

LEG CLUBS: giving patients a voice in leg ulcer management

A growing number of community-based clinics are implementing patient-centred care for people with leg ulcers reports

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How empowered do patients feel when they visit a medical establishment? Empowerment can be described as facilitating the individual in the acquisition of knowledge and authority, enabling and permitting them to participate in and make decisions about their care. However, in practice, empowerment is a complex subject, as clinicians have to confront both the patient's and their own needs and agendas.

In recent years, the benefits of patient empowerment have been widely promoted and the concept is a core theme of the National Health Service Plan¹, National Service Framework for Older People², A Patient-Led NHS³ and in the recent government White Paper, *Our health, our care, our say: a new direction for community services*,⁴ where the emphasis is on individuals being listened to and empowered to make informed choices regarding their treatment and care. But, despite the rhetoric, patient empowerment is still rarely encouraged. In the author's experience, empowerment of the care recipient may be perceived in terms of role threat and loss of control and authority by managers and nurses who are used to operating in a 'nurse dominant patient passive' relationship. While publicly embracing the ideals of patient empowerment, some health care providers and

nurses strongly resist change when confronted with the reality of its implementation.

The Lindsay Leg Club Model

In the field of leg ulcer management, the Lindsay Leg Club⁵ Model delivers an environment for truly patient-centred holistic care through a synergistic combination of four binding principles:

- Non-medical setting;
- Collective treatment;
- Open accessibility, no appointment required;
- Integrated 'well leg' regime;

The instigator of the Lindsay Leg Club Model was a district nurse employed by an NHS Trust and attached to a rural general practice. She was involved in identifying the social isolation needs of the patients within her caseload and proceeded to identify, innovate and set up a community-based leg ulcer clinic.

The emphasis is on providing a clinic in which social interaction, participation, empathy and peer support ease loneliness, in surroundings where old friends can meet and new friendships are formed.

Objectives include:

- The empowerment of patients to be involved in making decisions pertaining to their own treatment;
- Addressing the effects of social

isolation by providing a venue for social interaction and peer support;

- Strategies to de-stigmatise and rebuild the self esteem of people with leg ulcers;
- Addressing sick role behaviours through education and informed beliefs, 'well leg' maintenance and prevention of recurrence once healing has occurred provision of an informal forum for health promotion and education.

How do the Clubs work?

The clubs are totally self-funding, with patients and the community finding various ways of raising money by holding coffee mornings for the rent, equipment, etc. Collaborative working is the foundation of Leg Club culture - patients and nurses work together in an open environment, where interactive learning is paramount. Shared knowledge allows an open forum where excellence in practice can be observed, recognised, critically evaluated and mirrored by all the nursing staff. This openness is necessary to provide patients with a sense of collaboration in their care, where a number of patients are treated together, hearing about and observing the differing treatments.⁵ The layout of the Leg Club is one of a social club with people with leg related problems ▶

attending as they wish and remaining to have coffee and tea throughout the session. Treatment is undertaken collectively in a separate area where two or three people can have their legs washed and dressed in the same room. This gives them the opportunity to compare healing and treatments. They are openly encouraged to discuss treatment issues with the skill mix team, carers and other patients, and this offers them control over their own leg ulcer destiny.

Leg Clubs are not owned by the health-care provider but by the local community. They provide a community-based venue at which patients may elect to meet and attend for treatment. Attendance at Leg Clubs is entirely a matter of patient choice. They are not intended to replace existing care delivery mechanisms but to complement them by responding to both the clinical and holistic psycho-social needs of patients.

Any new initiative benefits from consistency of purpose and a stable environment in which to develop and flourish. For staff this means stability and continuity of management, feedback and support. However, ultimately, successful Leg Clubs are the product of competent, open-minded and motivated nursing teams working to best-practice guidelines with management support.

In accordance with Leg Club guidelines, every Leg Club offers patients the option of receiving treatment in private, but data show that in practice less than 1% elect to do so, and patients are overwhelmingly in favour of collective treatment. Health and safety, and infection control are primary considerations for Leg Clubs, clearly covered by documented guidelines and risk assessment. Working practices and lifting protocols have been audited and approved by occupational health representatives, and pathways, for example diabetic, vascular and dermatology referrals, are incorporated into the comprehensive documentation.

The progress of Leg Clubs

Leg Clubs continue to evolve through a process of ongoing improvement based on the reflective practice and shared experiences of the members, debated at meetings such as the Leg Club Forum. The concept has been embraced by many forward thinking primary care organisations, and in Australia where the value of individu-

alised care and socialisation has been recognised as contributing to quality of life and increased healing.

It must be acknowledged, however, that patient empowerment is not an easy concept, and it is inevitable that some nurses and nurse managers are uncomfortable with the notion of moving from a 'nurse dominant patient passive' relationship to one of an equal partnership in care. The introduction of each new Leg Club has produced a vocal reactionary minority, but ultimately it is not necessary or desirable to compel all staff working within a community nursing team to work in Leg Clubs. Experience has shown that a small number of motivated nurses are quite capable of sustaining a viable Leg Club.

Leg Clubs have been shown to truly empower patients (members), enabling them to be real partners in the process of their care, de-stigmatising their condition, encouraging informed behaviours and facilitating the sharing of sensitive and/or emotional concerns, in a supportive empathic environment

Challenges to overcome

In the past decade radical changes have occurred within the primary care setting. General practitioners are looking into the cost-effectiveness of treatments for their patients and the provision of services available for purchase from an NHS Trust organisation. However, the advent of commissioned services for leg ulcer management in the community may present new challenges to the pursuit of patient empowerment and holistic care. For example, there are indications that many of these services may become assimilated within the existing GP surgery framework, in which clinics conventionally focus on clinical need, the treatment of 'sickness' and the alleviation of symptoms. The formal clinical environment reinforces 'sick role' behaviour, in which patients attend when they believe they require treatment and in which they assume a passive role in their care delivery. This culture is further encouraged when clinics

are incentivised on patient procedures rather than the ongoing maintenance of 'well legs' within the practice population.

Conclusion

Delivering holistic care in an environment that addresses social and psychological needs enhances concordance with treatment, healing rates and patients' quality of life. Data collected since inception of the first Leg Club in 1995 (there are currently 15 in the UK and four in Australia) illustrates dramatic reductions in both non-concordance and post-healing recurrence. Significant savings are also evident when costs are compared with conventional home visits. Leg Clubs have been shown to truly empower patients (members), enabling them to be real partners in the process of their care, de-stigmatising their condition, encouraging informed behaviours and facilitating the sharing of sensitive and/or emotional concerns, in a supportive empathic environment. The ethos of care, social support, friendship and medical treatment is what makes this form of community nursing care so unique.⁵

References

- 1 The NHS Plan: (2000) A Plan for Investment, a Plan for Reform. The Stationery Office, London.
- 2 National Service Framework for Older People (2001). Dept of Health, London.
- 3 A Patient-Led NHS (2005). Dept of Health, London
- 4 Our health, our care, our say: a new direction for community services: (2006) Dept of Health, London
- 5 Lindsay, E. Hawkins, J. (2003) Care Study: The Leg Club Model And The Sharing Of Knowledge. *British Journal of Nursing*. Volume 12, No 13 784-790

Start your own Leg Club....

In 2005, the Leg Club Foundation was formed as a registered charity to facilitate and support nurses wishing to set up Leg Clubs. Guidance is available from the Foundation, including publications and presentations for interested staff and managements. For those implementing the model, training is delivered, guidelines and documentation provided, and audit undertaken.

For further details on how to set up a Leg Club visit www.legclub.org
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