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The Lindsay Leg Club® Model: a model for evidence-based leg ulcer management

Ellie Lindsay

For many older people living in the community, loneliness is a significant issue. Retirement, poor mobility, the death of family or friends or the effects of demographic change on the cohesiveness of the family unit can all create an environment of social isolation. For older people suffering from leg ulcers, this isolation is often heightened, and can have detrimental effects on their health. Pain, odour and obtrusive bandages may exacerbate feelings of low self-esteem, depression and social stigma, which in turn can lead to poor concordance with treatment and low healing rates (Lindsay, 2000). Even when healing is achieved, poor concordance leads to high levels of recurrence.

Health beliefs play an important role when treating and managing patients with leg ulcers. One of the main problems the district nurse is confronted with when treating a patient in his or her own home, is poor concordance with treatment. As Becker (1974) asserted, even when an individual recognizes personal susceptibility (e.g. to leg ulceration), action will not occur unless he or she also believes that becoming ill will bring organic or social repercussions. So in an already isolated individual, the social repercussions are negligible, and motivation to act can therefore be very low.

It has also been claimed that a lack of an informal support network may result in patients becoming psychologically dependant on health care professionals (Poulton, 1991). Poulton further highlighted the importance of an holistic assessment, taking into account both the psychological and social factors of the patient's situation and being proactive in organizing other social contacts for the patient.

As a district nurse in Suffolk, I was aware of anecdotal evidence that social factors and isolation could significantly influence patients' response to treatment. Further enquiry – via literature review, examination of demographic factors and patients' daily circumstances, and a study of established leg ulcer clinics – led to the conclusion that a new type of clinic could help to address these issues. The conceptual framework for this new approach was a health belief model (Becker and Maiman, 1975), for obtaining and assessing the patient's views and perception of health and well-being. The model addresses the individual's con-

cerns, motivating factors, demographic issues, attitudes, interactions and enabling factors. Becker (1974) introduced self-efficacy into the health belief model, and identified an association between belief in the treatment, motivation and concordance.

The model assumes that wellbeing is a common objective for all and that locus of control is associated with mastery of health information, motivation, effective problem solving, sense of responsibility and desire for active participation in health care.

The first clinic to be based on these principles was set up by the author in the village of Debenham in Suffolk in 1995.

How a Leg Club works

Leg Clubs were conceived as a unique partnership between community nurses, patients and the local community, to provide leg ulcer management in a social, non-medical setting. In accordance with the themes of the *NHS Plan* (Department of Health, 2001) and clinical governance, patients are empowered with a sense of ownership and recognition that they are stakeholders in their own treatment. Emphasis is placed on social interaction, participation, empathy and peer support.

A Leg Club is characterized by four features that differentiate it from conventional leg ulcer clinics held in

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ABSTRACT

Leg Club® is a unique model of community-based leg ulcer care. By providing nursing care in a non-medical, social environment, the model has several benefits: it removes the stigma associated with leg ulcers and helps isolated older people reintegrate into their communities, which in turn improves concordance and has a positive impact on healing and recurrence rates. In an atmosphere of de-stigmatisation, empathy and peer support, positive health beliefs are promoted and patients take ownership of their treatment. The Leg Club model creates a framework in which nurses, patients and local community can collaborate as partners in the provision of holistic care. The model also provides an environment for appropriate supportive education, advice and information.

Key words: *Concordance, patient empowerment, leg ulcer, social isolation, Leg Club, holistic care*

a medical environment:

- It is community-based, held in a non-medical setting, e.g. a village/community centre or church hall, meeting room etc (*Figure 1*)
- Patients are treated collectively
- It operates on a drop-in basis (no appointments required)
- It incorporates a fully-integrated 'well leg' regime.

The practice of treating patients in isolation restricts the opportunity for peer support and education, and reinforces feelings of stigma that an individual may already be experiencing. In Leg Clubs, care is delivered collectively in a social, non-medical environment that facilitates socialization and peer support and empowers patients to participate in, and take ownership of, their treatment. In such an environment, example setting and role model emulation can flourish, providing powerful influences to help modify beliefs and change behaviour in non-concordant patients – influences that are not present in the typical one-to-one 'nurse dominant/patient passive' relationship. However, collective working can be extremely challenging for some nurses, although objections are typically a nursing perception, not an issue for patients. The receptionist and staff explain the collective treatment regime to new patients and ensure that provision is available for individual treatment should it be requested. To date, no patient has objected to being treated collectively and no incidents of cross-infection have occurred within the author's experience.

The principal aims of the Leg Club are therefore to:

- Empower patients to become stakeholders in their own treatment, promoting a sense of ownership and involvement
- Meet the social needs of isolated patients by

providing a mechanism for social interaction, empathy and peer support

- Rebuild patients' self-esteem and self-respect by de-stigmatizing their condition
- Facilitate an informal support network
- Achieve concordance to treatment through informed beliefs and modified behaviour
- Provide continuity of care and a coordinated team approach to its delivery
- Minimize recurrence by systematic post-treatment monitoring and 'well leg' checks
- Adopt a simple, flexible drop-in approach that encourages attendance for information and advice, facilitating early diagnosis of problems
- Provide an informal forum for opportunistic health promotion and education.

Leg Clubs are not 'owned' by a health care provider, but by the local community. They provide a community-based venue at which patients (referred to in the Clubs as 'members') may elect to meet and attend for treatment. They are not intended to replace existing care delivery mechanisms but to complement them by responding to both the clinical and psychosocial needs of members. Apart from the direct costs of care delivery, Leg Clubs are self-funded (running costs and equipment costs) through money raised by volunteers within the community. In setting up Leg Clubs, nurses truly 'get to know' the communities they serve, working alongside the community and members to provide an environment of genuine patient empowerment.

The Leg Club model incorporates strict criteria, governing environment and clinical practice, defined in written guidelines and comprehensive documentation. Defined safe working practices, covering areas such as infection control, risk analysis and the use of equipment must be implemented the opening of any new venue. Clinics are subsequently subject to regular audit to ensure continued adherence to Leg Club standards and enable comparative benchmarking to be undertaken. Routine data collection and analysis is a vital component of the model as it provides a measurement tool for clinicians to identify opportunities for continual improvement and sustained best practice.

Only clinics adhering to the Leg Club model and practicing to its prescribed standards are entitled to use the Leg Club title. To prevent the title being employed inappropriately it is protected by a Registered Trade Mark.

The impact of Leg Clubs

Statistical data have been collected and independently analysed since the inception of the first Leg Club at Debenham. An ethnographic study has identified patients' positive attitudes and a strong sense of ownership in 'their' club (Lindsay, 1996). Clinically, non-con-

Figure 1. Grundisburgh Leg Club.



The Leg Club model provides a framework in which older members of the community have an opportunity to play a valued and fulfilling role in their community and remain as active as possible..

cordance to treatment was virtually eliminated and there was evidence of higher healing rates, illustrated by many members whose long-standing ulcers either healed or greatly improved as a direct result of this change in approach.

It was evident that, before attending the clinic, some of the members had been aware of the severity of their ulcers and the need for treatment, but had not been concordant with it because they felt some antipathy to the medical establishment.

Some members disclosed that their attitude to their problems and treatment had undergone change as a result of knowledge they had acquired in the Club environment. Through awareness of their own and others' problems, they had become involved in related issues pertaining to their treatment and expected outcome. Their greater knowledge had led to an improved sense of self-worth and a belief that they were enabled to participate in their own treatment and care. The social aspects associated with their care emerged as the key factor in the healing process, and the clinical treatment became secondary. It was stimulating to observe how well individuals respond to an holistic approach to their care and the empowerment associated with that approach.

Prophylaxis

The 'well leg' programme of the Leg Club model is aimed at prophylaxis education and advice, and prevention and maintenance of further leg-related problems once an ulcer has healed. According to McAllister and Farquhar (1992), health beliefs have important implications for nursing given the role of the nurse in health promotion and patient teaching. Although primarily targeted at the older population, the informal nature of the clinic has encouraged patients as young as 19 to attend for advice and treatment, creating opportunities for early diagnosis, education and health promotion (Lindsay, 2001). People's willingness to attend for 'well leg' checks and ongoing health education has resulted in a dramatic reduction in the incidence and recurrence of leg ulcers to <4% per annum. This compares favourably with data from various studies demonstrating high recurrence rates for leg ulceration. For example, Callam et al (1985) undertook a survey of 600 patients with 827 ulcerated legs of which 67% had recurrent ulcers, 35% of whom had experienced four or more episodes of ulceration. The low recurrence rates associated with Leg Clubs support the rationale of patient empowerment and the synergistic effect of ongoing health promotion and education in an integrated well-leg regime.

Members' feedback

A small survey was designed by the chairman and

committee of Grundisburgh Leg Club to obtain their members' views of the two local Leg Clubs. The survey was conducted by both Grundisburgh and Debenham Leg Club committee members and the findings were collated and analysed by a statistician.

The survey indicated that a non-threatening environment was an important factor of the Clubs' success. The members commented on their reluctance to visit a medical centre for treatment, but found that attending a clinic in a social setting gave them a sense of purpose, a feeling that they shared a common problem, and were not in isolation. The data further identified that they formed friendships and gained an understanding of others' problems and needs, and their medically-related problems became secondary. Through this network of mutual support and friendship, concordance to treatment resulted from a strong sense of motivation. This was expressed through their trust in one another, confidence in themselves, and understanding of their own treatment.

Local involvement

Another interesting facet of the Leg Club model has been the development of roles within the local community volunteer group. In many parts of the world, retired people are seen as active individuals who participate in neighbourhood committees, educational activities, welfare work, and serving their neighbourhood in various ways. Therefore it is interesting to note that the majority of the Leg Club teams have community volunteers from this group who have elected to transfer from retirement status to become an extremely productive resource contributing to their community. Far from categorizing retired people as a frail, incapacitated or dependant group, the Leg Club model provides a framework in which older members of the community have an opportunity to play a valued and fulfilling role in their community and remain as active as possible. Their enthusiasm and energy has resulted in the creation of friendship clubs and peer groups where support and advice is offered to volunteers involved in newly formed Leg Clubs. The role of the volunteer receptionist has evolved to include newsletters, questionnaires, general information, fund-raising letters and information leaflets, organization of fund-raising events, maintenance of member registers and documentation. Two committee volunteers have successfully applied for substantial awards from the National Lottery. As one volunteer stated, 'I never thought life began at 84'.

Leg Club roll-out

In response to local demand, the second Leg Club was established in 1998 near Debenham, in the village of Grundisburgh. Further Leg Clubs have since been

If you require further information about the Lindsay Leg Club model, please

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- Email Ellie Lindsay: ellie@legclub.org
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facilitated and opened around the UK, in Dorset, Suffolk, Norfolk, East Sussex and Southend, Essex. Many more are currently at the embryonic stage, planning to open during 2004. Of these, Broadstairs, Kent and Chichester, West Sussex are in the concluding stages of set-up and will be opening their doors in May and June. There are currently four Leg Clubs in Australia, in Adelaide, Brisbane and the Gold Coast. The concept has been disseminated in the UK and overseas through journals, conference presentations and seminars, and is a past winner of a British Journal of Nursing Clinical Practice Award and Nursing Standard Nurse 2003 Award (Wound Care).

However, this success has not been achieved without overcoming considerable antipathy and resistance to change among peers within the author's local community nursing fraternity and nursing management. Successful Leg Clubs are the product of competent, open minded and motivated nursing teams working to best-practice guidelines with local health organization management support. However, patient empowerment is not an easy concept, and it is inevitable that some nurses and nurse managers are very uncomfortable with the notion of moving from a nurse dominant-patient passive relationship to one of an equal partnership in care.

Current Developments

In 2002, Queensland University of Technology was awarded a nursing research grant to undertake a two year randomized control study with St Luke's Community Nursing Service replicating the Leg Club model. The study aimed to examine the effectiveness of a community Leg Club intervention in improving healing rates, quality of life, health status, levels of pain, functional ability and the model's cost-effectiveness of care. Courtney et al (2004) demonstrated that the data collected from the initial results indicated that

significant improvements in all areas had been achieved in the intervention group.

Documentation is the corner stone to delivering evidence-based care. A software programme is currently under development to facilitate completion and analysis of the comprehensive Leg Club practice documentation. To ensure that prescribed procedures and standards are achieved and maintained throughout the Leg Club network, a comprehensive, 32-page audit tool has been compiled and employed.

Researchers from the Royal College of Nursing are undertaking a national audit of venous leg ulcers, funded by the Commission for Health Improvement (CHI). Leg Clubs are to be included in this project and selected Leg Clubs will participate in the audit programme. Researchers also plan to meet Leg Club members to discuss the role of expert patient groups (Department of Health, 2001).

Conclusion

Leg Clubs have been shown to provide tangible benefits for all involved in the delivery of leg ulcer management:

- Significant cost savings for the health care provider
- An environment of truly holistic care for patients
- An enhanced and productive nursing / community relationship
- A forum for health promotion and education
- An accessible setting for opportunistic early detection and treatment. ●

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KEY POINTS

- Leg Club is a social model of leg ulcer management.
- Clinics are held in a non-medical, social setting that socially empowers members and overcomes isolation.
- Members gain an understanding of others' problems and needs, so their own medically-related problems often become secondary.
- As a result of the network of mutual support and friendship generated in Leg Clubs, motivation to heal is strengthened, and concordance to treatment is strengthened.
- Evidence of greater healing rates has been illustrated as a direct result of this change in approach.
- The integrated 'well leg' regime has been demonstrated by members' ongoing concordance to the correct use of compression hosiery and readiness to attend for systematic aftercare and monitoring.