Undertake advanced examination and risk assessment of the feet of an individual with diabetes



Overview

This standard covers carrying out an advanced examination and risk assessment of the feet of an individual with diabetes. The activities described in this standard are likely to apply following referral to a foot protection team or specialist diabetes foot care service. This may be in the form of a self-referral or come from another health professional following a foot examination or other clinical examination. The individual may be accompanied by a carer who should be included in the discussions if the individual chooses to involve them.

Users of this standard will need to ensure that practice reflects up to date information and policies.

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Performance criteria

You must be able to:

- P1 communicate with the individual being examined and, with their agreement, any carers who are present, in a manner appropriate to them and which encourages an open exchange of information
- P2 confirm that the individual and carer understand the purpose and nature of the examination and give their consent
- P3 observe the feet to identify and record any
 - P3.1 gross foot deformities
 - P3.2 evidence of trauma
 - P3.3 bacterial or fungal infection
 - P3.4 skin changes
 - P3.5 cyanosis
 - P3.6 ulceration
 - P3.7 other abnormal phenomena
- P4 assess for:
 - P4.1 clinical features of neuropathy and or ischaemia
 - P4.2 peripheral sensory neuropathy using appropriate tools
 - P4.3 peripheral vascular disease by observing uniformity of temperature to touch, colour and by palpating pedal pulses or, if absent, by listening with Doppler
 - P4.4 biomechanical functioning
- P5 gather information on subjective symptoms and on general risk factors through discussion with the individual
- P6 review and record the individual's medical history and any medication they are taking
- P7 examine the individual's footwear and any orthoses and assess its suitability for foot type and risk status
- P8 request, or make a referral with a recommendation for a request, for an X-ray or MRI scan where this is required to confirm suspicion of abnormality or to rule out or confirm bone infection
- P9 measure and record the length, width and depth of any ulceration, probing to bone where indicated, note the cause and duration of the wound and categorise and record the type of wound identified, any discharge or infection, and the viability of adjacent tissue
- P10 take a deep wound swab or tissue sample of any ulceration you suspect is infected and send the specimen for microbiological examination
- P11 take all the relevant information you have gathered into account in assessing risk status and in determining appropriate care and treatment, and make a record of the examination, treatment plan and reviews date
- P12 explain the results of the examination and treatment plan to the individual

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and carer in an appropriate manner and at a suitable level and pace
P13 discuss what may be done to address any problems, by the individual
and by the health care team, and arrange for or undertake the further
treatment required, or make a referral to a specialist service, and
communicate the outcome to the person's general practitioner and any
other referral source

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Knowledge and understanding

You need to know and understand:

- K1 national guidelines on prevention and management of foot problems for people with diabetes, and on diabetes management, education and service delivery
- K2 theories of the causes of diabetes
- K3 signs and symptoms of diabetes, including WHO criteria for diagnosis
- K4 normal and abnormal blood glucose and HbA1c values
- K5 how to monitor glucose levels, HbA1c, blood pressure
- K6 the importance and effects of patient education and self management
- K7 the psychological impact of diabetes, at diagnosis and in the long term
- K8 how to gather information from patients adults, children and young people -about their health
- K9 the psychology of teaching and learning and of behavioural change
- K10 how to work in partnership with patients adults, children and young people and carers
- K11 the social, cultural and economic background of the patient/carer group and how these impact on self-care and self-management
- K12 the impact of nutrition, and physical activity on diabetes
- K13 the effects of smoking, alcohol and illicit drugs
- K14 how to manage hypoglycaemia
- K15 the medications used to manage diabetes
- K16 foot patho mechanics, diabetic foot pathophysiology, its manifestations and outcomes
- K17 how to examine feet and assess risk status
- K18 the wound healing process and evidence-based wound care
- K19 the long term complications of diabetes and when they are likely to occur
- K20 how to monitor cardiovascular risk
- K21 how to monitor for renal disease
- K22 how to monitor for diabetic retinopathy
- K23 relevant professional guidelines, standards and codes of professional conduct
- K24 the law and good practice guidelines on consent
- K25 your role in the healthcare team and the role of others
- K26 local guidelines and protocols on diabetes healthcare
- K27 local child protection procedures
- K28 local referral pathways, the way in which referrals are made and the referral rights of each type of healthcare practitioner
- K29 local systems for recording patient information
- K30 audit and quality assurance systems
- K31 sources of practitioner and patient information on diabetes

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- K32 sources of practitioner information about podiatry and wound care
- K33 contact details of local and national support groups
- K34 how individuals can access facilities for exercise and physical activity, education and community activities

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Additional Information

External Links

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):

Dimension: HWB6 Assessment and treatment planning

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