

Title: **CLINICAL GUIDELINES (FOR PODIATRISTS)  
FOR THE MANAGEMENT OF PERIPHERAL  
ARTERIAL DISEASE (PAD)**

Ref No: 1850 Version 3

Directorate: Allied Health Professionals

Classification: Guideline

Responsible for review: Podiatry Team Leader

Due for Review: 26-05-2020

[Document Control](#)

Ratified by: Professional Practice Associate Director for WCDT  
Clinical Director of Pharmacy

Applicability: Podiatrists

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## Peripheral Arterial Disease (PAD) Guidance for Podiatrists

### 1. Introduction

Peripheral Arterial Disease (PAD) is a common and significant presentation in many patients under the care of the Podiatry Service of Torbay and South Devon NHS Foundation Trust (TSDFT). About 20% of people aged over 60 years have some degree of PAD ([National Clinical Guideline Centre, 2012](#)). The prevalence is greater in people with cardiovascular disease and risk factors such as diabetes mellitus, smoking, and dyslipidaemia than in the general population ([Gresele et al, 2011](#)).

PAD is a range of arterial syndromes characterised by atherosclerotic obstruction of the lower extremity arteries (BMJ 2011), and is a marker of patients who are at increased risk of cardiovascular events, even when it is asymptomatic (NICE CG 147).

**Acute limb ischaemia** has an incidence of around 1 in 12,000 people per year ([Powell and Davies, 2010](#))

- **Chronic limb ischaemia** is much more common than acute ischaemia (Powell and Davies, 2010).
- **Critical limb ischaemia** occurs in around 1% of all people with peripheral arterial disease [[Gresele et al, 2011](#)], with an estimated annual incidence of between 50 and 1000 new cases per 1 million population [[European Stroke Organisation et al, 2011](#)].

### 2 Purpose

To support the clinical practice of Podiatrists within TSDFT with regard to the assessment and management of patients presenting with PAD.

The information and standards in this document will support and promote the following principles:

- Evidence based clinical practice
- High quality patient care
- Continuity of assessment techniques
- Continuity of decision making and patient management across the service
- Supporting individual clinical decisions/discretion

### 3 Definitions

Podiatrist	A registered health profession who diagnoses and treats disorders, diseases and deformities of the feet (HCPC 2012)
Podiatry Assistant	Non-registered staff who undertake a variety of delegated podiatric clinical activities within a defined framework
PAD	Peripheral Arterial Disease is the term used to describe a narrowing or occlusion of the peripheral arteries, affecting the blood supply to the lower limbs
ABPI	Ankle Brachial Pressure Index
HCPC	Health and Care Professions Council
GP	General Practitioner

## 4 Responsibilities

- 4.1 The Head of Podiatry Services will be responsible for the implementation and monitoring of this guideline. It will be presented at A staff meeting and an audit of compliance will be carried out.
- 4.2 This guideline applies to all Podiatrists and Podiatry Clinical support workers employed by the Podiatry Service of Torbay and South Devon NHS Foundation Trust.
- 4.3 Podiatry students of the University of Plymouth’s Podiatry Programme working under honorary contracts within the Trust are also governed by this and allied documents. This will be included in Induction packs
- 4.4 Qualified staff (HCPC Registered Podiatrists) will retain responsibility and accountability for the actions of clinical support workers and students in their supervision.
- 4.5 The terms “staff” and “podiatrist(s)” are used in this document to encompass all those individuals detailed in paragraphs 4.2 and 4.3. All such persons are responsible for engaging with, and implementing, the content of this document in their clinical practice.

## 5. Assessment and Diagnosis

Diagnosis of PAD is based mainly on patient history, with examination and ABPI being used to confirm the disease. PAD is sub-classified as either occlusive or aneurismal.

In occlusive disease, the lumen is narrowed either in a chronic or acute manner. In aneurismal diseases, weakening of the arterial media results in focal dilation of a blood vessel.

See appendix A for summary flow chart of arterial assessment and management. See appendix B for differential diagnosis

- 5.1 A holistic assessment of all patients presenting to the Service must include:

**Table 1 Standards of assessment for podiatry patients**

Standard	Rationale
Establish and document the patient’s main reason for referral to the Service	Establishment of the patient’s presenting complaint is vital. Failure to focus upon this can lead to non-compliance and dissatisfaction from the patient (Kroenke 1998)
Establish and record current symptoms (if present)	To determine the nature of the presenting problem, and to identify and ‘red flag symptoms’ that may indicate a serious underlying pathology
Record a complete medical and surgical history, including current medication	To establish any potential risks, and to determine the effect of this history on lower limb health, function and performance
Record and assess key personal information, including social status, activity types and levels, smoking status, diet and nutrition	To determine if any of these factors have a role in the presenting problem, or present as barriers to improving foot health/function or future attendance with the Service

5.1.1 Patients must be assessed for the presence of peripheral arterial disease if they have symptoms or risk factors (Lyden *et al* 2006; NICE CG147).

5.1.1.1 Symptoms of PAD See Table 2

**Table 2**

<b>Symptoms</b> suggestive of PAD
Intermittent Claudication
Rest Pain
Ischaemic Pain
Lower limb ulceration
Non-healing wounds/ tissue loss/gangrene

**5.1.1.2 Risk factors for PAD.**

The majority of patients with lower limb PAD are asymptomatic, and may not present with ‘classic symptoms’ of intermittent claudication (Lyden *et al* 2006). See **Appendix G** for Iceburg of PAD. This indicates that the majority of people with PAD have no symptoms. Therefore, it is vital that risk factors for peripheral arterial disease are considered (Bartholomew *et al* 2006) and appropriate referrals made so that risk factor modification and long term follow up can be properly monitored (Sign 2006). See Table 3

**Table 3 Risk factors for PAD**

<p><b>Risk factors</b> for PAD</p> <p><b>Smoking.</b> For people aged over 50 years of age, the principal risk factor for PAD is smoking. Less than 5% of people presenting with PAD have never smoked. Smoking appears to be a stronger risk factor for peripheral arterial disease than for coronary artery disease, and evidence for lower limb arterial disease suggests that the risk from smoking is dose dependent. Stopping smoking is associated with a rapid decrease in the incidence of claudication. After one year of stopping, the incidence is equivalent to that in non-smokers. (Clinical Knowledge Summaries September 2015). Patients with PAD should be actively discouraged from smoking (Sign 2006).</p>
<p><b>Diabetes Mellitus</b> (a five-fold increase in risk of developing critical limb ischaemia compared with people without diabetes) Clinical Knowledge Summaries, September 2015. People with both PAD and diabetes are at increased risk of cardiovascular events. Optimal glycaemic control is recommended for patients with PAD and diabetes in order to reduce the incidence of cardiovascular events (Sign 2006).</p>
<p><b>Hypertension.</b> Elevated blood pressure is a well-established risk factor for mortality, cardiovascular and cerebrovascular events. Hypertensive patients with PAD are at considerably increased risk of reno-vascular disease (Sign 2006).</p> <p>Hypertensive patients with PAD should be treated to lower their blood pressure (Sign 2006).</p>
<p><b>Hyperlipidaemia.</b> Lipid lowering therapy with a statin is recommended for patients with PAD and total cholesterol &gt;3.5mmol/l (Sign 2006).</p>
<p><b>Chronic kidney disease (CKD).</b> PAD is highly prevalent among persons with CKD. The presence of PAD in CKD patients markedly increases the short term risk of heart attack and stroke, and serves as the key cause of limb loss and mortality, with such rates being much greater than that of the general population. The risk of PAD increases as estimated Glomerular Filtration Rate (eGFR) values decreases. Patients who require dialysis have an increased risk of PAD. The chronic uremic state is associated with systemic inflammation in dialysis patients leads to hypoalbuminemia and an increased risk of PAD.</p>

The National Kidney Foundation Kidney Disease Outcomes Quality Initiative (KDOQI) guidelines 2012 recommend that all patients should be evaluated for PAD at the time of dialysis. KDOQI highlighted the need to provide medical interventions more promptly (including lifestyle, medication or revascularization strategies) during earlier stages of kidney disease. The KDIGO guidelines recommended that adults with non-dialysis chronic kidney disease (CKD) be regularly examined for signs of PAD. (Garimella 2014).

**Elevated inflammatory markers.**

Raised Inflammatory markers which include C- reactive protein (CRP) , monocytes, fibrinogen and homocysteine have been shown to be independent predictors of myocardial infarction and stroke in asymptomatic individuals, and also predictive of onset of symptomatic PAD. Several interventions have been shown to reduce CRP levels including diet, moderate alcohol consumption statins, fibrates and fish oil (Khawaja, 2009).

If when checking cyberlab you notice abnormal blood results highlight to the General Practitioner(GP).

**Thrombophilia** Thrombophilias can be defined as a group of inherited or acquired disorders that increase a person's risk of developing thrombosis (abnormal "blood clotting") in the veins or arteries. A quarter of patients with peripheral vascular disease have evidence of thrombophilia (Vig et al, 2006).

**Older age** 20% of the UK population aged 55-75 have PAD, of whom 5% have symptoms. Men over age 60 are at greater risk for PAD. Women after menopause exhibit the same risks as men over age 60 (National Institute for Health and Care Excellence NICE 2011).

**History of coronary artery disease/myocardial infarction/ischaemic heart disease**

Of the patients with known PAD, approximately 30% to 50% have evidence of coronary artery disease.

When a diagnosis of PAD is made, the patient should have a full cardiovascular risk assessment. ([Dhaliwal](#),G and [Mukherjee](#) D,2007).

Inform GP of your findings to ensure correct management.

**Iron deficiency anaemia**

Iron deficiency anaemia is prevalent among patients with Critical limb ischaemia. Anaemia and its severity are independent predictors of mortality and limb loss in patients with PAD. ([Desormais](#) | et al 2014).

The World Health Organization (WHO) 2001 defines anaemia as :

- § In men over 15 years of age: Hb below 13 g/100 mL.
- § In non-pregnant women over 15 years of age: Hb below 12 g/100 mL.

Inform GP if you note anaemia in conjunction with PAD.

**Overweight or obese.**

Obesity is adversely associated with a number of cardiovascular risk factors and increased risk of mortality

Those patients with Body Mass Index (BMI) over 30 should be treated to reduce their weight (Scottish Intercollegiate Guidelines Network (SIGN)2006).

Discuss with patient and if consent is given, refer to lifestyles team and copy GP into the referral.

**Family history of vascular disease**

Individuals with a family history of PAD have nearly double the odds of having PAD relative to those without such a history ([Khaleghi M et al, 2014](#)).

Document the presence of family history and include this in your letter to GP.

**COPD/asthma**

There is a high prevalence of asymptomatic PAD in the Chronic Obstructive Pulmonary Disease (COPD)/asthma patients. The diagnosis of peripheral arterial disease in COPD is important because it limits the patient's physical activity and impairs their quality of life. In addition it indicates a high cardiovascular risk that requires therapeutic measures. (Sign 2006).

Check vascular status of podiatry patients with poorly controlled asthma and COPD and inform GP of results. Encourage smoking cessation. Refer to Lifestyles team if patient consents and inform GP.

5.1.3 Patients must be assessed for the presence of PAD if they are being considered for interventions to the leg/foot, e.g. minor surgery (NICE CG 147).

5.1.4 Patients must be assessed for the presence of PAD if they have unexplained leg pain (NICE CG 147). Information regarding differential diagnoses of lower limb peripheral disease can be found in **Appendix B**.

**5.2 The vascular status of the patient must be assessed.** See Table 4 vascular assessment.

**Table 4**

<b>Vascular assessment</b>	
<b>Palpation of pedal pulses</b>	Palpate dorsalis pedis and posterior tibial pulses. Where possible, the popliteal and anterior tibial pulse may also be palpated. If you can palpate a foot pulse, you will have at least 80mmHg.
<b>Colour and temperature</b>	Assess and document the colour and temperature differentials and gradients of both legs, feet and toes.
<b>Doppler Ultrasound</b>	Use Doppler Ultrasound using an 8 MHz probe. If the patient has significant ankle oedema, a 5MHz probe can be used if available.  As a minimum, staff must record the audible characteristics produced by the Dorsalis Pedis and Posterior Tibial arteries.  Where possible, staff may also record the audible characteristics produced by the digital, anterior tibial and popliteal and peroneal arteries. When possible use headphones.
<b>Sub capillary refill time</b>	Record sub capillary refill time at the apex of the hallux of both feet (where absent, the next available digit should be used).
<b>Ankle brachial pressure index (ABPI)</b>	Objective evidence to substantiate the presence or absence of significant PAD may be acquired reliably (except in those with heavily calcified vessels).

<p>See Table 5 for ABPI Indications, contraindications, and when an ABPI does not need to be done.</p> <p>See Table 6 Interpretation of ABPI results</p>	<p>The ABPI is also predictive of atherosclerosis and cardiovascular disease at low values (less than 0.9), and can indicate an increased risk of cardiovascular morbidity and mortality. (Clinical Knowledge Summaries September 2015).</p> <ul style="list-style-type: none"> <li>• See <b>Appendix L</b> for Podiatry ABPI referral form ensuring a follow up with podiatrist within 2 weeks to review results</li> <li>• Issue and explain ABPI leaflet <b>Appendix O</b>.</li> <li>• Issue and explain PAD leaflet <b>Appendix N</b>.</li> </ul> <p>Follow standard operating procedures:</p> <ul style="list-style-type: none"> <li>• <b>Appendix C</b> SOP for manual ABPI.</li> <li>• <b>Appendix M</b> SOP for Huntleigh ABPI calculator.</li> </ul>
<p><b>Toe Brachial Pressure Index (TBPI)</b></p> <p>See Table 8 to interpret results</p>	<p>There is much less calcification of the toe arteries. Carry out TBPI and document results if :</p> <ul style="list-style-type: none"> <li>• Incompressible arteries</li> <li>• Abnormally high ABPI (ABPI of 1.3 or over)</li> <li>• Too painful at ankle to carry out ABPI</li> </ul> <p>Follow standard operating procedure <b>Appendix N</b> SOP for Toe brachial pressure index(TBPI).</p>
<p><b>Buerger's test</b></p>	<p>The Buerger's test is a useful adjunct to routine peripheral vascular assessment and, if positive, suggests more severe ischaemia with distal limb artery involvement. Follow <b>Appendix D</b> SOP for Buerger's Test.</p>

Table 5. ABPI Indications, contraindications and when an ABPI is not required.

<p>N.B Podiatrists must document rationale in the patient's clinical records for not arranging an ABPI</p>		
<p><b>An ABPI must be undertaken</b> in the following circumstances: (unless contraindicated).</p>	<p><b>ABPI is contraindicated when/if the patient:</b></p>	<p>An ABPI does <b>not</b> need to be undertaken when:</p>
<p>The patient is a non-traumatic amputee with one or more monophasic signal.</p>	<p>If ABPI too painful to perform in patients with acute cellulitis or painful ulcerations at the ankle. Toe brachial pressure index(TBPI) can be considered.</p>	<p>The patient has non-audible pulses on the Doppler. ( If non audible pulses check Doppler machine volume, positioning of the probe to account for anatomical variance and use headphones to eliminate back ground noise). Refer to vascular team if symptomatic of PAD</p>
<p>Any non-traumatic amputees receiving long term care from the Podiatry Service must have an ABPI completed annually.</p>	<p>Has Reflex Sympathetic Dystrophy Syndrome/ Complex Pain Syndrome</p>	<p>The patient has a full complement of biphasic/triphasic signals</p>
<p>The patient develops an ulcer,</p>	<p>Has cautions for measuring blood</p>	<p>The patient is currently receiving</p>

<p><b>and</b> has known PAD.</p>	<p>pressure, e.g. fistulae for dialysis, removal of lymph glands- use the other arm. Proceed with caution in patients who have had a stent or graft if it extends into the lower calf. Do not use a cuff on anyone with an arteriovenous shunt (fistula, anastomosis) for kidney dialysis or lymph node damage.</p>	<p>assessments and/or interventions from the Vascular Team- if unsure check on infoflex for record of vascular appointments and results</p>
<p>The patient has a wound on their foot that has failed to heal after 2 weeks of treatment or showing no improvement.</p>	<p>Patients with suspected or known acute deep vein thrombosis (DVT) or superficial thrombophlebitis.</p>	<p>The patient has had an Arterial Duplex Scan or angiography in the last 12 months and there have been no new ulcers, deterioration of ulcers, or worsening PAD symptoms. Staff should check Picture archiving communications system (PACS) for details, and put a copy of the report (where available) into the patient's records for future reference. Staff who are unable to access PACS (or Infoflex) must ask another member of staff who has access to the system to check for these results.</p>
<p>A differential diagnosis of PAD is being considered.</p>	<p>Recent surgery, ulcers, casts or bandages that cannot or should not be compressed by pressure cuffs.</p>	<p>If a previous duplex scan has shown that calcification is present, the ABPI should not be attempted. If no previous duplex, staff should try to compress an ankle artery in the first instance, and if it is not compressible, the procedure must be discontinued. The ABPI, if obtained for this group of patients, should be treated with significant caution and the issue clearly stated in any correspondence regarding the patient's condition. TBPI should then be undertaken.</p>
<p>The patient reports a significant deterioration in symptoms.</p>		
<p>Any new diabetic foot wound. It should be noted that ABPIs may be less reliable in patients with diabetes or patients with known calcification of their arteries.</p>		

If the patient has been discharged from the vascular team, and a significant deterioration is suspected, this should be highlighted to the patient's GP and contact the vascular clinic for advice.

ABPI less than 0.9	Presence of PAD
ABPI less than 0.8	Record as ischaemia when using SINBAD score
ABPI of less than 0.5	Critical limb ischaemia
ABPI is high (1.3 or more)	Consider the possibility of PAD, may indicate arterial calcification, particularly if the person has diabetes or renal failure. Take into account other symptoms and signs, and seek specialist advice if unsure of the diagnosis

TBPI > 0.7	Normal indicating no arterial disease
TBPI = 0.64 - 0.7	Borderline peripheral Arterial disease
TBPI < 0.64	Abnormal indicating peripheral arterial disease
TBPI < 0.6	Record as ischaemia when using SINBAD score

### 5.3 **Diagnosis of chronic Lower Limb Ischaemia**

- 5.3.1 Peripheral arterial disease may lead to intermittent claudication or critical limb ischaemia.
- 5.3.2 Intermittent claudication may cause calf, posterior thigh or buttock pain when there is narrowing of the femoral or popliteal artery (**See Appendix F** for diagram of lower limb arteries).

### 5.4 **Assessment of the severity of claudication pain.**

Intermittent claudication is the most common initial symptom of lower limb PAD (NICE, 2012).

#### 5.4.1 **Rutherford Classification**

As treadmills are not used in podiatry, assessment of severity of claudication is not within the podiatrist's remit, however a referral to vascular clinic via the GP could be requested if there is a discrepancy between history and clinical signs as it provides objective evidence of a patients maximum walking distance (Sign 2006).

- Stage 0 Asymptomatic
- Stage 1 Mild claudication
- Stage 2 Moderate claudication
- Stage 3 Severe claudication
- Stage 4 Ischaemic rest pain
- Stage 5 Ischaemic ulceration of the toes
- Stage 6 Severe ischaemic ulcers or frank gangrene

## 5.4.2 Epidemiology of Intermittent Claudication

Among patients with intermittent claudication, 16% will experience a worsening of their claudication symptoms, 7% will require lower extremity bypass surgery, and fewer than 4% will need primary amputation. (Primary amputation is where significant PAD leads straight to a major-above or below knee amputation). Approximately 1.4% of patients with intermittent claudication will progress to ischemic rest pain and/or gangrene. This rate is markedly higher among smokers and people with diabetes. See **Appendix G** Iceberg of PAD.

## 5.4.3 Features of intermittent claudication :

**5.4.3.1** Cramp-like pain after walking a predictable distance that is relieved by rest and reproduced by walking the same distance again.

**5.4.3.2** Distal pulses that may be felt at rest but disappear on exercise to the point of pain.

**5.4.3.3** Increase in symptoms with stairs/incline.

### 5.4.4 Staff must document:

**5.4.4.1** Claudication distance

**5.4.4.2** Time taken for symptoms to subside

**5.4.4.3** Effect of walking on an incline or stairs

**5.4.4.5** Which leg and muscle group(s) affected

## 5.5 Features of critical limb ischaemia: Table 7

Features of critical limb ischaemia	
<b>Rest pain</b>	<ul style="list-style-type: none"> <li>• Often described as relentless, unbearable, or burning pain in the foot.</li> <li>• This may be worse at night because the elevation of the leg in bed further limits perfusion.</li> <li>• People may report sleeping with the leg hanging out of bed, or sleeping in a chair to relieve the pain.</li> <li>• <b>Nocturnal pain</b> is pain in the foot <b>at night</b> relieved by hanging the leg out over side of bed</li> <li>• Pain is made worse by elevating the leg and of sufficient severity to cause the patient to wake.</li> <li>• Rest pain is usually preceded by a history of intermittent claudication but occasionally is not (for example intermittent claudication may not have been clinically apparent in a person with limited mobility).</li> <li>• Patients may habitually get out of bed for the toilet or to make a cup of tea at night. They may need direct questioning to ascertain that they are prompted to get out of bed by the pain.</li> <li>• If there is an underlying condition such as diabetes, over time the peripheral nerves may begin to degenerate (neuropathy) and the pain will subside. The patient may think the problem is resolving, but in fact it may be worsening. If this is noted it should be communicated to the patient's GP with a recommendation for vascular referral. Phone vascular clinic if advice is needed.</li> <li>• True rest pain - <b>constant</b> pain for &gt; 2 weeks requiring analgesia.</li> </ul>
<b>Dependent rubor</b>	<ul style="list-style-type: none"> <li>• Red or purple colour of the foot when not elevated-" sunset foot"</li> <li>• Patients with severe, chronic lower limb ischemia manifest early pallor on elevating the leg above the level of the heart and rubor with dependency.</li> <li>• See <b>Appendix D</b> for Buerger's Test</li> </ul>

<b>Absent foot pulses</b>	<ul style="list-style-type: none"> <li>May be due to anatomical variance, oedema, background noise or low volume. Check pulses by hand, check position and angle of Doppler probe, use headphones</li> </ul>
<b>ABPI results of less than 0.5 or absolute systolic pressure of 50 (with or without a foot ulcer) or less</b>	<ul style="list-style-type: none"> <li>Suggests the presence of critical limb ischemia.</li> <li>Absolute pressure is the highest systolic measurement at the ankle before it is divided with the brachial to give the ABPI.</li> <li>(If patient has ankle pressure of 70 mm Hg or less with a foot ulcer, and has diabetes refer urgently to the podiatry wound specialist team at Torbay Hospital).</li> </ul>
<b>Tissue viability changes</b>	<ul style="list-style-type: none"> <li>Ulcers or gangrene in a patient with chronic ischemia or critical ischemia will indicate a potential for imminent limb loss.</li> </ul>

**5.5.1 Patients with critical limb ischaemia require an urgent referral** for vascular assessment by the vascular team 01803 655594- secretary. Also contact vascular practitioners on 07833 402078/07867 201759. [sdhct.vascularsurgery@nhs.net](mailto:sdhct.vascularsurgery@nhs.net). Ensure the GP receives a copy of the referral. Use letter template on O Drive (shared podiatry drive)- Clinic Letters-Acute limb ischaemia (**Appendix J**).

Same day referral should be made and referrals should not be delayed.

**5.6 Acute limb ischaemia** develops quickly. There is a sudden decrease in limb perfusion, usually producing new or worsening symptoms and signs, and often threatening limb viability. It can occur in people who have had no previous symptoms [Norgren et al, 2007]. Not all people with acute limb ischaemia have risk factors [Brearley, 2013].

**5.6.1 Typical features of acute limb ischaemia (The six Ps) include:**

- Pain**- constantly present and persistent.
- Pulseless** -ankle pulses are always absent.
- Pallor**- (or cyanosis or mottling).
- Power** -loss or paralysis.
- Paraesthesia**- or reduced sensation or numbness.
- Perishing**- with cold.

N.B Not all of these are necessarily present

**5.6.2 If there is ischaemia due to an embolus:**

Usually cardiac in association with atrial fibrillation  
 Onset is acute (seconds or minutes).  
 Ischaemia is usually profound (because there is no collateral circulation).  
 Skin changes of the feet (such as marbling) may be visible. This can be a fine reticular blanching or mottling in the early stages, progressing to coarse, fixed mottling.  
 There is not usually a history of claudication, and pulses are usually present in the other leg.

**5.6.3 If there is ischaemia due to thrombosis:**

Thrombosis secondary to atherosclerosis  
 Onset is insidious (hours or days).  
 Ischaemia is less severe (due to collateral circulation).  
 There will often be a history of claudication, and pulses in the other leg may also be absent.

**5.6.4** The evolution to paresthesia and paralysis reflects the presence of severe potentially irreversible ischemia.

These patients should be sent straight to Accident and Emergency (A&E) Department immediately, phone ahead and send with covering letter (See **Appendix A** and **Appendix K** covering letter).

## 6 Referral Requirements

- 6.1 Podiatrists must inform the patient's GP, in writing, of the presence of any level of PAD to support the GP in managing the patient's risk factors to prevent further deterioration. (See **Appendix J**).
- 6.2 Patients who present with intermittent claudication do not necessarily need to be referred to secondary care for more detailed examination. A GP will, in the first instance, advise the patient about the importance of exercise, will manage cardiovascular risks (e.g. by prescribing anti-platelets or statins), and embark on vasoactive drug treatments. A referral into secondary care may be sought by the GP when the symptoms do not resolve or deteriorate further (NICE CG147 2012).
- 6.3 **Refer patients to their GP, requesting review of the patient, describing the signs and symptoms if:**
  - 6.3.1 Good foot pulses are present, however patient reports symptoms of intermittent claudication of less than 100 m.
  - 6.3.2 When the ABPI result falls in the 0.5-0.9 range, regardless of symptoms or ulcerations.
  - 6.3.3 If the patient displays any significant deterioration in ulceration.
  - 6.3.4 If the patient displays any significant increase in pain.
  - 6.3.5 When the patient reports rapid deterioration in the intermittent claudication symptoms over a short period of time e.g. 2-3 weeks of 100 m or less
  - 6.3.6 If calcification or false highs on ABPI (i.e. ABPI >1.2 or incompressible)
  - 6.3.7 If ABPI <0.5 where no symptoms, inform the GP - if no symptoms, vascular surgeons would not operate due to the substantial risks.
  - 6.3.8 Check medications are correct i.e. on an antihypertensive, a statin such as simvastatin 40mg and antiplatelet such as clopidogrel or aspirin 75mg.
  - 6.3.9 If there is a 20-30mmHg difference in the systolic pressure in the brachial arteries of each arm, or 15 mmHg for those with diagnosed hypertension. Differences of these magnitudes are potential indicators of increased risk of cardiovascular episodes, increased mortality, aortic arch and subclavian stenosis (Clark *et al* 2012).
- 6.4 If a patient does not meet the criteria for ongoing care, it must be made clear to the GP if the podiatry service will not be continuing to monitor the patient's lower limb arterial supply. The letter must contain the caveat that the GP can re-refer the patient to the service should their clinical needs or medical risk status increase, placing the patient at greater risk of significant deterioration in their foot health.
- 6.5 **Compression hosiery/bandaging.** If the ABPI results are <0.8 and the patient is wearing compression hosiery the results must be communicated with Practice and District nursing teams or the Lower Limb Therapy Service (lowerlimbtherapy.referrals@nhs.net) as a matter of urgency,

back this up with a letter, and if concerned remove compression hosiery (Vowden 2001). Any verbal communication must be followed up by a letter which should include risk factors. (5.1.1.3).

6.6 **Patient should be referred directly to the vascular clinic**, with the view for further vascular assessment and possible intervention if presenting with:

6.6.1 **Rest pain**/critical limb ischaemia (< 0.5 ABPI or <50mmHg) - with or without tissue loss. True rest pain is **constant** pain for > 2 weeks requiring analgesia (Nocturnal pain, however, is pain in the foot **at night** relieved by hanging the leg out over the side of the bed.).

6.6.2 Where there is tissue loss and absent pulses.

6.7 **Refer to vascular department using generic email [sdhct.vascularsurgery@nhs.net](mailto:sdhct.vascularsurgery@nhs.net).**

6.7.1 Put “for attention of vascular practitioners” in the subject box.

6.7.2 Referrals must include name, address, date of birth, NHS number, medical history, medications, vascular assessment details, main vascular complaints. See **Appendix K**

6.7.3 Send copy to the patient’s GP.

**6.8 Diabetic foot ulcers with PAD**

6.8.1 If SINBAD score of 3 or above. Refer to level 2 Podiatry at Torbay Hospital immediately.(SINBAD is an acronym wound scoring tool which stands for Site, Ischaemia, Neuropathy, Bacterial infection, Area, Depth).

6.8.2 If SINBAD score of 2 and no improvement within 2-4 weeks refer to Torbay Hospital Podiatry level 2 via podiatry appointments, copying the diabetes podiatry specialists with the referral details.

**6.9 Wound Ischaemia Foot Infection Classification (WIFI) (Mills et al, 2014)**

The new classification system takes into account foot wound depth and infection as well as limb perfusion and is titled WIfI (wound, ischemia, and foot infection)and is a means of assessing outcomes and efficacy of interventions. Use the WIFI to assist in SINBAD scoring. Follow local guidelines for vascular referrals- see appendix A

**Wound – Clinical Category**

<b>Ischemic rest pain</b> ; Pre-gangrenous skin change, without frank ulcer or gangrene.
<b>Minor tissue loss</b> : small shallow ulceration) < 5 cm <sup>2</sup> on foot or distal leg (Pedis or UT Class 1); no exposed bone unless limited to distal phalanx.
<b>Major tissue loss</b> : deeper ulceration(s) with exposed bone, joint or tendon, ulcer 5-10 cm <sup>2</sup> not involving calcaneus –); gangrenous changes limited to digits. Salvageable with multiple digital amps or standard transmetatarsal amputation (TMA) + skin coverage.
<b>Extensive ulcer/gangrene</b> > 10 cm <sup>2</sup> involving forefoot or midfoot; full thickness heel ulcer > 5 cm <sup>2</sup> + calcaneal involvement. Salvageable only with complex foot reconstruction, nontraditional TMA (Chopart/Lisfranc); flap coverage or complex wound management needed.

WIFI Classification of ischaemia			
Grade	ABPI	Ankle systolic pressure	Toe brachial pressure index
None	0.8 or above	100mmHg or more	60mmHg or more
Mild to moderate	0.6 -0.79	70-99 mmHg	40-59mmHg or more
Moderate to severe	0.40-0.59	50-69 mmHg	30-39mmHg
Severe	Less than 0.4	Less than 50 mmHg	Less than 30mmHg

<b>Clinical manifestation of infection</b>	IDSA (Infectious Diseases Society of America)/PEDIS (Perfusion Extent/size Depth/tissue loss Infection Sensation. Infection severity)
Wound without purulence or manifestations of infection	<b>Uninfected</b>
Infection present, as defined by the presence of at least 2 of the following items: Local swelling or induration Erythema >0.5 to ≤2 cm around the ulcer Local tenderness or pain Local warmth No local complications or systemic illness Purulent discharge (thick, opaque to white, or sanguineous secretion)	<b>Mild</b>
Infection in patient who is systemically and metabolically stable but has one or more of the following: Cellulitis extending 2cm, lymphangitis Spread beneath fascia Deep tissue abscess Gangrene Muscle, tendon, joint or bone involvement	<b>Moderate</b>
Infection in patient with systemic or metabolic toxicity	<b>Severe</b>

## 7. Podiatric Management

- 7.1 Patients who have an ABPI done by an assistant practitioner will be booked in with a podiatrist for interpretation the results and check their treatment plan within 2 weeks.
- 7.2 Patients with PAD must receive written and verbal education from Podiatry staff to empower them to manage their condition, and to enable them to self-monitor for signs of deterioration. Patients with PAD and diabetes should be treated according to the current NICE Guidelines. It is vital to make patients aware that making changes to their lifestyle will have a positive impact on disease outcomes (NICE CG 147).
- 7.3 Patients with suspected PAD should be given a PAD Leaflet (**Appendix N**), and the content of the leaflet explained.

- 7.4 All patients with peripheral arterial disease who are smokers should be signposted to the NHS Stop Smoking Service, and the health benefits of not smoking reinforced.
- 7.5 Any patient with suspected PAD and obesity (measured using the Body Mass Index) should be encouraged to speak to their GP about weight management strategies, which could include a referral by the GP, to the Weight Management Service. All patients with BMI over 40 or BMI over 35 with co-morbidities can be referred. See **Appendix H**.
- 7.6 Provide general advice on exercises and life style e.g. eat 5 pieces of fruit and vegetables a day. Encourage patients to walk at least 25 minutes per day. Explain to the patient that this can be broken down into smaller sections which add up to 25 minutes.
- 7.7 Patients with peripheral arterial disease should receive regular evaluation of their symptoms if they meet the service criteria for ongoing care. At each follow-up appointment, they must be asked if there has been a change (either an improvement or deterioration), or whether their symptoms are stable.
- 7.8 Advise patients who are being discharged after their initial assessment to see GP or practice nurse if problems occur. Patients referred to podiatry for a vascular assessment presenting with low podiatric needs must be discharged back to GP's care after a provision of foot care and footwear advice and appropriate information leaflets. The results of assessment and intervention (e.g. ABPI test) must be communicated to patient's GP and referrer. Any patients with PAD must, as a minimum, have an annual review with a podiatrist.
- 7.9 **Stable claudication.** If there is no deterioration in symptoms or tissue loss/ulceration present the patient may only warrant attention to his/hers lifestyle (see **Appendix H**). Encourage the patient to walk through the claudication pain, if possible, to develop a collateral blood supply. During the assessment, check the patient's medication. The Heart Protection Guidelines recommend Aspirin 75mg and/or Clopidogrel (Plavix) ,Simvastatin 40 mg. (If the patient is not, then alert the GP when communicating on the PAD assessment as per recommendation from the vascular department of Torbay Hospital. N.B. Some patients may be on Warfarin or other anticoagulants.
- 7.10 Podiatry patients with stable claudication should have an Ankle Brachial Pressure Index (ABPI) test conducted as a part of their annual review.
- 7.11 **Communicate your clinical findings and care plan with the patient's GP.** See **Appendix E**, for letter guidelines.
- 7.12 If a patient reports a significant deterioration, the podiatrist must undertake a thorough assessment of the patient's lower limb arterial supply. If a patient is receiving delegated care from a Podiatry Assistant, the patient must be referred back to a Podiatrist for review.
- 7.13 As a minimum, a Podiatrist must palpate the patient's pulses, listen to them on a 5 or 8 MHz Doppler, and check the patient's sub capillary refill time. An ABPI must also be considered. Use internal referral form for ABPI (**Appendix L**) and book in for review with a podiatrist following ABPI appointment. The results of this assessment of the patient should be communicated to the patient's GP (**Appendix J**).
- 7.14 **Post vascular surgery treatment of podiatry patients**

Each podiatry patient with PAD should have their vascular status re-assessed after by-pass surgery or angiography. Graft surveillance is provided by the vascular clinic and it should commence 6 weeks post surgery.

## 8 Monitoring Compliance and Effectiveness

- 8.1 The Head of Podiatry Services will retain overall accountability and responsibility for the content, monitoring and implementation of this document.
- 8.2 Periodic clinical audit, patient satisfaction surveys and an annual peer review of staff compliance and competency will be included in the on-going process to monitor quality, compliance and effectiveness.
- 8.3 Responsibility for undertaking the various review processes will be devolved by the Head of Podiatry Services to competent staff members.
- 8.4 Audits and patient satisfaction surveys will be registered, published and actioned in line with current Trust policy whilst peer reviews will be subject to internal scrutiny and as a part of the annual appraisal processes.

## 9 Training and staff support

Follow-up training sessions on vascular assessment should be provided for all podiatrists as well as podiatry clinical support workers.

Item	%	Exceptions
All podiatrists and podiatry Clinical Support Workers will be trained and competency assessed during induction with regards to how to recognise the signs and symptoms of PAD and how to undertake the associated tests such as ABPI, Doppler and Buerger's Test	100	None
All podiatrists will understand the referral pathway to the Vascular Assessment Clinic	100	None
Podiatry staff will receive bi- annual vascular assessment training sessions delivered by a vascular practitioner. Individual staff development needs may also be addressed as part of their annual appraisal and line management supervision	100	

All podiatrists to attend CPD vascular updates every three years as per Health and Care Professions Council (HCPC )recommendations	100	
The staff will be informed of up-to-date changes in policies and guidelines	100	
How will monitoring be carried out?	Peer review	
When will monitoring be carried out?	Annually	
Who will monitor compliance with the guideline?	Lead podiatrists/team leads	

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## 10. Associated documentation

Scottish Intercollegiate Guidelines Network 89 Diagnosis and Management of Peripheral Arterial Disease October 2006; <http://www.sign.ac.uk/>

### References

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[Khaleghi M](#) et al, 2014. Family History as a Risk Factor for Peripheral Arterial Disease DOI: <http://dx.doi.org/10.1016/j.amjcard.2014.06.029>

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Lyden, SP Joseph D (2006) *The Clinical Presentation of Peripheral Arterial disease and guidance for early recognition* Cleveland Clinic Journal of Medicine vol. 73(S4) pp s15-21

Mills JL et al. *The Society for Vascular Surgery Lower Extremity Threatened Limb Classification System: Risk stratification based on wound, ischaemia and foot infection*. *Journal of Vascular Surgery* 2014; 59:220-34

National Institute for Health Clinical Excellence (2012) *Lower Limb Peripheral Arterial Disease: diagnosis and Management- Clinical Guideline 147* Issued August 2012

NICE cost impact statement: peripheral arterial disease 2011

Ray, SE Srodon, PD Taylor, RS Dormandy, JA (1994) *Reliability of ankle:brachial pressure index measurement by junior doctors* British Journal of Surgery vol. 81(2) pp. 188-90

Ruff D (2003) *Doppler Assessment: Calculating the Ankle Brachial Pressure Index* Nursing Times vol. 99(42) pp 62  
Sign 89 Diagnosis and management of peripheral arterial disease. October 2006

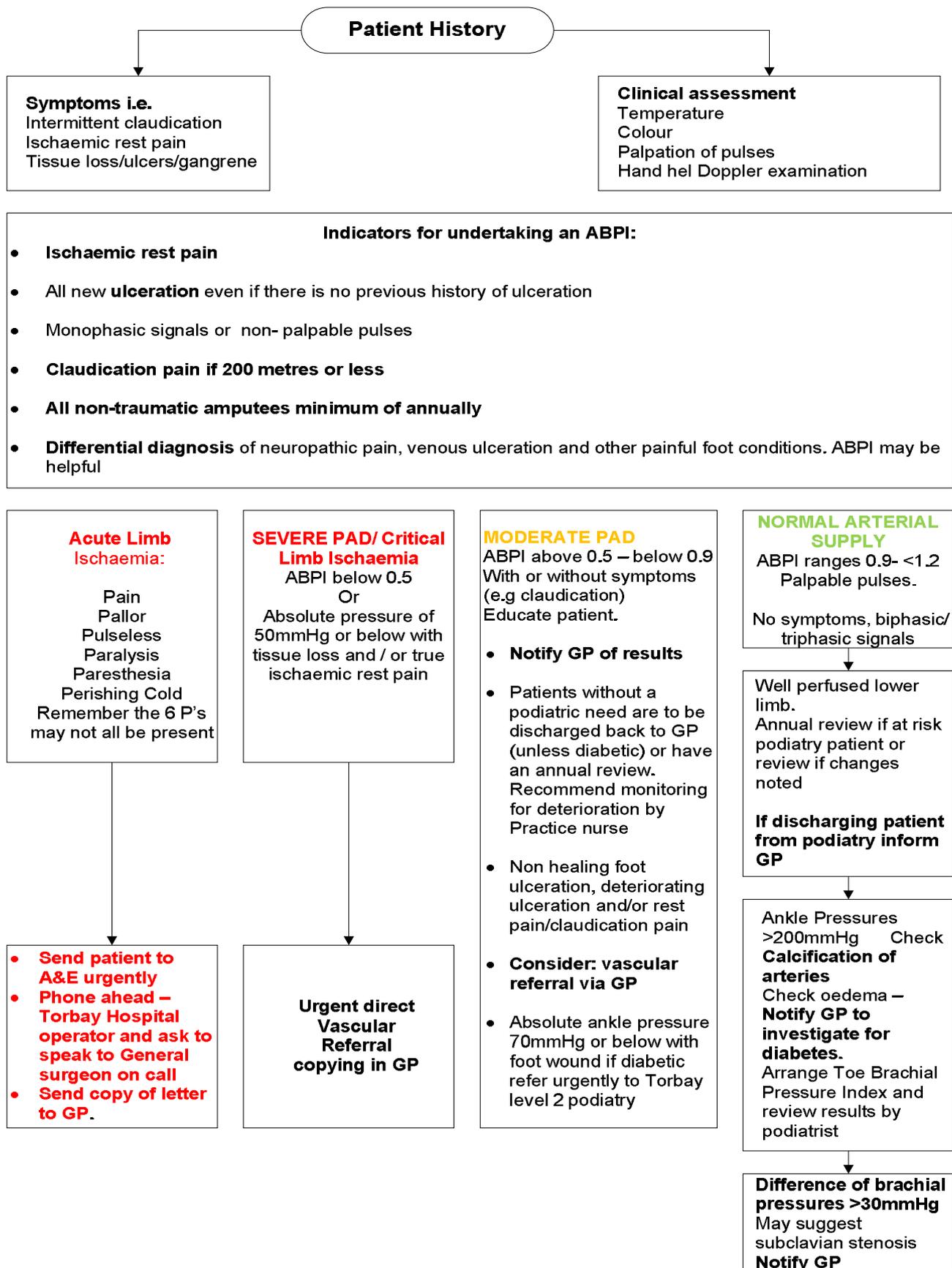
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**Summary Flow Chart of Podiatry Arterial Evaluation of the Lower Limb**



## Differential Diagnoses

Podiatrists should consider a differential diagnosis but still refer if concerned highlighting the alternatives conditions which may mimic PAD.

The table below, taken from Sontheimer (2006) shows the differential diagnoses of PAD the characteristics associated with these conditions.

Differential Diagnosis of Claudication				
Condition	Pain location	Characteristics of pain	Does exercise cause pain?	Effect of rest on pain
Baker cyst, symptomatic	Behind knee and down calf	Tender to touch, associated swelling	Yes	None; pain is present at rest
Calf claudication	Calf muscles	Cramping	Yes	Subsides quickly
Chronic compartment syndrome	Calf muscles	Tight, throbbing	Yes	Subsides slowly
Foot arthritis	Foot and arch	Aching	Yes, with varying degree	Subsides slowly
Foot claudication	Foot and arch	Severe, deep; associated numbness	Yes	Subsides quickly
Hip arthritis	Hip, thigh, and gluteal region	Aching	Yes, with varying degree	Subsides slowly
Hip claudication	Hip, thigh, and gluteal region	Aching, associated weakness	Yes	Subsides quickly
Nerve root compression	Down one leg and posterior	Sharp, stabbing	Yes, almost immediately	Subsides slowly
Spinal stenosis	Hip, thigh, and gluteal region	Some pain, but weakness predominates	Yes, after some time, includes standing	Subsides after some time; accompanied by position change (e.g., sitting down)
Venous claudication	Entire leg, but worse in thigh and groin	Tight, throbbing	Yes	Subsides slowly

Differential diagnosis may also include:

### Neuritis

May include pain, paraesthesia, paresis (weakness), hypoesthesia (numbness), anesthesia, paralysis, wasting, and disappearance of the reflexes. Possible causes include: shingles, leprosy, Guillain-Barre syndrome, diabetes, Vitamin B12 deficiency, MS, alcohol dependency etc.

### Neuropathic Pain

A complex, chronic pain state. With neuropathic pain, the nerves are damaged or dysfunctional, causing a variety of symptoms including numbness, pain and tingling.

### Chilblains

These are small, itchy and painful reddish blue swellings which develop on the fingers and toes when the skin cools down, causing the tiny blood vessels to constrict severely. Because of the poor blood supply, chilblains sometimes don't heal very quickly and can become infected. Sufferers of Raynaud's phenomena can be prone to chilblains.

## **Raynaud's Phenomenon**

A common disorder in which the small blood vessels in the extremities are over-sensitive to changes in temperature. It affects between 3-20% of the adult population worldwide, and is prevalent mainly amongst women. In this condition, the blood supply to the extremities is interrupted. During a Raynaud's attack the digits become first white and dead looking. They may then turn blue and finally red and burning when the blood flow is restored. There may be considerable pain, numbness or tingling. These symptoms are due to an intermittent lack of blood in the affected parts when the arteries normally supplying them spasmodically contract. An attack will often be triggered by exposure to cold of any kind. Emotions, such as anxiety, may also play a part as can smoking.

## **Venous stasis**

Refers to loss of proper function of the veins in the legs. This may occur following injury to the veins, which can result in superficial phlebitis, or following deep venous thrombosis. Swelling in the lower legs and ankle can also occur as a result of chronic congestive heart failure and kidney disease. Oedema is often present; the superficial veins in the legs may be varicosed. Patients often complain of a feeling of fullness, aching, or tiredness in their legs. These symptoms are worse with standing, and are relieved when the legs are elevated.

Standard Operating Procedure	
<b>Title:</b> Podiatry - Ankle Brachial Index (ABPI) Method by Podiatrists	
<b>Prepared by:</b> Nail Surgery Specialist Podiatrist	
<b>Presented to:</b> Vascular Practitioner and Podiatry Leads	<b>Date:</b> 31/10/16
<b>Links to policies:</b>	Nail surgery guidelines for Podiatrists 0698 and podiatry assessment policy

1. **Purpose of this document**

To ensure the patient receives enough information about the proposed assessment, and that it is performed consistently by podiatrists, their assistants and students. The ABPI is a quantitative assessment of peripheral arterial circulation used as a guide to clinical management as the vascular status bears a direct relationship to tissue viability.

2. **Scope of this SOP**

This procedure will apply to all Health Care Professions Council (HCPC) podiatrists, their assistants and podiatry students. Competencies required – HCPC podiatrists and their assistants competent to carry out ABPI and understanding the results.

3. **Patients covered**

Patients under TSDFT and who are showing signs of peripheral vascular disease (PAD) and may need nail surgery, or have a slow healing foot ulcer.

4. An ABPI may be appropriate if there are clinical signs of PAD, and there is a need to establish its extent, i.e., nail surgery assessment or assessment for wound care.

5. **How to undertake ABPI procedure**

- 5.1 Explain to the patient the reason for the test, the significance of the results and the likely time involved. Gain consent.
- 5.2 Lay the patient supine for at least 10 minutes (20 minutes would be preferable).
- 5.3 Measure the arm/ankle if necessary to ensure correct cuff size as this can influence your results.
- 5.4 Large adult cuff 32.1cm- 43.4cm.
- 5.5 Regular cuffs-26cm-35cm.
- 5.6 Child cuffs 17-25cm. Wrap the cuff around an arm with the arrow over the artery. Locate brachial pulse with fingers and then apply gel and position Doppler probe at 45-60degrees upwards towards the blood flow. Maintaining the Doppler probe position, gradually inflate the cuff until the signal disappears. STOP if too painful. Do not compress over 240mmHg. Monitor the pressure gauge, and slowly deflate the cuff and record the pressure at which the Doppler signal first returns. This is the resting systolic pressure.
- 5.7 Ensure the cuff is fully deflated by squeezing the air out of the cuff before repeating the test. Repeat for other arm.
- 5.8 Wrap the sphygmomanometer cuff around the ankle.

- 5.9 Locate dorsalis pedis with the Doppler probe ensuring a sharp clear signal. Maintaining the Doppler probe position, gradually inflate the cuff until the signal disappears. Monitoring the pressure gauge, slowly deflate the cuff and record the pressure at which the Doppler signal first returns.
  - 5.10 Locate the posterior tibial pulse and repeat the procedure. Repeat for the other leg. The ABPI is calculated for each leg separately.
  - 5.11 Considering one leg at a time chose the higher of the pressure measurements taken from dorsalis pedis and posterior tibial pulses. If you cannot hear one of these pulses try the anterior tibial or peroneal instead. Record this in the records is you used these sites.
  - 5.12 Add the ABPI sticker to the front of the notes and complete the date ABPI was carried out.
  - 5.13 Divide this value by the higher of the two brachial measurements.
  - 5.14 Average values for healthy adults range from 0.9-1.31.
  - 5.15 Values <0.8 suggest some obstruction or narrowing.
  - 5.16 Refer to appendix A summary flow chart of PAD guidelines for referral guidelines
  - 5.17 Refer to Combined Vascular/podiatry clinic vascular team for advise if considering nail surgery, the options would be conservative treatment, avulsion without chemical.
  - 5.18 If a wound refer to WIFI 6.7.3 of PAD guidelines to inform SINBAD scoring  
 0.6-0.79 mild to moderate ischaemia.  
 0.4-0.59 Moderate to severe ischaemia  
 Less than 0.4 severe ischaemia.  
 <0.5 Severe PAD/Critical limb ischaemia absolute pressure 70mmHg or below with a foot ulcer, and 50mmHg or below without foot ulcer. Absolute pressure is the highest blood pressure measurement taken at the ankle before you divide it by the brachial pressure to get the ABPI ratio. Healing unlikely to occur and limb pre-gangrenous requiring urgent referral to vascular team.
- 6 Limitations of ABPI:
- 6.1 Calcification causes arteries to be incompressible, perhaps in as many as 65% tibial and 50% pedal pulses in people with diabetes, leading to raised pressures.
  - 6.2 Intra-observer variability.
  - 6.3 Test can be painful. If too painful, undertake toe brachial pressure test.
  - 6.4 Consider using 5MHz probe for severe oedema.
  - 6.5 The ABPI does not show any distal occlusion to the cuff or micro vessel disease like Raynauds. It does not show the presence of distal micro emboli or athero-sclerotic plaques.
  - 6.7 In atrial fibrillation the systolic pressure may vary from beat to beat.
  - 6.8 False reading may be due to repeated inflations/ leaving inflated too long or wrong sized cuff.

Name		
NHS no		
Date	Clinician name and signature	
	Left	Right
Brachial		
Dorsalis Pedis		
Posterior tibial		
ABPI = Highest ankle Highest brachial		

**Standards:**

Item	%	Exceptions
If pulses are monophasic or other signs of ischaemia, an ABPI will be performed before considering nail surgery.	100	If this test showed > 0.8 by nurse within last 3 months or if too painful or diabetic with calcified vessels.
If signs and symptoms of claudication and rest pain coincide with ulceration an ABPI will be performed.	100	If known to vascular team or had vascular investigations within last 3 months or if too painful or diabetic with calcified vessels.
How will monitoring be carried out?	Peer review	
When will monitoring be carried out?	Annual	
Who will monitor compliance with the guideline?	Lead podiatrists	

**References:**

Current evidence to be reviewed every 2 years by podiatry specialists

*A full list of references giving the evidence base for the guidelines should be given here*

Clinical experience with Doppler audio sound. AG Lythgoe and A.Barlow. British Journal of Podiatry, February 2007. Vol.10.no1

The ankle:brachial pressure index. A Critical Appraisal. C Marshall. British Journal of Podiatry, November 2004, Volume 7, no.4

Vascular Disease Nursing and Management Edited by Shelagh Murray. 2001 Whurr Publishers Ltd

Leg Ulcer Guidelines- South Devon Health Care (Intranet) Select Clinical Guidelines, then the drop down menu on site index, and look for Tissue Viability. Then select Protocols and Guidelines, then Nursing Protocols and Guidelines, then Leg Ulcers 0392, Pages 10-15

Assessment of the Lower Limb Merriman and Tollafield Churchill Livingstone 1995

Vascular Disease Nursing and Management Edited by Shelagh Murray. 2001 Whurr Publishers Ltd

<b>Standard Operating Procedure:</b>	
<b>Title: Buerger's Test for Podiatrists</b>	
<b>Prepared by:</b> Nail Surgery Specialist Podiatrist	
<b>Presented to:</b> Vascular Practitioner and Podiatry Lead	<b>Date:</b> 31/10/16
<b>Links to policies:</b>	

1. **Purpose of this document**

To ensure this test is performed consistently by podiatrists, their assistants and students. The Buerger's test is a useful adjunct to routine peripheral vascular assessment and, if positive, suggests more severe ischaemia with distal limb artery involvement.

2. **Scope of this SOP**

This procedure will apply to all HCPC podiatrists, their assistants and podiatry students.

3. **Competencies required**

HCPC podiatrists, their assistants and students competent to undertake test and interpret results.

4. **Patients covered**

Patients under Torbay and South Devon NHS Foundation Trust who are showing signs of peripheral arterial disease or have a slow healing foot ulcer.

5. **Test**

- 5.1 Lie patient flat (if possible)
- 5.2 Elevate limb
- 5.3 Observe colour of foot and record in notes
- 5.4 Then hand leg over the side of the couch
- 5.5 Record colour on dependency ("sunset" colour is a positive Buerger's sign. The quicker this comes on and the more erythema, the more severe the PAD)

**Standards:**

Item	%	Exceptions
If signs and symptoms of claudication and rest pain coincide with ulceration a Buerger's Test will be performed	100	If known to vascular team or had vascular investigations within last 3 months
How will monitoring be carried out?		Peer review

When will monitoring be carried out?	Annual
Who will monitor compliance with the guideline?	Lead podiatrists

**References:**

Significance of Buerger's test in the assessment of lower limb ischaemia.  
R L Insall, R J Davies, and W G Prout  
J R Soc Med. 1989 December; 82(12): 729-731

## Guidelines for referral letters

Include:

Date of referral, name and designation, address and contact details of referrer

Name, NHS number and date of birth

The symptoms

The clinical findings are . . .

Dorsalis pedis/posterior tibial pulses are palpable/non palpable

Doppler signals:

Ankle Brachial Pressure Index (ABPI)

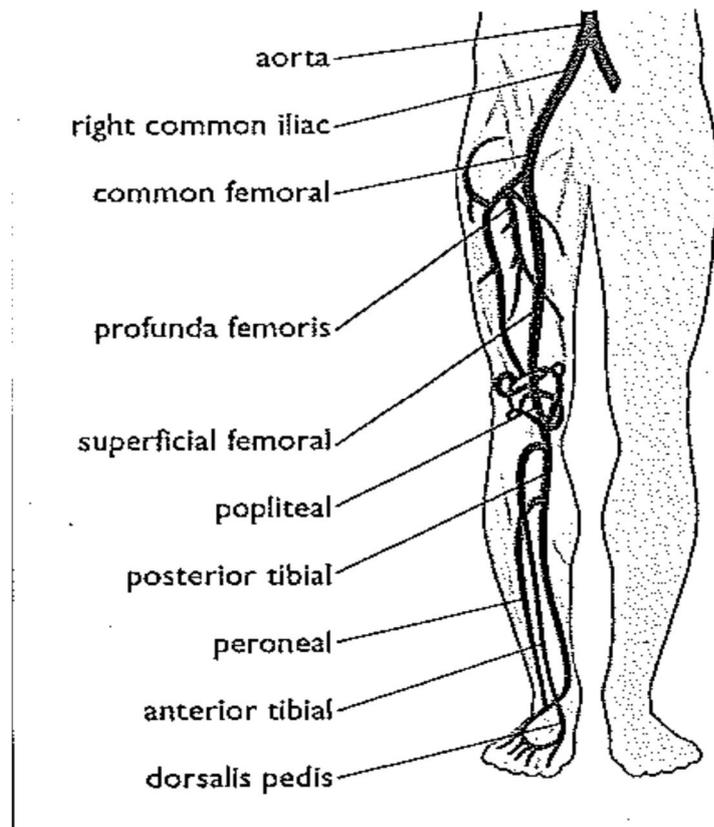
Positive or negative Buerger's sign

Associated risk factors are . . .

Our treatment plan is . . .

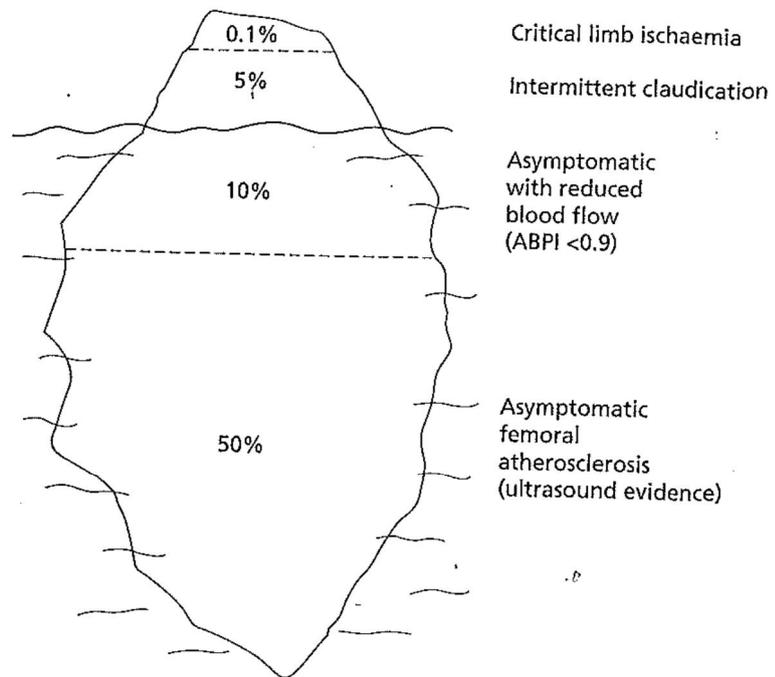
Copy to

Diagram of lower limb vessels



The iceberg of peripheral arterial disease

Figure 1.2  
*The iceberg of peripheral arterial disease. Prevalences of symptomatic and asymptomatic disease in middle-aged men estimated from population surveys.*



## Lifestyles Team

You can self-refer or ask patients to self-refer by calling 0300 456 1006, or by emailing them at [torbaylifestyles@nhs.net](mailto:torbaylifestyles@nhs.net).

Alternatively, you can download an [electronic Healthy Lifestyles referral form](#) and email it or download a printable form.

Services they provide include:

smoking cessation

Weight management

Fitness

Diabetes control

## Peripheral Arterial Disease Assessment Form

Linked to Clinical Forms Library:

[Peripheral Heart Disease Assessment](#)

Letter to GP

Department of Podiatry and Orthotics  
Castle Circus Health Centre  
Abbey Road  
Torquay  
TQ2 5YH

Telephone : 01803 217712

Dear Dr

Patients Name:

\_\_\_\_\_

NHS Number:

\_\_\_\_\_

Date of Birth:

\_\_\_\_\_

This patient was seen today for lower limb peripheral arterial assessment because they have one or more monophasic pulses (see below).

**Resting ABPI results:** for the right leg and for the left leg (manual or Huntleigh Dopplex)

**Diagnosis and plan:**

Vascular status: normal (0.9-1.2), mild to moderate (0.89-0.5) severe peripheral arterial disease (<0.5). *(Delete as appropriate)*

**ABPI 1.3 or over- falsely high reading-** consider the possibility of peripheral arterial disease- inform GP

**Normal ABPI (above 0.9-1.2) (TBPI above 0.7). No wound.** Continue with treatment plan, or review current plan if needed (with Podiatrist).

**Normal ABPI (above 0.9-1.2), with wound.** No indication for vascular referral. Continue with regular ulcer treatment.

**Moderate PAD (ABPI more than 0.5-less than 0.9). No wound.** With or without intermittent claudication  
Continue with treatment plan. Health / lifestyle education. Annual ABPI.

**Moderate PAD (ABPI above 0.5-less than 0.9) (TBPI 0.64-0.7 ). With wound.** Ulcer clinics. Consider vascular referral for non-improving wound. Inform GP.

**Severe PAD (ABPI less than 0.5). Without wound.** No rest pain. Refer to specialist podiatrist for review and treatment plan within 2 weeks. Alert patient of high risk status. Regular specialist podiatrist treatment. Emergency contact numbers and advice. If positive Buerger's to go through GP

**Severe PAD (Less than 0.5) with wound.** No rest pain. Refer to vascular clinic and specialist podiatrist. Inform GP

**Severe PAD(less than 0.5) . With rest pain. With or without a wound.**

Urgent vascular referral via e-mail ([sdhct.vascularsurgery@nhs.net](mailto:sdhct.vascularsurgery@nhs.net)). Inform GP.

Difference between brachial pressures of 20-30mm Hg might indicate sub-clavian stenosis. Inform GP

Critical ischaemia- absolute pressure of 70 or below with wound, 50 or below with no wound

Patients with vascular disease would benefit from antihypertensive medication if required, Clopidogrel 75mg OD (first line- NICE guidelines 2010) or Aspirin 75mg OD and 40mg Simvastatin (Heart Protection Study, 2002). Or a different statin if simvastatin not tolerated. (Highlight if necessary)

### **Referrals- Smoking/Healthy lifestyles/Bladder and Bowel etc**

I have advised (*patients name*) to keep as active as possible with regular walking and gentle exercise and to report any new leg or foot symptoms. I have advised on the importance of a healthy balanced diet and weight loss and the impact on cardiovascular risk. (NICE CG147)

**NICE guidelines suggest peripheral arterial disease with an ABPI value of 0.9 and less. However the ABPI result should be viewed with caution in diabetes due to arterial calcification causing falsely elevated result. If you feel further assessment is necessary I would recommend referral to the vascular team.**

I would be grateful if you would consider our findings, taking into account the above.

We will review the patient (*appropriate to treatment plan- please detail*)

Yours sincerely

**Podiatrist**

Copies to:

Patient  
File in podiatry notes

Referral letter for Acute Limb Ischaemia

Department of Podiatry and Orthotics  
Castle Circus Health Centre  
Abbey Road  
Torquay  
TQ2 5YH

Telephone : 01803 217712

Dear Dr

Patients Name:

\_\_\_\_\_

NHS Number:

\_\_\_\_\_

Date of Birth:

\_\_\_\_\_

This patient presented in the podiatry clinic today with acute limb ischaemia

We have alerted the on call medical registrar and have informed the Torbay Hospital Podiatry team, and the Vascular team on 01803 655594 /07833 402078/07867 201/759

**Current medication**

**Relevant medical history**

The patient has a podiatry appointment on \_\_\_\_\_ at \_\_\_\_\_  
am/pm

If the patient is admitted and unable to attend for this appointment please can someone contact the podiatry appointments office on 01803 217712. Or email [t-sd.podappts@nhs.net](mailto:t-sd.podappts@nhs.net)

Yours sincerely

**Podiatrist**

Copies:

Patient's GP  
File in podiatry notes

**PODIATRY ABPI INTERNAL REFERRAL**

**Linked to Clinical Forms Library:**

[Podiatry Ankle-Brachial Pressure Index \(ABPI\)](#)

Standard Operating Procedure	
Title: Podiatry - Ankle Brachial Index (ABPI) Method by using the ABPI calculator machine	
Prepared by: Prepared by Podiatry Team Leader	
Presented to: Podiatry department	Date: July 2012
Ratified by: Care & Clinical Policies Group	Date:
	Review date: November 2018
Links to policies:	PAD guidelines for podiatrists

**Purpose of this document** – To ensure the patient receives enough information about the proposed assessment, and that it is performed consistently by podiatrists, their clinical support workers and students. The ABPI is a quantitative assessment of peripheral arterial circulation used as a guide to clinical management as the vascular status bears a direct relationship to tissue viability.

**Scope of this SOP** – This procedure will apply to all Health Professions Council (HCPC) podiatrists, their clinical support workers and podiatry students.

**Competencies required** – all staff that use the machine to carry out an ABPI will be required to be competent in interpreting ABPI readings and referring on when required. .

**Patients covered** – Patients under Torbay and South Devon NHS Foundation Trust who are showing signs of peripheral arterial disease that may need nail surgery or have a slow healing foot ulcer.

1. Plug the ABPI calculator machine in.
  - 1.1 If paper needs changing have paper end towards you and click the top down.
2. Before the patient enters the room, connect the cuffs to the correct colour socket on the ABPI calculator machine.
3. Explain to the patient the reason for the test, the significance of the results and the likely time involved. Check with the patient there is no reason for not carrying out the test e.g. Patients with suspected or known acute deep vein thrombosis (DVT) or superficial thrombophlebitis.
  - Recent surgery, ulcers, casts or bandages that cannot or should not be compressed by pressure cuffs.
  - Proceed with caution in patients who have had a therapeutic intervention (stent or graft) which if it extends into the lower calf. Do not use a cuff on anyone with an arteriovenous shunt (fistula, anastomosis) for kidney dialysis.
  - It should be noted that ABPIs may be less reliable in patients with diabetes or patients with known calcification of their arteries.
4. Explain to the patient that the machine will make a gently humming noise and that the cuffs will inflate twice.
5. Explain to the patient that they will have to lie still with their arms by their side.

6. Explain to the patient that it is important that they do not talk during the test.
7. Turn the calculator on.
8. Lay the patient supine.
9. Wrap the green cuff around left ankle and mid foot, black cuff around right ankle and mid foot, yellow cuff around left upper and lower arm, red cuff around right upper and lower arm (If there is an amputation the cuff is still connected to the machine.)
10. Using the left button select the correct body diagram to represent the patient.
11. Confirm with the patient that they are ready for the test to start.
12. Start the test by pressing the middle button.
13. When the test has finished remove the cuffs from the patient.
14. Wipe the cuffs with clinell wipes.
15. Print out a copy of the results.
16. Mark on the printout the patient's name and NHS number and file in the notes. Explain to the patient the results.
17. Make referral onto vascular team if indicated. See Appendix A of PAD guidelines. Inform GP.
18. In the event of no result with Huntleigh machine, explain to the patient, leave them lying flat and do the measurement manually.

**Standards:**

Item	%	Exceptions
If pulses are monophasic or other signs of ischaemia, an ABPI will be performed before considering nail surgery	100	If this test showed > 0.8 by nurse within last 3 months or if too painful or diabetic with calcified vessels.
If signs and symptoms of claudication and rest pain coincide with ulceration an ABPI will be performed.	100	If known to vascular team or had vascular investigations within last 3 months or if too painful or diabetic with calcified vessels.
How will monitoring be carried out?	Peer review	
When will monitoring be carried out?	Annual	
Who will monitor compliance with the guideline?	Lead podiatrists	

**References:**

Current evidence to be reviewed every 2 years by podiatry specialists

Clinical experience with Doppler audio sound. AG Lythgoe and A.Barlow. British Journal of Podiatry, February 2007. Vol.10.no1

The ankle:brachial pressure index. A Critical Appraisal. C Marshall. British Journal of Podiatry, November 2004, Volume 7, no.4

Vascular Disease Nursing and Management Edited by Shelagh Murray. 2001 Whurr Publishers Ltd

Leg Ulcer Guidelines- South Devon Health Care (Intranet) Select Clinical Guidelines, then the drop down menu on site index, and look for Tissue Viability. Then select Protocols and Guidelines, then Nursing Protocols and Guidelines, then Leg Ulcers 0392, Pages 10-15

Standard Operating Procedure:	
Title: <b>STANDARD OPERATING PROCEDURE FOR TOE BRACHIALPRESSURE INDEX</b>	
Prepared by: <b>Specialist Podiatrist</b>	
Presented to: <b>PODIATRY department</b>	Date: <b>19.1.17</b>

Linked to PAD guidelines

**1. Purpose of this document**

2. In line with NICE Guidelines 2012 Lower Limb Peripheral Arterial Disease( PAD): Diagnosis and Management, to ensure that all patients showing signs of peripheral arterial disease who have had an Ankle Brachial Pressure Index ( ABPI) and have either incompressible arteries or have an abnormally high ABPI have toe pressure brachial index (TBPI) recorded and appropriate referrals made

3. **Scope of this SOP** – This procedure will apply to all HCPC podiatrists, podiatry assistant practitioners and podiatry students from University of Plymouth.

4. **Competencies required** – HCPC podiatrists, their assistants and students competent to undertake test and interpret results.

5. **Patients covered** – Patients under Torbay and Southern Devon NHS Foundation Trust Podiatry department who are showing signs of PAD or have a slow healing foot ulcer, monophasic pulses (or other symptoms such as claudication)

**6. Procedure**

6.1 Ensure the patient is rested and in a supine position ankles raised to same height as heart.

6.2 First assess brachial pressures (See SOP FOR ABPI)

**7 How to Perform a Toe Brachial Pressure Index (TBPI)**

7.1 Ensure the foot is stable

7.2 Attach the toe pressure probe to the Doppler .

7.3 Attach the 3 prong wire one end to the toe pressure probe the other end to the Doppler machine and sphygmometer

7.4 Place the cuff on the base of the hallux (second toe if appropriate e.g. 1<sup>st</sup> toe amputation , ulceration of hallux)

7.5 Put photo plethysmograph (ppg) on the pad of the large toe slightly towards the second toe and not touching the cuffs and with the wire pointing down.

7.6 Make sure the tape will hold the ppg in place but not compress the blood vessels by being too tight.

7.7 Turn on the doppler machine and you should see the patient's pulse as a waveform on the chart recorder.

7.8 Connect the sphygmomanometer to the toe pressure cuff and inflate slowly until you see the waveform disappear.

7.9 Note the pressure and continue to inflate until 20-30 mmHg above that pressure (super systolic).

7.10 Now slowly release the pressure in the cuff at about 2 mmHg per second declination until the waveform reappears.

7.11 This is the systolic pressure.

7.12 Make a note of it.

7.13 Deflate the cuff completely

7.14 Repeat the toe pressure on the other foot..

**8. How to calculate the TBPI**

Divide the highest toe pressure by the highest brachial pressure the result is the TBPI.  
Interpretation<sup>1</sup>

- 8.1 TBPI > 0.7 Normal indicating no arterial disease
- TBPI = 0.64 - 0.7 Borderline PAD
- TBPI < 0.64 - Abnormal indicating PAD

8.2 Record findings . Copy to GP of letter template, adapting as required or vascular clinic as appropriate following referral flow chart Appendix A of PAD guidelines. File copy with notes

8.3 If assistant practitioner feels a referral to vascular department is needed to seek clarification from a podiatrist and refer to referral flow chart as attached Appendix A of PAD Guidelines. Follow action box on ABPI clinic template

8.4 Referrals to the Vascular Department be e-mailed to generic e-mail address (which is manned Monday – Friday):

[SDHCT.vascularsurgery@nhs.net](mailto:SDHCT.vascularsurgery@nhs.net)

**9. To recharge the batteries**

As with all rechargeable devices ensure area is dry, hands are dry and do not leave on overnight as the plug may become hot

10.1 attach the large end of the recharger lead to the recharger plug

10.2 attach the other end to the top of the Doppler machine next to the headphone socket

10.3 plug in

**Standards:**

Item	%	Exceptions
If falsely high ABPI or incompressible foot arteries then a Toe brachial pressure index will be arranged	100	Unless currently under vascular team
How will monitoring be carried out?	Peer review	
When will monitoring be carried out?	Annual	
Who will monitor compliance with the guideline?	Lead podiatrists	

**References:** NICE Guidelines 2012 Lower Limb Peripheral Arterial Disease: Diagnosis and Management

**Appendix O**

[Linked to Patient Information Leaflet 25020 - Peripheral Arterial Disease](#)

**Appendix P**

[Linked to Patient Information Leaflet 25275 – Ankle Brachial Pressure Index](#)

**Doppler Assessment**

Linked to Clinical Forms Library:

[Doppler Assessment](#)

Appendix R

Your foot and leg circulation care plan

Name:

Date

Following your assessment today we found that you have:

- **Mild peripheral arterial disease**- evidence of a reduction in blood flow to your legs and feet
- **Moderate peripheral arterial disease**- significantly reduced blood flow to your legs and feet
- **Severe peripheral arterial disease**- severely reduced blood flow to your legs and feet

**Peripheral arterial disease increases the risks of a heart attack, stroke and if severe, leg amputation.** Peripheral arterial disease is a narrowing, hardening or blockage of the main blood vessels in the legs. This reduces the blood and oxygen flow to your legs which can result in aching/cramp in the calf or thigh muscles during walking. This is called **intermittent claudication. Importantly- It can be successfully treated.**

By making specific lifestyle related changes you can reduce your risks of heart attacks, strokes or worsening leg and foot problems. The podiatry team can support you to make any of these changes if you are interested.

Risk factors for circulation damage	You (tick)	Interested in reducing risk (Yes/ No)
<b>Smoking</b> <i>Any amount of tobacco or nicotine</i>		
<b>High blood pressure</b> <i>Resting blood pressure greater than 140/90</i>		
<b>Raised lipid levels (cholesterol)</b> <i>Total above 4 or LDL greater than 2</i>		
<b>Raised blood glucose levels with diabetes</b> <i>HBA1c greater than 53</i>		
<b>Lack of cardiovascular (heart) exercise</b> <i>Less than 2.5 hours per week of light exercise</i>		
<b>Excessive weight</b> <b>Body mass index over 30</b>		

Following our assessment and our decisions today, we will refer you to the following services for treatment or support:

- Your GP for review of medicines, blood pressure, cholesterol
- The vascular department (to consider further specialist assessment and treatments)
- Lifestyles team for:
  - Smoking cessation team (for support and information to help you quit)
  - Weight management team for support reducing weight
  - Supervised exercise class
  - Help with diabetes control

Podiatrists can refer or ask patients to self-refer by calling 0300 456 1006, or by emailing them at [torbaylifestyles@nhs.net](mailto:torbaylifestyles@nhs.net).

<b>Standard Operating Procedure:</b>	
<b>Title: Use of SINBAD Score for wound classification by Podiatry staff</b>	
<b>Prepared by: Podiatrist</b>	
<b>Presented to: All podiatry staff</b>	<b>Date: 11.11.16</b>

**1. Purpose of this document**

To ensure all Torbay and South Devon NHS Foundation Trust (TSDFT) Podiatry staff follow the same protocol when classifying both Diabetic and Non-Diabetic wounds.

To aid the referral of complex, deteriorating and static wounds to appropriately trained wound specialists and multi-disciplinary team environment in an appropriate and in a timely manner.

To aid clinicians to identify the care pathway required for onward referrals for patients with wounds.

To enhance wound healing and reduce the potential risk of amputation for patients by identifying and following care pathways.

To comply with the recommendations on how to assess diabetic foot ulcers (WUWHS, 2016).

**2. Scope of this SOP**

This procedure will apply to all Health and Care Professions Council Podiatrists, Podiatry Assistants (AP), Podiatry Clinical Support Workers (CSW) and Plymouth University Podiatry Students when undertaking treatment of a patient with a wound.

**3. Competencies required**

HCPC Podiatrists, AP's, CSW's and Plymouth University Podiatry Students who undertake treatment of patients. Staff will have 'bitesize induction' to inform use of SINBAD wound classification.

**4. Assessment**

Annual peer review. Medical records audit.

**5. Patients covered**

All patients of TSDFT with a wound.

**6. Procedure**

**6.1** Using the grid, score 1 for every 'yes' answer. Total the amount of 'yes' answers out of 6. This will give you the SINBAD score for the wound. Document the SINBAD score in the patient's notes with a rationale if no referral has been made.

				Additional Comments	As defined as
Site: hindfoot?	yes		no		
Ischaemia: clinical PAD?	yes		no	If <b>diabetic</b> , refer to Torbay If <b>non-diabetic</b> , has an ABPI been completed? Refer ulceration or gangrene with impalpable pulses and absent or monophasic signals direct to Vascular	ABPI <0.80 or Toe pressure <0.60 or symptoms suggestive of PAD - see Tables 2,6,7 of PAD guidelines
Neuropathy: sensory loss?	yes		no		
Bacterial infection: Clinical?	yes		no	If management with antibiotics not improving wound presentation refer to Torbay	
Area: 1cm <sup>2</sup> or more?	yes		no	Increasing in size refer to Torbay Level 2 step down clinic	
Depth: tendon or bone	yes		no	Refer immediately to the Hospital based team if positive probe to bone test and osteomyelitis suspected.	

**6.2** Wounds with a SINBAD score of 0 – 2 should be referred to a Community Diabetes and Wound Specialist Podiatrist by booking an appointment in a Community Ulcer Clinic or with a Wound Specialist Podiatrist.

**6.3** Wounds with a SINBAD score of 3 or more, or those which remain static for more than 2-4 consecutive weeks, should be referred to Torbay Hospital by sending a referral form (Appendix 1) by email to [t-sd.podappts@nhs.net](mailto:t-sd.podappts@nhs.net). Should you require additional support or clarification contact the hospital based team on 01803 655102 Mon-Fri 08.30-16.00.

**6.4** Consider the information from the ‘additional comments’ and ‘as defined as’ boxes in the SINBAD table as to when the classification score requires an immediate referral.

**6.5** Consider whether referrals have been previously made and the management/treatment plans advised. For example if conservative management for an ischaemic patient has been agreed, consider whether re-referral to vascular is appropriate. Again, should you require additional support or clarification contact the hospital based team on 01803 655102 Mon-Fri 08.30-16.00, alternatively contact your Team Lead.

**6.6** Diabetic patients with Ischemia should be referred to Torbay as per Peripheral Arterial Disease (PAD) pathway which can be found on the shared Podiatry drive under ‘Vascular, policies and procedures’.

**6.7** Domiciliary patients should be reviewed at home by a Wound Specialist Podiatrist if the wound remains static or is deteriorating, this can be requested on the daily outcome sheet. Should you require a follow up in less than the usual four week return, this should be requested by emailing [t-sd.dompodappts@nhs.net](mailto:t-sd.dompodappts@nhs.net).

#### Standards:

Item	%	Exceptions
	100	0
How will monitoring be carried out?	Note auditing, peer review	
When will monitoring be carried out?	Annual	
Who will monitor compliance with guidelines	Team Lead, DOM lead, Mentors and peers	

**References:**

World Union of Wound Healing Societies (WUWHS), Florence Congress, Position Document. *Local management of diabetic foot ulcers*. Wounds International, 2016

**ACUTE DIABETIC FOOT REFERRAL FORM**

Linked to Clinical Forms Library:

[Acute Diabetic Foot Referral Form](#)

**11. Document Control Information**

*This is a controlled document and should not be altered in any way without the express permission of the author or their representative.*

*Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.*

*If printed, this document is only valid for the day of printing.*

<b>Ref No:</b>	1850		
<b>Document title:</b>	Clinical Guidelines for the management of peripheral Arterial Disease (PAD)		
<b>Purpose of document:</b>	To support the clinical practice of Podiatrists within Torbay and South Devon NHS Foundation Trust with regard to the assessment and management of patients presenting with PAD.		
<b>Date of issue:</b>	26 May 2017	<b>Next review date:</b>	26 May 2020
<b>Version:</b>	3	<b>Last review date:</b>	January 2017
<b>Author:</b>	Podiatry Team Leader		
<b>Directorate:</b>	Community		
<b>Equality Impact:</b>	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
<b>Committee(s) approving the document:</b>	Clinical Director of Pharmacy Professional Practice Associate Director for WCDDT		
<b>Date approved:</b>	25 May 2017		
<b>Links or overlaps with other policies:</b>	All TSDFT Trust Strategies, policies and procedure documents		

	<i>Please select</i>	
	Yes	No
<b>Have you considered using Equality Impact Assessment?</b>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Does this document have implications regarding the Care Act?</b> <i>If yes please state:</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>Does this document have training implications?</b> <i>If yes please state:</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Induction and team updates		
<b>Does this document have financial implications?</b> <i>If yes please state:</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Equipment to conduct tests		
<b>Is this document a direct replacement for another?</b> <i>If yes please state which documents are being replaced:</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Update of original document		

**Document Amendment History**

<b>Date</b>	<b>Version no.</b>	<b>Amendment summary</b>	<b>Ratified by:</b>
11 November 2014	2		Care and Clinical Policies
26 January 2017	2	Review date extended	Care and Clinical Policies Group
26 May 2017	3	Revised	Professional Practice Associate Director for WCDDT Clinical Director of Pharmacy
19 February 2018	3	Review date extended from 2 years to 3 years	

## The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

**“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)**

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

[http://icare/Operations/mental\\_capacity\\_act/Pages/default.aspx](http://icare/Operations/mental_capacity_act/Pages/default.aspx)

## Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

**Rapid (E)quality Impact Assessment (EqIA)** *(for use when writing policies)*

<b>Policy Title (and number)</b>	<b>CLINICAL GUIDELINES (FOR PODIARTISTS) FOR THE MANAGEMENT OF PERIPHERAL ARTERIAL DISEASE (PAD)</b>	<b>Version and Date</b>	3 15.3.17
<b>Policy Author</b>	Podiatry Team Leader		
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
<b>Who may be affected by this document?</b>			
Patients/ Service Users	<input checked="" type="checkbox"/>	Staff	<input checked="" type="checkbox"/>
Other, please state...			<input type="checkbox"/>
<b>Could the policy treat people from protected groups less favorably than the general population?</b> <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>			
Age	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Gender Reassignment	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Race	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Gender	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Pregnancy/Maternity	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
		Sexual Orientation	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
		Religion/Belief (non)	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
		Marriage/ Civil Partnership	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population?</b> (substance misuse; teenage mums; carers <sup>1</sup> ; travellers <sup>2</sup> ; homeless <sup>3</sup> ; convictions; social isolation <sup>4</sup> ; refugees)			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>Please provide details for each protected group where you have indicated 'Yes'.</b>			
<b>VISION AND VALUES:</b> Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language <sup>5</sup> used throughout?			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Are the services outlined in the policy fully accessible <sup>6</sup> ?			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Does the policy encourage individualised and person-centered care?			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Could there be an adverse impact on an individual's independence or autonomy <sup>7</sup> ?			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA <input type="checkbox"/>
<b>EXTERNAL FACTORS</b>			
<b>Is the policy a result of national legislation which cannot be modified in any way?</b>			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>What is the reason for writing this policy?</b> (Is it a result in a change of legislation/ national research?)			
To guide podiatrists when treating PAD			
<b>Who was consulted when drafting this policy?</b>			
Patients/ Service Users	<input checked="" type="checkbox"/>	Trade Unions	<input type="checkbox"/>
Staff	<input checked="" type="checkbox"/>	Protected Groups (including Trust Equality Groups)	<input type="checkbox"/>
General Public	<input type="checkbox"/>	Other, please state...	<input type="checkbox"/>
<b>What were the recommendations/suggestions?</b>			
<b>Does this document require a service redesign or substantial amendments to an existing process?</b> <i>PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below</i>			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>ACTION PLAN:</b> Please list all actions identified to address any impacts			
<b>Action</b>	<b>Person responsible</b>	<b>Completion date</b>	
<b>AUTHORISATION:</b>			
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			
<b>Name of person completing the form</b>	Podiatry Team Leader	<b>Signature</b>	
<b>Validated by (line manager)</b>	Head of Podiatry	<b>Signature</b>	

