Challenging the belief that tissue viability is basic

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I have far too frequently heard the words 'Basic, a lot of what you do is basic... tissue viability is basic'. Perhaps you have heard them too; you may even have said them. I want to challenge this misconception.

Tissue viability encapsulates many areas, but may be divided into 3 broad categories:

- Pressure ulcer prevention and care
- Leg ulcer prevention and care
- Wound management.

Are these areas of care basic? Well, they are fundamental and should be every healthcare practitioner's business, but their intricacies are anything but basic.

Pressure ulcer prevention and care

For example, lets begin with pressure ulcer prevention and care. The European Pressure Ulcer Advisory Panel Conference in Aberdeen 2005 attracted medics, nurses, and therapists from across Europe, Japan, and the US to discuss the complex issues of assessing, preventing, managing and treating pressure ulcers. So much effort by so many for something so basic. Basic or challenging? I certainly see the challenge. Those who don't probably do not appreciate the old adage that 'you don't know what you don't know'.

As Butcher (2005) observed in the last edition of Wounds UK: 'Pressure area care is not about basics. Our understanding of the physiology of damage and tissue stress has grown immensely over the past few decades and we now know that pressure damage is anything but basic; it is a multi-factorial, dynamic process. It is, however, fundamental to good care.'

Leg ulcer prevention and care

A similar lack of appreciation of the complexity of tissue viability is apparent in leg ulcer prevention and care and its provision. Best practice is debated both within practice and the literature; the latter suggesting that variations in care continue. Yet, it is now 7 years since the venous leg ulcer (RCN, 1998) and chronic leg ulcer guidelines (Scottish Intercollegiate Guidelines Network [SIGN], 1998) were developed. Their implementation may be a challenge: there is no national database listing patients with leg ulceration; there is no National Service Framework; the NHS has not developed a national educational strategy for the delivery of leg ulcer care. This continues to be reliant upon motivated individuals and industry.

The ability to assess and plan care for a broad spectrum of wounds is important, but I am increasingly concerned by the number of more junior staff in primary care who have received little or no training in this area.

Yet, the opportunity to be innovative is seen within the framework of The Leg Club®, which offers evidence-based care in a social environment. The limitation of applying this social environment to other healthcare issues is restricted only by our imagination.

There are several challenges to the delivery of nursing within primary care from an individual nurse to an individual patient. These include:

- The implications of chronic disease management in an increasingly elderly, obsese, and sedentary population
- The demographics that are predicted to affect the number of nursing staff available to provide such care
- The increasing cost of providing care.

A social environment approach, such as the Leg Club® and programmes, such as the NHS 'Expert Patient' (2001) encourage a self-training programme that offer a strategy and initiative that could be applied to tissue viability.

Wound management

The significant spend on dressings within primary care should warrant the employment of a tissue viability specialist within each primary care trust and acute trust, yet, surprisingly, this is not the case. The increasing need for education within nursing homes to all aspects of tissue viability is sadly neglected. I am always amazed, and indeed disappointed, at the number of primary care staff who express their disillusionment at the lack of specialist support. A strategy for tissue viability education guidelines and the development of a formulary needs to be driven by a multi-professional approach across health care organisations, rather than developed solely by industry.

The ability to assess and plan care for a broad spectrum of wounds is important but I am increasingly concerned by the number of more junior staff in primary care who have received little or no training in this area. Sadly, it is not a part of mandatory training although at least 50% of a community nurse's time is spent providing wound care. There

is a real need for a consensus on pre-registration curricula that addresses these very needs.

National guidelines such as NICE's *Pressure Ulcer Risk Assessment and Prevention* (2001) and *Pressure Ulcer Risk Assessment and Prevention and Equipment Selection* (2003), along with the guidelines from SIGN (1998) and the RCN (1998), suggest that staff who have received specific education should provide services. If we really want to make a difference to service provision, the whole of the nursing spectrum needs educating, with adequate support throughout pre- and post-registration. Several higher educational institutes offer education to pre-registration and post-registration candidates, and many are multi-professional.

There is still much to do, and while it is common for practice nurses to need to undertake a specific course before delivering COPD, family planning, asthma or diabetes care, it is more unusual for them to attend tissue viability courses. I am witness to the positive changes that accredited courses can make to the delivery of care, and have worked closely with several practice nurses to achieve this. Unfortunately, the majority of practice nurses I meet still hold the view that tissue viability is basic, yet they continue to apply dressings to lower leg wounds for longer than 6 weeks without a specific leg ulceration assessment. The new contract arrangements for GPs and practices which include 'payment by results' also raises the question of the delivery of leg ulcer care within surgeries. There does not appear to be a payment for 'accurate holistic assessment'. Neither is this aspect of care considered to be part of the long-term disease management as it is for other conditions such as arthritis, diabetes, and asthma. While accepting that not all patients with wounds will need treatment in the long term, the high recurrence of leg ulceration suggests that many will do so. Of course, the lack of a national database of patients with chronic wounds can only leave us to speculate about this.

Raising the public, political, and professional awareness of the quality of care in the prevention and treatment of wounds is vital.

Tissue viability affects everyone, particularly the elderly who frequently present with chronic wounds. Too often a cult of youth and technology captures the headlines, and our specialty and its achievements go relatively unnoticed. As the profession of tissue viability develops, it is important to acknowledge that it may not be the professionals within tissue viability that will determine our future, but colleagues, patients, the general public, and politicians. Raising the public, political, and professional awareness of the quality of care in the prevention and treatment of wounds is vital. This remains the challenge to all those within tissue viability. Our specialty may be fundamental, and essential, but basic it definitely is not! **WUK**

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