Guidance on what to investigate across each service

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| GP LEVEL INVESTIGATION  **To understand if diabetic foot checks were undertaken at practice level and if any information offered to the patient on risk status of the foot and appropriate education.** |  | Was the patient told of their risk classification?  Is there a standard operating procedure for diabetic foot examination at annual diabetic review?  Are all members of staff undertaking the diabetes annual foot check trained to examine and record risk status?  Is each patient advised about foot care at each annual review?  Does the practice have written foot care information for patients at diabetic annual review?  Is every patient at increased or high risk of diabetic foot ulceration referred to community podiatry for regular review?  Is everyone at the practice (including nurses involved with wound care) conversant with pathways for referral of increased, or high risk and ulcer patients to podiatry and secondary care?  Are signs of deteriorating foot ulcers recognised and onward referrals made promptly? |

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| PODIATRY LEVEL INVESTIGATION  **To investigate if a patient was referred to, or under the care of, a foot protection team. Also, to map if communication and appropriate onward referral was timely, appropriate and followed NICE guidance.** |  | Are communications from community podiatry and secondary care for diabetic foot patients adequate i.e. detailed care plan, identification or risk?  What was the referral to treatment times within podiatry - 24 to 48 hours for a wound or longer?  In this specific case: what was the foot risk score at the last routine foot check prior to this episode?  Was preventative nail cutting and debridement of callus for those with diabetic risk provided before the ulceration occurred? Were risk factors assessed, documented and acted on when they were identified?  Was this individual known to podiatry prior to this episode? If so, were they under regular podiatry review?  When this individual first presented with a foot wound how long until presentation to foot team?  On classification of an increased risk foot, did referral occur?  Did the patient get referred quickly when they were determined to be at risk of diabetic foot ulceration?  When a patient presents with corns/ callus, was appropriate treatment offered and was the advice/care appropriate in terms of frequency?  Were prevention strategies employed to prevent ulceration?  Was there the provision of insole/ orthotic provision and return times?  Was vascular and neurological status checked at visit, and was the patient educated about risk factors such as smoking etc?  Did the patient receive education on risk of developing foot ulcers?  Had podiatry undertaken vascular assessments and neurological assessments according to NICE guidance?  Was the patient seen with a frequency appropriate to need?  Had the patient been offered diabetic foot education or advice?  Were signs of deteriorating foot ulcers recognised and onward referrals made promptly? |

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| HOSPITAL LEVEL  INVESTIGATION  **To investigate if, once a patient developed foot ulceration or foot problem, the patient received appropriate and timely interventions to address vascular factors, infection, offloading appropriate debridement, dressings and care. Also, to identify if this complied with NICE compliant services and recommended NICE guidance?** |  | If the patient was not under the care of the foot protection team and they ulcerated or developed a wound, was the patient then referred promptly within 24 hours to a member of the foot protection team?  Is there a summary sheet with care plan in the hospital/podiatry notes which has been shared with the patient and all professionals involved?  If the patient was referred, were they then seen promptly by a member of the multidisciplinary foot protection team?  Was this referral reviewed and the patient seen within a timely manner i.e. 24 to 48 hours?  On referral with a wound: was blood supply assessed, were ischemic factors explored further with imaging, duplex, angiogram, angioplasty etc., was there timely and appropriate vascular intervention?  Were debridement strategies used to reduce bacterial burden of wounds?  Were signs of deteriorating foot ulcers recognised and onward referrals made promptly?  After vascular intervention, were discharge pathways appropriate?  Did the patient receive onward referral to foot protection team for continued monitoring for deterioration of the foot /limb?  Was offloading provided for the patient when ulceration occurred to facilitate wound healing?  Did the patient get referrals for orthotics intervention/footwear to prevent ulceration or foot health deterioration?  Was this pathway for offloading intervention smooth and timely?  Did the patient receive education on risk to foot health, how to prevent foot problems and how to access help if needed?  Were risk factors such as blood supply to foot and neurological status documented?  On development of ulceration, did a prompt referral to a member of the foot protection team occur?  What was the measurements of time to referral?  Was infection recognised and did the patient receive appropriate antibiotics? Time to receipt of antibiotics.  Were X-rays undertaken to look for bone infection osteomyelitis and charcot-arthropathy in chronic wounds or wounds that probed to bone or delayed healing occurred?  If the patient had neuropathy, was this recorded and risk of Charcot foot addressed to prevent injury and foot deformity?  Did the patient have vascular investigations, and were foot pulses checked? Time to vascular referral for duplex, angiogram and time to vascular for interventions?  Was post-surgical management of the wounds by a member of the foot protection team?  Was post-surgical management timely and appropriately delivered by staff with relevant knowledge and skills in the treatment of diabetic foot?  Was the patient seen by a member of the foot protection team with appropriate skills for the care of the reaming limb post amputation?  Was the amputation avoidable/ unavoidable? |