

Wound care nurse of the year 2019: runner up

Clare Mechen, runner up at the BJN Awards 2019, describes the work of the Leg Club for which her team was shortlisted

I was honoured to be one of the finalists for the 2019 BJN Awards and to receive a ‘highly commended’ award. This has enabled me to showcase the significant benefits of delivering a lower limb care model that is based on delivering nursing care in a non-medical, social environment, which removes the stigma associated with leg ulcers and helps isolated older people reintegrate into their communities.

Often there can be a lack of senior engagement in wound care delivery and a lack of continuity and consistency of wound care and treatment planning (Ousey et al, 2013), yet leg ulcer management presents a significant challenge in primary care, with over 700 000 people in the UK estimated as suffering from such problems. Not only is it costly—the documented annual cost of leg ulcer care is a staggering £1.94 billion (Guest et al, 2017)—but there is also the fact that many patients with chronic wounds living at home may feel isolated; they may have symptoms that affect daily living and be anxious about their own ability to care for their wound. Research has shown that lonely people are more likely to visit their GP, have higher use of medication, higher incidence of falls and increased risk factors for long-term care (Cohen et al, 2006)—meaning there is a greater impact on general healthcare services.

Four years ago, the practice team was trying to provide care for a large number of patients suffering with lower leg ulcers. A proportion of these patients often find it difficult to comply with treatment plans, or to maintain important preventive measures needed to reduce risk of recurrence of future ulceration. Leg ulcers can remain unhealed for many months or even years. Caring for patients with chronic, non-healing

wounds is complex and time-consuming and this can be complicated by lack of communication between services, such as acute and community care (Woo et al, 2018). Having undertaken a practice audit of our appointment use and care provided, we found that over 50% of our workload was related to lower limb care and, despite offering care based on best practice, 55% of patients had been suffering with leg ulcers for over 6 months and several of these patients had

‘Clinical care never ends, with an individual being a member for life’

had leg ulcers for several years. However, with treatment rooms full every day and the practice nurse team struggling to keep up, it was time to rethink our service delivery. This was when we found the community-based Lindsay Leg Club model.

Leg Clubs represent an innovative psychosocial model of care that has been shown to improve the health and wellbeing of people with chronic leg conditions (Lindsay, 2017). Leg Clubs are unique in the way they work, by providing a community environment that enables clinical staff to provide holistic care and work alongside local volunteers, who provide social interaction for the Leg Club members. There is plenty of evidence that anxiety and depression can delay wound healing and poor management of wound symptoms can lead to poor concordance (Wounds International, 2012), so we felt, as a practice team, that a model of care encompassing a person’s physical, social, psychological needs would ultimately deliver better patient outcomes.

The development of our locally based ‘Best Foot Forward Leg Club’ has really transformed how we care for patients with lower leg conditions. It enables a consistent clinical approach by ensuring all staff are working to

the same standard and has significantly helped to empower patients to take control of their own care. From early beginnings when patients who had become members of the Leg Club started to call it ‘our club’ and the formation of new, cautious relationships, to today’s thriving, lively Leg Club with over 600 members, it is evident that the Club helped to transform lives. Early concerns from some clinicians and patients as to whether the model of treating people in a non-clinical environment and sitting next to each other would work were dispelled within the first few weeks. Members are happy to chat to each other and are able to offer true empathy—something that clinicians cannot do, unless they have had personal experience of lower leg ulcers. As clinicians it is truly rewarding to witness members willingly provide support and advice to each other and become experts in their own care.

Social activities are provided by our interactive and compassionate Leg Club volunteer team, who help members engage with each other and participate in the offered activities. This has resulted in a positive impact on members’ general wellbeing and feelings of self-worth when they are provided with the opportunity to socialise and develop supportive friendships in a no-stigma environment, reducing isolation and loneliness. These outcomes were supported by findings of a qualitative study to assert if this motivational model delivered in a social environment has a positive impact on participants’ wellbeing and quality of life (Lindsay and Mechen, 2018). We continually see such impact in a variety of patients; frequently there are patients who initially turn up in pain and are struggling to self-care and for some it can result in feelings of desperation about their lower leg problems. To see the change in a member’s outlook on their problem, their participation in the self-care and management plans and, for most, the gradual healing in their leg ulcers, can be quite profound for all concerned. The Leg Club model clearly demonstrates a link

Clare Mechen, Advanced Nurse Practitioner/
Nurse Manager, The Adam Practice Poole and
Best Foot Forward Leg Club, clare.mechen@legclubfoundation.com

between physical, social and mental health.

The clinical impact of the Leg Club psychosocial model of care has been clear with members showing improved concordance and partnership in treatment care plans. The friendly community environment and empowering approach to holistic care enables the nursing team to work in collaboration with individuals, discussing ideas or suggesting treatment changes with members and colleagues, with the aim of improving wound healing or overcoming an issue that is impairing healing.

Once a patient has had one ulcer they can be at high risk of developing further problems, with a 12-month recurrence rate of between 18% and 28% (Ashby et al, 2014). One of the key elements of the Leg Club model is the 'well leg' regimen, which is an integral part of the social model and is based on health education, advice, maintenance and as such, clinical care never ends, with an individual being a member for life. The 'well leg' regimen enables members to continue to self-care, with the continued support and guidance of clinicians, and helps to prevent further leg-related problems once an ulcer has healed. Evidence to support the benefits of this ongoing care regimen has come through shared personal accounts of individuals' journeys from disabling leg ulcers to self-management of healed legs (Mechen and Andrews, 2019).

Continuous audit is undertaken within the Leg Club to closely monitor infection and healing rates, and weekly data are collated by the Leg Club Foundation to provide evidence of the benefit of the model. From early days to now, our clinical data have now consistently demonstrated healing rates above the national average and a significant reduction

in recurrence rates, with over 73% of our 600-plus members now within the 'well-leg' programme, which continues to monitor and support members to keep their legs healthy. Our most recent data on recurrence rates show a significant reduction at 13%, compared with what is estimated nationally to be a 12-month recurrence rate of between 18% and 28% (Ashby et al, 2014).

For primary-care service providers the redesign of service delivery has made a considerable impact on appointment availability. Four years ago, in our practice, treatment appointments for lower limb care accounted for 50% of the total demand; current demand for lower limb care is no more than 15% of all nurse appointments across the practice, meaning better availability of nursing appointments for all our practice patients. This has given us the scope and capacity to develop other nursing services in response to patient needs.

Having seen the clear benefits of a model that truly puts the patient at the centre of care—enabling them to be fully empowered and in equal partnership with clinicians to make their own healthcare decisions—I am enthusiastic about disseminating this knowledge and supporting other colleagues to take up this model. I have shared this with the local clinical commissioning group to encourage other stakeholders to fully endorse the setup of other Leg Clubs in our area and this model has been included as a recommendation within the Local Enhanced Service specification. Supporting the Lindsay Leg Club Foundation charity in a consultancy role has enabled me to present the benefits of the psychosocial model to other colleagues, which has led to several new Leg Clubs opening across the South of England.

The Leg Club model provides an excellent opportunity for primary care health professionals and commissioners to be proactive, rather than reactive, and deliver a truly holistic, patient-focused approach to wound healing leading to improvement in patients' outcomes and cost savings. Optimising an individual's quality of life not only improves their general wellbeing but also their ability to self-manage their condition. The psychosocial concept of this care model fits within the current NHS agenda, including a focus on social prescribing, and offers a non-medical route that helps to reduce the impact on health of social isolation and loneliness. **BJN**

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