Healing leg ulcers in primary care: the Leg Club® initiative

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A leg ulcer can be defined as a break in a person's skin which becomes chronic in nature and takes longer than two weeks to heal (NHS UK, 2019). Evidence outlined by The National Institute for Health and Care Excellence (NICE) states that the prevalence of leg ulcers in the United Kingdom is around one percent over a lifetime, which still describes a large number of people (NICE 2022; Lim et al, 2018). The prevalence of leg ulcers continues to rise and a shift in lifestyle factors, including smoking and obesity, have contributed to this (Agale, 2013). Further risk factors for developing leg ulcers include immobility, advancing age, a history of varicose veins or deep vein thrombosis (DVT) and having a sedentary lifestyle (Scottish Intercollegiate Guidelines Network [SIGN], 2010; Lim et al, 2018). The challenge of caring for these chronic wounds often falls to staff in primary care. Therefore, they should have a good understanding of leg ulcers and how best to treat them. In the author's opinion, Leg Clubs® provide an ideal opportunity to manage lower limb wounds, while also tackling the wider holistic issues of leg ulcers, such as social isolation and loneliness.

KEYWORDS:
■ Leg Club® ■ Leg ulcers ■ Social isolation ■ Empowerment
■ Health promotion ■ Primary care

The Vascular Society (2022) explains that there are various types of leg ulcers — typically, three main categories. Venous leg ulcers, which account for at least 80% of cases; arterial leg ulcers, accounting for 15% of cases; and ulcers of other aetiology, which make up the final 5% (Vascular Society, 2022). Venous leg ulcers are typically caused by venous insufficiency, where the pressure in the leg veins reaches high levels, ultimately contributing to the formation of an ulcerated area (Vasudevan, 2014). Broderick et al (2020) explain that arterial leg ulcers stem directly from issues within patients' arteries. These include, but are not limited to, poor blood flow or arterial blockages caused by atherosclerotic plaques and high cholesterol levels (Broderick et al, 2020). Finally, poor management of conditions such as diabetes can lead to the development of foot and lower limb ulcers (NHS UK, 2019). Diabetes directly causes poor vessel health and neuropathy, with patients potentially not feeling that they have sustained a traumatic injury which can develop into an ulcer (Grennan, 2019).

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ASSESSMENT

Once a patient has developed a leg ulcer, it is important that clinicians take an holistic approach and assess them to establish its underlying cause (Davies, 2021). When carrying out wound assessment of the leg ulcer, healthcare professionals should consider and document the size of the wound, volume of exudate being produced, whether the wound is showing clinical signs of infection, and if the patient is experiencing any pain (Nagle et al, 2022). This will provide a baseline against which to measure if the wound is improving or deteriorating, so that the treatment plan can be changed accordingly.

Assessment should also involve measuring the patient's ankle brachial pressure index (ABPI) to determine their arterial vessel health status (Hampton, 2018), and whether compression therapy — gold standard treatment for leg ulcers — can be instigated (Weller et al, 2018). Simon (2015) outlines that compression should not be used on any patient who presents with an ABPI of less than 0.8. Information from the National Wound Care Strategy Programme (NWCSP) reports that measuring an ABPI using a doppler is the most efficient way to assess arterial leg health and palpating pulses is not enough to rule out arterial disease (NWCSP, 2022). The NWCSP (2022) also suggests 'first-aid compression' being instigated, i.e. mild compression for those where red flags have been excluded, until an ABPI can be performed — some compression being better than none.

In the author's clinical opinion, it is important to spend sufficient time assessing the patient's lifestyle, including their smoking status, diet and how much exercise they take. In addition, a detailed past medical history should be taken to ensure that a comprehensive holistic approach is taken, and the leg ulcer is treated according to its underlying causes, which, in turn, will contribute to faster healing.

LEG ULCER TREATMENT AND PREVENTION

Compression bandaging

It is recognised that compression bandaging therapy is the gold standard of leg ulcer care (De

Carvalho, 2018). In the author's current job role, the most common compression bandaging options come from Urgo Medical and Lohmann Rauscher, Urgo K2® and Actico® respectively. Shi et al (2021) outline simply that the use of compression bandaging heals ulcers more quickly, reduces pain, and improves patient quality of life. Compression therapy involves a gradual pressure increase from the ankle, where pressure is highest, to the knee, where pressure is lowest. Applying the compression bandaging correctly in this manner reverses the pathological changes in the venous system, thereby contributing to healing (Moscicka et al, 2019).

Compression hosiery

Compression hosiery or stockings are often used following healing to reduce the recurrence of leg ulcers (Nelson and Bell-Syer, 2014; Grillo-Ardila, 2016). They work by compressing the lower limb and helping to move blood in the veins back towards the heart and, once the calf muscle relaxes, it helps to prevent backflow of blood down the leg (Atkin, 2015). It is widely recognised that compression hosiery is a lifelong commitment to continue to maintain leg vessels following ulcer healing (Muldoon, 2019). However, Murdoch (2019) reflects that the use of hosiery often has a poor uptake, as patients do not understand the reasons behind using the garments, or find them difficult to put on and remove. Therefore, in the author's clinical opinion, healthcare professionals should educate patients, ensuring that they understand how compression hosiery works to reduce swelling and improve venous and arterial health, which in turn, will help them to have control over their own care. It is also important to note that compression hosiery comes in various standards to classify levels of compression (*Table 1*), with the most common in the UK being British Standard and European Class, and healthcare professionals should guide patients as to which to choose.

Table 1: Level of compression (Ellis, 2015)

	British Standard	European Class
Class 1	14–17mmHg	18–21mmHg
Class 2	18–24mmHg	23–32mmHg
Class 3	25–35mmHg	34–46mmHg

SKIN MAINTENANCE AND WASHING

There is evidence to suggest that regular washing in a simple solution such as saline or tap water and a good skin care regimen can be pivotal to leg ulcer healing (Royal College of Nursing [RCN], 2006). Following washing, any scales of dry skin should be removed using, for example, a debridement pad to allow for new epithelial growth (Lumbers, 2018). Legs should be regularly moisturised with an emollient prescribed by a healthcare professional (Chamanga, 2016; National Institute for Health and Care Excellence [NICE], 2019). However, in patients' homes, this is not always easy to achieve, and the author believes patients should be asked to directly participate in their skin care regimen, so that they are able to continue with this after healing.

HOW CAN PATIENTS PARTICIPATE THEMSELVES?

During a leg ulcer care journey only a small percentage of the patient's time is spent directly engaging with a healthcare professional, so it is crucial that they are able to carry out some self-care (Brown, 2018). For example, the NHS (2019) highlights that patients can help to reduce swelling and discomfort by elevating their legs whenever possible. However, the NHS recognises that managing leg ulcers can be difficult and daunting for patients, but by attending a local Leg Club® they can receive advice, guidance and encouragement to help them self-care (NHS, 2019).

WHAT IS A LEG CLUB®?

The Leg Club model of care is a community-based collaborative initiative. Initially, Leg Clubs were introduced to combat the impact of social isolation and loneliness for patients with lower limb ulcers, aiming to improve their response to treatment. It is well known that leg ulcers can be difficult to heal, and the number of patients affected by chronic, non-healing wounds is rising (Lusher et al, 2017). These clubs facilitate collaboration between healthcare providers and patients to ensure that patients receive holistic, person-centred care, enabling them to feel empowered (Lindsay and Hawkins, 2003).

Leg Clubs provide a social, non-medicalised environment for treatment where stigma is reduced, and patients have both professional and peer support to take ownership of their care (Lindsay, 2004). Recently, there has been a shift away from providing medical care in a clinical environment towards using other locations (Collins, 2019). This has been particularly useful during the Covid-19 pandemic where patients have often preferred the non-medicalised social settings (Galazka, 2020).

Social isolation and loneliness

Patients with leg ulcers can experience feelings of embarrassment and shame, which can ultimately lead to social isolation and a lack of interaction with others (Phillips et al, 2017). Symptoms of leg ulcers which have a detrimental effect on health and wellbeing include exudate volume, odour, and reduced mobility, all of which contribute to a loss of independence (Persoon et al, 2004). Upton et al (2014) also highlighted the direct correlation between chronic leg wounds and a negative emotional state, with patients experiencing depression and anxiety. Furthermore, the impact of social stressors has been directly linked to delayed wound healing (Walburn et al, 2017). The Leg Club model of care aims to increase social interaction to improve patient outcomes (Lindsay, 2004).

Leg Clubs offer a wide range of support to improve the patient experience, including:

- Social interaction as well as conventional wound treatment

Practice point

Healthcare professionals have unique relationships with their patients and can use their knowledge to inspire patients to take control of their care.

- Regular attendance even after healing has been achieved for ongoing assessment
- Prevention advice from healthcare professionals to ensure that wounds remain healed
- Patient encouragement to take an active role in their treatment
- A large array of treatments from one location by healthcare professionals.

(Lindsay, 2019)

HEALTH PROMOTION — MAKING EVERY CONTACT COUNT (MECC)

Recently, new guidelines known as making every contact count (MECC) have been developed (Public Health England [PHE], 2016a). MECC highlights the need for healthcare professionals to encourage patients to make their own positive lifestyle choices which will affect their health (PHE, 2016b; Bright and Burdett, 2019). Using open discovery questions and allowing patients time to talk, practitioners can share their knowledge in the hope that they may feel empowered to change their health behaviours.

The author feels that Leg Clubs provide the ideal arena for healthcare professionals to spend time listening to and educating patients. This helps them to feel better able to engage in their own care which, in turn, can contribute to positive health outcomes.

AUTHOR'S EXPERIENCE

Within her role as a general practice nurse (GPN), the author runs a Leg Club for patients in her local community, where she has met and treated patients with leg ulcers of different aetiologies. The author underwent training to ensure that she had the skills and knowledge to care for these patients and apply compression bandaging and hosiery safely. For the purpose of this article, the author will tell the story of one particular patient who had a beneficial Leg Club experience.

The author met this patient during her first week as a GPN. The patient was female, aged 75 and had been struggling with a leg ulcer for the past seven months. She had been undergoing treatment for leg ulcer care at the GP surgery, but felt that little progress was being made.

The patient was upset, lonely and embarrassed, feeling that she may never return to normal life. It was clear that she was experiencing some social isolation and felt the need to distance herself from her peers. The patient had never heard of attending a Leg Club but was keen to join if it could make a difference to her leg health.

By attending the local Leg Club, the patient quickly met others who were in a similar position and began to feel less alone. She engaged every week with other patients, which enabled her to hear about their positive experiences. By spending time with the healthcare professionals at the Leg Club, the patient had direct access to a range of treatment methods and was able to get advice and guidance from the nurses, which increased her confidence.

After several months of using compression bandaging, the patient's legs healed but she continued to come to the Leg Club on a regular basis to reduce the chance of recurrence. When explicitly asked, she said that coming to the Leg Club had given her the opportunity to get back out into the community and find others who were experiencing something similar.

Furthermore, the author feels that running a Leg Club has allowed the healthcare professionals to collaborate and share their skills and knowledge and has presented an ideal opportunity for training more junior staff to ensure that they feel confident when caring for patients.

CONCLUSION

Treating leg ulcers presents challenges for patients, the NHS and healthcare professionals. New research is regularly immerging about leg ulcer care and practitioners need to ensure that they remain up to date with their training and feel confident in their care delivery. Living with a leg ulcer can be daunting and isolating for patients. However, the introduction of Leg Clubs in the primary care setting allows patients to meet others in a similar position and provides them with easy access to a wide range of treatments. Professionals in primary care are well placed to initiate health promoting conversations and Leg Clubs offer an opportunity to empower patients to be involved in and take control of their own care. JCN

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KEY POINTS

- Healthcare professionals have unique relationships with their patients and can use their knowledge to inspire patients to take control of their care.
- Leg ulcers can be difficult and time consuming to treat, so staff need comprehensive training to feel confident to do this.
- Many patients find having leg ulcers to be socially isolating and embarrassing.
- Primary care staff can use health promotion techniques to enable patients to feel confident in managing their leg ulcers.
- Compression is the gold standard of treatment for leg ulcer care.