Empowering patients to take control of leg ulcer treatment through individualised management

Leg Clubs have been established to empower patients to become stakeholders in their own treatment. This case report describes how attendance at a Leg Club resulted in healing in a patient who previously was non-concordant with treatment.

According to Billings and Cowley,1 needs assessment is a priority issue in community health. Health-care team members need to examine their own areas of specialty to assess, analyse and identify different health-care needs and share their findings with the whole team.

Gillam and Murray2 suggested, however, that primary health-care teams know little about defining the needs of the practice population. Therefore, before the practitioner can begin to address factors that will influence the planning and delivery of care, a clear understanding of patterns of illness and distress and of service use and provision among general practice populations is needed.3

If nurses are to fulfil their role in the 'helping relationship', they need to understand basic needs and how these affect people's lives.4 Unless a nurse is aware of patients' perceptions of their problems and needs, and is prepared to try and see things from their point of view, progress may be limited.5

Maslow6 provided a guide to assessing priorities based on physiological needs, safety, social/affiliative, esteem and self-actualisation. However, Bradshaw’s7 taxonomy of needs is most widely used by general practitioners to assess patients' needs. These can be classed as:

- Normative — based on expert judgement
- Comparative — where one patient group is compared with another
- Expressed — based on requesting assistance or intervention by a professional
- Felt — what the individual says it is.

Cost implications

General practitioners require that patient treatment and provider organisations are cost-effective. In the UK over £400m is spent annually on leg ulcer care,8 and 25–65% of district nurses’ time is spent caring for patients with leg ulcers, with staff time and wound management costs continually rising.9

Leg Clubs

Historically, leg ulcer management has been undertaken by community nurses in the patient's own home or by a practice nurse in the surgery.10 However, care is also delivered in nurse-led ulcer clinics and Leg Clubs.11 Leg Clubs focus on addressing the needs of individuals in a social, relaxed, non-threatening environment. According to Russell and Bowles,11 patients benefit from attending leg ulcer clinics and being with and talking to other people who have a similar condition.

The Leg Club was conceived as a unique partnership between patients, community nurses and the local community. They aim to empower members, providing them with a sense of ownership and acknowledgment that they are stakeholders in their own treatment. These Clubs are held in a community venue on an informal drop-in basis. Their objectives are listed in Box 1.

The ethos of care, social support, friendship and medical treatment make this form of community nursing care unique.12 Treatment takes place collectively, with two or three people having their legs washed and dressed in the same room. This gives them the opportunity to compare healing and to discuss treatment issues with members of the healthcare team and/or carers, giving them a greater feeling of ownership and acknowledgment that they are stakeholders in their own treatment.

Box 1. Leg Club objectives

| To empower patients to be involved in making decisions about their own treatment |
| To meet the needs of socially isolated people by providing a venue for social interaction and an opportunity to establish peer support |
| To implement strategies to rebuild the self-esteem of people with leg ulcers |
| To provide an informal forum for health promotion and education |

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of control over their own leg ulcer 'destiny'.

Since the inception of Leg Clubs in the UK in May 1995 constant audit\(^1\) has demonstrated high healing rates and low recurrence. A recent randomised controlled trial, conducted in Australia, that compared the same treatment given either at home or in a Leg Club highlighted significant benefits in terms of patient morale and pain reduction (p=0.02).\(^1\)

**Case study**

James, a 68-year-old with non-insulin dependent diabetes, and his wife had recently moved from a major city to a warden-controlled flat in a rural area. James had become quite reclusive, yet strived to remain independent. After starting to show signs of multiple sclerosis (MS) 10 years previously, his wife had been mostly bedridden. Throughout this time, and before their move, the appropriate services had been unaware of the family's situation. His wife had not been seen, assessed or received a diagnosis from a medical professional. Their youngest child had had MS and had died of encephalitis. Three of their four remaining children were also diagnosed with MS.

At the suggestion of his home warden, James attended his local Leg Club, presenting with hypertension and recurrence of bilateral varicose eczema and ulcers. These had been static for six months, and he had self-treated with topical ointments, lotions, gauze and crepe bandages bought over the counter. The nurse visited James at home the next day to check that he cut off as soon as he arrived home due to discomfort, the bulkiness of the bandages which caused footwear problems, and a medicated paste bandage. James informed the nursing team that he had found most treatments difficult. He said staff at a London hospital and clinic had labelled him 'non-compliant' as he consistently removed his bandages and dressings, and preferred to self-treat with over-the-counter products.

Throughout the assessment James expressed anger and despair at the health-care system and the lack of treatment he perceived he had received. He was still reluctant to involve a member of the primary health-care team in his home situation. James had tried various treatments over the years, including four-layer compression bandages, which he cut off as soon as he arrived home due to discomfort, the bulkiness of the bandages which caused foot problems, and a medicated paste bandage, which triggered a rash. He was allergic to penicillin, Betnovate, parabens and several types of dressing.

At 6ft tall, James weighed 18 stone. He had bilateral leg oedema and evidence of ankle flare. His feet became dusky on dependence and had rapid refill of blood within the extremities. Around the periwound area there was eczema, which appeared raw, and he complained of discomfort. The eczema spread to his feet as pustules, and James informed us that he occasionally dispersed them with a needle. According to Dale and Gibson\(^1\) a patient who has had a leg ulcer for many years may develop low self-esteem. Consequently, they may lose the motivation to persevere with treatment and give up any hope of the ulcer healing, a belief that becomes a self-fulfilling prophecy as the patient ignores treatment advice and the ulcer does not heal.

As with all new patients, on first attending the Leg Club James was offered the option to have the initial assessment in private, which he declined. On assessment, his ABI was 1.2 in both legs. The practice nurse treated the ulcers with a fibrous hydrocolloid dressing (Aquacel, Convatec) in this instance, which was held in place using a bandage and elasticated visco stockinette.

As a result of the ABI measurements, compression was considered the most appropriate treatment. Options were discussed at length with James and he chose cotton (short-stretch) inelastic bandages.

There are a number of cotton extensible short-stretch bandages on the market, including Compitran (BSN Medical), Rosidal K (Vemon-Carus) and the cohesive short-stretch system Actico (Activa).

As James had restricted mobility, slept in a chair at night and openly stated that he had removed and reapplied bandages in the past, the consensus was to provide a bandage that would suit his lifestyle and reduce the potential for slippage that may occur due to his larger leg size. Actico short-stretch (Activia) was selected as its cohesiveness means that it is easily applied and removed and does not slip.

Compression therapy is the gold standard treatment for leg ulcers in patients with venous disease.\(^1\) Selection relies on several factors such as:

- Comfort (patient concordance)
- Quality of life issues — can the patient maintain independence?
- Nurse familiarity with the product
- Evidence of product efficacy\(^1\)

Quality of life is a subjective issue, particularly in terms of leg ulceration, as many factors conspire to affect or reduce quality of life. Furthermore, the tightness of the bandage (required to reduce pain, but increases pain and discomfort in others).

In James's case, the assessing nurse considered these issues and offered treatment to meet his needs. There was concern about his eczema, and it was decided to manage this with a Zipsoc dressing (Smith & Nephew), a zinc oxide-impregnated tubular stocking comprising 50% paraffin and 50% white petroleum jelly.

Following his initial visit to the Leg Club, the nurse visited James at home the next day to check for any sensitivity reaction and assess how he was practicing.
Toleration of the Actico Bandage. This remained in situ and he said he found it acceptable. James made it clear that he did not want any input from social services, his GP or the community nursing service.

James's ulcer healed in 11 weeks, during which time the oedema reduced. He found treatment acceptable, was concordant with compression therapy and his eczema resolved within a few days.

James attended the Leg Club each week and gradually integrated and became a valued member of the group. He appeared to enjoy the social occasion, friendships were formed and it provided him with respite from the situation at home.

When his ulcer healed, James was measured for compression hosiery to minimise the risk of recurrence and was transferred for 'well leg' monitoring.

Conclusion

The Leg Club model has the potential to reduce costs for the health service, increase social interaction for elderly patients, and guide treatment through evidence-based practice. Leg Clubs also offer education on prophylaxis, prevention of leg-related problems following healing, and general advice to promote well-being.

Sadly, within a week of his ulcers' healing James developed acute pancreatitis and died. He had previously provided written consent for us to publicise this case study and further consent was obtained from his family before publication.

After James's death, the district nursing team responsible for the Leg Club visited his wife to offer their condolences, and found she was extremely withdrawn and showed signs of clinical depression. Her son and the district nurses arranged for a referral, which resulted in a medical assessment and a diagnosis of MS. Following a long hospital admission and extensive physiotherapy, she returned home with a full social services home-care package.

The Leg Club provided James with physical care and psychological support and education about his disease. For the first time in many years, he was able to socialise and live outside the limiting discipline of caring for his disabled wife. He also had access to nurses who had expertise in dealing with the social isolation that often accompanies leg ulcers. This empowerment enriched James's life in a way that could not have occurred if he had continued on the original path of self-care.

Box 2. Maintaining the high standard

It is essential that patients such as James attending Leg Clubs can be confident in the knowledge that consistent, defined standards and procedures will apply. Only clinics that comply with documented Leg Club model guidelines can use the Leg Club title.

To this end, the wording and logo are protected by registered trademark in the UK and Australia.