

Building specialist capability: Developing a proficiency-based induction for tissue viability services

Nursing workforce pressures and variation in wound care knowledge create risks within specialist tissue viability services, where gaps between research and practice and limited structured education contribute to inconsistent care. A structured induction was developed for the tissue viability service at Leicestershire Partnership NHS Trust to strengthen practitioner confidence, clinical governance, and safe decision making. A clinical skills set, aligned with national standards, defines essential skills in wound assessment, pressure ulcer categorisation, infection control, lower limb assessment and negative pressure therapy. The induction incorporates supernumerary practice, mentorship, staged proficiency sign-off, reflective learning and integration with electronic patient records. Early outcomes show improved clinical reasoning, safer autonomous practice, enhanced team cohesion, and reduced organisational risk. Ongoing assessment, supervision and audit reinforce accountability and quality. A structured, proficiency-based induction reduces unwarranted variation, strengthens workforce capability and supports safer patient outcomes in complex wound care services.

Anita Kilroy-Findley

Clinical Lead Tissue Viability, Leicestershire Partnership NHS Trust, Leicester, UK

Sylvie Hampton

*Independent Tissue Viability Consultant & Lymphoedema Nurse, Hailsham, UK
Director of Wound Care Consultants Ltd, Wound Care Consultants Ltd, Hailsham, UK*

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- Clinical skills set
- Flexible learning
- Patient safety
- Staff confidence

There is a truism that a well-planned recruitment and selection process helps organisations avoid the challenges of under- or over-staffing, a pressing issue in today's climate of reduced nursing staff numbers. For a specialist tissue viability service, achieving alignment between workforce capacity and capability is even more critical. These services rely on practitioners with advanced knowledge, clinical judgement and specialist wound expertise to support safe patient care across the organisation (Welsh, 2018).

Evidence from wound care literature and national reviews highlights persistent challenges in the field. Wound care practice is frequently undermined by gaps in the evidence base, inconsistencies between evidence and practice, and the persistence of ritualistic approaches (Welsh, 2018; National Wound Care Strategy Programme [NWCSP], 2020). These issues are compounded by limited structured education at both pre- and post-registration levels (Welsh, 2018). In a tissue viability context – where practitioners are expected to provide expert assessment, guide complex clinical decision making, and influence organisational standards – a clear and structured induction is not merely a formality, it is a patient safety intervention in its own right. Without this

preparation, risks to patients, staff confidence and organisational governance multiply.

A well-designed induction creates a shared foundation of specialist knowledge, clinical standards and expectations (Workplace Emergency Management, 2025). It ensures that practitioners entering a tissue viability role – whether new to the specialty, newly promoted or expanding their responsibilities – develop the competence and confidence required to work safely and effectively (Cem, 2024).

The transition into tissue viability can be exciting, but also challenging, given the complexity of wound presentations, the breadth of advisory responsibilities and the need to navigate multiple clinical pathways and services. Regardless of the circumstances, a robust clinical induction is essential to ensure that practitioners develop the competence and confidence required to undertake the role safely and effectively, and the skills to respond to new challenges as they arise (Cem, 2024).

Induction, or onboarding, is a structured process that welcomes practitioners into a new role, supports patient safety, enhances staff experience and improves retention. It provides clear guidance on how the role functions and what will be expected of the practitioner. For tissue viability teams, induction must also orient staff to organisational policies, wound care

pathways, escalation routes and governance frameworks. This reduces errors, enhances productivity and strengthens continuity of care. It also introduces practitioners to specialist equipment, formulary dressings, digital wound imaging systems and processes for pressure ulcer reporting, investigation and audit. A well-planned and supportive induction not only ensures safe and effective patient care, but also fosters stronger team relationships and contributes to higher levels of job satisfaction and improved performance (Akinlotan, 2024).

Neglecting induction leaves practitioners unfamiliar with essential systems and processes, such as which dressings are available, how to access negative pressure therapy, where to obtain pressure ulcer prevention equipment, how to escalate deteriorating wounds, and how to deliver safe care while adhering to organisational policies. The Health Services Safety Investigations Body (HSSIB) highlights that such gaps pose direct risks to patient safety.

Although there is no legal requirement to provide an induction, a structured programme helps staff settle into their role, understand expectations, and integrate into the team (National Induction Framework, 2025). This is particularly important in tissue viability, where retention is vital to maintaining continuity, expertise, and organisational wound care leadership (Walker Schmidt et al, 2022).

Having supernumerary time at the start of the role and being supported by a buddy, is essential. In a tissue viability service, this enables new practitioners to shadow complex wound assessments, observe holistic prioritisation, understand when electronic advice is appropriate and gain insight into the wider responsibilities of the role. While staffing pressures may challenge this ideal, the value of protected supernumerary time cannot be overstated (NHS England, 2022). The risk of erroneous advice leading to patient harm should not be underestimated in a specialist service.

Development of a tissue viability induction programme

Despite the widespread use of induction programmes, little research has focused on the specific onboarding practices organisations use or their effectiveness in supporting newcomer adjustment (Klein et al, 2015). To begin addressing this gap, the tissue viability team at Leicestershire Partnership NHS Trust (LPT) developed a structured, evidence-informed induction programme tailored to the unique demands of their specialist wound care service. This programme aims to strengthen

practitioner confidence, reduce unwarranted variation and enhance patient safety across the organisation.

Drive for change

LPT offers a standard 90-day induction for new starters in the tissue viability team, covering Trust policy and procedures, local building induction, team induction, wellbeing resources and StaffNet. Included in this period is a personalised induction to a team's individual area, be it clinical or non clinical; for example, understanding the team administrator role and how they support patient flow through the service.

Previously, induction to the tissue viability team was not robust; although it encompassed shadowing, supervised practice, and visits to different clinical areas, it did not include a skills assessment to evidence safety to practise within a specialist team. This increased the risk of patient harm through inaccurate advice and potential litigation because of errors (NHS Resolution, 2021; HSSIB, 2023).

In June 2025, the LPT tissue viability team was expecting three Band 5 new starters, a Band 5 in the team acting up as a band 6, and a Band 6 secondment. This was the catalyst for a review of induction to the team and development of a clinical skills set (CSS) covering key proficiencies required of a team member.

Development of the CSS

The eight areas identified as core skills required of a Band 6 Tissue Viability Nurse (TVN) and a Band 5 wound care nurse align with national standards for:

- Wound assessment.
- Pressure ulcer categorisation.
- Topical negative pressure.
- Infection control.
- Dressings and product selection.
- Lower limb assessment and compression.
- Biofilm-based wound management.
- Mental capacity legislation and application.

Expected levels of knowledge are congruent with banding and service specification.

Each required skill can be achieved through the learning style favoured by the new starter [Table 1]. Learning is aimed at ensuring patient safety, supporting clinicians, meeting documentation standards, evidencing an ability to link theory to practice, and demonstrating an ability to work independently – all relevant to local implementation of the seven pillars of clinical governance (Scally and Donaldson, 1998; NHS England, 2023). Assessment for each element is verbal, practical or simulated. For

Table 1. Adult learning theories.

Theory	Key concepts
Transformative learning (Mezirow, 1991)	Critical reflection of one's own previously held beliefs and experiences that can reshape future practice; often facilitated through clinical supervision.
Experiential learning (Kolb, 1984)	A continuous cycle of development incorporating practice, reflection, theoretical knowledge and its application.
Self-directed learning (Knowles, 1975)	Personal accountability for identifying learning needs, seeking the knowledge, supervised practice and evaluation.
Social learning (Bandura, 1985)	Learning through observation of others, modelling behaviours, and shared experiences, i.e. shadowing.

relevant skills, actions to achieve include an understanding of escalation from a clinical and operational perspective, which supports professional ownership and accountability, as well as patient safety (Nursing and Midwifery Council [NMC], 2018).

Implementation

The proposed service specific induction was presented to and approved by the LPT Community Health Services senior clinical team (comprising multidisciplinary lead clinicians, clinical director and GP liaison), and the Operational Delivery Group (comprising transformation and governance leads, in addition to service leads).

Most new starters to the LPT tissue viability team are recruited from community nursing and have a grounding in wound care, both from experience and attending relevant study days. However, evidence suggests that wound care knowledge among nurses is highly variable and often insufficient without structured support (Welsh, 2018), reinforcing the need for a robust induction. Benner's novice to expert theory places most new starters to the team as moving from 'competent' or 'proficient' in the community to 'advanced beginner' or 'competent' in tissue viability (Benner, 1984, cited in Logan 2025). Although these may be construed as retrospective steps, it recognises the need to develop tissue viability clinical reasoning at an enhanced level compared to a generic community nurse.

On commencement in post, each new starter meets with a clinical lead to review the CSS, identify skills the starter feels they already have, their focus for the next 4 weeks, and personal responsibility for meeting the required skills. It is important at this meeting to identify any reasonable adjustments required to support them in their job, including learning and assessments for new starters (NMC, 2019). Suggested opportunities, support for self-directed learning, provision of resources, reassurance of expectations and monthly

reviews for their 3 month induction period are all discussed at this meeting. Additionally, a copy of the CSS is given for reference (and after each review). For the period of their induction the new starter is supernumerary, which is important in ensuring protected time for effective learning (NMC, 2018; NHS England, 2022).

Ongoing review and assessment

Patient safety and quality care is underpinned through the clinical governance process, which has been a central principle of NHS quality improvement since its introduction (Zahir, 2001; Black, 2010; Macfarlane, 2019).

At their first and second monthly review there is an opportunity to demonstrate key learning and proficiency to support 'sign off' in part of a particular skill, with actions to complete the rest. For example, previous work experience may mean sign off for navigation and completion of a full wound assessment (FWA), but further reading may be required to understand how identified co morbidities can delay healing and where that fits in their clinical practice [Box 1].

There is also an opportunity at these meetings to reflect on learning experiences, explore challenging situations, and agree next steps to focus on. Once the new starter begins to document supervised visits on the electronic patient record, SystmOne (S1), the TVN who supported the visit will review their record keeping, highlighting any areas for improvement (as per NMC and team-specific standards). This is assessed as part of the team quarterly record keeping audit: including key parts of FWA completion, risk assessment and communication; feedback is contemporaneous and the audit is repeated the following quarter.

Additional taught programmes are available for mandated subjects – Mental Capacity Act, pressure ulcer prevention and infection control. If not done prior to employment, completion of tissue viability study days in wound care and lower limb management are included as

Box 1. Wound assessment proficiency

Required skill	Actions to achieve
Accurate completion of a full wound assessment (FWA), and understanding of key associated concepts, i.e. factors affecting healing.	- Review SI FWA template: identify presets, how to document additional wounds, where to find important information relating to the FWA, and discuss with mentor/lead any areas you are not sure of. - Liaise with clinical lead for record keeping good practice examples, from record-keeping audit. Review these and discuss with mentor what you thought was good/bad about them, and what you will take forward to your own practice. - With your mentor/lead, discuss your understanding of clinical infection markers, what your treatment options are, and when you would escalate. - Review 10 wound pictures/cases with your mentor/lead, identifying which ones are infected/potentially infected, and your rationales. Discuss the dressings you would prescribe with rationales. - Identify four common physical health problems and outline to your mentor/Lead what effect they may have on wound healing. - Identify four common drugs and outline to your mentor/lead what effect they may have on wound healing. - Explain to your mentor/Lead what factors you will consider when deciding a treatment plan.

Box 2. Assessment methods.

Verbal

- Verbal assessment at monthly skills review with B7.

Practical

- Practical assessment using photographs from patient referrals and teaching packs.
- Practical assessment with TVNs during clinical visits.

Case-based/simulated assessment

- Practical assessment using case studies.
- Completion of MCA/best interests templates relating to two case studies
- Supervised assessment of referral processing and advice.

part of their induction. These provide a base to build on and are included as actions in the CSS. Individual team members have strengths in varying practice areas; new starters are advised of this and team members are aware of the value of their contribution in enabling development. This inclusive approach supports a positive learning culture (NMC, 2019).

All elements of the CSS can be assessed and full sign off achieved at any stage of the new starter's induction. This supports service need as well as validating their progress within the team (NHS England, 2024). For example, waiting list management and clinical triage are key parts of both a TVN and wound care nurse role. If sign off has been achieved in pressure ulcer categorisation and management, a new starter could provide electronic advice/book a visit for those referrals on the waiting list, while continuing to learn about clinical triage.

This flexible approach is important for maximising team productivity whilst inducting a new starter: increasing role proficiency enables reduced supervision and supports autonomous practice (NMC, 2019). Measuring progression in core skills at review meetings is done through reflection and case discussion from both clinical visits and clinical photographs/information related to specific skills areas (i.e. infection recognition, lower limb pathway

and MCA). Clinical supervision is offered on any element the new starter finds particularly challenging; to date this has always been for MCA.

Assessing critical thinking and its application to clinical reasoning in tissue viability is threaded throughout the sign-off process for each core skill. As the new starter progresses through their induction, their chosen learning styles are utilised to explore why a clinical decision has been made, what interventions may be appropriate and what projected patient outcomes are anticipated, providing an opportunity to demonstrate their ability to link theory to practice (Simmons et al, 2011; Levett Jones, 2018; Morgan et al, 2025). Development of band-appropriate clinical reasoning is essential in assuring clinically safe practice and positive patient outcomes (Diamond-Fox and Bone, 2021).

Final CSS sign off involves a variety of approaches [Box 2] and includes a reflective discussion with the new starter on further learning to progress skills, e.g. tissue viability leading change framework (Ousey et al, 2016). Although it can be argued that the use of photographs for infection recognition, pressure ulcer categorisation, and lower limb assessment is subjective, accurate assessment of up-to-date photographs at clinical triage

and waiting list management is fundamental in prioritising referrals and maintaining patient safety (Beeckman et al, 2019; WUWHS, 2020; Murphy et al, 2006).

Where a new starter has achieved the majority of the core skills, but still has isolated elements to be signed off, an action plan to achieve that element is agreed, with review and sign off within 6 weeks at their 1:1. Should a new starter not achieve most of the clinical skills required for sign off, despite guided support and additional opportunities – and providing there are no mitigating circumstances or health concerns – the LPT Performance and Conduct policy is triggered. This is an important aspect of clinical governance and professional accountability (Scully and Donaldson, 1998; NMC, 2018; NHS England, 2023).

Challenges and learning

Implementation challenges were two fold: the number of new starters requiring TVN support to develop core skills, and the limited clinical lead time available to complete monthly reviews. To manage this, we incorporated group supervision, rotational, self-directed and social learning – approaches that all new starters identified as effective – alongside experiential learning during TVN-supported visits.

The two clinical leads are reviewing the assessment and sign-off processes in light of learning from this cohort. For example, some skills may be signed off by experienced team members rather than exclusively by a clinical lead. Feedback has been consistently positive: new starters reported feeling supported throughout, recognised the lifelong learning required in tissue viability, and valued the investment in their development. Effective onboarding is known to enhance engagement and retention, and this was reflected in the team's experience. Existing team members felt the process better equipped new starters, prompted reflection on their own knowledge, and reinforced their confidence in their expertise.

Further refinement of the CSS template is planned, including the addition of sections for transferred skills, more detailed action boxes, and pre/post confidence scoring for each core skill.

Conclusion

Commencing a new role within a specialist tissue viability service inevitably brings a period of adjustment, whether the practitioner is entering the specialty for the first time, progressing within it or expanding their responsibilities. A structured and supportive induction is essential to ensure that

practitioners gain the specialist knowledge, clinical reasoning skills and confidence required to deliver safe and effective wound care.

The induction programme developed by the Tissue Viability Service at Leicestershire Partnership NHS Trust provides this foundation. It introduces staff to organisational and local systems, wound care governance processes, specialist equipment, and clinical expectations, while supporting their integration into the team. In doing so, it strengthens practitioner competence, enhances patient safety, aligns with competency-based frameworks, and contributes to improved outcomes across the organisation.

Induction is far more than a formality; it is a fundamental component of safe practice and workforce development, particularly within specialist services, such as tissue viability. By incorporating supervised practice, reflective learning, photographic assessment, and staged sign-off, the new induction supports the development of autonomous, accountable practitioners capable of delivering evidence-based tissue viability advice. This approach protects patients, reduces organisational risk, strengthens team cohesion, enhances staff satisfaction and supports long-term retention. ●

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