

Leg Club update

Chronic venous leg ulceration

As a former district nurse and latterly a tissue viability clinical nurse specialist (CNS), I have always been interested in patients with unmet psychosocial needs relating to chronic venous leg ulceration (Brown, 2003). The high recurrence rates of venous leg ulcers is well documented (Mayberry et al, 1991; Moffatt and Franks, 1995). It therefore always seemed a futile exercise to heal leg ulcers and then discharge patients from care, complete with compression hosiery and an information booklet, but with no further interventions planned. While this problem was readily acknowledged in my trust, limited clinic space, leg-ulcer clinic waiting times and lack of staff were cited as barriers to implementing a more proactive service.

Chronic venous ulceration often follows a pattern of active ulceration, healing and recurrence (Flaherty, 2005). Even when healing does occur, the underlying aetiology, i.e. chronic venous hypertension, persists. Chronic venous ulceration must therefore be considered a long-term condition.

There are numerous support groups available for sufferers of long-term conditions such as back pain, arthritis, diabetes and multiple sclerosis (Subramaniam et al, 1999). However, very little support is offered to patients with leg ulcers.

In 2005, I conducted a small phenomenological study into how chronic venous leg ulceration impacts on a patient's social life (Brown, 2005a,b). The findings indicate that leg ulcer patients do not experience higher levels of social isolation in comparison to their healthy peers, as suggested by many studies (Hamer et al, 1994; Hyland et al, 1994; Charles, 1995). Nevertheless, they do feel that having

a leg ulcer sets them apart from other people. I therefore became interested in the Lindsay Leg Club Model of care and decided to set one up.

The Leg Club

Our Leg Club has been in existence for 2 years and, to date, we have seen almost 200 new patients. It is held in a scouts headquarters and we have been overwhelmed with response from leg ulcer sufferers. Initially we had concerns about finding volunteers to form a committee to run the social side of our Leg Club. Eventually, however, a committee was formed which regularly organises quiz nights and raffles to generate income for the Club.

Several issues have emerged as a result of starting up our Leg Club. It is apparent that the prevalence and incidence of leg ulceration figures quoted in several epidemiological studies (e.g. Cornwall et al, 1986; Callam et al, 1987; Philips et al, 1994) vastly underestimate the number of patients with chronic venous leg ulcers.

Many of our members have lived with their leg ulcers for years and have never sought medical advice, and yet they choose to attend the Leg Club for treatment. In addition, we have now seen several people with non-cancer-related lymphoedema who previously were unable to access services in the primary care trust (PCT) because there was no provision for them. Having recognised this unmet need in the PCTs that I serve, I have put forward a business plan to enable me to open a non-cancer-related lymphoedema clinic. This is an example of how working with the local community enables health professionals to identify local health needs and redress care inequalities.

The unique working environment of the Leg Club brings with it many benefits. Members have their ulcers

treated collectively and in full view of everybody who attends, although privacy is offered if required. This is a deliberate strategy designed to destigmatise this chronic condition and encourage peer support and empathy (Lindsay, 2001).

Transparency of practice allows constant monitoring of issues such as infection control, manual handling, bandaging skills and wound management in an unobtrusive and supportive environment. Our Leg Club is considered locally to be a centre of excellence and is used as a training venue for nursing staff to practice their compression bandaging and Doppler techniques.

As a tissue viability CNS I have found the Leg Club to be an ideal teaching setting, an example being the application of lymphoedema bandaging. The Leg Club uses the latest advances in compression therapy, e.g. the new two-layer hosiery systems. Having mastered the technique myself, I have been able to pass on these skills to all Leg Club staff who, in turn, are now able to treat lymphoedema patients appropriately. This cascading of skills is not just confined to Leg Club staff as the nurses disseminate the information to all their colleagues. This is particularly important as our PCT has a wound care representative 'ban' in place and many of our staff are unable to be released to attend formal update study days.

In addition to treatment, our members are able to access hairdressers, a chiropodist and a reflexologist, who offer their services at a nominal charge. A group of our members have started a sponsored slim to raise funds for the Leg Club, which is definitely health promotion in action. Recently, a member was hospitalised and several Leg Club members went to visit him, which was a moving experience as before joining

the Club the man had no family or friends and thought that no one cared about him.

Quality-of-life issues

The Lindsay Leg Club Model of care is not suited to all patients, but everyone deserves to be offered a choice in their treatment (Department of Health, 2000). If we are to offer truly holistic care rather than just talk about it, the psychosocial needs of our patients must be addressed. Research has found that leg ulceration management is most effective in a community leg ulcer clinic (Bosanquet et al, 1993–4); however, the outcomes are generally measured in objective terms and the studies tend to be based within the medical model.

Quality of life has been demonstrated to improve by attending a leg ulcer clinic (Moffatt et al, 1992; Franks et al, 1994; Charles, 1995; Liew et al, 2000; Charles, 2004). However, this is generally only significant when complete healing has taken place and many of these studies do not continue to collect data once the study period is over. What happens to the patients' quality of life over time when their ulcer does not heal or, once healed, recurs?

The majority of our members continue to attend the Leg Club even when their ulcers have healed and are closely monitored for signs of recurrence. While the evidence clearly suggests that leg ulcer clinics are beneficial to the NHS in terms of reduced nursing time and cost-effective treatment (Moffatt et al, 1992; O'Hare, 1994; Morrell et al, 1998), the patient's perspective of attending a leg ulcer clinic has not yet been explored (Flaherty, 2005).

As a result, I have proposed a PhD study to explore patients' perceptions and experiences of attending a traditional leg ulcer clinic and compare

them with those of patients who choose to attend a Lindsay Leg Club. The aim of the study will be to explore issues such as health beliefs, stigma, demographic data, sick-role behaviour, and sociological theories such as group dynamics and social exchange theory, in order to find out if there is a theoretical framework underpinning the success of Leg Clubs.

Conclusion

Setting up a Leg Club involves a huge amount of hard work and commitment from all of those involved. Strong personal bonds are forged within the nursing team and with members who are united in their support of the Lindsay Leg Club Model. This commitment is necessary to fend off the negativity that may be voiced by colleagues who are not wholly supportive of the model because it challenges the traditional medical model of leg ulcer delivery.

The benefits of running a Lindsay Leg Club are positive for not only leg ulcer sufferers but also the nursing staff who have gained in terms of knowledge, newly acquired clinical skills and increased job satisfaction as a result of offering their patients truly holistic care.

For further information on the Lindsay Leg Club Model visit www.legclub.org

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Annemarie Brown, Tissue Viability Clinical Nurse Specialist, Castle Point and Rochford Primary Care Trust and Southend Primary Care Trust