HOME-BASED WOUND CARE
SPAIN

Healthcare providers involved

- Home-based wound care is mainly delivered through public **Primary Health Care teams** serving defined geographical areas.
- **Primary care nurses** lead the patient assessment, treatment, follow-up and patient education.
- **GPs** manage underlying conditions; **case managers, wound specialists and allied health professionals** support complex needs where available.
- **Hospital** at Home services may provide hospital-level treatment.

Level of interdisciplinarity

- Nurses coordinate day-to-day wound care, GPs manage comorbidities and specialists support complex cases.
- Collaboration uses electronic health records, referrals and, in some areas, joint consultations or multidisciplinary meetings.
- Implementation varies: sequential consultations do not always support shared decisions or continuity after discharge.
- Advanced practice nursing roles and integrated pathways offer opportunities for more interdisciplinary care.

Training and education of healthcare providers

- Nurses require a four-year nursing degree (240 ECTS) or a recognised equivalent. No official wound care nursing specialty or mandatory postgraduate wound care qualification exists.
- Master's programmes, postgraduate diplomas and continuing education develop advanced skills. Some regions, notably Andalusia, have advanced practice wound care nursing roles. Training remains variable, with no mandatory national standard for advanced wound care education.

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Financing of home wound care

- Home wound care is mainly tax-funded through the Spanish National Health System (SNS) and managed by regional health services. Eligible patients generally pay no direct charge for public nursing visits or procedures.
- Mutual insurance schemes and private insurance offer additional coverage, depending on policy terms. Private nursing can also be self-funded. Some outpatient products and devices require patient co-payments.

Reimbursement system and challenges

- Products are supplied by public healthcare services or dispensed through pharmacies on prescription or authorised order if included in SNS benefits. Coverage is selective; pharmacy co-payments may apply. Patients do not generally purchase all supplies and then claim reimbursement.
- Regional formularies, procurement rules and authorisation requirements create unequal access. Advanced technologies, including some negative-pressure wound therapy devices, may require specialist oversight and specific supply arrangements.

Protocols and guidelines for wound monitoring

- Healthcare institutions and professional societies provide guidelines covering wound assessment, prevention and treatment. Implementation relies on local protocols, training and referral pathways. Healing is documented in electronic records, sometimes supported by photographs and serial measurements.
- Implementation and auditing remain inconsistent. Audits may assess prevention, documentation, protocol adherence and outcomes. Interoperable records and standardised outcome indicators are priorities for improving evaluation.

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Handling complications and emergencies

- Primary care teams assess complications and contact GPs or specialist services according to severity.
    - Life- or limb-threatening complications, including sepsis, major haemorrhage and acute limb ischaemia, require emergency care through services such as 112.
- Home follow-up resumes after stabilisation, with an adjusted care plan. Referral pathways vary regionally; clearer severity assessment

Role of telemedicine and digital tools

- Electronic health records support documentation and communication.
    - Some services use e-consultations and clinical photography for specialist advice and remote monitoring, particularly for rural patients or those with reduced mobility.
- Adoption varies, and no dedicated national wound telemonitoring platform exists.
- Challenges include interoperability, data protection, image quality, training and device access. Telemedicine complements rather than replaces face-to-face assessment and procedures.

Continuous education and best practices

- Regional health services, universities, nursing colleges and scientific societies offer courses, practical workshops, conferences and postgraduate programmes. AEEVH, SEHER and GNEAUPP also disseminate research and educational resources. Formal CPD accreditation mechanisms exist.
- Access depends on location, funding, motivation and organisational support. Competency assessment is not routine. Structured, competency-based programmes and stronger integration into nursing curricula and quality improvement are needed.

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Patient-centered wound care

- Patient autonomy is supported by legislation. Care planning should consider clinical, functional, psychological and social needs, self-care capacity, support and preferences. Nurses educate patients and carers and support informed, shared decisions.
- Goals should reflect prognosis and personal priorities; palliative care may prioritise comfort over healing.
- Workload and resource constraints limit implementation.
- Patient-reported outcomes can help shift care beyond dressing changes towards quality of life.