The leg ulcer: A shared approach

Leg ulcers can have a detrimental impact on an individual's wellbeing, as well as placing a large financial burden on the NHS. This article emphasises how the clinician must strive to build a concordant relationship with the patient to maximise healing outcomes.

"As there are so many multifactorial aspects to both leg ulcers and quality of life, it is important that the healthcare provider understands the impact the ulcer has on the individual."

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It is estimated that between 70 000 and 190 000 people in the UK have an active leg ulcer on any one day (Posnett and Franks, 2007), which can affect the individual's general wellbeing, and quality of life, as well as placing a massive financial burden on the NHS.

Leg ulceration in this article is defined as "an open lesion between the knee and the ankle joint that remains unhealed for at least 4 weeks and occurs in the presence of venous disease" (SIGN, 2010).

One of the new challenges for those working in the NHS is the demand for the provision of high-quality care while working towards cost-efficiency savings. Consequently, the need to work in partnership with the patient to achieve outcomes is vital.

The drive to promote concordance and adherence to treatment and care has to be delicately balanced with the need to respect autonomy and individual differences. The code of practice states: "You must treat people as individuals and respect their dignity" (Nursing and Midwifery Council, 2008). With this in mind, the tissue viability service has attempted to build therapeutic relationships with people with leg ulcers using different strategies to assist concordance and healing.

Quality of life

Many studies have been conducted to gauge the impact a leg ulcer can have on a person's quality of life, such as those by Herber et al (2007) and Hareendran et al (2005). The overall consensus has been that leg ulcers have a negative impact on many aspects of daily living. People with leg ulcers can experience pain, reduced mobility and poor quality sleep, itchiness, odour, exudate, and leg swelling (Adeyi et al, 2009).

All of these factors place a direct negative pressure on the individual's emotional wellbeing and are often linked to social embarrassment and isolation, depression, anger, and anxiety (Adeyi et al, 2009). As there are so many multifactorial aspects to both leg ulcers and quality of life, it is important that the healthcare provider understands the impact the ulcer has on the individual.

To achieve a personalised approach to each patient, working in a one-to-one manner and building a relationship is favoured (Hampton and Lindsay, 2005). It is this development of the partnership between the healthcare provider and the individual with a leg ulcer that can reduce dependant behaviour and improve communication to aid compliance with treatment.

Compliance refers to the way in which the patient's behaviour coincides with

Table 1. The core components of a therapeutic relationship (McCormack, 1997).

- **Power:** The therapeutic nurse–patient relationship is one of unequal power. Although nurses may not perceive themselves as having power in the relationship, nurses have more power than the patient. The power of the nurse comes from the authority of their position in the healthcare system, specialised knowledge, influence with other healthcare providers and the client's significant others, and access to privileged information. In any professional–client relationship, there is an imbalance of power in favour of the professional, and is reinforced in healthcare services by the inherent vulnerability of a client needing care.
- **Trust:** Patients expect the nurse to have the necessary knowledge and skills and to demonstrate caring attitudes and behaviours, and so entrust their care to the nurse. Trust is critical, as the patient is in a vulnerable position in the relationship. Part of this trust is keeping promises to patients. If trust is breached, then it becomes very difficult to re-establish it.
- **Respect:** Respect for the dignity and worth of the client is fundamental to the relationship. The nurse needs to know and understand the culture and other aspects of the patient's individuality, and to take these into account when providing care. Part of respect is being non-judgmental of the patient, and seeking to discover the meaning behind the patient's behaviour.
- **Intimacy:** This does not refer to sexual intimacy. Intimacy relates to the kinds of activities nurses perform for and with the patient, which create personal and private closeness on many levels. This can involve physical, emotional, and spiritual elements.

medical advice (Anderson 2012). This term is less frequently used today, in favour of the term "concordance", which is defined as a "negotiation between equals and a therapeutic alliance" (Royal Pharmaceutical Society, 1997), suggesting a "process of agreement versus yielding to others" (Price, 1996). It is via this negotiation that healthy leg behaviours can be developed and sustained (Anderson, 2012).

Developing the clinician/patient partnership

Clinicians are in a privileged position in which they can offer physical and psychological support to the individual requiring care. The ability to provide medical intervention goes hand in hand with the need to develop an empathetic, therapeutic relationship. A therapeutic relationship is often suggested to be the essence of nursing with the main components comprising power, trust, respect, and intimacy (*Table 1*; McCormack, 1997).

Another important component of a therapeutic relationship is the need to foster autonomy in the person with the leg ulcer. Clinicians must respect the autonomy of the person they are caring for by being understanding and showing a willingness to compromise. However, the person with a leg ulcer may be declining treatment due to previous bad experiences and may, therefore, need a more tailored approach to wound management.

For many people, any previous negative experience may be relived during further care and thus their anxiety must be shared and responded to appropriately. For example, the person with a leg ulcer may previously have been unable to tolerate compression bandages, but felt pressured into wearing them by the clinician. Therefore, any new suggestions regarding bandage use from the clinician may be extremely stressful for the patient, so an agreement that allows the person with the leg ulcer to feel they have control over the situation must be created to promote concordance.

To aid concordance, a tubular bandage could be used initially so that the individual has the option of removing it if necessary. This option could be used with the aim of progressing to a double layer bandage. Once the person with the leg ulcer feels this can be tolerated, bandaging can be applied and hosiery use discussed to ensure open and effective communication of the plan of care. However, this may be a slow process and to promote trust in the relationship between clinician and patient, it is often the case that extra appointments or an intense period of visits must be factored into the care equation. The age of the individual may also have an impact on attendance, for example, which will require flexibility on behalf of the clinician.

Many people with leg ulceration are of working age and this could prove to be a barrier to regular intervention. To facilitate care in these instances, twice-weekly, early-morning clinic visits could be beneficial. These clinic visits could initially be arranged to provide an intense intervention over a short period of time (i.e. 4–6 weeks). During this time, empathy with these individuals can be built and a concordant care partnership developed. Once these people feel able, they can progress to hosiery kits to enable self care and be discharged back into the hands of their regular care provider.

To maintain a healthy leg, family and friends should be involved in the management of the ulcer when appropriate. They can offer support when, for instance, leg elevation is painful and daily living has become complicated. For the person with the leg ulcer, knowing that their small children will be collected from school, or their ironing is being done, can alleviate some of the stress of living with the ulcer.

Ensuring elevation

In older people, where memory may be an issue, family and friends can remind them to elevate their legs and laminated cards promoting elevation can be placed

strategically around the home to jog the older person's memory. It is vital that everyone involved in the care of the person with the leg ulcer is made aware of how to elevate the limb safely, and if elevation is considered a risk, it should not be undertaken. For example, the use of a foot stool may be quite safe, but the adding of hardback books on top to elevate higher may pose a risk of injury.

Advice leaflets are also a valuable tool that can build on the interaction between the clinician and the individual with the leg ulcer. A leg ulcer advice sheet that incorporates a self-help section can aid the person with the ulcer in their self care. An example of foot exercises that may be advised is dorsiflexion. This refers to the action of hinging the foot upward at the ankle lifting the top of the foot so that it points to the shin. Another example is seated or standing toe raises to engage the calf muscles in aiding venous return of the blood in the limb.

Another vital piece of information within the advice leaflet should be the necessity to alternate rest with activity during the day to reduce oedema and the amount of exudate. The older person with the leg ulcer may take an afternoon rest and elevate the limbs during this time. By explaining that by resting/elevating more frequently during the day, the ulcer may reduce, with the person perhaps being encouraged to feel more part of the healing process.

It is important to remember that, often, the person with the leg ulcer is the expert in the care of their own limb. It is, after all, their leg and they may have tried many different treatments before presentation to the service. Their opinion and assistance should be sought throughout the process and they should be actively involved in their leg care as much as deemed appropriately possible. The clinician must develop good communication skills and a confident knowledge base to ensure this occurs. The way in which the person with the leg ulcer is spoken to will affect concordance and it is important that the way in which certain phrases are used is considered.

Marks et al (2005) advise using mitigated directives, such as "maybe you can", or "let me say", to present more of a joint action and aid concordance. It is also important that the clinician has a sound knowledge base of the condition and underlying comorbidities to ensure patient confidence.

However, it is vital that the person with the ulcer understands that each clinician will have a different knowledge base and that each will play a part in their care. The aim should be to inspire confidence in the person with the leg ulcer to feel they can take part in their care and healing, while remembering there may be many different disciplines involved in their care. It is also important the individual recognises that their ulcer may be a symptom of their underlying comorbidities.

Conclusion

Leg ulcers have an impact on many aspects of a person's life and unless these have been experienced by the clinician, they cannot imagine to what extent.

Therefore, clinicians must strive to build therapeutic relationships with people with leg ulcers in the aim of achieving healing. Clinicians should be wary of labelling people "noncompliant" or "nonconcordant" and strive to understand what has caused this distancing between the clinician and patient. Concordance requires a sound knowledge of the condition and treatment options, and the healthcare provider must be focus on communication streams to effectively express this to the patient to encourage confidence in care. The overarching aim is to support people with leg ulcers in taking control of their wound care, while ensuring that appropriate knowledge and education is shared between all. WE

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