The challenges ahead for tissue viability nurses

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Welcome to the first issue of *Wounds UK* with a new editorial team. I will be taking over from John Timmons as Editor and Karen Ousey is replacing Keith Cutting as Clinical Editor. Our thanks to them for all their hard work over the last few years and we hope to maintain their high standards.

Over the coming issues we hope to focus on several key objectives. These include:

- Identification and sharing of good practice — both clinical and strategic
- Identification and dissemination of existing resources
- Collaborative working with the commercial sector
- Encouraging and developing new authors both as individuals but also by working more closely with education providers
- Focusing on education and training
- Maintaining a strong political focus — addressing issues which challenge wound care practitioners across the UK.

Sharing good practice

One of the first issues the editorial team wish to address is the many areas of good practice across the UK, liaising closely with both regional and national groups to identify existing resources and those in development. In this way, it is hoped that resources and practices can be disseminated and shared, improving patient care across the whole of the UK. In future issues, we plan to provide information on the activities of regional and national groups, specifically highlighting where protocols and guidance have been developed.

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Addressing challenging issues

In terms of addressing issues that challenge practitioners across the whole of the UK, pressure ulcers seem to be high on the clinical agenda at present, with tissue viability nurses (TVNs) across the regions debating key issues around definitions: what is avoidable/unavoidable and can we agree on this without having to undertake a root cause analysis for every patient who develops pressure damage? There are areas where there seems to be consistency, for example, the project within Scotland (www.tissueviabilityonline.com/), yet other areas have little, if any agreement.

There is also concern at the inconsistencies across high level strategic documents, for example, the High Impact Action: Your Skin Matters – Technical sheet (Queen's Nursing Organisation [QNI], 2010) specifies that in counting pressure ulcers it is only a healthcare-associated incident after 72 hours. This seems hugely at odds with other documents which propose windows of six hours for assessment (National Institute for Health and Clinical Excellence [NICE], 2005), and many local policies which state a timeframe of 24 hours. The definition of 'incipient' pressure ulcers seems unfounded and is not referenced. This will have a huge impact on organisational data collection, with 'blame' for occurrence of damage being incorrectly attributed based on a seemingly random, time-based definition.

Furthermore, the whole process of collecting incidence data appears confusing and conflicting. Clinicians are unsure if they are counting new patients or new pressure ulcers, recording a pressure ulcer once or recording it at its worst category (which may mean counting it twice if the patient deteriorates). Equally, is re-categorising acceptable, i.e. if you categorise a pressure ulcer as 3 but then slough is removed and the full extent of damage is visible, can you 'change' to a 4. This seems to be the only way as both un-stageable and suspected deep tissue injury (European Pressure Ulcer Advisory Panel/National Pressure Ulcer Advisory Panel [EPUAP/NPUAP], 2009) are not included within UK definitions. The document appears to imply we are not counting category 1 damage (in contradiction with what many organisations already collect and

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report). It does, however, specifically state that data on incontinence-associated dermatitis (IAD) should not be included, something many clinicians are striving to improve as moisture lesions or IAD seem to be 'lumped together' with sacral pressure damage, despite having different causes and management to pressure ulcers.

Equally, this highlights huge discrepancies in practice where some areas openly state that their data does not discriminate (Foxley and Baadjies, 2010), and other areas where clinicians put a huge amount of effort into ensuring that anything that is not a pressure ulcer is excluded.

To many ground level clinicians, it seems that decisions are being taken without appropriate consultation, leading to a considerable amount of hard work to figure out what is workable and what is, in some cases, utter nonsense.

Focusing on education and training

The people who work in the NHS are among the most talented in the world, with other countries seeking to learn from our comprehensive system of general practice, and its role as the medical home for patients, providing continuity of care and coordination (Department of Health [DH], 2010). The coalition government has stated that the DH will have a progressively reduced role in overseeing education and training, with the new system being designed to ensure that education and training commissioning is aligned locally and nationally with the commissioning of patient care (DH, 2010). It is therefore vitally important that tissue viability practitioners develop and understand the healthcare needs of their population base, and are able to maintain their education and skills to deliver evidence-based care.

This development of knowledge and skills will need to be achieved from a variety of sources, including formalised courses delivered by higher education institutions, local study days, conferences, books, journals and specialist practitioners. The funding of formalised courses may become difficult to access and so the effective development of partnerships with industry that do not bias the choice of treatment will need to be explored.

Working collaboratively with commercial organisations

The principles of working collaboratively with industry are not new, but many clinicians and managers view collaborative working with a degree of suspicion. In the current healthcare environment, where there are huge financial pressures, collaborative working can only be seen to be beneficial. The DH (2008) proposed that partnership working is at the core of improving clinically effective, safe, personal and high quality care. In future issues, we hope to highlight areas where working closely with industry can be for the benefit of all concerned with pooling of skills, experience and resources, working for mutual benefit, with the patient as the principal beneficiary (*Figure 1*). The DH (2008) suggest that creating new partnerships between the NHS, universities and industry will enable pioneering new treatments and models of care to be developed and delivered directly to patients. We will be looking at ways of working with industry and their trade organisations to ensure that the best and most cost-effective care is available to patients.

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Wounds UK strives to be a forward-thinking, clinically useful journal. By focusing on these issues, in addition to our usual clinical content, we hope to provide you with a relevant and meaningful resource for years to come.

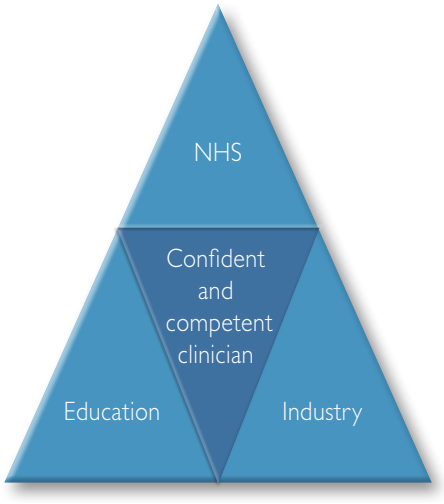

Figure 1. Tripartite working.

We look forward to working with you all. WUK

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