Tissue viability nurses: discussing representation, education, medical, safety, legal and financial matters

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Specialism in nursing is not a new concept, indeed, as far back as 1910, nurses were described as specialists (Hamric and Spross, 1983). Significant developments have been seen in the role of specialism in nurses since its inception in the 1960s in the USA (Hamric and Spross, 1983). However, despite the need for specialist nurses, their emergence has been irregular with wide variations in the interpretation of their roles and functions (Ousey, 2014).

Although the concept of the tissue viability nurse (TVN) was born in the UK in the 1980s (Pagnamenta, 2014), it was probably the Touche Ross report of the early 1990s that really cemented the role-out of these posts across trusts (Touche Ross, 1993). This famous, now quite dated, report noted that the cost of pressure ulcer prevention was more expensive than pressure ulcer treatment annually. Having cognisance of the report findings, the idea that significant cost savings could be made through a more streamlined tissue viability service became a key driving force for the growth of these posts (Bale, 1995).

Over time, it has become increasingly evident that the sustainability of tissue viability is closely linked to economic, educational, technological, social and political needs (Flanagan, 1997; White, 2010; Ousey and White, 2010). Thus, the main focus of the role of TVN has been the need to coordinate services, to alleviate fragmented care and to help trusts achieve key performance indicators (Ousey and White, 2010). Over time the role has changed radically, with the focus on cost and quality increasingly making up a significant proportion of the overall workload. This has been challenged by individuals tending to focus on the local rather than the national/international perspective, reducing the potential for a collective impact of tissue viability nationally (Ousey et al, 2014).

Lately, there has been much discussion suggesting that the economic argument, which was the original driving force for the development of the tissue viability role, is at risk of threatening the continuance of the position (White, 2010). Indeed, the failure to provide clearer evidence of the value of tissue viability from a national perspective, demonstrated through a greater delineation of the functions and outcomes of the role, is argued as being a real threat to the sustainability of this role within the UK (White, 2010). It is timely, therefore, to open the debate surrounding the role of the TVN, and to contribute to this debate, two experts in the field of tissue viability have been approached to provide their responses to a number of pertinent questions. ***Zena Moore***

Since its inception, has the role of the TVN developed as it should?

KO: This is quite difficult to answer. The TVN post has developed steadily since the 1980s and over the decades has become a complex role that has continued to grow. Many TVNs are now, among other things, nurse prescribers, lead their own clinics, facilitate multidisciplinary working, offer health promotion and health education, offer specialist treatment across a range of simple and complex wounds, manage budgets, manage staff and teach in higher education institutions. So, yes, the role has developed; however, there is no national guidance or framework to which TVNs or nurses working in a tissue viability service can measure their clinical outcomes against.

JM: There is no doubt that tissue viability has expanded its role and function since its inception. However, this is also true of other specialist roles, such as dermatology, continence and vascular nursing. Despite this, it remains a 'Cinderella' service. Recent and deserved focus within the NHS in relation to safer care/reducing healthcare-acquired pressure ulcers has seen great strides being made within tissue viability to achieve targets, which is testament to the many dedicated teams that work in this field. Unfortunately, this has been rewarded with little, or no reported inward investment in the field. I am concerned that if more work continues to be added to the role, that the passion and drive will diminish, with serious consequences for patient care and outcomes. We perhaps also need to re-focus our efforts to where we can make a difference to patient care sooner, thereby addressing potential complex wounds sooner. I would argue that tissue viability needs to be part of specialist multidisciplinary team akin to that of most podiatry services. We need to avoid duplication of effort, streamline services and avoid multiple referrals for patients. We also need to focus on creating patient awareness and reducing the social stigma

associated with wounds, alongside creating and agreeing metrics and competencies that allow benchmarking.

Would tissue viability in the UK benefit from a single, strong, 'professional' society, which would be empowered to give accreditation?

KO: Tissue viability in the UK has a range of professional societies that they can look to for advice and up-to-date research and evidence; these include the Tissue Viability Society and Wound Care Alliance. Many TVNs, not all, are members of the Royal College of Nursing (RCN), who offer professional advice. Within the RCN there are a range of societies that focus on specific clinical areas, e.g. orthopaedics and research. I appreciate there is no specialist RCN society for tissue viability; so maybe it is time that we approach the RCN and present a proposal for a TV society? TVNs can access and undertake a range of post-qualifying courses that provide in-depth knowledge and skills development in this specialist area of clinical practice both at degree and masters level. These courses are offered across a range of higher education institutions via face-to-face teaching, blended learning or distance learning, so practitioners have a wide range of teaching and learning styles to choose from. Each of these courses is accredited. I believe we need to be careful when we discuss accreditation: a clear definition of what accreditation means is required when we discuss societies that can be empowered to give accreditation. There are continuing professional accreditation points offered when attending some conferences, yet these points cannot be transferred to degree or masters studies.

JM: Yes, without doubt, despite the excellent work of all the relevant bodies available. I can't help but think that if we could all move forward with a common purpose that this would improve our voice at a national and international level. It has been attempted before; perhaps we should reconvene some meetings with this in mind, and/or approach the RCN, as this is not only an issue for colleagues working within a tissue viability department — other nursing staff and professions allied to medicine need help and advice in relation to tissue viability. Some organisations do not have tissue viability teams that they can refer to, others have waiting lists, and while there is a plethora of publicised woundcare information to refer to this is not always easy at the bedside. My fear is that this will worsen, as the current government's agenda is to have 50% of community care provided by non-NHS bodies. Communication is essential to good care and multiple stakeholders can invariably lead to differing and non-compatible systems that can without careful management slow as opposed to facilitate timely onward referral.

Has the clinical nurse specialist (CNS) in tissue viability instilled the appropriate degree of clinical confidence in the role?

KO: Yes, I think it has. Many of the CNSs in tissue viability across the UK are proactive in ensuring that their tissue viability service provides evidence-based interventions and produces guidance and policies that reflect the needs of the patients. Over the last few decades, tissue viability as a specialist area has gained momentum with it being recognised as a nurse-led service. This is not the case globally, where tissue viability is often led by doctors. Since the inception of the Quality Agenda, CNSs in tissue viability have led the way in reducing avoidable harm and have been able to evidence that their services have been integral to a reduction in pressure ulcer development.

JM: We need nationally agreed competencies and metrics with which to benchmark against. If we can't agree these, how can people commission services or agree how to form a good service? We need not only to establish links to any multidisciplinary teams but have a truly multidisciplinary approach to care. For example, our team has referral criteria that states any patient with a wound that fails to respond to appropriate treatment within 4 weeks needs be referred for assessment. We also have a set criteria for how referrals are triaged, we run clinics, visit patients at home or in the hospital. In addition, we complete audits, run a university-based education program, are involved in research and the safer care agenda, have excellent relationships with the hospital's management, loan stores, podiatry, lymphoedema, plastics, vascular, orthopaedic and dermatology departments. Despite this, we still get patients who seem to have had a tortuous route to our clinics, with problems that can be easily addressed. It is essential that we improve referral pathways to ensure the patients see the right person in the right setting at the right time, so they have access to the right intervention, with outcomes being monitored. If we fail to address these issues, the ageing population and legacy of years of dependence on the NHS to correct health problems as opposed to health prevention could put untenable pressure on services. We must be creative and brave in trying to address these needs, while addressing inefficiencies and recording and celebrating our outcomes. I welcome the new focus in NHS England Five-year forward view (5YFV) on health prevention, but am yet to meet a health economist who agrees with the economies quoted.

Do TVNs pay appropriate attention to medico-legal issues such as pressure ulcer prevention?

KO: Since the publication of the Francis report and other key documents, the area of medico-legal (something that involves both medical and legal aspects) has gained much attention from all health care professionals. TVNs themselves are aware of the importance of accurate documentation

following all interventions, and the need to communicate effectively with the patient's family and carers. The definitions of unavoidable and avoidable pressure ulcers has helped TVNs to be able to measure interventions and measure outcomes. The CNS or consultant nurse for tissue viability will often lead on producing local and often national guidance for pressure ulcer prevention to ensure that all practitioners are aware of the importance of preventing avoidable damage. As before, TVNs are considered to be the teachers — sharing their knowledge and skills and cascading best practice to all team members, while highlighting the consequences of not providing or documenting interventions.

JM: I agree with the above comments – medico-legal issues are always at the forefront of TVNs' agenda, be it while reviewing the literature and evidence for practice, giving patients advice and support or when teaching/assessing staff either formally or informally on how to accurately describe and document wound care or select correct equipment.

Should CNS TV have greater accountability, as might be expected of such a role?

KO: All nurses have accountability and understand this. Nurses are accountable to their employer to follow their contract of duty and are accountable to the Nursing and Midwifery Council (NMC) in terms of standards of practice and patient care. It is prudent to mention that TVNs may delegate tasks to more junior members of the team, but they need to refer to the NMC (2015) code that states: 'Be accountable for your decisions to delegate tasks and duties to other people'. To achieve this, you must:

- 11.1: Only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions
- 11.2: Make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and
- 11.3: Confirm that the outcome of any task you have delegated to someone else meets the required standard.

The full NMC (2015) code is available at: http://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/revised-new-nmc-code.pdf

Should the TVN have a better understanding of health economics, more so than just 'cost effectiveness'?

KO: Over the last five years, TVNs have certainly had to learn about the importance of cost-effective treatment and being able to offer clear rationales and in many cases business cases to justify their decisions to use certain therapies. I think that all TVNs should understand the principles of health economics, but I do not believe they require extensive knowledge of this. Health economists spend a substantial amount of time at university studying this area and we cannot feasibly expect all TVNs to undertake degrees to develop their knowledge. However, TVNs should, if possible, spend time with a health economist to discuss the impact this has on their own clinical practice and which areas they should be considering when changing practices or therapies.

JM: TVNs must be accountable for their practice. In addition, some have budgets and many currently are adept at writing business cases. However, in some organisations, innovations are stifled by bureaucracy. In relation to health economic data and its implications for practice, I agree that we need to embrace this but that we must be clear that we want to look at 'real world data' as opposed to health economic models that bear no reflection on day-to-day practice. We must also consider shedding the mantra of commercial xenophobia and embrace partnerships with industry to achieve these aims. WUK

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