EDUCATION: BUILDING ON THE PAST AND PREPARING FOR THE FUTURE

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This paper considers issues relevant to lymphoedema education from both the provider and participant perspectives. Current education in the UK is based on a model developed by the British Lymphology Society (BLS), which identifies four groups of patients with differing needs. Application and continued relevance of this approach is discussed in light of the introduction of the NHS Knowledge and Skills Framework (KSF). The need to develop both clinical competence and higher-level generic skills for specialist/advanced practice is also discussed.

Key words

Lymphoedema education
Competence
Advanced practice
Specialist practice

Currently, the provision of education for lymphoedema management in the UK is generally based on two documents published by the British Lymphology Society (BLS). The first, *Chronic Oedema Population and Needs*, which was published in 1999 and revised in 2001 (BLS, 2001a), identifies four patient groups and their particular needs. A related document, *Framework for Education* (BLS, 2001b), directly links the needs of patients in each of the four groups (*Figure 1*) to educational outcomes required to enable practitioners to meet the respective patient needs in terms of knowledge, skills, attitudes and in relation to practice development.

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Based on the author's experience as a member of the BLS working group responsible for both documents and as a provider of lymphoedema education over many years, this paper summarises the development of the current approach. It then discusses how the population and needs model has been applied to date in providing education, including the strengths and limitations of that provision in terms of ensuring competency and preparing practitioners who are able to develop lymphoedema practice.

Thereafter, the potential benefits and challenges posed by the competency approach adopted by the NHS Knowledge and Skills Framework (KSF) (Department of Health [DoH], 2003a) are highlighted. Finally, issues that the KSF raise in planning future education and the need to differentiate between the application of specialist skills and being a specialist or advanced practitioner are discussed.

Historical perspective

Early education in relation to lymphoedema involved little more than a 'see one, do one, teach one' approach. Having learned about lymphoedema management in Europe, Caroline Badger, who was the first lymphoedema specialist practitioner in the UK, initiated much of what would more accurately be described as training, rather than education, in the late 1980s and early 1990s (Sneddon, 1992). As the development of relevant skills and teaching of others was cascaded throughout the UK, the focus of training was upon compression bandaging and hosiery. Some healthcare professionals (HCPs) applied what they had learned cautiously, conscientiously observing the effects and developing their practice from what they had learned.

However, it soon became apparent that many practitioners, lacking sound understanding of the underlying pathophysiology and treatment principles, were ill-equipped to carry out a thorough assessment of patients and were, as a consequence, often implementing treatment strategies inappropriately. Badger and others recognised a need to develop a more comprehensive model for education and sought to do this through an Education Advisory Committee, which comprised committed members of the BLS (at that time still the British Lymphology Interest Group). Initially, many society members who had by this time developed considerable skill in all aspects of care apart from manual lymphatic drainage (MLD), were resistant to the recommendation that particular training was required. However, the model was gradually accepted and developed as the basis of the education currently offered.

The model shown in *Figure 1* was based on the idea that there were

The chronic oedema population			
Group 1	Group 2	Group 3	*Group 4*
At risk	Mild, uncomplicated oedema	Severe, complicated oedema	*Those with advanced disease*
They need			
Information	Information	Information	*Information*
Advice	Advice Maintenance Monitoring	Advice Specialist treatment	*Advice* *Palliation* *Cautious application of specialist treatment*

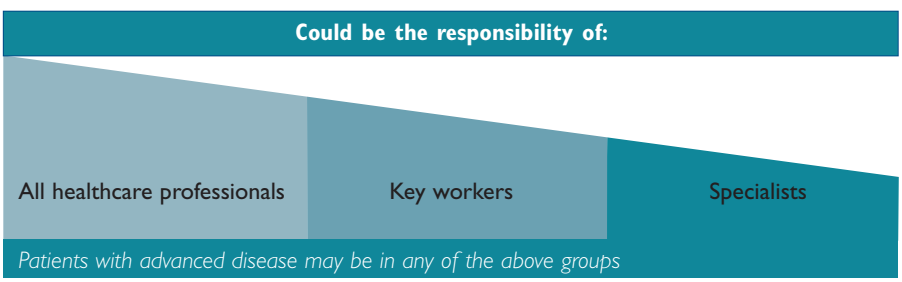

Figure 1. Structure for the delivery of services to meet the needs of four different groups within the chronic oedema population (adapted from Macmillan Cancer Relief, 1997). Parts in italics (group 4) were later added to the BLS model.

different patient groups with differing needs (Badger, 1995). A relatively small population were thought to require specialist treatment and, consequently, a small number of practitioners with specialist skills, as indicated in *Figure 1*, would be required. A substantial number of people were anticipated to be at risk of developing lymphoedema and in need of advice and information from whatever HCP they came into contact with.

The linchpin of the model was defined as the key worker, who would have all the skills to assess patients and refer on to specialists where required. They would also take on the long-term maintenance and monitoring of patients once the initial intensive treatment phase was complete, and so free up the specialists to concentrate their efforts on the most complicated cases (Badger, 1995).

A BLS working party developed the model further and added an additional category (patients with advanced disease, group 4) (BLS, 2001a).

Education developed on the basis of the population and needs model (BLS, 2001a) and a second document, *Framework for Education* (BLS, 2001b), which linked education needs of practitioners to the patient population needs, was then developed. *Framework for Education* identified expected outcomes of courses required to prepare practitioners to manage the four patient groups and so was a guide for practitioners, managers and educators. Many short, stand-alone courses have evolved in the UK with the purpose of preparing HCPs to meet the needs of those patients in group 1; these courses are generally provided by experienced lymphoedema specialists on an ad hoc basis. A small number of courses are offered (some in conjunction with higher education institutions [HEIs]) to meet the needs of those managing group 2 or 3 patients. Involvement of clinical experts in the teaching of any course on lymphoedema has been a key underlying principle.

The following considers how the *Chronic Oedema Population and Needs* document (BLS, 2001a) and the related *Framework for Education* (BLS, 2001b) have been applied in the provision of education, and some of the strengths and limitations of the current framework are highlighted. Thereafter, the current context is discussed and issues requiring consideration for future planning of education provision are identified. As the purpose of the BLS documents was partly to facilitate the growth in numbers of competent practitioners who were able to provide care for various types of patients, competence is also discussed. Competence has been defined as: 'The complex synthesis of knowledge, skills, values, behaviours and attributes that enable individual professionals to work safely, effectively and legally within their particular scope of practice' (Allied Health Professions Project, DoH, 2003c).

Current education provision

Courses for all healthcare professionals to meet the needs of patient group 1

Many experienced lymphoedema practitioners offer single study days to raise awareness and meet the needs of the many HCPs dealing with people at risk of developing lymphoedema. It is anticipated that such education will enable participants to provide patients at risk with preventative advice and facilitate early referral to an appropriate specialist should oedema develop (Sneddon, 2004). Although the *Framework for Education* identifies competencies relevant to this level of education, there is no assessment of their achievement. However, the BLS have sought to standardise the content of such days to a certain extent by the publication of an education pack for BLS members (Sneddon, 2004). Provision of education in respect of the other three patient groups has been less standardised, depending on the interpretation of the key worker and specialist roles and the availability of resources.

Courses for key workers to meet the needs of patient group 2

Courses purporting to prepare key workers may vary in the depth of understanding and level of competence they seek to achieve, even if the actual content sounds similar. The amount of teaching

time varies. Some incorporate opportunities to practice in between teaching sessions. Some are formally assessed practically and academically, and others are not. Therefore, the level of competence that may be achieved is uncertain, and those identifying themselves as trained key workers may vary considerably in their clinical abilities and confidence on completion of the course. Finding the most appropriate course requires examination of the aims, intended learning outcomes, academic level — if accredited — and the extent to which knowledge and competence are assessed. As so many lymphoedema practitioners continue to work in isolation, it is essential that even key workers feel confident to make appropriate treatment decisions on completion of their chosen course. However, in some areas, lymphoedema specialists training key workers are able to continue to provide support and supervision of newly-trained key workers until they have developed sufficient competence and confidence.

A number of factors contribute to the variations in key worker courses. One factor that has recently come to light is the dissatisfaction with the criteria that define patients in this group (mild, uncomplicated lymphoedema) (BLS, 2006). Practitioners are concerned that the degree of swelling is an unhelpful determinant of needs (personal communication). On one hand there may be considerable complications, even when the swelling is mild (less than 20% excess limb volume), in which case the presence of complications would be more important. However, the management of some listed complications, such as digit swelling, are considered within the capabilities of a key worker. In an ongoing review of the model, there is a recognised need to reconsider the definitions in this category to facilitate its application.

A related difficulty has been the fact that so few patients seem to fall into the mild and uncomplicated category, as defined in the document. Although it is understood that key workers may treat more complicated patients, the intention was that this should be under the supervision of a specialist, who would 'prescribe' and supervise the treatment. However, many key workers find themselves without the support of a specialist in their area and under pressure to take on more responsibility than they are prepared for. In an attempt to overcome this, some trainers have felt pressurised into extending the skills covered within key worker courses, such as with the application of compression bandaging. A concern about this development is the extent to which it is possible to also include teaching that develops appropriate clinical reasoning skills to ensure safe application of these additional interventions, without extending the course substantially.

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Also, contrary to the original intention, many key worker courses include treatment skills such as support bandaging, primarily for use in patients with advanced disease, where minimal compression is indicated. However, understanding of the complex pathology of swelling in patients with advanced disease, differential diagnoses and comorbidities, which would enable safe application of bandaging may be omitted or inadequately addressed in key worker courses. There is also a risk that practitioners, faced with lack of specialist support, may apply these skills to patients with more complicated needs. At best this may result in sub-optimal treatment outcomes at the expense of practitioner time and great inconvenience for patients. At worst it may exacerbate the oedema in the long-term, if, for example, not applied in conjunction with MLD to clear oedema from the adjacent trunk area, which can be difficult to detect if the practitioner is inexperienced.

Finally, there are pressures on educators from health service managers and commissioners of courses to keep the amount of time required for attendance and the cost of courses down to a minimum. To ensure participation of HCPs, the amount and depth of teaching and assessment may be compromised.

Specialist skills courses to meet the needs of patient group 3

Until recently there has been a dearth of opportunities in the UK to undertake training in MLD, which is fundamental in meeting the needs of patients in this group. With too few practitioners able to spend several weeks in Europe to access training, many patients had this component omitted from their treatment regimen. Recent initiatives, such as the Macmillan Lymphoedema Education Project, which has trained an additional ten specialists as teachers of the Casley-Smith method of MLD in the UK, and the introduction of training in the Leduc and Vodder methods, have facilitated access to training and increased the availability of practitioners with specialist skills. MLD schools recognised by both the BLS and MLD[UK] include Asdonk, Casley-Smith, Foeldi, Leduc and Vodder. All will offer courses run by approved teachers of the method and comprising adequate practice to ensure confidence and competence in MLD application, which is always assessed. Some courses are accredited and, therefore, also incorporate academic assessment. All courses require regular updates and revision of skills to ensure high standards are maintained. However, managers and professionals alike, in view of competing demands for continuing professional development (CPD) in more generic aspects of the practitioner's role, have

recently questioned the need for such frequent updates. Alternative strategies for ensuring good practice require further exploration.

Courses to meet the needs of patient group 4

People who have advanced cancer may have pre-existing lymphoedema, which becomes exacerbated. They may also develop a more acute swelling, particularly of lower limbs and torso as a result of combined pathological processes. It has also been recognised that people with other progressive diseases such as renal, liver or cardiac failure may have similar problems and needs. One difficulty in interpreting the educational needs of practitioners dealing with patients in this category is that their needs may reflect the skills required for any of the other three groups. All patients with advanced disease will at least be 'at risk' of developing lymphoedema. Some may develop mild oedema, while others will develop more severe or complicated oedema. There is perhaps a need to clarify this category further, as the presentation may change quickly and there are problems specific to this group that are not explicit in the current model.

Currently, some key worker and specialist skills courses include discussion of modification of strategies taught to alleviate some of the symptoms arising at the end of life. However, a more detailed understanding of the aetiology of oedema and the potential contribution of other pharmacological and physical interventions may be required to offer maximum benefit to patients.

Comprehensive programmes of education

Within the UK, three education programmes leading to a recognised academic award exist, which equip HCPs with the skills required to manage all of the identified patient groups (Bradford, Glasgow and Thames Valley Universities). These have the advantage of enabling participants to develop additional generic skills to facilitate the development of practice.

Strengths and limitations of the current needs model and related education provision

The population and needs model has provided a helpful structure for those planning services and education, and for practitioners to identify their own learning needs on the basis of the patients they care for. Together with the *Framework for Education* (2001b), it has provided a basis for a core curriculum for training courses and, to a certain extent, a minimum standard for competence for practitioners in relation to the needs of patients. It has legitimised and supported practitioners' requests to attend training programmes.

To enable the specialty to develop, urgent attention is required to equip more practitioners with generic skills in research, education, management and service development.

However, as indicated above, there are some difficulties with the current differentiation of groups and clarification in some areas would be helpful. The BLS will hopefully address these limitations in the ongoing review, which the author is leading. Also there are gaps, with few providers offering comprehensive preparation to meet the needs of all the patient groups identified. Many of the gaps might be filled through more generic education programmes that enable a practice-based focus so that learning and assessment can be clearly applied to practice.

There is no published evidence on the impact of education based on the population and needs model. Such evaluation may be facilitated if the *Framework for Education* (BLS, 2001b) was developed further. It may be helpful if the listed outcomes reflected the levels of working and a more detailed competency-based approach linked with the KSF. The recently published document, *Lymphoedema Framework: Best Practice for the Management of Lymphoedema. International Consensus* (2006) will also be helpful when reviewing both of the BLS documents, as it details the treatment skills required in different specific clinical situations.

An additional, general shortcoming of the current approach is the predominant focus on clinical skills. This has gone some way to meeting an urgent and ongoing need to increase the number of clinically competent practitioners and so facilitate patient access to appropriate treatment. Moreover, student feedback suggests current provision is meeting their perceived needs. In the author's experience, students attending lymphoedema courses tend to be very focused. They have identified particular knowledge or skills they are seeking to acquire and generally have a plan (however vague), know what they want and will be disappointed if they don't get it. They may have identified a patient/service need that is inadequately met, a gap in their knowledge or skills, or have an interest in a particular issue that they wish to develop, or seek a post in a particular aspect of care.

To enable the specialty to develop, urgent attention is required to equip more practitioners with generic skills in research, education, management and service development. Learning and applying specialist clinical skills does not necessarily mean that the practitioner fulfils the role of a specialist. To do so, additional skills are required, as discussed in the next section. Although a number of capable lymphoedema practitioners do fulfil the role of specialist practitioners, most have struggled to develop services and learned much from trial and error. Such struggles might be minimised if more were able to access appropriate educational preparation and support to develop and enhance their potential.

Preparation of the specialist or advanced practitioner

Specialist lymphoedema practitioners, regardless of their professional

background, require more than clinical competence. According to the PREP report (United Kingdom Central Council for Nursing, Midwifery and Health Visiting [UKCC], 1994), a specialist nurse is one who exercises higher levels of judgement and discretion in clinical care and demonstrates higher levels of decision-making. Such a nurse should also monitor and improve standards of care through supervision of practice, clinical audit, contributing to research, teaching and supervising others and leading practice developments. The Chartered Society of Physiotherapy (CSP) identifies similar requirements for physiotherapists in specialist roles (CSP, 2006).

Miller (1995) identified that acting as a change agent and advocate, together with advanced education, were components of the specialist role. These abilities required a broad range of skills, including teaching, research and leadership. The terms advanced, consultant, or extended role/scope practitioner are sometimes used synonymously with that of specialist practitioner. The extended role/scope practitioner is associated with undertaking roles previously within the doctor's remit, especially diagnosis (McGee et al, 1996) and is a vital part of the modernisation of the NHS, which has enabled doctor's hours to be cut and reduced waiting lists and times (CSP, 2006). However, McGee et al (1996) highlight a different perception of the advanced nurse practitioner, as one that promotes the development of nursing and pioneering of new approaches and ideas. Regardless of how the advanced practice role is implemented, it will be distinguished by a high degree of autonomy, authority and accountability (Walsh, 2006). While well-honed clinical skills are essential for a specialist or advanced practitioner, it is important that the educational development of such practitioners does not limit them by encouraging them to know more and more about less and less (Humphries, 1994).

The consequence of a limited interest in, and knowledge of, lymphoedema by the medical profession generally has made it necessary for practitioners to take on the responsibilities of diagnosis and treatment-planning in advance of their colleagues working in other specialties. From the author's experience, many practitioners who attend lymphoedema courses have been thrust into a 'specialist' post for which they are inadequately prepared. Such responsibility has often been placed on practitioners with little support from managers and colleagues who have little understanding of lymphoedema, or appreciation of the high level of skill and knowledge required. Appropriate education, including and beyond clinical skills, is required to support the development of high level assessment and diagnostic skills, complex decision-making and clinical reasoning skills. More strategic practice development and research skills are also needed.

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The Knowledge and Skills Framework (KSF) and the implications for lymphoedema education

As part of the Agenda for Change reforms (DoH, 2003b), the National Health Service Knowledge and Skills Framework (KSF) (DoH, 2003a) clearly links competence and responsibility to pay and career progression. The intention is that key competencies for specific clinical roles can be identified and matched against the abilities of individual staff members, thereby determining training needs. This should also support the development of a fair system of grading, remuneration and career progression linked to the requirements of each post.

The implications for education are that CPD should be more effectively planned. However, concerns have been expressed about the competencies approach, fearing that it is too narrow and will encourage managers to support CPD courses that are short, cheap and purely clinical because the impact can be easily demonstrated (Watson, 2002). On the other hand, the KSF identifies the wider aspects of specialist roles such as leadership, research and development. So, if applied correctly, the framework may support achievement of the learning needs of practitioners beyond clinical competence. It may also be helpful in that there is a requirement for practitioners to have a personal development plan based on the KSF, agreed with their manager, and reviewed at least annually to support their career development.

Gould et al (2007) suggest that further benefits may ensue because managers will need to become better acquainted with the demands of individual posts and invest time and effort into appraisal and meeting training needs. Furthermore, managers cannot be seen to block career progression by not permitting access to relevant training. Whether time constraints make this possible remains to be seen. It is vital that practitioners who are already demonstrating diagnostic and higher level decision-making skills have this acknowledged and reflected in their grading. There is also an opportunity for practitioners to identify gaps in their knowledge or skills and make a case for further specialist or non-specialist education to enable them to develop their roles, their service and the specialty. It is likely that practitioners will need to make a sound case for support to access particular education programmes and provide managers with the relevant information. Detailed information on chosen courses will need to be scrutinised. Accredited programmes will generally provide this in the programme specifications

available on the website of the institution. This can then be compared with that provided by other non-accredited courses.

Conclusion

The identification of specific needs relevant to four patient groups has provided a useful structure for the development of lymphoedema education and services. A strong clinical focus in education is required to extend the availability of practitioners who are able to comprehensively assess and manage the care of patients in each of the identified groups. Clearer recommendations on the scope and level of competence for practitioners managing the various groups, which could be understood in relation to the KSF, would be extremely helpful for practitioners, managers and educators. Specifying the skills requirement more precisely would facilitate identification of training needs to meet the needs of different patient groups. Clarification of the level of decision-making required would ensure that practitioners were appropriately prepared and rewarded for the roles they were expected to undertake, and managers would know what to expect from professionals in the various roles.

Practitioners need to have a good understanding of the KSF and be proactive in their analysis of their own development needs and those of the service, and to be able to present these needs clearly to managers. The greater focus on CPD, competency and career progression will put enormous pressure on managers when allocating funding for education. Practitioners will need to make a strong case for resources, and educators will need to make it clear what will be achieved through undertaking particular courses and programmes.

Appreciation of individual development needs, beyond the boundaries of lymphoedema, is vital for those who wish to see the specialty develop or to advance their career. It is important that some practitioners who are able and wish to take up the challenge of higher levels of education are supported so that there are specialists able to take a more strategic approach in developing the specialism and advancing practice through research. It is to be hoped that the implementation of KSF will support the need for education that is not solely focused on content and clinical competence, but will also recognise the need to prepare practitioners who will lead future practice developments to enhance patient care. JL

Key Points

- Adequate opportunities for practice and assessment of practice are necessary within training courses to ensure practitioners are safe and competent.
- Specialist practice is more than the application of specialist skills.
- New lymphoedema knowledge will come from better understanding of genetic molecular and cellular events.
- Grounding in research methods is essential for development of practice.
- Opportunities for experienced practitioners to undertake higher degrees are essential to develop services further and enhance patient care.

References

Badger C (1995) Education proposals for the population at risk. *Clin Dermatol* **13**: 507–9

British Lymphology Society (2001a) *Chronic Oedema Population and Needs*. 2nd edn. BLS, Kent

British Lymphology Society (2001b) *Framework for Education*. BLS, Kent

British Lymphology Society (2006) *Your BLS*. Discussion at the BLS annual conference, October 2006, Birmingham

Chartered Society of Physiotherapy (2001) *Specialisms and Specialists: Guidance for Developing the Clinical Specialist Role*. CSP, London

Department of Health (2003b) *Agenda for Change Agreement*. DoH, London

Department of Health (2003a) *The NHS Knowledge and Skills Framework*. DoH, London. Available online at: www.dh.gov.uk

Department of Health (2003c) *Allied Health Professions Project: Demonstrating Competence through Continuing Professional Development. Final Report*. DoH, London. Available online at: www.dh.gov.uk/AdvancedSearch/SearchResults/fs/en?NP=1&PO1=C&PI1=W&PF1=A&PG=1&RP=20&PT1=CPD+reports&SC=__dh_site&Z=1. Accessed January 2007

Gould D, Berridge E, Kelly D (2007) The National Health Service Knowledge and Skills Framework and its implications for continuing professional development in nursing. *Nurse Educ Today* **27(1)**: 26–34

Humphries D (1994) *The Clinical Nurse Specialist. Issues in Practice*. Macmillan Press, Basingstoke

Lymphoedema Framework (2006) *Best Practice for the Management of Lymphoedema*. International Consensus. MEP Ltd, London

Macmillan Cancer Relief (1997) *Lymphoedema Education and Practice*. Macmillan Cancer Relief, London

McGee P, Castledine G, Brown R (1996) A survey of specialist and advanced nursing practice in England. *Br J Nurs* **5(11)**: 682–6

Miller S (1995) The clinical nurse specialist: a way forward? *J Adv Nurs* **22**: 494–501

Royal College of Nursing (2003) *Clinical Governance: An RCN Resource Guide*. RCN, London

Sneddon M (1992) Creating educational opportunities to improve care: Management of the oedematous limb. *Professional Nurse* **7(12)**: 818–22

Sneddon MC (2004) *Raising Awareness of Chronic Oedema: Guide and Resource Pack for Teachers of Introductory Courses*. 2nd edn. BLS, Kent

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1994) *Post-registration Education and Practice (PREP) Report*. UKCC, London

Walsh M (2006) Development of the nurse practitioner role. In: Walsh M, ed. *Nurse Practitioners: Clinical Skills and Professional Issues*. 2nd edn. Butterworth Heinemann, China

Watson R (2002) Clinical competence: starship enterprise or straitjacket? *Nurse Educ Today* **21**: 426–80