

Monica Gilmartin RGN, HVCert,
Dip Counselling, community staff
nurse, South East Hertfordshire
Primary Care Trust

A primary goal in the treatment of people with chronic wounds is achieving optimum levels of physical, mental and social health. Monica Gilmartin describes the nursing care of a patient with competing health needs

KEY WORDS

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A holistic approach to wound care

Ms Black is a 60-year-old widow with no children, who has severe rheumatoid arthritis and uses a wheelchair. She has pulmonary disease and requires continuous oxygen therapy. For the past two years her 90-year-old mother, who has dementia, has lived with her.

Ms Black has a chronic leg ulcer over the posterior-lateral malleolus which is painful for long periods. The wound is dull, does not look healthy and is not healing; the edges are devitalised and ridged and 95 per cent of the wound bed is sloughy, with moderate amounts of green/yellow exudate. The wound is redressed twice a week.

A vascular surgeon, a rheumatologist and a dermatologist have all seen Ms Black, specifically to give advice on management of the leg ulcer, without success. At the patient's request, she is presently awaiting an appointment with an alternative vascular surgeon.

Holistic assessment Ms Black has complex health problems affecting wound healing and intrinsic and extrinsic factors that have repercussions for compliance with treatment. She required a holistic assessment of her needs as recommended in wound-care literature (Flanagan, 1997; Morison et al, 1997).

Rheumatoid arthritis Patients with rheumatoid arthritis are at increased risk of leg ulceration and these ulcers tend to be multifactorial in origin (McRorie, 2000). Punnett et al (1990) found that major factors in the formation of leg ulcers were trauma or pressure (45.5 per cent), venous hypertension (45.5 per cent), and arterial disease (36.4 per cent). Only 18 per cent of these leg ulcers were vasculitic in origin.

Ms Black stopped seeing her original rheumatologist 10 years ago and was referred to a new one by her GP a year ago in another attempt to get advice on managing her leg ulcer. A course of high-dose steroids was prescribed to treat vasculitis, but there was no improvement. Unfortunately Ms Black did not return for her follow-up appointment.

Respiratory function Ms Black's compromised respiratory function is a major factor in the delay to her healing. While local hypoxia can be a stimulus to the growth of new blood vessels, oxygen plays a critical role in the formation of collagen, new capillaries and epithelial repair as well as in the control of infection (Morison et al, 1997). It is, therefore, important that there is close liaison with the GP to manage promptly

episodes of respiratory distress and clinical infection. Ms Black is also taking a maintenance dose of prednisolone 5mg for her respiratory disease, with frequent prescriptions of higher doses during acute stages of the illness. This is another risk factor, in that cellular activity at certain stages of healing may be compromised by steroid therapy (Morison et al, 1997).

Stress management A major factor that affects Ms Black's overall health and wound healing is the increased level of stress she is experiencing while caring for her mother. She is constantly anxious about her mother's safety and her sleep and rest are disrupted. It is emotionally draining, she is less able to manage her own needs and her social life has been severely curtailed. Research on stress in carers showed that cytokine activity is affected and wound healing is delayed (Kiecolt-Glaser et al, 1995).

For a number of reasons, relieving stress has proved to be a difficult problem to solve. An important factor is that nursing interventions to relieve stress take more time. Ms Black's dressing changes take 15 minutes twice a week. Tackling her social problems takes longer and requires a commitment to actively listen to her in order to identify feelings and needs and to negotiate, plan and implement care (Morrison and Burnard, 1997). The purpose of the nurse changing the care plan in this way, is to relieve stress at a time when she is less able to cope. The aim is for her to regain the control and independence that she values. Ms Black said she felt less stressed because the nurse was aware of her problems.

Problems with continuity of care Ms Black has competing health needs but her respiratory insufficiency is the most disabling problem. When a number of health professionals are involved in a client's care, there is a potential for conflict between the various therapeutic regimens. For example, following consultation with a vascular surgeon, compression bandaging was applied. Ms Black said that her respiratory consultant advised against this, therefore she did not continue compression and did not return for a follow-up appointment.

Awareness of the management strategies of individual disciplines and good liaison are important for effective patient care (Bennett and Moody, 1995). A significant professional and structural barrier to liaison, is the divide between primary and secondary care. Moffatt and Harper (1997) advocate formulating treatment discharge plans between the primary health care team and secondary care, and suggest that this can lead to improved compliance with treatment.

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Compliance with treatment Compliance is described as the extent to which a patient’s behaviour coincides with his or her clinical prescription (Marks et al, 2000). It is more difficult to identify whether the patient’s behaviour is intentional and what is underpinning it. I have some difficulty in identifying to what degree Ms Black’s deteriorating health may legitimately be related to non-compliant behaviour. Another reason for this reticence is the strong connotation of blame that this terminology implies.

Compliance is not generally a constant feature in a patient’s behaviour – certainly it is not with Ms Black. Marks et al (2000) pointed out that it is not a fixed event but a constantly changing process. One of the main determinants appears to be that of a cost-benefit relationship. Clients will usually follow the prescribed course as long as the health benefits in reality or in theory outweigh the costs to them in terms of necessary changes to lifestyle (Furlong, 2001).

This pattern of compliance applies to Ms Black. She had been severely anaemic in 2000 and had been prescribed ferrous sulphate. When I reviewed Ms Black’s management I found that she had stopped taking this because it gave her diarrhoea. Increased visits to the toilet were disrupting her life. As part of a new care plan she agreed to try ferrous sulphate again with a minimal dose, but the demands remained too great. It was decided to focus on improving her diet with iron-rich foods and monitoring her haemoglobin with blood tests. We had to accept that our objective was not going to be achieved and we reached an acceptable compromise (Meichenbaum and Turk, 1987).

Non-compliance rates are increased with chronic disease or long periods of treatment (Ley, 1988). Ms Black’s commitment to leg elevation, rest and exercises is probably not as great as it was in the beginning. She always asks quite mechanically ‘how is it?’ during dressing changes but when challenged on this point she has admitted that she now feels a degree of resignation and acceptance of the ulcer as part of her life. It is therefore understandable that given the length of time involved on top of all her other problems, compliance with demands of her wound care plan are frequently overridden.

However, when the wound deteriorates or becomes infected and painful the focus shifts back and Ms Black will rest and also asks the GP for a new referral. This pattern is a feature of this study and it has been found that compliance is greatest where gains in acute symptom control are the main focus as opposed to health strategies aimed at maintaining health and prevention (Furlong, 2001).

Follow up and non-compliance The most obvious non-compliant behaviour in this study is that Ms Black has failed to return for follow-up appointments with her consultants. Three issues that I feel may be pertinent to Ms Black are trust, power and assertiveness.

Ms Black has received conflicting advice. Her understanding of the information given to her by her respiratory medical team was that the rheumatology drug regimen was inappropriate and damaging, and similarly that compression bandaging was inappropriate. These experiences have left her confused, suspicious and feeling vulnerable to medical mismanagement.

Another major issue which impacts on compliance is that of power. Marks et al (2000) suggest that non-compliance can be a means of resisting medical dominance. The patient-doctor relationship is generally an unequal one. The doctor has the knowledge, which is power, and most importantly controls the parameters of the consultations and the relationship. Ms Black has had appointments cancelled at the last moment, and has waited many months for referrals only to be given a very brief consultation.

Meichenbaum and Turks (1987) advocate that such organisational issues should be addressed. It has been shown that where patients have these types of experiences, the relationship is already compromised and non-compliant behaviour is more likely. Ms Black has felt devalued through these experiences and her only way of asserting her own power is by not returning.

She also has a habit of not returning to a doctor she is not happy with, which indicates a lack of assertiveness. If she felt able to challenge health care professionals in a more constructive, direct way her health might be much better. Certainly her wound care would have been more consistent and coordinated.

Conclusion In reviewing this case, I have demonstrated the importance of planning wound care from a holistic perspective. I have also explored the relationship between wound healing and client behaviour through examining the issue of compliance. This study has also highlighted the importance of effective liaison between all health professionals and particularly between hospital and community staff.

I have learnt to respect my patient’s right to care for her mother at the expense of her own health, but it has been hard to watch the health of both these women deteriorate. Actions rather than words are often instructive in understanding patients’ needs. ■