

Document Type:	Standard Operating Procedure	
Reference Number : 2414	Version Number: 1	Next Review Date: 09/08/2022
Title:	Diabetic Foot Screening for Primary Care and Community Teams	
Document Author:	Lead Diabetes Podiatrist	
Applicability:	All patients as indicated	

1. Purpose of this document

To provide an up to date method and referral pathway for the screening of diabetic feet in patients who are able to attend their GP practice and patients who are considered to be house bound. In line with NG 19 Diabetic Foot Problems: Prevention and Management. nice.org.uk/guidance/ng19 (last accessed 3.4.19)

2. Scope of this Standard Operating Procedure

This standard operating procedure applies to all registered and unregistered health care professionals working in primary care and community teams who have been trained to undertake diabetic foot screening.

3. Competencies required

Any member of staff who has to screen diabetic feet as part of their current job role must have received training in how to do this. Training can be arranged by contacting the podiatry administration hub: 01803 320667

In addition to this any member of staff who has to screen diabetic feet as part of their job role is recommended to complete the Foot Risk Awareness and Management Education e-learning programme every 2 years.

www.diabetesframe.org (last accessed 3.4.19)

4. Patients covered and frequency of screening

All adults with diabetes, both type 1 and type 2, should have a foot screen at diagnosis and then at least yearly thereafter. Foot screening should occur more frequently in patients found to be at risk, if a foot problem should arise and on admission to hospital.

5. Risk Factors

Preventing foot complications begins with identifying those at risk. The risk of foot ulceration and amputation is increased in patients with the following risk factors:

- Previous foot ulceration or previous amputation
- Peripheral Neuropathy
- Peripheral Arterial Disease
- Foot Deformity / significant callus

- Renal replacement therapy
- Visual impairment

An inability to self-care such as dementia or learning difficulties

6.0 How to identify those at risk – *Community nursing teams can use the diabetic foot screening tool. An electronic template is generally used in primary care.*
(Appendix -1 Community Nursing Diabetic Foot Screening Tool)
[Community Nursing Diabetic Foot Screening Tool](#)

6.1 Step 1

Remove any dressings or bandages from the feet.

Thoroughly inspect each foot, remembering to look in-between the toes and at the back of the heel.

6.2 Search for:

- Any active ulcers or open wounds
- Sinister blisters containing blood or pus
- Callus
- Callus with bleeding
- Deformity such as hammer toes, clawed toes, bunions, excessively flat or high arched feet, toe amputations, Charcot foot, thickened and deformed nails.
- A hot, red swollen foot that could indicate an acute Charcot

6.3 Step 2 – Test for neuropathy

In primary care, use a 10g monofilament. Ask the patient to close their eyes.

Test the monofilament on the back of the patients hand or cheek to familiarise them with the sensation.

Ask the patient to say yes when they feel the filament.

Test 3 sites on each foot:

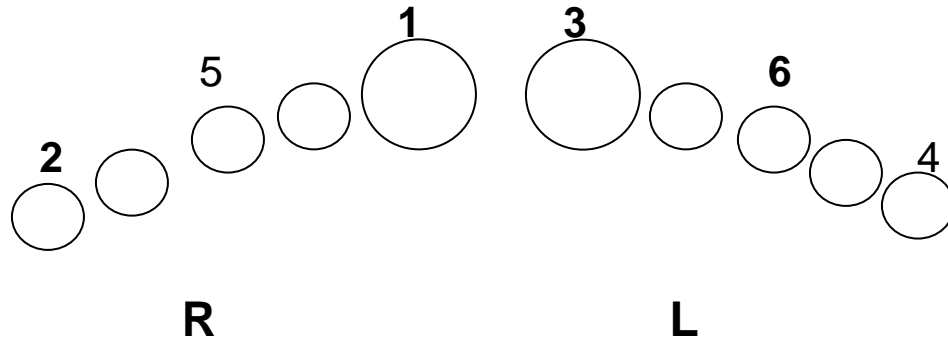
- under the big toe
- under the 1st met head
- under the 5th met head

An inability to feel 1 or more test site will indicate the presence of neuropathy.

Remember – Neuropathy is progressive and will usually get worse with time.

6.4 For house bound patients, carry out the Ipswich touch toe test.

6.5 The toes should be touched in the following sequence:



If 2 or more sites are not felt, the patient should be classed as having neuropathy.

6.7 Step 3 – Check the blood supply

Palpate the dorsalis pedis and posterior tibial foot pulses. If either one cannot be felt use a hand held Doppler to listen to the signals. A monophasic foot pulse at one or more site would indicate a reduced blood supply and the patient should be classed as having the risk factor of ischaemia or poor circulation.

6.8 Step 4

Search for the presence of deformity or significant callus. The two often appear together and are a risk factor for ulceration as they indicate high pressure areas under the foot.

7.0 Step 5

Does the patient have a visual impairment that stops them checking their feet?
If the answer is yes, and the patient does not have a carer who can check their feet, then this should be classed as a risk factor for ulceration.

Does the patient have a condition such as dementia or a learning difficulty that prevents self-care?
If the answer is yes, and the patient does not have a carer who can check their feet, then this should be classed as a risk factor for ulceration.

Is the patient undergoing renal replacement therapy?
If the answer is yes, then the patient should immediately be classed as being at high risk of developing foot ulceration.

Has the patient had a previous episode of foot ulceration or a previous amputation?
If the answer is yes, the patient should be immediately classed as being at high risk of developing foot ulceration

7.1 Classify the patient's risk level:

<p>At low risk of ulceration: No risk factors identified</p>
<p>At moderate risk of ulceration: Any of the following risk factors have been identified:</p> <ul style="list-style-type: none"> • Neuropathy • Poor circulation • Deformity/callus • Visual impairment • An inability to self-care
<p>At high risk of ulceration:</p> <ul style="list-style-type: none"> • Undergoing renal replacement therapy • History of previous ulceration or amputation • Neuropathy and deformity/callus • Poor circulation and deformity/callus • Neuropathy and poor circulation combined • Any combination of 2 or more risk factors
<p>Ulcerated foot: Ulcerated foot or warning sign of foot ulceration or suspected Charcot</p>

Patients with diabetes who are found to be at risk should be advised to check their feet daily and report problems immediately.

For house bound patients or patients in residential care, a plan for checking the feet should be agreed with the care staff, relative or carer.

Any patient found to have an active foot ulcer, warning sign of foot ulceration or suspected Charcot arthropathy, should be referred to the podiatry department within 24 hours.

All patients who are found to be at risk should be referred to podiatry for on-going care and education:

Podiatry Administration hub,
St Edmunds, Victoria Park Road, Torquay.
☎ 01803 217712
t-sd.podappts@nhs.net

(Appendix 2 – Referral pathway and foot screening tool)
[Referral Pathway and Screening Tool](#)

8.0 Inform the patient of their risk level and issue with the appropriate leaflet.

A series of 2 minute videos for each of the risk levels, low, moderate, high risk and ulcerated foot are now available in the healthcare videos library.

[Diabetes Foot Risk Level Videos](#)



These can be shown to the patient during the consultation or be accessed at a later date.

- [Charcot Foot \[.pdf\]](#)
- [Looking after your diabetic foot ulcer \[.pdf\]](#)
- [Advice about your footwear \[.pdf\]](#)
- [High-risk feet \[.pdf\]](#)
- [Holiday feet \[.pdf\]](#)
- [Low risk \[.pdf\]](#)
- [Moderate risk \[.pdf\]](#)

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.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	2414		
Document title:	Diabetic Foot Screening for Primary Care and Community Teams		
Purpose of document:			
Date of issue:	09 August 2019	Next review date:	09 August 2022
Version:	1	Last review date:	
Author:	Lead Diabetes Podiatrist		
Directorate:	Allied Health Professionals		
Equality Impact:	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		
Committee(s) approving the document:	Care and Clinical Group		
Date approved:	17 June 2019		
Links or overlaps with other policies:			

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes <input type="checkbox"/>	
	Please select Yes No	
Does this document have implications regarding the Care Act? <i>If yes please state:</i>	<input type="checkbox"/>	<input type="checkbox"/>
Does this document have training implications? <i>If yes please state:</i>	<input type="checkbox"/>	<input type="checkbox"/>
Does this document have financial implications? <i>If yes please state:</i>	<input type="checkbox"/>	<input type="checkbox"/>
Is this document a direct replacement for another? <i>If yes please state which documents are being replaced:</i>	<input type="checkbox"/>	<input type="checkbox"/>

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
09 August 2019	1	New	Care and Clinical Group

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

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)

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

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pdf.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes No

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our [GDPR](#) page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdf@nhs.net,
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [Data Protection](#) site on the public internet.