Postoperative wound separation: transfer

This is original independent practice. All patient-specific observations, events and individual care arrangements are fictional. Assume that today's date is 4 November 2026. Urgent transfer has been accepted after today's community nursing assessment. Allow 45 minutes: 5 minutes for reading and 40 minutes for writing. You are a registered nurse in the community nursing clinic. Using the case notes, write a transfer letter to Ms Elisa Bayona, Surgical Receiving Nurse, Emergency Surgical Unit, 32 Station Road, NSW 2000, Australia. Highlight Mr Gargallo's current wound findings, the uncertainty requiring surgical assessment and his immediate nursing handover needs. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O
Patient details and background			
1. Name: Mr Rafa Gargallo; DOB 09/08/1968 (58 yrs)	☐	☐	☐
2. Transfer: 04/11/26, community nursing clinic → emergency surgical unit	☐	☐	☐
3. Lives with partner; normally independent with personal care	☐	☐	☐
4. Partner informed of transfer with patient's consent	☐	☐	☐
5. Patient upset about parking charges at previous appointments	☐	☐	☐
6. Medical history: hypertension; no diabetes	☐	☐	☐
7. No known drug allergies; no anticoagulant treatment	☐	☐	☐
Surgery and earlier wound care			
8. 24/10: open sigmoid colectomy for recurrent diverticulitis	☐	☐	☐
9. 29/10: discharged; incision closed, scant serous drainage	☐	☐	☐
10. 30/10: small dressing stain; no wound-edge separation	☐	☐	☐
11. 01/11: dry wound; changed to smaller dry dressing	☐	☐	☐
12. 03/11: clips removed as scheduled; edges remained approximated	☐	☐	☐
13. 03/11: pain 2/10; walking independently	☐	☐	☐
14. Old shoulder wound, 2018: required prolonged dressing care; fully healed	☐	☐	☐
Current assessment — 4 November			
15. 04/11 10:30: coughing → sudden blood-stained wound drainage	☐	☐	☐
16. 10:40: lower incision open over 3 cm; subcutaneous tissue visible; moderate blood-stained drainage	☐	☐	☐
Current assessment — 4 November			
17. Depth/fascial integrity not established; no visible bowel; no probing	☐	☐	☐
18. Current pain 6/10; ↑ from yesterday	☐	☐	☐
19. 10:45: T 37.6°C; pulse 96 beats/min; BP 118/74 mmHg; RR 18/min; SpO2 97% air	☐	☐	☐
20. Alert; no vomiting; abdomen not distended; no dizziness or shortness of breath	☐	☐	☐
21. Last food and drink 08:00 today	☐	☐	☐
Treatment and immediate transfer plan			
22. 10:50: sterile absorbent dressing applied; no packing	☐	☐	☐
23. 11:10: registrar accepted urgent transfer; ambulance arranged	☐	☐	☐
24. Registrar: no further wound manipulation before surgical assessment; nil orally pending review	☐	☐	☐
25. No antibiotics commenced; wound swab not taken	☐	☐	☐
26. Please notify registrar on arrival; reassess wound/observations/pain; escalate deterioration immediately	☐	☐	☐
27. Operative report, current medication list and community nursing assessment accompanying patient; receiving team alerted	☐	☐	☐
28. Previously booked routine dressing review 06/11 now superseded	☐	☐	☐
29. Patient asks whether another operation will be necessary; registrar to discuss after assessment	☐	☐	☐

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