

How to...

Ten top tips on compliance, concordance, and adherence



Author:
Irene Anderson

Leg ulceration is a long-term condition that has a significant impact on the people living with it, as well as a high economic cost. Compliance and concordance are frequently highlighted as challenges to healing and understanding these terms can aid in the development of effective strategies to help patients successfully manage leg ulceration. Inevitably, some people will not wish to take control of their treatment, or will be unable to do so due to advanced dementia or failing to have the mental capacity to make such decisions.^[1]

This article defines the key terms of “compliance”, “concordance”, and “adherence”. It also considers recent reports of the patient experience of ulceration, as well as programmes to help engage patients in leg ulcer care and concludes with ten top tips to consider when forming partnerships with patients.

Compliance

Compliance in the healthcare setting is defined as: “the extent to which the patient’s behaviour (in terms of taking medications, following diets, or executing other lifestyle changes) coincides with medical advice”.^[2] The Royal Pharmaceutical Society^[3] advocated a shift from “compliance” to “concordance” in an attempt to promote openness and empathy in patient–clinician relationships. Issues such as long waiting times, long periods of treatment, and complexity of treatment can lead to noncompliance.

Concordance

Clinicians are now encouraged to embrace patient–clinician partnership and negotiation with patients who have long-term conditions. They are also encouraged to embrace concordance in all aspects of healthcare, including leg ulcer management.^[4] The RPS defined concordance as: “A negotiation between equals ... a therapeutic alliance ... this alliance may, in the end, include an agreement to differ. Its strength lies in a new assumption of respect for the patient’s agenda and the creation of openness in the relationship”.^[3]

Adherence

Adherence describes the patient and their decision to either accept, reject, or modify their treatment. Intentional non-adherence can be rational from the patient’s perspective and aligned with their beliefs and experiences, even when at odds with clinical rationale.^[5]

Concordance and adherence are influenced by motivation, health beliefs, social and economic factors, previous experience, and the influence of those around them. Sustaining and adhering to healthy leg behaviours can prove challenging if the patient’s motivation is reduced by recurrence and other setbacks, such as pain. Therefore, clinicians need to have an understanding of what it is like to live with leg ulceration and should always promote healthy behaviours even when the patient seems to be working against this.

The experience of ulceration

Pain is, in most cases, near the top of the patient’s list of concerns. It can be related to the ulcer, treatment, or both, therefore, strategies must always prioritise pain management and seek to engage patients in their care or such efforts will be wasted.

Green et al^[6] interviewed nine people with venous leg ulcers. Patients spoke of their experience of slow healing and multiple recurrences, and the effects it had on their lives. Pain featured heavily in all the interviews and participants expressed reluctance to take analgesia unless their symptoms were severe. Even then, the pain was not effectively controlled. Pain was also accompanied by chronic lack of sleep. A positive observation made by some participants was the perception of quality care when there was consistency in terms of dressings, compression, and feedback on the wound state.

The key lessons from this study, and others before it,^[7] are that, unless the clinician understands the effects of ulceration on people’s lives and demonstrates empathy and skill in alleviating such symptoms as far as possible, then partnership and concordance are unattainable goals and the burden of protracted ulcer healing and recurrence will continue.

*Irene Anderson is
Principal Lecturer,
Tissue Viability and
Reader in Learning
and Teaching in
Healthcare Practice,
University of
Hertfordshire,
Hatfield, UK.*

An American study^[8] used a questionnaire across seven outpatient clinics to investigate patients' experiences of ulcer recurrence, wearing hosiery, and education related to leg care, post-healing. Results indicated that 73% of patients wore their hosiery daily and 90% felt they had received enough information about caring for their legs post-discharge from the leg ulcer service.

Reasons for not wearing hosiery related to difficulties in application and removal, with a small number reporting pain when wearing hosiery. The researchers found that a quarter of their participants had gained weight during treatment. In terms of future research, it would be interesting to consider any correlation between weight gain and practical difficulties in applying and removing hosiery, as well as incidence of ulcer recurrence.

Promoting self-care strategies

van de Glind et al^[9] describe a "Lively Legs" project in the Netherlands. The project was particularly concerned with exercise and encouraging the wearing of compression garments. Twelve nurses were trained to deliver a structured programme of counselling, lifestyle advice, health education, and leg exercises, complemented by written information. The structure involved 3–6 sessions over a 6-month period. Fifty-three patients were recruited to the programme and 49 completed it. The clinicians involved were asked about the experience through questionnaires, focus groups, and interviews.

Potential barriers to patient recruitment into such programmes were investigated. One barrier was the difficulty identifying patients from digital patient record systems due to variances in how patient diagnoses were recorded (i.e. the fact they had a leg ulcer was not clear on the system). Another factor was the organisation of services where there might be competing organisations and, therefore, little incentive to refer patients to an external programme. There were also practical issues, such as the amount of time a nurse had spare to undertake the programme, the influence of changing managerial personnel in clinical areas, and lack of familiarity with the programme by potential referrers, such as GPs.

Interestingly, patient recruitment was also a problem in areas where nurses were less motivated and engaged in the programme. Inevitably, only the most motivated patients joined the programme. This means that the hardest to reach patients remain the people who would most benefit from an intervention.

Miller et al^[10] reported outcomes on 155 participants enrolled in a leg ulcer prevention programme in Australia. Participants undertook six sessions that blended e-learning, face-to-face activities, and written resources. Health behaviours were measured pre- and immediately post-intervention. The study showed there was an increase in healthy behaviours following the programme in those participants who had exhibited few prior to the intervention. Further research is needed to assess the sustainability of such outcomes and their impact on ulcer healing and recurrence. The researchers highlighted that helping patients to identify their own health goals was important in achieving positive health behaviours.

Brown^[11] reviewed the evidence on lifestyle advice and self-care strategies. She concluded that increasing mobility and ankle mobility reduced ulcer recurrence. The review highlighted how confused patients can become by advice they perceive as conflicting, for instance, being told to exercise, and also to rest with their feet elevated. This illustrates the need to give clear instructions and advice to patients, ensuring that they, and their carers, have the opportunity to ask questions.

TEN TOP TIPS

1 Treat pain: The clinician must recognise the patient's pain and ensure adequate pain relief is provided. Patients should be encouraged not to be afraid of medication and to take it preemptively where necessary, rather than waiting until pain becomes unbearable.

2 Consider patient capacity and experience: Most patients adhere to treatment most of the time and clinicians must provide encouragement and support, backed by written information for the patient. It should not be assumed that more education is the answer to concordance. Patients should be given choices appropriate to their decision-making capacity and the clinician should be prepared to listen and compromise.

3 Be skilled: The clinician's lack of knowledge, and possibly the lack of confidence in explaining disease processes and the physiological effects of therapy, may contribute to a lack of patient understanding. Clinicians should ask themselves the following questions: "Have you had your bandaging skills appraised recently?" "How up to date are you in terms of techniques and bandage/hosiery types?" "How good are you at explaining complex information in lay terms?"

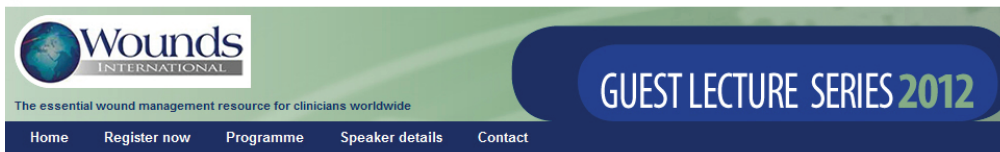
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Wounds International has recently brought together a group of key experts, patients and carers to discuss the human cost of living with a wound and the role of clinicians, industry and organisations in improving the wellbeing of patients.



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- Increase understanding of the impact of living with a wound on the wellbeing of patients and their carers
- Improve clinicians' ability to share decisions about treatment
- Emphasise importance of good listening skills and highlight ways to improve communication
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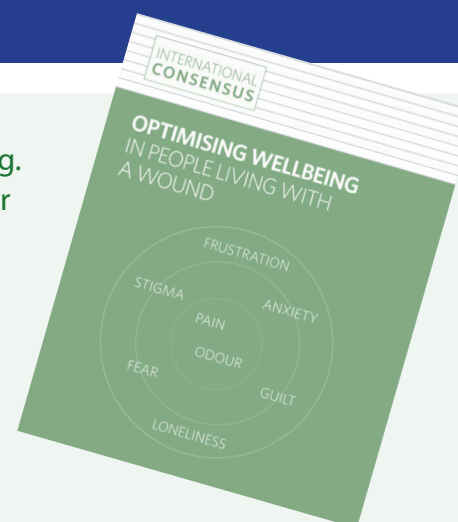
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This lecture coincides with the launch of a new consensus on patient wellbeing. **Trudie Young**, Lecturer in Tissue Viability at Bangor University, Wales, and chair of the working group said: "This document provides a **practical framework** for clinicians, patients, organisations and industry to understand and promote **wellbeing** as a fundamental aspect of good wound care. We think it can really make a difference."

Download the document at: www.woundsinternational.com



4 Recognise social isolation: Social isolation is a common problem for people living with leg ulcers and impacts negatively on patient outcomes.^[12,13] Family, friends, and carers should be involved in care if they are available and if the patient wants this. Wound malodour should be managed effectively as this can damage relationships. Where appropriate, social service and voluntary sector resources for community support should be suggested to the patient.

5 Be realistic: The reasons underpinning why patients do not feel able to comply or adhere and adapt treatment plans to their environment should be explored. There is little point telling a patient to elevate their legs if their job involves periods of standing, but prompts could be devised that would remind them to put their feet up at break times or when they get home. A higher class of hosiery to wear during work hours should be suggested to help control oedema. Patients may feel unable to tolerate full compression initially so beginning with reduced compression may be a good compromise. Team working and clear documentation are important factors in reducing the risk of professional conflicts when compromises are made with patients.^[13]

6 Consider travel difficulties: Rich and McLachlan^[14] found that cost, lack of transport, and lack of confidence all impacted on patient engagement. Clinics may be in areas where people feel unsafe, especially if it is unfamiliar to them. Late afternoon or early appointments may mean travelling in the dark, at rush hour, or expensive travel times. Permission to introduce patients to each other should be sought as they may be able to travel together. Clinicians should also explore whether there is a voluntary car service for vulnerable patients. The clinic experience should be made both sociable and clinically effective to keep patients motivated to return.

7 Show compassion and empathy: Patients have reported that a gentle manner and friendly demeanour make them feel secure and cared for.^[1] Clinicians should try wearing bandages and hosiery themselves and attempt to imagine what it might be like to have pain, oedema, leakage, and itchy skin for 24 hours, every day.

8 Do not try to do everything at once: The clinician should ensure bandages and hosiery are as comfortable as possible; constriction and slippage will be uncomfortable and potentially harmful. Ankle movement should not be restricted for mobilising and exercise, and footwear advice should

be given before the patient has compression. When a wound is heavily exuding, the clinician should be prepared to change bandages more often until it is under control. Itchy skin should be managed through an appropriate skin care regimen, as well as using lining material to keep wool padding away from the skin. Charts can be used as reminders for leg elevation and exercise. Additionally, patients should be involved in measuring and recording outcomes, such as oedema reduction. Praise and encouragement are important too; we all respond to this if it is realistic and nonpatronising.

9 See the patient with “fresh eyes”: The clinician should go back to the beginning of the patient's assessment in case something was overlooked. Factors to consider are comorbidities, skin conditions, social factors, anxiety, and depression.^[15] The advice of an experienced colleague who does not normally see the patient should be sought. They may see subtle changes in the patient that are less obvious to the clinician who sees the patient regularly.

10 Communicate effectively: Marks et al^[16] discussed the effect that certain phrases may have on the patient, by differentiating between the terms “aggravated directives” and “mitigated directives”. An example of an aggravated directive is “you need to” or “I want you to,” which requires action rather than answers from the patient. The use of aggravated directives is less likely to result in adherence and is not in the spirit of concordance. Mitigated directives, such as “maybe you can” or “let me say” are more effective, since they are presented as a joint action.

CONCLUSION

Concordance and adherence will be promoted if the clinician has a sound knowledge of the condition and treatment options, as well as good communication skills, compassion, empathy, and an understanding of the patient's need. Clinicians also need to have clinical skills in leg ulcer management, which includes evidence-based, effective patient education and support programmes. People change according to circumstances so labelling should be avoided and people should be allowed to change their mind. To paraphrase Price,^[1] accept patients have “a life, not just an ulcer”. ■

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