Community nurses’ experiences of treating patients with leg ulcers

Edwin Chamanga, Janice Christie, Eamonn McKeown

Community nurses offer holistic nursing care to patients at home, including attending to people with leg ulcers. It is known that leg ulcers can have a significant impact on patients’ quality of life. Nonetheless, little is known about community nurses’ views and experiences of providing holistic leg ulcer care and, in particular, their insights into the impact of leg ulcers on patients’ quality of life. Using a focus group of five healthcare support workers and four individual interviews with two associate nurses and two district nurses, this study explored community nurses’ experience of attending to patients with leg ulcers. Following transcription of the data, a thematic analysis was undertaken. It was concluded that community nurses need more training to support their work in leg ulcer management and more time to deliver patient-centred care.

KEYWORDS:
- Wound care
- Leg ulcers
- Community nurses’ experience

Community nurses spend approximately 25–50% of their working time attending to patients with leg ulcers (Simon et al, 2004), however, their views and experiences of attending to these patients are poorly explored (Walsh and Gethin, 2009).

There is evidence that treating chronic wounds such as leg ulcers does have a substantial emotional burden on healthcare staff, especially when these wounds fail to heal (Morgan and Moffatt, 2008; Posnett et al, 2009). Unfortunately, this burden has not been fully explored, except for a general acknowledgment that leg ulcer care impacts on individual patients, health services and society at large (Health Service Executive, 2009). Therefore, this area needs to be further investigated to improve the experiences of community nurses and enable better service delivery.

BACKGROUND

Within developed countries, leg ulcer care is mainly provided in the community by nurses (Barrett et al, 2009) — in the UK, 87% of leg ulcers are managed in the community (Callam et al, 1985). Community nurses promote overall health and achieve good outcomes through nursing interventions and collaboration with other agencies, such as dieticians and GPs (Royal College of Nursing [RCN], 2013).

In the UK, community nurses receive leg ulcer referrals from GPs, carers and other healthcare providers, such as nursing homes. Following a referral, community nurses will visit the patient and perform an initial wound assessment (Hickie et al, 1998). Any patient with a leg ulcer needs to be holistically assessed by a competent practitioner, usually the nurse, and have a tailored treatment plan developed to meet his or her needs (RCN, 2006). However, in the author’s experience, what constitutes an individualistic approach varies between practitioners.

Depending on the severity of the wound as assessed by the community nurse, the patient may be referred to other members of the multidisciplinary team, such as the tissue viability nurse specialist.

THE STUDY

Literature review

A literature search was undertaken for articles that examined the experiences of community nurses attending to patients with leg ulcers.
The search identified that although there was plenty of information about the views and experiences of patients with leg ulcers, there was less concerning the experience of community practitioners (Douglas, 2001; Brown, 2005; Maddox, 2012).

There was also evidence that leg ulcer management had become task-oriented rather than patient-centred (Persoon, et al, 2004; Parkinson, 2006; Morgan and Moffatt, 2008). Nonetheless, wound care in general, and leg ulcer management specifically, are two of the most common reasons for referral to community nursing services (Rubi et al, 2003). Furthermore, in the UK there has been a drive to foster the individualised side of nursing, as part of the six ‘Cs’ highlighted in the Department of Health [DH] document Compassion in Practice (DH, 2012).

Quality of life
Quality of life in patients with leg ulcers has been extensively explored in both qualitative and quantitative studies (Chamanga, 2010). Findings show that patients with leg ulcers experience pain, discomfort, social isolation, malodour, altered body image, exudate leakage and reduced mobility through having to wear bulky bandages (Persoon et al, 2004; Ellis, 2004; Stevens, 2006).

Study aims
The study aims were:
- To explore community nurses’ views of the daily lives and needs of people with leg ulcers
- To explore community nurses’ rationales for treatment and experiences of caring for people with leg ulcers.

Methods
A descriptive qualitative approach (which aims to gain first-hand knowledge of people’s experiences of a particular topic) (Sandelowski, 2000) was adopted to collect and explore community nurses’ views and experiences of providing leg ulcer care, and to organise this information into themes. The author used a focus group and semi-structured interviews with a range of community nursing staff as shown in Table 1.

Sampling
For this study, a ‘purposeful sample’ of nine nurses employed by one community health service in an inner-city NHS trust was selected. The aim of purposeful sampling is to focus on particular characteristics of a population that are of interest, which will best enable one to answer the research question. In this case, the sample was a group of community nurses with leg ulcer patients aged 18 and over on their caseload. The author felt that this sample of nurses possessed the appropriate experience and skills to answer the research question (Burns and Grove, 2011).

Recruitment
Participants were recruited across the community service and included district nurses (DNs), associate nurses (ANs) and healthcare support workers (HCSWs). The author presented the aims of the study to a group of community nurses at a meeting, then emailed potential participants with information about the research, and requested anyone interested in taking part to contact him directly.

The subsequent focus group and interviews took place during working hours to better enable staff participation in the research.

Data analysis
As the data was collected from different focus groups, themes such as ‘general experiences’ or ‘bandaging knowledge’ (see below) were isolated and analysed for recurring sub-themes (in the form of vignettes), which were checked by a moderator before being sent to the participants for verification.

Ethical consideration
Ethical approval was sought and granted from a university ethics committee and the local NHS community services trust gave its permission for the study to be conducted within the locality. The district nursing service director fully supported the research and appointed a senior member of staff to act as the key contact between the researcher and the respective community nursing team managers.

Findings
The following findings were identified from the data:
- Leg ulcers were a significant burden on community nurses’ caseloads, requiring extensive resources
- Community nurses did have an understanding of the impact of leg ulceration on patients’ quality of life
- There was a lack of knowledge and practical skills around leg ulcer management
- There was insufficient time to complete leg ulcer assessments and care plans, leading to poor communication
- There was insufficient time to deliver leg ulcer care.

General experiences
The participants in the study reported a high leg ulcer-related workload in their caseloads, with some nurses saying that they attended to between six and seven bilateral leg ulcer patients per day. The pure volume of cases led in some cases to them becoming task-focused and no longer enthusiastic about the care they were providing:

HCSW: ‘Yes, we are having increasing numbers of leg ulcer referrals on the caseload.’

<table>
<thead>
<tr>
<th>Table 1: Professional make-up of respondents</th>
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<tr>
<td><strong>Staff position</strong></td>
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<tr>
<td>Health care support workers (HCSW)</td>
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<tr>
<td>Associate nurses (AN) — also known as</td>
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<tr>
<td>community nurses in some organisations</td>
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<tr>
<td>District nurses (DN) — team leaders</td>
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HCSW: ‘Yes, we are having increasing numbers of leg ulcer referrals on the caseload.’
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AN: ‘Per day you can have six to seven bilateral leg ulcers.’

DN: ‘It becomes a daily routine and less thought process is put into patient care.’

ANs reported that their daily lists were extensive and they did not have sufficient time to complete holistic patient assessments or design patient-centred care plans. This challenge was also echoed by DNs:

DN: ‘The leg ulcer assessment process can take up to two hours, including holistic assessment and bandaging … in most cases, it is difficult to complete a full assessment on first contact.’

Members of the HCSW focus group commented that, as a result of nursing shortages, they were often delegated leg ulcer tasks that they were not competent to deliver:

HCSW: ‘At times, when patients contact the community nurses requesting a visit, it will happen the following day because the nurses are stretched.’

Poor communication and documentation were two of the recurring themes with the HCSWs. They reported that their task allocation for patients with leg ulcers was hindered by a lack of appropriate handovers. Given that the ANs and DNs were responsible for performing the initial assessments, the HCSWs felt that they were often not well-informed of the patients’ diagnoses or care plans:

HCSW: ‘It’s like they say, “Go and do that dressing…”, but you need a proper handover.’

HCSW: ‘One clinician says, “This patient is supposed to be on this treatment,” but then the next nurse comes along and says something different.’

Clinicians’ understanding of the impact of leg ulceration on patients’ lives

Part of the focus group and the individual interviews involved a focusing exercise, using photographs of leg ulcers from actual clinical practice. This was done as a way of bringing real live community scenarios into the interview room and to remind participants of the impact of leg ulceration.

During this exercise, all of the participants confirmed that they had seen similar leg ulcers in clinical practice and wished they could have done more for the affected patients. However, there was little they could do to help improve the patients’ standards of living except for advising them to attend a day centre and signposting them to other service providers, such as Leg Clubs, befriending services, lunch clubs, etc.

The participants understood that leg ulcers affect patients’ mobility and social well-being, particularly when the exudate becomes malodorous as devitalised tissue separates from healthy, newly-formed tissue:

HCSW: ‘The leg ulcers become smelly…’

AN: ‘This affects the patient’s emotional and mental status.’

DN: ‘Patients present with decreased mobility, malodour and leg ulcers that take longer to heal.’

Participants noted that it was not only the wound bed that impacted on patients’ quality of life — DNs and ANs in particular stated that bandaging also had an effect:

DN: ‘Some patients like bandages and some patients don’t.’

DN: ‘Summer can be challenging with the bandages, as they become hot and sweaty.’

AN: ‘At times patients complain that they are tight and bulky.’

Bandaging knowledge

It was highlighted in both the focus group and the individual interviews that there was a lack of information being disseminated about good leg ulcer practice. The ANs reported that there had been cut backs on the amount of training they could access. Similarly, internal organisational training was not standardised — this meant that some participants had an opportunity to practice their bandaging skills while others did not:

HCSW ‘One of the things is that there is a culture of not teaching us.’

HCSW: ‘When I started with the trust I was in the leg ulcer clinic and they taught me how to bandage. Otherwise I would have been like my colleagues who were never taught.’

The ANs and other participants who were team leaders reported that due to their complex roles and workloads it was difficult to balance competing demands. In addition, without clearly designed care plans in patients’ homes, it was difficult for other team members to follow through with care, as each nurse provided the care they thought appropriate on any given day.

This was reflected by the HCSWs as a lack of clinical guidance. They felt that their colleagues — the ANs and DNs — were not supporting or guiding them correctly:

HCSW: ‘In some of the homes there are no care plans in the house….so you don’t know what to do.’

HCSW: ‘One nurse changes the care plan to what he or she think is best; then the next person comes along and changes it back.’

This was acknowledged by the ANs and other team leaders, who reported that the lack of patient-focused care plans was a direct result of there being insufficient time to perform holistic patient assessments in the first place, which in turn meant that healing rates were prolonged.

Staff shortages

Staff shortages as a result of planned holidays, poor staffing levels and/or financial constraints were not anticipated by the author as being relevant to the study. However, with hindsight, staffing levels and cost-saving messages did have a significant impact on nurses’ views and experiences of delivering care to patients with leg ulcers:

DN: ‘The initiatives expect us to deliver complex care closer to home…’
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DISCUSSION

This study was conducted in an inner-city London borough and this may have had a bearing on the findings, considering the high demands placed on the team by a large local population. Nonetheless, the data collected revealed some rich information. Findings from both the focus group and the individual interviews showed that the management of leg ulcers in the community is a challenge, a view shared by all the participants. These challenges ranged from feelings of being overstretched; frustration at not meeting the patients’ needs holistically; and disappointment about the inability to always provide evidence-based care due to time constraints and funding cuts.

The nurses’ views were based on their extensive clinical experience of attending to patients with leg ulcers and they reported that holistic patient assessment and care planning were important.

In addition, training and supervision were vital in facilitating holistic patient-centred care. The participants also identified that organisational, financial and staffing constraints have a great bearing on community nursing practice, acting as potential barriers to improved care.

The participants acknowledged that the cornerstones of good leg ulcer management included elements such as reassuring patients and making them comfortable. However, these elements were reportedly difficult to deliver in clinical practice due to factors beyond the nurses’ control — factors such as staff shortages and financial cutbacks, which made it difficult to spend time with patients.

A raft of new directives (DH, 2013) require community healthcare services to reduce costs and make efficiency savings. Charles (2004) stated that accurate diagnosis and effective treatment can achieve a reduction in leg ulcer prevalence, clinical time and cost.

However, Persoon et al (2004) stated that the above-mentioned challenges have led community nurses to become much more task-oriented rather than patient-focused.

Handover

Communication and effective handovers are paramount to the delivery of safe patient care (British Medical Association [BMA], 2004; Arora et al, 2005). However, this study highlighted inconsistencies in handovers as a result of poor documentation, for instance, where community nurses are not provided with a full handover by the nurse who performed the initial leg ulcer assessment.

Quality of life

Numerous reports and studies have shown the negative impact of leg ulcers on patients’ quality of life (Badger, 2004; Persoon et al, 2004; Briggs and Flemming, 2007). It is worth noting that in this study, community nurses did display an appreciation of this impact and aimed to ensure that patients with leg ulcers were comfortable and felt in control of their lives, despite having a leg ulcer. The nurses interviewed during this study reported that they did try and identify each patient’s needs during assessments; they also considered physical and psychological comfort to be a primary focus of their care.

Delegation to junior staff

As reported by one participant, leg ulcer bandaging requires a high level of technical skill to produce improved patient outcomes (Friman et al, 2010). However, due to the impact of staff shortages and other local factors on community nursing teams, HCSWs are often asked to visit leg ulcer patients, even though they admit that their leg ulcer management skills are limited.

This issue of delegating tasks to junior staff as a way of managing limited resources in clinical practice was also reported in a research study by Friman et al (2010). Evidence has also shown that there is a mismatch between increasing levels of patient need in the community, compared with the actual numbers of community staff available to deliver it (RCN, 2012). This mismatch has led to a dilution of skill mixes, partly due to a decline in highly skilled community practitioners (RCN, 2012). This situation is exacerbated by the fact that community nurses have a higher age profile, with 38% of community nurses aged over 50 in comparison to 23.6% in the acute sector (RCN, 2012).

Different government directives have challenged the way community health care is delivered, with increasing calls for care ‘closer to home’ (Parkinson, 2006; RCN, 2012; RCN, 2013). However, this has not necessarily been supported with increased staffing levels. As a result, community nurses are now overstretched and are being expected to do more, with fewer resources.

Overall, the findings from this study echo the comments made by Walsh and Gethin (2009), that community nurses’ views and experiences of attending to patients with leg ulcers are poorly explored.

IMPLICATIONS FOR PRACTICE

Similar studies with bigger groups need to be conducted in other areas to help establish the views and
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patients could receive patient-centred, holistic, and evidence-based care.

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It is possible that this gap in clinical practice could be bridged through patients’ involvement in their own treatment and by goal setting. Patients could have a say in their own care plans, as well as having the opportunity to decide which elements of their leg ulcer care they wished to focus on at any given time, supported by clinical advice from community nurses. In such circumstances, goal setting could enable care plans to be set with the patient and not for the patient.

CONCLUSION

Community nurses’ experiences of managing patients with leg ulcers are influenced by a number of external influences such as workload, the general working environment and government efficiency savings.

This study — although only featuring a small sample size — did highlight that community nurses were overstretched and that there were areas of poor practice, particularly the quality of handovers and documentation. The lack of leg ulcer care plans being located in patients’ homes was also a problem, as was the paucity of time available to complete holistic patient assessments.

The community nurses interviewed here were aware of the impact of leg ulceration on patients’ quality of life. However, there were administrative and organisational challenges to be addressed before
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