Nail Surgery Guidelines for Podiatry Services

Approved by: Community Health Services Clinical Policy Group and Clinical Quality and Governance Committee

On: 27 May 2010
     14 June 2010

Review Date: May 2012

Directorate responsible for Review: CHS Adult Services

Policy Number: TP012

Signature: 
Helen Thompson
Acting managing Director
Community Health Services
Policy Title: Nail Surgery Guidelines for Podiatry Services
Directorate: CHS Podiatry Services
Name of person/s auditing / authoring policy: Amin Pabani

Policy/ Service Content:
For each of the following checks is this policy sensitive to people of different age, ethnicity, gender, disability, religion or belief, sexual orientation & transgender?

- The checklists below will help you to see any strength and / or highlight improvements required to ensure that the policy / procedure is compliant with equality legislation.

A. Check for DIRECT or INDIRECT discrimination against any minority group of SERVICE USERS:

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If yes is answered to any of the above items the policy may be considered discriminatory and requires review and further work to ensure compliance with legislation.

B. Check for DIRECT or INDIRECT discrimination against any minority group relating to EMPLOYEES:

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**TOTAL NUMBER OF ITEMS ANSWERED ‘YES’ INDICATING DIRECT or INDIRECT DISCRIMINATION = 0**

Number of ‘Yes’ answers for Service users

Number of ‘Yes’ answers for Employees.

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<td>Is there any evidence that some groups are affected differently?</td>
<td>Yes</td>
<td>Pregnant women – Phenol use is contraindicated in this group given potential risks involved. Would use alternative treatments</td>
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<td>Is there a need for external or user consultation?</td>
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<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
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<td>Is the impact of the policy/guidance likely to be negative?</td>
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<td>If so can the impact be avoided?</td>
<td>N/A</td>
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<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
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<td>Can we reduce the impact by taking different action?</td>
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**IMPACT**

(Please Tick) [ ] High [ ] Medium [ ] Low [ ] X

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

If you have answered “Yes” to any of the above questions, it is likely the policy/service will need a full EIA, please complete a full impact assessment. If you have identified a potential discriminatory impact of this procedural document, please refer it to policy/service administrator; together with any suggestions as to the action required to avoid/reduce adverse impact.

**Signatures of authors / auditors:** Amin Pabani, Head of Podiatry

**Date of signing:** 5 May 2010
## Nail Surgery Guidelines for Podiatry Services

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<th>Version:</th>
<th>2 (replaces previous guidelines expired June 09)</th>
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<td>Ratified by:</td>
<td>CHS Clinical Quality and Governance Committee</td>
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<tr>
<td>Date ratified:</td>
<td>14 June 2010</td>
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<tr>
<td>Name of originator/author:</td>
<td>Amin Pabani</td>
</tr>
<tr>
<td>Name of responsible committee:</td>
<td>CHS Clinical Quality and Governance Committee</td>
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<td>Date of issue for publication:</td>
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<td>Review Date:</td>
<td>May 2012</td>
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<tr>
<td>Target Audience:</td>
<td>Podiatry staff involved in nail surgery</td>
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CONTRIBUTION LIST

Key individuals involved in developing the document

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<td>Head of Podiatry Services / Professional Lead</td>
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<td>Health &amp; Safety Manager</td>
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Comments were received on amendments to this version (see below for list of sections updated)

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#### Appendices

- **Appendix I** Podiatry Services ‘Your nail Surgery’ – Pre-op Leaflet
- **Appendix II** Letter to GP informing of pending surgery
- **Appendix III** The Benefits and Risks of Nail Surgery – An Aid for the Practitioner
- **Appendix IV** Maximum Safe Dose Chart for Local Anaesthetic
- **Appendix V** Podiatry Services ‘After Your Nail Surgery’ Post-op Leaflet
- **Appendix VI** Podiatry Services ‘After Your nail Surgery (2)’ Redressing Instructions
- **Appendix VII** Letter to GP informing completion of treatment – Sample
Nail Surgery Guidelines for Podiatry Services

1. **INTRODUCTION**

Ingrowing toenails (onychocryptosis O/C) and thickened nails (onychogryphosis O/G) are common conditions treated by NHS Podiatrists\(^1\). Most patients present with discomfort, pain and / or infection\(^2\). Partial or total nail avulsions can produce rapid relief of symptoms. Tanner (1989) describes high recurrence rates (45%) in the conservative management of onychocryptosis, unless additional measures are taken to prevent regrowth of the nail. The most reliable method being ablation of the nail matrix with phenol\(^4\), producing recurrence rates of 2-8%\(^3\). Baran & Eckart (2002) state that where pathological examination of the nail matrix is not required, phenol cautery is the best alternative; providing confidence in the current provision of nail surgery intervention by Podiatry Services and the continued use of phenol in preventing regrowth of nail.

There are currently no other suitable alternatives to phenol available. Previous research on the effectiveness of sodium hydroxide has shown it to be an unsuitable alternative\(^12\).

The most common method of treatment, within podiatry services across Leicester, Leicestershire & Rutland, is the removal of all or part of the nail under LA, followed by phenolisation of the nail matrix for approximately 3 minutes to prevent regrowth of the nail. Research/studies quote risk of recurrence as varying from 0-7%\(^5\). Indeed Bostanci, Elmekci & Gugey (2001) found the success rate to be 98.8%, McCourt (1999) describes success rates of greater than 95%. Dunlop (1998) describes Laxton's study (1995) as having attained patient satisfaction rates of 85%.

2. **BACKGROUND**

These guidelines set parameters within which all podiatry staff (and any enlisted support staff) conducting / partaking in nail surgery under Local Anaesthetic (LA) or otherwise, with or without the use of phenol, are required to act. Staff must work within their scope of practice, adhere to all related Trust policies / procedures and the Society of Chiropodists and Podiatrists Minimum Standards of Practice.

These guidelines were devised following extensive nail surgery practice peer / literature reviews and following extensive consultation both within Podiatry locally and nationally and with tissue viability, infection control and health and safety. Significant investigative work ensued to ensure practice is as safe as possible, given risk factors involved with the use of phenol, involving external agencies such as manufacturers, pharmacy etc.

The resultant guidelines are now deemed to have exhausted all possible safety channels and have incorporated best practice, often National, where evidence is lacking.
3. **AIMS**

3.1 To ensure evidenced based / **safe** practice as far as possible. Where little evidence is available, consensus opinion of best practice has been the main source of evidence.

3.2 To standardise, as much as possible, the nail surgery process, including assessment, consent, clinical preparation, training, redressing etc, whilst acknowledging that there may be slight differences in technique, dependant on practitioner training and development.

3.3 To provide an auditable ‘quality’ outcome, having standardised the procedure ie success / failure and patient satisfaction. Thus allowing continual evaluation and improvement in Service delivery.

4. **SCOPE**

4.1 These guidelines are applicable to all clinical and support staff working within podiatry services that either directly conduct nail surgery or assist the process e.g. as a clinical surgery assistant, booking of appointments or when conducting a nail surgery assessment (there may be staff that do not partake in actual surgery but are still able to assess for suitability and refer in for surgery).

4.2 The guidelines detail overarching principles and detail procedures that must be adhered to for safe practice.

4.3 These guidelines should also be used alongside relevant Trust infection control; decontamination; medical devices, care and control of medicines and health and safety policies that may have been or may be developed.

5. **ROLES, RESPONSIBILITIES AND ACCOUNTABILITY**

5.1 Podiatry staff – it is the responsibility of each and every single member of podiatry staff either involved either directly or indirectly with the nail surgery process / procedure to:

5.1.1 Have read and understood these guidelines.

5.1.2 Have read and understood ‘Guidelines on Safe Use of Phenol by Podiatry Services’, where phenol is to be used as part of the procedure.

5.1.3 Ensure they adhere to the principles and operating procedures therein.

5.1.4 Discuss any deviation felt necessary on a case by case basis with the Head of Service / Professional Lead and obtain agreement prior to action where possible.
5.1.5 Justify in the patients record, fully, any deviation from guidelines required.

5.1.6 Report any problems / issues that may result in breach of compliance to their line manager.

5.1.7 Report any breaches noted with other users to their line manager.

5.1.8 Follow Trust incident reporting procedures in case of an adverse outcome or event.

5.1.9 Take personal responsibility for own actions, decisions and safety and responsibility for the safety of others when conducting or assessing for nail surgery suitability

5.2 Podiatry team leads – these staff are additionally responsible for ensuring that:

5.2.1 Staff comply with the guidelines.

5.2.2 Operational systems and facilities promote safe and effective practice

5.2.3 Issues and incidents are reported and/or escalated in a timely manner.

5.2.4 Systems are in place to monitor safe practice e.g. peer review and clinical supervision.

5.2.5 Appropriate PPE is readily available, in good order and used appropriately.

5.2.6 All monitoring, assurance and audit mechanisms are carried out and adhered to and reported on in a timely manner as required.

5.3 The Head of Service / Professional Lead – has overarching responsibility for ensuring that the guidelines are adhered to and are updated as necessary and will ensure that:

5.3.1 Staff and team leads are compliant with the guidelines and report as required.

5.3.2 Financial arrangements support guidelines and that any potential difficulties are investigated, reported and resolved in a timely manner.

5.3.3 The Trust is provided with assurance of compliance to guidelines as required.
5.3.4 Appropriate monitoring and audit mechanisms are in place to enable the Trust to demonstrate and evidence compliance and will report as required.

5.3.5 The Trust is advised on any changes to procedures warranted via change in local, national and professional body regulations.

5.4 Overall clinical responsibility and accountability.

5.4.1 The nail surgery procedure and thus the suitability of the patient is ultimately the responsibility of the operating clinician – despite previous assessment and clearance of patient as being suitable. The operating clinician has therefore a duty to ensure all medical history, contraindications etc are rechecked and accurate and no new information is forthcoming nor changes occurred before proceeding. Should the operating clinician not be satisfied of patients suitability, they should not proceed but instigate further investigation.

5.4.2 The assessing clinician has a responsibility to investigate thoroughly and be satisfied of the patients suitability to undergo the proposed procedure, as though they were to operate, before referring for surgery. In case of an adverse event, some accountability may also rest with the assessing clinician.

5.4.3 Clinicians involved in aftercare have a responsibility to appropriately escalate any adverse outcomes as soon as they become apparent.

6. TRAINING, EDUCATION AND MONITORING

6.1 Qualification, training and knowledge requirements

6.1.1 All podiatrists undertaking nail surgery must have the following qualification, training and knowledge requirement:

6.1.1.1 Current registration with the Health Professions Council (HPC).

6.1.1.2 Undergraduate or post graduate training in nail surgery.

6.1.1.3 Knowledge of and training in aseptic technique.

6.1.1.4 Certificate of Local Anaesthesia (required to administer LA only)

6.1.1.5 Knowledge and understanding of and have signed the Patient Group Direction for the administration of Mepivacaine Hydrochloride Injection (plain) 3% w/v
in children aged 3 years and over, prior to use in this patient category.

6.1.1.6 New members of staff, practitioners having not been actively conducting nail surgery but looking to do so and returnees to work, must undertake an induction period prior to autonomous practice. Induction period should consist of observation, signed off (deemed as fit / safe to practice) supervised practice and reflection sessions; programme to be determined on individual basis by Team Leader in conjunction with Head of Service / Professional Lead.

6.1.2 All Podiatry, Nursing or Clinical Surgery Assistants must have the following training and knowledge requirements:

6.1.2.1 Previous background training e.g. ACCO certificate, NVQ or equivalent.

6.1.2.2 Knowledge of and training in aseptic technique.

6.1.2.3 Have undergone appropriate in-house training – ‘The Role of the Podiatry / Clinical Nail Surgery Assistant’ training package, complimented by ‘on the job’ training, conducted signed off supervised sessions as deemed necessary (see 6.1.1.6 above) and completed / had signed off the competency assessment for safe use of phenol (See Guidelines on Safe Use of Liquefied Phenol by Podiatry Services).

6.1.3 All operating podiatrists and assistants must also have the following qualification, training and knowledge requirement:

6.1.3.1 Current certificate in Basic Life Support (Adult and / or Child (paediatric))*

6.1.3.2 Current certificate in Anaphylaxis*

6.1.3.3 Evidence of relevant CPD training.

6.1.3.4 Evidence of regular clinical supervision in accordance with Trust Policy / Podiatry Services Clinical Supervision Framework.

6.1.3.5 Knowledge and understanding of the Guidelines on Safe Use of Liquefied Phenol by Podiatry Services.
6.1.3.6 Knowledge and understanding of all the relevant Trust infection control policies e.g. MRSA, Blood Bourne Viruses.

6.1.3.7 Knowledge of the relevant resuscitation policies and emergency procedures (including accessing an outside line and number for emergency services & knowledge in the use and whereabouts of Adrenaline packs) within the location where nail surgery is performed.

6.1.3.8 Knowledge and understanding of and have signed relevant PGD for use of Adrenaline in case of suspected anaphylactic reaction.

*Where either the operating clinicians’ or assistants’ certificate has elapsed, surgery may continue so long as one practitioner i.e. Podiatrist or Assistant holds a current certificate and with the approval of the relevant Team Leader / Head of Service / Professional Lead.

In the event that the certificates of both operating clinician and assistant have elapsed, surgery may only continue where medical backup and resuscitation facilities are available and with the prior approval of the Head of Service / Professional Lead.

6.2 Ongoing Competency Assessment

6.2.1 Podiatrists / assistants must undertake a minimum of 3 nail surgery sessions (appropriately spaced) in any 12 month period to maintain their competency. It is the responsibility of the practitioner to make known to the line manager that breach may be imminent, to enable this to be facilitated.

6.2.2 Assistants must undertake annual competency assessment for the safe handling and application of Phenol (see Guidelines on Safe Use of Liquefied Phenol by Podiatry Services).

6.2.3 Podiatrists / assistants will undergo peer review / critical observational assessment process (see Podiatry Services Clinical Supervision Framework) at least once every 3 years to ensure safe, effective practice and compliance with Guidelines on Nail Surgery.

6.2.4 Podiatrists / assistants will have regular in-house and external update training as appropriate.

6.2.5 Ongoing clinical supervision processes will support the above.
6.3 Audit / Safety Monitoring

6.3.1 An annual success rate and patient satisfaction audits will be undertaken for nail surgery – as the peer review process aims to establish similarity and promote ‘best’ practice across the county, this will highlight any issues that may veer from this as success rate would likely be affected e.g. inappropriate or under use of phenol.

6.3.2 The Trust’s incident reporting system shall be used to monitor incidents of safety breach and/or adverse clinical outcome e.g. phenol burns (blistering due to phenol), ulceration etc. Immediate investigation and action will be taken as appropriate to strengthen safe effective procedures e.g. via training or policy change.

6.3.3 Podiatrists / assistants will undergo 3 yearly peer reviews as stated above.

7. CRITERIA FOR NAIL SURGERY

Partial or total nail avulsion (PNA / TNA) should only be carried out on patients’ with a diagnosis of O/C or nail pathologies such as involuted nails, O/G, as a prophylactic measure for recurrent infection or other conditions as deemed appropriate by the referring and/or assessing podiatrist. Any referrals made for conditions not commonly treated using this method, should be fully justified. Nail surgery must only be effected following appropriate assessment of patient suitability, to include taking account of full medical and social history.

8. ASSESSMENT OF PATIENT AND APPOINTMENT BOOKING

8.1 A full assessment and investigation of the patient must be completed to determine suitability for surgery.

8.1.1 Completed by the referring / assessing podiatrist.

8.1.2 Recorded using the standardised EPR Nail Surgery Assessment form.

8.1.2 In case of computer failure, a paper copy is to be completed (to include re-assessment of patients’ suitability). This will be uploaded onto the EPR document at next earliest opportunity with reference note to justify date difference. Paper copy to be scanned on for proof. Practitioner to consult with Team Leader.

8.1.3 Assessment should include full review and updating of medical history, assessment and investigation for contra-indication to surgery, potential risks, possible drug interactions, allergies, patients’ general well being, ability to comply, understanding, phobias etc
8.2 The patient is entitled to be made aware of any frequently occurring risks imposed by the procedure (see section 9). The most severe being the risk and subsequent consequences of anaphylactic shock. On onset of such an allergic reaction, one of the first physiological responses is that of extreme and widespread vasodilation, resulting in a significant fall in blood pressure (BP).

8.2.1 The use of BP monitoring has, therefore, been deemed to be an excellent indicator and early warning mechanism for the detection of anaphylaxis (anaphylaxis mandatory training). BP should be taken and recorded at assessment stage as a base line (to indicate patients normal range) and it be explained to the patient that the measurements taken are purely for patient safety and not to diagnose hyper / hypotension, as this is not within Podiatry scope of practice.

8.2.2 Further checks will then be made during the procedure to monitor for signs of anaphylaxis (see section 10, 11, 12).

8.2.3 It is essential to note that the BP readings, on their own, should not be taken as indication of anaphylaxis, but all other signs and symptoms should be assessed in conjunction.

8.3 On affirmation of patients’ suitability for nail surgery and having attained consent (verbal or written at this stage, see section 9) the patient should then be put forward for the appropriate procedure according to local guidelines, as a minimum:

8.3.1 Patients should be offered the first available surgical appointment according to their priority of need.

8.3.2 A minimum of the first (within 48 hours) and second redressing (within 2 weeks) appointments should be made at this time and the patient informed accordingly. This is aimed at obtaining patient compliance and commitment for post-operative checks. Further redressing appointments should be made at the discretion of the practitioner, until healed. (See section 14).

8.3.3 A pre-operative patient information leaflet containing surgery, first and second redressing appointments should be given or sent to the patient (appendix I) with a map of location for surgery.

8.3.4 A standard letter be sent to the patients’ GP, informing of planned procedure and date of surgery (appendix II) and inviting the GP to disclose any knowledge of possible contra-indications or known risks to surgery. The GP should be given time to respond e.g. 2 weeks.
9. CONSENT TO TREATMENT

9.1 Patients’ have a *right* to make *informed* choices about the treatments that affect them. Seeking consent is to enable this process to occur. (Consent, The Society of Chiropodists and Podiatrists – 2005).

9.1.1 The podiatrist must explain fully the procedure, alternative treatments available and consequences of no action together with success rates for the treatment, to the patient and / or their carer in a manner that is appropriate to their needs, using an interpreter if required.

9.1.2 The podiatrist must explain the intended benefits and most frequently, seriously occurring risks to the patient and / or their carer in a manner that is appropriate to their needs, using an interpreter if required. (See appendix III – The Benefits and Risks of Nail Surgery – An Aid for the Practitioner)

9.2 Care should be taken when disclosing potential risks so as not to unduly alarm the patient and the extent and content of disclosure is at practitioners’ discretion.

9.3 The podiatrist must complete, in full, the appropriate consent form as per Policy – GP011 Policy for Consent to Examination or Treatment taking into account any issues relating to The Mental Capacity Act 2005 (most likely used forms will be consent form 3 & 4)

9.4 The consent form should be signed by the patient or appropriate guardian or body holding responsibility for the patient and interpreter if used.

9.4.1 It is recommended that consent should be sought in advance of the day of treatment, wherever practicable e.g. at assessment stage, as consent must be given voluntarily and not under any form of duress or undue influence from health professionals, family or friends. This may be verbal or written. Obtaining prior consent will allow the patient time to absorb the information provided and confirm their willingness and desire to continue on day of surgery.

9.4.2 Where the treatment is for a person under the age of 16, it is considered good practice to obtain their signed consent as well as that of the consenting guardian, if appropriate.

9.4.3 The consent form must be signed / signed again (depending on whether consent obtained at assessment was verbal or written) on the day of the surgery and the patient offered a copy.
10. PREPARATION FOR SURGERY

10.1 The surgical room must be clean and tidy prior to nail surgery. Consideration needs to be given to available space, ventilation, layout etc.

10.1.1 The surgical area must be adequately prepared, ensuring appropriate cleaning and preparation of surfaces (ref: CH/PC101 Infection Control Guidelines for Cleaning and Decontamination)

10.1.2 All necessary equipment, instrument packs (via CSSD), consumables and emergency aids e.g. Adrenaline packs, emergency contact numbers etc. should be to hand.

10.1.3 All necessary Batch, Lot, Sterilisation Numbers and Expiry Dates should be checked and recorded on the standardised EPR Nail Surgery Report form (EPRR).

10.2 The patient must be reassessed, in case of change of circumstances or new information becoming available, and suitability for surgery confirmed (bearing in mind responsibility and accountability of operating clinician).

10.2.1 The procedure, intended benefits and most frequently and seriously occurring risks should be discussed again.

10.2.2 The patients’ BP should be taken and recorded (EPRR) prior to surgery.

10.2.3 The patients’ weight should be taken and documented (EPRR) to facilitate the correct calculation of the Maximum Safe Dose (MSD) of Local Anaesthetic (LA) that can be administered to an individual for the purpose of nail surgery (See section 11).

10.3 The podiatrist should ensure that the patient is suitably prepared for the surgery e.g. check post operative footwear is adequate, has brought any inhalers or medication that may be required, has arranged return transportation and is still able to attend for the planned redressing appointments.

11. LOCAL ANAESTHETIC (LA)

11.1 To aid in the calculation of MSD, the use of Class IV scales is considered to be adequate. The use of this category of scales is not considered to be diagnostic, as the calculation does not reflect the ‘actual’ dose to be administered. These scales should be uniquely identified and calibrated annually to maintain a degree of accuracy.
11.1.1 To aid in the calculation of MSD, a chart should be available at each surgery site with the MSD for a range of weights (appendix VI)

11.1.2 The MSD should be recorded (EPRR)

11.2 LA cartridges must be checked for the following:

11.2.1 Previous use, damage, cloudiness, bubbles or foreign objects and disposed of safely in available ‘doop’ boxes.

11.2.1.1 Check type of anaesthetic to be used on each patient.

11.2.1.2 Batch number and lot number if available and expiry date.

11.3 A previously sterilised dental or disposable syringe should be loaded by the podiatrist (holds ultimate responsibility and accountability) and a separate needle should be used for each toe to be operated on, in order to reduce the risk of cross infection

11.3.1 The injection sites should be cleaned with a steret or equivalent.

11.3.2 The needle end of the cartridge should be cleaned with a steret or equivalent before inserting the needle.

11.3.3 A small amount of LA should be expelled to ensure free flow of LA through needle.

11.3.4 Ensure patient is in a comfortable position before commencing injection and that the couch is free from obstruction to enable collapsing of the back rest in the event of a clinical emergency. Gloves should be worn during injection as skin barrier is being breached.

11.4 When injecting, a good technique ensures minimum pain to the patient.

11.4.1 Avoid placing finger on plantar surface of toe to reduce the risk of needle stick injury.

11.4.2 H’ block technique should be avoided as there is a risk of impeding blood flow via a tourniquet effect.

11.4.3 If using disposable syringes, it is good practice to aspirate before injecting. Most dental syringes are however self-aspirating.

11.4.4 Needles must never be resheathed or removed by hand, they must be safely removed and disposed of in a sharps bin (ref:
11.4.5 All cartridges must be kept for at least 20 minutes post injection, to confirm the total dosage administered in the case of anaphylactic shock; then disposed of safely in available ‘doop’ boxes.

11.4.6 The total volume of LA administered, the strength, the calculated dose and the time of administration should be documented (EPRR).

11.5 The podiatrist should test for anaesthesia using a suitable implement e.g. point cut on orange stick or neurotip, after first demonstrating ‘sharpness’ to patient on a sensate part e.g. hand; implements designed to penetrate the skin e.g. needles should not be used to test for anaesthesia. The patient should be made aware of still being able to appreciate touch and pressure.

11.5.1 Should anaesthesia not be achieved further LA can be administered up to the safe maximum dose or maximum limit allowed per digit (appendix VI).

11.6 Post LA the patient’s blood pressure should be taken and recorded (EPRR), as this is the most likely time when anaphylaxis may occur.

12. THE OPERATIVE STAGE

12.1 Preparation - All podiatrists and assistant must follow sterile, aseptic techniques, to include hand washing, gloving, use of primary and secondary fields etc.

12.1.1 An plastic apron worn over a freshly laundered uniform is considered to be a satisfactory barrier to cross infection during nail surgery.

12.1.2 A fresh apron must be worn for each new procedure and discarded as clinical waste.

12.1.3 Sterile gloves should be worn for the procedure.

12.2 Instruments – packs via CSSD should be checked and appropriate CSSD documentation completed, any discrepancies should be reported. Sterilisation cycle and pack numbers should be recorded (EPRR) (ref – Podiatry Services – Decontamination of Medical Devices (Instrumentation) Guidelines / Operating procedures).

12.3 Sterile Field / Swabbing – sterile fields must be maintained for primary and secondary field using sterile drapes.
12.3.1 Expiry dates and type of appropriate skin prep used must be checked and recorded (EPRR).

12.4 **Tourniquet** - The use of the Esmarch bandage (tourniquet) to exsanguinate the digit in preparation for surgery is considered to be most appropriate. Skillful use of this produces the best desired affect.

12.4.1 Latex free *ring* digital tourniquets e.g. Tournicots may be used if considered appropriate and certainly in the case of latex allergies. These are single use items only and care must be taken to ensure timely removal.

12.4.2 Tourniquets (tournicots) should be checked for damage prior to use.

12.4.3 The tourniquets (tournicots) should be applied in the appropriate manner and the time at which this occurs should be noted by the Assistant and documented (EPRR).

12.4.4 Under normal circumstances, the tourniquet (tournicot) should not be left in-situ for longer than 20 minutes. However, this is at the discretion of and dependant on the clinical judgement of the Podiatrist. Should the total time exceed 20 minutes, the reasons for this should be fully justified in the patients’ records.

12.4.5 The time at which the tourniquet (tournicot) is removed should be noted; this and the total time of application should be recorded (EPRR).

12.5 **Phenol** – Phenol (as liquefied phenol) is a potent caustic and is highly toxic. It is therefore imperative that all staff using phenol exercise extreme caution and care. The use of phenol in the controlled destruction of the nail matrix, following removal of the nail, is deemed to be the most effective and successful method.

12.5.1 Podiatrists and assistants must be aware of and follow ‘Guidelines on Safe Use of Liquefied Phenol by Podiatry Services’ and current phenol COSHH Safety Data sheet.

12.5.2 The operating room should have sufficient ventilation and have been monitored and cleared for safety with regards to Workplace Exposure Limit via appropriate risk assessment.

12.5.3 Phenol must not be decanted

12.5.4 Glycerine / polyethylene glycol 300 must be made available and be to hand in case of accidental burn

12.5.5 Suitable Personal Protective Equipment must be used in addition to impermeable sterile gloves and apron i.e. approved full face visor shield or eye goggles with a mask
12.5.6 Care must be taken on opening the container housing the phenol bottle and removing the bottle, as leakage may have occurred.

12.5.7 The expiry date, batch and lot numbers should be checked prior to use by the Podiatrist and Assistant and recorded (EPRR).

12.5.8 The tissue surrounding the nail sulcus into which the phenol is to be introduced, should be masked with a suitable agent e.g. paraffin wax (from Bactigras) to prevent unwanted phenol burns to the patient (considered best practice).

12.5.9 Care must be taken not to use excessive phenol to prevent splashes.

12.5.10 The phenol is introduced into the sulcus and agitated. A new applicator must be used for each phenol application and used applicators must never be returned to the bottle. Applicators must be safely disposed of in the clinical waste.

12.5.11 Contact time – total phenol contact time can be 30 seconds to 5 minutes, 2-3 minutes is usually adequate. Phenol maceration has occurred when the colour of the matrix changes to a pale whitish blue. This is at the discretion of the Podiatrist and usage time must be recorded (EPRR).

12.5.12 Post phenol, irrigation is not advised as phenol cannot be neutralised with alcohol and this may lead to phenol burns. The nail matrix may be dried using sterile gauze.

12.5.13 Used phenol bottles should be labelled and housed securely e.g. in the medicines (metal) cupboard until safe disposal within approved ‘doop’ boxes.

12.6 **Vascular return** - on removal of tourniquet (tournicot), vascular return i.e. the return of blood flow and normal skin colour must be checked for, witnessed and documented (EPRR).

12.7 **Post Operative Dressing** – the surgical site may be covered with an antiseptic, paraffin wax dressing e.g. Bactigras as a primary dressing to prevent adherence of secondary dressing to the wound.

12.7.1 A haemostatic dressing e.g. Kaltostat may be used with light pressure to stem any bleeding; this should not however replace digital pressure and elevation.

12.7.2 When bleeding subsides, the haemostat can be removed and the toe dressed as a non-bleeding wound.
12.7.3 If bleeding continues the haemostat should be left in situ and reviewed within 48 hours.

12.7.4 A non-adherent secondary dressing e.g. Melolin or Release (1 or 2 usually sufficient) should be used with tubular bandage and an appropriate fixative e.g. Mefix.

12.7.5 It is not considered necessary to use compound dressings or excessive numbers of dressings as this may traumatise the wound further.

12.7.6 Care must be taken in ensuring timely review when using the paraffin wax impregnated gauze and haemostatic dressings (within 48 hours) as these can dry out and cause undue trauma to the wound, thus delay healing.

12.7.7 A final blood pressure reading should be taken at this stage and recorded (EPRR).

13. **THE POST OPERATIVE STAGE**

13.1 **Post Operative Instructions** - the post operative instruction leaflet (Appendix VII) should be completed in full - indicating type and amount of anaesthetic used, date and time of administration, date and time of redressing appointments and a contact number. The leaflet is issued and supported with verbal advice.

13.2 **Dressings issue** – research shows that compliance with redressing is better if dressings are issued to the patient.

13.2.1 Sufficient dressings should therefore be issued to the patient to last them between redressing appointments.

13.3 **Instruments** – these should be repacked and returned to CSSD without washing.

13.5 **Clinical Waste** - all clinical waste must be disposed of according to Trust Policy.

13.6 **Environmental Cleaning** - cleaning and decontamination of the clinic should be carried out appropriately (ref: CH/PC101 Infection Control Guidelines for Cleaning and Decontamination)

14. **REDRESSING**

14.1 Initial re-assessment of the wound and redressing should ideally take place within 48 hours post operatively.

14.1.1 Should the dressing have adhered to the wound, it should be irrigated using 0.9% normal saline
14.1.2 A non-adherent dressing should be applied and secured appropriately.

14.1.3 Patients should be issued with a redressing instruction sheet (Appendix VIII) at the first redressing appointment.

14.1.4 Patients are reviewed further in 2 weeks (maximum) and then as necessary at the discretion of the podiatrist or according to local arrangements until the wound is healed.

15. DOCUMENTATION

The podiatrists must maintain an accurate record of every treatment using the appropriate EPR documentation or keep a paper record for uploading at a later stage in case of computer failure (paper copy scanned as proof).

16. AUDIT / DISCHARGE

Once the wound has healed a standard letter should be sent to the patients’ GP (appendix IX) informing them of the completion of treatment.

16.1 Prior to discharge, above, the patient is requested to complete a patient satisfaction survey. This is placed directly into an envelope and sealed, by the patient, and forwarded for audit data collection.

16.2 The patient is placed onto a TIARA ‘review’ list for success rate audit to be effected 12 months hence.

16.3 Patient is contacted, 12 months post healing, to determine regrowth and potential success of procedure.

16.4 Patient may need to be offered further appointments to assess any issues related to failure.

16.5 Audit results are analysed and reported on annually.

16.6 The patient may then be discharged with advice on re-accessing the service should it be necessary.

A method of being able to discharge a patient but still enter onto a review / recall list for audit purposes, is being investigated. Should this be found possible – the patient could be discharged post healing. A further amendment to these Guidelines would be affected as appropriate.

17. ACTION DETAILS:

**Overall document responsibility / review** – Head of Podiatry Services / Podiatry Professional Lead

**Overall Accountability** – Head of Podiatry Services / Podiatry Professional Lead

**Dissemination** – Podiatry Team Leaders to staff
Implementation responsibility – Podiatry Team Leaders
Monitoring responsibility – Podiatry Team Leaders
18. REFERENCES


7. Charnwood and North West Leicestershire PCT Podiatry Control of Infection Policy (2005)

8. Charnwood and North West Leicestershire PCT Control of Infection Policy


13. Core Update in Local Anaesthesia, Huddersfield School of Podiatry (2002)

14. The Role of the Podiatry / Clinical Nail Surgery Assistant by Georgia Dacres (Team Leader) H&B PCT Podiatry Services

15. The Role of the Podiatry / Clinical Nail Surgery Assistant – Competency / Safety Checklist by Georgia Dacres (Team Leader) H&B PCT Podiatry Services


Appendix I

WHAT YOU NEED TO DO BEFORE YOU COME

- You should arrange to be driven home. After a local anaesthetic to numb your toes, you are not considered fit to drive. (Road Traffic Act 1988).

DO NOT DRIVE HOME
It is also not advisable to walk home or take public transport.

- Arrange to be able to rest as much as possible, with the foot raised on a stool, for up to 24 hours.

- Bring a list of medication with you. In particular, let us know if you are taking Warfarin or any other blood thinning tablets.

- Let us know if you have had any local anaesthetic injections within 24 hours of the surgery.

- Bring a loose slipper; open toed sandal or similar footwear to wear after the surgery, as the dressings may be bulky.

If you have any other questions please do not hesitate to contact the Podiatry Service within office hours on:

Telephone: _____________________________

Leicestershire County and Rutland Community Health Services

Podiatry Services

Your Nail Surgery

Patient Name: _____________________________

<table>
<thead>
<tr>
<th>Appointment</th>
<th>Nail Surgery</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Redressing</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Redressing</th>
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GENERAL INFORMATION

Nail surgery is a minor operation done under a local anaesthetic and is usually performed when other treatments have failed.

You can eat and drink as normal before the surgery and you should allow at least an hour when you come to have the operation.

THE OPERATION

The Podiatrist will give you local anaesthetic injections, usually one to either side of the affected toe, to numb the toe before surgery. Once the toe is numb, the Podiatrist will either remove the ingrowing side of the nail or the whole nail. (Your toe may remain numb for 2 - 4 hours)

A chemical will then be applied to destroy the root of the nail to prevent it from growing back.

A dressing will be applied to the toe and you can go home the same day. An appointment will be made, where possible, for you to come back to a clinic within 48 hours to have the dressing changed. You must then change the dressing regularly, until the toe is healed. This may take several weeks. The Podiatrist will advise you on how to do this and will check on you periodically.

It is essential that you are able to attend for these redressing appointments.

POSSIBLE RISKS

As with any operation and use of local anaesthetics, there are associated risks. The risks from nail surgery are low; most frequently occurring risks include:

- The nail may grow back
- The toe may bleed
- You may get some pain
- You may develop an infection

The Podiatrist will talk to you about these. Please also follow instructions in the leaflet, ‘After Your Nail Surgery’, as these will help minimise risks.

CONSENT

You will be asked to sign a consent form on the day of the surgery, even though you may have already signed one previously. Patients under 16 years of age will need a parent or guardian to sign the consent form and accompany them on the day of the operation.
Dr XXXXXXXXXXX
Bushloe End Surgery
48 Bushloe End
Wigston
Leicester

Our ref: TIARA

Dear Dr XXXXXXXXXXX

Re: Patients Name
Patients Address 1
Address 2
Postcode
Patients DOB

I am writing to inform you that an appointment has been made for the above patient to attend:
Narborough Health Centre
Thornton Drive
Narborough
Leicester

The appointment is for minor nail surgery, and will take place on __(Date)__________ at _(Time)__. This will involve the use of a local anaesthetic and application of tourniquet and phenol.

If you consider there to be any contra-indications to this or you foresee any potential problems, I would be grateful if you could contact the clinic directly as soon as possible.

Yours sincerely,

Podiatry Booking Service
Patients’ have a right to make informed choices about the treatments that affect them. It is therefore important that the patient be given sufficient information to enable them to make this choice.

Information should be presented as simply and as clearly as possible.

The content and extent of information delivered will involve a degree of clinical judgement i.e. the patient is informed as fully as he/she wishes, disclosing the most frequently occurring risks but care should be taken not to cause undue anxiety or alarm. It is realistic to disclose risks that have an occurrence rate of one or more per thousand procedures. (Consent – The Society of Chiropodists & Podiatrists, 2005).

Benefits of Nail Surgery

The intended benefits of the procedure will be individual to the patient and should be discussed as such.

In general, benefits will be to cure the ingrowing toenail, to resolve pain or problematic nail conditions, to eliminate or reduce risk of / from infection.

Risks from Nail Surgery

As with any surgical procedure and the use of local anaesthetics (LA), there are associated risks. With nail surgery, these risks are low; most frequently occurring risks include:

- **Nail Re-growth** – Literature suggests a re-growth rate of 2-8% (7% in South Leicestershire PCT – local audit) or conversely a success rate of 92 – 98%. Should this occur the nail may cause no further problem. In some cases the surgery might need to be repeated.
- **Delayed Healing** – Due to the use of phenol in producing a chemical burn, healing may be slow. On average, healing time can be between 4 – 12 weeks dependant on age, general medical status, and individuals’ ability to heal and post operative care taken.
- **Pain** – During the procedure, this is usually attributed to the injection of LA causing the usual minor scratch or stinging sensation. Post operative pain or discomfort, though reduced by the analgesic affect of phenol, may occur and thus require painkillers e.g. paracetamol.
• **Phenol Burns** – Though every precaution is taken to prevent this i.e. masking the surrounding area, occasionally the phenol may spread to healthy skin. This may cause pain, associated with burns, and may delay the healing.

• **Post Operative Infection** – Phenol, being a potent caustic, usually destroys any infecting organisms in the site and every precaution is taken to prevent further / cross infection. However, as the surgery involves an open wound, infection may still occur – presenting with throbbing pain, swelling, redness, inflammation and heat. Should this occur, antibiotics may be required.

• **Bleeding** – There is usually little or no bleeding during the procedure, however, post surgical bleeding may occur. This is minimised by rest and elevation of the foot. Any bleeding disorders or medication that may increase the likelihood of bleeding must be screened for and actioned appropriately at the assessment stage.

• **Anaphylaxis** – There is a very small chance that such an allergic reaction may occur due to the LA, chemicals, gloves etc being used. Every precaution is taken by screening for likelihood, use of blood pressure monitoring as an indicator, the availability of adrenaline in the unlikely event and annual basic life support and dealing with anaphylaxis training undertaken by all staff involved.

This list is by no means definitive but aims to cover those most frequently occurring risks. Practitioners may choose to disclose all or some of or indeed more than the above.
Appendix IV

MAXIMUM SAFE DOSES OF (MEPIVACAINE HYDROCHLORIDE) SCANDONEST 3% PLAIN LOCAL ANAESTHETICS TO BE USED IN PODIATRY PER PATIENT PER 24HOURS, COMMENSURATE WITH BODY WEIGHT

<table>
<thead>
<tr>
<th>Weight (in stones)</th>
<th>Weight (in pounds)</th>
<th>Weight (in kg)</th>
<th>Millilitres of local anaesthetic</th>
<th>Number Of cartridges</th>
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<tr>
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<td>70</td>
<td>32</td>
<td>6.4</td>
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<td>7</td>
<td>98</td>
<td>44.5</td>
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<td>8</td>
<td>112</td>
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<td>10.2</td>
<td>4.6</td>
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<tr>
<td>9</td>
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<td>57</td>
<td>11.4</td>
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<tr>
<td>10</td>
<td>140</td>
<td>64</td>
<td>12.7</td>
<td>5.7</td>
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<tr>
<td>11</td>
<td>154</td>
<td>70</td>
<td>14.0</td>
<td>6.3</td>
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DO NOT EXCEED 14ML OF SCANDONEST 3% PLAIN REGARDLESS OF PATIENTS BODYWEIGHT

OR 2 CARTRIDGES PER DIGIT
### POST OPERATIVE APPOINTMENTS

<table>
<thead>
<tr>
<th>Appointment</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Redressing</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Redressing</th>
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**Podiatry Services**

**After Your Nail Surgery**

Patient Name: _____________________________

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**Post Operative Instructions**

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POST OPERATIVE INSTRUCTIONS AND ADVICE FOR PATIENTS

• Dressings should be left on and kept dry until your first redressing appointment.

• If you bleed through this dressing do not remove it, but place extra dressings provided over the top.

• Rest the foot / feet as much as possible for the remainder of the day.

• Raising your leg(s) e.g. on a footstool, helps reduce swelling and any bleeding that may occur.

• Pain – may occur after surgery and is usually mild to moderate.

• Should any pain occur, you can take your normal painkillers e.g. paracetamol as directed on the packet. Do not take aspirin or anything containing aspirin as this may increase bleeding.

• Complications are rare, but do sometimes happen.

If you have any concerns, please contact the Podiatry Department.

LOCAL ANAESTHETIC

You have been given a Local Anaesthetic today and there is a limit to the amount you can have within a 24 hour period. Should you require emergency treatment for any reason, within this time, you must give the following details to the emergency services, doctor or dentist:

<table>
<thead>
<tr>
<th>Agent Administered</th>
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<tbody>
<tr>
<td>Amount / Dose</td>
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<tr>
<td>Date</td>
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<tr>
<td>Time</td>
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Contact Details:

<table>
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<tr>
<th>Podiatrist</th>
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<tbody>
<tr>
<td>Clinic Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Central Booking Number</td>
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If out of hours, please contact your G.P.
## POST OPERATIVE APPOINTMENTS

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<tr>
<th>Appointment</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Redressing</th>
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<td>Date</td>
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<td>Time</td>
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<td>Location</td>
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**Podiatry Services**

**After Your Nail Surgery** (2)

Patient Name: ___________________________

Redressing Instructions

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TP012 - Nail Surgery Guidelines for Podiatry Services
Status – Final, version 2  Approval Date  14 June 2010  Review Date May 2012
Reviewer;  Amin Pabani, Head of Podiatry Services
Following your operation you will need to redress your toe(s) using the dressings, supplied by your Podiatrist.

Please note the following instructions and advice:

- Your toe may weep for several weeks, 4-12 weeks on average depending on the individual and the type of operation.

- Change your dressing every other day using a clean, dry dressing and touching the wound as little as possible.

- On the day that you are not changing your dressing, keep the toe(s) dry during showering / bathing.

- On the day you do change your dressing, shower or bathe as normal keeping the old dressing on, as this helps to loosen the dressing.

- Do not use strongly scented bath products.

- Following your shower / bath, remove the old dressing and bathe the foot / feet in warm salt water for up to 5 minutes. Do not use antiseptics.

- Keep foot / feet moving in the water as the salt can form a layer over the wound and not allow fresh water to it.

- When dry, dress the toe(s) with the clean dry dressings supplied, as demonstrated at your redressing appointment.

- Take care not to put tape all the way around the toe; as if your toe swells it may affect the circulation.

- If your toe(s) is weeping a lot you can change the dressings daily.

- Avoid wearing tight footwear

- If you knock or bang your toe(s) this may bleed or weep more than normal. This should stop itself.

If you have any concerns, please contact the Podiatry Department.

Contact Details:

<table>
<thead>
<tr>
<th>Podiatrist</th>
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<tr>
<td>Clinic Telephone Number</td>
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<tr>
<td>Central Booking Number</td>
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</table>

Dr XXXXXXXXXXX
Bushloe End Surgery
48 Bushloe End
Wigston
Leicester

Our ref: TIARA

Dear Dr XXXXXXXXXXX

Re: Patients Name

Patients Address 1
Address 2
Postcode

Patients DOB

Further to previous correspondence; the following procedures were carried out:

The treatment has been successfully completed.

Remarks:

Yours sincerely

Podiatrist