Swinging sugars, dancing feet: what's the DSN got to do with it?

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Joan, like so many others with type 2 diabetes, was very reluctant to switch to insulin. It took several months for her to give it a try. It was not an easy transition and involved many visits and frantic phone calls. One I remember in particular was when, instead of pushing the pen plunger down to inject, she had carried on twisting it up. I will never know how many units of insulin she had received on that occasion!

Then at last the phone calls stopped and all seemed well. The next call from Joan was to tell me that she had been in hospital to have her big toe amputated.

Education is the key

Not once during this period of care had I examined Joan's feet, checked her footcare knowledge or even asked her about her feet. I was too intent on controlling her blood sugars. I am a DSN with a passion for the diabetic foot and was horrified that by focusing on the job in hand I had failed to address wider issues of diabetes care. On this occasion I had on my diabetes control hat, not my foot hat.

These gruesome results of end-stage neuropathy should act as a reminder to us that footcare messages — particularly for those with at-risk feet — need to be reinforced in every way possible and at every opportunity.

Scale of the problem

I recently attended a concert given by Tina Turner (wearing 4-inch stilettos). As I looked around, I was reminded that perhaps 5–10% of the thousands filling the arena have diabetes. All around me were high-heeled shoes thrusting metatarsals down onto unpadded soles, and open-toe sandals with fourth and fifth toes splaying out onto a floor littered with cigarette butts and lager. I wondered how many at-risk feet there were — feet that due to sensory neuropathy were unable to tell their owners how much they were being abused.

Who should provide education?

One of the problems with diabetes foot care is that the responsibility lies between disciplines. Whose responsibility is footcare education? Unlike commencement of insulin therapy, which traditionally has been seen as the role of the DSN, foot education could be and indeed is given by general practitioners, practice nurses, district nurses, podiatrists, orthotists, vascular surgeons, diabetes physicians and DSNs. This haphazard and confusing situation may mean that some people with diabetes receive good education, others receive poor education and unfortunately some, like Joan, receive no education.

DSNs naturally

It has been suggested that the best time to give foot education is at the time of the foot assessment when the inability to feel pain, pressure and heat can be clearly demonstrated to the patient. However, teaching footcare to patients with sensory neuropathy is a considerable challenge. Careful consideration must be given to the educational strategies needed to overcome the barriers to learning brought about by possible denial and lack of sensation.

If any of the healthcare practitioners mentioned above have the necessary skills to undertake such teaching it has to be the DSN and yet it would seem that at the very time that patients need a skilled, experienced educator most of us are busy starting people on insulin, which could be seen as a less challenging educational feat.

Many of the patients I meet with end-stage diabetic foot disease declare that they have never received any foot education. I do not know whether the education was such that it passed by unrecognised or was cast aside as irrelevant (because the patient's health belief was that he/she was not at risk), or whether in fact no education had been given. Certainly the often heard, 'Your feet are a little numb — you need to take care of them', is not sufficient for patients to take on board the vital information and practices needed to preserve their feet.

Footcare organisation

Footcare is not only about patient education. As DSNs we need to be certain that our localities have good organisation of foot services for people with diabetes, as suggested by the Report of the UK St Vincent Diabetic Foot and Amputation

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Group (1995) and more recently the International Consensus and Practical Guidelines published by the International Working Group on the Diabetic Foot, (1999). Both these call for:

- Healthcare practitioners in primary and secondary care to be skilled in, and understand the importance of, regular foot screening and education.
- Adequate provision of podiatry and orthotic services.
- Fast track referral routes to a multidisciplinary specialist foot care team when necessary.

Rayman (2000) suggested that DSNs show a lack of interest in the diabetic foot. I was initially surprised at this statement, but then remembered how few DSNs were at the last four foot conferences I have attended. I have also been surprised by the lack of knowledge shown by many community- and hospital-based nurses whom I teach.

Conclusion

We cannot afford to be complacent. Diabetes does not have a good track record as far as the foot is concerned. Amputation rates appear to be increasing rather than decreasing (Hewitt, 1994) and the St Vincent aim of reducing them by half still seems to be a dream for the future. As DSNs we are particularly well equipped to reach and teach patients, carers and other healthcare practitioners about the diabetic foot. Not only do we have the knowledge of diabetes, but we have also learnt the motivational education techniques needed in this notoriously difficult area of diabetes. ■

Rayman A (2000) Nursing aspects of diabetic footcare. *Practical Diabetes International* **17**(4)supp: s3

Hewitt D (1994) Data currently available to the Department of Health. In: Dawson A and Ferrero M (eds) (1996) *Chronic Disease Management Register*. HMSO, London: 34–8

International Working Group on the Diabetic Foot (1999) *International Consensus on the Diabetic Foot.* International Working Group on the Diabetic Foot, Amsterdam

UK St Vincent Diabetic Foot and Amputation Group (1995) Report of Diabetic Foot and Amputation Group. *Diabetic Medicine* **13**(Supp4): s27–s43

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