Encouraging compliance and concordance in leg ulcer patients

Ensuring the patient's concordance and compliance is key when it comes to managing leg ulcers, yet maintaining healthy leg behaviours can be difficult. The author discusses the challenges in ensuring patients comply with their care and lists practical tips to keep them motivated.

KEY POINTS

- The Royal Pharmaceutical Society (RPS) advocated a shift from compliance to concordance to promote openness and empathy in patient/professional relationships.
- Physical and mental capacities need to be evaluated to reach manageable treatment plans.
- Patients will notice if clinicians lack skills and confidence, which will have an effect on their relationship.

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INTRODUCTION

Leg ulceration is a long-term condition that has a significant impact on the people living with it. The economic cost of leg ulcer management is high and compliance and concordance are frequently highlighted as challenges.

Understanding these terms can help in developing effective strategies to help patients manage the condition. Inevitably, some patients will not be able to take control, such as those with advanced dementia, who lack the mental capacity to make their own decisions. Even so, it is important to understand the patient and any difficulties they may be experiencing with leg ulceration (Ebbeskog and Emani, 2005).

In quality of life studies (Rich and McLachlan, 2003; Ebbeskog and Emani, 2005), pain is always high on the patient's list of issues. Therefore, whatever strategies are used to engage patients in their care, acknowledging and managing pain must be prioritised to ensure those efforts are not wasted.

Compliance

Compliance describes 'the extent to which the patient's behaviour (in terms of taking medications, following diets, or executing other lifestyle changes) coincides with medical advice' (Sackett and Haynes, 1976). The Royal Pharmaceutical Society (RPS) (1997) advocated a shift from compliance to concordance in an attempt to promote openness and empathy in patient/professional relationships. Issues such as long waiting times, extended periods of treatment and complexity of treatment can lead to non-compliance.

Concordance

Clinicians are now encouraged to embrace negotiation with patients who have long-term conditions, and to embrace concordance in all aspects of health (Moffatt, 2004a). The RPS defined concordance as:

> ***'...a negotiation between equals... a therapeutic alliance...' (RPS, 1997).***

Adherence

Adherence describes the patient's decision to accept, reject or modify their treatment. Intentionally not adhering can be rational from the patient's perspective, even when it is at odds with professional rationale (Price, 2008). According to Price (2008), compliance is the nature of 'yielding to others,' concordance is the process of agreeing (even if this is to disagree) and adherence is the way in which the patient makes choices and participates in his or her care.

The concordance and adherence of the patient is complicated by:

- Motivation
- Health beliefs
- Social and economic factors
- Previous experience
- The influence of those around them.

Sustaining and adhering to healthy leg behaviours can be very challenging if the patient's motivation is reduced by recurrence and other setbacks, such as pain. Therefore, clinicians need to have an understanding of what it is like to live with leg ulceration and always promote healthy behaviours even when the patient seems to be working against this.

The following is a list of important considerations that will help to encourage concordance and adherence:

1 RESPECTING AUTONOMY

By being understanding and willing to compromise, you ensure that patients feel they have some control over their treatment and can share any anxieties with you, which gives you more of an opportunity to challenge misunderstandings about ulcers.

2 KNOWLEDGE AND EXPERIENCE

Patients who find it difficult to explain their disease process are not uncommon, but most patients adhere to treatment for the majority of the time. Verbal information given to patients needs to be backed up by other media, such as leaflets and multimedia resources.

Do not assume that more education is the answer. Feed the patient small pieces of information, starting with the most important points. Link the information to the treatment and to the outcomes. For instance, discuss a leaflet about compression bandaging, apply the bandage and then involve the patient in measuring and recording the oedema and/or pain reduction or skin improvements.

It is important that patients have choices. For instance, it may be that a patient's lack of 'compliance' is due to the fact that he or she is using a bandage that does not fit properly.

3 CAPACITIES AND CAPABILITIES

Physical and mental capacities need to be evaluated in order to reach manageable treatment plans. Check for psychological/mental health or learning difficulties. Impairments of sight, hearing and manual dexterity will all impact on adherence.

Language difficulties will make explanations more challenging but resources will be well spent if patients have a good understanding of self-care, such as ankle movement, leg elevation and skin care. An interpreter will be able to clear any confusion relating to language, and cultural beliefs.

4 INSPIRING CONFIDENCE

A clinician's lack of knowledge and, possibly, lack of confidence in explaining disease processes and the physiological effects of therapy may contribute to a lack of patient understanding.

Have you had your bandaging skills appraised? How good are you at explaining complex information? Your patient will spot any lack of skills and confidence, which will have an effect on your relationship.

5 SOCIAL ISOLATION

Social isolation is a very common problem for people living with leg ulcers (Brown, 2005a). Lack of support and encouragement impacts on whether patients will tolerate treatment (Brown, 2005a and b). It is important that family and friends are involved if possible, and if the patient is willing. Manage problems, such as wound malodour, to avoid the patient's relationships being affected. Where appropriate, work with the patient to explore social service and voluntary sector resources for community support.

6 ARE YOU ASKING TOO MUCH?

Explore the reasons why patients do not feel able to comply or adapt treatment plans to their environment. There is little point telling patients to elevate their legs if their job involves standing, but you could help them to devise prompts to remind them to put their feet up at break times or when they get home. Patients may feel unable to tolerate full compression. Reduced compression is better than none at all. Team work and clear documentation is important in reducing the risk of professional conflicts (Brown, 2005b).

7 TRAVEL

Rich and McLachlan (2003) found that cost, lack of transport and lack of confidence impacted on patient engagement. Clinics may be in areas where people feel unsafe. Late afternoon or early appointments may mean travelling in the dark or during rush hour. Do clinic times reflect the needs of your client group? Seek permission to introduce patients as they may be able to travel together. Explore whether there is a voluntary car service for more vulnerable patients. Try to make the clinic experience sociable to motivate patients.

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8 DO NOT PRE-JUDGE

In Flanagan et al's (2001) community nurse focus group there appeared to be a general pre-judgement of the patient's willingness to comply with treatment. Some nurses did not really believe in the benefits of hosiery, considering it 'uncomfortable and ugly in appearance'. Strike a balance between being optimistic and realistic based on what the patient is able to manage. Give patients time to choose options and try things out.

9 COMPASSION/EMPATHY

Clinicians do not always demonstrate understanding or empathy regarding what it is like to live with a leg ulcer. Ebbeskog and Emami (2005) asked patients about their experiences of having ulcers redressed. Patients said gentle handling and a friendly demeanour made them feel cared for. Try wearing the bandages and hosiery for a period of time and imagine what it might be like to have pain, oedema, leakage and itchy skin 24 hours a day.

10 DON'T TRY TO DO EVERYTHING AT ONCE

Here are some tips to help keep the patient motivated:

- If necessary, build compression therapy levels up gradually. Ensure bandages and hosiery are as comfortable as possible, as constriction and slippage is harmful and very uncomfortable
- Make sure ankle movement is not restricted for mobility and exercise
- Give patients advice on footwear before they are introduced to compression as the patient may be upset to find that his or her footwear does not fit after bandage application. If they have not been warned about this, they may even reject the bandage. If exudate levels are high, find out why and be prepared to change bandages more often until the problem is under control
- Manage itchy skin by instilling good skin care and using lining material to keep wool padding away from the skin
- Consider the use of elevation and exercise charts as motivation tools and reminders to patients and carers
- Resistance bands used for fitness workouts can be useful to help with ankle exercises if looped round the foot. Such a device near the patient's usual chair can act as a reminder that he or she needs to exercise
- Involve patients in measuring and recording outcomes such as oedema reduction
- Give lots of praise and encouragement. We all respond to this if it is realistic and not patronising.

11 SEE WITH 'FRESH EYES'

Go back to the beginning of assessment to check if something was overlooked. Have you looked beyond the ulcer at factors such as co-morbidities, skin conditions, social factors, anxiety and depression (Moffatt, 2004b)? Ask an experienced colleague who does not normally see the patient to attend to his or her care from time to time. They may notice subtle changes that are less obvious to someone who sees the patient more regularly.

12 COMMUNICATION STYLES

Marks et al (2005) discuss the effect that certain phrases may have on the patient, by differentiating between the terms 'aggravated directives' and 'mitigated directives'. An example of an aggravated directive is 'you need to' or 'I want you to', which requires action rather than answers from the patient. The use of aggravated directives is less likely to result in adherence and is not in the spirit of concordance.

Think about the way you say things to patients and consider how your own beliefs influence the approach you take. Mitigated directives, such as 'maybe you can', 'maybe we ought to' or 'let me say' are more effective since they are presented as joint action.

CONCLUSION

Concordance and adherence require a sound knowledge of the condition and treatment options. They also involve the possession of excellent communication skills, compassion and empathy.

People change according to circumstances so avoid labelling and do not close the door. Allow people to change their mind without 'losing face'. To paraphrase Price (2008), we should accept that patients have 'a life not just an ulcer'. WUK

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