

The link nurse ideology and issues of competency

The two tissue viability nurses at the Newcastle-upon-Tyne Hospitals NHS Trust had responsibility for over 2000 acute beds and needed a way to disseminate knowledge to clinical staff to improve referral appropriateness. A new link nurse system was adopted in order to empower link nurses, and ultimately, their colleagues. The Trust now has over 70 active link nurses whose competency in tissue viability is closely monitored, and whose teaching is tailored to meet individual need. The link nurse study days have been validated by Northumbria University and link nurses can now gain accreditation for their role.

Fania Pagnamenta

KEY WORDS

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Nurses need to provide a good standard of care based on up-to-date information, and have a responsibility to update their practice (NMC, 2002). This can be difficult because of both time constraints and the speed with which theory and practice change. It is, therefore, important that as new developments arise, the practice of ward-based nurses is updated accordingly.

To assist this process, link nurse schemes have been developed. Link nurses have been defined as practising nurses with an expressed interest in a speciality, with formal links to specialist staff, such as clinical nurses specialists (MacArthur, 1998). The link nurse role involves attending meetings to discuss ideas and new developments, and relaying the findings to other nurses in the ward to improve their practice.

Fania Pagnamenta is Tissue Viability Nurse, Newcastle-upon-Tyne Hospitals NHS Trust, Newcastle-upon-Tyne

Flanagan (1996) explained that tissue viability link nursing networks are a frequently used and effective method of disseminating research findings in the clinical setting. Despite an increasing volume of research evidence, it is well documented that this information only rarely informs professional practice (Collins and Robinson, 1996). As a result, considerable attention has been given to methods of promoting the development of evidence-based practice within the NHS (Department of Health, 1995).

There are many practices in the area of tissue viability that are still based on tradition, myth and ritual, rather than supported by good research-based evidence (Hill, 1996). While some of this tradition is accepted as good practice, this is not always the case and, as a consequence, can be costly both in terms of financial and personal outcomes. Morrison (1995) believes that nurses still have a lack of basic wound management knowledge, for example, they neither understand the process of wound healing, nor have the ability to differentiate between slough and pus. In a more recent study, Mockridge and Anthony (1999) found that while there was an improvement in wound care knowledge, there was still room for further progress.

The link nurse system has an advantage in that it can facilitate the education

of ward nurses in all relevant wound care developments. There is a wealth of literature published every month in the nursing press, however, clinical staff don't always have the time to sieve through all the information available to find the aspects relevant to clinical practice. Tissue viability teams in some trusts, the Newcastle-upon-Tyne Hospitals NHS Trust included, have assumed the responsibility of finding this relevant information and ensuring that it is passed on to the link group.

Criticism of link nurse systems in wound care

There have been many criticisms of link nurse systems in wound care, the main one being that the time and cost of training ward nurses into becoming effective link nurses is time spent absent from the ward and, consequently, away from the patient (Tinley, 2000). Charalambus (1995) commented that due to financial constraints within the reformed NHS, many managers now place more emphasis on cost-effectiveness, which means that nursing time spent away from the patient while training has to be taken into account. Managers often question if the role of the link nurse is worthwhile as taking nurses away from the ward can be costly in terms of temporarily replacing that nurse and/or paying for the study. Managers may be concerned that the link nurse system means time spent away from the patient, but they should remember that this is time

spent acquiring and learning new skills and updating knowledge. All of which, ultimately, will lead to an improvement in care.

Morrison (1995) highlighted that failure to treat wounds effectively with evidence-based knowledge can have detrimental consequences for the patient. These include delayed healing, leading to an extended period in hospital, with the obvious financial implications as well as social costs to the patient and their family that this incurs. The availability of better information for hospital managers as to what a link nurse system entails may help alter attitudes and further demonstrate that link nurses have a positive and important role to play. After all, it is the clinical setting where tissue viability link nurses have to prove to managers that they are an asset.

The Newcastle-upon-Tyne Hospitals NHS Trust system

The tissue viability team at the Newcastle-upon-Tyne NHS Trust consists of two tissue viability nurses (one post currently vacant) working in one of the largest acute trusts in the UK. The Trust has in excess of 87 in-patient wards, and multiple clinical areas where tissue viability skills are required, such as theatres, outpatient clinics and day treatment centres.

With responsibility for over 2000 acute beds spread over four sites across the city, the tissue viability team desperately needed a way of developing knowledge among clinical staff to improve referral appropriateness.

A link nurse scheme was in existence, with the tissue viability nurses and link nurses meeting once a month when feasible. Unfortunately, attendance at the link nurse meetings was dropping month by month to a handful of people with a specialist interest in tissue viability. Guest speakers were booked for few attendees and the team felt that, in essence, they were 'preaching to the converted'. It was concluded that a new approach was essential if the scheme was to survive.

The launch of the new scheme

The new scheme was launched in January 2003, with the first edition of the *Happy Maggot*, a quarterly newsletter written by the tissue viability team to disseminate information about current tissue viability practice. Over 200 copies of this newsletter were distributed to all clinical areas, including theatres and outpatients, inviting a nurse with a special interest in tissue viability from each ward to join the scheme. This generated a response from approximately 40 link nurses. This

was followed by a global e-mail where a further 20 link nurses were recruited.

It was decided that on recruitment, the link nurse, the ward manager, the matron and the tissue viability nurse would sign a professional agreement or contract. The contract constitutes a new approach to the link nurse scheme and formally stipulates that the link nurse will attend 2 study days per year, and then disseminate the knowledge that they have acquired. Conversely, the ward manager is contracted to support the link nurse's enthusiasm and attendance to the scheme activities with effective off-duty planning. It is recognised that nurses have problems attending meetings owing to clinical pressures, unforeseen workload, duty rotas and holidays (Charalambus, 1995; Ibbotson, 1999).

The personal link nurse action plan

Once the idea of the professional agreement was finalised, a personal action plan for each link nurse was formulated, which would steer their personal learning and ensure that the duties of the link nurse were fulfilled throughout the year (Tables 1 and 2). In the first year, for example, the link nurse is asked to review all the dressings used on his/her ward and to rationalise the dressings stock used in

Table 1

The personal link nurse action plan: year 1

Action	Rationale	Support required	Evaluation: TVN comments
<p>The tissue viability link nurse will:</p> <p>Read the new edition of the <i>Wound Management Formulary 2003</i></p> <p>Review all dressings used on his/her ward/unit</p> <p>Rationalise dressing usage</p> <p>Organise any required changes to top-up system</p> <p>Continually evaluate dressing requirements</p>	<p>To rationalise all dressings used on the ward</p> <p>To improve patient outcomes</p> <p>To provide cost- and clinically-effective wound care</p>	<p>Support is required by:</p> <p>Ward manager</p> <p>Materials</p> <p>Management</p> <p>Tissue viability team</p> <p>Modern matron</p>	
<p>The tissue viability link nurse will:</p> <p>Critically read all information contained in delegate file</p> <p>Discuss new information with ward team</p> <p>Refer and assist colleagues in the referral of patients to tissue viability team</p> <p>Strive to continue to update knowledge with regard to tissue viability</p> <p>Update files when new information arrives</p>	<p>To ensure that:</p> <p>Information is shared among ward colleagues</p> <p>Dressings are used correctly and cost-effectively</p> <p>Therapy beds and mattresses are ordered, used and cancelled appropriately</p> <p>Referral to tissue viability team is appropriate</p>	<p>Support is required from:</p> <p>Ward manager</p> <p>Ward colleagues</p> <p>Tissue viability team</p> <p>Modern matron</p>	

Table 2

The personal link nurse action plan: year 2

Action	How met	Data completed	Evidence	Reference number in portfolio
The tissue viability link nurse will: Read and understand new literature given during the 2-day study block				
Complete the prevention of pressure ulcers self-assessment training pack				
Evaluate a new product, suitable for his/her clinical area in preparation for the review of the Trust Wound Management Formulary				
Support his/her clinical area in the introduction of the wound assessment, intervention and evaluation care plan				
Compile a personal professional plan in relation to tissue viability				

Table 3

Year 1 and 2 study days programme

	Day 1	Day 2
Year 1	Tissue viability nurse's role Wound assessment and wound bed preparation Pad formulary (continence advisor) Empowerment, team building and change management Formulary*	Skin assessment Therapy beds update Clinical concepts of seating Group work on trust-wide issues relating to tissue viability
Year 2	Silver debate Promoting continence Wound assessment Formulary* Evaluation/Group work	Diabetic foot Venous leg ulcers Burns and plastics Pressure ulcer risk assessment University: recognition through portfolio Personal professional plan in relation to tissue viability

*20 mins for each company representative to discuss a product in the Trust's formulary

their clinical area (Table 1). The tissue viability team is often frustrated by the inappropriate levels of stock available on wards. For example, despite the fact that 10cmx20cm sized dressings are available for post-operative wounds, wards continued to use two 10cmx10cm sized dressings, a more expensive option. During the second year (Table 2), the link nurse is asked to assist the tissue viability team in the

evaluation of dressings for inclusion in the Trust's *Wound Management Formulary*, which is due to be updated in 2006.

Additionally, the link nurse also has responsibility for a yearly project. Tinley (2000) suggested, for example, the development of teaching packs, producing poster displays, promoting to other hospital staff what tissue viability

entails, and becoming involved in trials of new equipment and products.

The study days programme

The study days programme is an ongoing scheme which is different in content each year so that tissue viability practice is continually updated. At the first study days following the launch of the scheme (Table 3), the role of the tissue viability nurse was discussed to raise awareness of the team's workload. Even in the literature there is a gross misinterpretation of the tissue viability nurse's role: for example, Cave (1998) believes that specialist nurses (and he specifically quoted tissue viability nurses) were guilty of just wasting time.

A large pink A4 file was compiled, including articles on current tissue viability issues and information about the team, referral criteria, and the personal link nurse action plan. The file was given as a resource to all link nurses and their wards. The responsibility for keeping it up-to-date lies with the link nurses themselves, with guidance from the team: new information is sent to each member directly with instructions about inclusion in, or removal from, the file at regular intervals throughout the year. ➤

The link nurse as an educator

The role of the tissue viability link nurse was also discussed during the study days, as the link nurse must be fully aware of what is expected of them. The role of the tissue viability clinical nurse specialist and the link nurse are closely interlinked. From a workload point of view, it would be impossible for a specialist nurse to assess and plan the care of individual patients, along with the other responsibilities of being staff advocate, practitioner, educator, consultant, researcher, and change agent (Storr, 1988).

The role of the link nurse as an educator and source of reference is fundamental (Teare, 1998). The role for the link nurse must be considered seriously: the individual must have a minimum background knowledge to be effective, and they must be a keen, enthusiastic, motivated volunteer with a special interest in tissue viability (Charalambus, 1995).

In the Newcastle-upon-Tyne Hospitals NHS Trust, the tissue viability team need to educate all ward staff so that they are able to assess and plan the care of patients who require tissue viability care. This is an onerous task with 5000 nursing staff being just one component of the multidisciplinary team. The role of the link nurse is to assist the tissue viability team in disseminating such knowledge, not just to nurses in clinical areas, but also across the healthcare teams, such as medical and other professions allied to medicine. Both Powell (1995) and Smith (1996) explained that the primary function of link nurses was to be a ward resource of knowledge on wound care, to implement the wound care and prevention policies of the trust at ward level, and to collect audit data. The role also develops the individual professionally, serving as a first step towards clinical specialisation in wound care.

Teare (1998) observed that one of the main drawbacks of his link nurse system was the way in which all the speciality matters (in his case, infection control) would be concentrated on the link nurses; colleagues taking the view that it was not their concern. Deskillng other ward nurses on the ward and reducing

their responsibility can be avoided if the link nurse is recognised as an educator, providing regular teaching sessions and resource files. As Charalambus (1995) suggested, a good link nurse takes responsibility for passing on information to other nursing colleagues. Ching (1990) believed that the knowledge imparted by a competent link nurse can motivate ward staff. In reality, it is acknowledged that there is no way of ensuring that increased motivation takes place, or that there is an easy way of evaluating motivation *per se*.

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The issue of competence

A crucial consideration when setting up a link nurse project is the issue of assessing competence. The question of how competent a link nurse will have to be to perform their role in tissue viability, has not yet been answered in the literature. Furthermore, ensuring that adequate standards are achieved (and are maintained) is also important, as the tissue viability team is ultimately responsible for the education and training of the link nurses.

Marshall and Luffingham (1998) believed that greater role definition would be achieved through the introduction of core competencies, such as the ones introduced in their Trust and supported, more recently, by the *Government in Agenda for Change* (Department of Health, 2003). Benner (1984) identified five levels of competencies in nursing:

- ▶▶ The novice
- ▶▶ Advanced beginner
- ▶▶ Competent
- ▶▶ Proficient
- ▶▶ Expert.

The expert nurse will take nursing practice forward to an advanced level.

Benner's expert nurse is able to assess and act upon a patient's condition, diagnose and intervene, thereby reducing the need for direct clinician involvement. His definition of an expert nurse's skills equates with those of specialist practice, such as expertise, research, education, experience, and consultation (Hamric and Spross, 1983), which are also described and incorporated in the *Continuing Professional Development Portfolio* developed by the National Association of Tissue Viability Nurse Specialists (Scotland) (2002). This list is not exhaustive and has since been updated. For instance, Fenton (1985) added the competency of leadership. Leadership skills are essential to the specialist nurse. A link nurse should work at a competent to proficient level, and have the relevant competence to practice at that level.

Competence and competencies are job-related, being a description of an action, behaviours or outcome that a person should demonstrate in their performance. Competency and competencies, on the other hand, are person-orientated, referring to the person's underlying characteristics and qualities that lead to an effective and/or superior performance in a job. According to Woodruffe (1993), competence is an aspect of the job that an individual can perform, while competency is an individual's behaviour underpinning competent performance.

A theoretical framework

Short (1984) devised the following normative conceptualisations of competence, which form the basis for the various contemporary approaches to competence:

- ▶▶ Performance may be measured for competence regarding specific behaviours (behavioural or performance approach)
- ▶▶ Competence may be seen as indicative of a degree of capability deemed sufficient in a particular activity (generic approach)
- ▶▶ A holistic conceptualisation of competency, which includes knowledge, skills, attitudes, performances and levels of sufficiency (holistic approach).

In the behavioural or performance approach, competence is seen as a ▶▶

Key Points

- ▶▶ Nurses need to provide a good standard of care and are responsible for updating their practice.
- ▶▶ Link nurses are practising nurses with an expressed interest in a speciality, with formal links to specialist staff.
- ▶▶ A link nurse scheme was developed at the Newcastle-upon-Tyne Hospitals NHS Trust in an attempt to improve referral appropriateness to, and reduce the workload of, the tissue viability team.
- ▶▶ The scheme is now almost in its third year, has over 70 active link nurses, and has succeeded in improving referral appropriateness.
- ▶▶ The link nurse study days have been validated by the local university and the nurses can gain accreditation for their role.

description of an action, behaviour or outcome in a form that is capable of demonstration, observation and assessment. Competence is usually defined as something a person is, or should be able to do (Mansfield and Mitchell, 1996). Its focus is more on performance than on knowledge, and it is more concerned with what people can do rather than what they know. Performance criteria provide an assessor with statements on which judgements about an individual's ability to perform a specified activity to an acceptable level can be made (Manley and Garbett, 2000). Criticisms of the behavioural approach centre on a number of points, as described by Ashworth and Morrison (1991):

- ▶▶ Transferability of competence: relying on a performance approach to assess professional competence gives no guarantee that an individual will perform appropriately in a variety of contexts (Norris, 1991)
- ▶▶ Competence is fragmented: element

of competence fragment the role. Focusing on tasks and skills is reductionist, ignoring underlying attributes and the complexity of performance in the world of practice (Manley and Garbett, 2000).

- ▶▶ Technical skills are emphasised at the expense of knowledge and understanding. The approach fails to measure the underlying cognitive and affective skills that are needed for effective practice, and to analyse and assess critical thinking skills (Le Var, 1996; Lillyman, 1998).

Competency in practice

A list of pre-specified skills that have to be ticked off to show that competence has been achieved doesn't solve the difficulty of ensuring inter-observer reliability and consistency of interpretation, all compounded by the context of the assessment (Somers-Smith and Race, 1997). The alternative approach (Philips and Bharj, 1996) is to take the subjectivity of assessor perceptions into account, so that the assessment of competence can be regarded as both valid (because it is context-sensitive and involves the judgement of experienced practitioners and teachers) and reliable.

The assessment of the competency of the link nurses must therefore be holistic; it must contain a mixture of different types of assessment. Nurses at the Newcastle-upon-Tyne Hospitals NHS Trust are assessed on a ticked-off list for certain competencies, such as:

- ▶▶ Total negative pressure (vacuum assisted closure; VAC) training
- ▶▶ Maggot therapy
- ▶▶ Nail cutting
- ▶▶ Pressure ulcer prevention
- ▶▶ Pressure ulcer management,

with the understanding that this would give them a basic knowledge and ability to perform a straight-forward VAC dressing, apply larvae, or understand issues surrounding pressure ulcer prevention and management, with expert guidance from the tissue viability team.

All practical competencies have a relevant training pack for information

and reference (available at the study days or permanently on the Trust's intranet).

Competency as a continuum

It is expected that knowledge, values, attitudes, performance, and the general wound skills of link nurses will be assessed within the yearly context of the IPR (individual performance review) by their managers. This will evidenciate the current developmental needs of the tissue viability link nurse, as well as the support and continuing education requirements. A plan of action to move their practice forward will, therefore, be formulated on a yearly basis for the individual link nurse.

It is acknowledged that there are difficulties associated with preparing different action plans for different staff in terms of time constraints, personal aptitudes and clinical area needs. Furthermore, the manager's knowledge of tissue viability will be infinitely variable and ensuring a certain level of competency will prove difficult. The tissue viability team will assist with education to support the ward manager and the link nurse to fulfil their needs where support is asked for or is blatantly required. Due to work pressure, the team will not be able to support all areas and a certain amount of trust in the manager's ability to successfully perform the IPR will have to be taken for granted. The tissue viability team also performs a yearly review.

It is also acknowledged that, at times, there will be a certain level of conflict between link nurses and their manager and/or other staff groups when working through their action plan. For example, in year one it is requested that link nurses look at their stock of dressings to ensure that their ward has the most appropriate dressings for their patients' needs: this can put them in direct conflict with their ward manager who holds the budget. Link nurses must be equipped with the relevant knowledge to ensure that they can formulate a good evidence-based argument to make the required changes.

Link nurses are from different clinical grading (from D to F), and may not have conflict management skills. They have been encouraged to seek assistance from the tissue viability team to make the necessary changes in their clinical areas if conflict in their work environment arises and assistance is required.

Achievements and future plans

The link nurse scheme is now almost in its third year, and has over 70 link nurses with a special interest in tissue viability; they are recognised in the Trust and their names appear on the tissue viability site on the Trust's intranet. Furthermore, link nurses are now able to get academic recognition for their role in the link system through the University of Northumbria. Link nurses have to submit a portfolio, demonstrating knowledge gained at the compulsory study days and its application in practice. This 'module' offers 10–20 points towards a diploma or degree and, while it is in the early stages, a few link nurses have already successfully gained accreditation: more are expected to take the module in the next academic year.

Conclusion

The introduction of a link nurse system in the Newcastle-upon-Tyne Hospitals NHS Trust has proved invaluable. Link nurses have to sign a professional contract to ensure that they will attend a compulsory 2-day study block per year. They are assessed on a tick-off list of skills, as well as on tissue viability knowledge, values and attitudes. They can submit a portfolio and gain accreditation from the local university.

It will prove extremely difficult to audit the impact link nurses have in their clinical areas; however, it is clear that anecdotally the team's workload has decreased dramatically, referrals are more appropriate and link nurses provide a good degree of cascade training. This is especially true as since January 2005 the tissue viability 'team' consists of just one clinical nurse specialist who would not have been able to provide an effective service

without the help, assistance, and competency of the tissue viability link nurses. **WUK**

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