Correspondence

The important role of the health care assistant in pressure ulcer prevention

Dear Sir,
I believe that with regard to tissue viability we are in danger of ignoring a vital group in health care; the healthcare assistant. By the very nature of their practical role, healthcare assistants are ideally placed to be at the forefront of pressure ulcer prevention. Most healthcare assistants spend their time delivering the most intimate care for patients, i.e. washing, toileting, skin care, transferring from bed/chair, mobilisation, etc. Surely we need to highlight the valuable role and essential service they provide, and integrate this into ward-based strategy for pressure ulcer prevention?

I have organised a 2-day workshop for healthcare assistants emphasising all aspects of pressure ulcer prevention, at the end of which I hope to have equipped them with the knowledge to enable them to perform pressure ulcer risk assessment, nutritional assessment and simple or non-cavity wound care. Following the workshop, the healthcare assistant completes a workbook and a set of competencies to demonstrate their ability. I must emphasise that the health care assistants are continually reminded that they do not work in isolation, but within a team, and must always report their assessments to the nurse in charge.

I am aware that some of my colleagues within tissue viability may criticise this venture as some feel that a healthcare assistant should not be involved with assessment. Frankly, I feel that those healthcare assistants who successfully complete the workshop and demonstrate competency, are able to show an ability which I am afraid some registered nurses cannot. In my experience, few registered nurses are interested in attending pressure ulcer prevention study days, whether this is due to apathy, lack of interest, or because they feel that this is knowledge that they should already have acquired, I am unsure.

I read with interest and empathy the letter 'Practical guidance in tissue viability is needed for student nurses' (*Wounds UK* 1(1): 93) regarding the poor knowledge of tissue viability among nursing students. Mrs Wickham called for 'practical guidance on core competencies essential to carry out evidence-based care', and I concur wholeheartedly, but I would add, let us not forget the healthcare assistant.

Nursing has always been essentially a practical profession, and the healthcare assistant has a practical role. I would argue that the fundamentals of patient care, good skin care, nutrition and pressure ulcer prevention are part of every nurses responsibility, but there is a logical position of care for the healthcare assistant which needs to be recognised and developed to gain the best from this important group of workers.

Pauline Beldon, Tissue Viability Nurse Consultant, Surrey

The difficulty of transferring theory into practice

Dear Sir,
After reading Margaret Wickham's letter 'Practical guidance is needed for student nurses' (*Wounds UK* 1(1): 93), I believe the problem seems to be with the mentors feeling confident in their own skills. This issue I do find worrying, but unfortunately not surprising, having reviewed various items of documentation in many Trusts. I personally feel that all nurses should have the skills to assess a wound and pressure ulcer risk, and devise a management plan, and lastly, be aware of when a patient needs referring for specialist input.

These are core skills, but from Ms Wickham's comments and many others' findings in practice, perhaps we do need to look at competency in relation to these perceived 'basic' tissue viability skills in order to drive standards upwards. I know competencies are being developed for healthcare assistants; perhaps development or use of the same competencies as a start is needed. This is extremely important if we are to support our students in their clinical placements. The students, certainly within my own university, have both theoretical- and skills-related training on aspects of tissue viability in the classroom setting but, in practice, it is to the mentors we look to ensure that the students consolidate the learning through clinical application. The mentors have a responsibility, as all qualified nurses do, to maintain and update their own clinical skills, including those in tissue viability. They also have a responsibility to acknowledge any deficits in their knowledge and take steps to address these if necessary to their sphere of practice.

The acquisition of new knowledge in the area of tissue viability could be said to have never been easier: there is a wealth of published literature; trusts are increasingly employing the services of tissue viability nurse specialists, who as part of their role, have a remit for providing on-going educational sessions for staff within the trusts. Formal education programmes are available at universities around the UK, and for those who find accessing them difficult, distance-learning packages are available.

As for the point raised regarding an independent agency assessing the educational programmes, this would be difficult due to the diverse nature of such programmes. Nurses need to take responsibility for what they attend and, more importantly, what they get out of the programme.

The problem seems to be the age old difficulty of transferring theory into practice; competencies seem at present to be considered the answer to this. The creation of minimum standards which are achievable by all staff coming into contact with potential or actual tissue damage may be the answer, but it will require time, resources and management support in order to achieve this. However, the costs if trusts don't do this could be equally as expensive in the long run, if the problem is perpetuated.

Patricia Davies, Senior Lecturer in Tissue Viability, University of Central England, Birmingham

The use of Doppler ABPI in patients with lymphoedema

Dear Sir,
We were interested to read the article 'LOI: an alternative to Doppler in leg ulcer patients' by Janice Bianchi (*Wounds UK* 1(1): 80–5). Our group of lymphoedema practitioners has recently been considering the issue of arterial assessment in people with lymphoedema before the application of compression. The literature does not provide clear guidance regarding the use of Doppler ABPI or pulse oximtery in lymphoedema, and it is not entirely clear how gross oedema and the presence of fibrosclerotic tissues will affect the results of either test.

Lymphoedema may result from a wide range of cancer and non-cancer-related causes and, as awareness of lymphoedema is growing; patients in which co-existing lymphatic and venous disease is present are increasingly being referred to us. As a group we are aware of the implications of the SIGN guidelines in relation to arterial assessment, and some lymphoedema practitioners routinely use Doppler ABPI in their practice. However, there remain many differences of opinion within our speciality regarding the value of these tests in this patient group, with many practitioners continuing to rely solely on medical history and clinical examination.

The role of Doppler ABPI in people with lymphoedema is a subject for debate at the British Lymphology Conference in Glasgow in October 2005. The Scottish Lymphoedema Practitioners Group is also currently writing a protocol for the use of Doppler ABPI in lymphoedema. We would welcome any thoughts or guidance from other readers regarding this area of practice.

Anne F Williams, Chair and Marie Todd, Deputy Chair, Scottish Lymphoedema Practitioners Group