Developing a tissue viability nursing assistant role


Summary
This article describes the approach taken to introduce and develop the role of the tissue viability nursing assistant in the tissue viability team at the University Hospitals of Leicester NHS Trust. It highlights the achievements and challenges to date and identifies future plans for this role.

INCREASED PATIENT activity and demand for health care has necessitated the introduction of strategies to meet this demand, for example skill-mix reviews, changing roles and broadening professional boundaries. As the roles and responsibilities of registered nurses evolve, develop and change, ways of delivering services in acute trusts need to be re-evaluated. The tissue viability service is no exception, as it interacts with patients and staff groups across trust and primary care settings. The introduction of the role of tissue viability nursing assistant (TVNA) at the University Hospitals of Leicester NHS Trust (UHL) was achieved through discussion and planning in both the team and the directorate of nursing. Many titles are used for unregistered caregivers, including support workers, healthcare assistants, nursing auxiliaries and clinical team members. Although these roles may vary when looked at in detail, for the purpose of this article the term ‘nursing assistant’ (NA) will be used to refer to all groups.

Literature review
A substantial amount of literature has been written about the role of the nursing assistant in hospital and community settings, but little of it appears to relate to specialist teams. The literature attempts to identify what nursing assistants do (Perry et al 2003, Thornley 2000) and the debate usually explores the advantages and disadvantages of introducing and developing these roles (Daykin and Clarke 2000, Huston 1996). Some argue that the role is invaluable and has scope for further developments, including registration (Rheumaque 2003), while others feel the role and art of nursing is being eroded by a less expensive workforce (Akid 2002). Others believe assistants are not appropriately valued and rewarded for the role they provide (Field and Smith 2003, Thornley 1996, 1998). It is not the aim of this article to explore this debate in detail; however, this project was undertaken with an awareness and realisation that these varying views may be encountered as the role was introduced into a tissue viability team that delivers a service across a large trust.

The present government supports new roles and ways of working to match skill mix and patient needs (DoH 1999, 2000, 2001, 2002a, 2002b). Alan Milburn, in his speech at an RCN fringe meeting at the 2001 Labour party conference, called for a greater role for nursing assistants (Mulholland 2001). Brown (1999) described how the introduction of a nutritional support healthcare assistant improved and enhanced a specialist service. It was also reported this year that a training programme for healthcare assistants at Plymouth Hospitals NHS Trust had averted a ‘staffing crisis’ (News 2004).

At UHL, nursing assistants undertake clerical, administrative and nursing duties. Some roles also incorporate traditional medical tasks such as phlebotomy and cannulation. UHL is not unusual in this – Thornley (2000), in a national survey, identified that these roles were being undertaken by nursing assistants. In this survey, 57 per cent of nursing assistants were undertaking dressings and wound care. Pearcey (2000) found that between 30 and 40 per cent of nursing assistants surveyed felt they made the decisions on treatment and dressing types for pressure ulcers. If these figures were combined with delivering pressure ulcer prevention, it is likely that the figure would be higher. It is thus essential that tissue viability specialists are aware and proactive in promoting high standards in care and education, and ensuring appropriate boundaries regarding unregistered caregivers are supported and maintained. This will ensure safety for the patient and the accountable practitioner.

History
In April 1999 the three acute hospitals in Leicester merged to form the UHL. At this time the tissue viability service was provided independently (Box 1) and used different hospital systems. When the hospitals merged, a tissue viability co-ordinator was appointed to lead the newly formed service and a 0.4 whole time equivalent (WTE) grade F was employed at Leicester Royal Infirmary for the medical directorate. A 0.2 WTE assistant role...
Dietician also joined the team to enhance the work of the service. An extensive review of the service identified several limitations that were affecting the delivery and subsequent development of the service (Box 2).

A tissue viability strategy was drawn up in 2000 that included innovative developments to assist in combating the limitations and improving the service. In 2001, a case of need was presented to the trust board for three TVNAs. This included the current position, the proposed role and its benefits, and the possible consequences of not supporting the role. In 2002, finance was received from charitable funds to provide two WTE assistant posts for a one-year pilot (Box 3).

**Aim of the role**
The aim of the role was to provide a wide range of nursing and administrative activities, thus supporting greater efficiency and effectiveness. This would assist in meeting the growing demands on the tissue viability service. Key elements of the post were:

- Acting as a team member.
- Assisting the nurse specialist in direct care activities.
- Preparation and education of patients.
- Improving supplies and ward stocks and limiting wastage of time.
- Education of staff in relation to the service, particularly the use of pressure-reducing and pressure-relieving equipment.

**Introducing the role**
The job description was approved at Whitley grade B. The job specification identified NVQ 2 as essential and NVQ 3 (in care) as desirable. This stipulation was to support the nature of the role, as some responsibility and autonomy is required, with certain activities being complex and non-routine (see RCN 2003 for definition of NVQ levels). A trust paper, ‘Guidelines on the development, implementation and evaluation of new nursing roles in practice’, was used as a model for the implementation, with the aim of providing a structure and a robust process.

Initial work took the form of brainstorming and discussion to identify the practicalities of the post. These included accountability, training, induction, supervision, boundaries and how to evaluate the success of the post. In her study, Pearcey (2000) suggests nursing assistants are making decisions that were previously made by registered nurses and that those who achieve NVQ 2 qualifications feel they should be making more decisions than they do. It was essential that we were clear as a team about the

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**Box 1. Tissue viability services at three acute hospitals in Leicester**

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<tr>
<th>Hospital</th>
<th>Beds</th>
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<tr>
<td>Leicester Royal Infirmary (LRI)</td>
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<td>Leicester General Hospital (LGH)</td>
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<td>Glenfield General Hospital (GGH)</td>
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**Box 2. Limitations affecting the tissue viability service at UHL**

- Level of workload for specialist nurses was often in excess of contracted hours and at a consistently fast pace
- Day-to-day activity was often on a reactive basis, rather than taking a proactive approach
- Current demands limited the availability of specialist nurses to provide expertise, advice and support to clinical staff
- Specialist nurses were inadequately resourced in terms of administrative and clerical support, reducing the time available for clinical care and proactive innovation
- Little time was available for audit, research and development
- Ability to respond to long-term service development and professional priorities was hindered

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**Box 3. Summary of implementation process at UHL**

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
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<tr>
<td>2000</td>
<td>Review of nutrition and tissue viability service:</td>
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<tr>
<td></td>
<td>Tissue viability strategy</td>
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<td>2001</td>
<td>Case of need for administrative support and nursing assistant role</td>
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<tr>
<td>2002</td>
<td>Funds received:</td>
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<tr>
<td></td>
<td>(June) Job description and specification finalised</td>
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<tr>
<td></td>
<td>(August-November) Brainstorming, finalisation of practicalities of role, development of education and assessment pack</td>
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<td></td>
<td>(October) Interviews</td>
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<td></td>
<td>(November) Start of the post</td>
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<tr>
<td>2003</td>
<td>(April) Review of progress and bid for continuation funds:</td>
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<td></td>
<td>(November) Further funds to support posts until April 2004</td>
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boundaries of the role and that this could be relayed to the postholders to ensure appropriate expectations.

The team discussed any individual concerns to ensure full agreement, support and clearly defined boundaries. An assessment package was prepared, using the NVQ framework of competencies, which assessed skills and behaviours considered essential for the role. This method of experiential learning (Kolb 1984) was coupled with an induction programme that included attending relevant education and mandatory training events in the trust. The package aimed to identify current levels of practice and support the development of additional skills in an agreed framework. To enable the recognition of the abnormal (Dealey 1995), the physiology of wound healing was taught and assessed. The nurse specialist on each site was responsible for the assessment, with support from other team members who had experience of NVQ and competency assessment.

**Accountability**

Ultimate responsibility and accountability rest with the delegating nurse specialist, in line with the Code of Professional Conduct (NMC 2002). Because of the nature of referrals to the tissue viability service, many wounds and patient needs are complex and are considered outside the remit of the TVNA role. Much discussion centred around which, if any, dressings could be undertaken. Simple and complex wounds were defined, and an agreement was reached – that complex wounds were not to be dressed by the TVNA. Advice was also not to be given, but information could be. These decisions were to be reviewed as the role progressed. At this point there was concern that the TVNAs would be demoralised as they would be undertaking fewer dressings than they had on the wards. This was discussed with the successful applicants to ensure they fully understood the remit of the role and to prevent unrealistic expectations of day-to-day activities.

**Implementation**

Two TVNAs were selected for the pilot and were seconded to the post for one year. One was placed at LGH and the other at GGH. They were to work directly with the nurse specialist. Both the successful candidates were known to the trust for their previous interest and assistance on the wards relating to tissue viability. One of the candidates already had NVQ 3; the other was undertaking the course. Individual skills were fairly similar, with one of the candidates having slightly more information technology skills.

**Evaluation**

Evaluation of the role centred primarily on workload for the nurse specialist. All the nurse specialists kept a spreadsheet of the number of patients seen and time spent clinically. This was difficult to analyse, as the number of patients, the complexity and the time spent with patients vary as do medical preferences, relationships, the profile of the service in an area at a given time and the skills held by the staff in a particular area. For example, once a patient is referred in a particular area, more referrals tend to come in from that area, until the staff gain confidence and knowledge. The ability to be proactive and introduce and be involved in new initiatives trust-wide was used as an indicator of success. This included audit, dissemination of ideas, training and supporting directorates with quality initiatives such as benchmarking and prevalence audit.

**Benefits**

A positive impact was noticeable almost immediately after the introduction of the role. The assistants employed knew many of the systems and contacts in the trust, which helped them to communicate more effectively and make an impact on the service. They already had an excellent understanding of tissue viability, wound care products and pressure-relieving devices, and as a result, completed their assessments fairly rapidly.

**Increase in consultations**

As the TVNA has been trained to assist the nurse specialist in the assessment and treatment of patients, an increase of 50-70 per cent in patient visits has been identified. The impact of this has been twofold: not only is the nurse specialist’s time spent more cost-effectively but also more patients can be assessed and started on appropriate treatment earlier, thus increasing the standard of care patients receive. The assistants prepare trolleys and patients, remove dressings, wash legs if necessary and find the notes. They also act as the often-needed second person, which ensures the assessment and delivery of care are more comfortable and swift.

Over time, ward stocks of dressings have been streamlined and organised by the assistant and the ward staff, thus reducing the time spent looking for dressings and the pharmacy budget. After the process was introduced, the assistant will clear away dressings and ensure the patient is comfortable, enabling the nurse specialist to complete documentation and communicate with ward staff, medical staff and other departments, as required. The team considers it essential that the nurse responsible for the care of that patient is involved in the visit. However, because of high demands on the nurse’s time, this varies between discussion, information giving and direct presence during the assessment. This places additional emphasis on the importance of consented photographs and thorough documentation.

**Pressure-relieving equipment**

At the start of the post, LGH and LRI used owned equipment in departments and hired as necessary. GGH used a central bed store system, which was coordinated by the nurse specialist. The TVNA at GGH undertakes the role of co-ordination, delivery, collection and maintenance of this store, with the support of the nurse specialist. This has directly freed up time available for patient visits and other initiatives. At LGH, weekly bed audits are carried out on nine wards to monitor equipment usage and identify whether the
equipment used matches patient need. Equipment is then allocated accordingly (Box 4). This takes approximately four hours and is done by the TVNA, with support and guidance from the specialist nurse.

By speaking with staff, discussing patient needs and using an excellent knowledge of dynamic and non-dynamic pressure-relieving devices, cost savings of £800 a month on one hospital site have been made. Ward staff also highlight a feeling of greater support and are building up their own knowledge and skills relating to this equipment, so more appropriate choices are made first time. Since the audit was introduced, the referrals recorded by the tissue viability service for assessment, prevention and treatment of pressure ulcers have reduced, which has had a positive impact on the prevalence audit. The information recorded is disseminated to the senior nurse of the directorate, ensuring two-way communication and consultation.

**Introduction of leg ulcer clinic** A leg ulcer clinic has been introduced on one site. This is a flexible clinic, used when an appropriate number of patients are referred requiring assessment and treatment of leg ulcers. The clinic enables focused and dedicated time to meet these patients’ needs, in an environment appropriate for treatment. This has reduced the wait for assessment and application and enabled a more thorough service and more effective use of time. The whole service has therefore benefited. The centralised clinic also provides a useful location for staff and students wishing to enhance their knowledge of leg ulcer care and bandaging techniques. In addition, the patients seem to enjoy the chance to receive care away from the ward environment. Research supports the introduction of leg ulcer clinics, which are usually set up in the community, as they are cost-effective and improve healing and compliance rates (Collier 1996, Moffatt and Oldroyd 1994).

**Improved flexibility** The team has benefited from the appointment of the TVNAs. We are now able to function as a team rather than as three specialist nurses on separate sites. We are more flexible in our approach to providing the tissue viability service across the trust’s three sites. Although the pilot was originally designed to be on two sites, benefits are also being realised by the LRI site as each TVNA works at the LRI one day a week. This is enabling progress, with new initiatives such as the pressure relief mattress audit to be undertaken on this site with a view to realising cost savings.

**Job satisfaction** Motivation and job satisfaction have increased for the specialist nurses as more appropriate use is made of their skills. The TVNAs have also found they have developed their skills and feel they make a positive and valued contribution to the service. The team is trialling an assessment booklet and wound care guideline, which we hope will be used across the trust as a framework and standard for teaching and assessing TVNAs in the basics of wound care. This will provide consistency for the TVNAs relating to their role in wound care and will help to ensure that they have the knowledge to support their practice. Registered staff in the clinical area will act as assessors with the support of the tissue viability team; this will enable them to understand the role of the ward TVNA and delegate appropriate care.

**Challenges**

One of the greatest challenges to the introduction of this post has been defining and maintaining the boundaries of the role. As the knowledge and profile of the TVNA has increased, nursing and medical staff on the ward have asked them to work outside their remit. This has placed them in the uncomfortable position of having the knowledge, but not the position, to make decisions. The role of the registered nurse is not clearly defined in all areas of care in such a rapidly changing workplace (Hunt 1990). It has been suggested that registered nurses lack confidence or clarity in their roles (Reeve 1994, Tierney 1992). Nazarko (1999) suggests that nurses under pressure might allow NAs to undertake tasks they would not normally consider. However, robust studies to support this theory are lacking (Pearcey 2000).

If registered nurses are not clear about their own role, it is likely they will not be clear about the role of the NA. This has led to overlapping of roles and possible confusion of duties and expectations (Pearcey 2000). Because of the nature of the role of specialist nurse in tissue viability, and the combined experience of the team members, the team is confident that both roles are understood. The nurse specialist and the TVNA work closely together, and as relationships

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**Box 4. Impact of the tissue viability nursing assistant role**

- Increased number of patient visits achievable, both to individual patients and in total
- Less time wasted looking for dressings on the wards and waiting for assistance
- Reductions in mattress hire costs on Leicester General Hospital site
- Introduction of leg ulcer clinic enabling more effective use of time
- Ability to provide flexibility within the service and cover other sites as required
- Great reduction in administrative duties performed by specialist sisters on pilot sites
- Increased availability for advice and guidance on preventive measures
- Increased job satisfaction for all post holders
- Increased activity for audit, product evaluation, training, conference participation and teaching

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and confidence in knowledge and ways of working develop, role conflict is dealt with quickly and appropriately. Discussion and agreement ensure accountability is maintained and the TVNAs are not placed in a position for which they are not competent or rewarded.

The Code of Professional Conduct (NMC 2002) states that delegation must be appropriate and that adequate supervision and support must be given. Part of being accountable for one’s practice is the appropriate delegation of roles using clinical and professional judgement (Strachan 2000). As a team, we aim to support ward staff in appropriate delegation relating to tissue viability. We attempt to deal with issues as they arise and integrate delegation and accountability into any training in which we are involved for both registered and unregistered staff. It is the responsibility of the tissue viability team to support nurses in accepting responsibility for decision making relating to wound care and tissue viability and to ensure the TVNA and specialist roles are not considered interchangeable but are complementary.

Conclusion

The introduction of the TVNA post has had a significant impact on the tissue viability service. The nurse specialists have been freed to focus on using their expertise where needed and enabling proactive developments in the service to be undertaken. The postholder is part of the team, operating at all times in line with the philosophy of the service. Cost savings have been made relating to the hire of pressure-relieving equipment, while patients have received appropriate prevention and treatment. Preparation, training, assessment and evaluation have been integral to this role. We hope to gain funding for these posts to become substantive so that we can build the service and meet increasing demand.

As a result of the success of the pilot and close links with nutrition, steps are being made to support the clinical nurse specialist in nutrition with the assistant role. The equipment audit has recently begun at GGH and U&I, and it is hoped to mirror the cost savings and educational benefits that have been identified at LGH. The role has fully used the skills of the TVNA to support and enhance the service without diminishing the role of the specialist nurse.

The enthusiasm, motivation and commitment of the assistants and the team have ensured the success of the pilot. The development of this role has been focused on clear objectives, and the specialist nurses have retained control and accountability of delivery, standard and delegation of care, as befits their role as specialist.

ACKNOWLEDGEMENTS

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