Understanding the impact of leg ulcer bandaging on patient quality of life

Edwin T Chamanga

Various research studies have identified the sometimes problematic relationship between patients with leg ulcers and practitioners, such as community nurses. The author contends that this mismatch needs to be addressed in order to improve patient quality of life through leg ulcer bandaging. He makes several recommendations for practice and highlights that community practitioners need to use innovative practice to help improve the quality of leg ulcer bandaging care they deliver. The overall aim of this article is to establish the extent of community practitioners’ understanding of the impact of leg ulcer bandaging on patient quality of life.

KEYWORDS:
- Wound care
- Leg ulcers
- Quality of life
- Compression

BACKGROUND

Literature has shown that some patients with leg ulcers have a significantly poorer quality of life compared with those who do not have leg ulcers. Morgan and Moffatt (2008a) have identified that nurses may not fully understand the complex challenges faced on a daily basis by patients with leg ulcers.

IMPACT OF LEG ULCERS

Leg ulcers are defined as any skin damage below the knee that takes more than six weeks to heal (Dale et al, 1983). However, leg ulceration is not a diagnosis, but only a manifestation of an underlying medical condition, which needs a clear diagnosis (Dean, 2006). Leg ulcers can be of arterial, venous or mixed aetiology (Morris and Sander, 2007), often taking many months or years to heal (Graham et al, 2001; Nemeth et al, 2004; Moffatt et al, 2006).

It is estimated that 1–2% of the general population in the UK will develop a leg ulcer at some point in their lives (Laing, 1992). Indeed, the risk of developing leg ulcers rises with increasing age as the condition is often complicated by co-morbidities.

Table 1: The effects and implications of leg ulcers

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<thead>
<tr>
<th>Effect/Implication</th>
<th>Percentage/Rate</th>
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<tbody>
<tr>
<td>Fifty percent of community practitioners’ time is spent treating patients with leg ulcers</td>
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<td>Studies have also shown that pain affects 48–90% of patients with leg ulcers</td>
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<tr>
<td>Fifty percent of venous leg ulcers will heal within four months</td>
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<td>Twenty percent of venous leg ulcers will heal between four months to a year</td>
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<td>Another 20% will heal within a period of two years</td>
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<td>Around 8% do not heal even after five years</td>
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<tr>
<td>Leg ulcers are a chronic problem with a recurrence rate between 26% and 69% — 26% of these recur within the first year; 31% within 18 months</td>
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associated with arterial and venous disease, such as vascular calcification or varicose veins.

As a result of improved life expectancy, the prevalence of leg ulcers in the population is likely to increase (Franks and Moffatt, 2006), and even at their current incidence leg ulcers are a major economic burden — it is estimated that treating leg ulcers absorbs £400–600 million of the UK health budget per year (Bosanquet, 1992; Freak et al, 1996).

Unfortunately, leg ulceration can also be a life-long problem, with two-thirds of patients with healed leg ulcers having at least one recurrence (Morris and Sander, 2007).

LITERATURE SEARCH

For this article, the author performed an extensive literature search on the subject of community practitioners’ views and experiences of leg ulcer bandaging and its impact on patient quality of life (using databases such as NHS Evidence; CINAHL Plus; Medline; Ovid; Scopus).

Research into quality of life in patients with leg ulcers began in the early 1990s, so the literature search spanned a 20-year period — 1993 to 2013. Some of the key search words used were:

- Quality of life
- Community practitioners
- Leg ulcers
- Bandaging.

During the previous 20 years, there have been major advances in knowledge around how to treat or manage leg ulcers (Table 1), requiring ongoing management over many months or even years.

Chronic conditions were defined by the World Health Organization [WHO] (2004) as having ‘one or more of the following characteristics’:

- Permanence
- Leaving residual disability
- Caused by non-reversible pathological alternation
- Requiring special training of the patient for rehabilitation

- Requiring a long period of supervision, observation or care.

Although leg ulceration fits the criteria for a chronic condition, research evidence indicates that nursing care usually focuses on wound care and the application of bandaging, rather than the patient as a whole (Persoon et al, 2004; Heinen et al, 2007).

‘During the previous 20 years, there have been major advances in knowledge around how to treat or manage leg ulcers’

Furthermore, while there has been considerable research into the negative effects of leg ulcer bandaging on patient quality of life, little is known about community practitioners’ views and experiences of bandaging patients with leg ulcers.

Quality of life

Quality of life was defined by WHO (2004) as an individual’s perceptions of their position in life, in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns.

Quality of life in patients with leg ulcers has been examined within a range of qualitative and quantitative research studies (Persoon et al, 2004; Chamanga, 2010). However, limited research evidence exists regarding practitioners’ perceptions and understanding of the impact of leg ulcer bandaging on patient quality of life.

LEG ULCER MANAGEMENT

Patients with leg ulcers often experience problems such as pain, discomfort, malodour, ulcer deterioration and high volumes of exudate. Unfortunately, poor management can also contribute to these factors. Common management problems that can affect patients with leg ulcers include:

- Wrongly applied bandages that are not easily tolerated by patients
- Poorly fitting shoes, which means patients’ mobility is reduced or compromised. They may also be afraid of falling and becoming socially isolated through lack of mobility
- Patients with heavily exuding wounds remaining in wet bandages for extended periods of time, leading to excoriation of the skin.

Figures 1–5 show examples from the author’s clinical practice, where patients often present with bandaging issues. These illustrate some of the management problems that can develop through practitioners’ lack of knowledge and awareness of the impact of bandaging on patient quality of life. As a result, patients may be left feeling negative and discouraged by their experience of leg ulcer treatment (Table 2).

DISCUSSION

Although a number of studies have explored the patient/professional relationship and its impact on care delivery (Ribu and Wahl, 2004; Thorne et al, 2004; Morgan and Moffatt, 2008a,b), and the patient’s acceptance of therapy (Playle and Keely, 1998), only a few have looked at the community practitioner’s experience of treating patients with

<table>
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<th>Table 2: Implications for quality of life of leg ulceration</th>
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<td><strong>Physical</strong></td>
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<tr>
<td>Pain</td>
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<tr>
<td>Sleep disturbance</td>
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<tr>
<td>Poor mobility</td>
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<tr>
<td>Poorly fitting shoes</td>
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<tr>
<td>Wrongly applied bandages</td>
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<td>Walshe, 1995; Persoon et al, 2004; Franks and Moffatt, 2006; Briggs and Fleming, 2007</td>
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Leg ulcers (Hollinworth and Hawkins, 2002; Morgan and Moffatt, 2008b; Walsh and Gethin, 2009).

Knowledge and understanding of treatments
A study by Hollinworth (2002) of 50 clinical practitioners both in the community and acute settings, identified that some exhibited poor and outdated wound care knowledge. Martin and Duffy (2011) note that nurses employed in the community often practise in isolation, which may hinder their ability to access, understand and incorporate the most up-to-date research findings into their everyday clinical practice.

The author has noted a lack of up-to-date clinical knowledge evident in modern clinical practice, which results in some of the poor patient care depicted in Figures 1–5. Figure 3, for example, shows retention bandaging being applied from the ankle up, which increases the risk of a tourniquet effect where the leg may become oedematous and swollen (Anderson, 2008; Beldon, 2009).

Benbow (2004) notes that some practitioners do not have sufficient understanding of wound care and the dressing products they use in clinical practice. This can result in inappropriate care being delivered, ultimately leading to wound deterioration or delayed wound healing, and having a negative impact on patient quality of life (Dowsett, 2002; Persoon et al, 2004).

An example is shown in Figure 1, where a small area of lymphorrhrea (lymph fluid from a cut, torn, or burst blood vessel leaking onto the surface of the skin) at the back of the patient’s leg resulted in extensive excoriation and maceration on the dorsum and underfoot respectively, due to wet bandages being left in place. This resulted in a significant loss of trust between the practitioners and this particular patient, as the ulcer was smaller and exuding less when the patient was attending to it.

Issues with treating excessive exudate
Certain authors (Cutting and White, 2002; Adderley, 2008; Beldon, 2009) argued that high volumes of wound exudate on leg ulcer bandages can be explained by high bacterial growth on the wound bed, inadequate compression therapy in venous ulcers, the use of inappropriate dressings, or incorrect wear time.

Although many dressing options are now available, patients continue to experience the indignity and social embarrassment of wearing soiled clothes, causing reduced quality of life (Menon, 2012). In the author’s clinical experience, inadequate compression therapy for venous ulcers, as well as inappropriate levels of compression, are being applied, as patients sometimes present at the author’s leg ulcer clinic with wet, unravelling bandages and exposed tendons. Figures 4 and 5 show how leg ulcers often deteriorate following poor application of compression bandaging or inappropriate wear time.

Anderson (2002) reported that increased volumes of exudate in leg ulcers can cause patients anxiety and discomfort. In such cases, the author recommended that the frequency...
of dressing change be increased, otherwise this may impact on the practitioner/patient relationship.

Differing perceptions
There is some evidence of a mismatch between what patients and community practitioners expect from leg ulcer care and treatments, particularly with regard to outcomes (Ribu and Wahl, 2004; Morgan and Moffatt, 2008a).

This is illustrated by a case from the author’s own practice (Figure 2), where the patient wanted to reduce the volume of exudate being produced by the wound to get a good night’s sleep. However, the primary focus of the practitioners involved was to heal the wound, despite the fact that the patient had lived with leg ulcers for over nine years, with multiple comorbidities, and was unable to tolerate pain management regimens and reduced compression. In cases like this, a good understanding of quality of life issues is critical and should underpin any treatment decisions.

Both the literature and the author’s observations of clinical practice confirm that practitioners sometimes focus more on the wound’s progress than on what the patient actually wants (Husband, 2001; Persoon et al, 2004; Briggs and Flemming, 2007).

Out of 17 studies reviewed by Persoon et al (2004), five involved patients being unhappy with practitioners who did not adequately explain the treatment, did not listen to them and provided inconsistent advice. This also accorded with evidence that practitioners sometimes lack empathy (Anderson, 2000).

According to a study by Morgan and Moffatt (2008a), all five patients interviewed felt that their leg ulcers were not important or of any interest to the practitioners involved in their care, a theme that reoccurs in a number of papers (Heinen et al, 2007; Maddox, 2012). Similarly, the patients interviewed by Morgan and Moffatt (2008a), as well as those in a separate study by Ribu and Wahl (2004), confirmed that in most cases practitioners did not seem to understand how leg ulceration and bandaging impacted on their everyday lives, leaving them feeling exposed and vulnerable.

‘Practitioners are often not comfortable having their practice examined’

RECOMMENDATIONS FOR FUTURE PRACTICE

Patients’ understanding of the impact of leg ulceration and leg ulcer bandaging on quality of life are already understood. However, the perceptions of community practitioners are not so well documented. As shown by the literature, wound care is a major part of community practitioners daily activities, yet their experiences in this area are not well-established (Walsh and Gethin, 2009; Maddox, 2012).

There may be various reasons for this. Morgan and Moffatt (2008b) reported that practitioners are often not comfortable having their practice or perceptions examined. Similarly, they are subjected to a number of pressures, such as institutional victim blaming, political directives and staff shortages, which have contributed to poor support for patients with leg ulcers (Anderson, 2000).

Further studies need to be conducted to examine community practitioners’ understanding of the impact of leg ulcer bandaging on patient quality of life, particularly as research has shown that the idea of the ‘expert patient’, joined-up nursing care and the concept of the ‘ideal nurse’ can facilitate improvements in patient quality of life (Ribu and Wahl, 2004; Morgan and Moffatt, 2008a).

The expert patient

Research has shown that patients are often aware of the advantages and disadvantages of various treatments. For example, they may understand which bandages are more comfortable or have experience of dressings that are more absorbent than others (Ribu and Wahl, 2004; Briggs and Flemming, 2007; Morgan and Moffatt, 2008a).

Indeed, in 1999, the government set out the expert patient programme in the White Paper, ‘Saving lives: our healthier nation’. Research and practical experience in the UK has shown that patients with chronic diseases need not be mere recipients of care — they can in fact become key decision-makers in their treatment (Department of Health [DH], 1999).

According to a DH (2001) evaluation of approximately 1,000 patients with chronic conditions, the expert patient programme enabled individuals to gain confidence and skills to better manage their condition on a daily basis. Of course, the expert patient programme hinges on educating and supporting patients to manage their condition (Donaghy et al, 2010), which may not always be possible with the typical chronic leg ulcer patient if they have not been educated to manage their condition. However, these patients may have lived with leg ulceration for months or years, meaning that they should be able to make a valuable contribution towards their own care.

Letting patients lead their care also incorporates them into the team, creating an effective patient/practitioner relationship where the practitioner can gain an understanding of patients’ views and values. This helps to create an atmosphere where the patient can seek advice from the practitioner and likewise the practitioner from the patient, as seen in Leg Clubs (Edwards et al, 2005; 2009). In practical terms, this means that the patient might alert the nurse when bandages are wet, falling off or uncomfortable.

Joined-up nursing

In clinical practice, the consistency of dressing changes has always been problematic due to staff shortages or different practitioners ordering wound care products without closely following the patient’s care plan.

In the author’s experience, standard bandage application can be a complicated task. However, given that leg ulcers are a chronic condition that can have a significant impact on patient quality of life, it
is important to follow the care plan, otherwise the lack of consistency and continuity can have a significant impact on healing (Ribu and Wahl, 2004; Anderson, 2010).

On the other hand, as shown by Ribu and Wahl (2004), patients can become experts in their own leg ulcers, advising practitioners on which bandages to apply and when to apply them. This was particularly relevant in the cases demonstrated in this study, where patients reported seeing different practitioners at each visit.

A study by Dowsett (2009) showed that 42% of community patients’ wound assessments and care plans were poorly executed. Accurate care-planning, as well as following the care plan consistently, will help to resolve the problem of community practitioners not being able to implement up-to-date evidence-based practice (Martin and Duffy, 2011).

The ‘ideal’ nurse
Studies by Ribu and Wahl (2004) and Morgan and Moffatt (2008a) have shown that the ideal practitioner is one who sees patients as individuals, understands their leg ulcer condition and makes an effort to engage with them. This helps to address the earlier theme of practitioners not being involved enough with patients or their leg ulceration (Heinen et al, 2007; Maddox, 2012).

This also mirrors the Queen’s Nursing Institute (QNI, 2011) campaign ‘Right nurse, right skills’, which was aimed at preventing the decline in care behind closed doors which was aimed at preventing the decline in care behind closed doors that demonstrated in this study, where practitioners not being involved enough with patients or their leg ulceration (Heinen et al, 2007; Maddox, 2012). This also mirrors the Queen’s Nursing Institute (QNI, 2011) campaign ‘Right nurse, right skills’, which was aimed at preventing the decline in care behind closed doors by making sure that all community practitioners have the right skills to meet patients’ needs.

A separate DH publication (2012), ‘Compassion in practice’, outlines the importance not only of the care nurses give, but also the way they deliver it, including how they listen and what they say.

Given the fact that leg ulcers constitute a chronic condition, which is likely to increase in the future, community practitioners need to possess an understanding of how leg ulcer bandaging impacts on patient quality of life. This can also help address issues raised previously, where some practitioners seem to be more focused on the ulcer and bandaging rather than the patient as a whole (Persoon et al, 2004; Heinen et al, 2007).

CONCLUSION

According to the literature reviewed in this article, as well as the author’s clinical experience, there is a mismatch between the expectations of leg ulcer patients and community practitioners, such as nurses. This mismatch needs addressing in order to improve patient quality of life through leg ulcer bandaging.

The recommendations outlined above will not necessarily bridge all of the differences between patients’ and practitioners’ expectations, as these are varied and the recommendations are not necessarily applicable to all clinical settings. Therefore, community practitioners need to consider innovative ideas to help improve the quality of the leg ulcer bandaging they deliver — this starts by considering the impact of leg ulceration and bandaging on an individual’s quality of life.

This article is only a reflection of what the literature and the author’s clinical practice has to say about practitioners’ experiences of the impact of leg ulceration/bandaging on patient quality of life. Therefore, further studies are needed to fully explore this topic.

REFERENCES


Five-minute test

Answer the following questions about this article, either to test the new knowledge you have gained or to form part of your ongoing practice development portfolio.

1 – What are the basic symptoms of leg ulcers?
2 – Can you outline the principles of compression bandaging?
3 – What is meant by the phrase ‘expert patient’?
4 – What do you understand by the phrase ‘joined-up care’?
5 – Can you outline the benefits of treating patients as a whole, rather than focusing on the leg ulcer?