Does the UK need wound ostomy continence nurses?

Currently, in the UK, a nurse specialist practices in accordance with an agreed definition of a UK clinical nurse specialist (CNS). The specialist role by indication, e.g. clinical nurse specialist tissue viability, confers an expectation of expertise within the field of wound care. In some instances the nurse's role may be advisory leaving the day-to-day clinical, hands-on care to the ward or clinic nurse. In other situations the CNS may be the clinician who manages and delivers the specific care required by the patient. In either case, the care remit generally resides within a narrow area of practice and, when necessary, other specialist nurses may be contacted to provide the requisite support in associated areas of care, such as stoma or continence care.

In the USA, opportunities exist to expand a nurse specialist role to that of wound, ostomy and continence specialist nursing. These nurses have their own society, Wound Ostomy Continence Nurses Society (www.wocn.org) and their own certification board, Wound Ostomy Continence Nurses Certification Board (www.wocncb.org). These specialist nurses are experts in three areas of specialist care which appear to integrate in an acceptable and logical fashion. An acknowledged parallel role does not exist in the UK. The questions arises, is there a place for the WOC nurse within the UK healthcare system? In the current atmosphere of staff cutbacks — especially in areas of specialism — should such a role attract new recruits? Innovation in practice should not lie dormant, and this 'new' concept should be considered and be subjected to critical analysis. KC

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What advantages, real or perceived, do you feel there are for the combination of roles within wound, ostomy and continence nursing?

DK: In the 1980s and early 1990s, when the International Association for Enterostomal Therapy was debating the issue of the 'full scope of practice' (wound, ostomy and continence; WOC) for enterostomal therapists, there were heated debates about the wisdom of such a move. Traditional enterstomal therapists, who were committed to the care of the person with an ostomy, were concerned that the ostomy patients would end up receiving second class care. I remember that Norma Gill-Thompson (the first enterstomal therapist and founder of the first enterostomal therapy school at the Cleveland Clinic in Ohio) was particularly concerned about this. But Ms Gill-Thompson also acknowledged that the expansion of the role to wound and incontinence-related skin care would be based on foundational knowledge and skills that would be acquired from stoma care.

In hindsight, the difficult decisions that the WOCN leadership made to expand the scope of practice and 'take on' the care of wound, ostomy and continence patients, has served our specialty and our patients well. The volume of ostomy patients has decreased for various reasons, such as earlier diagnoses and sparing surgeries. In most facilities there would not be a high enough volume to sustain a full-time ostomy-only specialist. By expanding the role to include wounds and incontinence, there will be no lack of patients, no matter what the setting: acute care, home care or extended care. Many of the patients I see in my acute care clinical practice require several of my WOC nurse competencies, which overlap and complement each other, for example incontinent patients often develop pressure ulcers. Offering this comprehensive service is efficient and cost-effective for the healthcare system.

WOC nurses often address the problems that no one else wants to deal with. We serve our patient population well. I am reminded of the following quote from Claire Fagin and Donna Diers (1983): '*Nursing is a metaphor for intimacy. Nurses are involved in the most private aspects of people's lives and they cannot hide behind technology or a veil of omniscience as other practitioners or technicians in hospitals may do. Nurses do for others publicly what healthy people do for themselves behind closed doors.*'

Do you see problems in education, training, quality of care and research, when combining wounds, ostomy and continence into a single role within the UK healthcare system?

AB: Continence specialist nurses often lead integrated services and cross the boundaries of social care and healthcare within the community. This is a broad role that encompasses clinical, educational research, financial management and business planning. Continence encompasses sub-divisions of specialities such as bowel management and neurological continence management, and within acute care, urogynaecology and urology. It would be difficult to imagine how one specialist nurse could develop the level of expertise required to be involved in these areas, as well as two other clinical disciplines.

DK: *WOC nurses often address the problems that no one else wants to deal with.*

AB: *It would be difficult to imagine how one specialist nurse could develop the level of expertise required to be involved in these areas.*

TY: *From a service provision point of view, would managers see the role extension as a potential cost-saving by replacing three staff with only one?*

Within the UK, some continence and ostomy services are jointly managed by a consultant nurse with an expertise in one of these areas. However, these individuals manage a team which has dedicated specialists for ostomy and continence within it. There are obvious areas of integration that can be combined when providing education and training — skin care and incontinence, for example. This would be an advantage in terms of making nurses more aware of the relationship between disciplines, but not each in depth. If nurses are not provided with appropriate education and training, the quality of care will suffer. Specialist nurses use research and audit evidence to set policies and standards that can be delivered and monitored locally. Although the skills required to undertake research and auditing are similar across these areas, research skills in themselves imply a development of specialism in the area.

TY: As it currently stands in the UK, post-registration education is not tailored to a combined approach, with each specialism having its own educational provision. Nevertheless, this is not an insurmountable obstacle and education providers should be able to accommodate the needs of the practitioner.

The quality of care issue is more of a concern, as tissue viability nurses (TVNs) within the UK may feel that they are already working to capacity with purely a wound care remit, and to take on further workload would result in a dilution of time available for each component and potentially a reduction in quality. Currently within tissue viability in the UK, there is already a fragmentation and diversity of roles, e.g. wound care specialists, leg ulcer specialists — would further diversity enhance patient care? From a service provision point of view, would managers see the role extension as a potential cost-saving by replacing three staff with only one? Tissue viability nurses have built up their skills in what can be a very diverse field; would this opportunity continue if their time was spent on other areas?

Healthcare will always be a trade off between what is practical, expedient, and affordable. Does it mean that the combination of wounds, ostomy and continence leads to a compromise in the quality of care?

DK: The knowledge and skill required to be a WOC nurse continues to expand, well beyond the knowledge that it takes to be an ostomy nurse. Each person's own healthcare environment may drive sub-specialisation based on the caseload of the particular organisation. So, in an organisation where the majority of patients need wound care, wound care becomes the driving force and the WOC nurse must focus his or her energies in that sub-specialty area, while still maintaining basic competency in the full scope of practice of wounds, ostomy and continence. I would argue that this is practical and expedient for the healthcare system, and saves resources and money in the long run.

For example, as a generalist WOC nurse, sub-specialised in wound care, I do basic ostomy care, but when it comes to that extraordinarily complex ostomy patient with a 'difficult' stoma, I consult with or refer that patient to my WOC colleague who runs a specialty ostomy outpatient clinic. This is practical, advisable and ultimately delivers the best quality of care to our patients.

The only compromise comes if one is too arrogant to accept that each WOC nurse cannot master it all and that we need to work in interdisciplinary and interprofessional collaboration.

'The new professionalism calls for us to have a clear sense of direction, to be well focused in our priorities, and to be unified in their pursuit . . . We must assert a distinct, sharp image, developing and brandishing our highest profile in what we do and what we are.' (Styles, 1982).

AB: A clinical nurse specialist, often trained to master's level, is an advanced practice nurse whose care focuses on a specific patient population, for example continence, ostomy and wounds. Specialist nurses divide their time into five general areas: clinical practice; teaching; research; consulting; and management. Their assessment skills tend to be more focused than nurse practitioners, since they focus on a particular area of specialty. But, they make up for this by being able to provide more expertise than nurses who have their responsibilities divided into many different sub-areas. The current healthcare situation in the UK is one of increasing cuts in services and diminishing roles. Specialist nurses are under increasing pressure to justify their existence and the efficacy they have within the healthcare system.

DK: *Combining wound, ostomy and continence roles challenges WOC nurse researchers to carefully construct their research designs.*

AB: *Continence specialist nurses can make a real difference to patients with continence problems.*

TY: *It would be expedient to review the models of care adopted in the USA to see how the balance between workload and quality can be achieved.*

Clinical governance was introduced as a way of defining clinical quality. Four main areas are measured within organisations, including resource use, risk management, patient satisfaction and professional management. Within this framework, professionals need to demonstrate knowledge, skills and competency in their role. Combining wound, ostomy and continence care would provide a more affordable solution, but would dilute the time and resources available for each clinical area.

The multidisciplinary team uses the continence specialist as a resource to maintain and update their knowledge and skills. Patient and professional expectation is that a specialist will be able to offer a high level of expertise. Nurse specialists provide a unique contribution to the health and well-being of individuals, families, groups and communities. Rather than looking to combine roles, we need to promote and enhance specific roles which will in turn promote and advance the practice of nursing.

Continence specialist nurses can make a real difference to patients with continence problems. They provide specialist clinical advice and support to both patients and their families. By undertaking a comprehensive assessment they can diagnose and treat continence problems and help people to manage their incontinence. They are often a first port of call for many patients, allowing most to be treated effectively within primary care, thus preventing inappropriate referral to secondary care. Continence nurses often coordinate services for people with continence problems. Although they provide personal support and guidance, when necessary, they refer patients to a medical consultant. Specialist continence nurses are there for people with continence problems to diagnose, and for the whole spectrum of symptoms and variability of the condition.

There are already few continence services that cover both acute and primary care and this leads to delays in referrals and a lack of continuity of care for patients. Referral rates to continence services have increased by about 30% over the past five years. Combining these three roles would lead to an unmanageable caseload, an increase in waiting times and may put patients at risk. Specialist nurses are uniquely prepared to assume the role of case manager by organising and coordinating services and resources, and controlling costs.

TY: Although I have suggested earlier that care may be compromised, this might not be the case: it may be a reduction in the quantity rather than quality of the work; however, for those patients that may have to wait longer to see the specialist their care is no doubt lacking. It would be expedient to review the models of care adopted in the USA to see how the balance between workload and quality can be achieved. It may result in having a team of specialists all having skills across WOC each delivering a high standard of care. However, does this differ to what we have today in one individual having skills in wound care, leg ulcer management, etc, with just the aspects of the specialism changing to include ostomy and continence management?

Nurses are not always active in disseminating empirical findings. Would combining the three roles augment this situation?

DK: In my opinion, the impact of combining wound, ostomy and continence roles on disseminating empirical findings and advancing evidence-based practice in itself is limited. Much more important is the commitment of professional nurses and professional nursing organisations to best practice, evidence-based practice and nursing research. This may or may not happen, regardless of whether nurses are practising in a single specialism, or the entire scope of wound, ostomy and continence practice.

In the USA the trends that have helped WOC nursing improve our professional practice and embrace evidence-based nursing practice include:

- Turning enterostomal therapy into a nursing specialty in the 1970s (many of the first ETs were patients)
- Requiring the BscN as the entry level into practice in 1985
- Encouraging WOC nurses to attain advanced practice degrees
- Turning WOC educational programmes from hospital-based programmes to university-affiliated programmes (this is ongoing)
- Forming the Wound Ostomy Continence Nurses Society Center for Clinical Investigation (CCI) to encourage and support WOC nursing research and the dissemination of findings
- Launching other initiatives (such as poster and manuscript awards) to foster and encourage WOC nursing research and the dissemination of findings.

Combining wound, ostomy and continence roles challenges WOC nurse researchers to carefully construct their research designs so they are robust and statistically significant, and appropriately generalizable. Having a professional organisation that actively supports and helps translate research into practice stimulates all WOC nurses to embrace evidence-based best practice.

AB: Part of the specialist nurse's role is to disseminate research and empirical findings in order to guide practice and raise the standard of care provided for all patients. Specialist nurses are often responsible for writing clinical guidelines and policies and, in order to fulfil this part of the role, it is necessary to critique a wide range of medical and nursing journals. Although the research grounding required to undertake a critique necessitates the same level of understanding, the clinical areas are very distinct. Continence advisers need to cover a wide range of topics including medications and product reviews to ensure they keep their knowledge and competence up-to-date. Patients are increasingly becoming 'experts' in their own illnesses, and are challenging nurses to enable them to make an informed choice about their care. Combining roles would not necessarily augment dissemination of empirical findings; the issue is more about nurses being given access to findings and the time to read the information available.

TY: I would disagree with the question, in tissue viability there are an overwhelming number of vehicles for disseminating research, i.e. journals, European Pressure Ulcer Advisory Panel (EPUAP) Guidelines, National Institute for Clinical Excellence (NICE) guidelines, European Wound Management Position Papers, Scottish Best Practice Statements, conferences and educational events supported by industry. The research is translated into clinical practice, with benchmarking and audit used as methods of reviewing the care provided. The problem appears to be a lack of good quality research, rather than the dissemination of weaker, less robust forms of evidence. However, this may be changing with pressure ulcer research being centrally funded (Nixon et al, 2006). The position of the specialism has also been strengthened by recognition from other disciplines demonstrated by the recent series of articles in the *British Medical Journal* (Jones, Grey and Harding, 2006). Although a personal opinion, I find my colleagues in tissue viability are well informed and strive to ensure their practice is evidenced-based and I would presume this would be the case even if the role had different components. WUK

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