Alberta Diabetes Foot Care Clinical Pathway

Implementation Guide

The Diabetes Foot Care Clinical Pathway (DFCCP) is a set of evidence-based tools and resources to support providers in performing foot screening exams to determine the education and referrals required for the patients to reduce their risk of developing a foot ulcer. The pathway consists of five steps:

1. **Screening** – Examining the patient's feet
2. **Assessment** – Using the foot screen results to assess the patient's risk
3. **Referral** – Referring the patient to the right provider
4. **Treatment** – The patient receiving the right treatment
5. **Follow-Up** – The patient returning for the next preventative foot screen

This guide is based on feedback from the early adopters of the pathway, who have successfully implemented the pathway into their clinical workflows. It is intended to support primary care providers and teams in implementing the pathway into their practice.

> "*The foot care pathway, with its patient and professional resources, has been a key element in improving our patients with diabetes' outcomes and quality of life. It helped us to start having discussions at a clinic level of how often foot screens were being done, how this data was being captured and how foot risk levels should be incorporated into our care."*
>
> South Zone Primary Care RN

Click on this link to access the Diabetes Foot Care Clinical Pathway: www.ahs.ca/footcare

Key Success Factors to Implementing the Diabetes Foot Care Clinical Pathway

Successful implementation of the DFCCP requires adequate preparation and embedding the pathway into workflow:

Step 1: Preparation *(pre-implementation)*

1) Clearly define who will perform the diabetes foot screen (i.e. RN, LPN)
2) Train the providers who are responsible for performing the foot screen (Resources include the Health Care Provider Guide and Learning modules Saving Limbs and Lives)
3) Understand and map the referral services in your area/community using the Referral Process Guidelines (adapt as needed to reflect local providers). See an example of the Services Map. Identify which High Risk Foot Teams are nearest to your community using the High Risk Foot Teams List. Determine which services are offered through your primary care setting, such as foot care nurses (within practice setting and outside practice setting)
4) Embed tools and referral guidelines into your EMR, and develop reminders and reports indicating who has had a foot screen and who is due for a foot screen; alternatively, document on the paper version of the Foot Screening Tool and scan into the EMR

Step 2: Embed pathway into workflow
(Performing the foot screen and implementing the pathway)

For an overview of this process view the DFCCP Overview

1) Foot Screen – Begin screening patients using the Screening Tool

2) Assess the patients' risk (low, moderate, high, urgent) using the Risk Assessment Form

3) Refer as required (develop formal linkages to referral services, ensure the outcome of the patient is communicated back to the referring provider). Timeline to refer according to risk:

Low	**Moderate**	**High**	**Urgent**
No referral needed	*Within 1-month*	*Within 1-2 weeks*	*Within 24 hours*

4) Have the patients receive appropriate treatment (within your clinic or elsewhere)

5) Determine the follow-up frequency to repeat foot screen based on risk level and follow-up Timeline for follow-up:

Low	**Moderate**	**High**	**Urgent**
1 year	*4-6 months*	*1-4 weeks*	*Once stable*

Consider implementing the pathway in one or two clinics as a pilot; then implement in the remaining clinics once the new tools/processes have been optimized.

Step 3: Ongoing monitoring for the sustainability of the pathway implementation

It is important to track the number of diabetes foot screens performed: use reminders and reports from the EMR to monitor the number of patients in the panel who have received a foot screen and the patients who are due for a foot screen, based on their follow-up timelines.

Barriers and Enablers

Below are some examples of the barriers that you may experience during your implementation and solutions to help you overcome them.

Potential Barriers	Solutions
Time: appointment time allocated with patients is too short to accommodate a foot screen	○ Consider a blitz of foot screen in your clinics ○ Create a foot screen appointment
Tracking: not tracking if a patient has received an annual diabetes foot screen or other diabetes complications monitoring as per Diabetes Canada Clinical Practice Guidelines	○ Care Plan for Adults Diabetes Patient Care Flow Sheet ○ Contact DON SCN™ to be connected to PCNs who have built a tracking template into their EMRs

The DON SCN™ offers guidance on overcoming barriers, finding strategies for successful implementation of the pathway in your clinics/programs, and providing in-person/telehealth education on how to perform a foot screen. Please contact us if you need support: don.scn@ahs.ca