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Exploring Patient and Caregiver Perceptions of Primary Healthcare Sector Home Care for Simple Acute Wounds

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Ling Jia Goh, MClin Res, MHA, Adv Dip (CCNC), BHS (Nursing), Dip (Nursing with Merit) • Senior Staff Nurse • Department of Nursing • National Healthcare Group Polyclinics • Singapore
Xiaoli Zhu, MN, PostGrad Dip (Wound Care), BHS (Nursing), Dip (Nursing) • Wound Nurse Clinician • Department of Nursing • National Healthcare Group Polyclinics • Singapore

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GENERAL PURPOSE:

To provide information about a study exploring patient and caregiver perceptions of home wound care for patients with simple acute wounds in Singapore.

TARGET AUDIENCE:

This continuing education activity is intended for physicians, physician assistants, nurse practitioners, and nurses with an interest in skin and wound care.

LEARNING OBJECTIVES/OUTCOMES:

After completing this continuing education activity, you should be able to:

1. Assess benefits and barriers to home wound care management.

2. Analyze the methodology, results, and implications of the study.

ABSTRACT

BACKGROUND: To control healthcare expenditure, patients with simple, acute, low-risk wounds are encouraged to perform self–wound care at home. However, patient perception of this care is not known.

OBJECTIVE: To explore patient and caregiver perceptions of home wound care for patients with simple acute wounds in the primary healthcare sector in Singapore.

METHODS: This study used the constructivist grounded theory approach. Nine participants from 2 polyclinics were interviewed. In vivo codes were extracted, and the constant comparative technique was applied throughout the analytical process.

RESULTS: Fear, lack of knowledge, and the difficulty in performing care resulted in many patients avoiding self–wound care. Age, educational level, and cost did not have much impact. Participants with some first aid knowledge and those who appreciated the flexibility of self–wound care were more likely to embrace this concept. Participants also suggested that telecommunications and mobile nurses could assist in this concept.

CONCLUSIONS: Generally, patients are willing to accept this self–wound care concept. To ensure successful implementation, nurses should encourage eligible patients to attend educational programs to prepare them to perform wound care at home.

KEYWORDS: acute wounds, attitudes, beliefs, caregivers, perceptions, self–wound care, simple wounds

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INTRODUCTION

A society in which the older adult population is growing and more people are afflicted with chronic diseases means an increased demand for healthcare resources and an associated increase in healthcare expenditure. In 2011, Singapore spent $4 billion on healthcare; it is estimated that this amount will triple to $12 billion in 2020.[1] Telemedicine, as a potential mode of healthcare delivery, could help to relieve the burden faced by the healthcare system. One application in wound care is guided self-management, where patients perform wound care at home with nurse monitoring and appraisal of wound healing progress via telecommunication. In Singapore, most patients visit primary healthcare facilities for the management of simple to complex wounds and continue visiting the clinic until the wound heals. If simple, acute, low-risk wounds could be managed with telewound care, healthcare resources could be more efficiently distributed. Nurses could focus more on caring for complex wounds in the clinic and diverting more effort toward researching and implementing best practices in improving wound care. For successful implementation of this telewound care modality, there is a need to understand the home wound care management concept and assess its acceptability to patients and caregivers.

There are many benefits to self-care In a qualitative study done in Italy, self-care procedures were greatly advocated by patients who need to manage multiple family, work, and social roles.[1] The freedom and flexibility of integrating self-care procedures into daily activities allow patients to continue engaging in family responsibilities, employment, social outings, and travel.[1–8] Patients gain autonomy when in control of their own health and treatments, improving self-worth.[1,2,4–6,8,9] Time and expense saved on transport and waiting in the clinic give patients the additional freedom to do other activities.[1,6] Perceptions of sickness decrease because there are fewer interactions with physicians and less time spent in healthcare facilities.[1,4] Further, social support from staff and family increase patients' willingness to perform self-care procedures.[1,4,6,8]

Barriers to self-care also exist. Fear of pain, blood, adverse reactions, uncertainty, and the complexity of medical procedures may impede patients from performing self-care procedures.[2,7,9–13] In some studies, for complicated procedures, patients insisted that only trained medical professionals should handle them, because even with training, patients and caregivers doubted that they could manage the procedure as successfully as healthcare professionals.[2,8] Some patients felt that getting them to perform the procedures was a shift of healthcare responsibility.[1] Patients also expressed that therapy within the home environment would be inconvenient because the treatment equipment could take up or alter the space at home.[6,9,10] Lack of self-efficacy and motivation were positively associated with patients' unwillingness to do self-care procedures.[1,7,11,14] For some patients, the medical center provided and paid for transport, so there was no incentive to perform the procedure at home.[1]

For caregivers, the overwhelming responsibility, stress, and fear of causing harm and pain to loved ones are taxing.[1,3,6–8,11] The influence of friends and family and the cost of performing the procedure at home also seem to play a role in patient decisions about whether to perform self-care procedures.[10,11,13]

Singapore is diverse and multicultural, and perceptions of care are greatly influenced by this unique environment. Because of this, it can be difficult to generalize the outcomes of other studies to Singapore. Moreover, other studies have explored perceptions of performing self-care procedures, but have not focused on wound care specifically. Differences in the type of self-care procedure, sociocultural environment, healthcare operations, and financing systems indicated the need for a local study.

METHODS

The aim of this study was to explore patient and caregiver perceptions on performing wound care at home for patients

with simple acute wounds in the primary healthcare sector in Singapore. Grounded theory methodology was determined to be best suited to investigate these perspectives and how social circumstances could account for these thoughts and behaviors.

This study took place in two polyclinics that provide primary healthcare services to the community. The polyclinics chosen were as diverse from each other as possible in terms of location, patient profile, and types of wound to encourage maximum variation sampling. The first polyclinic is situated in the old neighborhood in the northeast region of Singapore. This neighborhood has a high percentage of older adults, and therefore the clinic sees higher rates of surgical wounds, skin tears, and abrasions from accidental falls. The second polyclinic is in the western region of Singapore, where there are more construction and industrial sites than residential dwellings; this means more encounters with wounds sustained by blue collar workers from work incidents.

Participants recruited into the study had to be at least 21 years old. Patients with simple wounds such as superficial lacerations or abrasions, first-degree burns, surgical wounds without dehiscence, and skin tears were included. Those with cognitive impairment, hearing impairment, vision impairment, venous ulcer, arterial ulcer, mixed ulcer, diabetic ulcer, pressure injury, fungating wound, and/or wounds requiring follow-up management by specialists or podiatrists were excluded. Nurses were briefed on the details of the study and were asked to introduce the study to patients who met the eligibility criteria. Eligible patients were asked for permission to allow researchers to approach them to discuss the study in more depth. In total, 9 patients were enrolled.

Data were collected via face-to-face semistructured interviews. The interviews took place during the wound healing phase. Participants who had performed wound dressing changes before did the procedure themselves; none enlisted the help of their caregivers. Audio recording started once the interviews commenced and ended at the end of the interviews. Participants were asked open-ended and nonleading questions according to an interview guide. Probing was done throughout the interviews to ensure that all questions in the interview guide were answered.

Permission to conduct the study was obtained from the relevant ethical boards (National Healthcare Group Domain Specific Review Board and University of Manchester) and the chief nurse and nursing managers of the two polyclinics. Written consent was obtained, and participants were informed that the interviews would be recorded. If the participants felt uncomfortable with the interview/audio recording, the interview would stop. Participants were given a serial number not linked to their identity. Caution was exercised when quoting in vivo codes to ensure that the codes were not long enough or unique enough to be linked to the participants.

Data analysis was done in accordance with constructivist grounded theory. Constructivist grounded theory was developed by Charmaz[15] based on the assumption that social reality is constructed and theory is not discovered but coconstructed by the researcher and participant and is influenced by the researcher's perspectives and values. In vivo codes were used, meaning participants' words were used as codes. In vivo codes help to preserve participant meaning, views, and actions in the coding itself (a unique feature of Charmaz's constructivist grounded theory).[15] For every transcript, the codes were constantly compared and sorted into categories. Repeated codes within the same transcript were deleted. The constant comparative technique was applied throughout the analytic process to facilitate coding into categories. Interview statements and incidents within the same and different interviews were compared to look out for similarities and differences. Coding and constant comparison were done by the principal investigator with help from her university supervisor.

Rigor was ensured by maintaining credible study data, having an auditable data collection, and the analysis process. At the end of each interview, the interviewer would summarize the information given by the participant to obtain his/her feedback as a form of validating the information given. Emerging concepts were cross-checked with the next participant. For interviews conducted in Chinese, the principal investigator did backward translation into English, which was counterchecked by the coinvestigator; both of the investigators are bilingual in English and Chinese. The assumptions and values of the interviewer were recorded at the end of every interview, and the process of coding to the development of theory was recorded.

RESULTS

The ages of the participants ranged from 25 to 80 years; 2 of the 9 participants were 65 years or older. There were 6 males and 3 females. One of them was Malay, 1 of them Indian, and the rest were Chinese. Six of them were employed, 1 was a student, and 2 were retired. All reported having good family support, were in good health, and could independently perform activities of daily living. Four participants had surgical wounds; 2 had infected superficial wounds; 1 had abrasions; 1 had lacerations; and 1 had abnormal tissue growth.

Five of the interviews were conducted in English, and 4 were conducted in Chinese. The interviews ranged from 5 to 46 minutes; interviews that were shorter yielded fewer codes. In total, 643 codes were extracted from the 9 interviews, of which 93 codes were grouped into categories and sorted into different themes (Table). The principal investigator conducted the interviews over a period of 2 months in 2016, with guidance from her supervisor from the University of Manchester. Three

Table.
INTERVIEW CODES

No.	Theme	Category	Codes
1	Personal factors	Fear of infection/pain	8
		Lack of knowledge	8
		Personal characteristics	14
2	Procedural and wound considerations	Location and nature of wound	10
		Nature of wound care procedure	8
		Resources	5
3	Socioenvironmental economic factors	Family support	8
		Environmental factors	9
		Time and cost efficiency	8
4	Self–wound care program	Target audience	2
		The program	13

participants felt that their wound dressing changes were complicated because they were on the back, scrotum, and kneecap, whereas the rest felt that their wound dressings were simple. Eight participants had performed wound care at home, and the only participant who did not verbalized that the wound was located on his buttock, which was not accessible to him. However, he agreed with the concept of wounds managed at home if the wound was simple and accessible to him. In sum, 7 of the participants agreed with concept, but 2 still preferred to go to the clinic for wound care.

Theme 1: Personal Factors

Fear of Infection. Participants feared infection beneath the wound, worms appearing in the wound, and not knowing whether there was an infection. Some feared that not being hygienic enough would lead to contamination of the wound and wound deterioration. Lack of knowledge about wound products and procedural steps was the basis of these fears. One participant feared that the underlying cause of the wound was a sign of cancer, which could go undetected while performing wound care at home. Participant 3 said,*

"*This is my fear that is why I came this small wound don't know how to manage if I know how to manage, I will manage, if 1 week still not recover and keep on inflamed and swell, then there is something wrong ask me to eat antibiotics, ask me to take painkillers must be in recovery state if it is deteriorating could be cancer we don't know our body anytime.*"

Fear of Pain. Pain from removing the dressing and during cleaning impeded participants from performing their own wound care. Participants stated that if nurses performed the dressing change they could rest back or hold onto their chairs while in pain. Ironically, pain from mobility and walking to the clinic led to two participants advocating doing wound care at home. Participants also suspected that those who frequently sustained wounds were less scared of pain and therefore more likely to be interested in self–wound care.

"*Coming to polyclinic initially was a painful affair for me because I take bus, and I am wheelchair bound so coming to polyclinic was a headache for me.*"

Lack of Knowledge. Participant 2 felt that those who were medically trained or had some knowledge of first aid were more confident performing dressing changes at home and felt that those without medical knowledge were at a disadvantage. These participants would sometimes hesitate when questions surfaced to think whether their steps were right. These reactions could be a result of fearing the wound would deteriorate if some steps were performed incorrectly.

"*If do at home, we would question, do we have the confidence, what is this thing, is this thing recovered, is there worms?*"

In the clinic, the nurse could assess the wound and appropriate actions would be taken immediately if the wound was not improving. The ability to assess wound condition was therefore very important to participants to avoid undesirable consequences.

"*My wound actually got some infection back then; they actually change the medication, they consult me, after much discussion okay we would be doing this, using iodine to clean your wound, speed up your healing, at the same time to kill these infection areas, but if I myself is doing it at home, I wouldn't know that there is an infection, only know that it is normal, just clean or something not right, then I come back, maybe the situation might be worsen or the situation not so bad but just a slight infection only which can be avoided.*"

*All quotes are published verbatim from the study transcript. The publisher is aware of the errors but has opted to preserve the patients' own words as qualitative data.

Personal Characteristics. Individual personality and mobility were important in deciding whether to perform self–wound care at that point or in the future. Patients had to be independent and motivated and have right attitude toward performing wound care at home. In contrast, education level and age did not play a significant part. Participants who did not like caring for their wound at home felt the process of caring their wounds was inconvenient and would rather return to the clinic.

"*Yes, I asked the nurse, I asked the nurse everything from step 1 to step 5 why you do this for me, and the nurse asked me why I want to know because I say if I got no time, I overseas sometimes, I have to do my own dressing so you are right you must teach me everything, don't leave everything behind.*"

"*I don't mind doing in the polyclinic since I am able to reimburse; why am I going through the hassle when I am able to claim make use of the services that is being provided, make use of the policies that allows you the benefits the welfare for you just coming down to get it done with.*"

Theme 2: Procedural and Wound Considerations

Location and Nature of the Wound. Even if a wound is simple, if the locations of the wound are inaccessible, participants may still view their wound as complicated. Participants felt that these "complicated" wounds should only be managed in the clinic, and how complicated the wound was should be determined by the patient, not the healthcare provider.

"*Anatomically, you have to sit in a specific posture very hard to do it you cannot lie down, you had to be sitting, and you have to put your leg down somewhere you have to see so from procedure point of view myself it was not that easy.*"

"*Mostly I think if people see serious, I don't think they will do it by themselves but sometimes even this serious (referring to his wound which was simple), they won't dare to do it.*"

Nature of the Wound Care Procedure. Participants with wounds that were easy to reach, either on the limbs or abdomen, felt the procedure was easy and could be completed within 5 to 15 minutes. For a procedure that required many steps, participants felt that nurses could do a better and faster job.

"*If I am doing it myself, maybe I take 15 minutes to do, but if the nurse doing it for me, 5 to 10 minutes, finished because they are trained, they know exactly so they actually cut short the time.*"

"*Many steps means taking it out, having to apply this then apply that, very difficult to manage by self.*"

Resources. To manage dressing changes at home, the home environment should be equipped with a complete set of materials. Participants had mixed experiences obtaining the required materials. Some participants stated they had easy access to the materials from their pharmacy, whereas some participants said it was inconvenient because they had to make sure that there were sufficient dressing packs or could only obtain their wound products from the pharmacy within the clinic.

"*Unless I have all the materials, everything intact, have the materials at home, everything have then maybe okay but unless don't have anything no swab no whatever all these things, then it is better to come here (clinic) you can buy at pharmacy anytime, the materials, the bandage, or whatever.*"

"*But there are still some materials that need to come back to the clinic to get the only inconvenience is I must make sure I have sufficient dressing pack for me.*"

Theme 3: Social, Environmental, and Economic Factors

Family Support. Participants were reluctant to ask family to help because they did not want to trouble family members with their own problems. They also feared that caregivers would not perform the correct steps. Family members were also reserved when asked to help because of schedule constraints and lack of knowledge about the procedure. Fear of being blamed if something went wrong created a resistance, discouraging family members from helping. However, participants preferred to get family members to help if they could because family members knew and understood the patients better than the nurses did. For older adults with mobility difficulties, family members could provide support and encouragement for them to manage at home because there would be difficulties coming to the clinic.

"*Do not want family members to clean because do not want to always trouble family members or burden them. If can, we should do it ourselves if there is no mobility issue. Family members, they have things that they need to do. I just need to come here myself, and I think this is a small problem.*"

"*The problem is that she can only do that for me on weekends because week days, my time and her time are different because by the time, I come back is 2, 3 in the morning, weird hours my parents are reluctant to help because they are not medically trained they are afraid they do the wrong procedures you see they don't want to be a risk taker.*"

Environmental Factors. Facilities in the clinic were better in performing wound care and were more environmentally friendly because medical waste could be disposed of together. However, two participants preferred doing dressing changes at home because of unpleasant encounters with nurses in the clinic. They felt that there were different levels of care in the clinic environment, and it was stressful not knowing the personality of the nurse they would meet with. Both agreed that it takes just one unpleasant encounter to establish a negative or unproductive care relationship. Participants felt that the ideal place to perform home dressing should be in a clean and bright room with door closed so that there would be no disturbance from family members. More human contact and movement were associated with an unclean environment.

"*Firstly when doing at home, you do dressing must prepare plastic bag, and this plastic bag after doing dressing must discard basically it is not environmentally friendly because every time you do you use a plastic bag, but for polyclinic, it is a general waste; they have a central collection they do dressing at the end of the day, they just discard the whole entire thing.*"

"*First and foremost, the person who wants to do dressing at home, his house should be very clean. It is not just at home, you just do your floor have dirt, when you open up your wound, the dirt will fly up before you put in, the dirt also comes in. You have to mop your floor with detergent, good one, and add in Dettol and everything and clean make sure the fan the blades are clean the dust sticks onto the blade also unhealthy also when spin make sure the lights must be very bright, if your light not bright enough, you can't see. So, you buy a lamp with florescent light, then you can see your wound. This is proper dressing.*"

Time and Cost Efficiency. Participants felt that time would be wasted in travel and waiting if they were to return to the polyclinic for simple dressing. Their scheduled appointments could be given up to help others who were more in need. Cost was not a concern for working adults because most of the participants' companies offered excellent medical benefits. Nevertheless, participants did agree that the cost of wound care at home was less than in the clinic. One participant felt that the time, resources, and costs saved would eventually benefit the national economy.

"*You are giving room for more patients to be seen. If I am coming down unnecessary every day, that means I am eating up the space of some other patients.*"

"*Money doesn't matter because my company reimburses for everything, so money wasn't a matter.*"

"*You save the time of the person, you save the money these all contribute to your nation's success time is money, and the money is also money time money both you are saving.*"

Theme 4: Self–Wound Care Program

Participants welcomed the idea of implementing a self–wound care program and felt that organization should take into consideration several factors such as the target audience, structure of the program, how the program would be implemented, and the necessary resources when implementing such program.

Target Audience. Participants felt that they would attend if they have the time. Although 2 participants felt that age did matter, this was contradicted by the oldest participant, who was 80 years old and showed keen interest to learn.

"*For people, like the senior citizens, unlikely they want to learn because to them, they don't know anything. They, the elderly, will have a reluctance of learning things even though you go for training or basic wound care.*"

The Program. Participants felt that learning through communication with the nurses and having the session conducted 1-to-1 would be beneficial. The program could also be structured like a first aid or training course. Patients felt that information about step-by-step dressing procedure, how to assess wound condition, infection control, common mistakes in dressing, and where to get the required materials for home dressing should be included in the teaching. Nurses should do an impromptu assessment of the patient's capability before allowing the patient to do home dressing changes. Participants felt that patients should not be left alone to do wound dressing without monitoring. They should be advised to return to the clinic after few attempts of home dressing to allow evaluation of the wound progress by medical professionals. Alternatively, participants suggested having a mobile nurse or using telecommunications to help in monitoring the wound. Resources in the form of brochures, booklets, advertisements, or websites should be given out to enhance participants' learning.

"*Because some patients might not be comfortable to ask question when in a group. Same thing like in a lecture, in a lecture, the lecturer ask any questions, the people would not be so vocal, keep it to themselves, after end of the lecture, they would approach the lecturer to say I have some questions to ask you.*"

"*If there is a mobile nurse check on me if I am doing correctly or to look at the condition or her advice, that says that your dressing, you are doing quite well, you should maintain doing it or your dressing is not doing well and I advise you to go polyclinic to take a look and get those infected area healed before you go to your own self-help.*"

"*Supposedly somebody is doing the wound dressing, if he feels that something is different, you encourage him to take a picture and upload it so remotely you are able to monitor that, and you can tell him or her that I can see something.*"

DISCUSSION

Fear of infection and contamination leading to wound deterioration suggested that participants feared complications that resulted from performing wound care at home. The fear of complications was secondary to knowledge deficit. This finding was similar to previous studies in which participants feared adverse reactions and complications such as contracting infection, peritonitis, and associated threats.[3,9–11] Similar to other studies,[8,11,12] pain was a discouraging factor when performing self–wound care. For participants refusing self-injection and home hemodialysis, the fear of equipment such as needles and technically complex dialysis machines[8,11,12] resulted in avoidance of performing the procedure themselves. This finding was different from the present study, which could be attributed to the fact that the two previously studied procedures were "life or death" procedures where the stakes were much higher than a routine wound dressing.

Lack of knowledge about wound conditions, dressing change procedure, and where to get materials impeded participants from performing wound care at home. This differed from most studies conducted in the United States, United Kingdom, Canada, Italy, and Australia, and could be because patient education was more extensive and focused in those countries as compared with Singapore. To perform wound care at home, patients had to be confident, alert, responsible, active, attentive, independent, and willing to learn. This finding was similar to previous studies where self-efficacy and confidence were important characteristics in determining patient willingness to perform self-care at home.[7,11,12]

The location and nature of the wound were important considerations for performing dressing changes at home because wounds could be classified into different levels of seriousness and could occur on any part of the body. These factors were not considerations in previous studies of home dialysis and self-injection because the body parts involved in home hemodialysis, peritoneal dialysis, and injections were more accessible to patients, such as the upper extremities and abdomen. Participants found that wounds that occurred on the back or buttock were difficult to manage independently because of the inability to visualize and reach the wound. Participants gave mixed assessments of the level of difficulty in performing wound care, which was similar to previous studies.[1,3,4,6–8] For self-injections, participants found the procedure distressing because it involved a lot of gadgets and details.[11] Rejection for self-injection was higher than other types of home care procedure, because participants could choose other treatments, such as oral medication, to control their condition. However, for wound management, dressing changes are the only way to manage an open wound. Flexibility in performing wound care at home was a motivating factor for many participants in this study, and this finding was similar to previous studies.[3,6,8]

There was reluctance to ask help from family members so as to avoid burdening them with tasks related to at-home wound care, and this finding was consistent with previous studies in which participants felt it was unjustifiable and unfair to "enslave" caregivers with overwhelming responsibilities.[1] Caregivers were also reluctant to help because of lack of knowledge. Similarly, caregivers of patients on home hemodialysis had reported feeling inadequate in performing hemodialysis, fearful of complex therapy, and stress when assisting with hemodialysis.[1,7,8]

Participants felt comfortable performing wound dressing changes at home, and this finding was consistent with finding on home hemodialysis.[1] However, participants in the hemodialysis study also felt that the large and bulky equipment invaded their home environment;[6–9] this was not a concern for participants performing wound care because required materials take up much less space. While patients on home hemodialysis felt socially isolated while dialyzing at home,[8] this was not a barrier for patients performing wound dressing at home, because wound dressing changes can be completed in only 10 minutes and patients are hands-on throughout the process, preventing boredom.

Participants enjoyed the flexibility in performing wound dressing at home, and this was similar to previous studies in which participants loved the increased autonomy and control that came with the flexibility inherent in performing home procedures, such that participants were able to fulfill social and family responsibilities while caring for their health.[1,2,4,5,9]

Unlike a recent study done in the United States,[10] cost was not a concern because of the differences in healthcare financing systems. In Singapore, most of the medical costs are either reimbursed by companies or heavily subsidized by government. In the United States, cost of healthcare is very high, and these costs are either paid out of pocket or through private insurance, which can charge high premiums.[16]

Both practical sessions and theoretical information from clinicians were essential to the success of self–wound care. This finding is consistent with previous studies[3,8] in which participants requested a written resource manual or written information to be brought home for reference.[3] While a previous study[3] found that patients preferred support in the form of

support groups, participants in this study preferred telecommunication or having information uploaded on the internet. Because both studies had quite similar age range, the most likely explanation is cultural. In Singapore, people typically are not confident of speaking up in a group; therefore, many advocated the use of telecommunication.

Implications for Clinical Practice and Future Research

The level of knowledge required in performing self-care, the level of difficulty of the self-care procedure, and the amount of personal motivation determine patients' willingness to perform self-care.

Based on the finding that most patients are comfortable performing wound care at home, staff can actively encourage patients with simple low-risk wounds to manage wound care at home. Management could also implement self–wound care training programs to equip patients with the necessary skills and knowledge to perform wound care at home.

Findings from this study may not be generalizable to other people or other settings because these results could be unique to the few participants in this study. However, these data could be used to develop a questionnaire to be used in a cross-sectional quantitative study. A quantitative study with larger sample size would be more representative of the target population. Calculations could then be performed to assess which factors were more likely to be associated with patients performing wound care at home.

CONCLUSIONS

This is the first Singapore-based study to understand patient perceptions of self–wound care. The aim of this study was successfully achieved with the 4 key themes identified. Participants generally had positive attitude toward performing wound care at home, so the home manageable wound care concept should be encouraged. Personal factors; procedural and wound considerations; and social, environmental, and economic factors were important in deciding whether to accept the home wound care concept. Prior to performing wound care at home, patients should attend a self–wound care program. However, future studies should be done to understand the perspectives of the broader population in Singapore. Caution should be exercised when generalizing these results to different populations.

PRACTICE PEARLS

- Personal factors; procedural and wound characteristics; social, environmental, and economic factors; and an effective self–wound care program all play into a patient's decision and ability to manage his/her wound at home.
- New models of care delivery, such as distance wound care monitoring, could be established as patients move from passively participating in care to taking an active role in managing their wound.
- A structured program could be implemented to teach and assess wound dressing changes before allowing patients to perform the procedure at home. The program should provide strategies to address patient fears and equip them with adequate knowledge to perform the procedure.
- Patients with the ability to perform simple acute wound dressing changes should be provided with the reassurance and encouragement to do so to reduce dependency on healthcare professionals in a bid to reduce the increasing demand for healthcare resources.

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