Improving outcomes in diabetic foot care: Collaboration and education the order of the day

LYNNE WATRET
Non Medical Prescribing Advisor, NHS Greater Glasgow, Glasgow, UK

Twenty-two years ago, I entered the brave – relatively new – world of the tissue viability nurse (TVN), in a busy city hospital. The hospital included a specialist diabetes ward, vascular service, and large renal unit. Not surprisingly, my first thoughts on patient referral soon turned to enquiring as to whether the patient had diabetes.

I quickly sought out the support of the diabetes specialist podiatrist and happily for me – and no doubt for the patients I encountered – this positive relationship was sustained. Thereafter, when I moved into primary care, it was a natural progression to continue to work collaboratively with the podiatry service.

Attendance at the Management Clinical Network – multidisciplinary groups from primary, secondary, and tertiary care working in a coordinated manner to ensure high-quality clinically effective services throughout Scotland – on diabetic foot care formalised this working relationship. Suffice it to say, the articles presented in this supplement support this view that, in order to provide the best quality of care for all patients, collaborative working is crucial within a knowledgeable workforce. The articles demonstrate a range of clinicians' experiences in, and approaches to, diabetic foot care, but ultimately, everyone can learn from this to improve patient outcomes.

WHY ARE DIFFERENT APPROACHES NECESSARY?

Since one in 20 people have diabetes (Diabetes UK, 2012), the chance of clinicians encountering a person with diabetes on a daily basis is high. Furthermore, this number does not include those people who have diabetes and do not know it yet!

All clinicians, regardless of whether they work in an outpatient department, surgical or medical ward, oncology, mental health ward, maternity unit, practice room, treatment room, district nurse team – the list is endless – should pause and reflect on how many of the patients currently on their caseload have diabetes. I asked recently asked this question of a vascular nurse ward manager in passing; out of 30 patients, he concluded that 21 had diabetes, perhaps not surprising that there was a disproportionate number in this area, but a telling fact, nonetheless.

Given their proportion of the population, and the complications that their condition predisposes them to, people with diabetes are present in all areas of health and social care. Therefore, it is essential that clinicians, regardless of which clinician, have the requisite knowledge and skills to determine, with the patient when possible, "what happens next". A successful outcome should not depend on serendipity, but correct clinical judgement.

In this supplement, Sharp (page 8) poses the question: "Who is responsible for the care of the person with diabetes in the prevention and treatment of foot lesions?". Nurses are not expected to be podiatrists – or experts on all aspects of care – but they are expected to know when to refer, who to refer to, and how to refer. Since they are often the first to encounter the patient, an understanding of processes should be viewed as an integral part of the management plan. While the reasons behind diabetic foot disease are multifactorial, as healthcare professionals, we must ensure our own practice is not a contributing factor to poor outcomes.

Rodgers et al (page 14) explored some of the issues around the assessment of a foot ulcer when carried out by a nurse or a podiatrist if the patient has diabetes. Ultimately, as noted by Rodgers et al and Cook (page 20), much depends on the knowledge and skills of those involved.

"If the premise is that it is acceptable to use different risk assessment or descriptive tools, then it is equally important to state that the outcomes for the patient should be consistently good."

USE OF DIFFERENT ASSESSMENT TOOLS

If we accept that both podiatry and nursing have evolved and developed different tools to predict the risk of ulceration and form management plans based on risk and clinical judgement, then it is essential that both specialties are familiar with the range of tools and pathways used. This does not necessarily mean that everyone should use generic tools, but there is a mutual understanding of why these tools are used and our expectations of those using them. If the premise is that it is acceptable to use different risk assessment or descriptive tools, then it is equally important to state that the outcomes for the patient should be consistently good.

Milne (page 10) explores the view that we do not need to change what we are currently doing in terms of ulcer grading, but work with it. Holistic vascular assessment takes into account a comprehensive vascular assessment, as well as the patients' environmental and social issues, and the same should be true of the assessment of people with diabetes and a foot ulcer. Transferable skills can be used to provide a holistic patient assessment and develop and execute a pathway of care, which includes referral to the multidisciplinary foot team (MDT) and ongoing shared care.

If a foot lesion is classified using a recognised pressure ulcer tool, such as European Pressure Ulcer Advisory Panel (EPUAP and NPUAP, 2009) and the individual has diabetes, this, in turn, can act as a prompt to refer the patient on within 24 hours of identifying the lesion to the MDT. Use of further transferable skills on assessment include identifying common areas that can involve perfusion, pressure, friction and shearing forces, as well as environmental and social factors. These are areas that the nurse can be proactively involved in patient care.

COMMON THEMES

It would appear that common themes are emerging. These include the holistic assessment of the patient pertinent to the specialty – be it of venous ulcers, pressure ulcers, or diabetic foot ulcers. In turn, common themes emerge regardless of the type of ulcer: the effects of comorbidities, vascular supply, pain management, wound care, social and psychological issues that promote functional ability, quality of life, and wellbeing.

DELIVERING EDUCATION

At a local level, TVNs and vascular nurse specialists have a major role to play in delivering education about the diabetic foot. These nurses can provide support to their colleagues who encounter patients with diabetes and foot lesions, and help support shared care between nurses and podiatry. However, there is also a consistent expectation that TVNs, vascular nurse specialists, and diabetic podiatrists collaborate in shared teaching and learning opportunities? If the articles in this supplement demonstrate shared themes and expectations that the patient will receive the correct care, at the correct time, by the correct person, then this should follow.

This also provides an opportunity for shared experiences, as well as development of critical thinking skills to explore common themes, variances, and management solutions. This can help break down barriers, develop a common language, and promote mutual respect. The patient will receive consistent care with reduced variations in practice by a skilled workforce.

All clinicians should be expected to recognise as part of their personal development plan the knowledge and skills necessary to care for patient with diabetes. Tissue viability and vascular nurses have a role to play in this endeavour. WUK

REFERENCES

Diabetes UK (2012) Diabetes in the UK 2012. Available at: http://bit.ly/MoJ1Nv (accessed 08.03.2013)

European Pressure Ulcer Advisory Panel, National Pressure Ulcer Advisory Panel (2009) *Treatment of Pressure Ulcers: Quick Reference Guide*. National Pressure Ulcer Advisory Panel, Washington DC