

Raising the profile of tissue viability: who will lead the way?

Jacqui Fletcher

Those of you who have spoken to me within the last six months will probably be aware (because I have whinged incessantly) that I am about to submit myself to the tender mercy of the NHS for the first time at my not inconsiderable age. Why is this worthy of editorial comment? Well, I have tried to be a 'good' patient, but before submitting myself to the surgeon's knife I had some key questions:

Q: What is your surgical site infection (SSI) rate?

A: My dear, what is an SSI?

Q: What do you use for skin prep?

A: mmm, iodine and hydrogen peroxide

Q: What postoperative dressing do you use?

A: I really don't know, it's a clear plastic thing.

He also recommended that I checked into a convalescent home for two weeks post surgery!

How can this happen in a hospital that has an excellent tissue viability service? Why does the surgeon not know basic information or care that he has not got a clue what the National Institute for Health and Clinical Guidelines (NICE) SSI guidelines say. I was not a good patient, I wrote and told him I wanted chlorhexidine (obviously quoting the NICE guidance and two more recent reviews which underpin this decision), and saying that I was bringing my own postoperative dressing. I am pleased I did because a week later I received a phone call saying that they had changed the date of my admission,

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oh at least a month previously, and when I asked to speak to 'my' surgeon was told that there was no point as he would be retired by the time I was admitted. I was not impressed, I had spent almost two hours discussing the options I had and the intricacies of how my care would be provided with this man and now, six working days before I was scheduled for admission, they were telling me I had a new consultant (but they did not know who it was), and it was unlikely that I was going to see him as I was to be admitted on the day and first on the list.

When I told friends and colleagues, every single one of them said, 'I'm not surprised'. Why were they not surprised? What happened to 'no decision about me, without me'? Why is the system that I have worked in all my adult life become so prone to flaws that no one 'bats an eyelid'? If I had not been the 'pushy' patient, I would be being admitted on a random date, under the care of someone I had never met, who may have a completely different plan for me (and when I met him, he did). Again, why is this worthy of editorial comment? Well, it underpins the lack of interest from our medical/surgical colleagues in the basics of wound management. I am not questioning his surgical technique, but I want to know that the care I receive at every single level has, where it exists, evidence underpinning it. In addition, that the person supposedly making decisions about what happens to me, actually knows what is happening, not some vague approximation of what it may have been once. The risk of postoperative complications is influenced by the whole of the care the patient receives and every element of that should be important, so I am back

to my original date, I am being prepped as per SSI guidelines, I am taking my own dressing, and my new surgeon could not tell me his rate – but knew exactly how many postoperative complications he has had in the last year (which is fine by me).

So, how do we raise our profile...

With all the changes in health care at the moment, it is even more important that the tissue viability community presents itself as an important and vital speciality. To ensure this we need to maintain educational programmes for all grades of staff, promote evidence and research-based practice, be able to audit all our practices and have clear outcomes to our interventions. Who will lead this? One possible solution is to have a group of professional practitioners that have a collective voice which is heard. Arguably, we have that voice through national and local tissue viability groups, consultant nurses, advanced practitioners and academics. Yet, how do we define the differences between each of these groups, and what qualifications and experiences do they possess that allow them to make strategic decisions to shape the future of the speciality?

With respect to the role of the advanced practitioners, there would appear to be no definitive definition. The International Council for Nurses (2001) defined advanced practitioners as:

A registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or

country in which s/he is credentialed to practice. A Master's degree is recommended for entry level.

The Nursing and Midwifery Council [NMC] (2006) defined advanced practitioners as:

Advanced nurse practitioners are highly experienced and educated members of the care team who are able to diagnose and treat your healthcare needs or refer you to an appropriate specialist if needed.

Interestingly, there is no reference to Masters degree in the NMC definition, yet the education system for pre-registration nurses will become all degree by 2013, so surely the minimum qualification specialist/advanced practitioners should possess should be a Masters degree. Therefore, do we need to support senior practitioners to develop their academic credibility through studying at Masters level and insisting that all academics involved in tissue viability possess a PhD? Or, should we promote the importance of clinical credibility and say that only those who carry a case load can become leaders in tissue viability?

What we need are leaders who possess the underpinning knowledge and skills to confidently and knowledgeably discuss raising tissue viability as a speciality, who understand health policy and have a vision for the future supported by clear outcomes.

White (2008: 98) stated that 'tissue viability has risen without a trace and is not "recognised" in the sense that it has minimal public/media profile, its scope is not defined or broadly accepted outside of nursing'. Indeed, in a survey of 60 leading health organisations, 48.8% identified problems accessing specialist care, while 69.1% reported that specialist nurse services were overloaded and did not have capacity for new referrals (Royal College of Nursing [RCN], 2010). If this is true, can those who have a clinical workload really take tissue viability forward? Do these practitioners have the time or even the resources to make a difference to the strategic planning of tissue viability services?

Alternatively, do academics have the clinical expertise to fully understand the 'real clinical world'?

Do we have many 'dual' people, how many academics retain a clinical role and, equally, how many clinicians participate in the academic pursuits of research and education if you believe that either combination are really necessary?

Who do we see as our leaders and visionaries and how do they become these 'leaders'. It is possible to identify clearly those who hold professorial or nurse consultant roles relevant to our field, because there are so few of them. However, it is far less straightforward to identify how those people got there. How do we provide a pathway or route for the new upcoming practitioner, what do you need to become a professor or nurse consultant? Perhaps we should start by asking what the title may signify to the average clinician and, indeed, to the average patient.

Maintaining the focus on what patients can expect, the majority of patients would hope to complete any healthcare event without developing a complication, be that an infection or a pressure ulcer. While SSIs have received considerable media attention over the last 10 years, it is only recently that the national media have started to discuss the problems of pressure ulcers with, for example, the *Daily Mail* recently devoting the centre two-page spread to: 'Why, in the 21st century, are NHS patients dying in agony from bedsores?' (Scurr, 2011). As the public interest increases, it will be interesting to see what data the NHS are able to provide on the occurrence of pressure ulcers and standardisation of prevention strategies which are implemented. Despite the growing political profile of pressure ulcers, the recent Patients' Association document (2010) highlighted considerable inconsistencies, which local data collection has borne out further (Fletcher, 2011). We are unable to determine what we are doing and if we are improving, if we do not know where we are starting from and how we are measuring.

The Tissue Viability Society (TVS) have recently convened a working

group to look at standardising key issues in pressure area care, particularly around pressure ulcer occurrence, which I will be working alongside in my new role as a NICE Fellow. The first activity of this group will be to look at setting up a reliable and updated communication network for all clinicians involved in tissue viability, and by means of an electronic survey method will establish what is actually happening in clinical practice. This will give a baseline from which to work on setting some key measures.

Further information regarding this working group can be obtained from Dr Carol Dealey on Carol.Dealey@uhb.nhs.uk. **WUK**

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