

Revisiting the role and responsibilities of the Tissue Viability Nurse

SAMANTHA HOLLOWAY

Reader, Programme Director, Cardiff University School of Medicine, Cardiff

CONTRIBUTORS

KAREN OUSEY (KO)

Professor of Skin Integrity at the Institute of Skin Integrity and Infection Prevention, University of Huddersfield

ZENA MOORE (ZM)

Professor and Head of the School of Nursing and Midwifery, School of Nursing & Midwifery Royal College of Surgeons in Ireland, Dublin, Ireland

ALISON SCHOFIELD (AS)

Tissue Viability Clinical Nurse Specialist, Northern Lincolnshire and Goole NHS Foundation Trust

KIRSTY MAHONEY (KM)

Senior Tissue Viability Nurse and Clinical Operational programme improvement Lead, Welsh Wound Innovation Centre, Welsh Wound Innovation Centre, Pontyclun

On defining 'experts', the seminal work of Benner (1984) proposed that the key characteristics of expert practice were having in-depth knowledge and higher levels of clinical judgement. With regard to Tissue Viability Nurse Specialists (TVNSs), Flanagan (1998a) highlighted the lack of consensus and consistency in the job titles used to describe expert practice, which perpetuated an inadequate understanding about what TVNSs do. Flanagan (1998a) also argued that an evaluation of the role was needed in order to determine the impact TVNSs have on patient outcomes. In a subsequent study, Flanagan (1998b) explored the factors influencing TVNSs in the UK and as part of the findings identified a disparity in role expectations. Based on his findings, Flanagan recommended that a clear position of authority should be

established for TVNSs within an organisation that recognised by other staff to reduce the potential for role confusion.

However, the key skills that a Tissue Viability Nurse (TVN) — the S for Specialist is now typically omitted — should possess and the definition of the role has been subject of debate for a number of years. Bale (1995) proposed that there were five key skills, including: establishing an accurate diagnosis, making sure that the treatment plan is practical for those delivering the care, monitoring the effectiveness of care using objective methods, liaising with other healthcare professionals and facilitating an optimal standard of care and arranging an appropriate follow-up care. However, Flanagan (1996) had argued that the approach to the development of this role has been rather haphazard with the lack of a clear definition creating uncertainties about the specific responsibilities of the position. Some of the confusion may relate to the literal translation of the term 'tissue viability' which infers the 'preservation of healthy tissue' when in fact the more common application in clinical practice is that this includes the prevention and management of tissue damage in individuals with acute and chronic wounds (Flanagan, 1996).

More recently, Ousey and colleagues (2014) described the complexities of the role of the TVN which included responsibilities related to cost effectiveness, patient safety, patient care, education and resource management. Ousey et al also highlighted an additional consideration, namely that there may be a range of specialities involved in the care of patients with compromised skin integrity. A consequence of this is that TVNs often take on the function of coordinator of care but within a system that does not necessarily

recognise their level of authority or breadth of responsibilities of their position.

To address some of the issues surrounding the definition of a TVNS, the National Association of Tissue Viability Nurse Specialists, Scotland were the first UK-based group to develop a competency-based framework to define the breadth of practice for TVNSs (Finnie, 2001; Finnie and Wilson, 2003). The intention was that this project would help to define specialist practice within tissue viability, support professional development and also provide a quality assurance mechanism to protect the public. However, despite the availability of these competencies, Ousey et al (2014) argued that a lack of consistency of the role remained. In response to the continuing lack of recognised criteria and educational levels for clinicians working within a Tissue Viability Service, Ousey et al (2016) developed the Tissue Viability Leading Change (TVLC) framework, the main aim of which is to address gaps in training and education by providing clinical competencies for staff working within a tissue viability service. It is also hoped that this programme can foster strategies to measure patient and service outcomes to drive clinical effectiveness (Ousey et al, 2016).

Overall this evidence suggests that whilst there has been some progress in characterising the competencies for a TVNS (Finnie and Wilson, 2003) or those working within a Tissue Viability service (Ousey et al 2016), some discrepancies remain with regards to the definition of a TVN as well as the expectations of that role. Coupled with the challenges of providing effective healthcare services within an NHS system in crisis (Triggle, 2018), it seems timely to revisit the role and responsibilities of the TVN.

Samantha Holloway

1. An accepted view of tissue viability is that there is a focus on prevention of skin damage and also facilitating wound healing where complications arise. Does this definition encompass all aspects of the role of a Tissue Viability Nurse (TVN)? If not, what aspects are lacking from this definition?

KO: This is an interesting question, for many years we have attempted to define the TVN role — unfortunately, there remains an array of definitions. Many people have focussed on the clinical aspects of the role with little clarity as to what this means in practice and indeed what knowledge and skills the post holder should possess. While I agree clinical skills are essential, the TVN role has rapidly developed and we must include the skills of education, business planning, presentation and publication skills, problem solving, critical analysis and strategic understanding. Without these skills and knowledge, the speciality will not respond effectively and in a timely fashion to the ever-changing health needs of both patients and care environments.

ZM: Tissue viability is a relatively new discipline, which started in the 1980s and has been defined as a growing speciality that primarily considers all aspects of skin and soft tissue wounds, including acute surgical wounds, pressure ulcers and all forms of leg ulceration (Ousey et al, 2014). However, TVNs have a multifaceted role. At its core the focus on prevention and treatment is logical for the role of the TVN, however, the role is, or should be, much broader than this. Fundamentally, the role should encompass a number of key elements as evidenced internationally (National Council for the Professional Development of Nursing and Midwifery, 2008) namely, clinical, patient/client advocate, education and training, audit and research and consultant. As an expert clinician, the TVN is pivotal in bridging the gap between the needs of patients, and the provision of an evidenced-based wound

care service. S/he also plays a central role in influencing the future of TV services by actively engaging in audit and research (Moore, 2010a; 2010b). In addition, as an educator, the TVN has the opportunity to provide healthcare practitioners and patients with the information needed to make well-informed clinical decisions. Education facilitates the enhancement of competency among practitioners and also empowers patients to take a leading role in their own health care (O'Connor et al, 2015). By ensuring the TVN role encompasses all of the key elements of the role, this will ensure the delivery of quality, cost-effective and efficient TV service.

AS: The TVN role as all nurse roles has developed over time and whereas the advisory and support element of TV services for complex non-healing wounds is still relevant, there are other aspects to the role that must be acknowledged. TVNs are strategic developers, business planners and educator deliverers. Band 7 and 8 TVNs manage teams, analyse data, create clinical policies and pathways and work in partnership with many stakeholders to ensure evidence-based clinical quality practice is at the forefront of the service delivery. There is no clear definition to the role of a TVN, nor is tissue viability a specialism in its own right, there is no standard or register; given the complexities the role encompasses, I would argue that it is underestimated in value in the NHS today and that a clear definition and standards are required.

KM: The definition *"prevention of skin damage and facilitating wound healing where complications arise"* is definitely an oversimplification of the role of a TVN. Other aspects that are not considered in this definition are symptom management for patients where healing may not be an option. The definition also implies that the role involves mainly clinical interventions, whilst in practice most TVNs also support clinical innovation, service improvement, audit of

practice, managing local wound formulary, teaching and education and disseminating best practice. Whilst the role of the TVN may vary slightly from Trust to Trust, most TVNs do much more than just preventing skin damage and facilitating wound healing.

2. It has been argued that TVN and Tissue Viability teams could act as the coordinator of care for a patient with a wound to facilitate a more seamless approach. In your experience is that currently happening in clinical practice? And if not what enablers are needed to make this happen?

KO: Health care is constantly attempting to identify teams, and indeed individuals, who can coordinate care efficiently and cost effectively that enhances the patients experience. I believe that the TVN teams do coordinate care for the 'skin' aspects of care, however, management of a patients journey must be an integrated team approach. Patients rarely have only one healthcare need, that is to say, many patients will have a range of comorbidities that will require expert assistance, e.g. diabetes, vascular issues etc. We cannot expect one specialised team to fully understand all the complexities. Arguably, if we are seeking to coordinate care, do we need a specialist nurse or team or should we be looking for a team of support staff who can ensure that appointments, referrals, discharge planning etc is coordinated?

ZM: Commonly, individuals under the care of tissue viability services present with many different comorbidities and are often referred from disparate clinical services. Given the clinical complexity of many individuals attending tissue viability services, the TVN will need to be in a position to rapidly receive advice from other specialists, as and when the need arises. To do this successfully, the TVN will need to act as a navigator of care for individuals with wounds (Moore et al,

2014). One of the challenges in achieving success in this navigator role arises when there is a lack of understanding by other clinical services about the precise role of the TVN. As a result a priority may not be given to the referrals from the TVN, thereby impacting negatively on the patient receiving prompt appointments. To enhance the likelihood of success, there must be a clearly established referral mechanism, underpinned by well-designed care pathways integrated into electronic health records (Moore et al, 2014).

AS: The National Wound Care Strategy Programmes (NWCSP) lower limb workstream has developed a navigational tool that follows this pathway, and when implemented will address this, in combination with the Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) remodelling of service delivery within the NHS Long Term Plan (NHS, 2019). In order to improve outcomes in wound care, one would have to turn the current system of referral to the specialist when a wound is chronic, upside down – the specialist on assessment should develop the treatment and appropriate referral pathway for the patient to increase healing rates and reduce recurrence, especially in lower limbs. From local audits I can evidence where patients have attended services for months and years before a specialist referral has been implemented.

KM: In an ideal world, the TVN would be the most appropriate person to coordinate care and this could be a model for future service development. It has been recognised that wound healing often requires a multidisciplinary approach and may need input from other specialties; it has also been recognised that TVNs may not need to see all wounds and strict criteria should be in place. However, current challenges are a lack of clear referral criteria to a specialist service, poor communication and insufficient support from medical colleagues. Enablers could be

healthcare providers recognising the value of TVNs in supporting patients through their wound care journey, clear guidance where TVNs should lead within a pathway and full support within the Trust/UHB; thus ensuring patients receive the right care by the right person within an appropriate time frame.

3. Would you agree that the National (UK) healthcare initiatives seem to have directed the focus of tissue viability towards the prevention of pressure ulcers? What are the potential benefits of this and is there a risk that other aspects of wound prevention and management could suffer as a result of this approach?

KO: There was a focus on pressure ulcers for many years that highlighted the importance of preventing pressure damage for both healthcare clinicians and the general public. These initiatives resulted in a range of education tools and increased awareness across social media that have proved successful. As a result of these highly successful campaigns, we have now seen the focus move towards other areas associated to tissue viability and wound management exemplified through the Legs Matter campaign and the National Wound Care Strategy Programme. So, no, I do not believe the original focus towards pressure ulcers has resulted in other aspects suffering, rather it has proved to be the catalyst to draw attention to complex speciality of tissue viability and wound management.

ZM: Some of the best-documented achievements in tissue viability services arose when there was a greater understanding by senior management teams within the health service, of the impact that TVN teams could make to the achievement of quality care metrics. One good example of this is the pressure ulcer prevention campaign, where many services have sustained their achievements in zero hospital-acquired

pressure ulcers over time. However, given the significant time and energy it takes TVNs and their staff (including the frontline clinical staff) to keep the focus this campaign, there will undoubtedly be an adverse impact on other aspects of wound prevention and management. This is compounded by the challenges in gathering data required for reporting of pressure ulcer incidence and prevalence (Smith et al, 2016; Coleman et al, 2016). TVN services are not solely focused on pressure ulcer prevention, thus, it is important that there is recognition that wounds of other aetiologies are equally as important.

AS: I agree. Pressure ulcers, due to their status of patient harm, have become very political and therefore gained a higher status in wound care in the NHS. Due to this, much more open and honest reporting of PUs has been seen nationally and educational programmes have been developed, such as the NHS Improvement's Stop the Pressure campaign. However, the Burden of Wounds study (Guest et al, 2017) indicated that leg ulcers and venous leg ulcers specifically are the highest burden of wounds we have; and with best practice implementation we can demonstrate a higher proportion of prevention, healing rates and less recurrence by implementing best practice and focus here also, not to mention financial gains. Acute TVNs especially have become pressure ulcer verifiers, with limited time for any other focus, and inequality for patients admitted with other wound types?

KM: The role of the TVN has been influenced by pressure ulcer strategies across the UK. Whilst prevention of avoidable harm is focused on pressure ulcers, and is positive because awareness will hopefully reduce the occurrence of pressure ulcers, other wound aetiologies often receive a Cinderella service. I have never seen a datix for a patient who had a venous leg ulcer and had not put into compression due to poor clinical assessment; yet this could be seen as patient harm due to prolonged healing times and poor quality

of life. Maybe if poor clinical assessment for patients with leg ulcers was reported as harm, we may see money invested into services for leg ulcer patients or other wound aetiologies.

4. The North American approach combines the management of wounds, stoma care and continence management into one role, the Wound, Ostomy and Continence Nurse (WOCN). Do you think it is time to revisit the role of the TVN in the UK and consider expanding the scope of practice to stoma care and continence management? What might be the potential advantages and barriers to this concept?

KO: Yes, of course, we should consider this! TVN teams already advise, manage and treat moisture associated skin damage — the TVN teams do not simply look at a wound bed and ignore signs of maceration, the periwound area or do not consider and implement strategies to manage continence. Some staff may say 'we are too busy managing wounds without having any more to do!' But these teams already assess continence issues and manage the skin around stomas. We should be managing the patient holistically and not simply focussing on the wound. There may well be subtle differences to the American model but this requires careful and in-depth consideration.

ZM: Although there are close connections between each domain, I'm not sure that it is a good idea to expand the role of the TVN to include stoma care and continence management. TVNs already have a very busy case load and the risk I see is that there may be a challenge to provide adequate attention to all elements of the role, if this were to be expanded further. In addition, there would need to be significant education development, in order to prepare the TVN for this expanded role. Although TVNs have always embraced education opportunities, I would be concerned that too much pressure would be put on the TVN service to provide expertise in all of these fields.

AS: There are some TVNs in the NHS who have undertaken these MDT roles but in service management often not the clinical delivery. There is a danger of diluting and ultimately making the TVN role extinct, but as the NHS transforms – and it must – integrated ways of working have to be embraced. In my view, teams of specialists in MDT teams would work well, by combining skills and competencies, the patient will receive the best care at 'the right place at first time.' A TVN may be able to expand her scope of practice to continence care, however, resources are already under pressure in all services, so wouldn't this just further reduce services and put more pressure on existing ones?

KM: Whilst sometimes our roles overlap when maintaining skin integrity, I believe that the role of the TVN should be kept separate from continence and stoma care. Firstly, there may be some resistance from the stoma and continence nurses within the UK who might not wish to delve into the role of the TVN. Our knowledge bases and skill sets are quite different and although they can be acquired, already stretched staff may not want to take on more work. Collaboration should take place where our roles converge, such as when treating incontinence-associated dermatitis, by promoting a consistent approach to patient care, thus reducing variance and improving cost-effectiveness and quality of care.

5. Imagine you have been tasked with setting up a new Tissue Viability Service. What metrics would you put in place to measure the effectiveness of that service? And how would you disseminate your successes (and failures)?

KO: It is difficult to measure the effectiveness of a new service in the first year as there is nothing to benchmark against. Therefore, data must be collected that can be used to benchmark during the first year. When setting up a new service, it is useful to ascertain why this service is being developed — is it because there has been an increase

in visits to GPs or EDs for wound-related issues, failure of, for example, leg ulcers to heal? Firstly, I would audit the number of patients using the service, presenting diagnosis, where the referral came from, the reason for referral, any decreases in GP or ED visits. Time to healing in line with recognised guidance can be an indicator of the effectiveness. This will provide baseline data to be able to compare to over the following years. Success can be measured by comparing healing rates to national data and should be published.

ZM: The quote by Peter Ducker "*you cannot manage what you cannot measure*" is of real importance in the development of any new service. With this in mind, it is important at the outset to know what the TVS is intended to achieve, what an indicator of the achievement of the goal(s) would look like, and how to measure the indicator(s). Further, given that there are several stakeholders involved in the TVS, depending on the perspective of each, the goals and indicators may differ. For example, from the patient's perspective, issues personal to them might be of key importance, such as symptom management, healing of the wound, quality of life, relationships with the team and overall experiences of attending the clinic. For the service manager, issues of importance might be, costs, waiting lists, staff and patient satisfaction, and achievement of policy directed goals of care. So, for me, if I was developing a new TVS, I would look at it from a number of perspectives. Namely, the individual level (how does the patient feel about our service), the aetiological perspective (how are our healing rates/symptom management compared to the national/international norms), the service perspective (are we within budget, are we achieving quality targets, are we effective in terms of outputs), and the wider tissue viability perspective (are we generating evidence for practice, are we using evidence in practice, am I acting as a mentor/guide for others in the field).

AS: A new service for me would be interdisciplinary and as a community TVN, that would act as coordinator. For measurement of services, the information we collect and record is vital; IT systems need updating in the NHS, some Trusts are still using paper to document. Data analysts, business teams in Trusts should be working alongside senior clinicians to evidence effectiveness from audits. Quality improvement projects need implementing and then delivery to Clinical Commissioning Groups (CCGs) to ensure resource and focus is provided; in an ideal world! I attended the TVLC course at Huddersfield University – a module aimed at TVNs to improve their business skills, which was extremely useful in developing these skill sets that seem to be becoming more norm in specialist nursing practice.

KM: There are many metrics for services that could be measures such as:

Patient related:

- ▶▶ Healing times
- ▶▶ Patient satisfaction
- ▶▶ Ensuring all patients have a full holistic assessment
- ▶▶ Ensure all patients are on a pathway and that treatment is being instigated.

Cost effectiveness:

- ▶▶ Ensure all Trust staff are adhering to formulary

- ▶▶ Monitor formulary spend
- ▶▶ Monitor antimicrobial spend
- ▶▶ Equipment spend (mattresses/NWPT).

Education:

- ▶▶ All TVNs should demonstrate skills, knowledge in clinical practice (not sure how exactly, maybe MSc level for lead nurses, BSC for Band 5/6 nurses should also have a competency programme)
- ▶▶ Ensure that all Trust staff (non TVNs) have attended wound management programme run by TVNs and have had competencies signed off.

Success/failure is usually fed back at board level and clinical lead meetings and should be part of Trusts' overview of services in the same way that infection rates/mortality rates are reported. May be there should be a financial incentive for services that reach targets. It would be helpful if the role of the TVN could be agreed across the UK, however, due to the diversity of health provision this may be difficult.

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