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Primary care experience “The pro-active student”.

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## **Wound care Assessment**

### **Scenario.**

You are going to be given a 3 stage scenario of a person who has wound care issues. This will be following a holistic format in relation to community practice; this will include the use of A&P, patho-physiology and how this may AFFECT WOUND CARE progress.

The scenario will be staged in 3 work books and the patient details will remain the same but the wound type will be different to mimic the healing process.

Review the scenario and ask for prompts from the facilitator for that work shop. You will have 30 minutes at each scenario and you need to identify the answers to the questions that are provided for you. Remember this is about team working, knowledge transfer and management of a situation in the community environment which allows the use of transferable skills.

### **Scenario.**

#### **Over view.**

Mrs Marlene Miles is an elderly lady of 82, who whilst out clearing rubbish from her garden has had a rusty metal gate swing back and hit her on the central tibial area (also known as the gaiter area) which has caused a blunt trauma wound, she has contacted the District Nurse as she had the contact number from a past incident where she had had sutures removed after a minor operation for a skin growth removal. She has waited several hours for the bleeding to subside and has not had any fluids since her breakfast early this morning over 5 hours ago.

She has had no history of falls in the past and she considers herself as a carer for the old folk who she visits as a volunteer at the local Elderly people's retirement home.

Mrs Miles has no active illness but has been taking 300mg of Aspirin for the past 10 years as she read in her women's retired magazine about this reducing the risk of a stroke.

She has generally been well although recently she has noticed that she is becoming a little dizzy if stands up to quickly.

She lives alone since the loss of her husband several years ago and has a bedroom down stairs with on suite bathroom as she does not like to be on her own upstairs at night (as this is where her husband passed away).

She has been independent up until today and has a good net work of friends and social clubs, has no family close by but her niece rings once a week and visits when possible as she lives a considerable distance away.

### **Scenario 1. Acute wound management.**

Mrs Miles has requested a visit from you as the District Nurse team as she has a lot of pain and there has been some bleeding from the wound. The nurse has not reviewed the wound and this is the first visit.

On meeting Mrs. Miles you are aware that she is looking pale and a little anxious about the wound as she has put a towel around it, the wound when you visit is still bleeding and Mrs Miles refuses to look at the wound.

She is rationale and can make informed decisions; she does not want to go to hospital and has negotiated with the team that she would prefer to be reviewed in her own home and the care managed from here as the surgery is over 2 miles away and a bus journey for Mrs Miles would be extremely painful and difficult in the initial stage. As stated she refuses to go to hospital for assessment due to a fear of hospitals.



Remember that you must be recording all actions and the assessment in full, with in a 24 hr period were appropriate so not all of the information has to be recorded at once ( NMC 2007).

Questions to answer by the student and the team.

1. What is your initial plan of action?
2. What assessment criteria are required initially?
3. What tools may help you to determine the appropriate dressing.
4. What dressing do you think should be in place and why. **USE BNF**
5. What evidence have you for the dressing choice.
6. What is the primary dressing to consist of and why?
7. What is the secondary dressing to consist of and why have you chosen this.
8. What restrictions may there be for your choice of dressing. I.e., financial, ethical, availability.
9. What other implications have you to take into account for choice of dressing.
10. What multi –professional team members need to be involved and why.

You are with a qualified Nurse draw on their experience of the management of the wound.

### **Answers to guide student**

#### **Question 1.**

- Initial management should be to ensure safety of patient and ensure that all appropriate equipment is brought into the area where care is to be delivered. Preparation is key to developing trust in this situation.
- Equipment, dressing pack, non sterile and sterile gloves, apron, cleaning solution? And dressing Choice?
- Paperwork, you need to decide which are the initial vital issues and which can be left until later assessment.

### **The General Assessment.**

#### **Question 2.**

ABCDE APPROACH,

CHECK THAT THE PATIENT IS NOT GOING INTO, **Hypovolemic** shock, AFTER THE TRAUMA.

WHAT are the signs and symptoms of this type of shock? **Can you list these need to complete with full range of observations.**

May need to check blood for FBC and U&E due to medication and check platelet count after completing the initial assessment and dressing protocol.

Check pain level how, what tool can you use ( Verbal 0-10 analogue scale of pain).

Do they need analgesia if so what type? (Voulo 2010).

CHECK VITAL SIGNS, WHAT VARIATIONS TO NORMAL WOULD YOU FIND, TACHYCARDIA, increased cardiac rate due to lack of fluid volume.

TACHYOPNEA LEADING TO – POTENTIAL HYPERVENTILATION AND LOSS OF CONSCIOUSNESS.

AVPU score (Alert, verbally responsive. Responds to pain, unconscious).

CHECK PATIENT IS SAT DOWN AND COMFORTABLE, REDUCE ANXIETY. APPROPRIATE COMMUNICATION STRATEGY. PSYCHOLOGICAL SUPPORT IS VITAL AND TRUST (OUSEY 2008).

This confirms orientation and mental capacity

INITIALLY –PPE (personal protective clothing)TO PROTECT YOUR SELF AND CLOTHING, FIND PROTECTION FOR FLOOR ETC, DARK COLOUR TOWEL IF POSSIBLE REDUCES VISUAL IMPACT OF BLEEDING. (RCN 2006, DH2001).

As you are with a qualified nurse it may be appropriate for you to engage the client and commence an activities of daily Living process , and develop a holistic assessment, whilst the mentor starts to remove the outer towel and reviews the wound.

### **Question 3.**

Again you must think logically.

Do we wash the wound and review the wound bed if so what do we use to wash the wound?

Clean with free flowing tap water or saline (look in the BNF) research by Vowden and Vowden, identifies that the wound should be cleaned with water preferably running tap water.

Avoid use of any contact with gauze to wound bed. Micro fibre dispersement to the wound bed, Causes contamination and can prevent healing of the capillary loops. Use materials to dry around wound bed only and catch blood to keep limb free of contamination.

Wound Map, yes or no it is an emergency and this can be done later? When bleeding resolved. Identify is this a partial or full thickness wound.

Pain score to identify the skin area.

Photograph? Ethics at this stage.(may require Later)

Dimensions using ruler, will give a quick general idea of the area of wound involvement and depth.

Wound chart to plot dimensions may be appropriate. The Bates Jensen wound assessment Tool (2006) is a good example of this process. Refer to Vuolo (2011).

### **Question 4**

Use BNF and the booklets to identify the wound dressing type.

Review the wound appropriately at this stage

Check wound margins

Location

Feel surrounding tissue, for haematoma foreign bodies.

Check surrounding skin for perfusion and general health of tissues.

### **Question 5**

Primary dressing is the initial dressing that makes contact with the wound

Alginate best type of dressing, Kaltostat only product licensed to deal with haemostatics **bleeding** (page 942-3 in BNF) March 11 editions. Segal (1998) also supports this choice, also advocates the use of adrenaline with caution but this should be discussed with GP to rule out any other contradictions or multi pathology, as you do not have the full case history with you.

Need to be aware of cost so only order small amounts initially as FP10 (patient prescribed).

Ask student to review this process and why it is a good primary dressing.

Good for heavy exudates, easy to manipulate to wound margins, and are autolytic (break down and become bio degradable so do not need to be cleaned out completely from the wound bed, less traumatic for patient and wound healing.

### **Question 6**

Primary dressing should consist of

Alginate initially with a NA dressing to provide non adhesive cover (page 937 BNF). Mepitel, N.A. dressing etc.. these are used to reduce the risk of the dressing actually adhering to wound site or wound margins and destroying potential capillary re-growth in the form of granulation tissue from being disturbed.

Avoid paraffin gauze as dry out and cause adhesion issues.

### **Question 7**

The advice to follow here is to think of the location of the wound and the support the limb needs. It is a wound to mid gaiter area so the leg cannot have a dressing that only covers this area it needs support from joint to joint to prevent the tourniquet effect.

You also have to remember that you are having to apply direct pressure so a dressing just over the wound would not provide adequate support (Voulo 2011).

Options are

Dressing pads over the NA dressing and then blue line tubifast depending on leg size see BNF pages 952.

Avoid tubigrip as leg may swell and the tubigrip can slide and cause damage due to leg swelling and inflammation.

May use a toe to knee bandage of tubinet to hold the dressing pads, soft ban and 10 cm crepe bandages initially. It should always be a 10cm crepe bandage as this allows for spiral formation bandage or 50% lap over bandage.

Secure with tape.

### **Question 8&9**

Discuss the reasons for the prescription and what may be implications for not ordering such a lot of products are there any alternatives in the BNF,

Think about you being in the patient s home is there storage space?

Does the patient want it there?

Do you have someone who can collect prescriptions or how are you going o ensure adequate stock maintenance?

### **Question 10**

Ensure that the patient is involved in these decisions.

Pharmacists – stock control

GP to review medication. Must stop the ASPIRIN immediately,

**CAUSING BLEEDING ask student to provide the rationale again look in the BNF page 152**

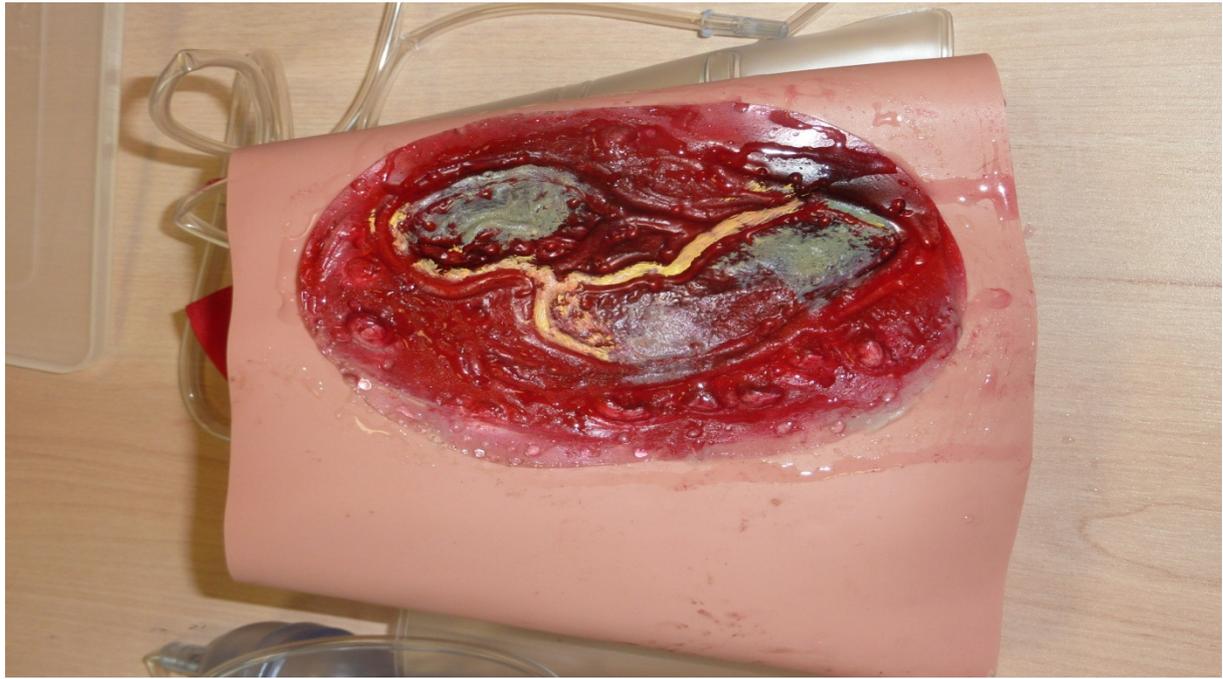
**Appropriate Analgesia**

**OVER DOSE FOR PROPHELACTIC CARDIO VASCULAR SUPPORT 300 mg, recommended for some patient groups 75mg**

There has been no evidence in research to support the use of generalised aspirin having an effect on general population, has been good links to diabetes and post MI trials (Ridker et al 2005).though recent trials have linked to aspirin usage being an effective prophylaxis against bowel cancer.

May need social intervention for support for shopping initially and house work, voluntary, private and social services may need to be involved. Discuss with the patient.

## Scenario 2.



The wound initially with the intervention and support from the nursing team has been developing well up to now in a controlled healing pattern. You have visited the wound daily for the initial week until you were sure the bleeding had stopped and that the granulation process had started to commence. Initially although you called daily you only disturbed the dressing when there was strike through (bleeding or exudates that had come through the secondary dressing) and often this would only be changed every 2<sup>nd</sup> day. To try to encourage capillary loops to reconnect and grow back forming the granulating tissue. This is a normal part of healing and links to the natural inflammatory stage.

The same dressing protocol has now been in place for 3 weeks.

The wound when you called today was malodorous and the dressing was wet from a larger amount of serous exudates “a fluid that has exuded out of a tissue or its capillaries due to injury or inflammation” online Medical Dictionary(<http://medical-dictionary.thefreedictionary.com>).

Your patient looks tired and there is some swelling to the toes and the knee area. She states that she has throbbing pain in her leg that has become worse over the past 24hrs. She looks flushed and is clammy to touch when you hold her hand.

The staff nurse has asked you to use your transferable skills to review the situation and through discussion and assessment review with her and the patient the change of care if any required. Consent has been arranged by the Nurse for this and she will directly supervise your decisions and choices.

## **Questions to ask**

1. What should the initial course of action be if wound is potentially infected?
2. What vital signs should you record as part of this assessment?
3. Can you describe and document the changes to the wound bed. Where would you write this?
4. What other signs and symptoms would you review in order to conclude that there was infection present? Use your observational and sensory skills to identify this.
5. Has there been any change in the patient's health that may affect the wound healing and how may you identify this.
6. What tools would you use alongside the Roper Logan and Tierney model of intervention (2002)? Think about the holistic re-assessment of the patient and how the tools can help you to develop an understanding of the patient's homeostasis (general well being).
7. Can the patient give consent to photography if this is appropriate?
8. Are there issues with the aging skin process, which may have an impact on wound care?
9. How long does the typical wound take to heal for an adult at what stage is this wound? What dressing choice do you need to be making?
10. Which multi team professionals may now need to be involved and why?

## **Answers for discussion for scenario 2.**

### **Question 1.**

The wound when dressing is removed and you note the changes from the last visit

Should the wound be swabbed and sent for culture and sensitivity?

You should explain your actions to Mrs Miles to reduce anxiety and explain that you may need to contact other members of the multi professional team with her permission.

Advice her that you will reassess the dressing protocol and that you will with her consent review the care plan and re-assess her needs. National Pressure Ulcer Guide ([www.npuap.org](http://www.npuap.org)) Use of ABCDE approach

### **Question 2**

Temperature check for pyrexia. Ask student what are the normal ranges and the abnormal ranges of temperature, pulse, may be tachycardic, normal ranges of pulse, breathing rate and depth, normal range, this is important to identify if the patient has systemic or localised infection problems (Ousey 2008).

Check memory and cognition to ensure that fully responsive to environment and if risk of further deterioration call out GP or hospital admission

Where do they record this information?

### **Question 3**

Record in the nursing care plan or on a wound chart such as the Bates Jensen wound assessment Tool (2006).

You should record the depth, size, length and breadth as well as the wound bed colour, odour and type and amount of exudates is present

These can be purulent, heamo purulent, high viscosity (Cutting 1998).

Check for the wound margins and also surrounding skin for heat, redness, swelling (Oedema), and friability of skin (erythema).

The wound base has pockets of granulation give these a % of the wound bed area.

The wound has sloughy greenish patches which are indicative of infection, again give these as a percentage of the wound area.

There is a sloughy yellow strand (wet necrotic tissue running through the wound area can you allocated a percentage of the wound bed to this).

Note also the wound edges.

### **Question 4**

Use a recognised pain assessment chart, verbal analogue is often quick and easy to score ie 0-10, 0= no pain and 10 excruciating. Ask when and where does it hurt most as you need to re-assess analgesia at this point before dressing change.(Stubbing and Chesworth 2005) identify that unresolved pain reduces the rate of healing and affects quality of life

Identify any signs of demarcation or localised lumps or hardness, as this was a blunt trauma full thickness wound there could have been rust or metal barbs that have located in the leg and now due to immune system they are attempting to be expelled from the wound area.

Use your hands to check for localised swelling and heat.

Check for alteration in size of limb by comparing both limbs to see if any changes noted.

Check back of the calf for signs of DVT and also for the capillary refill of the great toe or Hallux, (2-4 second capillary refill bearing in mind the age of patient).

Check colour of both limbs and also note if any blanching or ruber (heamatacritic staining due to break down of haemoglobin in the skin tissue causing a brown staining). Ousey and McIntosh (2008).

Check for bleeding excess.

There is a recognised algorithm for the signs of wound infection this is from European Wound Management Association (EWMA) document 2006.

[http://ewma.org/fileadmin/user\\_upload/EWMA/pdf/Position Documents/2006/English\\_pos\\_d oc\\_2006.pdf](http://ewma.org/fileadmin/user_upload/EWMA/pdf/Position_Documents/2006/English_pos_d oc_2006.pdf) or Ousey book page 94

Check the wound itself, what do you note.

Incidence of wound infection in the UK is predicted at 10% of all wounds ( Kingsley 2001).

### **Question 5**

She is more lethargic, eating less disturbed sleep pattern due to pain.

Check to ensure she is eating appropriately should increase the carbohydrate and protein content of the diet.

Advise increase calorific content to 2500 calories and increase protein (1 boiled egg = 40 grams of protein) this is the daily amount required for an adult.

Visually assess for ill fitting clothes do you need to weigh the patient.

Re-assess the nursing assessment document to identify life style changes.

### **Question 6 and 7**

Tools include

Waterlow to assess the pressure points due to reduced mobility.( J. Waterlow 2005)

Wound map or grid to identify changes to the actual wound site

Wound bed preparation tool

**TIME mnemonic** = **T**issue management, **I**nflammation, **M**oisture, **E**pithelial (edges) (Watret, 2005).

Doppler assessment to check for vascularity of wound? Should not be done on infected wounds

M.U.S.T. (malnutrition Universal screening Tool) score to assess nutritional and hydration levels.

European Pressure Ulcer Advisory Panel, NICE and the RCN (2005) state that (EPUAP) guide for pressure ulcer assessment should be used with any person that has reduced mobility.

Other scores may include, Norton, Braden Gosnell.

Baseline observations

Photography if consent agreed. Has capacity changed?

Take blood sample for U&E, FBC and platelet count, need to check protein and albumin levels, also check for anaemia as this reduces transportation of O<sub>2</sub> and nutrients as well as leukocytes and fibroblasts.

May need to use a food diary to check diet and fluid intake.

### **Question 8**

Collagen production loses about 1% per year so as we get older the skin becomes weaker in strength. This means that scar strength will be reduced.

The remaining collagen deposits reduce the elasticity of the skin and therefore the formation of wrinkles, less perception of sensory organs and increased risk of potential further injury.

Feel cold easier

The epidermis cells are renewed every 20 days this is increased by a 1/3<sup>rd</sup> by age 50.

There are fewer skin capillaries so less oxygenation of wound and skin, which also reduces the transportation of nutrients to injured sites and fluids which are rich in proteins (Herbert 1999)

Re-epithelisation takes twice as long for a 75 yr old as compared to a 25 yr old. This then identifies that there will be an increase in healing time for the older person. It

has to be remembered that there is a reduction in hormone production and this means that skin and hair become dryer and may need supplementing with creams when you are dressing the limb (Woodrow 2002).

Remember scar tissue formation using collagen means that any hair follicles and sweat ducts will not be replaced known as atrophy.

### **Question 9**

As this wound is a deep wound there will be no specific time for wound healing, this type of healing is known as tertiary, which means that the wound is intentionally kept open to allow the wound to attempt to granulate from the bottom up (also known as delayed primary intention). There is also primary and secondary intention healing processes. Vuolo (2009).

This wound has passed from the initial stage of wound healing- Haemostasis.

It has moved into the inflammation stage and proliferation stage, It is at this cross over point at present, this can be identified by the wound still being supported with the increased vascular permeability allowing serous fluid to carry in cells and plasma proteins to try increase the support to fight off infection, there are signs of granulation and contracting wound edges, which increases the move towards the proliferation stage, but as the wound is infected there is no movement in the maturation, Vuolo (2009).

Viewing the wound you can identify that it is exuding heavily, there are indications of localised infection, you have taken a swab so need to await results or ask GP to commence on a broad spectrum antibiotic until result comes through. The limb has demarcation lines and swelling so may need to think about not using a bandage type.

Anti microbial dressing as a primary can include (BNF 942-948)

Silver dressing alginates are often used,

Honey dressing

Gel as a primary filler and silver as a secondary dressing, this may be expensive, overly moist and difficult to apply

Flamazine cream can only keep this as an open tube for 1 week, may not be cost effective, effective in a cross infection process.

Iodine based dressing may be used if appropriate.

Charcoal based dressing; this also helps with odorous wounds.

Secondary dressing can be:

a foam dressing, (BNF 941-2)

Na wound contact dressing/silicone type or dry dressing

Do you need a soft ban/crepe combination to hold it in place as leg swelling?

Tubiline may be appropriate (page 954 BNF)

Or would a foam dressing that is adhesive be sufficient.

Things to bear in mind

Patient's life style,

Patient choice

Expense of the dressing protocol

Storage and stock levels.

### **Question 10**

District nurse, management of wound

GP to overview the care, manage analgesia and check the investigations, prescribe antibiotics.

Tissue viability? If unsure of the dressing choice

Chemist to deliver and audit stock levels.

May need a social worker if struggling with home circumstances

If struggling with meals for the short term can use voluntary or private companies, farm foods etc.

Review with the patient any needs both actual and potential.

### **Scenario 3.Work Book**

Mrs Miles after being reviewed by the multi professional team has improved in her general condition, she is sleeping better and the pain has reduced over the past 3 weeks. The GP commenced her on amitriptyline to reduce the pain and help with the sleeping which is taken nocte.

The antibiotics course of cefalexin (BNF 341) over 10 days has allowed the wound to heal and the dressing choice from the district nurse team has improved the wound bed, removed the slough areas and the exudates levels have now reduced to a minimal.

Mrs Miles did have extra support from the social worker and was allocated a care package that aided her with personal care and meal preparation. This package has been reviewed and along with the improved mobility there was an agreed phased withdrawal of care to aid self empowerment. The social support from friends is now ample to keep her socially active, she has started to walk to the shop and feels that she is eating better.

The wound has now moved from the proliferation stage to the maturation stage of healing. The wound is now shallower, loop capillary granulation is present and the wound margins are looking pink and vascular and the collagen formation is producing a clean scar surface. Keratin in the scar tissues is returning the skin tone to the area. The wound is now in its final phase.



### **Questions scenario 3**

1. What assessment tools would you use at this stage of the patients treatment.
2. How would you record the wound changes/ where would you record the changes to patient treatment.
3. What type of dressing would you choose for the patient here and why would you use this dressing protocol.
4. The swelling has now resolved from the wound area but you identify that due to Mrs Mile's age and life style she has residual swollen ankles, what health promotion advice would you give her to help with this issue.
5. Mrs Miles is now able to commence much of her social duties, how do you advise that you will be disengaging from the care package.
6. Who would be the most appropriate professional to refer the care to and why?
7. Mrs Miles asks you to take the old dressing stock away and to use it for someone else, what do you advise, discuss this ethically within the team.
8. Mrs. Miles now has dry skin on her legs and this is a concern to you, what treatment do you recommend and why, she has no allergies that you are aware of and she now has restored ability to self apply treatments.
9. Whilst you are with Mrs Miles she enquires if there are any support groups or any further information she can come into contact with, she jokes about being a "silver Surfer on the internet. Where would you advice her and what types of information would be appropriate for her.
10. You are to hand over the patient to a colleague from a different team what summary would you give , the person has access to old notes so you only need to give a summary of your last meeting.

### Answers scenario 3

#### Answer 1 and 2

We could have used a wound healing scale throughout where you can match the wound type with the stage it is at i.e. in this case the wound will have moved from full thickness wound with necrosis through to partial thickness with healing process at the maturation stage and the shallow bed moving from granulation to Scar formation.(Voulo 2010).

Could use photography rather than wound map to give patient visual reassurance and also the reduced risk of cross contamination or damage to the fragile wound margins (DH2001).

It is vital at this stage that you reassess the whole documentation and update all care plans and patient pathways. Close down any tools that are no longer required and review with your patient what they feel is important for them in the wound management as you will be handing on to another professional or filing as completed care episode(NMC record Keeping 2007) .

The pneumonic **wound picture** can help you ensure that you have completed the assessment correctly;

Helps you recall key facts for wound assessment.	
<b>W</b> ound-or ulcer location	<b>P</b> ain when does it occur, where does it occur is it directly linked to certain events; Analgesia used throughout and type of pain scale.
<b>O</b> odour (in the room or after uncovering the wound )	<b>I</b> nduration is it hard or soft to touch
<b>U</b> lcer/Wound category, stage or classification remember to include if it is full/partial thickness and wound bed.	<b>C</b> olour of wound bed and % of areas of healing.
<b>N</b> ecrotic tissue 5 of the wound bed is it dry necrosis or slough colour and moisture of wound will indicate this.	<b>T</b> unnelling length and direction, towards patient right/left ,head /foot
<b>D</b> imensions what was and what is the wound depth, breadth and length, what was and now is the exudates type if any	<b>U</b> ndermining , where what length is this and which direction is it tracking to and from( length and direction, using clock references to describe)
	<b>R</b> edness or other discolouration in surrounding skin
	<b>E</b> dge of skin loose or tightly adhered and edges flat or rolled under.

Remember that this will link to the patient's notes using the Roper Logan and Tierney model of Nursing for Activities of daily living (RLT 2002).

### **Answer 3**

This is the last stage of the healing process so we need to ensure that a protective dressing is in place. This is important now as aesthetic management may be a psychological factor for the patient.

Key questions are what are suitable, can it be a waterproof dressing and how often will it need changing at this stage.

Choices could include:

Foam dressings, adhesive or non adhesive, needs changing every  $\frac{3}{4}$  days

Hydrocolloid rehydrates wound and cause autolysis and healing can become easily malleable in warm environment.

Transparent film dressing, allow you to view wounds can see when they need to be changed and allow O<sub>2</sub> to pass through the dressing, be aware of the state of surrounding skin and also nurse needs to know how to take them off correctly.

Dry dressings can be used but again be aware of the surrounding skin types.

Review these in BNF 2011 pages 936-51

If using again think of the economics of the dressing, including if primary and secondary dressings are required or not and what the patient's life style involves, i.e. showers bathing, mobility, type of clothing she likes to wear.

### **Answer 4**

Initially Mrs Miles would have been advised to rest her limb as much as possible with the affected limb being placed slightly higher than the heart when lay down.

Now that she is active the calf muscle pump will be helping to reduce the swelling by the continual transportation of blood through the systemic system of veins and arteries. The process of aging will mean that the pumps are not as efficient as they were when she was younger, so it may be appropriate at this stage to discuss the use of a Doppler scan if not already done and assess her for some type 2 hosiery to help support the calf muscles and increase their efficiency.

Types of hosiery can be identified in the (BNF pages 995-60).

Also she had issues of feeling a little light headed on the initial statement so further clarification of pacing her day and not standing up to quick will reduce the risk of potential trauma in the future through losing her balance. (Woodrow2005).

### **Answer 5**

This is about communication strategies and how you impart information and listen to a person's concerns should they have any issues.

Think about your approach, what is the best process to commence the conversation.

Are you ready to be able to support your decisions and are you prepared to compromise the care package to ensure that concordance is achieved.

Think about Egan's, Soler (Egan 2004) position, NMC and your guidelines around professional practice and the duty of care to ensure the patient has support.

### **Answer 6**

The person Mrs. Miles should be referred to is either the practice nurse at the surgery, who you can hand over all the relevant information and dressing protocol.

Or if the team have a clinic for wound management, you should be encouraging the patient to attend there, remember that age is not the primary reason for a home visit and it is the responsibility of the nurse that resource allocation is used appropriately.

### **Answer 7**

The property is that of the patients As an FP10 prescription has been signed and delivered to the patient, so the nurse should not remove stock from the patient.

The NMC accountability (last update April 2009). Is specific in that it states that you must act in a legal and safe, professional manner at all times.

The removal and re usage of any equipment has the potential risk of being a fraudulent act; increases risk of cross contamination of products and can be seen as theft.

It may be advisable to either ring the environmental health agency to collect and dispose of it or ask her to double bag and dispose of the left over products.

### **Answer 8**

There are many products that can be either prescribed or bought over the counter at the local chemist.

The allergies are at present none noted, so it would depend on the type of treatment and the use of the product, these can be lotion, emollient, moisturising cream. One of the commonest and cheapest moisturisers is Aqueous cream and is cheap easy to apply and causes little difficulty with skin irritation there are several brands and these can be identified on page 702 of the BNF, remember that when applying it should be gently rubbed in and allowed to absorb, apply it by going with the hair follicles and not against them.

### **Answer 9**

Leg club is a web site for people who have had lower leg problems

<http://www.legclub.org/>

<http://www.healthyllegs.nhs.uk/userfiles/docstore/pdf/newsletterdec06.pdf>

<http://www.epuap.org/>

<http://www.midyorks.nhs.uk/News/The+winners+09-10.htm>

### **Answer 10**

Using the wound picture mnemonic

Hand over an oral report of the patient and their needs as you see it.

This will help you to become used to how information sharing and networking is carried out in community practice.

Reference list of books used

British National Formulary March 2011 bnf.org

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