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A Model for Chronic Wound Care in a Community Setting: An Implementation Study with Multiprofessional Integration

Model Of Care For Chronic Wounds In A Community Context: Implementation Study With Multiprofessional Integration

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Summary

Chronic wounds constitute a clinical and social problem that demands continuity of care, minimum standardization of procedures, and coordination among professionals, especially in contexts where economic and logistical barriers lead to irregular care. This article describes, in academic language and with a focus on implementability, a community-based model for chronic wound care structured from an initiative organized in a community-based multidisciplinary outpatient setting, led by a pharmacist with experience in pharmaceutical services and health management. It starts from the diagnosis that the effectiveness in managing chronic wounds depends both on clinical decisions and on the service's capacity to sustain triage, follow-up, supply provision, and health education flows, with systematic record-keeping and operational governance. Instead of presenting measured clinical outcomes—which require a prospective database—the text organizes the service design, explains mechanisms for multidisciplinary integration, outlines the pharmacist's role in supporting care, and proposes an evaluation architecture compatible with implementation science and quality in healthcare. The goal is to offer a descriptive, replicable, and auditable roadmap for community initiatives, connecting access, continuity, and record-keeping discipline to a concise set of process, implementation, and outcome indicators capable of guiding improvement cycles and future empirically based publications.

Keywords: chronic wounds; community care; multiprofessional integration; service implementation; quality in health; clinical pharmacy; continuity of care.

Abstract

Chronic wounds are a clinical and social challenge that requires continuity of care, minimum standardization of practices, and coordinated interprofessional work—especially in settings where economic and logistical barriers disrupt treatment. This paper provides an implementation-oriented description of a community-based chronic wound care model structured within a multidisciplinary outpatient setting, led by a pharmacist with a background in pharmaceutical services and healthcare management. The analysis starts from the premise that chronic wound outcomes depend not only on clinical decisions but also on a service's capacity to sustain triage, follow-up, access to supplies, patient education, and systematic documentation. Rather than reporting quantified clinical outcomes—which would require prospective datasets—the paper organizes the service design, clarifies mechanisms of interprofessional integration, frames the pharmacist's role in supporting care, and proposes an evaluation architecture consistent with implementation science and healthcare quality. The contribution is a descriptive, replicable, and auditable roadmap for community initiatives, linking access and continuity to disciplined documentation and a concise set of process, implementation, and outcome indicators to support quality improvement cycles and future evidence-based publications.

Keywords: chronic wounds; community care; interprofessional integration; implementation science; healthcare quality; clinical pharmacy; continuity of care.

1. Introduction

Chronic wounds defy the logic of episodic care. Unlike acute events,

Its management extends over weeks or months, requiring continuous monitoring and successive adjustments.

conduct and coordination of interventions that frequently extend beyond the strictly local field.

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of the injury. In most cases, the wound is a visible expression of systemic processes — metabolic, vascular, infectious, and inflammatory factors — combined with social determinants that They influence adherence, self-care, mobility, nutrition, access to resources, and capacity to... attending returns. In this scenario, the crucial question is rarely "which product to use," but How to ensure continuity, consistency, and security over time.

The fragmentation of care is a recurring obstacle in community settings. It is It is common to alternate service locations, and the interruption of the use of supplies due to restrictions. economic, the reception of divergent guidelines, and the loss of connection with the follow-up. This A series of disruptions fuels variability in care, rework, risk of complications, and worsening of symptoms. progressive improvement in quality of life. In contrast, arrangements that organize a clear flow — from screening to longitudinal monitoring and referral to higher levels of complexity — tend to to reduce loss to follow-up and improve coordination. The critical point, however, is that initiatives Community-based initiatives can remain sporadic when they lack standardized routines. Minimum registration instruments and evaluation mechanisms limit institutional learning. and the possibility of replication.

The organization of a community-based model for chronic wound care, therefore, depends Less about "good intentions" and more about operational design: defined entry point, evaluation. minimally standardized, resource management and patient education, follow-up with criteria explicit guidelines for referral and record keeping. When these elements come together, the The operation gains viability, reduces dangerous variations, and creates conditions for future measurement of Processes and outcomes with traceability. This chain of events is essential to transform a Healthcare experience in a consistent, auditable, and improvement-oriented service. incremental.

2. Theoretical contribution

The analysis of community-based models for chronic wound care requires distinguishing, without separating, two Complementary dimensions: quality and implementation. Quality relates to the alignment of care is taken to meet clinical and safety standards; implementation describes the conditions under which this Care becomes executable, consistent, and sustainable in the real-world context, with its limitations of resources, time and variability

The structure-process-outcome model provides an operational language for describing Quality in services. Structure involves team, training, availability of supplies and Instruments, service environment, and record-keeping system. The process includes screening, assessment, Therapeutic plan, health education, follow-up, and referrals. Outcome includes progress of Wound, pain, infection, functionality, quality of life, and service utilization. In contexts

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In community settings, this architecture reduces the risk of care being guided by improvisation and facilitates... Building auditable routines, with critical points clearly defined.

However, the description of structure and process does not guarantee that a model will hold up. Implementation science adds a pragmatic perspective by emphasizing that interventions only produce results. Value when they reach the target audience, are adopted by teams, maintain minimum loyalty and They remain operational over time. Determinants such as access barriers, availability of resources, coordination capacity, record-keeping culture, and local governance. They directly influence the adoption and maintenance of the service. In initiatives aimed at populations Vulnerability, reach, and continuity become especially relevant: the potential effectiveness of Care is lost when there is no follow-up, when the record is inconsistent, or when the execution... It varies significantly between appointments.

Multiprofessional integration, in turn, should not be treated as a statement, but as... Clinical and operational coordination mechanism. In chronic wounds, decisions regarding local management, control of comorbidities, infection surveillance, pain management, and self-care guidance. They need to converge into coherent messages for the patient, otherwise confusion and reduction will increase. adhesion. In this arrangement, the pharmacist plays a relevant cross-cutting role by acting at the interface. between pharmacotherapy, medication safety, and health education. Therapeutic regimens Complex medications, polypharmacy, risk of drug interactions, duplication, and poor adherence are frequent in patients. with comorbidities; furthermore, continuity of care depends on clear guidance in daily life. Medication reconciliation, structured counseling, adherence support, and event monitoring. Adverse events constitute functions capable of increasing consistency of care and reducing avoidable risk. when integrated into the service flow.

Thus, the theoretical basis for a community-based model of chronic wound care rests on... combination of (a) quality architecture by structure–process–result, (b) principles of (c) multidisciplinary coordination geared towards clinical and operational coherence. The practical goal of this combination is to produce a A service simple enough to operate under real constraints and disciplined enough to allow Measurement and continuous improvement.

3. Methodology

A descriptive format oriented towards service implementation is adopted. The object of analysis It is not a cohort of patients, but the setup of a community-based wound care model. Chronic care as a service: its essential components, the logical sequence of the care flow, the Operational routines and a measurement proposal compatible with field conditions. The description It prioritizes elements that can be operationalized and audited, while preserving conceptual separation.

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between service design and inference of clinical effectiveness.

In the absence of a consolidated quantitative basis — such as the number of patients monitored, Time to healing, complication rates, or time series of indicators—these are not established. Data-driven effectiveness analysis. Instead, the methodological approach organizes the model into In terms of critical processes and coordination mechanisms, it outlines a measurement matrix. a prospective approach that allows for the evaluation, in future stages, of process results, results of Implementation and clinical/experiential outcomes. This strategy maintains rigor by avoiding undue extrapolations and, simultaneously, provides a methodological path to transform Clinical practice based on empirical evidence through systematic data collection and standardized instruments. and data governance.

4. Description of the community-based model for chronic wound care.

In chronic wounds, clinical stability rarely results from a single action; it depends on... Continuity, monitoring, and successive adjustments. In a community context, this continuity It often fails when regular access and multidisciplinary coordination are not combined. The organization of care, therefore, is structured as a care pathway that integrates intake, assessment, and evaluation. Initial therapeutic plan with resource management and longitudinal follow-up, including criteria. explicit referral guidelines and minimum registration procedures.

To reduce the dispersion of care and avoid an episodic pattern, the entrance is designed to... in order to accommodate people with chronic wounds who are vulnerable to receiving care, stabilizing a flow that facilitates return visits and monitoring. By focusing care on a defined route, it reduces- if the probability of loss to follow-up is reduced, the chance of making sound clinical decisions increases. over time, rather than disconnected interventions.

In the initial stage, minimum standardization is treated as a condition for comparability and governance. The evaluation needs to be feasible in routine practice and, simultaneously, consistent enough for to allow longitudinal reading. Thus, an essential core is recorded: lesion characteristics (appearance, exudate, wound edges, signs of infection and perilesional conditions), relevant systemic factors (comorbidities, pain and functional limitations) and pharmacotherapeutic overview (medications in use, Adherence, risks, and guidance needs). The operational gain is not in sophisticating the data collection, but in making it repeatable and comparable.

At this point, multi-professional coordination materializes: distinct responsibilities. They need to converge on consistent messages for the patient. Medical contributions focus on Clinical stratification, etiological hypothesis, definition of conduct and referrals when necessary. Pharmaceutical contributions focus on drug safety, review of schemes, usage advice, adherence support and risk monitoring, in addition to streamlining the

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Access to supplies and medications with traceability and error prevention. The goal is consistency.
longitudinal, with reinforced guidance during follow-up visits, rather than fragmented advice.

In therapeutic terms, the problem of material access to care cannot be treated as
External variable. Provision and management of supplies — materials for dressings and, when applicable,
Medications — reduce barriers, but require governance: clear delivery criteria, registration of
Consumption, traceability, and waste control. Without this component, therapeutic interruptions.
Supply shortages tend to compromise progress and disrupt follow-up.

Regarding longitudinal follow-up, it serves a dual purpose: clinical and
Implementation-wise, clinically it allows for reassessment, adjustment, and decision-making based on progress.
Comparable; operationally, it tests the viability of the flow and the maintenance of the standard. Periodicity
Risk-oriented, consistent record-keeping, and sufficiently defined referral criteria.
They reduce ambiguity and prevent delays in the face of signs of severity (suspected ischemia, infection).
Systemic, extensive necrosis, or progressive worsening). Without follow-up, care reverts to the systemic format.
It becomes episodic and loses its chronic nature.

Finally, community ties and territorial legitimacy function as conditions for
Feasibility. Articulation with local networks (public and community-based) influences entry.
Referrals and adherence; communication consistent with the service design increases reach without
distort expectations. When this institutional dimension is aligned with the care flow, it ceases to...
It becomes ancillary and goes on to support the continuity and maintenance of care.

5. Implementation architecture and measurement plan

Measuring a community-based chronic wound care service requires balance: lean data collection...
sufficient to fit into the routine and, at the same time, structured enough to generate learning.
and governance. Instead of a large, unusable dashboard, an architecture of
Measurement with three complementary domains: consistency of the care process, outcomes of
Implementation and clinical/experiential outcomes.

From a process standpoint, the question is simple: is the care being delivered in a way that...
Consistent? Pragmatic indicators capture this core with low complexity: time between
initial reception and assessment, completion of standardized assessment, delivery of guidance.
Structured, regular follow-up appointments as planned, pharmacotherapeutic review documentation.
and referrals triggered by clinical criteria. Sophisticated technologies are not a prerequisite;
Discipline in registration and clear definitions are essential.

In terms of implementation, the focus is on the adoption and maintenance of the workflow in the real world.
More important than complex metrics are measures that identify where the model loses strength:
Reaching the target audience, professionals adhering to the minimum requirements, and staying true to the process.

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(completeness and consistency between services), feasibility (time and ability to sustain) inputs) and maintenance in regular cycles, including partnership stability and routine review of This approach reduces the typical risk of initiatives that start intensely and then dissolve. due to a lack of governance.

In outcomes, selection should prioritize observable and comparable measures. Evolution of Area/volume when applicable, signs of inflammation/exudate, self-reported pain, occurrence of signs Infection and the need for more complex referrals constitute a clinical core. plausible. In a community context, the experiential dimension is equally relevant: understanding of the care plan, trust in the service, barriers to adherence, and quality of life related to wound. These outcomes depend on prospective and standardized data collection; without it, any claim Effectiveness remains at the narrative level.

The governance of measurement should remain simple to avoid bureaucratization. Three Operational routines are usually sufficient: initial assessment form with a minimum checklist, form return visits with records of progress and interventions, and periodic case review meetings and Indicators with recorded decisions. With this, care becomes process; process becomes measurable; and the measurable becomes the basis for adjustment.

6. Discussion

Continuity and reduced variability are the decisive criteria for an arrangement. Community-based care for chronic wounds. The proposed care pathway meets this criterion by organizing Entry, assessment, treatment plan and follow-up under multidisciplinary coordination and discipline of registration, transforming a set of services into a service with a trajectory.

Access barriers represent the main vector of disruption in community contexts. Mitigating them requires not only a timely offer, but an operational design that supports the provision of supplies, patient education, and follow-up routines. Coordination with local networks and partnerships reinforces this. Continuity not for symbolic reasons, but to increase the capacity for referral, to reduce Loss of follow-up care and strengthening territorial legitimacy, with a direct impact on adherence to the flow.

In technical terms, multi-professional coordination operates as a safety mechanism. Chronic wounds involve clinical and pharmacotherapeutic decisions that, when disconnected, They produce contradictory messages and increase the risk of misuse. When structuring the role Pharmaceutical care as a cross-cutting component — medication safety, regimen review, Counseling and adherence — it becomes possible to reduce avoidable risk and increase consistency of guidance, especially for patients with comorbidities and polypharmacy.

The main limitation, under traditional effectiveness criteria, is the absence of an empirical basis. Formal outcome definition. This does not invalidate the proposal; it delineates the typical stage of service maturity.

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Community-based initiatives: first, the model is specified and the registry is established; then, adoption is measured. fidelity and feasibility; finally, one moves on to evaluating outcomes with greater rigor. This Progress is particularly relevant when the goal is to produce auditable evidence without inflating the data. conclusions.

The institutional dimension also deserves attention: community initiatives frequently They depend on individual leadership and organizational memory, making them vulnerable to change. Team and context. Indicator language and lightweight auditing reduce this weakness by transforming routine governance and allowing incremental corrections based on operational signals, not on Isolated perceptions. In short, quality of care and quality of service are inseparable; Where the process is not sustainable, care tends to become fragmented.

7. Final considerations

Community-based organization of chronic wound care requires continuity and coordination. Multiprofessional and disciplined record-keeping. Structuring the service as a care pathway — with organized entry, minimally standardized assessment, resource management, patient education and longitudinal follow-up with referral criteria — creates operational conditions for To reduce variability and sustain care over time.

The crucial methodological breakthrough is transforming practice into data: standardized forms, Regular indicators and a forward-looking basis allow us to move from service description to evaluation. incremental, starting with consistency of process and implementation results and moving forward, progressively, towards clinical and experiential outcomes. In community initiatives, this Sequentiality is often the dividing line between one-off actions and sustainable services capable of maintaining Quality, learning from one's own functioning, and becoming replicable.

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