Clinical features and management of atopic eczema in children


Abstract
This article describes atopy and the clinical features of the different types of eczema. Clinical assessment and diagnosis are included along with possible differential diagnoses. The various treatment options are also explored.

Aims and intended learning outcomes
ECZEMA IS A chronic inflammatory, pruritic (itchy) skin condition that can be caused by a combination of environmental and genetic factors. In the majority of cases eczema develops in early childhood, affecting one in five children in the UK (Royal College of Nursing (RCN) 2008).

Skin dryness and pruritus are the primary symptoms and these frequently lead to interrupted sleep patterns. Atopic eczema typically involves periods of disease exacerbation and remission, and although it often improves with age, it can continue into adulthood (Primary Care Dermatological Society and British Association of Dermatologists 2005).

The aim of this article is to provide an overview of the management of atopic eczema and some insight into trigger factors, support measures and medications that can minimise the distress of this condition for children. By reading this article and completing the Time out activities the reader should be able to:

■ Summarise the presenting features of atopic eczema, distinguishing it from skin conditions such as scabies.
■ Outline trigger factors that can initiate or exacerbate eczema.
■ Explore with parents the challenges of eczema and identify ways of managing the condition that promotes dignity for the child and family.
■ Describe available treatment options and note key recommendations about who should initiate particular therapies.

Atopy and types of eczema
Atopy describes a genetic tendency to the development of eczema and associated disorders such as asthma, rhinitis and hayfever (Ring et al 2005). An atopic tendency can increase susceptibility for changes in skin hydration, leading to skin barrier function disruption. This can lead to increased vulnerability to environmental irritants and allergen penetration that can make eczema worse (Cork et al 2004). Atopic individuals can be more likely to develop a hypersensitivity to common environmental allergens, such as house dust mites or pollen. Other types of eczema, such as discoid, pompholyx, contact dermatitis and venous eczema, have different disease patterns and are less common in children. The main types of childhood eczema are atopic and seborrhoeic eczema.

Atopic eczema in infants usually affects the face (Figure 1) and extensor surfaces of the limbs and while...
it may involve the trunk, the napkin area is usually spared whereas in older children, flexural involvement (Figure 2) predominates (National Institute for Health and Clinical Excellence (NICE) 2007). In contrast to atopic respiratory disease, atopic eczema affects more females than males, but the reasons are not understood (Harper et al 2006).

Eczema can cause considerable physical, emotional and social distress for a child and family members. This article summarises recent guidance from NICE (2007) highlighting key points for the diagnosis and management of atopic eczema in children from birth to 12 years of age in primary care.

Assessment and differential diagnosis
In the presence of an itchy skin condition, atopic eczema may be a likely diagnosis in cases involving three or more of the following criteria (NICE 2007):
- Past or current involvement of skin creases, such as behind the knees or at the elbows.
- Personal or immediate family history of asthma or hay fever.
- Tendency to dry skin.
- Flexural eczema (current or past history) (Figure 2).
- Onset under two years of age (Figure 1).

Differential diagnosis In very early atopic eczema, a differential diagnosis of seborrhoeic eczema should be considered. Pityrosporum is related to the presence of the yeast and can develop on sebum (natural oil) producing skin areas. It is commonly seen in babies up to six months of age as cradle cap (Figure 3). It can involve greasy yellow patches that form a thick scaly layer on the scalp, extending to the eyebrows, nape of the neck and postauricular areas. Seborrhoeic eczema can also present as a facial rash, particularly to the eyebrows and near to the nose (Cohen 2004). Skin creases and dermatitis of the nappy area can also be involved (Figure 4).

Scabies (Figures 5 and 6) is a common, highly contagious, intensely pruritic differential diagnosis to be considered in the development of sudden onset of pruritic skin in children or as an exacerbating factor in children with eczema, particularly if the web spaces of the hands or feet or family members are also affected.

Now do Time out 1

Clinical assessment of disease severity
Clinical assessment of a child with eczema should include the extent and severity of active eczema and the lichenified (thickened skin due to rubbing), signs of infection (such as crusting, weeping, pustules, the extent of which may rapidly worsen with extensive pruritus and excoriation, fever or malaise). Skin examination should include observation for possible side effects of oral or overuse of topical corticosteroid therapy, such as skin thinning, tendency to bruising and telangectasia (small noticeable blood vessels) and loss of skin elasticity leading to striae (stretch marks). These potential side effects can be of great concern to parents and can lead to a fear of using adequate treatment (NICE 2007).

History taking should include:
- The onset and distribution.
- Family and personal history of atopy, eczema or other skin disease.
- Contact with potential aggravating factors, such as pets.
- Sleep pattern and dietary history.
- The normal skin-care routine.
- Response to current and previous treatment regimens.
1 Diagnosis and consultation

Imagine you are consulted by an anxious parent who has noted some worrying skin lesions on their nursery school-age child. How would you help this person decide what the problem is and help them to distinguish eczema from scabies? If you have shared such a consultation in the past, which part of your explanation seemed the most useful?

- Medicine regimens and known allergies.
- General health, growth and social development.
- Effect on family, school and social activities.

Occasional reports suggest that use of topical and oral corticosteroid therapies can lead to a retarded growth pattern, however, this is only seen in exceptional cases (Ring et al 2005). Growth failure in children with atopic eczema is more commonly associated with sleeplessness and poor appetite due to pruritus. Growth and development monitoring is therefore an important part of the clinical evaluation of children with atopic eczema. Centile charts can help monitor whether growth measurements are within ‘normal’ ranges.

Assessing the severity of eczema is essential in guiding clinical management. NICE guidance (2007) includes an evaluation of 13 different eczema severity measurement tools. NICE (2007) reports that many eczema severity assessment tools, such as the SCORing Atopic Dermatitis (SCORAD) and Eczema Area and Severity Index (EASI) instruments have been validated and deployed in the research setting, therefore nurses may find some measurement tools too complicated or time consuming for use in a clinical setting.

NICE guidance suggests that the use of a structured, validated instrument, such as the Patient-Orientated Eczema Measure (POEM), the Children’s Dermatology Life Quality Index (CDLQI) or the Dermatitis Family Impact (DFI) questionnaire, is sufficient to provide an objective measure of eczema severity and response to treatment (NICE 2007).

Now do Time out 2

Holistic assessment

Healthcare professionals should adopt a holistic approach when assessing a child’s eczema. NICE guidance (2007) suggests that the severity of eczema and quality of life should be assessed at each consultation. It is recognised that the severity and quality of life may not be directly related, and clinically mild eczema can have a negative effect on individuals and family members. The level of tolerance, especially to pruritus can vary. It can affect the individual’s sense of integrity, self-esteem and it can increase dependence on parents (Faught et al 2007).

2 Using scoring tools

Visit relevant websites and literature resources and compare scoring tools designed for the assessment of eczema. For example:

- **NHS Evidence**
  Skin disorders
  www.library.nhs.uk

- **National Eczema Society**
  Healthcare professionals
  www.eczema.org/professionals.html

The following questions will help you to evaluate their individual merits:

- To what extent does this instrument enable me to capture all the relevant features of the eczema, enabling comparisons to be made later?
- Does the scoring system offer a clear scale to help me use the scores consistently and share these with other colleagues?
- If I were to discuss such scores with a parent, how accessible is this instrument to a lay person?
or parent discusses the condition. Is the account tinged with anger, frustration or a sense of disgust? Explore perceptions about whether the condition limits social opportunities and especially the child’s ability to form and sustain friendships. Establishing whether the condition is seen as a challenge, a burden or an inescapable trap will help you to ascertain the current state or morale and can lead to further discussions about treatment and psychological support.

Now do Time out 3

**Coping strategies**

Pause to describe some of the ways in which families you have known have coped with persistent eczema. Can you identify positive and negative aspects? Have you played a role in helping families to find a more constructive approach to eczema – one that promotes integrity for the child and the family as a unit?

**Potential trigger factors**

Healthcare professionals should seek to identify major potential trigger factors. A detailed history should be taken of any suspected allergies that might exacerbate the eczema.

**Irritants and environmental factors** Some commonly used products, such as soap, detergents and woollen clothing, can have an irritant effect on the skin in people with eczema. Extremes of temperature and excess contact with water, particularly hot water, can also exacerbate it (Harper et al 2006). Atopic individuals are more likely to become sensitive or allergic to environmental substances, for example, house dust mites, animal dander, pollen and mould spores.

Some individuals with house dust mite allergy experience uncontrolled eczema, particularly to facial skin. There is conflicting data about the effectiveness of house dust mite eradication strategies in managing childhood atopic eczema. NICE (2007) concludes that many techniques can be time consuming and expensive and it can be difficult to establish their value. It can be useful to introduce simple measures such as pillow and mattress covers, however, if house dust mite allergy is suspected or proven (National Eczema Society 2009).

**Infection secondary to atopic eczema**

Bacterial colonisation of the skin is enabled by epidermal damage and is therefore common in children with eczema. This has been reported to contribute to continuing disease activity in some cases, but it may not always lead to clinically infected skin (NICE 2007). The development of secondary skin infection in eczema (fungal, viral or bacterial) is common and should be excluded as a possible cause of exacerbated eczema or a failure to respond to moderately potent or potent corticosteroid topical therapies. Fungal and yeast infections can proliferate in areas, such as the folds and creases in the skin. However, they usually respond to topical antifungal preparations.

Bacterial skin infection commonly involves *Staphylococcus aureus* or *Streptococcus pyogenes* (Shah and Mohanraj 2003). Such infections present as severe exacerbation of pruritus and discomfort, and evidence of serous weeping and or honey-coloured crustings or pustules. There may be lymphadenopathy, fever and malaise. In cases of suspected bacterial infection to localised skin areas, a topical corticosteroid preparation combined with antibacterial properties may be sufficient.

Care must be taken, however, with continued use of topical antibacterial products. It has been shown
that long-term or incomplete courses of fusidic acid preparations can lead to resistance and reduced efficacy (Shah and Mohanraj 2003). It is advised that topical antibacterial preparations are only used for up to a two-week period (NICE 2007). An oral antibiotic therapy course of up to two weeks, according to local prescribing guidelines, should be considered in cases of generalised or severe infected eczema or failure to respond to topical therapies.

A skin swab can be useful in eczema that is failing to improve so that the bacterial load and antibiotic sensitivity can be checked. The staphylococcal bacterial load inside the nose can be high and can lead to self-contamination and cases of recurrent skin infection. A nasal swab may be advocated in a small number of cases of heavy infection and a nasal antibiotic preparation may be selectively prescribed. Bacterial transmission between an affected child and family members can be possible and should be considered in cases of recurrent infected eczema.

Skin infection is a common complication of eczema. Taking a skin swab in managing eczema remains controversial. NICE guidelines (2007) suggest that skin swabs taken for bacteriological culture are generally of limited use in children with eczema due to the tendency for colonisation of the skin with Staphylococcus aureus. Skin swabs may be useful, however, in cases of recurrent infection, concerns about microbial resistance to antibiotics commonly used for Staphylococcus aureus or clinical suspicion of unusual organisms.

Now do Time out 4

4 Antimicrobial resistance

Refer to your local guidelines for advice and information about local patterns of resistance to antimicrobials. Determine the arguments made for the policy that has been adopted.

Eczema herpeticum Signs of eczema herpeticum include:
- Areas of rapidly deteriorating, painful eczema.
- Clustered blisters consistent with early-stage cold sores.
- Crusted punched-out erosions that may coalesce.
- Fever, lethargy, malaise or distress (NICE 2007).

If eczema herpeticum (Figure 7) (widespread herpes simplex viral infection) is suspected in a child with atopic eczema, urgent specialist dermatology advice is usually required.

Immediate treatment with oral aciclovir and systemic antibiotics is required if secondary bacterial infection is also suspected. If eczema herpeticum involves the peri-ocular area, an urgent ophthalmological assessment should be sought.

Varicella (chickenpox) Chickenpox can present in children with atopic eczema as a generalised pruritic rash and can severely exacerbate eczema (Figure 8).

Contact allergens Contact dermatitis is the term used for adverse inflammatory skin changes caused by contact with a certain product, due to either an irritant or allergic reaction (Gebhardt et al 2000). Bruckner et al (2000) highlight a greater risk of certain substances, for example, fragrances, as a common cause of skin sensitisation in individuals with atopic eczema.

Food allergens Possible food allergy should be considered in a child who develops symptoms following ingestion of certain foods and when moderate or severe uncontrolled eczema persists despite optimum management. Cow’s milk, eggs, peanuts, soya and seafood are some of the most common food allergens in children (Harper et al 2006).

Children with suspected food allergy should be referred for specialist investigation and assessment, particularly if accompanied by systemic features, such as vomiting, altered bowel habit or failure to thrive (NICE 2007). Dietary manipulation has been shown to have the potential to reduce eczema severity in children with proven food allergy (NICE, 2007). Clinical guidelines suggest that a child following a cow’s milk-free diet for more than eight weeks should be referred for specialist dietary advice. The guidelines also suggest that diets based on unmodified proteins from other species, including sheep and goat’s milk or partially hydrolysed formulas, should not be used in children with atopic eczema for managing suspected cow’s milk allergy (NICE 2007).

A further suggestion in clinical guidelines (NICE 2007) is that a six- to eight-week trial of extensively
hydrolysed protein formula or amino acid formula should be offered in place of cow’s milk formula for bottle-fed infants aged under six months with moderate to severe eczema that has not been controlled by optimal use of a standard treatment regimen consisting of emollient and topical corticosteroid preparations.

Principles of management
The main aims of treatment are to relieve symptoms, maintain skin integrity, prevent infection and improve quality of life. This includes identification and avoidance of exacerbating factors, good skin care and anti-inflammatory treatment. Management should follow a stepped approach (Box 1) tailoring treatment according to the severity (NICE 2007).

Emollients
Evidence suggests that emollients should form the basis of treatment for atopic eczema to accelerate the regeneration of skin barrier function by preventing moisture evaporation and maintaining skin hydration and integrity. Emollients can be soothing, reduce pruritus – the itch/scratch cycle – and reduce the degree of skin lichenification and the risk of secondary infection (Held et al 2001, Cork et al 2003). The importance of consistent emollient use is advised, even when the eczema appears to be controlled well (NICE 2007). Used in recommended quantities, emollient therapy can reduce the frequency and potency of the topical corticosteroid treatment that is required (Cork et al 2003, Grimalt et al 2007).

Children with eczema may require up to 500mg weekly of ‘leave on’ emollients (NICE 2007). A leave on emollient is a moisturiser that is applied and left on the skin for therapeutic use. Emollients are available in a range of preparations, including creams, ointments, lotions, gels, aerosol sprays, shower and bath products. A choice of emollients should be offered for washing and moisturising to help minimise the use of soaps and hygiene products containing fragrances.

Concordance depends largely on the cosmetic acceptability (NICE 2004a). Clinical guidance reinforces that children are entitled to be fully involved in decision making about their health (Department of Health (DH) 2004). Other guidance addresses issues of consent in children and young people (DH 2001). Nurseries and schools should have access to products required for individual children.

In comparison to cream preparations, ointments contain the least potential sensitisers. As creams are water based, the addition of preservatives is required to prevent microbial growth. Ointments are greasier and occlusive, so they work effectively. However, they may not be cosmetically pleasing. Creams are lighter but require more frequent application. Pump dispensers are useful to prevent re-contamination from open containers.

Aqueous cream is commonly prescribed as a moisturiser to be applied and left on the skin. It was originally intended, however, to be used only as a soap substitute. It has a high water content which can reduce its efficacy as a moisturiser that is left on the skin. Cork et al (2003) found aqueous cream led to stinging and discomfort in a significantly higher proportion of children with atopic eczema, in comparison with other emollients. Bath or shower emollients may help to ameliorate some of the drying effects of water by leaving a layer of oil on the skin (Ersser et al 2007).

Some emollients contain antipruritic properties that may be useful to improve comfort. Others have

<table>
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<tr>
<th>Box 1 Stepped approach to treatment</th>
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<tr>
<td><strong>Mild atopic eczema</strong></td>
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<tr>
<td>Emollients.</td>
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<td>Mild potency topical corticosteroids.</td>
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<tr>
<td><strong>Moderate eczema</strong></td>
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<td>Emollients.</td>
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<td>Mild potency topical corticosteroids.</td>
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<td><strong>Severe eczema</strong></td>
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<td>Bandages.</td>
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<td>Phototherapy.</td>
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(National Institute for Health and Clinical Excellence 2007)
ointments are heavily used (Ersser et al 2007). Slipperiness in the bath and a possible fire risk when dermatitis, folliculitis, overheating (by occlusion), and potent topical corticosteroids, however, NICE (2007) reports that available studies are inadequate for evaluation to address this.

Oral corticosteroids Short courses may be required to gain control in severe cases under close specialist supervision.

Antihistamines Sleep disturbance is common. Many of the eczema symptoms are unrelated to histamine release therefore oral antihistamines may be of little benefit to reducing pruritus. NICE guidance (2007) suggests that a short trial of an appropriate sedating antihistamine may be useful in promoting sleep in the short term if sleep disturbance has a great impact, although this must be balanced with a risk of drowsiness during the daytime.

Now do Time out 5

Second-line therapies
Second-line treatments may be indicated when there is a failure to respond, an inadequate response to treatment or in cases where there are marked side effects from use of topical therapies.

Topical calcineurin inhibitors It is recommended that physicians with a specialist interest in dermatology initiate topical calcineurin inhibitors (NICE 2007). They are not recommended as first-line treatments for eczema (NICE 2007). Topical tacrolimus is licensed as an option for second-line treatment of moderate to severe atopic eczema in children aged two years and above (NICE 2004b).

Pimecrolimus is recommended in its licensed indications as an option for the second-line treatment of moderate atopic eczema on the face and neck in children aged two to 16. These can be effective non-steroidal anti-inflammatory treatments that, in...
contrast to topical corticosteroids, do not cause skin atrophy and may be indicated where there is a serious risk of adverse effects from further topical corticosteroid use. Topical calcineurin inhibitors can be particularly useful in areas of skin, such as the face and flexures, where higher than mild topical corticosteroid therapy is not advised. They can be applied to active eczema areas that involve broken skin (NICE 2004b). There is limited data on the long-term side effect profile.

There are some concerns about the increased risk of localised infection and a theoretical risk of cutaneous malignancy associated with long-term cutaneous immunosuppression. Application of these therapies is not advised within two hours of moisturising and some individuals may experience a burning sensation. Children and their parents should therefore receive advice about discontinuing therapy in cases of uncontrolled infection and about ensuring adequate sun protection (NICE 2004b).

**Wet wrap dressings** Used by clinicians trained in their use, wet wrap dressings can be a useful short-term therapy to treat an acute flare-up of severe atopic eczema (Lawton 2007). Wet or paste bandages are applied over a layer of emollient or topical corticosteroid underneath cotton stockinet or garments. This technique can cool, hydrate and protect the skin and prevent scratching. Such occlusive treatment is contraindicated in the presence of infected eczema and can increase the absorption of topical medications (Lawton 2007). The general consensus is that wet wrap therapy should be instigated and supervised by a practitioner with specialist dermatology expertise.

The National Patient Safety Agency (NPSA) has warned about the potential fire hazard associated with paraffin-based skin products on clothing and dressings near an open flame. It recommends that information about the potential fire risks are issued to families of children requiring these products (NPSA 2008).

**Phototherapy and systemic treatments** Oral corticosteroids can be used in short courses to control severe eczema. Long-term use should be avoided, where possible, due to the risk of significant side effects. Oral corticosteroids have an immunosuppressive effect, therefore, concomitant antibiotic therapy is important where the skin is infected. NICE (2007) suggests options of ultraviolet light and other systemic immunosuppressive treatments can be considered with dermatology supervision when other management options for moderate to severe eczema have failed or are inappropriate.

**Complementary therapies** NICE guidance (2007) highlights that effectiveness and safety of complementary and alternative therapies for atopic eczema in children, such as homeopathy and herbal medicine, have not been adequately scientifically assessed. This clinical guidance outlines that some Chinese herbal medicines have been found to contain unlabelled, potentially harmful ingredients. They are associated with liver toxicity and, therefore, great care should be taken with the use of such products.

Now do Time out 6

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**Treatment review**

**Referral to secondary care**

The following is a list of the recommendations for referral to hospital paediatric dermatology services for assessment, advice and support (NICE 2007):

- Uncertain diagnosis.
- Urgent referral is advised if severe uncontrolled bacterial or viral infection is suspected.
- Moderate to severe eczema failing to respond to appropriate therapies in primary care, particularly in cases where excessive volumes of topical or oral corticosteroids are required or where the child or parent/carer may benefit from specialist advice about treatment.
- Sleeplessness.
- Cases where additional social or psychological support is required.
- Suspected contact dermatitis.
- Eczema herpeticum.

Allergy tests are not generally necessary in most children with mild eczema. Allergy testing, such as prick or patch testing, can be useful in some children with poorly-controlled eczema. NICE guidance (2007) suggests there is no evidence to demonstrate the value of high street allergy tests in managing childhood eczema.

**Conclusion**

Eczema can cause considerable distress for children and their families. Emollients and other therapies have a major role in eczema symptom relief, and should not be underestimated or under-prescribed. Effective therapy involving access to a range of appropriate skin care products and good clinical support can significantly improve the quality of life for children with atopic eczema and their families. Parents should be informed of how to minimise and treat exacerbations of eczema, how to recognise skin infection and how to access relevant help. It is important to recognise and understand...
the nature of eczema and the burden it can impose on children and their families. Children with eczema are generally managed in primary care with multidisciplinary clinical support from secondary care, dermatology specialists, children and young people’s services and community paediatric teams. Good links between the parents, health care and educational teams are vital to assist with some of the difficulties encountered. National eczema support groups can provide guidance with coping strategies and an extended network for family support.

Now do Time out 7

Practice profile

Now that you have completed the article you might like to write a practice profile. Guidelines to help you are on page 44.

References


Find out more

Further information on eczema and other skin conditions can be found at:

- British Association of Dermatologists www.bad.org.uk (Last accessed: October 9 2009.)
- British Dermatological Nursing Group www.bding.org.uk (Last accessed: October 9 2009.)
- Atopic Eczema in Children from Birth up to the Age of 12 Years www.nice.org.uk/CG57 (Last accessed: October 9 2009.)
- Primary Care Dermatology Society www.pcds.org.uk (Last accessed: October 9 2009.)
Continuing professional development

Practice profile

What do I do now?
- Using the information in section 1 to guide you, write a practice profile of between 750 and 1,000 words – ensuring that you have related it to the article that you have studied. See the examples in section 2.
- Write ‘Practice Profile’ at the top of your entry followed by your name, the title of the article, which is: ‘Clinical features and management of atopic eczema in children’, and the article number, which is PN223.
- Complete all of the requirements of the cut-out form provided and attach it securely to your practice profile. Failure to do so will mean that your practice profile cannot be considered for a certificate.
- You are entitled to unlimited free entries.
- Using an A4 envelope, send for your free assessment to: Practice Profile, RCN Publishing Company, Freepost PAM 10155, Harrow, Middlesex HA1 3BR by November 2010. Please do not staple your practice profile and cut-out slip – paper-clips are recommended. You can also email practice profiles to practiceprofile@rcnpublishing.co.uk. You must also provide the same information that is requested on the cut-out form. Type ‘Practice Profile’ in the email subject field to ensure you are sent a response confirming receipt.
- You will be informed in writing of your result. A certificate is awarded for successful completion of the practice profile.
- Feedback is not provided: a certificate indicates that you have been successful.
- Keep a copy of your practice profile and add this to your professional profile – copies are not returned to you.

1. Framework for reflection
- Study the checklist (section 3).
- What have I learned from this article?
- To what extent were the intended learning outcomes met?
- What do I know, or can I do, now, that I did not/could not before reading the article?
- What can I apply immediately to my practice or client/patient care?
- Is there anything that I did not understand, need to explore or read about further, to clarify my understanding?
- What else do I need to do/know to extend my professional development in this area?
- What other needs have I identified in relation to my professional development?
- How might I achieve the above needs? (It might be helpful to convert these to short/medium/long-term goals and draw up an action plan.)

2. Examples of practice profile entries
- Example 1 After reading a CPD article on ‘Communication skills’, Jenny, a practice nurse, reflects on her own communication skills and re-arranges her clinic room so that she will sit next to her patients when talking to them. She makes a conscious decision to pay attention to her own body language, posture and eye contact, and notices that communication with patients improves. This forms the basis of her practice profile.
- Example 2 After reading a CPD article on ‘Wound care’, Amajit, a senior staff nurse on a surgical ward, approached the nurse manager about her concerns about wound infections on the ward. Following an audit which Amajit undertook, a protocol for dressing wounds was established which led to a reduction in wound infections in her ward and across the directorate. Amajit used this experience for her practice profile and is now taking part in a region-wide research project.

3. Portfolio submission
Checklist for submitting your practice profile
- Have you related your practice profile to the article?
- Have you headed your entry with: the title ‘Practice Profile’; your name; the title of the article; and the article number?
- Have you written between 750 and 1,000 words?
- Have you kept a copy of the practice profile for your own portfolio?
- Have you completed the cut-out form and attached it to your entry?