Speaker Abstracts
The effectiveness of EMLA® as a primary dressing on painful chronic leg ulcers – a pilot randomised controlled trial

Anne Purcell1, Andrea Marshall2, 3, Tom Buckley4, Jennie King5, Judith Fethney6, Wendy Moyle2

Affiliations:

1 Central Coast Community Nursing Service, CCLHD
2 Menzies Health Institute Queensland, Griffith University, Australia
3 Gold Coast Health
4 Sydney Nursing School, University of Sydney
5 Nursing & Midwifery Directorate, CCLHD
6 Research Support Unit, University of Sydney

Anne Purcell

Anne has been a Registered Nurse for 36 years and a Nurse Practitioner in the specialty of wound management for 8 years for the Central Coast Local Health District Community Nursing Service and sub-acute facilities. She is currently a PhD candidate at Griffith University, Gold Coast. Her paper today is related to her candidature the title being ‘The effectiveness of EMLA® as a primary dressing on painful chronic leg ulcers – a pilot randomised controlled trial’

Introduction

People living with chronic leg ulcers frequently experience wound-related pain. Eighty-five percent of patients report moderate to severe pain mostly during dressing change which can be unresolved after five weeks. Persistent poorly controlled leg ulcer pain can prevent timely and effective wound management strategies being implemented which can negatively influence wound healing and health-related quality of life (HRQoL). Wound-related pain may not be alleviated by oral analgesics alone. Topical analgesics are occasionally prescribed as primary dressings however, research is limited.

Materials and Methods

We conducted a pilot randomised controlled trial to test the effect of EMLA® on wound-related pain, wound healing and HRQoL when used as a primary dressing. Sixty patients were randomly assigned to receive EMLA® (intervention) or usual care (control). The intervention group received EMLA® daily for 4 weeks followed by usual care. Using validated tools, wound-related pain was measured at every dressing change (pre, during and post change). Wound surface area and HRQoL were measured at baseline, 4 and 12 weeks.
Results

Mean pain scores at baseline were similar in the intervention and control groups (p = 0.84). There was no significant difference in pre-dressing mean pain scores between groups over the intervention period. Mean pain scores for the 4 week intervention period were statistically significantly lower in the intervention group compared to the control group during and post dressing change (Table).

<table>
<thead>
<tr>
<th>Over 4 weeks</th>
<th>Intervention Group</th>
<th>Control Group</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean pain score (95% CI)</td>
<td>Mean pain score (95% CI)</td>
<td></td>
</tr>
<tr>
<td>During-dressing change</td>
<td>3.55 (2.76 – 4.34)</td>
<td>4.94 (4.11 – 5.77)</td>
<td>0.02</td>
</tr>
<tr>
<td>Post-dressing change</td>
<td>2.71 (1.98 – 3.44)</td>
<td>3.92 (3.16 – 4.68)</td>
<td>0.03</td>
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The intervention group used on average 50% less oral pain relieving medications per day during the 12 week study period: intervention group: mean (SD): 0.97 (0.73) v 1.49 (1.12); p = 0.05. There was no difference between the study groups in HRQoL or wound healing rates.

Conclusion

This study suggests that this novel pain relieving strategy may be effective in reducing pain for patients with chronic leg ulcers when used as a primary dressing and does not negatively impact wound healing or HRQoL. Larger studies are required to more comprehensively evaluate this treatment in a larger population before implementation into clinical practice.

Keywords

Chronic leg ulcers, EMLA, pain
Friday 14th August 2015 – Session 3 Free Papers

A randomised controlled trial investigating the impact of prescribed seating in pressure ulcer prevention

Authors: Martina Tierney (1), Professor Suzanne Martin (2), Jackie Casey (2), Olivia McVey (1), Orlagh Daly (2), Martin Cominotto (1)

Affiliations: 1. Seating Matters, Limavady, Co. Derry, Northern Ireland
   PO Box 9, Seven Hills, NSW 1730
   2. School of Life and Health Sciences, University of Ulster, Newtownabbey, Co. Antrim, BT37 0 QB, Northern Ireland

Email Correspondence: olivia@seatingmatters.com

Presenter’s biography: Martina has been an occupational therapist for over 30 years and in that time has worked extensively in the field of seating, postural management and pressure care. As Clinical Director at Seating Matters, Martina oversees the Clinical Team working on research, education and clinical trials. Through these key areas, she aims to continually improve the knowledge available to therapists regarding seating and pressure care.

Introduction: While guidance is available on most aspects of pressure ulcer prevention and management, there has been little discussion of how to specifically address these issues in patients who are seated for long periods. This research investigates the effectiveness of specialist seating provision within a nursing home environment and how it has the potential to impact positively on the health and wellbeing of residents and their caregivers. It will identify the key principles of correct positioning, seating and positioning and the influence this can have on the pressure ulcer incidence of older people.

Materials & Methods: A mixed methods design was ethically approved and employed. Participants were recruited from three long term care settings before random allocation. The control group continued to use their existing seating while the intervention group was provided with seating tailored to their individual needs following a complex assessment. Participants were observed for pressure care, saturated oxygen levels, posture, function and comfort.

Results: This research study demonstrate that specialized seating can contribute to a reduction in pressure ulcer incidence as well as improved posture, saturated oxygen levels, functional ability and social interaction. Seven of the intervention participants who had red skin areas at the beginning of the trial no longer presented with these at the end of the 12 week trial period. None of the intervention participants developed skin redness. One participant in the control group developed a pressure ulcer in their existing seating and those with redness noted at the beginning of the trial remained following the trial period.

Conclusions: Some of the key findings indicate that the provision of an individually assessed seating system can improve skin integrity, reduces the risk and incidence of pressure ulcers and can improve quality of life factors and ease of completing
ADL’s. The evidence also suggests there are potential economic benefits to the long term care facility.

**Keywords:** Pressure ulcers, seating, posture, long term care
Hand Hygiene Auditing in Community Health

Author       Jill Sparks
Affiliations Community Nursing, WSLHD, Blacktown 2148, Australia
Email correspondence jill.sparks@health.nsw.gov.au

Jill’s nursing career commenced in 1988 at Anglicare, followed by 10 years at Northern Sydney Home Nursing Services during which time she completed her Masters in Wound Management. She took up her current position as CNC Wound Management WSLHD Community Health in 2001. She also has a clinical role as a team member of the Foot Wound Clinic at Westmead. She facilitates an after-hours Wound Interest Group in the Western suburbs. Jill is an active member of both the WSLHD and Community Wound Management Committees and a representative on the AWMA Venous Leg Ulcer Guideline committee.

Introduction
This paper describes audit tools used to ensure Hand Hygiene compliance with regard to Standard 8, within the community health setting

Material & Methods
Gold Standard Auditor training through Hand Hygiene Australia (HHA) was undertaken by three clinical nurse consultants for purposes of auditing across the community health sector, focusing on high risk clinical areas. Concurrently, an Opportunistic audit tool, designed specifically for the community setting, was trialled. Other strategies included two self-audits: 1 on the use of HH products and a second on “bling”.

Results
Using the HHA Audit Tool, a compliance rate of 80% was recorded. Using data from the Opportunistic audit tool, a compliance rate of 87% was obtained. This tool was found to be much easier to use. Results of the self-audit use of HH products revealed that approximately 1/3 of all respondents were not using enough Alcohol
Hand Rub, just over 1/3 were using the recommended amount & and the remaining 23% were using excessive amounts.

Conclusions
The HHA Audit Tool is designed specifically for the hospital setting & not recommended for community. A decision has been made not to continue with the HHA audit system and to continue with the Opportunistic Auditing process which is more user friendly and readily avails itself to training other auditors. The self-audit tool had its limitations and in its current form would not be used again.
Use of a 3D wound imaging device to assess wound progression and healing of diabetic foot ulcerations.

Presenter – Annie Walsh

Annie is a clinical podiatrist and researcher. She is an associate of the Liverpool Diabetes Research Collaborative Unit and is currently involved in clinical research under Professor Hugh Dickson related to wound imaging analysis for which she was granted scholarship funding from the Sydney based Ingham Institute of Applied Medical Research. She has been published in the UK's Journal of Wound Care and is currently a reviewer for the publication. Annie completed her undergraduate and honours studies in podiatry at AUT University, Auckland, New Zealand in 2010 under Professor Keith Rome. She is currently completing the final year of her master's degree in wound care through Monash University, Melbourne. Annie is a full-time senior podiatrist at the High Risk Foot Service, Liverpool Hospital, Sydney, Australia.

Authors Malone M1-3, Xuan W4, Dickson HG2,6 Bowling FL5

Affiliations 1 High Risk Foot Service, Liverpool Hospital, Locked Bag 7103, Liverpool, NSW 2170 Australia.

2 LIVE DIAB CRU, Ingham Institute of Applied Medical Research, Liverpool, NSW 2170 Australia

3 University of Western Sydney, NSW

4 Biostatistician, Ingham Institute of Applied Medical Research, Liverpool, NSW 2170

5 University of Manchester, Central Manchester Foundation Trust, Manchester Diabetes Centre, Manchester, UK

6 Ambulatory Care, Liverpool Hospital, Locked Bag 7103, Liverpool, NSW 2170 Australia

Email correspondence: matthew.malone@sswahs.nsw.gov.au

Introduction

The emerging adoption of 3D wound imaging technology has provided clinicians with even greater wound measurement options. No data is available to guide clinicians which of these measurements may yield the most reflective marker of wound progression to healing. Using a 3D wound imaging system we utilised 5 measurements that would best reflect measurements of interest to wound care clinicians and reported on their ability to reflect wound progression to healing.

Materials and Methods

We prospectively analysed 21 diabetes foot ulcers from initial presentation through to healing. Using previous data that suggests wounds heal in a linear fashion we examined the linear relationship between the mean wound measurement variable of interest and time.
using linear regression and Pearson correlation coefficient. Secondly we examined the Intra-rater reliability between user measurements with Intra-class correlation coefficients.

Results
Statistical analyses showed a linear healing slope for each wound measurement as having a value greater than 0.70 and a statistical significance of $p = 0.0001$. This indicated that all five wound measurements of interest were useful prognostic markers of wound progression to healing. Low variability of measurements between users also indicated good inter-observer reliability (approx area 0.97, planimetry area ICC 0.97, surface area ICC 0.98, planar surface volume ICC 0.89, curved volume ICC 0.63).

Conclusion
This pilot study has identified 5 measurements that maybe useful for clinicians in tracking wound progression to healing with the measurement of wound surface area being most reliable in addition to having the lowest variability between observers. In a ‘real life’ clinical scenario where one patient may have their wound photographed by a different clinician weekly, limiting the variations of clinicians who take the photographs to two ‘buddies’ will yield high reliability between measurements.

Key words: 3D wound imaging, diabetic foot ulcers, wound measurements
More than cellulitis.

Authors  
Lesley Jack¹, Lili Salaniqiqi²

Affiliations  
¹Blacktown Hospital, Blacktown, NSW, 2148, Australia
²Blacktown Hospital, Blacktown, NSW, 2148, Australia

Lesley Jack is a CNC in Stoma therapy & Wound care at Blacktown & Mt Druitt Hospitals., a position she has held for the past 10 years. Prior to that she worked at Westmead Hospital from as the stomal therapist for 11 year and in the Palliative Care Unit at Mt Druitt hospital. She is an active member of Australian Association of Stomal Therapy Nurses & currently involved with the CEC Pressure Injury Working group.

Lili Salaniqiqi is a RN 5th year surgical nurse who is currently on a 6 month rotation with Lesley Jack in the Stomal therapy/Wound Care role. She is a trainer/facilitator for the surgical ward and is undertaking front line management training.

Introduction

This case study is presented from a nursing perspective & describes the experiences of managing a 51 year old woman who presented to hospital with a 2 year history of bilateral leg lymphoedema and a diagnosis of cellulitis. A delayed request for wound review where no treating team was in charge, lead to multiple complications and interventions

Interventions

Intensive Care Unit to control up-trending sepsis, haemodialysis to treat acute renal failure. Intravenous antibiotics and a range of topical antimicrobial solutions were used to treat the local wound infection. Surgical debridement was followed by topical negative pressure therapy which continued in the home. Sudden deterioration initiated readmission for surgical debridement, antibiotics via peripherally inserted central catheter (PICC) in conjunction with Vera Flow therapy. Intermittent Pneumatic compression therapy was applied to the affected leg for management of lymphoedema.

Results

Wound is slowly improving. Vera Flow remains in situ. Ongoing antibiotics therapy continues. Discharge is planned when wound suitable for Activac

Conclusion

Nursing observation & intuition should never be underestimated. Don’t be afraid to seek help or voice your concerns
Treating chronic wounds collaboratively in a rural correctional centre

Author: Amanda Cochrane, Clinical Nurse Educator Northern Cluster JH&FMHN

Amanda Cochrane has worked for Justice Health and Forensic Mental Health Network (JH&FMHN) since 2000 in varying roles and is currently the Clinical Nurse Educator for Northern Cluster. She provides education and support to staff, students and Transition to Professional Practice nurses at three correctional facilities and two police cells complexes within a 500km radius. She has been a member of AWMA for the past year and is also part of the JH&FMHN Wound and Stoma Care Committee which supports best practice and support in the area of wound and stoma care throughout JH&FMHN.

Email correspondence: Amanda.cochrane@justicehealth.nsw.gov.au

The health centre at the Mid North Coast Correctional Centre (MNCCC), functions in a similar fashion to a community health centre with a nursing led model of care. Patients who need access to specialist clinics need to travel to Sydney and our chronic wound care consultations are facilitated by videoconferencing with the Clinical Nurse Specialist (CNS) Wound and Stoma Care.

The aim of this paper/poster is to highlight the collaborative work JH&FMHN conducts in the area of wound care with limited services and the large geographical area. The challenges in proving care include the following:

- Limited access to specialised clinics.
- Infection control and the challenges with patient accommodation areas.
- The potential for dressings to be used to self harm, as a potential weapon and/or patients tampering with their dressings.
- Nutritional factors.

This paper/poster presents a patient’s journey, with large chronic bilateral Venous Leg Ulcers with Multi Resistant Staphylococcus Aureus infection. Within a short period of time staff had organised multidisciplinary care. This included co-ordinated videoconferencing consultations with the Wound and Stoma care CNS to assist and advise the staff of a holistic wound management plan for this patient, communication with the Clinical Nurse Consultant (CNC) Infection Prevention on appropriate infection control procedures, collaboration with Corrective Services New South Wales (CSNSW) on appropriate accommodation placement whilst in custody, and a referral was made by the medical officer, for review by a vascular surgeon. The paper/poster will also discuss the patient’s release planning to ensure appropriate follow up and care post release.
“The Carnival’s Not Over” – can disposable negative pressure wound devices facilitate an easier transition back to normal life following surgery? – A case series.

Authors: Carol A. Wilson (1), Fleur Trezise (2)

Affiliations: Bankstown-Lidcombe Hospital. Sydney South West Local Health District

Email correspondence: Carol.Wilson@sswhs.nsw.gov.au

Introduction:

Topical Negative Pressure Wound Therapy is now a well-established tool and is the wound clinician’s armoury to manage a variety of wound presentations.

Over the years this therapy has progressed from large, cumbersome machines reliant on a fixed power source, suitable for inpatient use only; to portable, disposable and “off-the-shelf” consumables. This case series examines the effectiveness of a new portable negative pressure therapy device called SNaP® (Smart Negative Pressure) on five patients discharged home following surgery.

The system consists of a cartridge, hydrocolloid dressing as the seal and either foam or gauze as the wound contact layer. At the time of this evaluation, SNaP® therapy differed from other disposable negative pressure systems currently available in Australia, as it does not rely on an electrical source or batteries to operate. Instead this system uses a noiseless spring device to generate consistent, even levels of pressure to the wound. The absence of any noise in the operation of this product was a prime motivator in undertaking this evaluation.

Materials & Methods:

SNaP® was implemented on five post-operative patients who would have been discharged home on an alternative negative pressure device currently utilised at Bankstown-Lidcombe Hospital. These patients were followed up in at either the Outpatient Orthopaedic Clinic or Outpatient Surgical Clinic by the author/s.

Wound types varied from lower extremity orthopaedic wounds, chest wall, groin wounds and diabetic foot ulceration.

The following aspects were reviewed: Ease of application and removal, reduction in wound size, wound bed and peri-wound condition, product integrity and the “patient story”.

Saturday 15th August Session 2 Free Papers
Results:

From a clinician’s perspective, the system was easy to apply and remove on the selected wounds and resulted in a simplified discharge process due to the disposable nature of the product.

From a patient’s perspective, the system provided a discreet, silent dressing that did not adversely impact on daily activities and facilitated a rapid return to work, school and home life.

A larger study is warranted comparing all disposable topical negative pressure devices currently available on the Australian market.
Parastomal wound management – Waving not drowning

Author: Robin Skillman

Affiliations: Clinical Nurse Consultant Stomal Therapy and Wound Management
Tamworth Rural Referral Hospital

robin.skillman@hnehealth.nsw.gov.au

The creation of a bowel stoma creates a care scenario that is as enriching as it can be challenging. The inherent implications of stoma formation for the patient are manifold and associated with a number of variables. These may include whether the stoma was created as part of an elective process, and of course, the reason for stoma formation, to cure, palliate or divert.

Short and longer term complications associated with stoma creation ensure a response that merges art and science in facilitating best outcomes. Such complications as early dehiscence of the mucocutaneous junction, laparotomy wound dehiscence, or parastomal ulceration related to disease pathology, all call for a wound care response that is challenged by the proximity of a bowel stoma.

Using short case studies, this presentation will discuss modalities of wound and stomal therapy management in the care of parastomal complications.

The management of wounds for which a bowel stoma was created to divert from faecal contamination, will also be addressed. These examples include ischial tuberosity and sacral pressure injuries, Fournier gangrene and hidradenitis suppurativa.
Pyoderma gangrenosum – a challenge for the specialist nurse

Author Deb Day

Affiliation ¹Stomal Therapy, Central Coast Local Health District, NSW

Email correspondence Debra.Day@health.nsw.gov.au

Deb studied stomal therapy nursing at the Australian College of Nursing in 2001. Deb has worked as a stomal therapy nurse for the Central Coast Local Health District for the past 11 years. She has held the position of stomal therapy CNC since 2011. Deb is a member of the Australian Association of Stomal Therapy Nurses and the World Council of Entero-Stomal Therapy (WCET). In 2014 Deb did her first conference presentation at the WCET World Congress in Gothenberg Sweden.

Pyoderma Gangrenosum is a rare ulcerative inflammatory skin disorder which can be difficult to manage. It can occur in multiple areas of the body usually on the abdomen, perineum and lower extremities. Aetiology and pathophysiology are poorly understood and multiple treatments have been employed. Prompt diagnosis, early intervention and appropriate treatment are paramount to the success of the management. Biopsy of the ulcer will not confirm pyoderma gangrenosum but it will rule out other conditions. Diagnosis is made based on history and clinical presentation. Management may include treatment of any underlying systemic disease

Peristomal skin conditions represent a high percentage of stoma complications. Peristomal pyoderma gangrenosum is less common, but it presents as a more challenging issue to the specialist nurse. The goal for management is to alleviate pain, provide a secure stoma pouching system and to promote healing. This will necessitate a multifactorial approach

Two case reports will be presented, where the use of a corticosteroid inhaler is used topically directly to the ulcer, in conjunction with systemic steroids or immune-suppressant therapy to successfully treat pyoderma gangrenosum
Toe blood pressure and the toe brachial index for predicting foot wound healing: systematic review

Authors  Jennifer A Sonter\textsuperscript{1,2*}, Alan Ho\textsuperscript{1}, Vivienne H Chuter\textsuperscript{1,3},

Affiliations  \textsuperscript{1}Health Sciences, University of Newcastle, Ourimbah, NSW, 2258, Australia
\textsuperscript{2} School of Science and Health, University of Western Sydney, NSW, Australia
\textsuperscript{3} Priority Research Centre for Physical Activity and Nutrition, University of Newcastle, Ourimbah, NSW, 2258, Australia

Email correspondence  \textsuperscript{*}J.Sonter@uws.edu.au

Background

Chronic foot wounds are a growing international concern as the incidence of risk factors such as diabetes, obesity, vascular disease and advancing age rises. Adequate blood flow to the most distal parts of the foot is essential for wound healing and to avoid amputation. Toe blood pressure and the toe-brachial index (TBI) provide information on perfusion of the distal tissues and skin of the foot. This systematic review and meta-analysis was performed to determine the prognostic capabilities of toe blood pressure and the TBI for predicting chronic foot wound healing or progression to amputation.

Methods

The medical databases MEDLINE, CINAHL, EMBASE, PubMed Central and the reference lists of retrieved studies were systematically searched in June 2014. Two authors independently reviewed selected studies reporting original research. Methodological quality was assessed using STROBE and CASP appraisal tools.

Results

Ten studies were reviewed; six investigated wound healing and four investigated amputation as the primary outcome. Study quality was inconsistent; most failed to report aspects of their methodology and different equipment or techniques were used. The use of serial
assessments resulted in greater predictive ability than a single measurement. Meta-analysis indicated a cut-off toe blood pressure of 30mmHg was associated with an odds ratio of 3.25 (95% CI: 1.96, 5.41) for risk of non-healing, however, significant heterogeneity was found ($I^2 = 73.9\%$, $p=0.001$).

**Conclusions**

Toe blood pressure and the related TBI may be useful in predicting the outcome of chronic foot wounds, however, further high quality research is required before clinical utility is confirmed. The use of serial assessments taken over time or a grading system of toe blood pressure and TBI values may improve accuracy and utility.
Lower limb vascular assessment in diabetes: a multifaceted assessment of objective screening techniques

Authors Vivienne Chuter1, Jennifer Sonter1, Sean Lanting1, Peta Tehan1
Affiliations 1Discipline of Podiatry, University of Newcastle, Ourimbah, 2258
Email correspondence Vivienne.Chuter@newcastle.edu.au

Introduction: Diabetes-related lower limb macro- and microvascular disease is associated foot complications including ulceration and amputation\(^1\). The nature of this multi-system disease process makes accurate vascular examination difficult. This study evaluated the reliability and diagnostic accuracy of the ankle-brachial index (ABI), toe-brachial index (TBI) and continuous wave Doppler (CDW) assessment in people with diabetes and determined the strength of the relationship of these with history of foot complications.

Materials & Methods: Ankle and brachial pressure measurements and CWD assessment were performed using handheld Doppler and toe pressures using photoplethesmography. Retesting was performed 7-10 days later. Sensitivity and specificity of the ABI and TBI were determined using colour duplex ultrasound as reference standard and receiver operating characteristic (ROC) analysis was performed to assess the clinical utility of the ABI and TBI. Logistic regression was used to determine the relationship between vascular measurements and history of foot complications.

Results: A total of 389 participants with diabetes were recruited to the various arms of this study. Reliability of CWD was generally poor-to-moderate ranging from k=0.17 (95%CI -0.15 to 0.49) to k= 0.44 (95% CI: 0.03 to 0.88). Reliability of the TBI and ABI were excellent ranging from ICC 0.75 (95%CI -0.19 to 0.28) to 0.81 (95% LOA -0.23 to 0.25). CWD had the highest sensitivity and specificity for detecting PAD (74% and 93% respectively). ROC analysis demonstrated the TBI had greater clinical efficacy for the diagnosis of PAD (ROC area: 0.75 p=0.0001) than the ABI (ROC area: 0.58, p= 0.27). Participants with a TBI of less 0.6 were almost eleven times more likely to have a history of foot complication (OR: 10.73,\(p=0.048\)). The ABI and CWD were not independently associated with history of foot complications.

Conclusion: CWD has the highest sensitivity and specificity for PAD however had poor clinical reliability. The TBI and ABI both demonstrated acceptable reliability however the TBI was more effective at detecting PAD, associated with elevated likelihood of foot complications and may be a more effective vascular test in people with diabetes.

Keywords: Diabetes, lower limb, vascular assessment, foot complications

ACI High Risk Foot Clinic Standards

Vanessa Nube\textsuperscript{a}

Kerry Newlin\textsuperscript{b}

\textsuperscript{a}Director, Podiatry SLHD | \textbf{Podiatry Department}

Concord Hospital, Building 30, Hospital Road, CONCORD NSW 2139

Tel 02 9767 5221 | Fax 02 9767 5297 | vanessa.nube@sswhs.nsw.gov.au

\textsuperscript{b}ACI Endocrine network manager

The Agency for Clinical Innovation (ACI) Endocrine Network identified the need for standards for the management of diabetes-related foot complications in NSW. The Standards define the characteristics of services to optimise the treatment of advanced diabetic foot conditions, improve the patient journey and prevent unnecessary hospital admissions and amputations. The Standards form part of the overall strategy to improve care for people with diabetic foot complications. The Standards will be used to guide planning and implementation of multidisciplinary High Risk Foot Services (HRFS) in NSW.

The standards can be found through the link below:

Developing meaningful performance indicators for a diabetes high-risk foot service: is it hot or not?

Nube V, Veldhoen D, Frank G, Bolton T & Twigg S

Abstract
Diabetes-related foot ulceration is the leading cause of non-traumatic amputation and leading cause of hospitalisation for people with diabetes in Australia. It is associated with depression and high mortality. High-risk foot services (HRFS) in Australia, like the Diabetes Centre at Royal Prince Alfred Hospital, are providing specialised multidisciplinary management for patients and some data on the healing outcomes and improvement in processes has been published. Performance indicators are a key mechanism in the quality improvement process. Excluding national amputation rates, there is no agreed set of performance indicators for monitoring outcomes or processes associated with the management of diabetic foot disease in Australia. This article discusses the processes for selecting and defining indicators that can lead to improving care and outcomes for people with diabetes-related foot ulceration and includes and describes the experiences of measuring outcomes and developing performance indicators for HRFS in the Sydney Local Health District. In time, we anticipate the formulation of national and international consensus performance indicators for diabetes HRFS that can be applied locally to particular patients, ulcer types and models of health care delivery.
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