

THE ROLE OF THE TISSUE VIABILITY NURSE

This article describes the role of the tissue viability nurse (TVN), which can differ from one Trust to another. However, at the core of the role is the provision of expert advice in the prevention and the treatment of wounds of differing aetiologies. TVNs require many skills, but communication skills are essential to liaise between the generalist nurse, the many multidisciplinary teams and the patient, as well as promote excellency in wound care.

Tissue viability is a relatively new discipline, which started in the 1980s and has been defined as a growing speciality that primarily considers all aspects of skin and soft tissue wounds, including acute surgical wounds, pressure ulcers and all forms of leg ulceration (Tissue Viability Society, 2014). However, tissue viability nurses (TVNs) have a multifaceted role, which has developed differently in each region to reflect local requirements.

Wound care is not the only aspect of the job; TVNs also deliver education, develop practice, and undertake audit and research. Some TVNs may manage a budget and some work within a well-defined speciality, however, most work across all specialities autonomously, without direct medical or nursing supervision, in collaboration with medical, nursing and all professions allied to medicine. Tissue viability is often part of the senior nursing team of an organisation and with that comes certain tasks that have to be undertaken within the corporate umbrella; tasks that sometimes do not have much to do with Tissue viability, but that are important to the organisation nonetheless.

Tissue viability work very closely with a number of NHS teams (such as procurement, pharmacists, finance

department, as well as all the clinical multidisciplinary teams) and non-NHS staff (for example, industry — who develop the dressings — but also care homes, hospices and private sector hospitals). In order to thrive, tissue viability teams have to be masters at communication as all of those aforementioned 'agencies' command very different relationships.

Tissue viability and pressure ulcers

Currently, most tissue viability teams (TVT) across the UK are working hard to reduce the incidence of pressure ulcers across all settings. TVTs have the responsibility to ensure that all damage is accurately categorised and reported as most Trusts have been set Commissioning for Quality and Innovation (CQUIN) targets, which typically involve an ongoing reduction of Trust-acquired pressure damage.

Failure to achieve these targets involves a significant financial penalty that Trusts can ill afford. TVTs are assisting their colleagues to implement protocols, such as the SSKIN (Surface, Skin inspection, Keep Moving, Incontinence and Nutrition) bundle of care; turning regimes (intentional rounding); providing continuous education on pressure ulcer categorisation; and finally,

“Wound care is not the only aspect of the job; tissue viability nurses also deliver education, develop practice, and undertake audit and research, as well as manage budgets.”

FANIA PAGNAMENTA
Nurse Consultant (Tissue Viability),
Newcastle upon Tyne Hospitals NHS
Foundation Trust, Newcastle

providing expert advice to manage pressure ulcers.

Dressing selection for wound formularies

Most Trusts develop wound formularies to assist clinicians with selecting from a shortened list of products. This is to support them in wound care. With a limited dressing selection, it becomes easier to use them efficiently; as training can be targeted, it becomes less confusing to select the appropriate product for a specific wound. TVTs are usually open to new suggestions, especially if what is available to the generalist does not meet their needs or those of the patients they care for. TVTs rely on feedback from generalists and are receptive to change protocols if required.

One of the most difficult parts of the TVN role is to make decisions on what product to list on a wound formulary as the evidence available is not based on clinical trials and this may come as a surprise to many generalists. There is a huge range of wound dressings available on the market. Evidence-based practice should underpin this choice but, in reality, most of it is based on intuition, unsystematic clinical experience and a rationale based on specific diseases/conditions.

Reddy et al (2008) reviewed all available randomised controlled trials (RCTs) published on pressure ulcer treatment. They reviewed 63 RCTs that evaluated dressings. Of these studies, only seven were classed as being high-quality studies and five of these showed there were no differences between different types of dressings.

However, clinically, some dressings work better than others. Horkan et al (2009) analysed all the systematic reviews undertaken on wound dressings for period of 10 years (1998–2008). They analysed 13 systematic reviews and meta-analysis papers that identified recurrent themes relating to wound-dressing studies. They concluded that the methodological quality of dressing

trials was poor, namely the number of participants recruited was consistently low, the sample size being erroneously estimated prior to the commencement of the study.

RCTs are notoriously difficult to conduct in wound care due to the number of variables involved and difficulty in recruiting a control group for comparison. Therefore, case studies are used to base some TV decisions on, often simply by trying a new dressing on a number of patients and observing positive results.

The reason there is little evidence to support dressing selection is that dressings are not like pharmaceutical drugs. In fact, dressings are considered 'medical devices', therefore, the dressings are CE marked, which means that they are safe to be used in the context for which they have been designed for, but the manufacturers are not required by law to provide any evidence of efficacy and, consequently, there is little incentive to fund large trials (Madden, 2012). Undertaking randomised RCTs is time consuming, expensive and difficult to perform in dressing evaluation.

The selection of dressings that are available is proliferating as companies want a share of a lucrative market, which had an estimated turnover of £1bn in 2009 (Department of Business, Innovation and Skills, 2010). Companies market their new products and employ representatives to walk the territory to promote them (Faulkner, 2009). The role of the TVT is to look at what little evidence there is and decide if a new dressing could be useful for certain wounds.

Evaluating a dressing is more than just a case of thinking: "Put it on a wound and see how it performs". It is instead about establishing a number of key factors, namely:

- ▶▶ Ease of use
- ▶▶ Staff education
- ▶▶ Patient comfort (application, and removal and during wear)

- ▶▶ Costs
- ▶▶ Access
- ▶▶ Range of sizes
- ▶▶ Wear time.

Firstly, how easy is the dressing to use, for example which side should be applied face down onto the wound? Introducing a new dressing into an organisation involves educating colleagues on its appropriate use. TVTs are small and many TVNs work alone in their organisation. Therefore, training generalists is time consuming, requiring an effective training plan to be put in place, prior to the introduction of a new dressing.

Patient comfort is also important so feedback from patients has to be collated. Different sizes should be available, for example, paediatric patients will often require much smaller dressings. Dressings need to be ordered and delivered, therefore, whether a dressing is sourced from NHS Logistics or is available on FP10 and can be prescribed, is also a consideration.

Costs are also a key factor to be considered. In the absence of cost-effective studies, TVTs have to decide whether a dressing is affordable and, in reality, the unit cost of a dressing is a relatively small factor. Issues such as wear-time, need for additional dressings and nursing time all constitute the most expensive elements of wound care.

Tissue viability team philosophy

Simplistically, there are two types of TVT and both follow different philosophies of care. There are teams whose ethos is to empower generalist nurses with the skills that are required to look after patients' wounds. These teams tend to be small; often there is only one TV specialist working by her/his self. The larger TVTs tend to undertake most of the wound care for patients in their organisation, where the belief is that wounds treated by a specialist will heal much quicker. In the absence of evidence of one philosophy working better than another, it is up to individual

establishments to decide which way their TVT will work.

Kohr (2007) explained how wound care has traditionally been classed as basic patient care, along with other activities such as toileting and feeding and, therefore, in the remit of generalist nurse's role. This view that it is 'basic' needs to be challenged as wound care is a skilled area of nursing requiring knowledge and competency. However, there is a fundamental level of knowledge about wound healing that generalists should possess.

Tissue viability and generalists

TVTs rely heavily on generalists who are the eyes and ears of what happens in their workplace to identify and refer patients who are not healing as expected. They need to know how and when to make appropriate referrals.

Generalists are continuously asked to work more with fewer resources. Vacant posts are left unfilled as the UK is embarking in a recruitment crisis and however good-willed generalists are, there comes a time where they really struggle to find the time to dress wounds as part of 'basic nursing care'. Wound care is increasingly delegated to Healthcare Assistants, especially in primary care and the role of the TVN is in educating and training unregistered colleagues, but also in supporting generalists in recognising their accountability in delegation.

From novice to expert in wound care

Benner (1984) described how nurses move from being novices to expert in making decision about their patients' care. As a nurse gains experience, they move through a continuum that sees them shift from working within strict protocols and rule-based thinking to intuition. In wound care, where each individual nurse is on the continuum is very visible indeed. While most nurses have workable wound care knowledge, some adhere strictly to written protocols even when the protocol no longer is suitable. For example, when a

postoperative wound becomes infected and the same type of dressing continues to be applied, without actively taking care of the infection. Moving from 'advanced beginner' through to 'competent', in the middle of Benner's continuum, a nurse would continue to adhere to the protocol, but would seek support from the TV specialist. Conversely, those that are 'proficient' would treat the infection and change the dressing regimen without requiring support from the TVNs.

At the novice end of wound care, nurses are guided by rules and by task completion, where a dressing is simply a task that needs doing. These nurses need dressing protocols to function and the role of the TVN is to provide these protocols, ensuring that they work effectively in their setting. TVNs also need to educate the novice nurse to recognise signs of infection, inflammation or any other deviant problem that causes a wound not to heal.

Nurses who have gained experience in wound care will inevitably be working with intuition, with the ability to recognise situations where a certain course of action worked well for a certain wound. With experience, they will recognise if a dressing will work in a given situation or not. These nurses will require a different input from the TVN. Their experience will also be of great assistance when developing wound formularies.

Tissue viability nurses as experts

TVNs have additional knowledge and skills; many have undertaken additional studies to Master's level and higher and have advanced clinical skills, such as sharp debridement or prescribing. They need to keep abreast of new developments in tissue viability and ensure their organisation's policies and procedures reflect current best practice guidance, for example, from organisations such as NICE, European Pressure Ulcer Advisory Panel, Scottish Intercollegiate Guidelines Network, Royal College of Nursing, World

Union of Wound Healing Societies to name but a few.

Conclusion

This article aimed to open a small window on the role of the TVN and their teams. The TVN job is a multifaceted role that can differ substantially from one setting and region to another. TVTs serve the need of the population they work with and the key message is that good communication between generalists and Tissue Viability is essential for the health and wellbeing of the patient. **WE**

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