Addressing social isolation and its impact on wound healing

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Active participation in social life is known to have health and wellbeing benefits, yet globally there are growing concerns about the rate and consequences of loneliness, especially among the older generation. In recent years, the demographic shifts in an ageing society have suggested that the numbers of older adults experiencing loneliness are likely to increase. Loneliness and social isolation can have a negative impact on people's health behaviours, risking the worsening of pre-existing health conditions.

Problems of the lower limb are particularly common among older adults. Leg ulceration has been referred to as 'the hidden health crisis' *(1)*. This condition presents several challenges to the individual, from physical and emotional distress, lack of esteem, depression, self-neglect, social isolation to financial cost to the person in terms of time off work, and travel to far-away centres or hospitals. In addition to the high costs of wound care in terms of nursing resource, wound care dressings, protracted healing time and high recurrence rates, many senior members of the population experience the social cost of leg ulcers, feeling hidden away, embarrassed, isolated, depressed, frustrated and attempting unsuccessfully to self-care. The social stigma attached to leg ulcers can cause many individuals to further withdraw from their social network *(2)* in a vicious circle of leg ulceration contributing to loneliness and social isolation, which can, in turn, negatively impact wound healing.

In recognition of the interconnected challenges to social and biomedical health, partnerships between health and social care organisations are evolving rapidly in the private and primary health sectors globally. Their aim is to provide a most effective seamless service meeting the needs of local ageing populations. There is now a consensus that clinical treatment alone (that is to say, without reference to the social environment of the individual patient) can have only a limited effect. On the other hand, a social model of care that mobilises broader community support can provide information and services to individuals to help them make long-term choices about their health and offer people access to a wider range of community services specific to meet their needs *(3)*.

Reality in everyday practice

Chronic wounds have a long-term impact on people's lives and create considerable expense for healthcare systems. Yet patient-centred care has not historically been a research priority. The evidence for patient-centred outcomes has been poorly recorded. Wound care is inter-disciplinary, and patients are often failed by the complexity of a system where a variety of different services may be involved in a patient's treatment journey, increasing the risk of communication or treatment failure *(4)*. There is often little help available in the form of support and advice on prevention of leg ulcers. An entrepreneurial approach to wound management relies on clinicians and the healthcare industry working collaboratively. However, redefining a nursing service from the traditional pattern of organised care delivery to the new philosophy and objectives of a person-centred organisation is not an easy task as change requires clear objectives, a well-defined strategy with realistic and achievable goals, and good communication.

Most importantly, regardless of age, everyone has an emotional need to

be cared for when facing any form of treatment. Their needs should be individualised and involve a two-way relationship between persons and professionals where individuals are encouraged to be equal partners. As professionals, we should allow people in our care and their families to have sufficient information to enable them to play an active part in their treatment, providing transparency in information-sharing facilitating patient input.

An individual observes things that busy professionals do not when in a clinical setting, therefore it is essential to include them at the centre of what we do in improving their care. Yet for many, once they reach later life, the ability to represent themselves disappears. Seniors who complain may all too often be written off as just 'old people's grumbles'. Yet sadly, the difficulties facing the older person experiencing clinics, hospital admissions or wound-related problems is not dissimilar from other groups with specific problems.

Health is an invaluable resource for older people and is important for quality of life, independence and increasing longevity due to improved global health care. Many people who live alone and are reliant on their families and friends in their everyday lives for social contact experience mixed emotions leading to uncertainty, anxiety and a deep sense of loneliness being suddenly withdrawn from their social groups and organisations. The number of older people living alone is rising, putting them at higher risk of social isolation, which can have a negative impact on an individual's physical, mental and social health. However, we need to be willing to do what it takes to incorporate a person-centred approach and be an advocate for our client group. This means giving those in our care a voice and being prepared to listen to what they have to say, and to act on this, so that individuals receive the support and advocacy that they need.

One major challenge in ageing societies today is how to create meaningful pathways for older persons to experience late life living with a wound and simultaneously contribute towards society. This is where the psychosocial Lindsay Leg Club® Model steps in. Leg Clubs embody the importance of social support and connectedness, defined psychological constructs essential in wellbeing and, most importantly, the impact of social support for physical and social health.

Leg Clubs: addressing social isolation in wound management

Responding to literature reviews citing a correlation between social isolation and non-concordance, the author developed a new type of clinic in which individuals become stakeholders in their care and are empowered to make informed decisions regarding their treatment. The psychosocial Lindsay Leg Club® model of care has been in operation since 1995. It was specifically designed to provide a social, non-medical model of care for people suffering from or at risk of leg-related issues and ulceration. The conceptual framework of the Leg Club® model was based on Becker's Health Belief model *(5)* that identified the relationship between a person's belief and behaviour. Since the launch of the first Leg Club in Suffolk, Leg Clubs have paved the way in developing a psychosocial model of holistic wound care based on empathy, education, social and peer support, empowering the whole person through social interaction as part of the therapeutic journey *(6)*. The psychosocial Leg Club model for lower limb care have the following objectives:

- To empower members (patients) to be involved in making decisions pertaining to their own treatment;
- To meet the social needs of socially isolated people by providing a venue for social interaction, peer support and positive role models;
- To implement strategies to destigmatise and rebuild the self-esteem of people with leg ulcers;
- To provide an informal forum for health promotion and education, encouraging informed beliefs and positive health behaviours.

They are characterised by four binding principles that differentiate them from conventional clinics:

- A non-medical setting – e.g. community/church/village hall. This avoids the stigma or fear of attending a medical setting and reinforces the community ownership of the Club.
- Informal, open access, no appointment required. This encourages opportunistic attendance for information and advice, providing greatly increased opportunities for early diagnosis and leg ulcer prevention and helps isolated older people reintegrate into their community.
- Collective treatment. People share their experience, gaining peer support, and encouraging them to take ownership of their treatment.
- Integrated 'Well Leg' regime, supporting maintenance of healthy legs, positive health beliefs and broad health promotion.

Therefore, Leg Clubs see people with wounds and people with healthy legs requesting assessment. Once someone has been registered at a Leg Club, they are members for life, in either the Treatment Regime (receiving treatment) or the Well Leg Regime (receiving advice and preventative maintenance and a broad scale of education and health promotion). The 'Well Leg' programme at the Leg Club is an integral part of the social model and is aimed at the members' mental and →

physical well-being, health education, advice, maintenance and prevention of further leg-related problem once an ulcer has healed. Members that have healed and wish to remain healed attend on a regular three / six monthly basis for a full reassessment, support and advice. Members of the Leg Clubs can rely on a safe venue where their physical, psychological and social needs will be met within a social model of care.

The concept of the social Leg Club model enables members to attend whenever they wish, and when they are transferred from active treatment, they continue to attend for Well Leg maintenance. The community Leg Club model of lower limb care provides additional benefits to promote healing apart from the provision of consistent, evidence-based clinical treatment. The Leg Club concept provides a model to address many factors likely to influence healing of chronic leg ulcers. Such factors include loneliness, decreased sense of control and morale, lack of knowledge and motivation and non-adherence to wound management and compression therapy. Evidence suggests that many people with lower leg problems made the decision to attend a Leg Club themselves, suggesting that there is large unmet need for help with lower leg problems that may not be seen in GP surgeries or by District Nurses. The results also showed that people join a Leg Club to receive advice and preventive care to maintain healthy legs. In fact, this was a more common reason for joining than attendance for treatment of an active leg ulcer. In the absence of a local Leg Club it is hard to see where these people would have turned to for advice.

Therefore, the Leg Club model is far more than simply the provision of lower limb care (although this is paramount) but rather a social model that seeks to address the myriad of issues individuals face. This approach contributes to the positive outcomes that can be achieved by members of their Leg Clubs through empathy and peer support. The model is founded upon people with leg problems 'owning' their community social clinic. It enables individuals and communities to have more power and responsibility to encourage and create better local services that fits well with the Leg Club philosophy. This is a philosophy that encourages individuals to become shared decision-makers in their treatment and is based on a psychosocial model of care. In addition, it gives clinicians greater control over the way health and social care services are delivered. The social non-medical approach gives healthcare professionals the opportunity to improve local health services in partnership with local people and puts them at the heart of the community they serve.

Leg Clubs are, in essence, a face-to-face service where social relationships are formed between persons in physical proximity to one another. It is through these social relationships, which afford a constant social engagement with others, that everyday concerns can be relieved *(7)*. The members (patients) themselves are delighted to be involved and previously non-adherent individuals have taken on the responsibility of supported shared care management of their condition. This has made a real impact in all areas of their lives, delivered excellent healing rates and notably low recurrence. It also provides an informal support network to carers, family and friends. In addition, the nursing teams have built important relationships with other professionals whilst putting the person at the centre of care delivery.

Each Leg Club has its own identity which is shaped by members and each is able to deliver care and treatment in a cost-effective manner with improved healing rates. Better outcomes within the Leg Club model are evidenced in many ways; through clinical and demographic audit, formal research and the motivation to strive for constant improvement. However, originality requires commitment and leadership and is a team effort.

Collaborative working is the foundation of Leg Club culture. Members and nurses work together in an open environment, where interactive learning is paramount. Treatment is undertaken collectively in an area where two or three people can have their legs washed and dressed in the same room, giving them the opportunity to compare healing and treatments. They are encouraged openly to discuss treat-

ment issues with the care team, carers and other patients, and this offers them control over their own leg ulcer destiny. Treatment is undertaken with, rather than on, the person. This openness is necessary to provide members with a sense of collaboration in their care, where a number of members are treated together, listening and observing the differing treatments.

Clinically, non-adherence to treatment has been virtually eliminated and recent research demonstrates evidence of greater healing rates, illustrated by many members whose long-standing ulcers either healed or greatly improved as a direct result of this change in approach. People's willingness to attend for 'Well Leg' checks and ongoing health education resulted in a dramatic reduction in the incidence and recurrence of leg ulcers.

Leg Clubs have also been found to provide a most effective forum for education in which training needs of nursing staff are highlighted and addressed by means of eLearning tutorials and peer guidance. The Leg Club Foundation charity provides an independent annual clinical audit in practice (UK) to identify areas of practice within the Leg Clubs and to ensure that clinical standards and infection control procedures are adhered to. Audit undertaken examines in detail reported practice of members being treated for preventive / leg ulceration management through the use of a questionnaire to:

- Ensure compliance with the key criteria of the Leg Club concept.
- Observe through a process audit, the clinical care delivered to patients.
- Identify areas of clinical practice which require examination and further educational input.
- Provide evidence of management policies and information.
- Compare the members' notes with an 'ideal' set of notes.
- Observe whether the clinic practice conforms to the 'ideal'.
- Provide suggestions on how the service could be improved.

Ownership and benefits

Leg Clubs are not 'owned' by the healthcare provider but by the local community established and run by volunteers in partnership with the clinical team and its members. In this sense, the Leg Club model unites the healthcare organisations, nurses, general practitioners, patients and the community in the common objective of improving individuals' health and wellbeing and to date has delivered dramatic improvements in the individuals' quality of life. By engaging the community and empowering people to become stakeholders in their care, the Leg Club Model encapsulates current global strategies for health and social care and align with all recent relevant strategic plans regarding issues of ageing, social isolation, mental health and wellbeing.

The Clubs are self-funding, with members, volunteers and the community finding various ways of raising money for the rent, equipment or refreshments. The only costs to a health provider are nursing time and dressings. Holistic person-centred care is addressed as observed from the social side, this shows as a smile and gentle touch on the arm when volunteers greet members at the door, caring looks when refreshments and healthy treats are served, the willingness of the volunteers to sit and listen to members talk about their way of living, their engagement with the community and their overall state of happiness. On the medical side, nurses care for more than just wounds on members' bodies *(8)*. Another important part of the Club's activities is the pastoral care of its members and volunteers. The nature of this care varies from the simple provision of tea, coffee and biscuits at each session, to sending flowers to mark important events or bereavements, to hospital visiting when appropriate. It is a significant part of the volunteer committee's role to listen to the needs and comments of the members and where possible to meet them.

There is growing evidence that participation in health decisions leads to better outcomes, and health providers are encouraging people to think about the implications of health choices and the benefits to them. Establishing a network of Leg Clubs that provide the highest standard of evidence-based care for local communities and ensuring that prescribed standards are maintained through education, training and audit requires time and manpower. The Leg Club Foundation (*CRN 111259*) provides guidance, support and mentorship during the setting up phase internationally. Health and safety and infection control are primary considerations for Leg Clubs, clearly covered by documented guidelines and risk assessment. Although the model has its own documentation, guidelines, and referral pathways covering all disciplines, the guidelines state that their local healthcare provider's protocols and procedures must be adhered to. During the embryonic stage of introducing a Leg Club, ensuring all aspects are covered, the nursing teams are recommended to meet and liaise with their multidisciplinary teams such as; tissue viability nurse, lymphoedema nurse, consultant vascular surgeon/nurse specialist, infection control nurse and the director of provider services, a factor critical to the success of any innovation.

Covid-19: a change in Leg Club working culture

The global coronavirus crisis has had a transformative impact on how health care is delivered. In an effort to curb the spread of Covid-19, the Government in the UK imposed social distancing regulations on public venues. This has reduced the number of face-to-face consultations and prompted a move towards greater use of telemedicine. An increase in the interconnected digital usage within health care, albeit challenging, has been positive of the radical adaptation of operational care delivery. Supported shared care, telehealth and remote monitoring has provided us with a great opportunity to embrace innovation and new ways of working, delivering a quality healthcare service that people expect and deserve. Access to smart phones and internet communication provided

healthcare teams with a smarter approach towards remote consultations, including those for wound management delivery. Some patients have found that technology has helped them to stay independent, undertaking their lower limb management through virtual consultations replacing physical interaction effectively from their own home.

For many psychosocial Leg Clubs, the coronavirus restrictions have meant either suspending their operations or significantly changing their operational policies in order to adhere to National Health Service directives during the Covid-19 crisis. New guidance was published by the Leg Club Foundation in June 2020 on how Leg Clubs can reopen safely, and some already have *(7)*. The guidelines include advice for Covid-19 infection and prevention control for volunteers, with checklists and risk assessment information. Volunteers are urged to maintain the highest standards of hand and respiratory hygiene; keep a safe distance; safely handle packages, surfaces and materials; and look after themselves in line with the latest government guidelines if they become unwell. Calls have also been made for Leg Clubs to regularly follow the updated government guidance.

A cultural change has also been undertaken within the Leg Club network, with signs of a growing online Leg Club community to take the model to the next level *(9)*. According to both the clinicians and Leg Club members the use of medical and communications technology and their experience of receiving health care during the pandemic has been successful. One Leg Club team recently published an article on how they had adapted to new ways of working. For example, members are taking photographs of their limbs, attending telephone consultations and appreciate the need to continue to use alternatives to routine practice. This positive mindset is important, as it will help to provide the best practice in leg-ulcer management and prevention before Leg Clubs can safely resume their pre-Covid-19 ways of operating. The desire to get Leg Clubs back up and running again is understandable, as the feelings of loneliness and social isolation among senior adults may be intensifying under enforced lockdown *(8)*. In the words of a 100-year-old member of one Leg Club, *'I can't wait to return when it opens, if I'm still here' (10)*.

Conclusion

Health is an important resource for all for quality of life and independence. The ethos of the Leg Club model is to encourage wellness, rather than treat illness, in all age groups. It is a proven alternative to the traditional management of leg conditions. The Leg Club model aims to promote increased motivation and understanding of conditions of the lower limb to their members (patients) in order to increase adherence with recommended treatment. Members are able to follow their peers' progress in healing each week and through the 'Well Leg' regime members are able to communicate and interact freely with members whose ulcers are now healed. This openness is necessary to provide members with a sense of collaboration in their care, where a number of members are treated together, listening and observing the differing treatments.

The psychosocial Leg Club model has demonstrated the positive changes achieved through the commitment and motivation of nurses and communities working together. While addressing the social isolation that often comes with this condition, the Leg Club model can also demonstrate its effectiveness in not one but four ways; clinical effectiveness, cost effectiveness, patient satisfaction and wellbeing *(11)*. Just as gratifying, we have found that the members of the Leg Clubs experience companionship, develop friendships, and become once again fully integrated into their communities, and thereby are given new meanings and wellbeing to their lives. ♦

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