

Specialist tissue viability services: a priority or a luxury?

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During the 1980s, the number of tissue viability nurses (TVNs) rose steadily in the UK, in response to mismanagement of patients with wounds (Fletcher, 1995). Since this time, and in response to the quality agenda, the necessity of promoting a tissue viability service (TVS) that is able to meet the needs of a changing population, while being cost effective and offering interventions based on research and evidence, has grown. The drive to reduce avoidable harm in healthcare and to make efficiency savings is continuing, with TVS being one of the key areas to deliver these targets. However, across the UK we have a wide range of role descriptions and job titles, yet little clarification as to the qualifications and skills required to deliver a successful TVS. Infection control specialist nurses have a clear identity with concise role descriptions representing a range of pay bands. Arguably, this is because they are aligned with a medical speciality, whereas TV is not. The introduction of 'Any Qualified Provider' (Department of

Health, 2011) has witnessed some services, including management of leg ulceration, being delivered by non-NHS providers at a reduced cost. So is TVS in danger of becoming more of a 'nice thing' rather than a priority? *Karen Ousey*

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Do we really need a specialised nurse or should all nurses and related healthcare professionals be responsible for promoting tissue viability?

DL: There is no doubt this needs a dedicated specialism. Ideally, this should be multidisciplinary, but it has been taken up mostly by the nursing profession. There have been many shortcomings, but this is reflected worldwide, not just in the UK. The interested nurses have repeatedly claimed that medical support is poor; and, more to the point, poorly represented in medical undergraduate curricula.

It could also be argued that nurses are not exposed sufficiently in tissue viability during training either. They are right on this point, but doctors and nurses — in general — have been far from agreement. They should be, as the budget for wound care probably reaches 5% of NHS expenditure. So, we do have relatively poor nursing and medical care in this field outside hospital specialist services; but there are centres of interest and exceptional expertise based in primary and secondary care. The tissue viability movement, which is largely nurse led, has lagged in progress because of poor university links (to promote education and research) and industry links. There are centres of excellence, and the TVS has been active for years, but

there does not appear to be the recognition for this specialist need to complement this huge clinical challenge. TVS should be a priority in primary and secondary health care. Improved general education could cope with most wound care, leaving the TVNs to teach and manage the more challenging patients. If this were to happen, they need Department of Health (DH), Royal College of Nursing and University mandates; supported strongly by the appropriate Medical Royal Colleges. In addition, collaboration with the industry has much to offer.

JM: As a practicing TVN, with over 16.5 years of experience it is hard not to vote in favour the continuance of the role, as without it I would be out of a job and it could be argued after 16 years in one specialism that my skills, while transferrable, may be viewed as limited. That is not to say I am blind to the challenges. It is foolish to think that one person or indeed a group of individuals that represent TVS up and down the country can be responsible for promoting tissue viability in all scenarios. Success and failure in a specialist role is dependent on the culture, knowledge and skills in the team and that team's ability to educate and equip other healthcare practitioners with the tools, skills and appropriate coaching to maintain skin integrity as a human right; or, conversely, minimise the impact of injury and optimise wound healing and/or palliate symptoms for patients that have a breach in the integrity of their skin.

JC: Health care is dynamic and alters to reflect the changes in the wider global environment. We have seen many changes in technology leading to advances in healthcare meaning that we can treat a wider and more complex range of

conditions. Social and political change has led to greater public scrutiny of healthcare providers and an increased demand for accountability at both an organisational, as well as individual, level. The question is, how do we ensure that our patients receive a good and safe standard of care?

It is right to expect that all nurses who are giving direct patient care, should be able to practice so as to 'do no harm' to the patient; this means that they are accountable and need to take responsibility for ensuring each patient is individually assessed, and care is planned and implemented to prevent incidents such as a pressure ulcer or a wound infection. There are, however, an increasing number of patients who have complex needs, with multiple comorbidities; for these patients and the nurses who look after them there is a role for a specialist practitioner.

Should tissue viability be aligned with a medical specialty? If so, which one?

DG: If the specialty is multidisciplinary, which it should be, then who should lead? This is challenging. Currently, we have one outstanding internationally renowned clinical and laboratory-based centre, which is self-supporting, and undertakes research and a diploma/master's programme. It is strongly supported by industry, which brings with it all the conflict of interest concerns, but has now had (at last) governmental recognition for its excellence in research and knowledge dissemination. There are healthcare departments attached to many other colleges and universities but, in the main, their educational ambitions are theoretical and not clinically led. In addition, there are outstanding small teams, mainly in secondary health care, of multidisciplinary members, who also offer superb clinical management and research, but with little organised teaching.

This specialty must be multidisciplinary. In the US, there have been well-supported

clinical independent and successful university-linked departments. In the UK, we have been slow in recognising the specialty; as a consequence no one, nurse or doctor (or even scientist) is training to be a departmental TV leader. This does need universities and colleges to work together with governmental recognition. There has been little economic analysis to support this ideal — which would surely be positive if it were undertaken. In the meantime, such TV departments must have a leader who can collaborate and organise; this could be a TVN, surgeon (general, orthopaedic, vascular), endocrinologist, dermatologist or scientist, but they would need to be dedicated and not undertake this as a session-a-week commitment.

JM: I feel that given the backdrop of the monetary challenges facing the NHS, consideration should be given to developing current TVS into a multidisciplinary TVS. This would see the TVN as one of the wider multidisciplinary team, which includes vascular, dermatology, plastic surgery and other medical professionals along with podiatrists, orthotists, chronic oedema, lymphoedema and pain specialists, as well as access to psychologists, physio, OT and seating therapists to name but a few. Referrals into a team would then be triaged to the relevant practitioner to ensure patients they see the right person at the right time and get optimum treatment first time every time. Unfortunately, we all have examples of patients who have been to see one healthcare practitioner after another with little measurable impact on the presenting complaint. It could be argued that this has happened because TVS have evolved as a Cinderella service and are often under resourced and overworked in comparison to other specialties that have well-defined boundaries. It is time to look at zero-cost options to address this.

Sixty percent of most district nursing team time is spent on wound care; would specialist wound care nurses improve patient outcomes? Could realigning existing service provision be the key to achieving key performance indicators and improving patient reported outcomes? To summarise, I feel tissue viability should not be aligned with one specialty but should be an equal partner with other specialists in a realigned TVS that has representation in proportionate numbers of all healthcare professionals involved in wound care that is designed to meet the needs of local users.

JC: Skin care is complex and multifaceted and requires a holistic approach; there are elements of mobility, nutrition, circulation etc that all contribute towards tissue viability. A holistic approach to care is central to nursing and this is why the specialty has evolved as a predominately nursing role outside of medicine. There is little doubt, however, that power and resources in healthcare are allocated to medical specialists and if tissue viability is to evolve then it would be wise for the specialty to be aligned to a field of medicine. It is difficult to say which branch because of the scope of practices encompassed in the specialism. It would be easy to say that the specialism should depend on local need and interest of the organisation and its clinicians. This can, however, lead to a fractured approach as medical staff from different specialties will have differing views. A wise choice would be to align it with one of the more dominant fields of medicine that has a high profile, for example, a branch of surgery such as vascular or plastic surgery, although not all organisations have clinicians in these fields.

Tissue viability has been described as a specialist area that transcends all healthcare settings, e.g. hospitals, community, palliative, paediatrics,

maternity and mental. As such knowledge and skills need to be of a medical advanced level, yet not all practitioners possess higher degrees. Is it necessary for TVNs to possess higher academic degrees?

DL: TVNs do need higher degrees; they need to be conversant with training, training-the-trainers, research and the meaning of evidence-based medicine. There is very little of the latter in wound healing and when TVNs (or specialist doctors; whoever is the trained individual) undertake another key role — the writing of protocols and guidelines — they need to be aware of the shortcomings of systematic review and meta-analysis, which repeatedly tells then that more research is need. Extensive experience of wounds in general, and difficult wound in particular, needs a breed of individual who is conversant and trained in recent advances (and ideally has contributed to them) to provide the optimal service. Wound healing is essentially a practical specialty but it has lagged behind diabetes, heart and vascular, and molecular research, for example. This needs addressing, at least to support the concept of the specialty at a departmental level. There can, of course, be all levels of expertise, but that responsibility does need coordination, cooperation and collaboration.

JM: I think it essential that TVNs/practitioners/those working in the field of wound care have a recognised approved higher degree or qualification in the field of wound care. It could be argued that to survive the current challenges we need to strive towards standardisation and push for equality of service provision. To achieve this, we need to do more than agree on the level of education; we need to agree a universal job description, agree a set of key performance indicators that are relevant, comparable, and measurable that can be implemented across organisations that add value to the patient journey and

service. The introduction of peer review of services is also warranted, so that we begin to understand what good practice looks like and know what failing teams need to aspire too. What is clear is that some services are thriving and growing, while others are being decommissioned. We need to be clear on what needs to be done to prevent further erosion of services for patients with largely hidden complaints, and little charitable backing or media presence. We need to engage people on all levels to preserve essential services.

JC: There is an expectation in most teaching hospitals that nurses who practice above a certain level should have academic credibility; as this is a requirement for almost all healthcare practitioners why should it be different for TV nursing?

The skills required by nurses to practice tissue viability are both generalist and specialist. All nurses involved in direct care should have a basic level of general knowledge about the skin, how it works and how to prevent harm. At a more advanced level, there is a need to develop a body of knowledge that will contribute towards the evidence base and the development of tissue viability as an independent practice. Nurses who practice as specialist nurses need to have access and contribute to this specialist body of knowledge. This will facilitate consistency in standards of care and drive them upwards, as well as provide added legitimacy to the role.

What key performance indicators should TV services work to?

DG: Clinical wound healing is still in its infancy. The gap between 'bench to bedside' remains wide. Currently the specialty is not expanding as fast as it might; the introduction of negative-pressure wound therapy (NPWT) and debridement techniques, US and use of antimicrobial dressings is not widely

understood or available, and knowledge of advances (biofilms for example) are not as well disseminated as they might be. Societies, such as Tissue Viability Society and European Wound Management Association, play a great part in education, practical workshops and publications, but attendance is not widely supported and criticism has been made of the dependence on industry support. There is not a clear standard for the specialty. As an example, doctors (because they claim they are not trained to) and nurses (because they allege they are not allowed to) do not undertake the level of maintenance debridement that all wounds need, particularly when they are stalled.

Standards can only be set on acquisition of a defined skill set or success in higher education. There are many examples of these that are widely available. Centres of higher education need to have their educational expertise tapped for this with collaboration of the professional bodies and the Department of Health.

JM: A good TVS should have a vision, mission statement and referral criteria that set out not only who, what, when, and how to refer, but also response times so that the referrer knows how long they or their patient will wait to be seen. They should operate within nationally and internationally agreed parameters and have policies and procedures in place along with robust treatment pathways and agreed onward referral processes that are transparent and can be audited. Targeted key performance indicators (KPIs) could include: time from the point of referral to healing for given wound types; reduction monitoring and investigation of pressure ulceration; the number of training and education sessions a service provides and the reported impact this has on practice. Wound management formulary provision and monitoring of expenditure, as well as other equipment provision, such as beds and mattress audits, can also be used as

an indicator of quality. This alongside patient engagement and a commitment to research must be at the forefront of any successful service. Failure to engage with service users and respond to the changing needs of the local population leads to ill-thought-out service provision. Without doubt it is also important that any service has mechanisms in place to support the ongoing needs and education of the staff they employ and have systems in place to both recognise success and manage performance when required.

JC: It is difficult to say what the precise performance indicators should be, for example, in terms of reducing the incidence of pressure ulcers/wound infections, the indicators would need to be locally agreed, depending on the local situation. There are, however, some key principles that must be incorporated when considering KPIs:

- ▶ KPIs should be arrived at by a consensus opinion informed by all key stakeholders. This includes those who commission and provide care, as well as the patient.
- ▶ They should be challenging and focussed and provoke examination of current practice, for example, the healthcare-associated infection targets (MRSA bacteraemia), when first introduced was greeted by infection control teams with cries of ‘this can never be achieved’ — how wrong were they?
- ▶ They should be measurable
- ▶ They should demonstrate benefits/improvements to the service.

Who is responsible for maintaining quality outcomes in healthcare and, in particular, for TV and how is ‘good quality’ defined?

DG: Systematic reviews and meta-analysis cannot be relied on for quality outcomes in wound care and TV. NICE and other similar bodies cannot take this on as the evidence base is so weak. There is not going to be a flurry of RCTs to answer this as they are so expensive to conduct. When a study such as the VULCAN study is supported by an HTA grant it needs to have the correct hypothesis and the appropriate outcome measures; it did not and silver dressings (which are part of the TV armamentarium) have been outlawed by many procurement managers.

Regretfully, there is also suspicion of Industry-led studies based on a risk of conflict of interest. Because the code of good practice is so powerful it is unlikely that studies are tainted; nevertheless, practitioners in TV need to understand when an advance has been made. Protocols and guidelines are, therefore, still written mainly through ‘expert opinion’. The standard of that opinion must be unassailable through the same code of good practice and declaration of conflicts of interest, but involve all parties.

Responsibility must be led by professional bodies and societies representing the multidisciplinary team. This will always be difficult as the current leaders of many TV departments are so disparate, each with diffident agendas. It is time for some unity with campaigning. It is possible that unification of TV services could promote best-quality standards. There is no shortage of published material on this but it is currently too widely disseminated; the excellence of systematic review methodology might be the way forward. Could a national Collaboration Centre be established with this in mind?

JM: I have addressed this in my previous responses — it is every healthcare

professional’s responsibility to maintain healthy skin integrity in partnership with the patient/client as this is a human right. It could be argued that if it is everyone’s role then it could, in turn, become nobody’s role as everyone assumes that someone else is responsible so why should they be. It is the TV’s role to engage services and keep this key quality measure on the agenda and maintain its visibility despite the competing challenges and changing nature of NHS provision. It is important to look after the skin across the health continuum to minimise the impact it has on patient-reported quality of life.

JC: We are all responsible for maintaining good quality outcomes in healthcare. Those of us who provide direct or indirect care as a speciality advisory service have a part to play, for example, if a nurse fails to refer a malnourished patient to a dietician, this may be detrimental to the patient. If the dietician does not attend to give advice, this may be detrimental to patient care. Even those who provide medical devices have a role to play to ensure the products they provide minimise the risk of harm to the patient.

Defining ‘good quality’ is difficult because of restrictions on limited resources. However, it is reasonable to expect that a patient should not leave our care in a worse state than when they entered into it and that avoidable harms, such as preventable pressure ulcers/wound infections, become never events. It is important that as professionals we recognise this concept of doing the patient ‘no harm’ and do not accept pressure ulcers/wound infections as an inevitable consequence of our treatments. 