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Perception of users on self-care of lower leg ulcers

Percepção do usuário no autocuidado de úlcera em membros inferiores

Percepción del usuario en el autocuidado de úlcera en miembros inferiores

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ABSTRACT

Objective: To know the perception of users on self-care of ulcers in the lower limbs.
Method: This is a qualitative, exploratory, and descriptive study conducted with 10 users registered in the complementary programme of a wound care clinic in Canoas, RS, Brazil. Data were collected using information from the medical records of the users and semi-structured interviews conducted between October and November 2016.
Results: The results were discussed according to thematic content analysis with three thematic categories: self-care and living with the ulcer, self-care deficit and supporting users with ulcer, and self-care and the ulcer care network, based on the Nursing Self-Care Deficit Theory.
Conclusions: Self-care is the result of dialogue between the user/nurse/health workers and the link they establish when they share care. The support of family members and the service can facilitate or limit care.
Keywords: Self care. Health services. Nursing care. Nursing theory. Wounds and injuries.

RESUMO

Objetivo: Conhecer a percepção do usuário no autocuidado de úlcera em membros inferiores.
Método: Estudo qualitativo, exploratório e descritivo, realizado com 10 usuários atendidos no Programa de Assistência Complementar de um Ambulatório de Feridas de Canoas (RS). A coleta dos dados deu-se entre outubro a novembro de 2016, por meio de informações contidas nos prontuários dos usuários e de entrevista semiestruturada.
Resultados: A discussão dos resultados deu-se mediante a Análise Temática de Conteúdo, constituindo três categorias temáticas: autocuidado e o convívio com a úlcera, déficit de autocuidado e apoio ao usuário com úlcera e autocuidado e a rede de atenção no cuidado da úlcera, fundamentadas na Teoria de Enfermagem de Déficit de Autocuidado.
Conclusões: O autocuidado resulta do diálogo entre usuário/enfermeiro/profissionais da saúde e do vínculo por eles estabelecido para um cuidado compartilhado, sendo o apoio de familiares e da rede de serviços um facilitador ou limitador do cuidado.
Palavras-chave: Autocuidado. Serviços de saúde. Cuidados de enfermagem. Teoria de enfermagem. Ferimentos e lesões.

RESUMEN

Objetivo: Conocer la percepción del usuario en el autocuidado de úlcera en miembros inferiores.
Método: Estudio cualitativo, exploratorio y descriptivo con 10 pacientes del Programa de Asistencia Complementaria de un Ambulatorio de Heridas de Canoas (RS). Los datos fueron recolectados entre octubre y noviembre de 2016, en los registros médicos y por medio de entrevistas semiestructuradas.
Resultados: La discusión de los resultados se dio mediante el Análisis Temático de Contenido, constituyendo tres categorías: autocuidado y la convivencia con la úlcera, déficit de autocuidado y apoyo al usuario con úlcera y autocuidado y la red de atención en el cuidado de la úlcera, fundamentadas en la Teoría de Enfermería de Déficit de Autocuidado.
Conclusiones: El autocuidado resulta del diálogo entre usuario/enfermero/profesionales de la salud y del vínculo por ellos establecido para un cuidado compartido, siendo el apoyo de familiares y de la red de servicios un facilitador o limitador del cuidado.
Palabras clave: Autocuidado. Servicios de salud. Atención de enfermería. Teoría de enfermería. Heridas y lesiones.

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INTRODUCTION

Lower leg ulcers are a serious social and collective global health problem. They appear spontaneously or accidentally and generally evolve into a chronic injury, accompanied by other preventable aggravations. Chronic injury is an injury that has not healed spontaneously in three months, usually involving infectious processes, and it is characterised as a complex injury when associated with systemic diseases that impair healing(1).

In Brazil, the venous ulcer is the most prevalent of lower limb ulcers, ranging from 70% to 90% of ulcers, followed by arterial ulcers with 10%. Chronic ulcers are classified as arterial, venous, mixed, and neutrophic and they are associated with chronic venous insufficiency, arterial insufficiency, neuropathy, lymphedema, rheumatoid arthritis, trauma, chronic osteomyelitis, sickle cell anaemia, vasculitis, and cutaneous tumours(2).

The guise of these considerations, the care of users with ulcers in the lower limbs, is a huge challenge for nurses(3).

In this study(4), the empirical corpus is based on the Nursing Self-Care Deficit Theory with three theoretical constructs – self-care, self-care deficit, and nursing system(5). This theory supports care with the fundamental premise that every person, at varying degrees, can be responsible for their own care and the care of those needing their care. In this study, self-care is contextualised by describing and explaining the capacity of users with ulcers to care for themselves by engaging in practices for their own benefit and continue these practices to safeguard their lives, health, and well-being. In this context, nurses assess the capacity of users to practice self-care and the therapeutic demands of these users. The self-care deficit, the essence of the theory, is the gap between the demand for therapeutic self-care and self-care itself; that is, when the demand for self-care is greater than the capacity of users to care for their injuries, in which case they can benefit from nursing care to remedy this incapacity originated by the injury. Nurses identify the deficit and intervene by educating users as to the essence and value of self-care, ensuring user commitment with practical efforts to meet the therapeutic needs of the lesion in an emphatic and resolutive way. The nursing system is outlined by the nurse according to the self-care needs of users and their capacity to perform self-care. If there is a deficit between what the user can do and what needs to be done to maintain care, the nurse must assist users with their healthcare. Users with an ulcer in the lower limbs can perform or learn to perform therapeutic self-care by adapting their needs and these self-care activities.

From the perspective of self-care, each individual is unique(5) and the distinct cultural and social characteristics reflect on how users cope with the lesion(6). This study is justified because it contextualises self-care and the need for users to practice self-care and interrelate the meanings of self-care, the self-care deficit, and the skin care nursing system. This approach can help healthcare workers better understand self-care, create strategies to qualify self-care in users with ulcers, especially nurses, and, consequently, cope with this serious social and collective health problem affecting the world populations.

In light of this panorama, the guiding question of this study was how do users with ulcers in the lower limbs perform self-care? The aim of this study was to know the perception of users on the self-care of lower limb ulcers.

METHOD

This is a qualitative, exploratory, and descriptive study(7) conducted with users of the supplementary assistance programme at a wound care clinic in Canoas, RS, Brazil. The clinic was selected because it is the workplace of one of the researchers and it specialises in skin care. The service capacity of the outpatient unit is 80 users and these users were attended at the clinic every week. The clinic has a multidisciplinary team with three nurses, three nursing technicians, two vascular surgeons, a dermatologist, two psychologists, and a nutritionist.

To participate in the supplementary care programme, the users had to be referred to the wound care clinic by a specialist, according to the local territorial zone. However, before being referred to the outpatient clinic, the users had usually passed through several points of care, such as primary care close to their homes or emergency room services. In these services, the users with ulcers receive guidelines from the medical and nursing teams on how to perform self-care. Once the extent of the lesion and the need for specialised care have been identified, users are referred to the wound care outpatient unit. Another way users access the outpatient units is through a hospital counter-referral when complex wound care is required, which, in most cases, occurs after limb amputation.

The outpatient unit has a specific schedule for nurses to perform nursing consultations. The nursing process(8) at the research location guides nursing actions and allows nurses to determine any self-care deficits and the roles of users or nurses regarding self-care for the wound.

The study population consisted of 35 users with an ulcer in the lower limb attended at the service. The sample was chosen by convenience and according to the following inclusion criteria: user of the service over 18 years of age, with lower limb ulceration, both sexes; in medical follow-up at the service; residing in the assigned area; and attending the clinic during the data collection period. The exclusion criterion was users registered in the home care programme.

The eligibility criteria resulted in 10 users with chronic ulcer in regular follow-up at the clinic.

Data were collected from October to November 2016, by means of a semi-structured interview and information obtained from the medical records. To collect the primary data, an interview was scheduled with each user with a semi-structured script used to obtain sociodemographic information from the users and the answers to the following questions: What do you think is important to take care of your ulcer? Who do you effectively depend on to take care of your lesion? What do you think could help with ulcer care? What improves the healing of ulcers? What makes it worse? Summarize your trajectory in the health services.

The interviews were conducted at the clinic in a private room to protect the privacy of the research participants. The interviews lasted around 50 minutes each and they were recorded and fully transcribed with the approval of the users. The participants signed two copies of an informed consent statement; one for the participant and one for the researcher. Data collection ended when the number of participants was exhausted.

The secondary data were obtained from the patient records and the records made by the nurses during nursing consultations, which included photographic documentation of wound evolution.

The methodological framework used to discuss the results was thematic content analysis(7) consisting of the steps pre-analysis, exploring the material or encoding, and interpretation of the results. Pre-analysis consisted of skim reading the answers to the open questions, which required direct and intensive contact with the collected material, with the observance of some qualitative validity criteria, such as exhausting the entire text, homogeneity and the clear separation of subject, exclusivity, as one element could only be present in one category, objectivity, and appropriateness or relevance to the aim of the study. The material was explored by reducing the text to significant words and expressions, followed by data sorting and aggregation, and selection of the empirical categories to specify the theme. Finally, the results were treated with the proposal of inferences and interpretations and interrelated with the Nursing Self-Deficit Theory and other clues of new theoretical and interpretative dimensions.

To protect the anonymity of the participant, they were coded with the letter E followed by a number from 1 to 10, as follows: E1, E2, E3 [...].

This study complied with the recommendations on ethics of Resolution 466/12 of the national health council(9), containing the guidelines and rules of research involving humans. This paper stems from the study "*Organização do trabalho e integralidade nos serviços: novas tecnologias no cuidado ao usuário com lesão de pele na rede de atenção à saúde no estado do Rio Grande do Sul*", approved by the research ethics committee of the Universidade Federal de Rio Grande do Sul, CAAE #56382316.2.0000.5347.

RESULTS AND DISCUSSION

In all, 10 users participated in this study, most of which were men with a low educational level. One of these users was working, three were on temporary leave, and six were retired. Their ages varied from 32 to 70 years. Six were married, two were separated, one was a widower, and one was single. The users reported two cases of amputation due to diabetic foot. The time the users had been suffering from an ulcer in the lower limbs was from 1 to 13 years and the time of follow-up at the outpatient wound care unit was from 8 months to 2 years.

As for history of the lesion, three users attributed the injury to diabetes mellitus, one informed they had had the wound for less than a year, one for around a year, and a third for approximately 10 years. The remaining seven users had had venous ulcers for 1 to 13 years.

Amputation, in the case of people with diabetic foot, occurs in 0.7% and 2.4% of cases(10), a significant percentage considering the irreversible nature and the physical, mental, and social implications of amputation.

As for the care trajectory of the users before being attended at the clinic, some of them went to the clinic in the advanced stage of the lesion after passing through different points of outpatient, specialised or hospital care. In the outpatient unit, nursing became a necessity for the users who were incapable of performing self-care or had some form of limitation (5).

The resulting empirical corpus of the interviews and the records led to three thematic categories, as shown in the Chart 1.

The results presented in Chart 1 are detailed below.

Self-care and living with the ulcer

The participants of this study had specific self-care needs and ulcers in their lower limbs. Some suffered from complications and two had undergone amputation.

Thematic Categories	Subcategories
Self-care and living with the ulcer	- If I had come here earlier, I would be cured by now... - The pain wouldn't let me live...
Self-care deficit and supporting users with ulcer	- Living with and being close... - I took the supplies and dressed the wound at home
Self-care and the health network in ulcer care	- I feel supported here... - Now I take care of it because the nurse told me what to do...

Chart1 - Thematic categories and sub-categories
Source: Research data, 2016.

The incapacitating nature of ulcers can affect the quality of life of sufferers(1) and prevent them from completing routine activities and maintaining their social lives. Therefore, it is important for users to understand these changes and adapt their habits and way of life. This reality was reported by the users, as follows:

> *I left my job, my home, and things that I did. I left everything, I stopped going to birthdays [...]. I didn´t feel like doing things or going out. The wound was a hassle and I could no longer take care of my home. (E2)*

The incapacity caused by these lesions is worrisome because it triggers several alterations and affects the quality of life of sufferers(11). It is crucial for nurses to apply the nursing self-care deficit theory(5) in cases where this deficit is detected in order to provide priority nursing interventions and help users understand their condition and take better care of themselves in this new life situation.

The users also mentioned problems with routine activities like sports, tending to pets, taking care of themselves, and even personal hygiene.

> *I stopped playing ball and I retired because of the wound. I'm not doing anything, I just lie there with my leg up. I can´t even take care of my dogs anymore, I know I can't. (E3)*

> *One of these days, I was cutting firewood and a splinter hit my foot, I thought it would just hurt, [...] but it caused a wound and I had to stop everything. (E4)*

The users are unable to perform the activities they were used to doing before the ulcer and are less willing to leave home. Therefore, they need support to gain or regain their commitment and cope with the limitations in their everyday lives. Users need the fundamental support of nurses for self-care since they are expected to care for themselves and their well-being and treat their lesion at home(5). Whenever users are fully or partially unable to perform effective and continued self-care, nurses must help them during the nursing consultations by involving them in the treatment and promoting self-care.

*If I had come here earlier, I would be cured by now...*refers to the self-care deficit(7) to which the users are subjected, serving as a warning for the need to guarantee nursing interventions with clear strategies for self-care. The reports were the following:

> *I put lots of ointments and used all sorts of things. I didn't understand why my wound would not close. But here, after the nurse used that special dressing, I started to get better. (E7)*

> *As soon as I retired because of the wound, she put lard and ashes. She was the one who dressed the wound. It got bad in three days. That's when this huge hole opened up. (E3)*

These statements show these users needed care and did not have the skills to take care of the lesion. Despite the value of cultural and popular influences, users can become vulnerable and boycott their own treatment rather than choose to follow the self-care guidelines. This failure to follow the correct treatment can interfere with healing(6) and calls for nursing interventions to help users remedy the self-care deficit(5) and change their habits. The proper care for the epithelialisation of the lesion has an almost immediate effect, reduces the skin epithelialisation period, and ensures the quality of life and therapeutic safety of users(11).

For the users, treatment for chronic ulcer care was considered complex and difficult to access in the services where they sought care. However, they also stated the following:

> *When I was referred to the outpatient unit, the nurse's dressing worked immediately and the wound got better. (E8)*

The indication for better ulcer care and the knowledge of nurses of the self-care conditions of users can shed light on the issues that led sufferers to remain affected by the lesion. Awareness of the social problems that affect ulcer care helps nurses provide more targeted guidelines that users appreciate and brings them toward the centre of care(5).

The users also referred to the impact the pain had on their lives and how it triggered new habits and routines; *the pain wouldn't let me live*... led them to look for help.

> *The pain wouldn't let me live... The pain was horrible, because anything you want to do, you feel a lot of pain. I thought the suffering would last forever. So I looked for help. (E7)*

> *I never want to feel that pain again, it won't let me do anything. That´s why I always come here and never miss a day. (E9)*

Pain was referred to by users as an unpleasant feeling that causes discomfort and involves several stages, from mild to very strong. It was mentioned as one of the important motivations to attend the weekly service in the outpatient clinic by the nurses, who also attributed the discomfort to the position of the wound in the lower limb and the dressing. Moreover, the users mentioned the irritability and diminished concentration the pain causes and their difficulty in coping with or tolerating pain in order to perform their daily activities. In contrast, users of the diabetic foot ulcer reported no pain. This type of injury has a neuropathic origin(11). Valuing this information from users is critical to ensure their adherence to treatment and self-care. The pain generated feelings of anxiety and suffering, discomfort, discouragement and lack of support, leading to social isolation, could have been better managed by users if they had had the opportunity to share these issues with the nurses(5, 11). Together, they could have better assessed the situations and found the best conduct for users as the active participants of their care and according to their singularities.

Self-care deficit and supporting users with ulcer

The care and support of users with ulcer involve a series of relationships that require attention and are constituted as zeal with mental and collective health(12). The results revealed the important interpersonal issues and impact the ulcer has on, for example, family relations, which often interfere with rehabilitation, healing, and survival. A stable bond, *living with and being close*... can both help and inhibit self-care.

The following is a report of a user about his everyday life with his wife:

> *She keeps insisting. There's no point in me telling her to stop, and it's agony. I take care of myself, and when I get home, I immediately put my leg up. [...] But when no one's looking, I keep working, I can't stop, I'm still collecting cans and I have more than a thousand. She knows and is always reminding me that I can't do that. She is the ulcer inspector. (E8)*

These details of daily life and the weakening of community and family ties influence the lives of users, making them even more vulnerable. Living with and being close to someone with a lower limb ulcer is linked to the belief that this condition comes with life changes, not only for the sufferer but also for the family, which is not always prepared to help with the self-care or the limitations and affective and effective exchanges(6). Another report also provided details on the help of family members:

> *At first, she didn't help me with the dressing. But when I got worse she started to help, and even washed the bandages and put them out to dry. Today she makes food for me, she is taking care of it. [...] She realised she was losing me. (E3)*

An indigenous user mentioned the partner's refusal to sleep in the same bed with him and her rejection of the ulcer treatment, an Unna boot, leading to several confrontations:

> *You know, the leg wound soiled the bed. My partner smelled that and said: it's bad, it's bad. [...]. She said it must be something in the boot, some product [...] Now I sleep on the couch, which is in the entrance of the house, outside, because in bed, she doesn't let me use the bed anymore. And this happens every day. (E9)*

This same user also revealed that he cannot perform certain tasks, such as cleaning the yard. Due to his inability to adapt to the changes imposed by the lesion, he is no longer accepted in the community.

> *What I go through has to do with the wound, they say bad things about me, they don't understand that I can't help. It is very difficult to live with this lesion. (E9)*

The way the indigenous community organises the village favours interaction between the groups. While some cut wood for the fire at night, others supply the food for the village, always in the form of collective work. The support offered by the family, whether emotional or functional, is critical to maintain or even promote indigenous health(13). Understanding how indigenous users organise their lives in the village and how they interact with others and with their families can help nurses identify self-care deficits(5). The example shows difficulties in adapting to life changes because the collective customs are part of a social construct and they are influenced by the setting in which these communities live, thus calling for the tireless effort of nurses to remedy this situation. This finding agrees with the Nursing Self-Care Deficit in the sense that adherence to self-care is linked to the education nurses provide to users(5). To further support nursing actions, meet the care requirements of users, and help them cope with their clinical conditions and self-care, nurses can invest in education, bridge the gap between users and indigenous communities with the service, develop better priority actions, and strengthen ties.

Other self-care deficit and support situations for users with lower limb ulcers were expressed according to the subjectivity of each user in the statements regarding self-care and the care trajectory and shed further light on the relationship between the self-care capacity and demand of users. The motivations reinforce the need to work with nursing interventions that provide conditions for individual education.

Moreover, the users mentioned they did not effectively adhere to wound treatment and only resorted to primary care services, emergency services, hospitals, or private practices when the wound got worse or when they needed to change the dressing with bandages, saline solution, and gauze: *I took the supplies and dressed the wound at home...* Many times, despite their knowledge of the lesion, some users continue with lifestyles that hamper therapy and perpetuate the self-care deficit(5).

> *I took the supplies and dressed the wound at home. They didn't ask me if I knew how to do it and they didn't do it there for me either. I'd do it every four days, every three days, put Aloe Vera, olive oil, some sugar. Then, when I took it off, it was full of bugs. The bugs went in, they were stronger than I. (E3)*

Reading between the lines, this statement reveals some factors that contribute to the self-care deficit in terms of user empowerment and the negligence of health workers who do not use their skills to teach users self-care and of the services for allowing this negligence to continue. Social structure and environmental factors have a huge impact on the care and health of users with lower limb ulcers, and may even determine their health trajectory and affect their access and use of the healthcare system(11).

Self-care and the health network in ulcer care

The Nursing Self-Care Deficit Theory(5) focuses on user capacity to fully or partially perform self-care. This requires the involvement of nurses/health worker since they can promote self-care for social transformation, which occurs at the services insofar as interpersonal relationships, dialogue, and communication are successful through help, receptiveness, respect, confidence, warmth, interest, and sensitivity toward others(5-6).

I feel supported here...reveals important aspects of the Theory in terms of qualifying services for the care and empowerment of users with a self-care deficit, especially in relation to the important role of nursing workers in care and the recognition of education to raise awareness and increase responsibility and quality(14).

Before reaching the wound clinic, some of the users had already gone through different points of care or cared for their lesions at home. Creating a link with nurses/health workers, previously unknown to them, was paramount for the initial establishment of trust and effective care(5). Below, some statements about the first appointment at the outpatient wound clinic.

> *When I arrived, they gave me hope of healing, I feel good here. (E2)*

> *When I walked in here and talked to the professionals, I had hope. A light shone, a door opened. I saw that there was a solution. (E7)*

> *They had never had a look at my leg, not even in the private consultation. The doctor wasn't bad, he just didn't solve anything [...] here it's different, they take a close look, talk to me, and answer my questions. (E10).*

These users brought different experiences on their lack of preparation to perform self-care.

> *Now I know what I'm doing. I learned a lot here. [...] If anyone from the village gets hurt, I tell them to come to the outpatient clinic because the professionals are very good. (E4)*

The close relationship established from the moment users notice the workers are interested in and recognise their condition and singularity from content-based conversation(6) pinpoints the reasons for getting information, acquiring insight, and applying it to concrete wound care situations with all the necessary changes of habits and lifestyles to support ulcer care and ensure well-being. The results confirm that satisfied users are more likely to adhere to the prescribed therapy and provide important information to caregivers based on effective communication and qualified listening(15).

Now I take care of it because the nurse told me what to do... stresses the relevance of nursing in the self-care of users based on approaching practices, cultures, and knowledge to the real needs of users with lesions, jointly established between users and nurses with agreed nursing care priorities. This agreement makes users the active participants of their care and shows them the choice has to be theirs to make and their way of life, family organisation, past knowledge of the lesion, and knowledge of popular practices should be considered sparingly to prevent interference with healing(6). Self-care is a requisite for all users. When self-care is not performed, the resulting self-care deficit(5) leads to a worsening of the injury. The re-standardisation of these actions is critical for the well-being of people with lesions and for the development of strategies that qualify the self-care of users in the nursing system.

At that point, nurses can assist users with difficulties in obtaining or regaining their self-care responsibilities based on an understanding of their reality and a combination of actions that support their culture and local beliefs(6). Talking to users about the lesion, the dressing, expectations regarding therapy, and coping strategies can help establish more solid ties, strengthen self-care, and ensure adherence to care(16).

A user who had had diabetic foot for about 10 years with numerous relapses stated primary care gave him access to consultations and dressings. Although he consumed alcohol, he did not associate this habit with the retarded healing process. The referrals between the different care points also proved fragile since the transit between primary care, emergency care, and hospital care created knowledge gaps. This discontinued care and, possibly, the lack of connection to a nursing system forced users to seek different healthcare services(7), generating the self-care deficit and the inability to meet their real needs(7). Nursing plays an important role in this rapprochement between the points of the health network because of the difficulties users have in assuming self-care and to facilitate and qualify access to the care points, regardless of the complexity of the injury or disease affecting the users who seek care(10). To holistically increase the problem-solving capacity of care for users with ulcers, nurses can promote self-care with the local authorities and connect the different points of care for this population.

For effective self-care, scientific knowledge must maintain a dialogue with popular knowledge and acknowledge the origin of meaning users attribute to their method of care(6). Users must assume self-care based on the guidelines they receive to choose what is best for them. In this case, co-responsibility in the implementation of care becomes critical.

Now I take care of it because the nurse told me what to do...shed light on the conditions required to make changes. The support and education of nurses proved fundamental to meet self-care demands. It was also important to know which guidelines users received and how they behaved in relation to them; not to discuss whether they are right or wrong but to promote education in which users become the active subjects of their treatment and can recognise actions that support or hinder wound care(5). Some important statements were made regarding this issue.

> *This is for life. (E4)*

> *Oh, now I take better care of myself. I rest more, if I don't take care of myself, it won't help. (E7)*

From the standpoint of self-care, nurses(5) must adapt the needs of users with lesions to their reality and encourage them to talk about their difficulties. They must also help them participate in care as the lesion heals and make them the co-participants of care to satisfy their own self-care demands.

FINAL CONSIDERATIONS

Users with lower limb ulcers recognised self-care was the result of the dialogue with nurses/health workers and the ties established with them for shared care. They equally stressed the importance of assuming a personal commitment and co-responsibility in ulcer care. In this case, the support of their families and the healthcare system became a facilitating or limiting factor of self-care.

In this study, the users attributed the self-care deficit to the different therapies and consultations. These results are an important step toward improving care for this population. Moreover, they signal the need to find more effective educational self-care interventions and support user autonomy by valuing self-care through nursing/healthcare contributions that are compatible with the needs of these users.

One of the limitations of this study was the research setting, namely an outpatient wound unit with a specific technical and organisational structure and contingents of professionals who provided skin care. Other primary or hospital care settings possibly deserved closer analysis also because of their care-related peculiarities and the singularities of wound care.

The results of this study are a contribution to education, research, care, and management. They also provided academic visibility to self-care by describing how users take care of their ulcers and ensure their well-being, thus providing nurses and health workers with information to assess the care contexts of users with an ulcer. The study highlighted the possibility of applying the Nursing Self-Care Deficit Theory when self-care is deficient and, therefore, demands action to extend the arsenal of care, increase user autonomy, and contextually insert nurses, health workers, managers, and services into the care of users with lesions. In some care settings, self-care practices disagreed with the capacity of users to choose, thus impairing their autonomy for self-care and delaying the lesion healing process.

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