Australian Podiatry Association

SUBMISSION TO THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

FEBRUARY 2020

The Hon Tony Pagone
Chair, Royal Commission in to Aged Care Quality and Safety.

Re: Australian Podiatry Association Submission to the Royal Commission in to Aged Care Quality and Safety

The Australian Podiatry Association has prepared the following submission to the Royal Commission in to Aged Care Quality and Safety.

The submission comes after much careful consideration of the concerns raised throughout the Interim Report of the Royal Commission. The Interim report presents great cause for disappointment, anger and frustration at the apparent neglect being displayed throughout various aspects of Australia's aged care sector. Feedback from numerous podiatrists working within this sector echo these sentiments and we all must clearly work harder to ensure the adequate and safe care of older Australians.

It is the responsibility of all residential aged care facility stakeholders including governments, regulators, proprietors and their employees, to ensure the standards of care are such so that residents and their loved ones can be confident of experiencing a better quality of life than they are currently receiving.

Australia has one of the best health systems in the world and it is a great shame to us all that the standards of care being delivered to some of our more vulnerable community members has been lacking when being provided through many residential aged care facilities.

The Australian Podiatry Association wholeheartedly supports the extensive work being undertaken through the Royal Commission and we have based our submission on real life evidence from dedicated podiatrists working within the sector.

Yours sincerely

Katrina Richards
President
Australian Podiatry Association

CONTENTS

EXECUTIVE SUMMARY

Podiatrists provide safe, professional and effective clinical care services in Residential Aged Care Facilities (RACFs) and provide essential services to support daily living. Podiatrists should be an integral part of any health care team operating in a residential aged care facility, however many patients in residential aged care facilities, particularly those with complex medical conditions who are often predisposed to poor foot health, are denied specialised foot health care. With an ever-increasing number of residents in aged care facilities requiring foot health care services, the need for podiatry services as a standard in such facilities cannot continue to be overlooked.

There is significant evidence of patients with high risk or chronic conditions such as diabetes not being provided with adequate neurovascular and other relevant testing and analysis. Given the prevalence of patients that are at high risk of lower limb complications with complex chronic health needs, it is absolutely essential that residential aged care facilities enable podiatrists to perform a range of relevant neurovascular, lower limb and foot assessments as a means of ensuring their ongoing foot health care needs of patients continue to be met.

Failure to provide adequate podiatric care can have serious implications. Pressure injuries, injuries from falls, blisters and wounds leading to ulceration are common amongst those in residential homes.

Patients in RACFs should be provided ongoing podiatric treatment on a more regular basis than would appear to be in place at RACFs at present. Such irregularity of podiatric treatment significantly increases the risk of developing infections or wounds, particularly for those identified through assessment as being at higher risk of such complications.

Conditions such as diabetic foot disease is a complex condition that is not easily identified, prevented or treated and if inadequately treated can result in serious complications including lower limb amputation and death. Sadly there are too many examples of the consequences of poor management of foot related complications resulting from poorly managed diabetic foot conditions.

The Australian Podiatry Association advocates for the promotion of foot health in Australia and welcomes this opportunity to submit to the Royal Commission in to Quality and Safety in Aged Care.

SECTION 1:

Podiatry care for people living in Residential Aged Care Facilities

Introduction

The Australian Podiatry Association (APodA) is the largest and oldest peak body representing podiatry and promoting foot health in Australia. We support our members with opportunities to develop their professional career, uphold standards and build connections.

We are committed to the advancement of podiatry to improve foot health in the community, enabling mobility and independence across the lifespan. The positive impact of podiatric care changes the lives of one in five Australians who suffer from foot pain.

The APodA advocates for better foot health and podiatric care provision for older Australians and aged care recipients. As people age, their health needs tend to become more complex with a general trend towards declining capacity and the increased likelihood of having one or more chronic diseases (WHO **https://www.who.int/ageing/health-systems/en/**). Podiatry is essential to the integrated care of older people.

Current evidence indicates that many older Australians are not receiving the standard of podiatric care needed to prevent lower limb and foot complications within the residential aged care setting.

Risks associated with this lack of appropriate foot care include increased falls risk; reduced mobility and independence; exacerbation of chronic physical and mental health problems; wound infection; lower limb amputation; and reduced quality of life.

Foot health in older Australians

Mobility in an ageing population is paramount to maintaining independence, dignity and quality of life. The ageing foot presents particular challenges in its management and treatment.

With the average person aiming for 10,000 steps per day, an 80-year-old foot could have walked over 290 million steps in a lifetime.

As a consequence the structures of the foot are often compromised It should therefore come as no surprise to learn that the fatty padding in the foot, either under the heel or the ball of the foot, can be considerably reduced in the ageing patient. The combination of pressure and reduced protection produces pressure-related problems unique to the foot; callouses and corns over boney prominences and metatarsal heads, heel pain from standing and walking, inter-digital neuromas and bursas or capsulitis.

As well as physical changes, there are often cognitive impairments related to chronic disease and complex medical presentations in the aged. Impairment in memory, loss of concentration, impairment in focus and judgment can affect personal care (1). These mental capacity deficits produce a higher risk profile for the aged foot, which requires professional input of a podiatrist as a regular provider of foot care.

With an increasing number of older adults, no longer being able to live independently and an ever-increasing number of residents in aged care facilities requiring foot care, appropriate allocation of podiatry services is required.

(1) McIntosh IB. The ageing foot – a challenge for the Chiropodist and Podiatrist. Podiatry Review. 2014 May-June.

Of particular concern is the rate of older Australians aged 65 and over reported to have diabetes. Based on the Australian Bureau of Statistics (ABS) 2014-15 National Health Survey (NHS), around 1 in 6 people aged over 65 reported having diabetes. The rate of diabetes tends to increase with age, with the highest prevalence (19.4%) reported in people aged 85 and over.

The most recent data highlighting the prevalence of Diabetes from the National Diabetes Services Scheme (NDSS) Australia is below. These figures represent only those registered with the NDSS and grossly underestimated the number of older Australians with diabetes.[2]

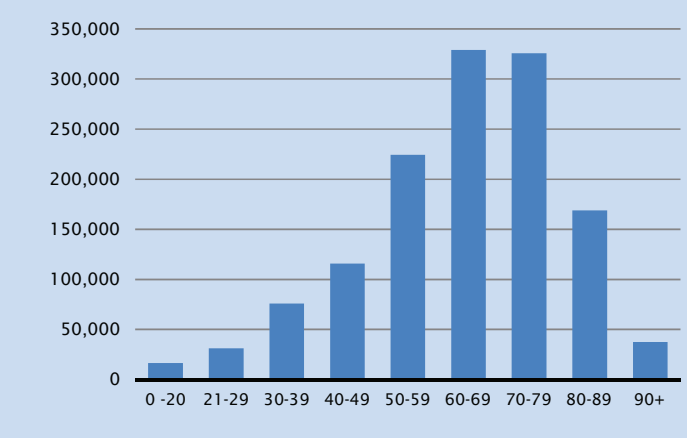
As at 30 September 2019

There were 1,324,948 people with diabetes registered with the NDSS

Diabetes Type	Number	%	Registered in Past Year
Type 1	121,076	9%	3,466
Type 2	1,153,748	87%	57,509
Gestational*	41,176	3%	41,176
Other	8,948	< 1%	1,067
Total	1,324,948	100%	103,218

*An additional 181,478 women who previously had gestational diabetes are registered with the NDSS. These women are at high risk of developing type 2 diabetes and receive regular reminder letters to have a diabetes check.

All People With Diabetes by Age Group



Over the last 12 months 103,218 people with diabetes were registered with the NDSS

Equivalent to 283 new registrants every day

Of these new registrants, 158 had type 2 diabetes, nine had type 1 diabetes and the remaining had either gestational or other diabetes

8,570 people with diabetes were aged 15 years or under

16,680 people with diabetes were aged 20 years or under

31,402 people with diabetes were aged 21 to 29 years old

75,911 people with diabetes were aged 30 to 39 years old

860,646 people with diabetes were aged 60 years or older

Diabetes can result in a number of acute and chronic health conditions including nerve damage, (neuropathy), increased risk of infection and delayed wound healing, which can lead to lower limb amputation and morbidity. Early intervention and management are essential to preventing complications leading to amputation.

(2) https://www.ndss.com.au/wp-content/uploads/snapshots/2019/ndss-data-snapshot-201909-all-types-diabetes.pdf

Current best evidence states that diabetic foot disease necessitates a coordinated, interdisciplinary approach that harnesses the complementary skills of medical, surgical, allied health disciplines and nursing.[3]

Without access to such coordinated interdisciplinary systems, more patients end up in hospital, stay longer, and undergo more amputations.[4]

More than 40% of diabetes related foot ulcers will become infected at some point, many will result in amputation.[5]

Podiatric care to reduce falls risk for older Australians

Falls in older people are a major public health problem. As people get older, they may fall more often for a variety of reasons including problems with balance, poor vision, and dementia. Approximately 30% of people over 65 years of age living in the community fall each year.(6)

Falls prevention guidelines recommend referral to a podiatrist. Podiatry treatment is effective in preventing falls in older people with disabling foot pain. Podiatry intervention is associated with a 36% reduction in the rate of falls in community dwelling older people.(7)

A recent systematic review and meta-analysis in to podiatry interventions to prevent falls in older people, stated the following key points:

- Podiatry interventions reduce falls in older people who live in their own homes.
- Referral to podiatry services provides reductions in falls.
- There is a strong case for trials of podiatry interventions to reduce falls in care homes.(7)

(3) Australian Diabetes-Related Foot Disease Strategy 2018-2022 – Diabetic Foot Australia

(4) Australian Diabetes-Related Foot Disease Strategy 2018-2022 – Diabetic Foot Australia

(5) Source Diabetes Australia

(6) Gillespie_LD, Robertson_MC, Gillespie_WJ, Sherrington_C, Gates_S, Clemson_LM, Lamb_SE.

Interventions for preventing falls in older people living in the community.

(7) Martin J Spink,[1,2] Hylton B Menz,[1] Mohammad R Fotoohabadi,[1] Elin Wee,[1] Karl B Landorf,[1,2] Keith D Hill,[1,3,4] Stephen R Lord,[5,6] Effectiveness of a multifaceted podiatry intervention to prevent falls in community dwelling older people with disabling foot pain: randomised controlled trial

Podiatry service provision in RACFs

Podiatrists should be an integral part of any health care team operating in a residential aged care facility because they play a significant role in the overall health and wellbeing of resident. Podiatry care has a direct impact on the mobility and quality of life of its residents. Mobility in an ageing population is paramount to maintaining dignity, independence and quality of life.

Podiatrists are qualified to offer safe, professional and effective clinical care services in residential aged care facilities. They are equipped with the skill set to provide essential services which support consumers in their activities of daily living. Essential services provided by a Podiatrist include regular assessment and treatment of the feet and lower limbs. Podiatry assessment and care focuses on alleviating foot pain to enhance quality of life, wound and pressure injury management to decrease the risk of complications such as ulceration and amputations, and footwear assessment/ recommendation/fitting to assist with falls prevention.

Where possible podiatrists should work as part of the Residential Aged Care Facility team collaborating with staff (for example, physiotherapy, GPs and nurses) in specific treatment programs and at times, identifying other health and welfare requirements. Podiatrists in RACFs should be responsible for regular basic foot care needs which includes cutting toenails, wound care, removal of corns and calluses, attending to dermatological issues i.e. tinea and ensuring that residents feet are in adequate condition to ensure they are able to carry out their daily activities. Podiatrists undertake these responsibilities using specialised equipment and consumables and must ensure that the instruments utilised are sterilised following Australian standards. These basis care needs are not able to be undertaken by other health professionals or staff at RACFs as they have not received adequate training and qualifications and do not have the adequate equipment to undertake this safely.

Podiatrists also undertake:

- The prevention, diagnosis, treatment and rehabilitation of medical and surgical conditions of the feet and lower limb
- Management of skin and nail disorders, corns, callouses and ingrown toenails, foot infections and ulcerations
- Treatment of the effects, on the feet and lower limb, of chronic disease and common conditions including bone and joint disorders, as well as neurological and circulatory disease
- Falls prevention, safety, maintenance of mobility and independence with regards to footwear and lower limb biomechanics

As a registered health professional podiatrists have obligations to maintain their registration under national law and have duties and responsibilities through various government funding schemes when providing services.

Practitioners have a duty to make the care of patients their first concern and to practice safely and effectively. Patients trust practitioners to act ethically and believe that in addition to being competent, practitioners will display qualities such as integrity, truthfulness, dependability and compassion. Maintaining a patient's dignity and informed choice in services provided should be at the core of any services provided.

Failure to provide adequate podiatric care to residents can lead to costly adverse health outcomes and diminish quality of life.

SECTION 2:

Inadequate podiatric care being provided by Residential Aged Care Facilities

Summary of recommendations

Recommendation 1:

Upon admission in to an RACF each patient should receive a full podiatric assessment including a neurovascular assessment and care plan.

Recommendation 2:

Treating podiatrists should be able to use their clinical judgement to determine how many residents to see per hour. For patients on Chronic Disease Management plans the duration must be 20 minutes minimum.

Recommendation 3:

Each resident should have a podiatry service every 6-8 weeks and more frequently for chronic or at risk patients or as deemed clinically appropriate by the treating podiatrist.

Recommendation 4:

Where a foot wound, blister or pressure injury is identified by staff a referral to a podiatrist and review should be completed as soon as possible and a podiatrist should play an integral role in all foot wound management.

Inadequate podiatric care provision by Residential Aged Care Facilities

The purpose of podiatric care in residential aged care facilities is to keep residents mobile and independent. Substandard care provided to residents can have a significant impact on their quality of life both physically and mentally.

Existing accreditation standards for residential aged care facilities as set out in the Aged Care Quality Agency's Quality of Care Principles include care and services to be provided for all residents who need them (section 3.11 Therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services). Despite this standard we are aware of generally substandard podiatric care being delivered to aged care residents as reported by a number of podiatrists across Australia.

Where appropriate we have mapped our information and recommendations to the Aged Care Quality Standards they refer to.

Aged Care Quality Standard 1: Consumer dignity and choice and

Aged Care Quality Standard 2: Ongoing assessment and planning with consumers.

Residents entry into care

Substandard care can be apparent from a resident's entry into the care home. All residents should have a complete podiatric assessment and patient care plan developed upon entry. This is especially relevant for residents who are at high risk of lower limb complications or those who have chronic conditions such as diabetes who should be provided with a full lower limb and foot neurovascular assessment upon admission.

However, we see evidence of patients with high risk or chronic conditions such as diabetes not being provided with a full neurovascular assessment. Such assessment evaluates the sensory and motor functions as well as circulation and is critical to include in a patient care plan for patients with diabetes.

Given the prevalence of residents that are at high risk of lower limb complications with complex chronic healthcare needs it is absolutely essential that on admission to a residential aged care facility a podiatrist must perform a neurovascular lower limb and foot assessment.

Continued monitoring of patient care plan

When a patient's care plan with goals is developed it may act as a means for facilities to meet accreditation standards and "tick the boxes" rather than achieving health outcomes for the residents. The goals should be taken note of by the facilities and these plans should be available to anyone in the health care team and be monitored and reviewed regularly. Patients should be directly involved in care planning and any goals set. The podiatry assessment and care plan should be undertaken every 12 months and must include:

- Identification of clinical risk level
- Residents podiatry goals
- Podiatry recommendations
- A 12-month review to assess foot status, goals and recommendations met or not met

Recommendation 1:

Upon admission in to an RACF each patient should receive a full podiatric assessment including a neurovascular assessment and care plan.

Aged Care Quality Standard 3: Personal care and clinical care

Aged Care Quality Standard 4: Services and Supports for Daily Living

Podiatry versus foot care

Podiatry is an essential service for organisations running residential aged care facilities. Feedback from the podiatry profession indicates that in actual fact 'podiatry' in many cases is not the service that residents are receiving. In many instances they are receiving nail care without adequate time or resources to provide an appropriate podiatric service.

Whilst the service of general foot care for residents is vital to support their independence and ability to perform daily living tasks many of these residents have complex healthcare needs which require a qualified podiatrist to assess diagnose and treat effectively.

We understand that many podiatrists employed are contractually obliged to treat a number well in excess of what is clinically appropriate leaving limited time for correct assessment and podiatric intervention. Whilst many residents require basic foot care such as nail care and management of common skin and nail disorders many patients will require treatment of corns, calluses, blisters and ingrown toenails. Residents with more complex health needs may require correct diagnosis and treatment foot infections, wound management, pressure injuries and ulcerations. Podiatrists are trained to recognise the seriousness of such conditions and treat and refer appropriately. If they are required to treat a set number of patients per visit this may not leave time to give the care needed to such complex patients.

Whilst general foot care and maintenance is sufficient for some residents, podiatric care is essential to those that require ongoing monitoring of any complex or chronic conditions, pressure injuries, wound management, ulceration or blisters.

How many residents per hour should a podiatrist see?

The answer to this question stems from three things:

1. ensuring residents receive an appropriate level of care,
2. ensuring compliance with funding legislation
3. the location of where these services take place.

The appropriate level of care for each resident varies depending on their clinical need and risk level. Evidence shows many facilities are encouraging over 30 residents be seen per day. This cannot be providing adequate care for residents.

Our recommendation is based on treating three patients per hour over an 8-hour day allowing for variance in time spent with each patient based on the podiatrists clinical judgement.

The podiatry service may be funded as a result of various Commonwealth funding such as Department of Veterans Affairs, or the Medicare Chronic Disease Management funding program (CDM). Medicare requires that the service is of at least 20 minutes' duration. If there are more than three residents per hour being seen (or more than 20 in a day), then there is an issue with compliance and risk to resident care: **https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-health_pro-gp-pdf-allied-cnt.htm**

Depending on the location of where services are delivered this can add to the time it takes to treat each patient effectively. Ideally a dedicated treatment area for the provision of podiatry services should be supplied by the facility rather than a bed to bed service and the relevant infection and prevention procedures be put in place. Effective infection prevention and control is central to providing high quality care for patients and a safe working environment for those who work in a health care setting. Podiatrists must adhere to the National Health and Medical Research Council (NHMRC) Australia guidelines for the prevention and control of infection in healthcare.

Recommendation 2:

Treating podiatrists should be able to use their clinical judgement to determine how many residents to see per hour. For patients on Chronic Disease Management plans the duration must be 20 minutes minimum.

How often should a podiatrist see each resident?

Podiatrists provide residents with foot care based on a clinical need. Clinical need is determined in the Podiatry Assessment and Care Plan which is performed on an annual basis, or sooner if the resident health status changes or

they have risk factors in which evidence supports more regular review. The industry standard for podiatry is 6-8 weekly consults. This means that each resident would typically receive 6.5 visits per annum.

Recommendation 3:

Each resident should have a podiatry service every 6-8 weeks and more frequently for chronic or at risk patients or as deemed clinically appropriate by the treating podiatrist.

The use of Chronic Disease Management referrals as funding for podiatry treatments

There are reports of a misuse of government funding within facilities, in particular the utilisation of chronic disease management funding through Medicare (CDM). Many RACFs are engaging podiatrists to treat a number of residents **only** if they have a valid CDM referral. In these instances RACFs are using this funding mechanism to service podiatric care and not paying for this service out of their own operating budget. A Medicare rebate is available for a maximum of five allied health services per patient per calendar year. If a patient is to be provided ongoing podiatric treatment, this equates to visits every ten weeks which is below the recommended industry standard of 6-8 weeks for general foot care.

- Some residents will not have access to all 5 visits for podiatry treatment as they may need other allied health services as part of the CDM referral
- Some residents require more regular podiatry than 10 weekly due to poor neurovascular status or being immunocompromised. These patients are at a high risk of developing infections or wounds if their feet are not attended to in a timely manner.

Utilising just the CDM referral for podiatry care may represent a breach of the Medicare Policy. The Policy states that the Medicare-rebatable allied health services should not replace services that are expected to be provided by the facility and at no additional cost to the resident. See section 8.12 of the questions and answers on the chronic disease management (CDM) items: **https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement-qanda#through**

It also states that residents should not routinely be referred for allied health services under Medicare. Therefore, residents who do require more frequent visits than 10 weekly or who don't have a current CDM and require podiatry should have this service paid for by the facility. Evidence obtained via our large survey of podiatrists within Australia working in this setting confirmed that in a majority of sites they are asked to only see residents 10 weekly as to not use any direct facility funding.

Facilities who are relying on government health funding through the chronic disease management program are putting their resident's health at risk by not providing podiatry services every 6-8 weeks or prior based on the treating podiatrists clinical recommendations. When serious health issues arise where a resident is required to be treated more frequently, by relying on the CDM service they are detracted from providing adequate care to those residents.

Aged Care Quality Standard 3: Personal care and clinical care

Failure to provide adequate podiatric services to residents with diabetic foot disease

Failure to provide adequate podiatric care can have serious implications. This is particularly concerning for the patient cohort seen within residential homes. Pressure injuries, injuries from falls, blisters and wounds leading to ulceration are common amongst those in residential homes.

Diabetic foot disease (DFD) is among one of the most serious complications associated with diabetes mellitus. DFD is a

complex condition that is not easily identified, prevented or treated. Diabetes can result in a number of acute and chronic health conditions affecting the feet, which includes loss of protective sensation (neuropathy), reduced blood supply (peripheral vascular disease) and delayed wound healing. Diabetic foot disease without appropriate prevention strategies in place can lead to the development of diabetic foot ulcers which without appropriate management can lead to lower limb amputation and death.

DFD is Australia's leading cause of amputations, is within the top 20 causes of all hospitalisations, has mortality rates worse than many cancers, and costs Australia an estimated $1.6 billion each year. Patients who develop DFD also need more consultations, referrals and hospitalisations than patients with heart disease, kidney disease or cancer.[8]

Table 1: Estimated burden of diabetes-related foot disease in Australia each day[9]

CHARACTERISTIC	AUSTRALIA [a]	PER 100,000 [b]
Populations		
People with diagnosed diabetes [c]	1,250,000	5,000
People at-risk of DFD [d]	300,000	1,000
People living with DFD [e]	50,000	200
Morbidity		
People with a previous diabetes-related amputation [f]	12,500	50
People in public hospital because of DFD [g]	1,000	4
People undergoing a diabetes-related amputation [h]	12	1 every 20 days
Morality		
People dying DFD [i]	4	1 every 60 days
Costs		
Estimated cost to public hospitals from DFD [j]	$1 million	$4,000
Estimated cost to all health systems from DFD [k]	$4.3 million	$18,000

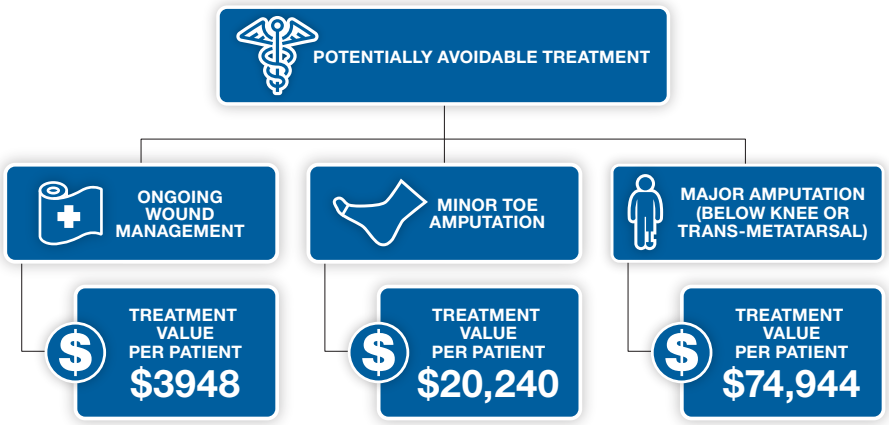
DFD = Diabetes-related foot disease; a Estimated burden for the 24,450,000 resident population of Australia in 2017 (14); b Estimated burden for every 100,000 resident population of Australia in 2017 (i.e. 100,000 / 24,450,000); c Number of Australians with diagnosed diabetes in 2017 (15); d Prevalence of those at-risk of DFD (~24%) (16-19) x number of Australians with diagnosed diabetes in 2017 (15); e Prevalence of those with DFD (~4%: 3% ulcer (with or without infection (17,19-21)) + 1% critical ischaemia (revascularisation) (17)) x number of Australians with diagnosed diabetes in 2017 (15); f Prevalence of those with a previous diabetes-related amputation (~1%) (22,23) x number of Australians with diagnosed diabetes in 2017; g Prevalence of inpatients in hospital each day for the primary admitting reason of DFD (~2%) (6,7) x available overnight public hospital beds in Australia in 2013-14 (49,153) (24); h Numbers of diabetes-related lower limb amputation hospital admissions in 2012-13 (4,402) (13) / 365 days in a year; i Number of deaths with DFD recorded as a cause of death in 2005 (1,700) (12,25) / 365 days in a year; j Estimated direct costs incurred by DFD to the Australian Public Hospital System in 2015 ($348million) (11,26) / 365 days in a year; k Estimated direct cost incurred by DFD to the Australian Health System in 2015 ($1.57billion) (11,27) / 365 days in a year.

Early intervention and management are essential in preventing diabetic foot ulceration and maintaining a person's quality of life, mobility and preventing avoidable lower limb amputation. Podiatrists play an essential role as part of preventing diabetic foot ulceration and management of diabetic foot ulcers.

(8) Pathway to ending avoidable diabetes-related amputations in Australia journal article

(9) Australian Diabetes-Related Foot Disease Strategy 2018-2022 – Diabetic Foot Australia)

Economic benefit of timely podiatric treatment with cost-effective scheduled medications[1]



Strategies for preventing diabetic foot ulceration and lower limb amputation include identifying those at risk, performing regular foot inspections, providing education to clients, their family and health professionals, ensuring that appropriate footwear is consistently worn and treating risks factors for ulceration. Clients who have developed neuropathy, peripheral vascular disease and foot deformities require a comprehensive assessment of their feet and regular ongoing podiatric care to treat and reduce risk factors associated with ulceration. This may include the removal of abundant callus, protecting blisters, treating ingrown or thickened toenail and management of other dermatological conditions such as fungal infections.

There are more than 4,400 amputations every year in Australia as a result of diabetes. Government data now show a limb is lost every two hours in Australia. (10) More than 40% of diabetes related foot ulcers will become infected at some point, with more than half of those requiring hospitalisation, many will result in amputation. Patients with diabetic foot ulcers have morbidity and mortality rates on par with aggressive forms of cancer.[11]

(10) Australian Commission on Safety and Quality in Health Care. The first Australian atlas of healthcare variation. Sydney: ACSQHC, 2015. https:// www. safetyandquality.gov.au/atlas/atlas-2015/

(11) Sources Diabetes Australia

Inadequate training of staff and lack of understanding of the risks of wound management

Podiatrists are the experts in recognising, treating and debriding foot wounds. In many facilities it is the registered nurse who is expected to fulfil this role and even more concerning the personal care assistant is exposed to podiatric conditions without understanding of the implication of not treating such concerns. Registered Nurses are not, in general trained to recognise, treat and debride foot wounds. They must undergo additional training in order to have met that competency level.

Personal care assistants fulfil the daily tasks of caring for a resident. This includes opportunities to recognise a pressure injury or ulceration on the foot such as showering and dressing of residents. Personal Care Assistants may not recognise or understand the implications of a wound, particularly of a resident with foot neuropathy or patient with high risk foot due to complications of diabetes.

Without painful presentations, health professionals often underappreciate the severity and incidence of DFD and do not prioritise advocacy for the services needed to manage DFD.[12]

Podiatrists are the experts in treating such conditions and should be referred to immediately in every such instance in the interest of delivering quality care and preventing avoidable complications.

Foot dressings left on for weeks or in poor condition

Podiatrists regularly need to apply a foot dressing on residents due to minor abrasions, foot wounds or pressure injuries. This must be documented and appropriate clinical handover to nurses to ensure dressings are removed or replaced for optimal wound care between podiatry visits.

There are many examples of foot dressings which are being left on for weeks at a time because staff are inadequately trained or have limited time to replace dressings. Furthermore, care assistants are unaware of the requirements for ongoing wound management and are inadvertently getting dressings wet, not reporting to nurses that dressings need replacing which may cause further damage and possible infection to those wounds.

Recommendation 4:

Where a foot wound, blister or pressure injury is identified by staff a referral to a podiatrist and review should be completed as soon as possible and a podiatrist should play an integral role in all foot wound management.

(12) Australian Diabetes-Related Foot Disease Strategy 2018-2022 – Diabetic Foot Australia

Aged Care Quality Standard 5: Organisation's service environment

Clinical handover process

Facilities should have a process for podiatry clinical handover including the documenting of such handovers. This is of particular concern for at risk patients.

In all cases where a pressure injury, blister or wound is present there should be a formal clinical handover process between the registered nurse or personal care assistant and the podiatrist and should be documented accordingly.

Podiatry care standards and the accreditation of residential care facilities

We recommend that any accreditation of RACFs should include the sign off of specific podiatry care standards which have been outlined in this submission to ensure adequate care of residents is being met.

The importance of podiatry in ongoing wound management

Many RACFs have made it quite clear that the role of a podiatrist within their facilities is to cut toenails (even fingernails) and not to touch any foot wounds. The problem with this, is that when wounds are discovered during treatments, whether it's an abrasion on a toe, a small superficial wound after removing an ingrown toenail, causing a small bleed from removing a corn or removing a large blood blister and finding an underlying pressure wound. It is their duty of care of a registered podiatrist in Australia to treat such a wound and not just cut the toenails. The treatment of even the smallest superficial wound may include;

- debridement,
- cleaning the area,
- choosing an appropriate dressing depending on the type of wound,
- reviewing the reasons for the occurrence of the wound and implementing strategies to reduce the risk of the wound re-occurring i.e. applying pressure distribution padding, modifying/changing footwear, and
- establishing recommendation of offloading strategies to be implemented by facility staff,
- establishing a dressing regime for the nurses to undertake between podiatry appointments.

It is opinion of the APodA that other professions within in the RACFs do not have the personnel to manage these types of foot conditions and injuries in a way to prevent further complications compared to a podiatrist.

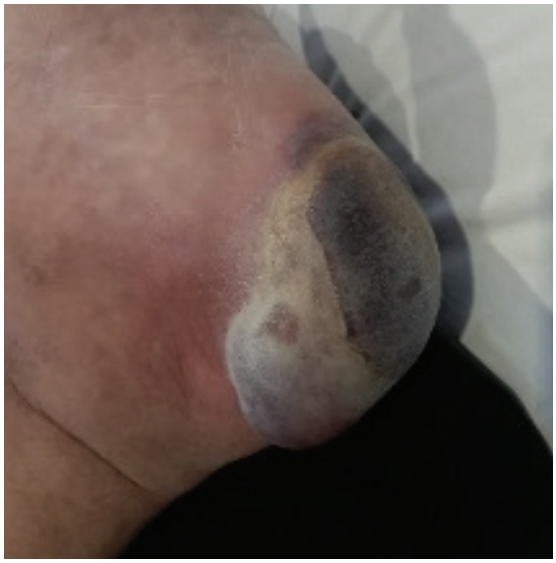
Furthermore, it is widely recognised in international and national evidence-based guidelines that no single healthcare discipline has the breadth of clinical skills to manage all aspect of care for people with DFD. People with DFD need access to regular evidence-based care that requires clinical skills in the assessment and management of metabolic, vascular, neurological, orthopaedic, biomechanical, ulcer and infection aspect of DFD.[13]

(13) Australian Diabetes-Related Foot Disease Strategy 2018-2022 – Diabetic Foot Australia

SECTION 3:

Example cases

Example case 1:

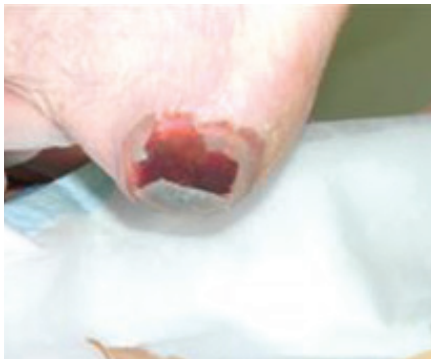


A resident who was at high risk due to an underlying infection developed a blister (unstageable pressure injury) on their heel. The blister grew at an alarming rate and should have been identified by the personal care assistant. A podiatrist who visited the facility every 8 weeks became aware of the blister on their normal treatment round. The blister had developed in such a rate that the podiatrist was extremely concerned that the blister would burst and the potential for a bacterial infection.

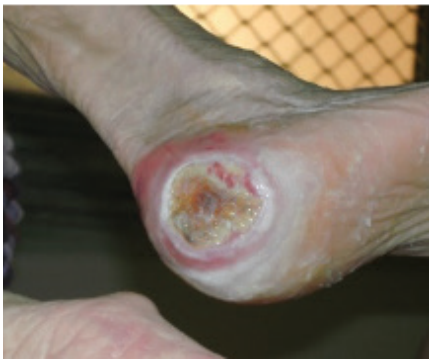
Unfortunately, As the blister was not treated in time it did burst and the resident was not able to fight off the infection. The resident died due to the infection in the days following. The failure to understand the seriousness of this occurrence and refer to a podiatrist between their normal scheduled visits resulted in serious consequences for this resident.

Example of proper podiatric intervention in the treatment of a pressure wound

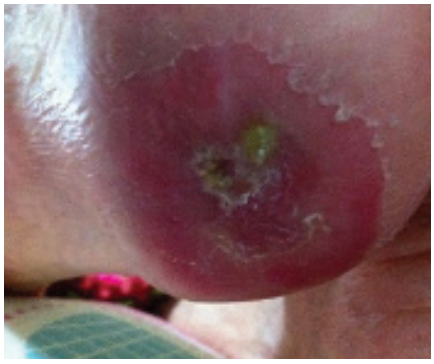
This resident (pictured below) returned to a facility after hospitalisation due to a hip replacement. A pressure injury had developed on her heel which with the correct intervention and adequately trained staff was managed by the nurses and podiatrist and successfully healed.



- Blood blister developed after being in hospital.
- Podiatrist debrided overlying skin and removed some of the congealed blood.
- Podiatrist dressed the wound and applied pressure relief.
- Discussed management with nurses.



- After a few weeks of ongoing care by podiatry and nurses.
- Carers also assisted by not getting the dressing wet during showering and when this occurred they immediately informed nurses.



- It took approximately two months to get it to this stage.
- However the same care is needed as the wound is not yet healed in this picture.

Example case 2:

A 93-year-old resident of a RACF who was receiving monthly podiatry treatment was in fact receiving monthly nail trims. This patient had had multiple conditions including heart conditions, chronic obstructive pulmonary disease, kidney disease, previous history of leg ulceration (triggered by skin biopsy) and other multiple comorbidities. The facility had put restrictions on the podiatrists scope of practice so that they couldn't treat anywhere proximal to the toes. The patient had been complaining to the facility of painful feet for months and had a wound that was not healing. This wound was being treated by a non-adhesive dressing. The patient's daughter decided to seek podiatry treatment outside of the facility through a privately run practice.

It was discovered that this patient had a large foot ulceration on his heel with poorly controlled pressure loading, moisture and fibrous tissue on wound bed interfering with wound healing.

The podiatrist managed to off-load the heel and regular sharp debridement was effective, and after ongoing treatment the wound healed and disappeared eventually in slightly over a month. If left untreated with the inadequate care being received at the facility this could have been a high risk of skin infection and potentially osteomyelitis and amputation if the inappropriate care was continued. Many patients in this position would not have the access to or the understanding to seek such treatment and would remain untreated with serious consequences. In addition, such situations are very difficult for a treating podiatrist who is essentially told they are prohibited in performing their usual scope of practice or loss of position.

SECTION 4

Summary and conclusion

Summary

Recommendation 1:

Upon admission in to an RACF each patient should receive a full podiatric assessment including a neurovascular assessment and care plan.

Recommendation 2:

Treating podiatrists should be able to use their clinical judgement to determine how many residents to see per hour. For patients on Chronic Disease Management plans the duration must be 20 minutes minimum.

Recommendation 3:

Each resident should have a podiatry service every 6-8 weeks and more frequently for chronic or at risk patients or as deemed clinically appropriate by the treating podiatrist.

Recommendation 4:

Where a foot wound, blister or pressure injury is identified by staff a referral to a podiatrist and review should be completed as soon as possible and a podiatrist should play an integral role in all foot wound management.

Conclusion

The Australian Podiatry Association advocates for the promotion of foot health in Australia and welcomes this opportunity to submit to the Royal Commission into Quality and Safety in Aged Care. If any of the points above require further clarification, please do not hesitate to contact us.

Yours sincerely

Nello Marino
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Australian Podiatry Association

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