very bad. When I left, they said to wash with soap and water, but it did not help, so I came back to amputate the other ... (M6)

Based on the users' reports about the people they counted for daily care and supported them, individual maps were compiled for each subject interviewed, the data being grouped in the Consolidated Map (Figure 1) for illustration of the typical social network of the carriers of chronic skin lesion.



Note: * PHC: Primary Health Care; BHU: Basic Health Unit; FHS: Family Health Strategy.

Figure 1 - Consolidated map of the carrier of chronic skin lesion

As for the people in her social network involved in the help and care related to the chronic skin lesion, the following children were identified: children, husband(s) wife(ves) and siblings, granddaughter, mother and father. Respondents reported that people involved in the care of the lesion most often offered psychological help and direct care with the lesion, such as changing dressings or lead to health care related to the lesion.

The one who takes care of my wound is my daughter and, sometimes, my husband. Just them. The other children never come here. (M9)

The one who helped me with the wound was first my wife and my daughter, and then my son, too. They were always around me, always asking me to go to the consultation and listening to me. (M2)

Whoever takes care of my bandages is my father, he is the one who does, we have a good connection, he listens to me, he helps me psychologically. (M5)

Some testimonials, however, made explicit how much the patients with a chronic skin lesion felt the need to receive care and which was not always supplied by their primary network.

I never told anyone other than my children and they helped me. I cried a lot because my husband did not help me, my children were outraged, caused a lot of sadness, thought: Argh! We are at the end of life, I thought that one would take care of the other, but not [...]. (M6)

A friend could help me ... a friend ... if you want ... one of them ... if you want, ask me how I am. (M4)

DISCUSSION

Studies have shown that basic diseases, such as systemic arterial hypertension (SAH), diabetes mellitus (DM), neoplasia, stroke and obesity are related as risk factors for the development of skin lesions. They also delay the healing process by interfering with coagulation factors and the supply of tissue oxygen⁽¹⁴⁾. The association between chronic venous insufficiency and hypertension highlights the importance of controlling and/or treating the insufficiency of both pathologies⁽¹⁵⁾.

Research carried out in the Family Health Strategy, in a municipality of Goiás, found a 21.2% rate of hypertension among patients with chronic skin lesions⁽¹⁶⁾. Another study showed that 36.2% had hypertension and 17.2%, diabetes⁽¹⁷⁾, in the same line as research with 50 people with chronic skin lesions, in which 26 had associated chronic diseases, with SAH being the most frequent⁽¹⁸⁾. The study also showed that 15.5% of the world's population over 30 years of age are DM patients, of whom about 15% develop wounds that are difficult to heal during life, especially in the lower limbs⁽¹⁹⁾.

The importance of the control and/or treatment of SAH, DM and chronic venous insufficiency in the Primary Health Care area is emphasized. Family health teams should act in an integrated way in the approach to risk assessment, in the adoption measures to promote health and care for those with chronic

diseases, with a view to positively impacting the health conditions of users with a focus on their quality of life⁽¹⁹⁾.

The maps analyzed in the constitution of the typical social network revealed fragile, conflictive and even broken ties in their family relations. These situations reveal the wear and loss of family members in helping and caring for the chronic lesion. This circumstance is mobilized by the chronicity characteristic of the lesions (relapses, prolonged care, need for access and movement to more complex services). These conditions lead these individuals to social isolation in their network of relationships, being the path of the therapeutic process to solving the solitary health problem and marked by interruptions^(9,20). In addition, reliance on advanced age care of study participants is another factor that increases the need for help and support from family members/caregivers.

In the elderly there is a decrease in the elasticity of the skin and the vascularization becomes slow, which increases the risk for skin lesions. In addition to the tissue changes associated with aging, the possibility of comorbidities, immobility and malnutrition exists in the elderly⁽²¹⁾. The period of skin lesions is directly related to the quality of life of these users, longer lesion time refers to lower quality of life⁽²²⁾.

Research on leg ulcers showed that the majority of those assessed resided only with their spouse or with another family member. Both wound conditions and age cause difficulties in the development of activities of daily living. Thus, the companion or family member can be an aid to meet the possible needs, especially in the non-healthy aging. However, in large part, it is important for the individual to develop his/her care independently^(20,22).

The patient with a chronic skin lesion needs to relate to and live with people who offer support, help and encouragement regarding the care of the lesion, so that family ties are one of the foundations of the treatment. Primary networks have significance and importance in achieving the commitment and inclusion of individuals in the planning of their care. Involving and preparing the family member are essential strategies for structuring a base of emotional support, because as soon as the lesion holder perceives that the family members are also willing to support and care, there is a tendency for these people to present self-esteem and autonomy and thus better adherence to treatment⁽²³⁻²⁴⁾.

Studies have reported that wound-associated odor and exudate can cause psychological problems regardless of the patient's age, sex or socioeconomic status, and can also result in changes in physical appearance that diminish the patient's self-image, impair the opportunity to participate in social and leisure activities, affect their well-being, culminating in social isolation⁽²⁵⁻²⁶⁾.

Regarding the formal secondary social network of the participants, it consisted essentially of health services, in which they sought care related to the demands generated by the skin lesion and related comorbidities. The informal secondary network is that which is constituted from the primary network when there is a common need or difficulty experienced by the members who are part of the same network and was not indicated by the participants⁽¹⁰⁻¹²⁾.

The secondary network of the third sector, based on the exchange in the aspect of solidarity and psychological and spiritual help, was reported by only one research participant. The secondary market network is the social network map of only one patient with a chronic lesion, the others, according to age and clinical condition of the lesion, no longer exert profitable economic activities. In this situation, the individual with a chronic skin lesion also lives in a restricted way to interlocation with the secondary social networks, restricting their relationships to the family sphere and caring for the lesion⁽⁸⁾.

In fact, the presence of a chronic skin lesion affects the individual's perception of their physical well-being and limits activities of daily living and work activities⁽²⁷⁾. Chronic skin lesions can cause harm to patients because they affect their lifestyle due to pain, depression, loss of self-esteem, social isolation, inability to work and often hospitalizations or outpatient clinic visits, leading the patient to social isolation, depression and constraints. The study also shows the social impact of the skin lesion, insofar as individuals feel discriminated against by the family, society and even by themselves⁽¹⁶⁾.

The entrance door of the participants for the treatment of skin lesions and comorbidities in the health services was hospital care for attention seeking. This assertion is in line with the one recommended in the health care network - HCN of the Unified Health System.

Although the horizontal relationship, that is, not hierarchical between levels and points of health care, is recommended, the organizational logic of the SUS in care networks from the PHC reaffirms its role as the main input port of the user in the health system; to be responsible for coordinating the walk of users to other points of attention of the network, when their health needs can not be met only by PHC actions and services; and to maintain the bond with these users, giving continuity to the attention (actions of health promotion, prevention of lesions, among others), even if they are being taken care of in other points of attention of the network⁽²⁸⁾.

However, it is explicit in this study that, although the hospital service is configured as a gateway/access to care, individuals with chronic lesion did not have a significant link with these services. During the study, fragile, conflictive or even broken links were observed. It is possible to relate this data to curative assistance practices limited to recognizing the individuals in their social and relational context, which have little impact on the quality of life and health of the individuals.

The presence of fragile links between health professionals and patients with chronic lesions is linked to the assistance practices still based only on the recovery of the disease, characterizing the lack of linkage in health services that offer fragmented care, lack of continuity of care, with focus in the acute conditions, in the passivity of the user⁽²⁹⁾.

On the other hand, it was also verified that the bond established during the process of caring for their lesion was referenced as being in the PHC and although, most of the time, he was a professional who could establish the bond and empathy from this proposal therapeutic plans and accountability with treatment. The long-term care, which is an attribute of PHC and is often identified by the user through the established

links with a team professional or even with the entire team, ends up strengthening relationships between users and staff, promoting concepts of responsibility and co-responsibility in chronic lesion care.

As a result of the complexity and the longtime-treatment, there is a need for technical ability, specific knowledge, adoption of protocols already validated, acting of an interdisciplinary team, articulation in the different levels of assistance and the active participation of the bearer and his/her relatives, following the integral care perspective^(6,30).

PHC, through the Family Health Strategy (FHS), becomes an important tool for achieving quality in the care of patients with chronic lesion. The focus is on the family and its relationships with the environment in which it lives, performing home care and in the unit, based on integral, continuous care, with a good quality of service to the health needs of the attached population⁽¹⁶⁾.

This ability to assess the patient and to draw up a unique plan for the treatment and follow-up of the chronic lesion, enhancing the positive aspects of the patient and family involvement in the care of the lesion, makes the nurse a foundation for structuring the care with the lesion. to enable the health team to care for this user. In this sense, when the nurse is directly involved with the care offered to the patients with cutaneous lesions, the importance of this professional can be traced, by outlining the singular care plans considering their social support networks, enhancing care, especially those carried out by the primary network.

Study limitations

The main limitations of the study were related to the difficulty of contextualizing the factors present in PHC that may make it difficult to construct care for patients with chronic skin lesions, both in the political and technical dimensions, since the literature on indicators and management aspects of this level of attention is scarce.

It is also worth mentioning the impossibility of generalizations, because it is a study that analyzed the social networks of patients with chronic skin lesions of only one family health unit. However, the study makes it possible to deepen the investigation of the dynamics of the social relations of other users, in different contexts, allowing new research based on other theoretical and methodological references, in order to increase the number of participants and social and relational contexts studied.

Contributions to the nursing area

The nurse, as a member of the health team, plays an important role in the care of patients with chronic skin lesions, diagnosing the problem, following their evolution and performing dressings at home and in health services⁽²⁹⁾. The approximation between the nurse and the individual favors the verbalization, besides the symptoms of the underlying disease and the tissue lesion, of other aspects of their daily life, such as: problems, anxieties and frustrations experienced before the care, relationship with caregivers and chronic wound treatment. Thus, from the creation of a space of reciprocity between the nurse and the individual, it is possible to create strategies for the promotion of self-esteem, autonomy and self-care⁽³⁰⁾.

In this sense, the knowledge of the situation of people with chronic skin lesions, their physical and clinical aspects, repercussions on the psychosocial dimensions in their relational and social context and to identify their support network, the nurse will have subsidies to elaborate a therapeutic plan adapted to the client's care needs aimed at improving their health conditions and changes in quality of life, in addition to qualifying their clinical practice.

The findings of this study bring an innovation for nursing in the theme of chronic cutaneous lesions regarding the identification of the support network as a subsidy for the qualification of attention to this population. In addition, the potential of using the social network map as a device within the scope of the light technologies for the work of health care of the health teams is signaled.

FINAL CONSIDERATIONS

In this study, it was possible to understand that the individual with chronic cutaneous lesion had a small primary network, with few people, establishing bonds between them and most of the time these networks were formed by relatives. It was also explicit that the family relations of these individuals were fragile. This fact may be related to the chronicity characteristic of the care given to these people and also because the family member is often not prepared to deal with this longitudinality of care.

The secondary networks of these individuals were formed, almost exclusively, by health services, where they sought care for their lesion. Again, the social isolation characteristic of the wearer of chronic skin lesions is exposed, since the pain of their lesions is confined to activities such as recreation, leisure, work and socialization.

Correlating data from the research with the literature, it was understood that, although the chronic lesion patient presents aspects of isolation, social networks are fundamental foundations in the search for healing, compromised care and improvement of the quality of life of these users.

In this study it was also observed that the figure of the nurse acting in PC is paramount in the care of the patient with chronic skin lesion, since it is this professional that adds the abilities to evaluate not only the patient with the lesion, but all the social context that surrounds this and, in this way, draw up a unique plan of care that strengthens their social support networks to promote the healing, healing and quality of life of users with lesions.

In view of the above, it is necessary to emphasize the importance of the construction of maps of social networks, in order to identify actors within the relational context of the skin lesioner, who are configured as supporters and promoters of the bonds of responsibility in the care of the lesion, adherence the therapies proposed and the quality of their lives.

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