A reflection on the progress of wound care education

Vanessa Jones entered nursing in 1970 when nurses were trained 'on the job'. She worked as a sister in hospital and the community before becoming involved in education, qualifying as a clinical teacher in 1981. In the past 37 years she has seen many changes in healthcare provision and education, many she feels not always to the benefit of nurse or patient. For the past 15 years she has specialised in education for professionals involved in wound management. In 1992 she joined the Wound Healing Research Unit, Cardiff as educational facilitator. In this article she reflects on past and possible future developments that may impinge on education in wound care.

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KEY WORDS
Education
Development of wound care
Specialism
Future needs

In the 1970s wound care was considered a major part of the nursing curriculum. It was a skill to be taught and tested in the clinical environment and nurses were assessed on their ability to perform an aseptic technique to the highest standard. When I became a clinical teacher, I became the assessor, putting many a nervous wreck with uncontrollable shaking hands through their paces — a situation that reached dangerous proportions if the procedure involved was taking out sutures!

Clinical tasks developed into an overly complex set of rules involving a 'clean' and 'dirty' hand with matching forceps that often overshadowed the student's ability to grasp the basic principles of cross-contamination. This ritualistic practice could, depending on the assessor's whim, focus more on the meticulous cleaning of the dressing trolley in an ordered fashion (even including the wheels) rather than focusing on sound clinical technique.

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However, the fundamental issue was that wound care was deemed to be so important that it was one of only four practical assessments made during the three-year training period. Of course during the 1970s the context of care was vastly different. People stayed in hospital longer and often sutures were removed before patients were discharged. Wards were cleaned under the jurisdiction of the ward sister with a strict daily routine so that dressing changes were only performed after one hour had elapsed between ward cleaning. Nurses were on the ward for longer shifts and uniforms were not to be worn outside the hospital — practices we have returned to in this century.

Criticism of this rigid pedagogical method of teaching and assessment saw a change in nursing education and the removal of formal clinical assessments. On reflection those of us who endured these nerve-wracking tests may say that there was a certain element of 'throwing the baby out with the bath water'. As learning became more self-directed and student-centred the introduction of *Project 2000* (UKCC, 1986) took away 'on the job' experience despite the fact that it was thought to be essential to supplement theoretical principles. Concerns were confirmed in a review of *Project 2000* in the *Fitness for Practice* document (Moore, 2005) which identified both public and professional fears regarding the number of practical skills newly qualified nurses were able to perform competently.

Educationalists need to design programmes that are responsive to the professional development of nurses, as well as the changing dynamics of the NHS and patients. In many ways it was easy to provide simplistic skills-based wound care training for pre-registration nurses in the 1970s and 1980s as it was considered to be part of general patient care. The 1990s saw a dramatic rise in the development of post-registration courses and modules (Fletcher, 1998). This was partly due to the recommendations set out by PREP (UKCC, 1994) but also the advancement of wound management in regard to both product development and biological research. Wound care at this time took a major leap from basic management for all wound types to the development of sub-specialities that focused on the chronic nature of wounds such as leg, diabetic foot and pressure ulceration.

Initially course development occurred alongside specialist units or

in larger higher education institutions (Flanagan, 1995; Jones, 1995). As the demand appeared to grow countrywide, many more stand-alone modules were developed in a bespoke fashion. Course numbers were buoyant and income generation from this area of nursing practice was assured for many institutions at this time (Gilchrist, 1997; Fletcher, 1998).

In 1993 the Department of Health suggested that the initiation of such courses should be part of an overall strategy at least in relation to pressure ulcer management. This clearly did not happen and although courses were validated by the individual nursing board of the country, at the time there was no overarching professional wound healing group or society that could exert enough control to provide strategic direction within the UK.

Within the resource-hungry climate of today's NHS, the survival of many stand-alone modules may be questionable. Larger institutions that are able to provide academic progression from diploma to degree to masters will have the lion's share of the decreasing student market. They will also have the technological support to deliver their courses in a format that is likely to meet student need, as the way in which students are able to access education has changed. Educationalists have been forced to find innovative ways of course delivery using CD-roms and the internet. Providing stand–alone modules at certificate and even diploma level in a traditional format may not be viable as it has become increasingly difficult to fill course places. Universities too have tight budgets and whereas previously Schools of Nursing could be responsive to NHS demands they are now overridden by the strategic direction of the higher education institution which may not accommodate the provision of wound care courses.

The increase in the provision of education was also accompanied by a growth in wound healing societies and journals. The Wound Care Society (WCS) and Tissue Viability Society (TVS) were the first UK groups who provided immeasurable support to practitioners in the pioneering days in the late 1980s. They, along with others that have since been formed have grown in stature and collectively have brought the attention of wounds into the political arena (Butcher, 2005).

As nurses have traditionally played a lead role in wound care in the UK the majority of the membership of such groups was from the nursing profession and this is still the case. Although the TVS had other members, it was through the establishment of the European Wound Management Association in 1990 that the multidisciplinary nature of wound care was formally acknowledged. The bringing together of not only different professions but different nationalities began a process of mutual understanding and partnership that has benefited the development of the specialty in many ways. EWMA provides an annual platform for all like-minded professionals to share knowledge and network and its validation of courses throughout Europe and the production of various position documents have provided educational support particularly in those European countries where wound care was less developed.

The bringing together of the world societies under the mantle of the World Union of Wound Healing Societies (WUWHS) every four years has also been a major achievement and will surely provide a platform for further worldwide developments in the wound care field.

However, such a strong body of people can be intimidating to those starting out in the specialty and all these organisations must ensure that for the future of wound care there continues to be an accessible pathway for the next generation of wound healing professionals.

The development of such large organisations confirm that there is certainly a worldwide interest in the subject area, but is wound care really viable as a multidisciplinary specialism in its own right? The nature of specialism throughout healthcare continues to fragment the ability to dedicate oneself simply to wound care, e.g. doctors remain within their established medical specialty — dermatologists, vascular surgeons, diabetologists and podiatrists all have an interest in diabetic foot care. Therefore education in wound care will still largely be provided by courses that are geared towards different professional specialisms who all have an interest in wound care.

However, encouragingly, the number of doctors enrolled on the Masters in Wound Healing and Tissue Repair at Cardiff has been increasing year on year. Their main area of specialism tends to be in burns and plastics. One of the reasons for this trend is that medics were previously able to pursue medical research and obtain an MD alongside their clinical duties. Under the new reforms introduced into medical training (DoH, 2004) this is now not possible and therefore medics are looking to obtain a higher degree via taught Masters programmes.

Nursing has to date been the only profession able to fully specialise in wound care and so education continues to be targeted towards their needs. Clinical nurse specialists have been established as part of the NHS for many years but recent governmental and educational changes have influenced their roles, responsibilities and pay structures. The introduction of the consultant nurse (DoH, 2000) and *Agenda for Change* (DoH, 2003) were concerted attempts to retain experienced nurses at the bedside but many nurses have struggled to become appointed as CNSs or tissue viability nurses at appropriate grades (Coull, 2004). Due to the disparity in roles and titles across the NHS it can be difficult to evaluate how effective such specialists are. This has become evident when an evaluation of their role resulted in what appears to

be spurious regrading under the Agenda for Change scheme (Personal communications). Different trusts have put nurses who apparently do the same job on grades varying from 6 to 8. Also previous clinical nurse specialists are being asked to go back to work on the wards so there is also erosion of the role in some areas.

The introduction of the nurse consultant post offered the experienced clinical nurse a new career structure and better pay awards. The obvious step for existing CNS or TVN masters programmes would be to gear the course to accommodate this new breed and many have pursued a masters degree with a view of obtaining such posts. Although other areas of nursing have achieved consultant status there are still few in wound healing or at least few that are linked to the expected salary. WUK

This, along with the increasing interest from other health professionals, clearly questions whether their role in wound care will be either strengthened or eroded in the future. There is one school of thought that specialism is developed at the expense of basic care. This may be true as anecdotally it would appear that simple and basic wound care is becoming non-existent in our hospital wards with an increasing reliance on the TVN/CNS to provide not just education and advice but hands-on care.

Undoubtedly wound care, healing, management or 'woundology' has come a long way. The foundations on which the work of the past 20 years was built were firm enough to allow the roof to be put in place. However before we 'raise the roof' is it time to review the foundations. Do we need to look back full circle at the building blocks of education and consider what we understand by basic training for all our undergraduates? Perhaps a return to cleaning the trolley wheels is too extreme but at least the ability to apply wound dressings observing the principles of cross-contamination may be a start.

Key Points

- In the 1970s wound care was a major part of the general nursing curriculum.
- With the development of both nursing and wound care, skills have become more specialised and less mainstream.
- Nursing has to date been the only profession able to fully specialise in wound care.
- It is necessary to ensure that there is an accessible pathway to wound care education.
- Basic wound care skills should be strengthened for non-specialist nurses.

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