Best Practice Update for the Diabetic Foot

Northampton Park Inn
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Programme

- What are Clinical Practice Guidelines (CPGs)?
- Why do we need them?
- How are CPGs going to improve patient care?
- How will they affect my current responsibilities and competences?

Questions?

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- Why do we need them?
- How are CPGs going to improve patient care?
- How will they affect my current responsibilities?

Clinical Practice Guidelines

- "……systematically developed statements to assist provider and patient decisions about appropriate health care services for specific clinical circumstances."

Institute of Medicine (1992)

Why do we need them?

- Decrease variation in practice
- Care is based on research
- Increase appropriateness of care
- Decrease errors in healthcare

CPGs (cont.)

- **Diagnosis, education, preventive screenings, risk reduction, and pharmaceutical treatment of diabetic complications occurs mostly in outpatient primary care settings.**
- **CPGs encompass the critical factors in diabetic patient care management:**
  - **Glycaemic control**
  - **Foot and Eye evaluations**
  - **ID and treatment of complications (hyperlipidemia, renal disease)**
- **It also incorporates flexible use of referrals: Diabetic Educator, Optometry, Ophthalmology, Podiatry, Nephrology, Endocrinology**

How will they improve patient care?

- Evidence-based practice
- Provides a way to measure outcomes (metrics)
- Did what was supposed to happen really happen?
- Are we meeting our performance standards?
- Are we meeting our professional standards

Wounds: Diabetic foot

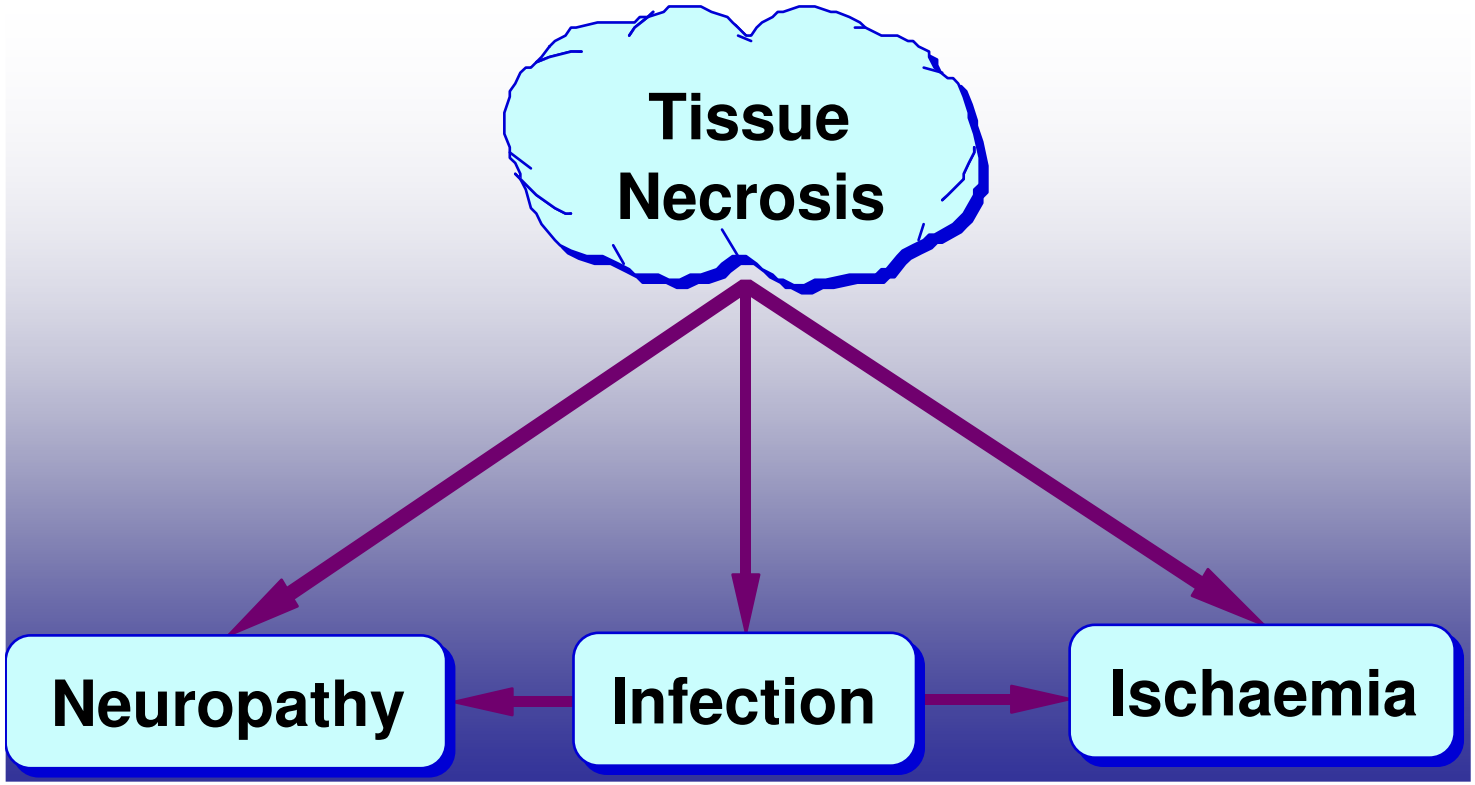
NICE Clinical Guideline CG10 Type 2
Diabetes - Foot care 2004

Diabetic foot

SIGN Clinical Guideline Management of Diabetes No 55 2001

'The diabetic foot may be defined as a group of syndromes in which neuropathy, ischaemia, and infection lead to tissue breakdown resulting in morbidity and possible amputation'

WHO 1995



The Deadly Triad

(Edmonds 1984)

Diabetic foot

SIGN Clinical Guideline Management of Diabetes No 55 2001

- Peripheral neuropathy in feet leads to loss of sensation and autonomic dysfunction
- Peripheral vascular disease in the form of atherosclerosis of the leg vessels causes loss of circulation (ischaemia which is often bilateral, multisegmental, and distal)
- Infection often complicates neuropathy and ischaemia and is responsible for considerable damage in diabetic feet

Diabetic foot

NICE Clinical Guideline CG10 Type 2 Diabetes - Foot care 2004
Clinical Knowledge Summaries Type 2 Diabetes 2008
SIGN Clinical Guideline Management of Diabetes No 55 2001

- Diabetic foot problems are a common complication of diabetes with prevalence of 20 - 40% for neuropathic causes and 20 - 40% for vascular disease causes also, with 5 - 7% leading to foot ulceration in any one year.
- Many causes of diabetic foot ulcers are avoidable
- Diabetic foot is the main cause of non-traumatic amputations
- Access to a podiatrist reduces the number and size of foot calluses and improves self-care

Diabetic foot

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- Much of the evidence supports a multidisciplinary team approach to management with recall and review
- Good patient foot care education may help to prevent diabetic foot ulcers
- Frequent assessment and reassessment is paramount to include history, skin assessment, vascular assessment, neurological assessment, foot deformity, nail infections, musculoskeletal assessment and footwear examination

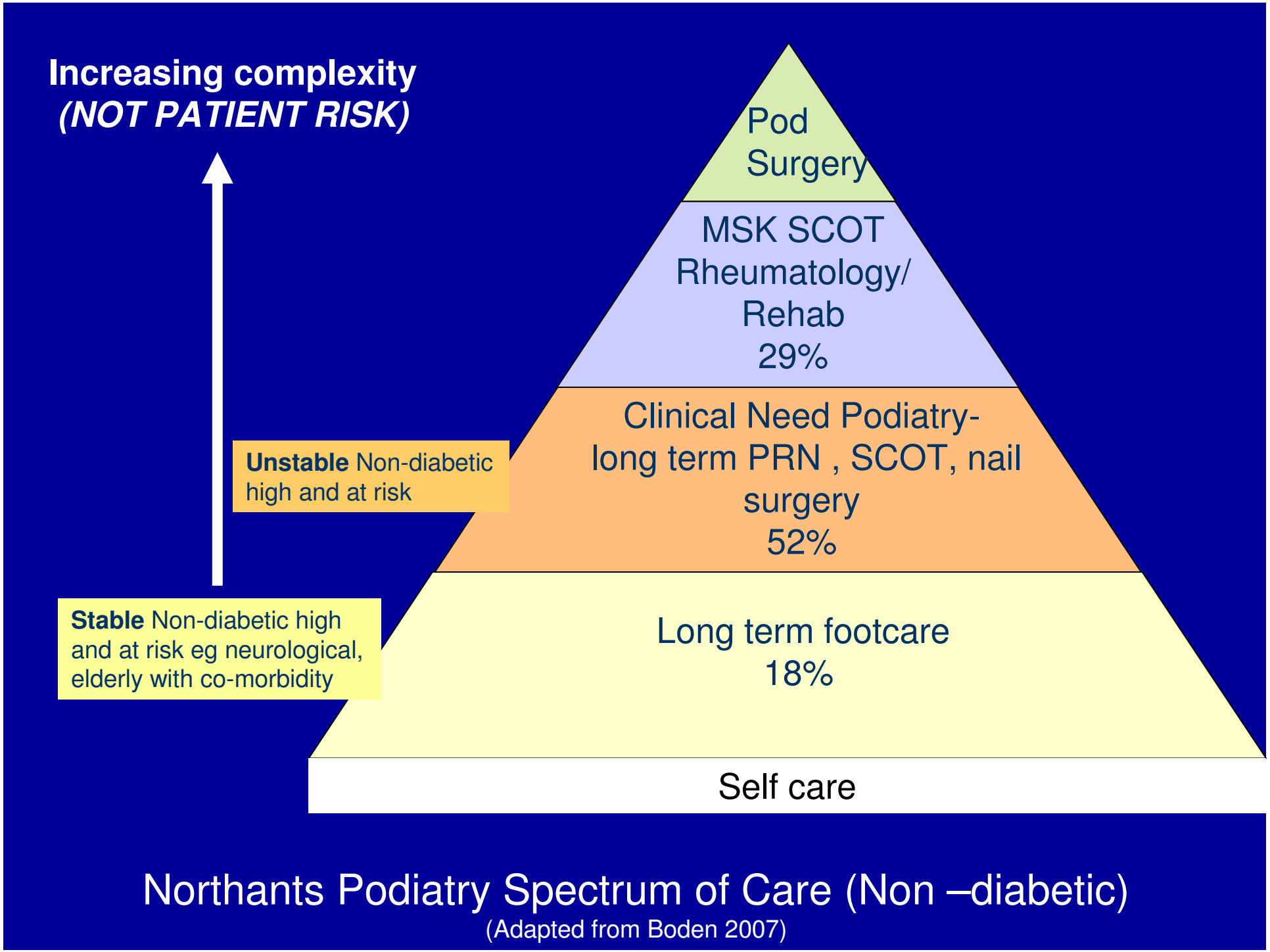
General management approach

- Effective care involves a **partnership** between patients and professionals and **all decision-making should be shared and recorded**
- Arrange recall and annual review as part of ongoing care
- As part of annual review, trained personnel should examine patients' feet to detect risk factors for ulceration.
- Examination of patients' feet should include:
  - Testing of foot sensation using a 10g monofilament
  - Palpation of foot pulses
  - Inspection for any foot deformity and footwear

General management approach

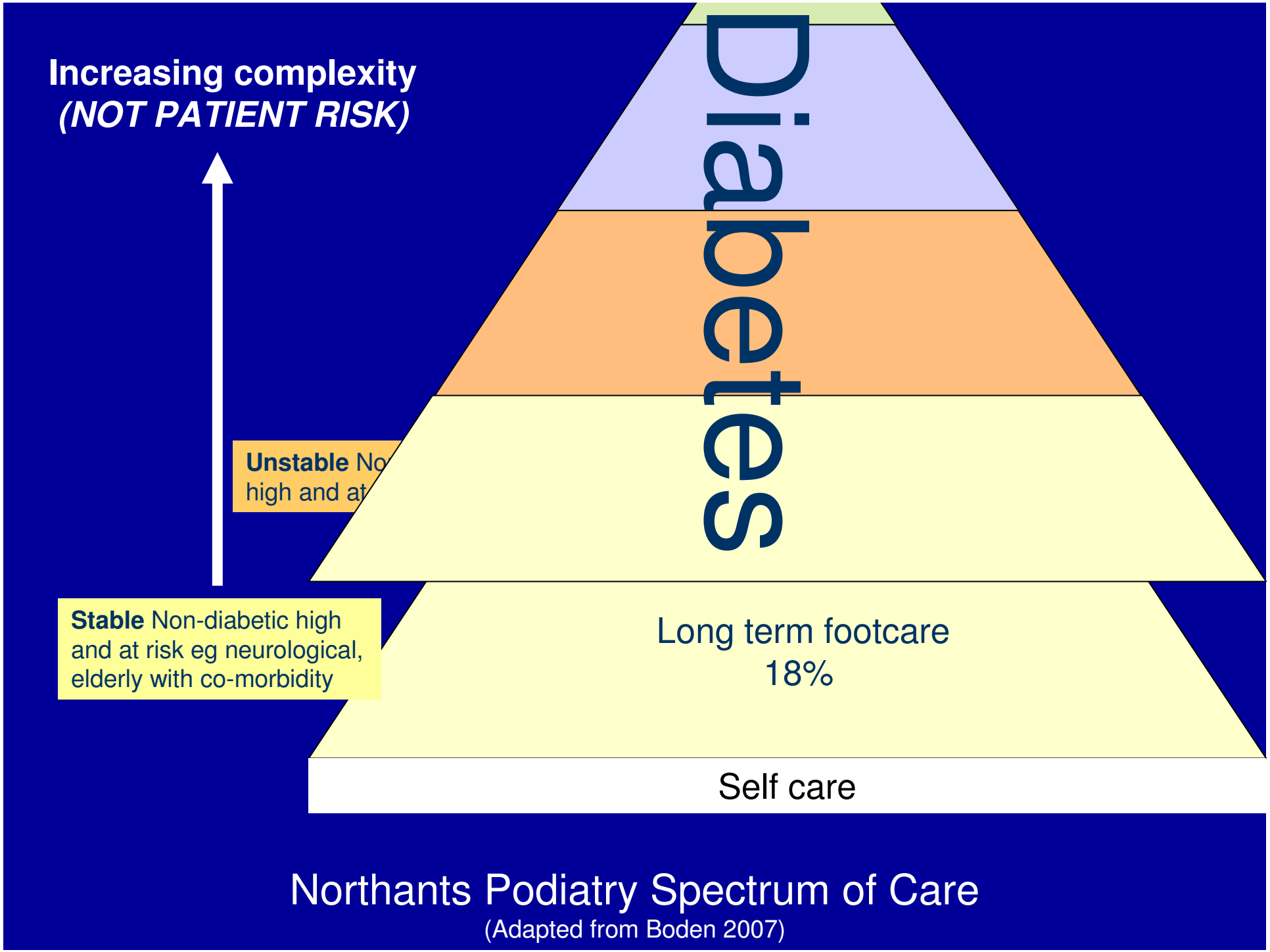
NICE Clinical Guideline CG10 Type 2 Diabetes - Footcare 2004

- Classify foot risk as
  - **At low current risk**
  - **At increased risk**
  - **At high risk**
  - **Ulcerated foot**
  - **If patient has had previous foot ulcer or deformity or skin changes manage as high risk**



Northants Podiatry Spectrum of Care (Non –diabetic)

(Adapted from Boden 2007)



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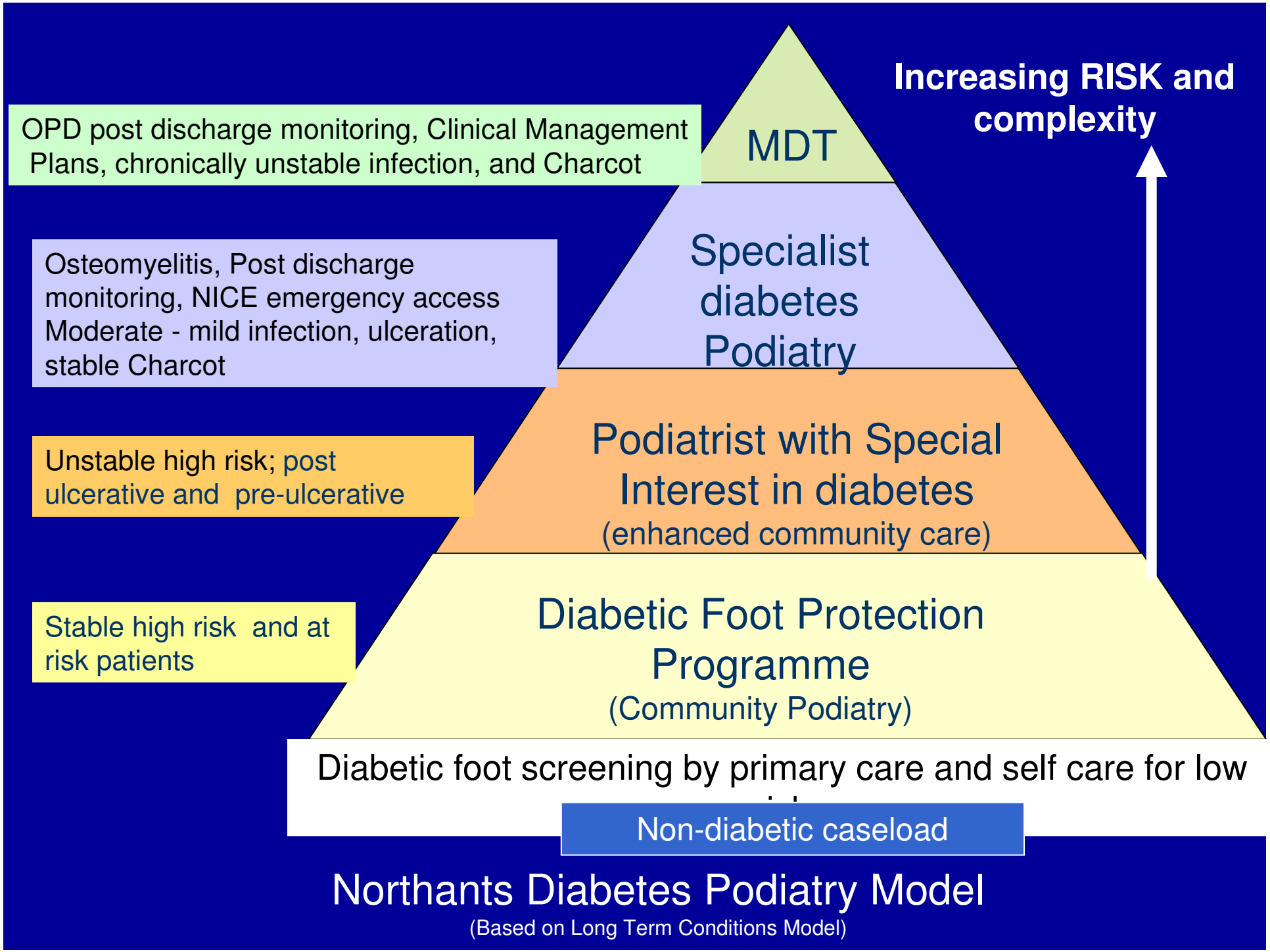
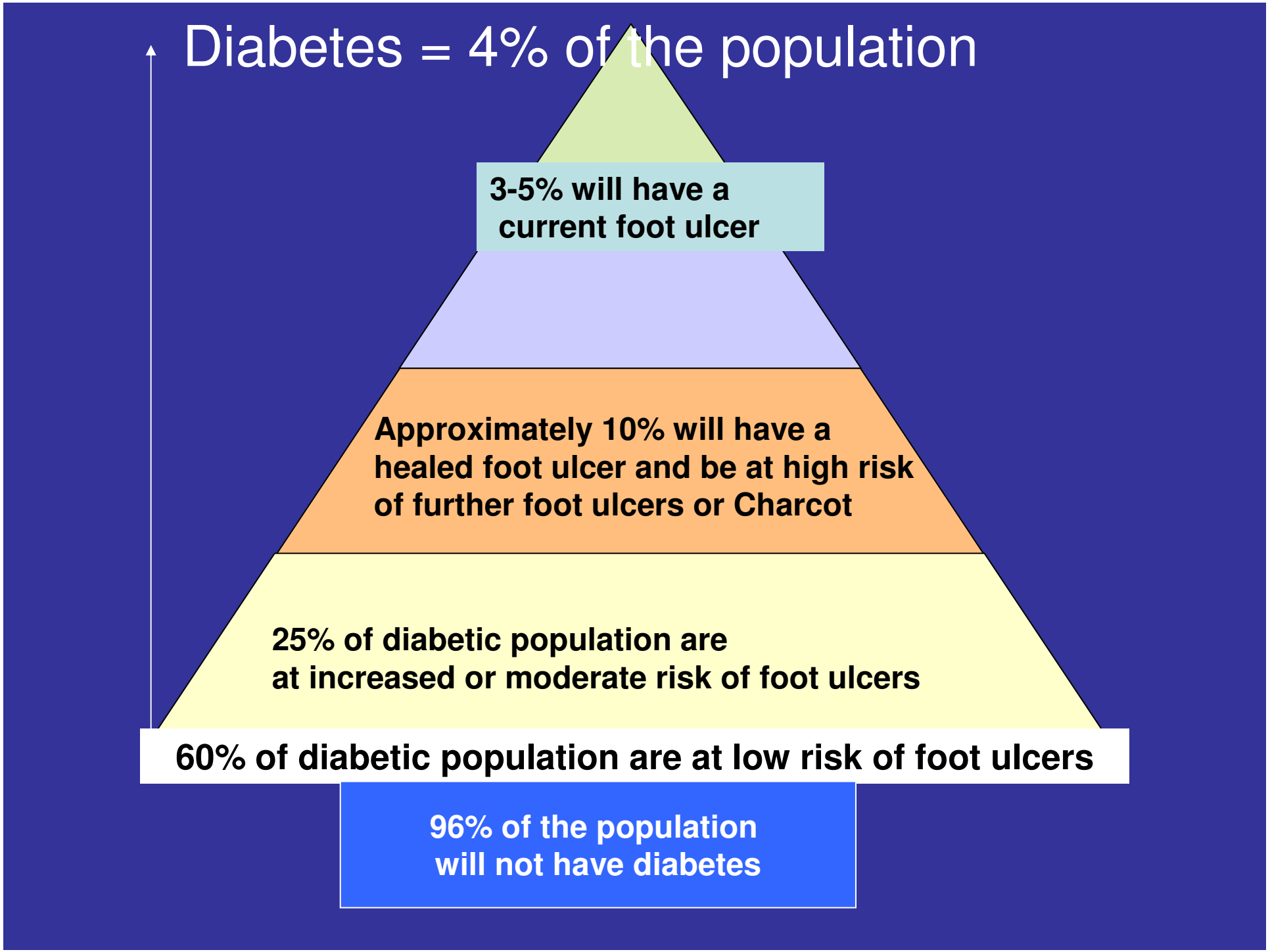

Increasing RISK and complexity
OPD post discharge monitoring, Clinical Management Plans, chronically unstable infection, and Charcot
MDT
Osteomyelitis, Post discharge monitoring, NICE emergency access Moderate - mild infection, ulceration, stable Charcot
Specialist diabetes Podiatry
Unstable high risk; post ulcerative and pre-ulcerative
Podiatrist with Special Interest in diabetes
(enhanced community care)
Stable high risk and at risk patients
Diabetic Foot Protection Programme
(Community Podiatry)
Diabetic foot screening by primary care and self care for low
Non-diabetic caseload
Northants Diabetes Podiatry Model
(Based on Long Term Conditions Model)

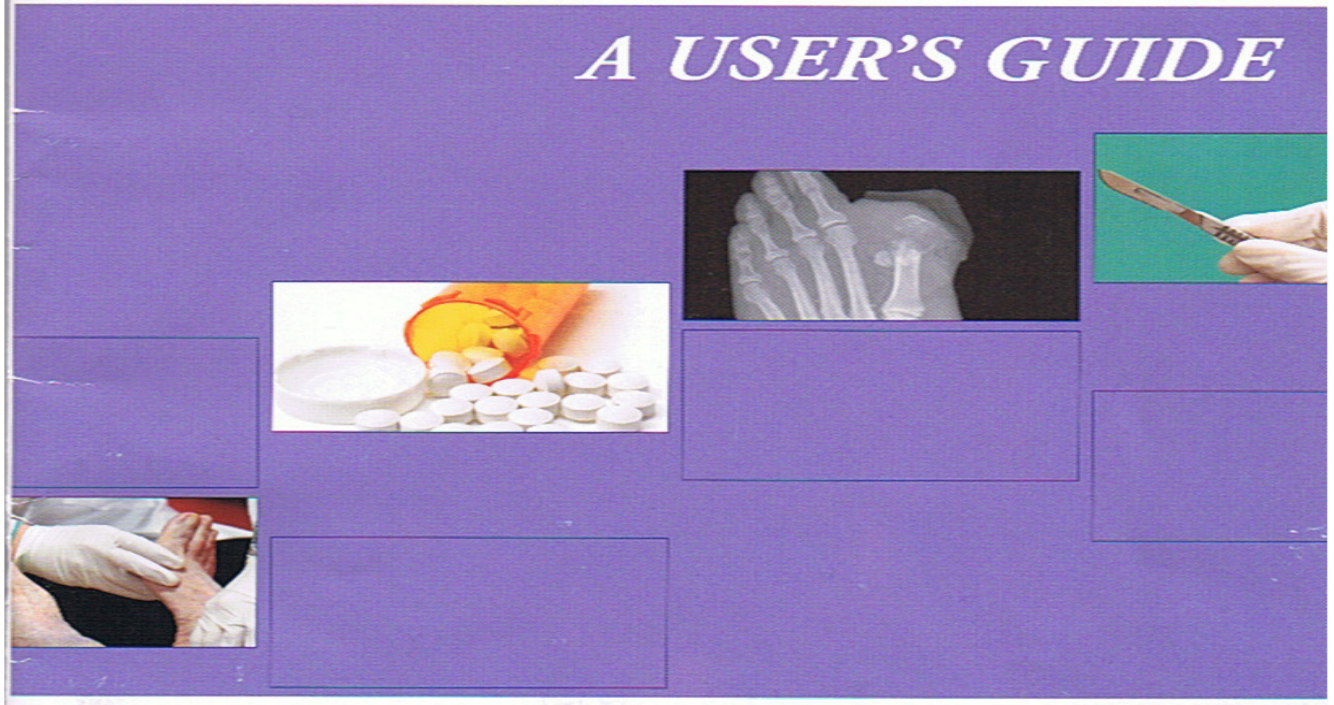

Diabetes = 4% of the population
3-5% will have a current foot ulcer
Approximately 10% will have a healed foot ulcer and be at high risk of further foot ulcers or Charcot
25% of diabetic population are at increased or moderate risk of foot ulcers
60% of diabetic population are at low risk of foot ulcers
96% of the population will not have diabetes

June 2012

TRIEPodD-UK

PODIATRY COMPETENCY FRAMEWORK FOR INTEGRATED DIABETIC FOOT CARE

A USER'S GUIDE



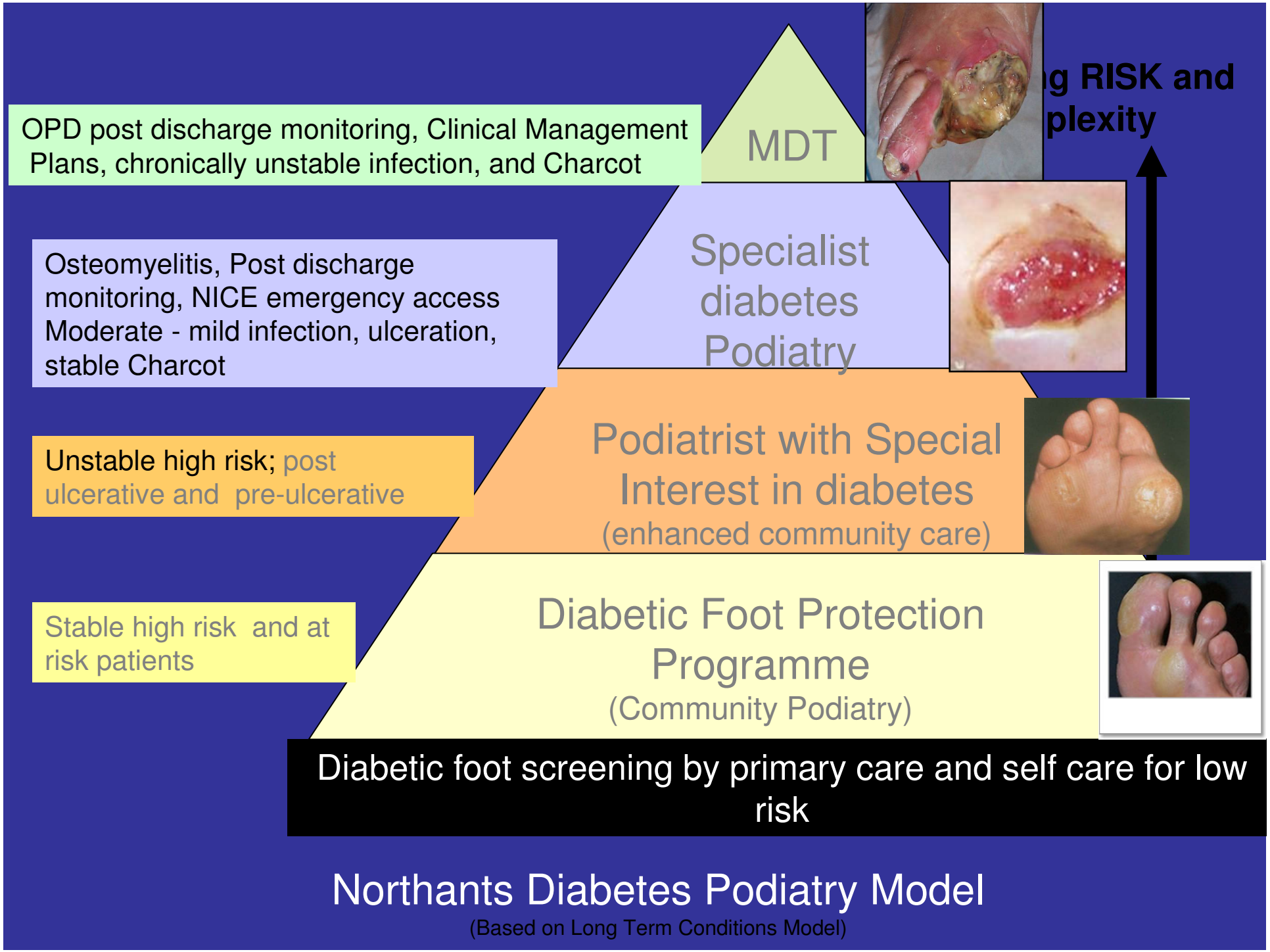
FDUK

The Diabetic Foot Journal

Scottish Diabetes - Foot Action Group

Skills for Health

The Society of Chiropodists and Podiatrists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Who should be referred?

Clinical Knowledge Summaries Type 2 Diabetes 2008

Refer the following to a **multidisciplinary team within 24 hours:**

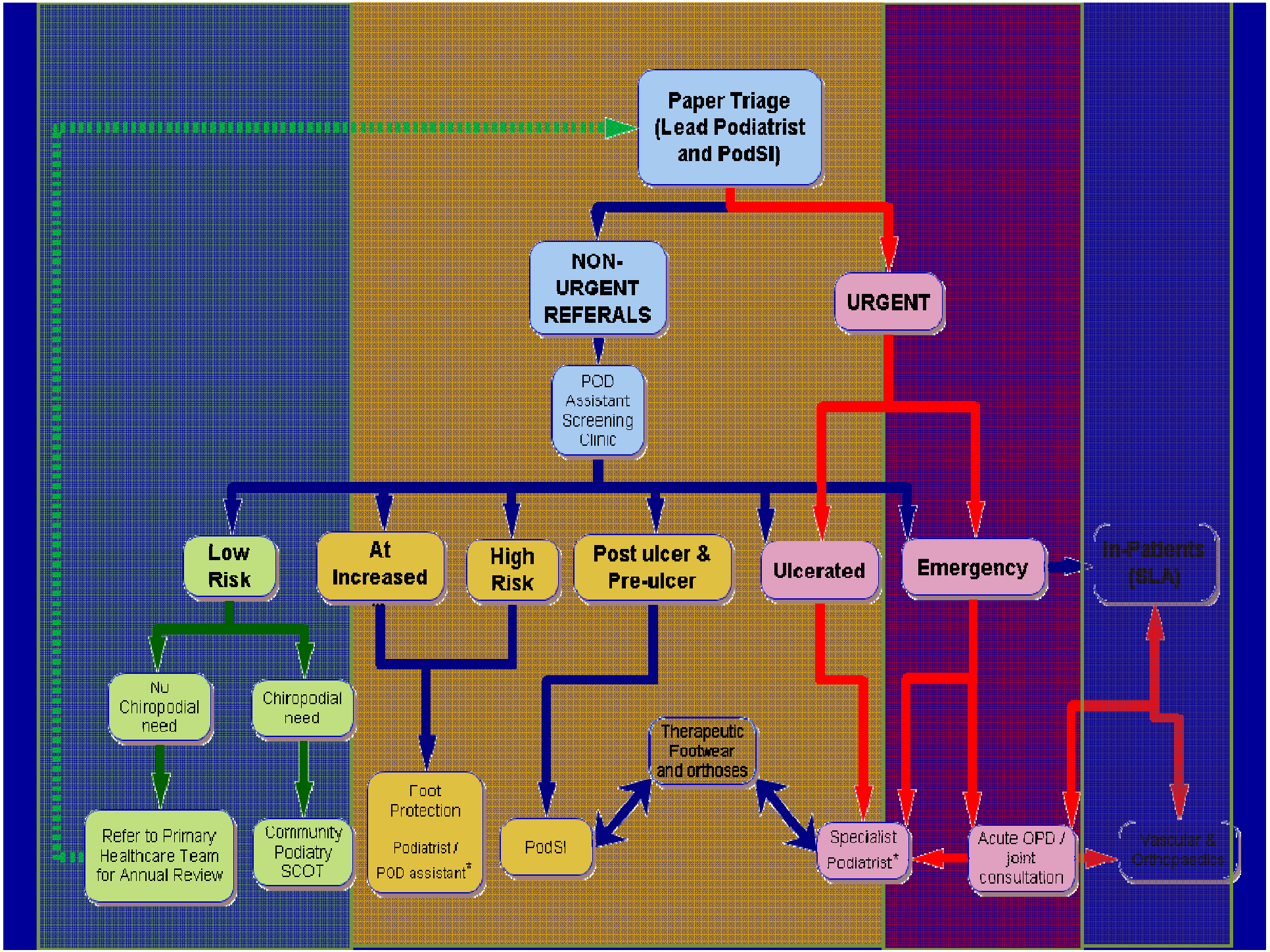
- New ulceration (wound)
- New swelling
- New discoloration (redder, bluer, paler, blacker, over all or part of the foot)
- Signs or symptoms of infection (redness, pain, swelling, or discharge)
- Deep ulcer — hospital admission may be more appropriate, clinical judgement is required

Who should be referred?

Clinical Knowledge Summaries Type 2 Diabetes 2008

Hospital admission is usually needed if any of the following are present:

- Pink or pale, painful, pulseless foot (indicating critical ischaemia).
  - Clinical judgement is required as some less severe, chronic cases of peripheral vascular disease where pulses are present but reduced, could be managed in a multidisciplinary clinic
- Spreading cellulitis, lymphangitis
- Crepitus
- Systemic symptoms of infection
- Lack of response of infection to oral antibiotics
- Suspicion of bone involvement (osteomyelitis)
- Immunocompromised or physiological instability


Paper Triage (Lead Podiatrist and PodSI)
NON-URGENT REFERALS
URGENT
POD Assistant Screening Clinic
Low Risk
At Increased
High Risk
Post ulcer & Pre-ulcer
Ulcerated
Emergency
In-Patients (SLA)
No Chiropodial need
Chiropodial need
Refer to Primary Healthcare Team for Annual Review
Community Podiatry SCOT
Foot Protection
Podiatrist / POD assistant*
PodSI
Therapeutic Footwear and orthoses
Specialist Podiatrist*
Acute OPD / joint consultation
Vascular & Orthopaedics

Thank You