How far should we extend practice in tissue viability?

The debate this issue examines some of the controversial issues surrounding the future of tissue viability. The increase in complexity of the patients we now treat is leading to the development of treatments which require new skills and will push the boundaries of the specialty. These include sharp debridement and hydrosurgery techniques, a range of new negative pressure devices and the need to improve diagnostics. Wounds UK's clinical skills course — 'Advanced clinical skills for tissue viability practitioners' in Paris in April will provide a new level of tissue viability education, but how far should we go with respect to furthering our skill sets? Should we continue to push the boundaries or should we consolidate the established skills we have? JT

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1. What changes/challenges to practice should tissue viability nurses expect in the coming years?

TY: The changes to practice may take the form of challenges to the role and its autonomy along with the task of providing and developing a service in a climate of ever diminishing resources. The development of the purchaser-provider and the commissioning of services may mean that advanced tissue viability services are not valued or that purchasers will not be prepared to pay for selected elements of care so that the service becomes fragmented. However, help may be at hand as the Department of Health (DoH) (2008) has acknowledged the geographical variations in the quality of care provided. In addition it has identified further challenges to the NHS such as rising expectations; demand driven by demographics; the continuing development of an 'information society'; advances in treatments; the changing nature of disease; and changing expectations of the health workplace. It calls for flexibility in service provision to respond to the needs of local communities.

The challenges for the tissue viability nurse (TVN) may be in providing a service that fulfils the clients' expectations as laid down in the *NHS Constitution for England* (2009) which states: 'You have the right to be given information about your proposed treatment in advance, including any significant risks and any alternative treatments which may be available, and the risks involved in doing nothing. You have the right to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary'.

The issues that have plagued tissue viability nurses for many years, such as the lack of definition of roles, continue to cause challenges for the specialty. The field of tissue viability continues to lack a strong defined identity and is weakened by its lack of recognition as a specialty in its own right. This deprives the field of many of the advantages bestowed on other specialties, such as NHS targets.

RW: One can make 'educated' guesses at answers to this. My response would be partly wishful-thinking, part prediction. TVNs can expect to demonstrate their value to trusts, insofar as they can show what they do, what outcomes they achieve, and, at what cost (as set out by Kath Vowden, 2008). In addition, sharing skills with other staff — something which is already evident — will have to be measured. This will be vital to their continued employment within the NHS, and will serve to forestall moves to provide 'independent' tissue viability services. It might even convince the key medical personnel of the value of tissue viability in achieving clinical outcomes. A prerequisite to all of this is the agreement of what constitutes 'tissue viability'. I would suggest that a broad-based definition be the most appropriate for all concerned. I believe that tissue viability should include such elements as skin care, continence care, lymphoedema, infection control in primary care, ostomy care, as well

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as the usual pressure area and wound care. The reasons for this are that all are intimately linked. Concerted care from the multidisciplinary TVN will improve clinical efficiency for the patient and the NHS. I would advocate something along the lines of the wound ostomy and continence nurse as exists in the USA. Therein lies job security as well!

2. What can be done to meet these challenges?

TY: Tissue viability has to define itself and achieve recognition as a specialism. The case has been made for integration with other areas but that has its limitations (White, 2008). A template for a gold standard service with a definition of minimum service provision should be established to ensure parity of care. Within this template the role and unique contribution of the TVN should be explicit. This may be linked to the primary care trusts' development of social enterprise organisations and new best practice tariffs which will pay for best practice rather than average cost, meaning NHS organisations will need to improve or deliver at a higher level in order to maintain their funding (DoH 2008a).

Quality audits of service may be able to highlight areas of advanced practice and comprehensive service provision. An excellent example of this is the Bradford audit (Vowden and Vowden, 2009). The DoH (2008) will be systematically measuring and publishing information about the quality of care which will include patients' own views on the success of their treatment and the quality of their experiences. There will also be measures of safety and clinical outcomes. All registered healthcare providers working for, or on behalf of, the NHS will be required by law to publish 'Quality Accounts' just as they publish financial accounts.

RW: The first steps have been taken already. Recent publications of audit data are important: these establish the true incidence and prevalence of wounds (which is one measure of demand for tissue viability). Perhaps a national database for wounds with mandatory input would help. Some leading tissue viability experts such as Madeleine Flanagan and Julia Schofield have publicly articulated a desire to engage with medical disciplines such as dermatology. This too will be crucial to the continuation of the specialty. There are negatives, however, as some trusts are still 'afraid' of audit as something that will expose their standards of care. I would like to see increased emphasis on improving pre-registration education in tissue viability.

3. What should advanced practice in tissue viability entail and why?

TY: It should encompass total clinical management of the patient that promotes speedy healing, restoration of function, cosmesis, symptom control and palliative care. To do this the TVN would need advanced diagnostic skills and access to the relevant diagnostic tests. In addition the clinician will require access to referral pathways to enable the client to move between care settings and disciplines when necessary. This would hopefully support the standard treatment of non-complex situations and identify and manage the complex situations either before or as they arise.

RW: So-called 'advanced' practice can only follow the widespread implementation of essential or fundamental standards of care. This has yet to be achieved. The spectrum of tissue viability services provided in the UK varies enormously both in range and quality; it is vital that the dissemination and monitoring of 'best practice' is implemented. Once again, this requires a definition for 'tissue viability' and its scope of practice. For example, TVN admission and discharge rights, freedom to order tests, freedom to cross-refer to other specialties. It is possible that these measures could avoid wounds developing into chronic cases through a lack of urgency and appropriate action. The empowerment of TVNs could overcome these hurdles. A clear research function, especially for nurse consultants, would also raise the profession's profile. The roles of nurse consultants, pre- and post-registration education, research, and multidisciplinary teams all need clarification before embarking on practice advancement.

4. What are the advantages of advancing practice?

TY: All too often TVNs find themselves constrained by time, resources and other limitations which result in a service continuing but not being able to develop. However

there are many excellent examples of advanced practice innovations and this is essential to keep the field progressing, and preventing it from becoming a stagnant entity. Ultimately, improved patient outcomes are the goal of advanced practice and service provision. This is often achieved within models of collaboration such as that demonstrated by the Welsh Wound Network (www.welshwoundnetwork.org).

RW: Advancing practice should mean the enhancement of skills across the spectrum, not to a select few. When appropriate, advancing practice has many advantages notably provision of best practice to all patients, cost-effective care and greater clinical skills. The establishment of formularies, based upon evidence, will help the move to use products efficiently — as will joint formularies between community and hospital trusts. Those involved in tissue viability will see it as 'indispensable', although there are many who remain to be convinced of this.

5. What are the disadvantages of advancing practice?

TY: One argument against advancing practice is a long-standing one of developing the specialism and making it an elite/exclusive domain of the TVN and thus deskilling the general nurse.

It is also easy to lose sight of what is at the core of tissue viability practice and to be seduced by technological advances. For example, a TVN who develops their ability to perform a full vascular assessment at the cost of their bandaging skills, thereby passing on these skills to those less qualified such as the health care assistants. This is an ongoing debate and personally I stand firm with the current position of the Leg Ulcer Forum who do not recommend that HCAs performing compression bandaging.

RW: There are none as far as I am concerned, given my concerns in the previous answer. It is always important to remember the basics; any team is only as strong as its weakest member. It is vital that as tissue viability moves forwards we do not leave other caregivers, such as community and ward nurses, behind. From my non-nursing perspective, I would like to see a greater commitment from the RCN for tissue viability, if only to present the impression of a united front.

6. Would this meet or match up with NHS goals and how?

TY: The DoH (2008b) has identified the need for new national standards for extended, advanced and autonomous roles. They have commissioned an advanced practice report from the Council for Healthcare Regulatory Excellence (CHRE) with a view to producing a consistent definition of advanced practice across the health professions. The report is due for publication in the spring of this year. Therefore advanced tissue viability nurse practice is definitely on the national agenda. Whether the views of the profession on the scope of advanced tissue viability practice will meet those of the DoH is as yet uncertain. In addition, within the Darzi Report (2008) the development of a set of metrics to define and measure the quality of nursing care. The metrics will reflect issues of safety, effectiveness and compassion.

RW: The goals for the NHS are set out in the Darzi report (2008). It is widely acknowledged that many more nurses will be required if the objectives of this report are to be met. While this report makes no direct mention of tissue viability per se (and actually very few mentions of nursing!), it does emphasise 'quality', 'personalisation', and power to clinicians and patients. The 'quality' component will be addressed through the implementation of best practice in tissue viability. About 90% of all health needs in the UK are met by primary care and this shift from secondary to primary care should result in a greater emphasis on tissue viability in the community.

7. What can be done to educate and support advanced practice within tissue viability?

TY: The Department of Health (2008b) states 'taking a pathway approach to nursing careers will better align careers with the full range of the needs of patients and the public, in health and in ill health. This will be supported by an educational framework and will provide a recognised career structure, better flexibility and career mobility. We will consider the best schemes to support nurses' time for, and

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funding of, education and promote equality of access to education'. This is very reassuring and sounds ideal but will it be reality? In certain trusts all study leave has been stopped due to workforce pressures. There is no doubt that educational delivery to meet the needs of advanced TVNs will require an innovative approach. Partnerships will be necessary and all too often TVNs have relied on sources in industry to fund their personal development. How realistic is it that our industrial colleagues will be able to continue the current — or indeed increased — levels of support in these times of economic crisis?

There may be a role for the various charitable organisations to facilitate learning and development through the established conference modes and new innovative developments such as the Tissue Viability Society's website due for launch at the annual conference in April 2009. (The website will be a state of the art educational vehicle and will provide a mechanism for peer support for a group of individuals that often work in isolation; thus facilitating communication and collaboration.)

The DoH (2008a) talks of introducing new responsibilities, funds and prizes to support and reward innovation. Strategic health authorities will have a new legal duty to promote innovation. New funds and prizes will be available to the local NHS which may provide another source of support for advanced practice within tissue viability. Finally, and very importantly, the research agenda has to support the building of evidence upon which practice can advance. An excellent example of this is the recent award from the DoH of £1,999,854 to fund the Pressure Ulcer Programme of Research (PURPOSE).

RW: I think that nurse consultants should take the lead, and, together with representative societies (the Tissue Viability Society, the Wound Care Society and the Leg Ulcer Forum) engage with those universities who run courses in tissue viability to agree educational needs. The same group should also engage with key medical/surgical disciplines such as dermatology, vascular and care of the elderly, to agree a role and scope of practice for tissue viability. I fear that time is running out for tissue viability. Having put great effort into advancing the needs of patients with tissue viability needs over the past 25 years, we now face oblivion for being too insular.

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