Wound-related pain: features, assessment and treatment


Abstract
This article explores the problem of wound-related pain. It provides an overview of the different types of pain associated with wounds, discusses approaches to pain assessment and considers a range of strategies that may be used to minimise wound-related pain.

Aims and intended learning outcomes
This article aims to explore the key principles that underpin the safe and effective management of patients who are experiencing wound-related pain. It discusses pain mechanisms and seeks to explain why and how wounds are experienced as being painful. The practice of wound-related pain assessment is considered and the article concludes by considering how best to manage wound-related pain.

After reading this article and completing the Time out activities you should be able to:
■ Identify the parts of the nervous system that are involved in the perception of wound-related pain.
■ Differentiate between nociceptive and neuropathic pain.
■ Consider the benefits of assessing and treating wound-related pain.
■ Explore the range of interventions that can be used to minimise wound-related pain.

Introduction
The management of wound-related pain has received increasing attention over recent years. In the past seven years, five guidance documents aimed at practitioners caring for patients with painful wounds have been issued (European Wound Management Association (EWMA) 2002, Wounds-UK and Mölnlycke Health Care 2004, World Union of Wound Healing Societies (WUWHS) 2004, 2007, Coloplast 2008).

This article aims to provide an overview of the clinical features, assessment and treatment of wound-related pain. It outlines the extent to which the management of both acute and chronic wound-related pain aids recovery from ill health and improves quality of life. The complex and subjective nature of the pain experience is discussed and a brief overview of the physiology of wound-related pain is presented. The article also explores the assessment and treatment of wound-related pain.

Types of wound-related pain
A range of terminologies has been used to describe the conditions under which a patient experiences wound-related pain. Figure 1 shows the WUWHS (2004) approach to classifying wound pain in terms of underlying causes.

The approach highlights four main types of pain – operative, procedural, incident and background – and also acknowledges the role played by environmental and psychological factors in pain perception. Alternative terminologies for wound pain are found in the Wound Pain Management Model, which uses the descriptors temporary, persistent and procedure-related to categorise types of pain. In this model, categories of pain type are not mutually exclusive and patients with chronic wounds may experience a number of different types of pain on different occasions (Price et al 2007).

Acute wound-related pain Wounds are generally categorised as either acute or chronic. Acute wounds, such as incision wounds following surgery, thermal burn injuries or traumatic wounds, are initially extremely painful, but often become less painful as healing progresses.

The rate of healing is dependent on many variables, including age, nutritional status and concomitant illness, and there is some evidence to suggest that pain-induced stress may be a barrier to wound healing (Soon and Acton 2006). Research conducted on acute...
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Wounds such as blisters and other types of superficial skin wounds suggest that psychological stress is associated with an increase in wound repair times, and that such delay is likely to be attributable to lower levels of pro-inflammatory cytokines secondary to depressed immune function (Soon and Acton 2006). Various physiological and behavioural responses are associated with acute pain. Pediani (2001) cited the adverse effects of poorly managed post-operative pain. These include:

- Decreased respiratory movement.
- Delayed mobilisation following surgery.
- Increased activity in the sympathetic nervous system.
- Changes in hormonal and metabolic activity.

Pediani (2001) also suggested that decreased blood flow resulting from activity in the sympathetic nervous system may be detrimental to healing because the deposition of collagen is adversely affected by a diminished oxygen supply to the wound. Choinière (2001) suggested that the inadequate management of procedure-related pain evokes an anticipatory conditioned response to pain.

Although this was originally related to the management of burn pain, it could be applied to a number of painful wounds. Choinière (2001) also highlighted the link between pain management, psychological resilience and recovery, suggesting that psychological resilience is likely to decline and fatigue levels increase when the experience of discomfort and distress persists.

**Chronic wound-related pain** Chronic wounds are associated with prolonged healing, which is usually secondary to a combination of local, regional and systemic factors that prevent an ordered sequence of healing (White 2008a). Pressure ulcers and leg ulcers are common types of chronic wounds, both of which have been consistently documented as being associated with significant pain and discomfort (Hopkins et al 2006, Briggs et al 2007, Spilsbury et al 2007).

Chronic wound-related pain is likely to have a complex aetiology (as discussed later) (White 2008b). Briggs (2006) highlighted the poor recognition of wound-related pain, which, it is suggested, is likely to be experienced by between half and three quarters of patients with leg ulcers. The experience of chronic pain may have a negative effect on quality of life, mental health, sleep quality and physical and social activity (Palfreyman 2008).

The American Pain Society's (1999) assertion that pain is the fifth vital sign signifies the importance of pain as an indicator of bodily dysfunction or disease. Within the context of wound care, there is general consensus that pain is a reliable indicator...
of localised wound infection and/or inflammation (Woo et al 2008). However, in chronic wounds, pain may be attributed to causes other than infection and inflammation. Grocott et al (2008) cited the example of leg ulcers and suggested that additional causes of wound pain include macerated or eczematous peri-wound skin, phlebitis or thrombosis, underlying bone pathologies, tight bandages and uncomfortable dressings.

Defining pain
It is widely acknowledged that the experience of pain is subjective and personal. This idea is supported by the explanation that environmental, social, psychological, developmental, emotional and cultural factors are important mediators of the pain experience (MacLellan 2006). The most widely cited definition of pain states that pain is: ‘an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage’ (International Association for the Study of Pain (IASP) 1994).

The concept of pain as a psycho-physiological phenomenon developed from work undertaken by Melzack and Wall (1965), which led to the development of the Gate Control Theory, followed by a three-dimensional model of pain (Melzack and Wall 1982, Briggs 2006, MacLellan 2006). The Gate Control Theory was important because it described the transmission and modulation or modification of noiciceptive signals from the peripheral and central nervous system (Wulf and Baron 2002). Hence, the presence of an inflammatory state within a wound will render a wound to be more painful and more susceptible to induced pain than in normal tissue (Clay and Chen 2005). This increased sensitivity may be experienced both in the wound itself (primary hyperalgesia) and in the surrounding skin (secondary hyperalgesia) (WUWHS 2004).

Rating pain
Consider the phrase ‘pain is what the patient says it is’. Do you think this is always correct? In what circumstances might this phrase be unhelpful?
The IASP (1994) defines hyperalgesia as an increased response to a stimulus, which is usually painful. The fact that hyperalgesia develops as a response to continued transmission and perception of pain signals, underlines the importance of good pain control when caring for patients who are experiencing pain.

Neuropathic pain

Neuropathic pain (sometimes referred to as neurogenic pain) has been defined as an inappropriate response caused by a primary lesion or dysfunction in the nervous centre (WUWHS 2004). The causes of neuropathic pain are less well understood (Clay and Chen 2005), but nerve damage as a result of trauma, infection, metabolic disorders or cancer are often implicated in this type of pain (WUWHS 2004). The symptoms associated with neuropathic pain are fairly well documented and include burning, tingling, electric or shooting sensations (Hollinworth 2005, MacLellan 2006). Neuropathic wound-related pain is considered more difficult to manage than nociceptive pain and usually requires specific drugs such as low dose antidepressants and anticonvulsants to dampen the hyperactivity of damaged nerves (Briggs et al 2007).

Allodynia is a neuropathic condition in that it occurs in patients with lesions of the nervous system where touch, light pressure or moderate cold or warmth evoke pain (IASP 1994). It is different to hyperalgesia in that a pain response is elicited from a stimulus that does not normally provoke pain. In other words, the original modality of the stimulus is non-painful, but the response is painful (IASP 1994). Tests to determine the presence of wound-related allodynia include the use of gentle wound irrigation (Briggs et al 2007) or gentle stroking with cotton wool over the wound site (Bennett 2001).

The extent to which neuropathic pain is a feature of leg ulceration was explored by Briggs et al (2007) in a six-month cohort study of 96 patients with venous and non-venous leg ulcers. Pain symptoms were recorded using the Leeds assessment of neuropathic symptoms and signs (LANSS) pain scale (Bennett 2001), which has been used in a variety of clinical settings to discriminate between nociceptive and neuropathic pain symptoms.

Briggs et al (2007) found that pain intensity ratings were statistically significantly higher in the patients experiencing neuropathic pain compared with those experiencing nociceptive pain (P<0.001), and suggested that people with a leg ulcer who have neuropathic pain have more intense pain than those with an ulcer that is predominantly nociceptive.

**Box 1 Rationale for assessing wound-related pain**

- The management of wound-related pain is often a high priority for patients.
- Pain management is more likely to be successful if performed in conjunction with regular and comprehensive pain assessment.
- Pain assessment information provides a baseline against which future pain assessment data may be compared.
- Pain assessment can help to identify factors that either help the patient to cope with pain or, alternatively, factors that make the pain worse. This can inform the planning of painful activities such as wound dressing.
- The symptom of pain has important diagnostic potential.

Given that patients who experience chronic wound-related pain may experience neuropathic pain, how might this affect their experience of activities such as wound cleansing and dressing placement and removal?

**Rationale for pain assessment**

Practitioners have a better chance of getting pain management right if pain is assessed regularly. Box 1 summarises the key reasons that make the assessment and management of pain a clinical priority.

**Box 2 Questioning patients**

What sort of questions might you use to explore the pain experience of some of the patients you encounter?
Approaches to pain assessment
Pain assessment is by no means straightforward. The choice of language, non-verbal communication and the style of conversation when discussing pain all need to take into consideration the cultural, economic, social, cognitive, demographic and environmental factors that might affect a patient’s willingness and ability to report and explain painful experiences (Closs et al 2004). Formal assessment and documentation of wound-related pain is recommended by a number of sources (Hollinworth 2005, Barrett 2007, WUWHS 2007). Formal pain assessment usually refers to the use of validated assessment tools and involves the use of pain scales designed to elicit information about pain intensity. Figure 2 depicts examples of the four most commonly used scales: the verbal rating, numerical rating, visual analogue and pictorial rating scales.

Deciding which pain scale to use is best done in accordance with patient preference (Barrett 2007). Closs et al (2004) found that most pain assessment tools have been designed and tested on relatively young adults and, while such tools are often considered more effective than the use of general questioning to elicit information about pain, a broader, more wide-ranging assessment of pain may be necessary among older adults and, in particular, older adults with cognitive impairment.

The view that older people may prefer a 0-10 numerical scale to other pain scales has been reported (Gibson et al 2004, WUWHS 2007). However, Closs et al (2004) suggested that the verbal rating scale (no pain, mild, moderate, severe) was found to be slightly easier to use than other scales among nursing home residents with some degree of cognitive impairment.

The WUWHS (2004) considered self-reported pain to be the gold standard in pain assessment and recommended that most patients should be deemed able to use a pain rating scale unless otherwise indicated. Pain assessment in patients who cannot communicate is difficult because proxy indicators such as vocalised signals and bodily movements become significant in terms of establishing the extent of the pain experience (Woo et al 2008). Pautex et al (2007) reported some success in the use of a pain assessment tool for patients with dementia. This tool is called the Doloplus-2 scale and features the use of observations of behaviour as a proxy measure for reported pain.

Wound-related pain may vary over time, necessitating frequent reassessment (WUWHS 2007). Pain related to wound dressing changes and procedures is often reported as the most distressing aspect of having a wound (Price et al 2008), and assessments of pain intensity should be taken before, during and after dressing changes or similar procedures (WUWHS 2004, 2007, Barrett 2007). Some of the literature on pain management cites that a persistent pain score of four or more out of ten on a numerical rating scale (or equivalent) indicates uncontrolled pain necessitating the review of pain management strategies (WUWHS 2004, Mularski et al 2006). The most recent guidance from the WUWHS (2007) makes no reference to pain score thresholds and instead states that a change in the pain level may indicate a need to reassess the wound and consider new complications, the wound care procedure, wound dressing, analgesic choice or other pain management interventions.
Barriers to assessing and managing wound-related pain

Research has identified failure by nurses to assess wound-related pain regularly and comprehensively (Hollinworth 2005, Briggs 2006, Barrett 2007). Information in this area is limited, but it has been suggested that nurses’ psychological responses to patients’ pain may go some way to explaining why talking to patients about their pain is difficult (Nagy 1999, Wilson 2008). Nagy (1999) identified that almost all of a sample of 32 nurses who worked in a specialist burns unit used ‘distancing’ as a way of coping with the reality of being involved in inflicting pain on patients during dressing changes. Distancing was described not as an attempt to deny the existence of pain, but to lessen its effect on the nurse by placing an emotional and/or physical distance between the nurse and the patient’s pain (Nagy 1999).

Nurses’ psychological responses to patients’ pain were also explored in Wilson’s (2008) vignette-based part replication study of McCaffery and Ferrell’s (1992) exploration of the relationship between patients’ characteristics and nurses’ assessment and subsequent management of post-operative pain. Wilson’s (2008) findings lent direct support to the proposal that patient lifestyle and socioeconomic status can lead to the attribution of bias with respect to nurses’ pain assessment and instigation of pain management strategies. In addition, Wilson (2008) suggested that one explanation for a nurse giving sub-optimal doses of opiate pain relief to post-operative patients was that his or her previous experiences of pain management problems, for example inadequate drug prescriptions for pain relief or delay in reviewing prescriptions, may have resulted in the use of coping strategies in the form of denial or rationalisation. Wilson (2008) provides an example of this by suggesting that nurses may draw on myths about respiratory depression, addiction and physical dependence to rationalise the use of sub-optimal pain relief.

Pharmacological approaches

Analgesic medication is the first-line treatment for wound-related pain, and a number of options, with respect to type or class of analgesia and route of administration, exist. The option of long-acting and slow-release formulations should be considered for background pain and fast acting top-up analgesia should be considered for managing procedure-related pain (WUWHS 2004). Multimodal approaches to pain management may increase the effectiveness of pain management while removing the need for high doses of single analgesics (Coulling 2007).

The effectiveness of analgesia in managing wound-related pain varies between individuals and wound types. In an international survey of the pain experience of more than 2,000 patients with chronic wounds, 58 per cent of patients reported the use of analgesia, with 82 per cent of individuals suggesting that this type of pain relief was effective (Price et al 2008).

The World Health Organization (WHO 2009) has developed a three-step ladder for managing cancer pain (Figure 3), which is also recognised as a valuable approach to managing wound-related pain (EWMA 2002). The WHO (2009) pain relief ladder recommends a step wise approach to the selection of analgesia, with the additional consideration of co-analgesics or adjuvant medication to provide a comprehensive drug-based treatment where more complex pain symptoms exist. Examples of co-analgesics that may be used in the treatment of wound-related pain include the tricyclic antidepressants and anticonvulsants, which can be added to an analgesic regimen where evidence of neuropathic pain exists (WUWHS 2004).

As shown in Figure 3, the basic progression of analgesic medication is from non-opioids (step 1), to weak opioids, for example codeine, (step 2), and finally to strong opioids such as morphine (step 3). Steps 2 and 3 of the ladder indicate that combinations of non-opioids and opioids should be considered. Although the model seems to imply that patients should be commenced at step 1 of the pain relief ladder, this is not always the case and individuals who experience high levels of pain will need to commence an analgesic regimen based on either step 2 or 3 of the ladder (WUWHS 2004).

Non-steroidal anti-inflammatory drugs (NSAIDs) dampen sensitivity and are particularly useful for controlling the throbbing or aching pain felt after a procedure such as a wound dressing (WUWHS 2004). Enoch et al (2006) suggested that NSAIDs may affect the inflammatory phase of wound healing adversely and may also be associated with a reduction in the tensile strength of the wound.

These claims are unsupported by clinical data, and consensus guidelines on managing wound-related pain support their use while highlighting certain contraindications and cautions (EWMA 2002, WUWHS 2004). In addition, there is some evidence to suggest that the healing rate
of chronic wounds (venous leg ulcers), treated with foam dressings containing a low dose of ibuprofen (112.5mg impregnated in a 15x15cm dressing released over a seven-day period), was similar to chronic wounds treated with the same dressing with no ibuprofen content (Gottrup et al 2008).

The research was in the form of a randomised, controlled double-blind clinical investigation on the performance and safety of an ibuprofen-containing dressing (Biatin Ibu) (Gottrup et al 2008). The 122 patients recruited for the study had leg ulceration, were being treated with compression therapy and, before the study, were experiencing either moderate, lots or complete pain (categories on a five-point verbal rating scale). The authors reported that both the ibuprofen foam and the comparator foam dressing were associated with clinically significant pain reductions, with the ibuprofen foam having a slight advantage in this respect (Gottrup et al 2008).

The recommended interval between the administration of the analgesia and the start of the wound dressing or procedure varies slightly. The WUWHS (2004) stated that a period of one to two hours before the procedure is appropriate when paracetamol and NSAIDs are being used. However, EWMA (2002) suggested that short-acting opioids, such as codeine, should be given up to one hour to take effect before commencing a wound-related procedure. Topical local anaesthetics can provide a degree of numbness for a short period of time while a particularly painful procedure is carried out (WUWHS 2004, Woo et al 2008). The most commonly reported use of topical local anaesthetic relates to the use of EMLA (eutectic mixture of local anaesthetics: lidocaine with prilocaine) cream before wound debridement in lower limb ulceration.

Briggs and Nelson (2003) undertook a systematic review of the literature with regard to the efficacy of this treatment when used before debridement of leg ulcerations. The review was based on six randomised controlled trials involving 137 patients. The authors concluded that while there was evidence that a local anaesthetic cream (EMLA) reduced the pain of debridement, there was insufficient evidence of the effect of this cream on side effects and healing. It is important to note that the British National Formulary (2008) states that EMLA should not be used on wounds.

Non-pharmacological approaches

Although analgesic treatments are considered important in terms of achieving pain relief during procedures such as dressing changes, they may not always be effective (Price et al 2008, Gibson et al 2004). Non-pharmacological approaches are targeted at the reduction of anxiety and stress and the improvement of personal coping skills (Woo et al 2008). Some publications on wound-related pain (EWMA 2002, Wounds-UK and Mölnlycke Health Care 2004, WUWHS 2004, 2007, Coloplast 2008) identify similar non-pharmacological pain relieving strategies for managing procedure-related pain. The most frequently cited include distraction, relaxation techniques, music therapy, patient involvement, giving information and making use of patients calling for ‘time out’ to signal interruption to the procedure and time for rest.

Distraction as a mode of pain management can be explained in the context of the Gate Control Theory (Melzack and Wall 1965). The technique takes the patient’s attention away from the pain experience as he or she attends to different sensory information. Research on the use of distraction with respect to wound dressing-related pain has been undertaken by Hoffman et al (2004), who reported the use of both the Nintendo video game and virtual reality video games for adolescent patients undergoing the removal of staples from skin grafts.

Research on the effect of more psychologically based interventions to manage wound pain has also been carried out by Gibson et al (2004), who undertook a pilot study of an educational intervention to manage the pain associated with wound care in an outpatient setting.

The pilot study focused on the use of a structured educational intervention to reduce procedure-related pain, and five patients who had a history of freedom from cancer pain

Steps:

- **Step 1**: Non-opioid +/− Adjuvant
- **Step 2**: Opioid for mild to moderate pain +/− Non-opioid +/− Adjuvant
- **Step 3**: Opioid for moderate to severe pain +/− Non-opioid +/− Adjuvant
- **Freedom from cancer pain**: Pain persisting or increasing
Dressing-related pain were invited to take part. Patients were provided with information about their procedure and were encouraged to explore ways in which their comfort levels might be improved during the procedure. Following on from this, a plan of treatment was compiled that identified pharmacological and non-pharmacological interventions. Pain and distress intensity ratings were recorded during the procedure. Four out of the five patients said that the education had been helpful, but the intervention resulted in less pain and distress (compared with not having an educational intervention) for only three of the five patients (Gibson et al 2004).

This small study identified some of the difficulties in researching interventions to reduce wound-related pain. In particular, it was noted that the status of the wound, for example whether improving or deteriorating, was likely to be the greatest determinant of wound pain and that this may override any psychologically based pain management intervention (Gibson et al 2004).

Evidence for the extent to which patients perceive the effectiveness of non-pharmacological interventions in reducing pain during dressing changes is limited. In a survey of more than 2,000 patients with chronic wounds, only a small number of patients identified that practices such as being careful and gentle, not rushing the dressing, and listening and communicating with patients could potentially help to minimise dressing-related pain (Price et al 2008).

However, given that such practices are relatively simple, their continued use by practitioners seems justified both on professional and moral grounds.

Distraction techniques

Think about some of the patients that you encounter in your clinical practice. What sort of techniques and strategies do you use to distract, relax or involve a patient while undertaking dressing changes? Are there any strategies that you could use in the future that you had not previously considered?

Dressing selection and wound care practices

Published guidance on the management of wound-related pain identifies the extent to which wound dressings and treatments have the potential to cause wound bed and peri-wound tissue trauma and pain (EWMA 2002, WUWHS 2004). Price et al (2008) reported that 40 per cent of patients perceived that pain during dressing changes was the worst part of living with a wound. Wound care practices that have been found to trigger painful sensations include (Hollinworth 2005, 2006):

- Exposure of the wound to air on dressing removal.
- The use of cool irrigation fluid.
- Dressing removal following adherence to the wound.
- Inappropriate dressing choices.
- Tightly packed cavity wounds.
- Wound swabbing and uncomfortable primary dressings causing stinging or drawing sensations.
- Retention or compression bandaging.

Dressings that adhere to the wound causing pain on removal and trauma to the wound bed should not be used (WUWHS 2004, Hollinworth 2006), as they can cause damage to delicate healing tissue in the wound and surrounding skin. Developments in wound dressings have resulted in the proliferation of low and non-adherent dressing materials designed to minimise wound trauma and pain. The performance of low and non-adherent dressings has been found to vary between products and wound types, (Briggs et al 2008). In particular, the soft silicone adhesive technology dressings, for example Safetac, have been found to be less painful before, during and after dressing change when compared with advanced dressings with traditional adhesives (WUWHS 2007). However, such dressings have been noted to be costly when compared with other products and minor dissatisfaction has also been noted with respect to the ability of the dressings to stay in place without the use of additional adhesive tape (Briggs et al 2008).

Any technique that features physical contact with the wound has the potential to cause pain. Hence, activities such as wound cleansing, dressing removal and placement, and debridement are likely to be problematic in terms of wound care. Wound cleansing is not always necessary, but if it is then cleansing solutions should be warmed to body temperature as patients may find cool irrigation solutions painful (Hollinworth 2006).

The peri-wound area can become painful secondary to maceration, excoriation, contact sensitivities arising from dressing materials and epidermal stripping caused by the removal of adhesive dressings (Hollinworth 2005, 2006). Maceration of the skin surrounding the wound that has a dressing applied suggests that the dressing has inadequate fluid handling properties and signals the need for dressing review. Skin barrier products offer some topical protection from excessive moisture and dressing adhesives, but care should be taken to follow the manufacturer’s instructions, and regular skin observations should determine the extent to which the skin protector is effective (Hollinworth and Stansfield 2008).

The importance of peri-wound skin protection in controlling wound-related pain is highlighted in the one of the consensus statements in the most recent WUWHS (2007) guidance. It states that: ‘Practitioners
should select an appropriate dressing to minimise wound-related pain based on wear time, moisture, balance, healing potential and peri-wound maceration.’

Conclusion

Pain is a distressing feature of having a wound. Practitioners caring for patients with wound-related pain need a sound knowledge base, good communication skills, a willingness to collaborate with colleagues and an understanding of the patient’s concerns to achieve the best outcomes in terms of pain minimisation and pain relief.

References


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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: Wound-related pain: features, assessment and treatment, and the article number, which is PHC374.
- 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 December 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 learnt 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 that 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?

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Please complete this form using a ballpoint pen and CAPITAL letters only, then cut out and send it in an envelope no smaller than 9x6 inches to:

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