

The role of the podiatrist in the management of high risk patients



NHS StructureThe National Health Service (NHS) offers a range of services throughout primary and community healthcare, intermediate care and hospital-based care. It also provides information services and support to individuals in relation to health promotion, disease prevention, self-care, rehabilitation and after-care, (DoH, 2009). The NHS is divided into two sections: primary and secondary care.

Primary care is the first point of contact for most people when they first have a health problem. This may involve consulting a doctor, dentist, pharmacist or optician. NHS walk-in centres and the NHS Direct telephone service also comes under primary care (DoH, 2009). Secondary care – known as acute healthcare, can be elective care or emergency care (DoH, 2009). Guidelines and PoliciesAll members of health care providing services, must work within and adhere to, guidelines set out by the National Institute for Clinical Excellence (NICE) and fulfil the requirements of the National Service Frameworks (NSFs).

NICE, an independent organisation, makes recommendations to the NHS, local authorities and other organisations in the public, private, voluntary and community sectors, on how to improve peoples health and prevent illness and disease. It provides guidance regarding new and existing medicines, treatments and procedures, and treating and caring for people with specific diseases and conditions (NICE, 2011). National Service Frameworks and strategies are policies set by the NHS, that define clear quality and standard requirements for the care specific patient groups and diseases. Strategies are developed in partnership with health professionals, patients, families, carers and other agencies to be truly inclusive, and are based on the best

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available evidence of what treatments and services work most effectively (DoH, 2010).

Clinical Governance frameworks aim to preserve high standards of care, by ensuring national and local policies, protocols guidelines and standards are adhered to. Team Working The multi-disciplinary team (MDT) approach is used in a variety of settings including education and the criminal justice system, with the general theory being, that this approach optimises the resolution of issues from all angles. The MDT concept is particularly used in difficult, multifaceted situations where goals are more likely to be achieved by employing a comprehensive team from diverse disciplines. In the authors personal experience, it proves beneficial for MDT members to make individual assessments, and frequently discuss findings with one another, to maximise the effectiveness of joint skills, in providing a comprehensive service. In various literature the terms multi-disciplinary and inter-disciplinary are used interchangeably to describe the involvement of more than one professional discipline. Squires and Hastings, 2002, differentiate the two: Multi-disciplinary approach - a number of disciplines are involved. Inter-disciplinary approach - those disciplines provide an integrated service. Recently, the term integrated care has also been used, (Diabetes UK, 2010). Various authors have reported on the importance of team work within the health professions. Squires and Hastings (2002), considered the key function of an MDT, within a healthcare setting, was to provide continuous, accessible and consistent care focused on the needs of individuals. This was supported by Jefferies and Chan (2004), who, when discussing MDT working, stated that it had been endorsed as the main mechanism to ensure a truly holistic

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approach and a seamless service for patients throughout the course of their treatment, and across the boundaries of primary, secondary, and tertiary care. For the patient a holistic approach means focusing on a variety of life domains. The team approach should promote coordination and communication and offer the patient one entire package, as opposed to many separate evaluations, interpretations and plans, (Squires and Hastings, 2002). As well as the benefits to service users, multi-disciplinary working is also described in Hepinstall (1993), as enhancing professional practice by enabling members of the team to broaden their knowledge and develop broader perspectives.

The podiatrist The podiatrists role is to improve/maintain the mobility, independence and the quality of life for patients by providing education, preventative care, diagnosis and treatment for a variety of problems affecting the feet, ankles and lower limbs. Podiatrists work within an MDT, with great importance being placed on identification, assessment and evaluation of patients “ at risk” of complications. Risk assessment identifies patients that require immediate treatment, and predicts those which may be “ at risk”. The term ??? at risk??™ usually refer those patients at risk of developing ulceration, infection and loss of tissue viability (Yates, 2009).

Lorimer et al claimed that “ any patient attending for podiatry treatment is at risk of developing complications”. Because podiatric procedures involve working with instruments on skin and nails, which may potentially compromise the protective properties of the epidermis. Rigorous infection control practices are fundamental to minimise the possibility of complications, but however stringent aseptic techniques may be, numerous <https://assignbuster.com/the-role-of-the-podiatrist-in-the-management-of-high-risk-patients/>

pathological conditions exist that can impact on normal healing processes, or impair the patients immunity. Yates (2009) described normal homeostasis of the lower limb being “ dependant on structurally sound and physiologically normal functioning of hormonal, circulatory, neurological, musculoskeletal and dermatological systems”. A disruption in any of these systems may affect tissue viability, and even minor injuries to epithelial tissue may result in adverse events within the lower limb.

Systemic and localised pathologies placing patients in “ high risk”

categories: (LORIMER et al., 2006)1. Vascular Disease/Circulatory

DisordersArterial - macro/micro vascular problems > ischaemia > limb

viability threatenedVenous - venous and lymphatic disease2. Neurological

DiseasePeripheral and central nervous system disease > motor, sensory and

autonomic signs/symptoms3. Compromised ImmunityAIDS, complement

cascade, neutrophil or macrophage disorders.

Secondary to medication - corticosteroids or antimetabolites. 4.

ArthropathiesE. g. Rheumatoid arthritis > deformity > pressure points >

tissue viability. 5. Metabolic and Endocrine DisordersE. g.

Thyroid or adrenal glands, diabetes mellitus. 6. OedemaAssociated with

many pathologies (venous inefficiencies, congestive cardiac failure, renal

disease). Excess fluid compresses vessels and increases the diffusion

distance between vessels and tissues. 7.

Haematological DisordersAnaemia > reduced oxygen deliveryLeukocyte

dysfunction > immunity compromised8. Nutritional DeficitsMalabsorption or

reduced intake of essential nutrients - vitamins, minerals, proteins. 9.

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Psychosocial problems Depression, dementia and other states which may impair self care. The main aims, when managing a high risk patient, are to prevent the development of complications and manage any already established wounds and/or infection.

Advising and educating the patient regarding their condition and prevention of complications is also a vital aspect of delivering a comprehensive treatment and management plan (Lorimer et al., 2006). Considering the numerous and varied pathologies encompassed within these high risk categories it is quite clear that numerous staff, from a multitude of health disciplines and agencies, need to work together to provide comprehensive care plans and achieve goals, as no individual can possess all the relevant competencies and expertise to solely manage a patient effectively (Foster, 2006).

Professionals from statutory, voluntary & private sectors could all be involved in a care plan and regular reviews of progress. The collaboration and coordination of various professionals is a central factor in achieving results (Squires and Hastings, 2002 and British Diabetic Association. 2007).

Diabetes Mellitus One particular patient group frequently cited in literature with regards to being high risk are those with diabetes mellitus (Diabetes UK, NHS evidence, NICE). Key statistics on Diabetes As well as being a serious debilitating condition in its own right, diabetes is a risk factor for developing other illnesses including coronary heart disease, stroke, renal disease, blindness and non-traumatic limb amputation as a result of foot and lower limb problems, (Chambers, Stead and Wakely, 2001). Because diabetes is a

multi-system disease, multi-disciplinary involvement, with access to a wide range of competent skills, is critical in this patient groups treatment, care and management (British Diabetic Association, 2007). The longer the duration of diabetes, increases the likelihood of the development of complications. Coexisting factors such as hypertension, hypercholesterolemia and smoking interact with diabetes to exacerbate complications, (Chambers, Stead and Wakely, 2001). Neuropathy is one of the commonest long-term complications of diabetes, with the distal peripheral nerves most commonly affected, causing progressive sensory loss to the feet and legs. Loss of sensation in feet may result in unidentified trauma, which increases the risk of developing neuropathic ulcers, gangrene and amputation (Menz, 2008).

Motor and autonomic neuropathy also contributes to the risk of ulcer development in the diabetic foot, as shown in figure 3. Managing the diabetic patient Boutlon et al. (2006), outlined the progress of diabetes care over the years: Traditionally in the UK, people with diabetes received care overseen by hospital doctors. In the 1970s some "shared care" systems were developed between hospitals and GPs.

By the 1980s some GPs established diabetes clinics within their practices, with evidence suggesting that these provided equivalent standards of care to that provided in hospital clinics. In 1990, with the introduction of incentive payments for providing "chronic disease management programmes", more GPs introduced diabetes clinics into their practices. A review of secondary care for diabetic patients, carried out by the Audit Commission in 2000, concluded that hospital diabetes services were overstretched, and suggested <https://assignbuster.com/the-role-of-the-podiatrist-in-the-management-of-high-risk-patients/>

that primary care could provide more routine care for patients, allowing them to receive continuity of care closer to home, leaving hospitals to concentrate on specialist care.

Since then, the shift from secondary to primary care of routine diabetes care has been encouraged by numerous government incentives and policies, including Diabetes National Service Framework and the General Practitioner Contract Quality and Outcomes Framework, underpinned by NICE guidelines (Boutlon et al. (2006). For many diabetic patients, the primary care team may well be able to provide all the necessary help and advice they need. Foster (2006) describes the podiatrist as being central in the diabetic care team, providing regular treatments, which enables a good rapport to develop between patient and practitioner. The podiatrists skills in examining and classifying the status of the diabetic patients feet and lower limbs, are used to determine appropriate and effective treatment plans. A consciousness of when there is a need to refer on and involve other healthcare professionals is crucial, and so establishing good working and supportive relationships with other members of the healthcare team is imperative.

To enable appropriate interventions and management of the diabetic patient, several, or all of the disciplines, shown in Figure 4, may be involved, although this is not an exhaustive list. Each healthcare professional has their own speciality and range of clinical expertise, which are all valuable within the multi-disciplinary management of this patient group, but there will also be areas of practice where shared skills allow for collaboration when working towards the overall goals of treatment. Multi-disciplinary working is endorsed by NICE and Diabetes UK, so all services are co-ordinated and promptly <https://assignbuster.com/the-role-of-the-podiatrist-in-the-management-of-high-risk-patients/>

accessible by patients with foot problems (National Diabetes Support Team, 2006). In the Department of Health document NHS Modernisation Agency (2002), it asserts that “ diabetes care has had a head start with new ways of working in many respects, having a long history of extended roles and inter-professional team working”. In 2008, following concerns expressed by both diabetic patients and healthcare professionals regarding the lack of integration between primary and secondary care, the Integrated Care Task and Finish Group was established, (Diabetes UK. 2010). It looked at how the provision of integrated diabetes care services could be successfully applied, and realised that once the diabetic patient becomes central, integration became fundamental with the increased number of services being provided.

There is even the possibility that there may be involvement from psychologists, cognitive behaviour therapists, health trainers, smoking cessation councillors, weight management groups or social workers. Primary Care - whos involved The Patient: To ensure that services meet the needs of the diabetic patient, it is fundamental to involve them in the planning or redevelopment of local services, (Diabetes UK. 2010).

General Practitioners: Oversee the monitoring of diabetes. Patients that need treatment adjustments or have been recently diagnosed, are usually be seen at their local diabetes clinic, within the general practice. Children and younger type 1 diabetics tend to be managed by hospital-based teams in diabetes centres, (Netdoctor, 2011). Practice nurse: Involved in routine checking of the health status of the diabetic patient and in health promotion.

Some have undertaken additional training in diabetes care, (Netdoctor, 2011). District nurse: Similar role to the practice nurse, but works in the community visiting people in their own homes. May be involved in assisting with insulin injections or blood glucose checks if people are unable to manage themselves, (Netdoctor, 2011).

Podiatrist: Carries out foot checks annually, or more often if deemed necessary. Provides routine regular foot/nail care and foot health education, to maintain mobility, protect tissue viability and reduce the risk of manifestation of complications by routinely assessing vascular status and efficiency, (Netdoctor, 2011). The podiatrist may be the first to discover a severely dysvascular foot, and highlight this to ensure immediate and appropriate care, (Foster, 2006). Dietician: Advises on diet and nutrition to help control diabetes and reduce chances of long-term complications, (Netdoctor, 2011). Pharmacist: Provides advice on medicines and may be involved in decision making regarding the best treatment plan for diabetic patient, if they also have other conditions being treated with medication. (Pharmacist input varies and they are not always considered part of the primary care team) , (Netdoctor, 2011). Optometrist: Checks annually for the signs of retinopathy. Falls Team: Physiotherapists and occupational therapists are among this team that provides specialist rehabilitation services, regarding falls prevention, management and exercises (DoH, 2008).

Diabetes UK Integrated Care Task and Finish Group (2010) emphasises the need for effective care planning and ease of access for primary care

professionals to specialist advice. Secondary Care - whos

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involved
Diabetologist: Oversees the clinical aspects of the diabetes service. Attends to newly diagnosed patients and advises on any required changes to treatment (NICE, 2004). Vascular Surgeon: Involved where peripheral vascular disease and ischaemia are present.

Intervention to unblock or bypass inefficient vessels may be necessary to maintain adequate perfusion of the lower limb, to facilitate wound healing and prevent limb loss, (Foster, 2006). Nephrologist: Often involved in the care of the diabetic patient, because long-standing diabetes causes problems with the small vessels of the kidneys. Poor glucose control and hypertension increases the risk of kidney disease worsening, and very poor kidney function may require dialysis or a kidney transplant, (Diabetes UK, 2011).

Diabetes specialist nurse: Provide a bridge between hospital care and the community, working closely with primary care teams, (Netdoctor, 2011).

Ophthalmologist: A hospital specialist in eye disease, involved if treatment is required for diabetic eye disease, (Netdoctor, 2011). Orthopaedic Surgeon:

Where neuropathy and ischaemia lead to ulceration, the foot may become badly infected, often with poly-microbial invasion. If infection is not managed appropriately bones or joints may become involved, with the only solution being amputation of the affected part, (NICE, 2004) .

Podiatrist: Routine monitoring and foot care of high risk patients. Involvement in exudate management, wound and ulcer care, sharp debridement and ongoing re-dressings. Provide appropriate offloading- total contact cast or pneumatic walker, when necessary and give patient advice to empower self manage

their diabetes. Orthotist: Assesses the need for, provides and fits

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bespoke/therapeutic footwear and orthotics, so susceptible areas, lesions and deformities (Charcot), can be off-loaded or accommodated.

Prosthetist: Involved post amputation, they design and fit model limbs, with the aim of enabling patients to lead as normal a life as possible.

Physiotherapist: Assess mobility and safety, providing walking aids/equipment, to allow people to maintain mobility and independence, following amputation. Occupational Therapist: Joint disease and deformity associated with diabetic complications may lead to difficulties in performing everyday tasks, which could cause anxiety and distress. Occupational Therapists create home rehabilitation programmes, where advice on useful equipment and home adaptations can facilitate patient function and independence. Microbiologist: Identify specific types of bacteria, by analysing swabs taken from wounds suspected of being infected, enabling specifically targeting medication to be prescribed. Radiographer: Produce X-rays, MRI or CT scans that are used to assist in diagnosis and identify calcified vessels, bone fractures/ deformities and osteomyelitis. An interventional radiologist works in conjunction the vascular surgeon to assess suitability of patients for revascularisation of the ischaemic foot (Boulton et al.

, 2006). Summary of the Multi-disciplinary Approach Numerous articles relating to multi-disciplinary care of the diabetic patient refer to Edmonds et al. (1996), who strongly endorsed its effectiveness by demonstrating the benefits of a team approach in the prevention of amputation for patients suffering from chronic, non-healing diabetic foot ulcers, noting that

podiatrists, orthotists,, nurses, physicians and surgeons all had a role within <https://assignbuster.com/the-role-of-the-podiatrist-in-the-management-of-high-risk-patients/>

the MDT. Caroline McIntosh, Head of Podiatry at the National University of Ireland, declares that “ multi-disciplinary team working is essential in order to achieve optimum management of the diabetic foot”, and that “ a team approach is imperative to achieve metabolic, vascular and mechanical control”, (Wounds UK, 2008). Because the patient is central within the MDT approach to treatment, care and management, the needs and preferences of individual patients, their families and carers must be considered when initiating treatment plans and outcome measures, (DoH, NSF for Diabetes, 2002). Unfortunately teams do not always work as efficiently and effectively as planned. Patients may be seen by many different health and social professionals over a number of years, but unless services are truly integrated and well co-ordinated, problems may arise that could compromise the quality of care being delivered, (DoH, NSF for Diabetes, 2002).

This is highlighted in a quote by a patient published in the Department of Health document Workforce Matters (2002): “ I sometimes find the advice given at the hospital clinic differs from that given by the diabetes nurse attached to the hospital. This again sometimes differs from the advice given by my doctors practice diabetes nurse. It is clear that different people do things in different ways but when advice is not consistent this can be problematic.

“ Since diabetic patients are prone to complications such as peripheral vascular disease, kidney disease, coronary heart disease and retinopathy, which may need hospital attendance, there is a chance that duplications of effort occur between primary and secondary care. Even minor variations in advice given, may cause difficulty to the patient, (Diabetes UK. 2010). It is <https://assignbuster.com/the-role-of-the-podiatrist-in-the-management-of-high-risk-patients/>

imperative that efficient communication between primary and secondary exists, and that all care providers are considered. The effectiveness of each team needs to be continually evaluated to ensure that all the relevant disciplines are able to participate in the clinical management of patients, (Jefferies and Chan, 2004). Diabetes UK Integrated Care Task and Finish Group (2010) endorses ongoing education, development and training for all professionals involved in caring for people with diabetes. The author is of the opinion that a proficiently functioning team is one which has; ??? Clear definitions of specific and shared responsibilities??? Good interpersonal skills.

Team members should be supportive and empathetic towards both service users and co-workers.??? Common goals - discusses and agrees care pathways and therapeutic interventions.??? A commitment to the principles of self care, endorsing long-term service user self-management, through education and empowerment.??? Processes that monitor the adherence to published guidelines.??? Suitable resources to avoid complications and provide timely intervention. Being part of a multi-disciplinary, integrated system can give the professionals involved a satisfaction of being an important team member, while working within their own capabilities, (Diabetes UK. 2010).

This author concludes with the opinion that the key to MDT working, in providing seamless and continuous care to the high risk patient group, fundamentally hinges on effective communication and consistency throughout, to prevent conflict of advice and treatment, and accomplish shared goals, while focussing on the patients best interests.

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