

NO FOOT IS AN ISLAND

KEY WORDS

- ▶▶ Foot ulcers
- ▶▶ Diabetes
- ▶▶ Patient-centred care
- ▶▶ Patient empowerment

Foot ulcers are a common cause of hospital admission in people with diabetes and cause great expense to the NHS, yet patients are not consistently receiving optimal foot care from a multidisciplinary team – and the team is incomplete without the patient. There is no doubt that, to be successful in supporting patients, clinicians need to understand how to empower people to take an active role in their own care and how to include the patient at the heart of the care process.

Foot ulceration is one of the most common reasons for hospital admission in patients with diabetes and a lot of money is spent on caring for them (Diabetes UK, 2012). In some cases we are not providing optimal foot care through a multidisciplinary foot care team approach (Chadwick et al, 2007).

So whose responsibility is it to make sure people receive optimal care? A patient may not be seen by a specialist diabetes practitioner unless they have been referred, and this referral may not be forthcoming unless diabetic complications are recognised and acknowledged by the clinicians involved. The patient also may not recognise these issues and, therefore, not come forward until it is too late to do something.

It was recently suggested that the British “stiff upper lip” was responsible for the late presentation of some cancers (Roberts, 2013). Perhaps the same is true for both the diagnosis of diabetes and the identification of diabetic complications, particularly foot problems and especially in those who have neuropathy.

The current healthcare system is focused on “patient-centred care”. However, that term means different things to different groups and there is no agreed definition of the concept. In a study by Gillespie et al (2004) it was suggested that the term meant a partnership between the patient and the clinician, including the need for sharing information and decision-making; a service designed around the patients, rather than the clinicians. Some interviewees in the study suggested there should be a shift in the balance of power in favour of the patient.

Communication and shared decision-making are crucial to patient-centred care (Gillespie et al, 2004). There is no doubt that, to be successful in supporting

patients, clinicians need to understand behaviour change and how to empower people to take an active role in their own care (Moran et al, 2008).

WHO SHOULD CARE FOR THE PATIENT?

If timely intervention is to be sought, the patient should be educated and empowered by clinicians to recognise when there are complications and know where to go for help. Frequently, a nurse or GP will first see the patient in primary care or acute services. At this point the clinician must be able to recognise a problem for what it is. Assessment skills are necessary for all clinicians, and knowledge of diabetes will help them identify when and where there is a problem.

The blurring of responsibilities within clinical roles means that any clinician, with training and experience, should be able to assess a patient's feet, and patients with diabetes should have their feet assessed at every meeting (Diabetes UK, 2012). With the knowledge of what to look for, an clinician can assess a patient and, if appropriate, refer them to other clinicians with more specialist knowledge and skills. The key is early recognition and detection of possible complications.

The multidisciplinary foot care team approach is one which has evolved over the last decade. Teams of clinicians, each with a different remit, can join together to ensure the patient experiences optimal care. The teams in diabetic foot care include a diabetes specialist nurse, dietician, doctor, ward or community nurse, orthotist, physiotherapist, and podiatrist. It is also necessary to include a vascular or orthopaedic surgeon and a radiologist. This team, however, is incomplete without the patient; any patient-centred approach should always include the patient and any carers.

Multidisciplinary foot clinics have been shown

to reduce the major amputation rate by 50% (Edmonds et al, 1986). The concept of the clinic has been evolving and, as the number of people with diabetes increases, a reorganisation of care is needed.

In some areas, patients are only seen at specialised clinics if they are deemed to be at high risk or have active foot ulceration. This leaves the screening and initial assessment to other clinicians, and a certain amount of knowledge is required to ensure that appropriate choices are made for the patient and done in a timely manner.

WHO SHOULD TAKE LEADERSHIP?

At any one time, everyone involved can be caring for the patient. Nurses have traditionally had the role of coordinating the care; however, there is no reason why the patient cannot coordinate their own care. Communication and the sharing of care and records are paramount to including the relevant people in the patient's care.

The Scottish Care Information-Diabetes Collaboration is a project which started over 10 years ago that seeks to join up care services for those with diabetes (NHS Scotland, 2011). It has evolved over time and now provides a platform for a single electronic patient record, which allows all clinicians, as well as the patient, to participate in care and record keeping. Personal communications can also be included in the records.


Once a person with diabetes is assessed by a clinician, data can be entered on the national database and a plan of care formulated. Depending on the level of risk, the care may require a referral to a multidisciplinary team. This coordinated approach is a single record which crosses both geographical and professional boundaries. Information can be updated in real time and shared between primary and secondary care teams. The system also provides a database which can identify the costs and success of treatment plans, leading to better care for the future.

This concept has been used in wound care as a paper-based record, which relies on the patient bringing the record to all appointments, and all clinicians completing the record when they have cared for the patient (McMath and Harvey, 2003). While this puts the patient at the centre of the care package, this can result in the duplication of records

when clinicians keep additional records. Patients also do not always remember to bring their record to each appointment. Interestingly, in this study some patients felt their care incomplete unless their patient-held record had been completed. The electronic record, however, is always available.

FOOT CARE SHOULD BE ON EVERYONE'S AGENDA

Early identification of an "at risk" foot in a patient with diabetes, and an understanding of the potential issues around it is everyone's business. Baker (2006) suggested that the integration of primary and secondary care services for care of the diabetic foot and the cross-boundary electronic record may help this goal. The ideal situation is to make the best use of the resources available, sharing responsibilities rather than duplicating them.

Patient-centred care, regardless of the definition, should mean that the patient is at the centre of the process and involved in their own care. The team involved in a patient's care may change depending on the situation, however, a single record leads to continuity of care and awareness of all clinicians associated with the patient. The blurring of roles and the sharing of care in the current climate means that we have the opportunity to provide seamless care for patients, making them central to their management plan and including them in its development. We can all improve our practice by sharing our knowledge with our colleagues in other disciplines while sharing the same goal of improving patient outcomes. 

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