Promoting self-management of multiple sclerosis in primary care


Abstract
This article discusses the impact of multiple sclerosis on people newly diagnosed and those living with this long-term condition. It highlights the role that primary care nurses can play in ensuring that people with the condition have the help and information they need to take charge of their own care.

Aims and intended learning outcomes
This article aims to provide a brief overview of multiple sclerosis (MS) and to identify how nurses working in the community can provide timely support and information that maximises patient independence and helps to manage signs and symptoms. After reading this article and completing the time outs you should be able to:

■ Describe the different presentations, the progression of the illness and the different types of MS.
■ Discuss the merits of self-care philosophy as applied to patients with MS.
■ Identify the areas in which patients might become expert.
■ Discuss the part information can play in promoting patient independence.
■ Reflect on ways in which nurses might problem-solve with patients, with reference to exercise, fatigue management or bladder control.

Introduction
MS is a neurological autoimmune condition affecting the central nervous system. The course of the condition is unpredictable, but for most people it begins with a pattern of relapsing and remitting symptoms and, in most cases, this becomes progressive. In other people it begins with a progressive course.

MS is an incurable, long-term condition and most people will live with it for decades, having been diagnosed in their twenties or thirties. There are several misconceptions about MS – for example, it is a terminal condition or a diagnosis results in the permanent use of a wheelchair. While it is thought MS can reduce life expectancy by around ten years, this does not help to predict its course for an individual. Many people with MS live as long as anyone else and everyone will experience different levels of disability. In the UK, the average life expectancy of an individual at birth is 79 (World Health Organisation 2009). All individuals living with MS need support to manage their symptoms.

The unpredictable nature of MS means a multidisciplinary care approach is needed – and is recommended by the National Institute for Health and Clinical Excellence (NICE) MS guidelines (NICE 2003). Primary healthcare nurses can play a major part in the ongoing treatment and care of people with MS and it is important that patients are treated by healthcare professionals who understand the condition.

Prevalence
Around 100,000 people in the UK have MS (MS Society 2009a). Most commonly, the condition is diagnosed in adults between the ages of 20 and 40. It can be diagnosed in people over 65 and in children, although this is rare. Three times as many women as men are diagnosed.

Research suggests that in the UK, MS affects approximately one in 610 people (MS Society 2009a). A primary care trust (PCT) with an average population of 200,000, therefore, will have around 286 patients with MS (United Kingdom Multiple

Local patterns of illness
Write a short profile of patients with MS in your geographical area. What, if anything, do they have in common? What patterns of illness do they report?

Keywords
Multiple sclerosis, self-care, exercise, continence, fatigue

Time out

These keywords are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review. For related articles visit our online archive and search using the keywords.
Sclerosis Specialist Nurse Association (UKMSSNA) 2007). This equates to each GP in England having approximately three patients with MS under their care (MS Society 2009a). Research suggests the prevalence of MS increases in countries further north or south of the equator (Pugliatti 2002) and it is thought that this is due to lack of vitamin D sourced through sunlight.

**What is MS?**

Multiple sclerosis literally means many scars and is a result of the immune system causing damage to the myelin sheath – the fatty layer surrounding the nerve axon that insulates, protects and aids nerve conduction. This inflammation leads to areas of scarring, or sclerosis, which causes disruption or slowing of the messages sent to and from the brain along the nerve fibres. This can lead to a variety of symptoms for the person with MS, depending on where the scarring – known as lesions – occurs in the brain.

### Table 1 Symptoms of multiple sclerosis and information available

Not everyone with multiple sclerosis (MS) will experience all of these symptoms, but the list below should indicate how the condition may release itself in some individuals.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Information resource</th>
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</thead>
<tbody>
<tr>
<td>Difficulties with balance and dizziness</td>
<td>MS Society, MS Essentials 26 – Balance and MS</td>
</tr>
<tr>
<td>Fatigue</td>
<td>MS Essentials 14 – Fatigue</td>
</tr>
<tr>
<td>Visual problems such as blurred or double vision</td>
<td>MS Essentials 05 – Vision and MS</td>
</tr>
<tr>
<td>Numbness, tingling or pins and needles – sometimes the sensory changes can feel painful</td>
<td>MS Essentials 17 – Pain and Sensory Symptoms</td>
</tr>
<tr>
<td>Bladder problems</td>
<td>MS Essentials 07 – Managing Bladder Problems</td>
</tr>
<tr>
<td>Cognitive problems</td>
<td>MS Essentials 02 – Memory and Thinking</td>
</tr>
<tr>
<td>Stiffness or spasms in muscles</td>
<td>MS Essentials 19 – Muscle Spasms and Stiffness</td>
</tr>
<tr>
<td>Emotional and mood changes</td>
<td>MS Essentials 10 – Mood, Depression and Emotions</td>
</tr>
<tr>
<td>Tremor</td>
<td>MS Essentials 04 – Tremor and MS</td>
</tr>
<tr>
<td>Bowel problems</td>
<td>MS Essentials 25 – Managing the Bowel in MS</td>
</tr>
<tr>
<td>Sexual problems</td>
<td>MS Essentials 12 – Sex, Intimacy and Relationships</td>
</tr>
<tr>
<td>Speech difficulties</td>
<td>MS Essentials 23 – Speech Difficulties</td>
</tr>
<tr>
<td>Swallowing difficulties</td>
<td>MS Essentials 24 – Swallowing Difficulties</td>
</tr>
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**Diagnosis**

Individuals are usually diagnosed with MS after they present with new neurological symptoms (as described in Table 1) after an earlier relapse. A magnetic resonance imaging (MRI) scan must show that lesions on the brain or spinal cord are separated by time (months or years) and space (distance apart). There is no single diagnostic test for MS, but most people go through a series of MRI scans, evoked potentials tests and a lumbar puncture for cerebrospinal fluid to be analysed for protein level and electrophoresis count, which is compared with a serum sample taken at the same time.

Lesions on the brain and spinal cord are seen as white patches on T2-weighted MRI scans. MRI scans are usually only used to diagnose MS or when someone

**Symptoms**

Early symptoms of MS can include blurred or temporary loss of vision, tingling in limbs and altered or loss of sensation, particularly in the hands and feet. Table 1 provides a full range of symptoms associated with MS. It is important to note that not all symptoms will be visible and that a lack of obvious symptoms does not necessarily mean a patient is ‘well’. MS progresses at different rates and presents in different ways.

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Lesions on the brain and spinal cord are seen as white patches on T2-weighted MRI scans. MRI scans are usually only used to diagnose MS or when someone
is on a drug trial; they are not used routinely to monitor disease activity or when someone has a relapse.

NICE sets out clear guidelines (NICE 2003) for diagnosing MS. These include encouraging open communication with the patient as soon as a diagnosis of MS is considered reasonably likely and, once a diagnosis is confirmed, providing access to skilled nurses, ideally with specialist knowledge, and further written information on MS.

Patients' experiences

Reflect on local patients' accounts of that period of uncertainty before their illness was diagnosed. What emotions and concerns did they experience and how did they cope? Are there any points to remember when you next help a patient review what diagnosis represented to them?

Types of MS and treatment available

There are generally considered to be three broad types of MS: relapsing remitting (RRMS), secondary progressive (SPMS) and primary progressive (PPMS). Some people with RRMS may, retrospectively, be said to have experienced ‘benign’ MS.

**General advice** Practice nurses are likely to come into contact with people living with MS for a variety of reasons unrelated to their condition, such as health screening, women’s health issues and immunisations. Advice on administering immunisations should follow NICE guidelines (2003), which state that people with MS should be offered immunisation against influenza and any other necessary immunisation, with the advice that there is no known risk of causing a relapse of their MS.

There is little research available on the impact of MS on the menstrual cycle and menopause, although some women state their symptoms are worse around the time of their period. Some disease-modifying drugs (DMDs) can cause irregular periods, although side effects should improve on their own after a few months of taking the treatment.

An MS specialist nurse should be contacted regarding patients whose symptoms worsen, such as in a relapse or if a patient is struggling with the management of an ongoing symptom. Now do Time out 4.

**Relapsing remitting MS** Around 85 per cent of all people with MS are diagnosed with RRMS (O’Connor 2002). Relapses are unpredictable and can last for days or several months (periods of remission can last for months or years). They usually occur when a new symptom appears or an existing one gets markedly worse at least 30 days after any previous symptoms began. The symptom will last for at least 24 hours before it is considered to be a relapse and the severity can vary.

‘Pseudo relapses’ need to be ruled out; these are temporarily worsened symptoms caused by a rise in core body temperature (as a result of infection or post vaccination, for example). It is important that health professionals recognise that not all symptoms can be linked to MS; extreme fatigue, for example, could be linked to anaemia, rather than being the result of a relapse.

Most typically, a relapse lasts between four and six weeks and can be treated at home with steroids (although, dependent on the severity of symptoms, these are not always needed) and a rehabilitation programme. More acute cases (such as temporary paralysis) may need hospital treatment.

The DMDs natalizumab, mitoxantrone, beta interferon 1a, beta interferon 1b and glatiramer acetate can help reduce the severity and frequency of relapses, but they are not effective in everyone. Routine monitoring of blood should take place for those people on DMDs.

People with MS are normally trained to self-administer treatments, but practice and community nurses may be involved in assisting with injection techniques and should monitor skin site reactions, especially if site symptoms are persistent or worsen, or if the skin breaks or becomes lumpy.

**Flexible treatment during relapses** It is important to recognise that relapses can occur at any time and to plan for flexible and responsive management during a relapse. New and innovative support methods are being explored. A pilot project known as a ‘relapse support service’, has recently been established for people with RRMS in Eastbourne. East Sussex County Council has worked with the MS Society as part of the government’s change agenda for social services to provide more flexible support for people with MS.

The pilot looks at the effects of providing a small number of people with a fund of £750 that they can use to pay for services when they are having a relapse. Services could include paying someone to walk their dog or collecting their children from school. It gives people independence and security,
and means they no longer need to rely on favours. More information on this pilot is available from the MS Society’s strategic lead for independent living, Brenda Joyce, at bjoyce@mssociety.org.uk.

5 Support networks

Are there any examples of innovative plans or schemes to support people with MS in your part of the country? What do you think is the key to success when different agencies work together to help patients take charge of their situation? Sharing your ideas with the MS Society may help you to network with other innovative practitioners and patients.

‘Benign’ MS

If, over a ten to 20-year period, a person’s symptoms of MS have not worsened and the individual shows little sign of disability, his or her MS could be described as benign. This description can only be applied retrospectively. It can also be misleading and uncertain: relapses can occur at much later stages of life and the word ‘benign’ in this case does not mean the MS will be necessarily completely problem-free.

Secondary progressive MS

Almost everyone with RRMS will develop SPMS at some point. Statistics show that 15 years after an initial diagnosis, 65 per cent of people with RRMS will have developed a progressive form, which can vary in severity and impact (Koch et al 2008).

SPMS is usually diagnosed after an individual shows a sustained build-up of disability, independent of relapses. In most cases, neurologists look for six months of clear progression before the transition to SPMS is confirmed. The speed of progression varies, as does the time it takes SPMS to occur.

Relapses can continue to occur in SPMS, but do not always do so. If they do, treatment consists of steroids (dependent on the severity of symptoms) and rehabilitation. Some licensed DMDs may help to reduce the frequency and severity or relapses, but there are no DMDs to slow or halt the progression of the disease. Other drugs are available to help alleviate symptoms such as muscle stiffness and bladder problems.

Primary progressive MS

PPMS offers little remission, as symptoms gradually worsen with no apparent relapses. It is diagnosed in 10-15 per cent of all people with MS, more commonly in individuals aged 50-60; the rate of diagnosis between males and females is the same. People with PPMS are more likely to have lesions on their spine, resulting in problems with lower limb movement, bladder and bowel control, and sexual function.

Steroids are not recommended to treat PPMS and there are no licensed DMDs in the UK for individuals with PPMS. Treatment is focused on rehabilitation and supporting independence, and in later stages individuals may require a range of support from informal and statutory carers.

Managing MS: how nurses in primary care can help

Following diagnosis, anyone with MS should be referred to an MS specialist nurse (MSSN), who will provide support with coming to terms with MS and point the patient towards further useful information. There is some variation in where MSSNs are based: some are in hospital in neurology departments, while others are based in the community. People can locate their MSSN, and other useful services, on a map on the MS Trust’s website at www.mstrust.org.uk/information/services

After an MSSN referral, most ongoing care is likely to take place in the community with periodic reviews by the MSSN. It is here that community and practice nurses can help patients by providing a link to information and support for common problems.

Self-care in MS

Self-care is increasingly recognised as an important component of the management of all long-term conditions (LTCs), including MS (Burgess 2002).

6 The self-care philosophy

Why is self-care such an important philosophy in MS support? Points might include patient self-esteem, successful relations with lay carers, cost-effective use of finite professional healthcare resources and improving the public image of patients dealing with a chronic illness.

In England and Wales, the Expert Patients Programme (EPP) community interest company is one opportunity for people with MS and other LTCs to come together and develop skills to help them manage the problems that arise from living with a long-term illness (Phillips 2009). Additionally, and specific to MS, Taking Control (Burgess et al 2001) has been developed as a resource pack for professionals to teach people newly diagnosed with MS.

The EPP course comprises six 2.5-hour sessions in consecutive weeks run by people with personal experience of an LTC. The course introduces participants to cognitive skills and shows ways to build on how they already deal with their conditions day to day. People with MS attending a course report better symptom control and a greater understanding of how to cope with the day-to-day problems of MS, including effective use of limited energy. Evaluations of national
outcomes by the Department of Health indicate, among other things, that patients demonstrate a reduced severity of symptoms and an improved resourcefulness and life satisfaction (DH 2009). For more information on EPP, visit www.expertpatients.co.uk

Accessing the right information
People with MS need access to timely and appropriate information. Information prescriptions may be a way that community nurses can ensure people with MS find the information they need. Topics covered in a prescription could include possible treatments, care services, benefits advice and support groups. Website links and contact details for other local helpful organisations are useful.

The MS Society, MS Trust and MS Resource Centre have a range of information that would be helpful to include in an information prescription. Health professionals could familiarise themselves with some of the literature available on the organisations’ websites. Table 1 outlines a full range of symptoms associated with MS and relevant publications that could provide more information.

Exercise for people with MS
Everyone can benefit from regular exercise, including people with MS. Exercise could be misconceived as a way of increasing fatigue or aggravating other symptoms of MS. However, research suggests people with mild to moderate disability can exercise without fear of provoking lasting symptoms or a relapse (Rietburg et al 2004). A 2004 randomised controlled trial monitoring the effects of exercise and yoga in people with RRMS showed significant improvements in the levels of fatigue of participants with MS over a six-month period compared with those not participating in physical activity (Oken et al 2004).

Case study: fatigue
Leonie Martin, 46, lives in Derbyshire with her family. She was diagnosed with MS ten years ago. Here is an extract from her diary on the effects of fatigue in MS:

‘Fatigue is an invisible adversary, making endless demands of your time and energy. You can’t fight it, but you can barter with it.’

‘Yesterday, I went for a walk. Setting off, I felt the welcome stretch to my 46-year-old leg muscles and forgot all about my MS. But this morning, I woke with fog in my head. My daughter gave up trying to talk to me when she realised I could barely string a sentence together. Today, I have the legs of a frail 70 year-old. I had plans, but they’ll have to wait. They are not urgent – I try not to leave things to the last minute any more. Today, I will lower my expectations and savour the memory of yesterday’s walk until tomorrow.

‘It has taken me several years, but I am better now at trying to see my glass as half-full, and the days when I feel 40-something can be brilliant.’

NICE guidelines on MS (NICE 2003) recommend a physiotherapy assessment as part of a multidisciplinary team approach. Due to demands of time, physiotherapists are frequently unable to maintain regular contact with individuals over the course of the disease. However, people with MS should be able to get an assessment whenever there is a change in their physical status via their GP, MS nurse or self-referral.

Some PCTs and neurology units have developed exercise-on-prescription courses where, following initial assessment by a physiotherapist, people can use local leisure centres and gyms. These have the benefit of providing social opportunities through group exercise and the link to specialist care if required, but patients are recommended to seek advice before starting new exercise.

Neuro-fit, for example, is an exercise-on-prescription class held at the River Park Leisure centre in Winchester. Saltney MS Therapy Centre and the MS Society branch for Conway County have also set up physiotherapy followed by exercise sessions at Eirias Park Leisure Centre in Colwyn Bay, Wales. Here they also provide one-to-one time with a fitness instructor who has knowledge of MS and the issues people may have in relation to exercise.

In some areas of England, MS Society branches can offer access to physiotherapy sessions, yoga and swimming classes, and similar exercise opportunities. MS Therapy Centres, which are found across the UK, have good facilities for physiotherapy and exercise sessions. Community nurses could explore local facilities for similar provision.

7 Promoting exercise

Consider how exercise, fatigue and the risk of MS relapse are conceived where you work. Is exercise seen in a positive way? If so, what steps could be taken to promote this to patients? Are there popular misconceptions that need to be challenged?

Managing fatigue
An MS Society survey found fatigue to be one of the most common symptoms of MS (MS Society 2007), and for some, it is the symptom that affects them the most. The exact causes of fatigue in MS are often difficult to ascertain and the effects can differ drastically between individuals. Some people have regular patterns of complete exhaustion, while for others fatigue is less predictable.

Fatigue management involves a combination of approaches that can be supported by members of the multidisciplinary team. Use of a fatigue diary in conjunction with energy conservation strategies can
be helpful. It is important that the often fluctuating and variable levels of fatigue are understood and taken into consideration. Before discussing treatment options for people experiencing fatigue, the professional should consider whether fatigue is a significant problem or a contributory factor to the patient’s current clinical state (NICE 2003). NICE recommends:

- Consider whether severe depression is evident. If it is, it should be treated.
- Factors such as disturbed sleep, chronic pain and poor nutrition should be identified and treated.
- Some medicines may exaggerate fatigue, so any medication being taken should be reviewed.
- General advice and training on the management of fatigue should be recommended, including encouragement to take part in exercise and use energy conservation techniques.

A fatigue diary can be helpful for someone struggling to manage the effects. A record of activities completed throughout the day should be rated against the level of fatigue a patient experiences while doing them, usually recorded on a scale of 1-10. The diary helps identify patterns in fatigue rates at certain times of the day, and in relation to activities completed, and can identify necessary lifestyle changes to relieve the effects. There is an example of a fatigue diary in MS Essentials 14 (MS Society 2009b).

Nurses in primary care are well placed to work with people who experience fatigue. They can assist in identifying contributory factors and energy conservation strategies, as well as possible changes to lifestyle and environment.

**Bladder control and catheterisation**

Many people affected by MS will experience bladder problems, either with storage or emptying, and both can contribute to problems with urgency and frequency. Medication can help with these symptoms. Acknowledging bladder control as a potential problem from diagnosis will ensure bladder function is appropriately monitored, although nurses should be aware of the sensitive nature of the situation and that not everyone with MS will experience difficulties.

Questions should be asked at routine appointments and urinary tract infections (UTIs) dealt with promptly. When bladder management is being planned, it is important to know whether the bladder is being emptied fully, so residual bladder volumes should be measured. Recurrent UTIs may also be an indicator of incomplete bladder emptying. Figure 1 (Fowler et al 2009) shows the first-line treatment route nurses and continence specialists can take to help people manage bladder symptoms.

Advice on pelvic floor exercises and help accessing equipment to promote independence are useful and recommended. For this, referrals to a continence adviser or physiotherapist for pelvic tone exercises should be considered, as should a referral to an occupational therapist or community nurse for an equipment assessment. Education about adequate hydration is also vital, as individuals often decrease fluid intake, mistakenly assuming this will alleviate rather than worsen their symptoms. Concentrated urine can irritate the bladder, making it more likely to contract; it can also make UTIs more likely.

When non-invasive measures are failing,
Continuing professional development

people will benefit from a specialist assessment from an MSSN or continence nurse specialist. For some people, self-catheterisation may be the best option and can help to maintain independence. For others, an indwelling catheter may be the only option, but this is only provided to those with moderate to severe mobility problems.

There are a variety of drugs available for continence issues in MS to help alleviate urgency and frequency; these should only be made available after other treatment options have been explored (Figure 1).

For people able to self-catheterise, an emerging, but as yet unlicensed, drug treatment is botulinum toxin (Botox). Botox is injected into the bladder wall and is said to have long-lasting effects – around ten months – in alleviating symptoms of urgency and urgency incontinence (Fowler et al 2009).

Benefits
To help patients with the financial burden of living with a LTC, health professionals in primary care are advised to recommend patients regularly check their benefits and what they are entitled to. The websites listed in the ‘Find out more’ box on this page should help.

Conclusion
MS is a long-term, frequently disabling condition that is most commonly diagnosed in young adults. Those diagnosed need integrated care that encourages independence and supports them in their home, work and social lives from the outset of their condition. Appropriate referrals and timely interventions from healthcare professionals can be significant in enabling someone to stay in work, remain active and avoid unnecessary health complications.

References


MS Society (2009a) MS Society Releases a Revised Figure for the Number of People in the UK with MS: www.mssociety.org.uk/research/research_news/research_news_man/june_2009/strength_in_num.html (Last accessed: December 8 2009.)

9 Practice profile
Now that you have completed this article, you might like to write a practice profile. Guidelines to help you are on page 39.

Find out more

The MS Society runs a network for health and socialcare professionals with a shared interest in improving services for people affected by MS. To join, go to www.mssociety.org.uk/professionals
For publications and written information on MS, including the MS Society’s MS Essentials, go to www.mssociety.org.uk/publications or call 020 8438 0799. The MS Society helpline on 0808 800 8000 is useful for patients struggling to cope with the emotional effects of MS.
The MS Trust offers a range of information and a useful UK map of MS services at www.mstrust.org.uk/information/services
For more information on the Expert Patients Programme, go to www.expertpatients.co.uk
Turn 2 Us offers an interactive benefits checker to help people quickly reference what they are entitled to claim. Go to www.turn2us.org.uk
www.direct.gov.uk/en/MoneyTaxAndBenefits/index.htm also offers advice on benefits.
Information prescriptions are a useful way of providing relevant information to patients. Go to www.informationprescription.info


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: Promoting self-management of multiple sclerosis in primary care, and the article number, which is PHC402.
■ Complete all 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 March 2011. 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?