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Editor

Innovation and teamwork

From the results of the UK Diabetes Prospective Study (UKPDS), which were presented in Barcelona at the 34th Annual Meeting of the European Association for the Study of Diabetes, it is evident that optimal control of blood glucose, blood pressure and obesity will significantly lessen the risks of tissue complications. Clearly the message to all patients and health care professionals is to work together to lessen the burden of disease.

This issue contains a number of articles highlighting new innovations and the need for teamwork in diabetic foot care. In Jones' wound care series (p.88), the focus is on debridement. The article describes the various methods of debridement including the mechanical technique of sharp debridement. This raises the question of responsibility of care and scope of practice.

Major debridement of wounds is considered the surgeon's responsibility, while minor debridement of foot ulcers is often seen as the domain of the podiatrist. Jones points out that since the expansion of specialist diabetic foot clinics, this procedure is now also performed by nurses.

Training and accountability

This advanced practice skill requires training and considerable experience. There may be advanced courses for nurses which include the acquisition of this technique in the management of diabetic foot problems. If not, it raises the issue of training and accountability. It may be that much of diabetic foot care is carried out in the community sector. It is incumbent upon all those interested parties to ensure that standards of foot care are equitable across the population. Failure to do so may lead to an increase in foot ulceration and amputation. When additional resources are made available, it would be prudent to invest in education and training. Without this basic foundation, future foot care may be jeopardised.

The first of a two-part series on professional education (p.109) reviews the pathways traditionally followed by members of the foot care team. It also explores some of the teaching and learning strategies adopted by some of the professions. The second part will explore the particular knowledge and skills required by different members of the team to effect optimal team management of diabetic foot problems. The development of the professionals and the changing scope of practice has to be nurtured. How best the diabetic population benefits from these changes is yet to be evaluated.

Importance of team support

The transference of innovative and best practice to the patient population depends upon a number of factors. Evidence-based medicine may be sparse in the field of diabetic foot care. The article by Whyte on the Newcastle Optima Slipper (p.95) is a case in point. The slipper may be one of the most appropriate methods to offload the neuropathic foot, and the experience from Newcastle suggests that this is so. However, until a clinical audit is performed, — which Newcastle are doing — it is difficult to predict how many centres will try out this particular therapy. New innovative practices need the support of the entire team, without which, many individual members may be reluctant to persevere.

A team approach is certainly required when dealing with the poorly vascularised foot. Fowler and Mitchell's article (p.105) describes the appropriate assessment of the ischaemic foot and emphasises the importance of timely and appropriate referrals to the vascular surgeon. Many members of the diabetes foot care team may have the necessary skills to assess the vasculature of the diabetic patient, and refer patients to vascular services for further opinion, detailed assessment and treatment accordingly. However, despite best intentions, anecdotal evidence suggests that many referrals are delayed or inappropriate. There may be a variety of reasons for this.

It is the responsibility of all those involved in diabetes foot care to find out the appropriate routes of referral and the clinical criteria that warrant swift intervention. ■

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