HEALTHY DEADLY FEET

Healthy Deadly Feet
Governance, Pathway and Domains

NSW GOVERNMENT

Acknowledgements

Acknowledgement

The NSW Ministry of Health acknowledges Aboriginal people as the traditional custodians of the lands and waters of NSW and pays respect to elders past, present and future.

Artist: Trudy Sloan

Healthy Deadly Feet

This painting represents Aboriginal communities working together/coming together and supporting each other. It represents educating each other in health and better lifestyles creating a path with healthy deadly feet for the next generation to come.
Trudy Sloane (the artist) is a proud Aboriginal Woman from the Wiradjuri Tribe, born in Dubbo NSW in 1987.

Terminology

Within NSW Health, the term 'Aboriginal' is generally used in preference to 'Aboriginal and Torres Strait Islander', in recognition that Aboriginal people are the original inhabitants of NSW (refer NSW Health Policy Directive) https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2005_319" PD2005_319

HEALTHY DEADLY FEET

Introduction

A study commissioned by NSW Ministry of Health and conducted by Services for Australian Rural and Remote Allied Health (SARRAH) in 2016 recommended an increase in the NSW Aboriginal workforce in foot care and podiatry to provide culturally safe and community focused care for Aboriginal people with Diabetes Related Foot Disease (DRFD). Diabetes is a chronic condition characterised by high blood glucose levels. It is associated with a range of complications including DRFD. Diabetes and DRFD are disproportionately prevalent in the Indigenous Australian population.

In response to the SARRAH report, the NSW Ministry of Health, along with several partners, developed the Healthy Deadly Feet (HDF) Project which aims to increase the Aboriginal workforce in foot care and podiatry in NSW Health and improve DRFD outcomes for Aboriginal people in NSW.

The HDF Project is supported by several stakeholders including Local Health Districts (LHDs), Speciality Health Networks (SHNs), Primary Health Networks (PHNs), Aboriginal Community Controlled Health Organisations (ACCHOs), Indigenous Allied Health Australia (IAHA), Health Education Training Institute (HETI), Technical and Further Education (TAFE) NSW, National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) and the Agency for Clinical Innovation (ACI).

The HDF Project will work with Aboriginal Health Workers (AHWs), Aboriginal Health Practitioners (AHPs) and Aboriginal Allied Health Assistants (AAHAs) in participating LHDs and SHNs in NSW.

These healthcare workers will receive education and training through HETI and TAFE NSW to become a HDF workforce. This workforce will be qualified and able to provide care for DRFD across three domains – culturally safe care, health promotion and education, and screening and early intervention.

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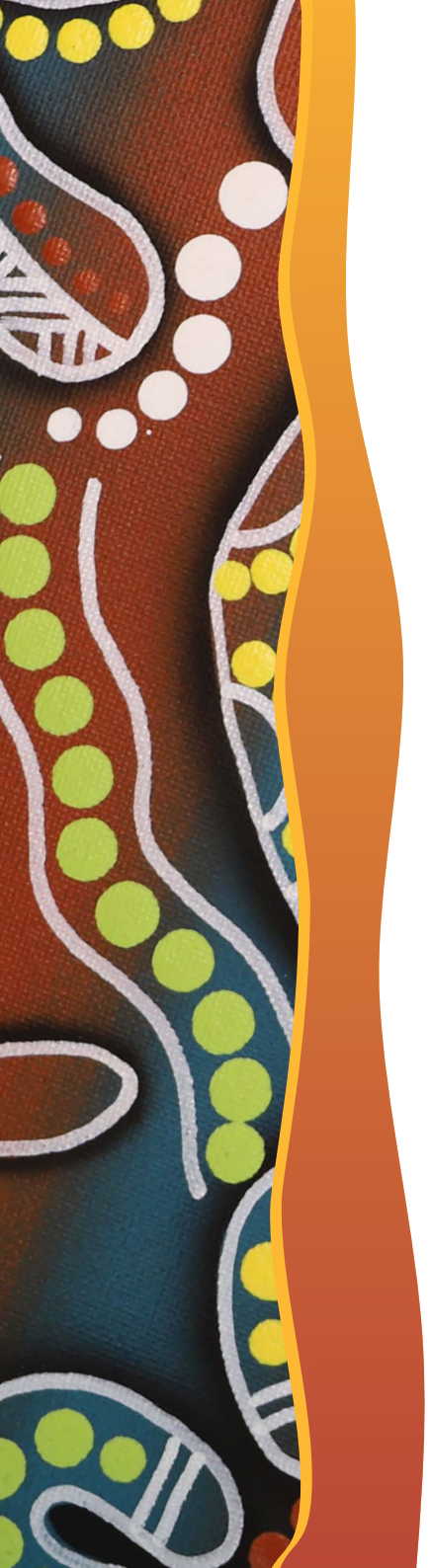

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Glossary

AAHA: Aboriginal Allied Health Assistant

ACCHO: Aboriginal Community Controlled Health Organisation

ACI: Agency for Clinical Innovation

AHP: Aboriginal Health Practitioner

AHW: Aboriginal Health Worker

DRFD: Diabetes Related Foot Disease

GP: General Practitioner

HDF: Healthy Deadly Feet

HETI: Health Education Training Institute

HIMF: Health Item Master File

HRFC: High Risk Foot Clinic

IAHA: Indigenous Allied Health Australia

LBVC: Leading Better Value Care

LHD: Local Health District

LOPS: Loss of protective sensation

NATSIHWA: National Aboriginal and Torres Strait Islander Health Worker Association

PAD: Peripheral Artery Disease

PHN: Primary Health Network

SARRAH: Services for Australian Rural and Remote Allied Health

SHN: Specialty Health Network

TAFE: Technical and Further Education NSW

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Governance Documents

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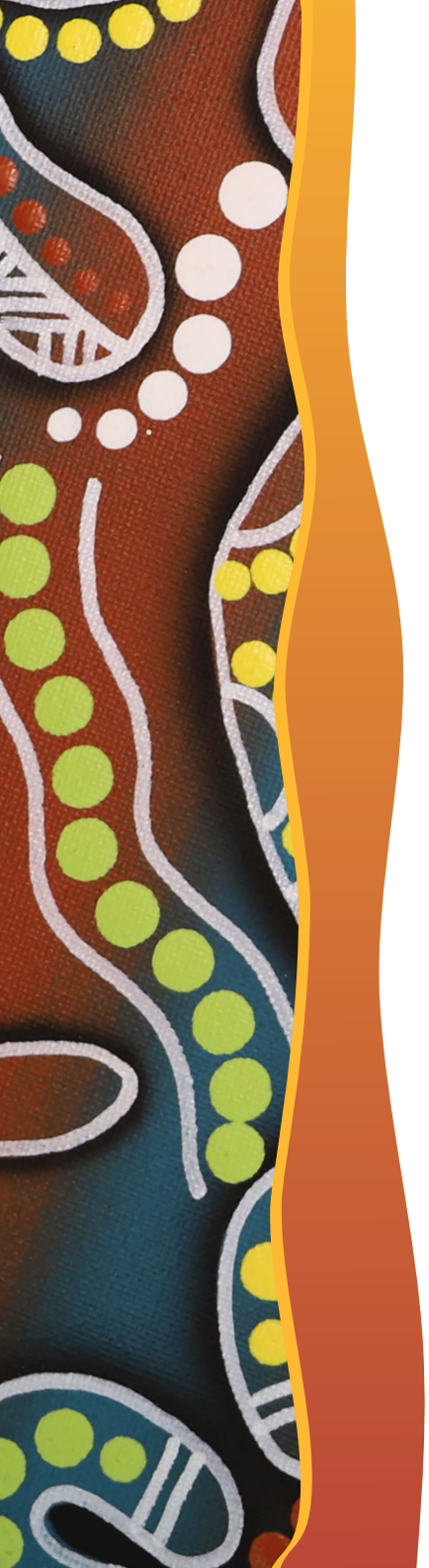

Pillars of the Program

1

LBVC* High Risk Foot Services initiative

Underpinned by a set of minimum and best practice standards, this initiative is increasing access to High Risk Foot Services across NSW

2

LHD/SHN support and roadshows

The NSW Ministry of Health is seeking engagement from all LHDs/SHNs to adopt the initiative.

3

Workforce Initiative

A key goal is to increase the Aboriginal workforce across both clinical and non-clinical roles with a particular focus around allied health.

4

Aboriginal Community Access

Increased Aboriginal community access into foot care services in a culturally safe environment.

5

Education and Training

Roll out cultural responsiveness training and development of the Healthy Deadly Foot Learning Pathway for appropriate workforces.

* Leading Better Value Care (LBVC)

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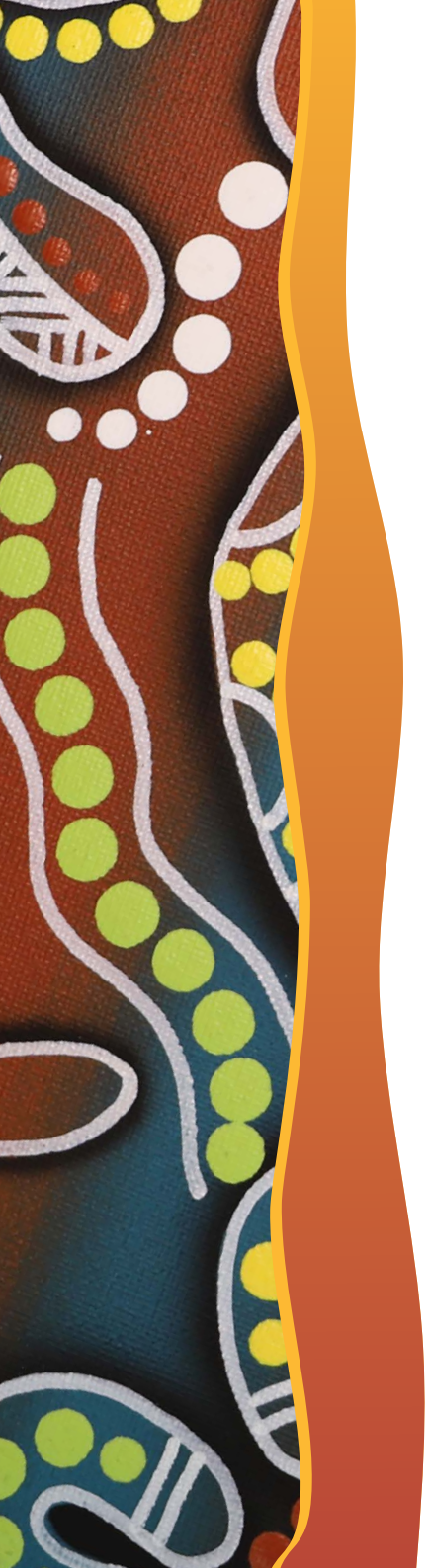

Decision Making Framework

Healthy Deadly Feet Model

MUST HAVES?

- Project Sponsors – Director of Workforce & Director of Allied Health
- Nominated project lead
- Clinical supervison and membership from podiatrist
- Managers of both Aboriginal Health and Aboriginal Workforce
- Aboriginal community engagement
- Completion of evaluation measure
- Aboriginal health impact statement

WORKFORCE OPTIONS?*

- Aboriginal Podiatrist/ Podiatrist (mandatory)
- Aboriginal Health Practitioner
- Aboriginal Health Worker
- Aboriginal AHA/AHA
- Other

BEST PRACTICE?

- Linked to High Risk Foot Service
- Training- Cultural Safety and Healthy Deadly Feet Learning Pathway (Domains 1-3)
- Collaboration between LHD/SHN
- Provision of implementation tool kit

HOW TO ESTABLISH HDF WORKFORCE ?

- Nominated lead
- Redesign of existing Workforce
- Enhancements to a new workforce

* Working within scopes of practice and Position Description

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Workforce Scope of Practice

There are three support worker roles that could work with podiatrists as Healthy Deadly Feet (HDF) workers in some or all of the domains of care.

ROLE	DEFINITION	KEY REFERENCE DOCUMENTS FOR THIS ROLE
Aboriginal Health Worker (AHW)	Better access liaison, health promotion and preventative health services to the Aboriginal Community (AHW Framework)	Aboriginal Health Workers Guidelines for NSW Health
Aboriginal Health Practitioner (AHP)	Provision of direct clinical services to the Aboriginal community (AHW Framework)	Decision Making Framework for NSW Health Aboriginal Health Practitioners Aboriginal Health Practitioners Guidelines for NSW Health
Allied Health Assistant (AHA)	Person employed under the supervision of an allied health professional who is required to assist with therapeutic and program related activities. Supervision may be direct, indirect or remote and must occur within organisational requirements (AHA Framework, Community Services and Health Industry Skills Council)	NSW Health Allied Health Assistant Framework

Possible workforce models for HDF workers include:

- AHW working in partnership with an AHA (with podiatry skills)
- AHP with additional foot care skills
- Aboriginal AHA (withfoot care skills)

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Domains of Care

These workers along with podiatrists will form a Healthy Deadly Feet team and address these three domains to support the HDF project.

1. Cultural care navigator – Helping to connect people with and in the system
2. Health promotion and education – Providing information and education
3. Screening and early intervention – Providing foot care and checking progress.

Domain Tasks/Activities

DOMAIN ACTIVITIES	HEALTHY DEADLY FEET WORKER ROLE
Domain 1 – Cultural care navigator	**AHW or AHP or AHA,** with additional training
Support and advocacy for Aboriginal people and communities to identify health needs specific to foot care.	
Point of contact for counselling and referral for Aboriginal people with foot care needs	
Interpretation of medical terminology specific to foot care if required	
Collaborate with other health care professionals to facilitate a multidisciplinary approach to foot care, both within the community and the health system	
Domain 2 – Health promotion and education	**AHW or AHP or AHA**, with additional training
Implementation of health promotion programs for diabetes-related foot care which may include information and support for healthy lifestyles (eg. nutrition, exercise, smoking cessation etc.)	
Provide both individual and group based learning activities in the area of foot care	
Domain 3 – Screening and early intervention	**AHP or AHA**, with additional training
Prepare for and perform basic foot hygiene (excluding scalpel work)	
Apply padding and cushioning (as described in the HDF procedure)	
Assist with support and advice to clients in the selection of footwear	
Assist with the cutting and filing toenails of very low risk feet (as described in the HDF procedure)	
Complete basic foot screening (as described in the HDF procedure)	
Conduct basic dressing (as described in the HDF procedure)	
Conduct basic first aid if required	

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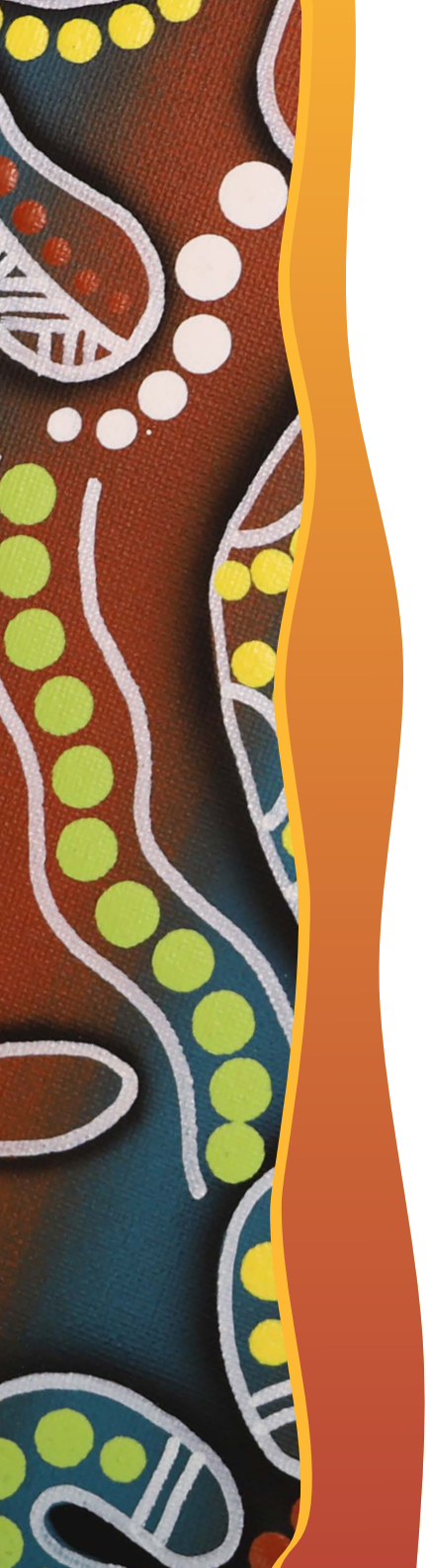
Training and education to support the HDF team

The HDF team will be supported by relevant training and education. Details of this training can be found in the Cultural safety and Healthy Deadly Feet team learning pathway. The table below summarises this training and education.

WHO MAY REQUIRE THIS TRAINING	WHAT TRAINING MIGHT BE REQUIRED
HDF worker	Formal and informal training linked to the domains of care and customised to the HDF project. This training would build on existing knowledge and skills
HDF team podiatrists	Delegation and supervision training for working with AHAs and AHPs
HDF teams, managers and workplaces	Cultural responsiveness training to maximise cultural safety for HDF teams

The formal component of the HDF worker training can be drawn from and build on existing qualifications. The following table is based on the expected existing qualifications for the three roles that might be included. These qualifications are:

- Aboriginal Health Worker – Cert III in Aboriginal and/or Torres Strait Islander Primary Health Care
- Aboriginal Health Practitioner – Cert IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice
- Allied Health Assistant – Cert IV Allied Health Assistance



Summary of HDF worker formal training needs

TRAINING COURSE SUBJECT AND CODE	DOMAIN OF CARE	EXISTING AND ADDITIONAL TRAINING NEEDED		
		AHW	AHP	AHA
HLTAHW005 – Work in Aboriginal and/or Torres Strait Islander primary health care context.	Domain 1 – Cultural Care Navigator	C	C	N
HLTAHW006 – Facilitate and advocate for the rights and needs of clients and community members	Domain 1 – Cultural Care Navigator	C	C	N
HLTAHW025 – Provide information and strategies in health care	Domain 2 – Health Promotion & Education	N	N	N
HLTAHW028 – Provide information and strategies in chronic condition care	Domain 2 – Health Promotion & Education	N	N	N
BSBMED301 – Interpret and apply medical terminology appropriately	Domain 1 – Cultural Care Navigator	N	N	C
HLTAHW023 – Plan, develop and evaluate health promotion and community development programs	Domain 2 – Health Promotion & Education	N	N	N
HLTAHA011 – Conduct group sessions for individual client outcomes	Domain 2 – Health Promotion & Education	N	N	N
HLTAHA006 – Assist with basic foot hygiene	Domain 3 – Screening & Early Intervention	N/A	N	N
HLTWHS002 – Follow safe work practices for direct client care Or HLTINF001 – Comply with infection prevention and control policies and procedures and HLTWHS001 – Participate in workplace health **and** safety	Domain 3 – Screening & Early Intervention — —	 C	 C	C
HLTAID003 – Provide first aid	Domain 3 – Screening & Early Intervention	C	C	N

C – Core unit from existing qualification

N – New learning may be required

N/A – Not applicable to this role

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Cultural Safety and Healthy Deadly Feet Team Learning Pathway

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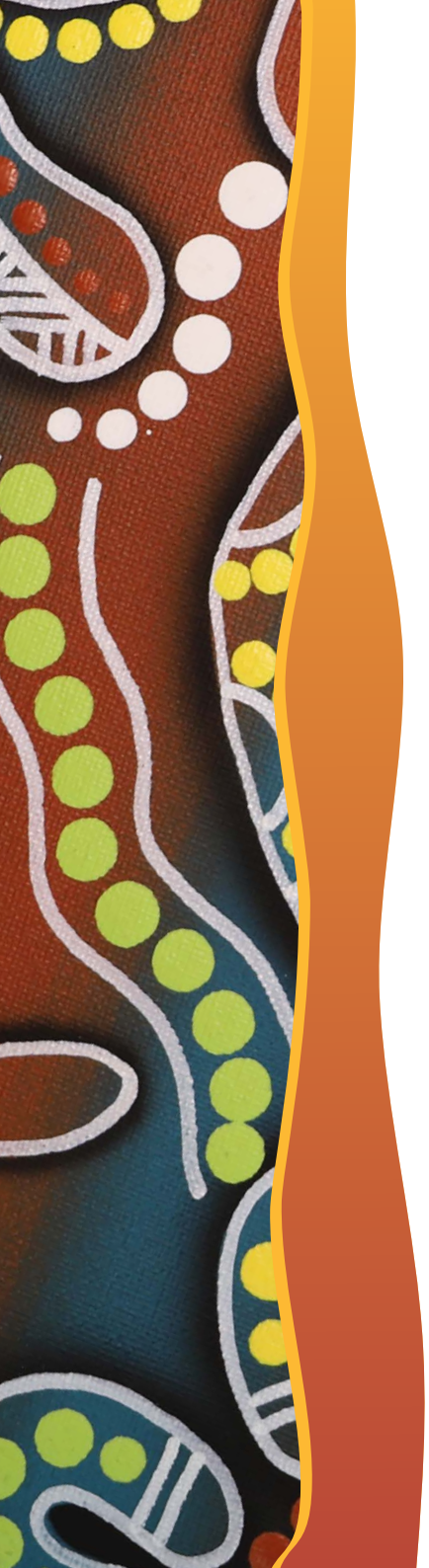

Introduction

The NSW Ministry of Health developed the Healthy Deadly Feet (HDF) Project with the aim to increase the Aboriginal workforce in foot care and podiatry in NSW Health and improve Diabetes Related Foot Disease (DRFD) outcomes for Aboriginal people in NSW. The HDF team includes HDF workers - Aboriginal Health Workers (AHWs), Aboriginal Health Practitioners (AHPs), Aboriginal Allied Health Assistants (AAHAs) and Allied Health Assistants (AHAs) and podiatrists who clinically supervise the HDF workers.

The HDF team will work with Aboriginal people of all ages across NSW who have or are at risk of developing diabetes and DRFD, as well as their families and communities. The HDF team will raise awareness in the Aboriginal community of the risk factors for diabetes and DRFD, strategies for prevention, and the treatment options and care facilities available.

The HDF team will support Aboriginal people in their communities across three domains of care:

1. Cultural care navigator

2. Health promotion and education

3. Screening and early intervention

Some members of the team will work across all three domains and others will work across one or two. HDF team examples include:

- AHW working in partnership with an AHA (with foot care skills)
- AHP with additional foot care skills
- Aboriginal AHA (with foot care skills)

The areas of work will be determined by the scope of practice of the individual members of the team. This pathway describes the education and training available to support the professional development of the HDF team. Components of the pathway will be relevant to all members of the HDF team, including:

- HDF workers
- HDF team Podiatrists involved with delegation and supervision of the HDF workers
- HDF teams, managers and workplaces

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HDF worker training

HDF workers along with podiatrists form a HDF team and address three domains of care. There is training to support each of these domains both formal and informal. The amount of training required by the HDF worker will be determined by their previous qualification and experience.

Domain 1: Cultural care navigator

This domain helps to connect people with and in the health system.

The HDF worker working in this domain will:

- Support and advocate for Aboriginal people and communities to identify health needs specific to foot care
- Be a point of contact for counselling and referral for Aboriginal people with foot care needs
- Assist with the interpretation of medical terminology specific to foot care if required.
- Collaborate with other health care professionals to facilitate a multidisciplinary approach to foot care, both within the community and the health system.

The professional development that will assist the HDF worker to complete the tasks included in this domain may include Units of Competency from HLT30113 Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care, the HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice and HLT43015 Certificate IV in Allied Health Assistance. Workplace based learning may also be used to facilitate this training if accredited training is not the preferred option. Details of the relevant units of competencies and the workplace based learning option can be found in the Domain 1 guideline.

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Domain 2: Health promotion and education

This domain involves the provision of foot care information and education to Aboriginal people.

The HDF worker working in this domain will:

- Implementation of health promotion programs for diabetes related foot care which may include information and support for healthy lifestyles (eg. nutrition, exercise, smoking cessation etc.).
- Provide both individual and group based learning activities in the area of foot care.

The professional development that will assist the HDF worker to complete the tasks included in this domain may include Units of Competency from HLT30113 Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care, the HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice and HLT43015 Certificate IV in Allied Health Assistance. Workplace based learning may also be used to facilitate this training if accredited training is not the preferred option. Details of the relevant units of competencies and the workplace based learning option can be found in the Domain 2 guideline.

Domain 3: Screening and early intervention

This domain involves both screening and the provision of basic foot care in partnership with a Podiatrist.

The HDF worker working in this domain will:

- Prepare for and perform basic foot hygiene (excluding scalpel work)
- Apply padding and cushioning (as described in the Healthy Deadly feet procedure)
- Assist with support and advice to clients in the selection of footwear
- Assist with the cutting and filing toenails of very low risk feet (as described in the Healthy Deadly Feet procedure)
- Complete basic foot screening (as described in the Healthy Deadly feet procedure)
- Conduct basic dressing (as described in the Healthy Deadly feet procedure)
- Conduct basic first aid if required

The professional development that will assist the HDF worker to complete the tasks in this domain would include the podiatry skillset – Assist with basic foot hygiene from HLT43015 Certificate IV in Allied Health Assistance. First aid training along with both Workplace Health and Safety and Infection control would also need to be covered. Details of the relevant units of competencies and the specific application to the HDF project can be found in the Domain 3 guideline.

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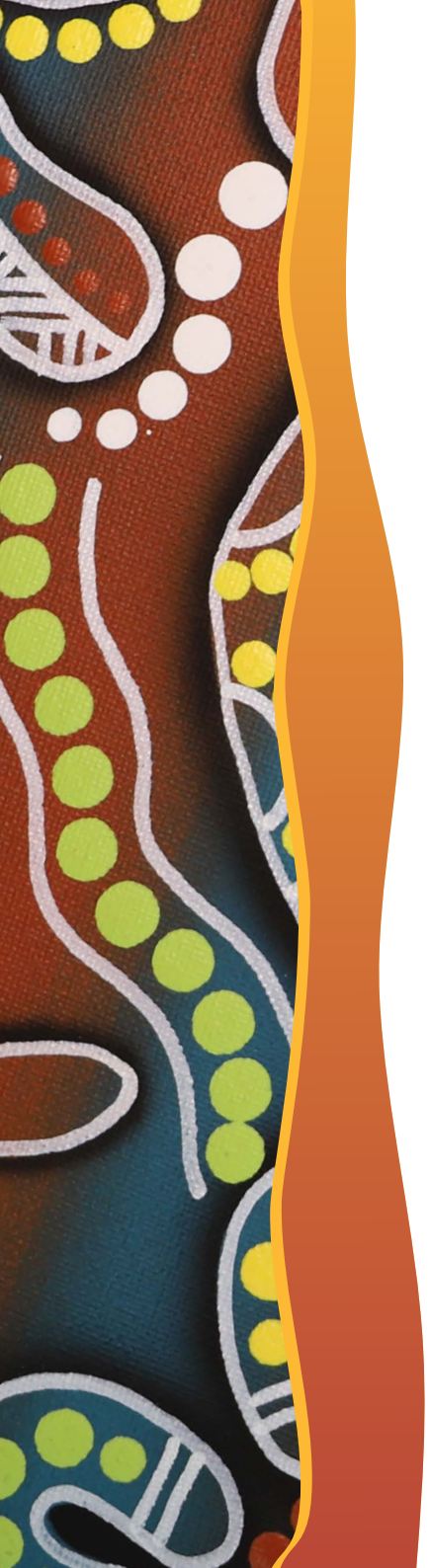

Summary of HDF worker formal training needs

ADDITIONAL TRAINING NEEDED	AHW	AHP	AHA
HLTAHW005 - Work in Aboriginal and/or Torres Strait Islander primary health care context.	C	C	N
HLTAHW006 – Facilitate and advocate for the rights and needs of clients and community members	C	C	N
HLTAHW025 – Provide information and strategies in health care	N	N	N
HLTAHW028 – Provide information and strategies in chronic condition care	N	N	N
Or CHCCCS001 – Address the needs of people with chronic disease	N	N	N
BSBMED301 – Interpret and apply medical terminology appropriately	N	N	C
HLTAHW023 – Plan, develop and evaluate health promotion and community development programs	N	N	N
HLTAHA011 – Conduct group sessions for individual client outcomes	N	N	N
HLTAHA006 – Assist with basic foot hygiene	N	N	N
Or CHCCCS013 – Provide basic footcare	N	N	N
HLTWHS002 – Follow safe work practices for direct client care	–	–	C
Or HLTINF001 – Comply with infection prevention and control policies and procedures **and** HLTWHS001 – Participate in workplace health and safety	C	C	
HLTAID003 – Provide first aid	N	C	N

C – Core unit from existing qualification

N – New learning may be required

Based on the following expected existing qualification:

AHW – Cert III in Aboriginal and/or Torres Strait Islander Primary Health Care

AHP – Cert IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice

AHA – Cert IV Allied Health Assistance

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HDF team podiatrists

Podiatrists will work with HDF workers across all three domains of care. In situations where the HDF worker is an Aboriginal Health Practitioner (AHP), the **Decision Making Framework for NSW Health Aboriginal Health practitioners undertaking clinical activities** will assist greatly. This framework includes a checklist to assist in preparation for an AHP to work in a clinical area as well as responsibilities around delegation and supervision. In situations where the HDF worker is an Allied Health Assistant (AHA), the **NSW Health Allied Health Assistant Framework** will assist greatly. This framework includes details about appropriate supervision and delegation when working with an AHA. Podiatrists may benefit from training in delegation in models where either an AHP or an AHA are working in the HDF team.

Cultural safety for Healthy Deadly Feet teams, managers and workplaces

HDF teams will need to function in culturally safe workplaces. It is a mandatory training requirement of NSW Health staff to complete both the online and face-to-face components of the **Respecting the Difference training**, found on My Health Learning. To ensure workplaces are culturally safe, cultural responsiveness training will need to occur, in addition to **Respecting the Difference** cultural awareness training. This training may occur in a number of ways in different LHDs and SHNs, however the outcome of increased cultural safety in the workplace is essential.

The NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool from the NSW Health Centre for Aboriginal Health can be used to identify any further change in practice and training to maximise cultural safety in the workplace.

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NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool

NSW Health is committed to improving the health and wellbeing of Aboriginal people.

Key to achieving this is making meaningful changes to organisational activities, structures and behaviours to make health services and hospitals culturally safe and respectful for Aboriginal patients, clients and staff. The NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool aims to identify ways of strengthening cultural engagement between NSW Health organisation staff and their Aboriginal stakeholders by bringing a continuous quality improvement cycle to cultural engagement.

The engagement tool has been designed to assist NSW Health organisations in moving towards a health system where cultural differences and strengths are recognised and responded to in the governance, management and delivery of health services. It will support health services to assess whether there has been a measured approach towards the delivery of culturally safe and accessible health services for Aboriginal patients and clients.

The engagement tool embeds the six Aboriginal specific actions of the National Safety and Quality Health Service Standards (Second Edition) and the six strategic directions of the NSW Aboriginal Health Plan.

Workplaces will need to demonstrate that they:

- Work in partnership with the NSW Aboriginal communities and their other local Aboriginal stakeholders to meet their healthcare needs
- Address specific health needs of Aboriginal people
- Implement and monitor targeted strategies
- Have strategies to improve cultural engagement of all of the workforce to meet the needs of Aboriginal patients
- Create a welcoming environment that recognises the importance of cultural beliefs and practices of Aboriginal people

An interactive PDF version of the engagement tool is available on the NSW Health website:
https://www.health.nsw.gov.au/aboriginal/Pages/cultural-engagement-tool.aspx

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Domain 1
Aboriginal Cultural Navigation

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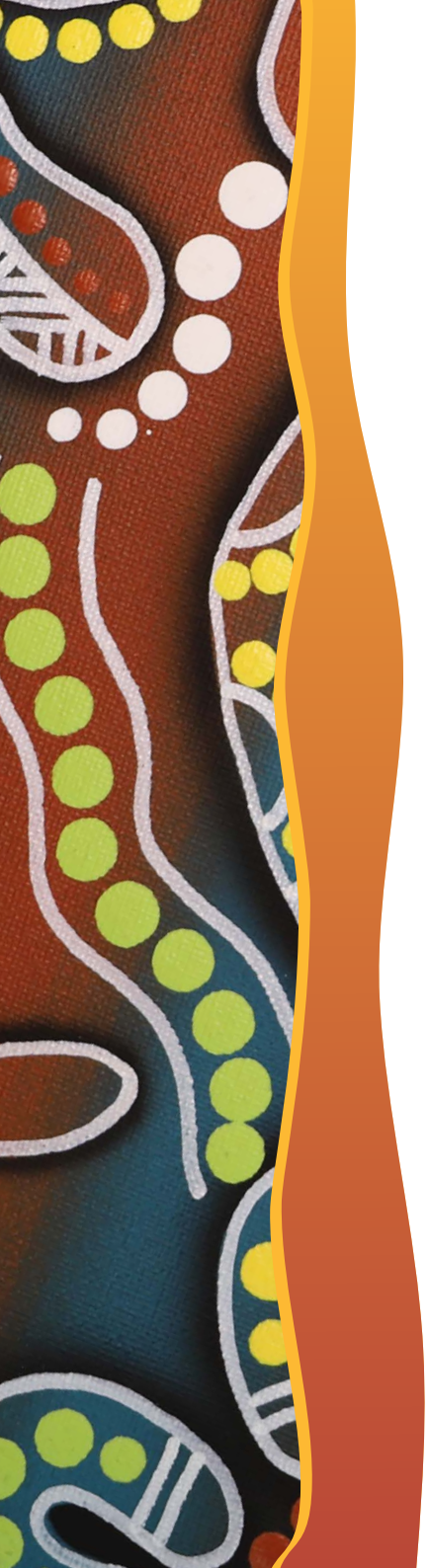

Aboriginal Cultural/Patient Navigation

- Support and advocacy for Aboriginal people and communities to identify health needs specific to foot care
- Point of contact for counselling and referral for Aboriginal people with foot care needs
- Interpretation of medical terminology specific to foot care if required
- Collaborate with other health care professionals to facilitate a multidisciplinary approach to foot care, both within the community and the health system

Aboriginal Cultural/Patient Navigation is provided by Healthy Deadly Feet (HDF) Aboriginal Health Workers (AHWs), Aboriginal Health Practitioners (AHPs), or Aboriginal Allied Health Assistants (AAHAs). They are available to support patients and their families who self-identify as having Aboriginal ancestry or as being part of an Aboriginal family. The Aboriginal Cultural/Patient Navigation supports and guides Aboriginal patients and their families by:

- Providing support at clinic visits
- Helping communicate with Podiatrist and HDF staff
- Assisting to find additional support, services and/or resources
- Connecting with traditional Aboriginal healers

Key Functions

The key functions may vary across health services and may be adapted to local needs, processes and policies. They will encompass services delivered under HDF specifically in relation to those with or at risk of diabetes and/or diabetes related foot disease.

- Advocacy for Aboriginal Clients and their families/carers/guardians
- Liaison within LHD/SHNs, especially the acute care facilities, and the Aboriginal community
- Liaison between the LHD/SHNs and the Aboriginal Community Controlled Health Organisation and General Practitioners to support health care planning and provision
- Creation of a culturally appropriate environment for Aboriginal people to receive health care
- Assist hospital-based Aboriginal clients and their families/carers/guardians, including Emergency Department in-take
- Help with pre-admission clinics, discharge planning and care plan intervention for hospital-based Aboriginal clients.

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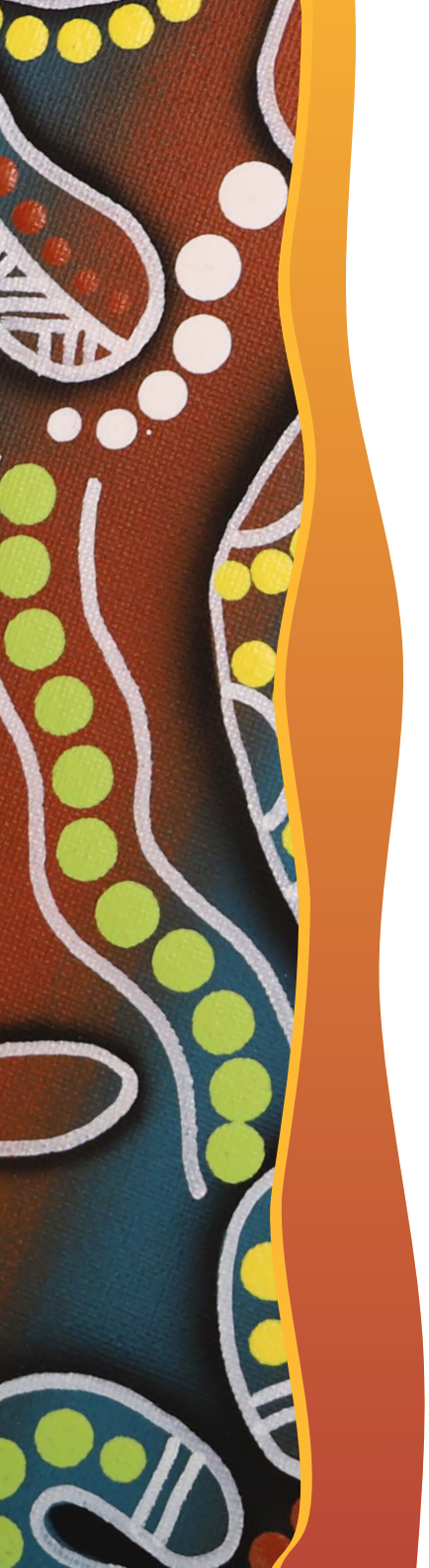

Training

All training needs to include local processes as determined by systems, policies and procedures in line with conditions of employment to NSW Health.

CATEGORY	SUITABLE QUALIFICATIONS	AWARD CRITERIA	ADDITIONAL REQUIREMENTS
Aboriginal Health Worker	• Certificate III in Aboriginal Primary Health Care • Certificate IV in Aboriginal Primary Health Care or equivalent • Diploma of Aboriginal Primary Health Care	• AHWs are employed under the Award requirements of "having or being willing to attain" the Certificate III Aboriginal and/or Torres Strait Islander Primary Health Care. • Organisations which on-board an AHW who has not yet attained the Certificate III Aboriginal and/or Torres Strait Islander Primary Health Care should be supported by the health service to attain the qualification	
Aboriginal Health Practitioner	• Certificate IV in Aboriginal Primary Health Care Practice		• Certificate IV in Aboriginal Primary Health Care Practice AND • Registration with the Aboriginal and Torres Strait Islander Health Practice Board of Australia
Allied Health Assistants	• Certificate IV in Allied Health Assistance		• Identifies as person who is Aboriginal

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Elements of the Role

To enable success within the role of Aboriginal Cultural/Patient Navigation, it is recommended that two competencies are completed. This includes working in an Aboriginal and/or Torres Strait Islander primary health care context (HLTAHW005), and facilitating and advocating for the rights and needs of clients and community members (HLTAHW006). While these are core competencies within the suitable qualifications for a AHW and a AHP, it is highly encouraged for LHD/SHNs to support AHAs within the HDF team.

HLTAHW005 – WORK IN AN ABORIGINAL AND/OR TORRES STRAIT ISLANDER PRIMARY HEALTH CARE CONTEXT	
ELEMENT	**PERFORMANCE CRITERIA**
1. Identify factors impacting on Aboriginal and/or Torres Strait Islander health and the delivery of primary health care services	1.1 Consider the national and local history of Aboriginal and/or Torres Strait Islander people as a factor in primary health care work 1.2 Consider the impact of social, political, spiritual, economic and environmental factors on the health of Aboriginal and/or Torres Strait Islander people
2. Apply primary health care principles	2.1 Ensure primary health care principles underpin service provision and work practices 2.2 Deliver services that support self-determination and empowerment in Aboriginal and/or Torres Strait Islander people and communities 2.3 Demonstrate commitment to achieving access and equity in health services for Aboriginal and/or Torres Strait Islander people 2.4 Establish and maintain networks with health care agencies and associated services to support Aboriginal and/or Torres Strait Islander health care
3. Work in a culturally appropriate and safe manner	3.1 Consider and respect local community values, beliefs and gender roles when providing health care to Aboriginal and/or Torres Strait Islander people 3.2 Deliver health services safely in line with organisation policies, regulatory requirements and community protocols

	3.3 Apply cultural safety protocols in the implementation of government policies, research and data collection, and the delivery of services to Aboriginal and/or Torres Strait Islander people 3.4 Identify any cultural factors that produce stress, impact personal wellbeing or have a potential to impact on own work practices, and report as appropriate
4. Apply Aboriginal and/or Torres Strait Islander health policies and resources	4.1 Identify relevant aspects of Aboriginal and/or Torres Strait Islander health strategies, policies, bodies and resources 4.2 Ensure policies and resources are applied in line with identified needs of Aboriginal and/or Torres Strait Islander people and communities 4.3 Identify barriers to access and equity in relation to Aboriginal and/or Torres Strait Islander health 4.4 Take available opportunities to advocate on behalf of Aboriginal and/or Torres Strait Islander people and/or communities 4.5 Reflect on work practices in Aboriginal and/or Torres Strait Islander community-controlled organisations and on current strategies, programs and models that address Aboriginal and/or Torres Strait Islander primary health care issues 4.6 Maintain confidentiality of client information

HLTAHW006 – FACILITATE AND ADVOCATE FOR THE RIGHTS AND NEEDS OF CLIENTS AND COMMUNITY MEMBERS

ELEMENT	**PERFORMANCE CRITERIA**
1. Identify the rights, needs and options available to the client	1.1 Use culturally appropriate and safe communication to assist the client to identify their needs in relation to health issues and services 1.2 Support client to identify needs that are not being met by existing services or supports 1.3 Provide client with information about their rights and options for meeting their needs 1.4 Assist client to identify their preferred option and negotiate other options, as required

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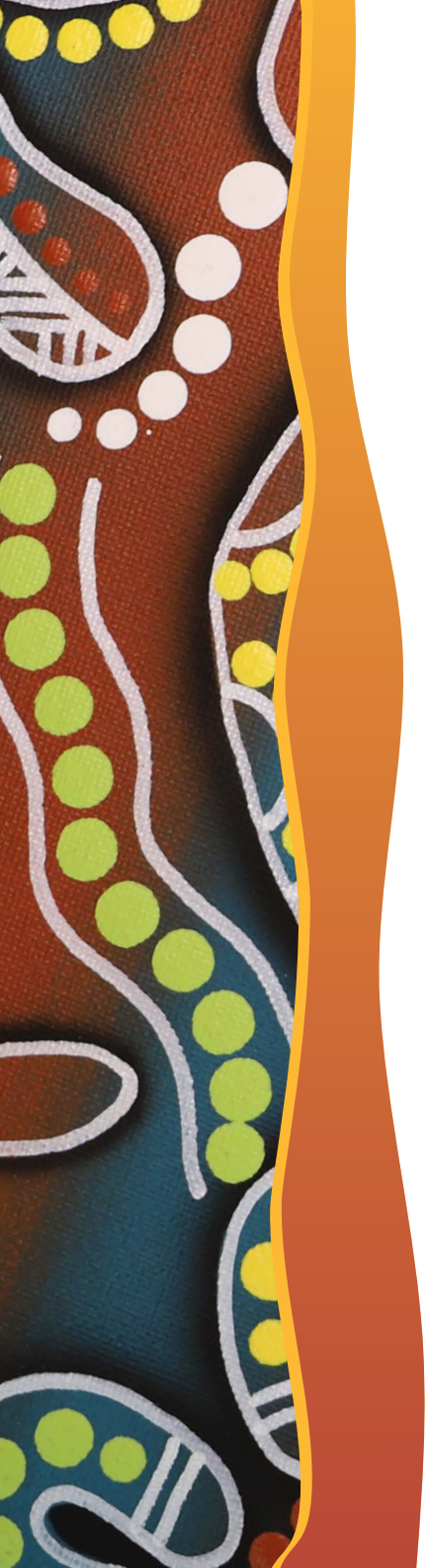
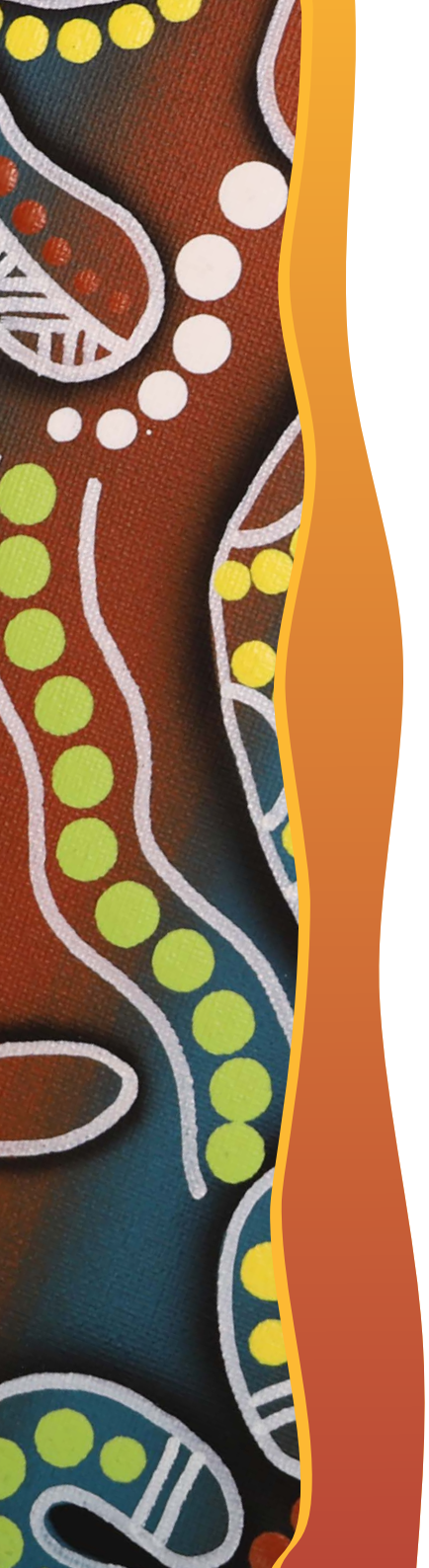


2. Assist the client to present their own needs	2.1 Assist client to make contact with relevant persons and agencies 2.2 Provide client with information and support them to present their rights and needs 2.3 Encourage client to communicate in their preferred language, and provide support as required 2.4 Assist client to put their views to relevant persons and agencies to meet their needs as required 2.5 Follow organisational procedures to arrange for interpreting and translation services as requested or required by clients
3. Advocate for the client when self-advocacy is not possible	3.1 Identify relevant individuals or agencies and contact them about the specific issue 3.2 Clearly represent the client's point of view to those involved 3.3 Use clear, appropriate and accessible language that values and respects each individual 3.4 Discuss progress and outcomes with client 3.5 Use translation and interpretation services to ensure the client's understanding and involvement in the process, as required 3.6 Maintain client confidentiality at all times when communicating client information
4. Liaise with health service providers to meet client and community needs	4.1 Inform multidisciplinary health service teams of ongoing and/or changing individual and community needs and issues that may impact on service provision 4.2 Communicate local community values, beliefs and gender roles to service providers, as required 4.3 Explain to service providers, as required, the role of traditional healers in the community

HEALTHY DEADLY FEET



4. Liaise with health service providers to meet client and community needs	4.4 Consult health service providers about the organisation and delivery of health services in the community 4.5 Undertake consultation to provide clients with reasonable and timely access to general and specialist health services required outside their own community
5. Promote the rights, needs and interests of the client	5.1 Regularly discuss rights and needs of clients with other workers and supervisor 5.2 Make suggestions to other workers and supervisor about ways to improve services to clients 5.3 Implement changes as required

HEALTHY DEADLY FEET

Domain 2
Health Education and Promotion

NSW GOVERNMENT

Health Education and Promotion

- Implementation of health promotion programs related in Diabetes Related Foot Care (DRFD). This may include providing information about healthy lifestyles and support changes in lifestyle (e.g. nutrition, exercise, smoking etc)
- Provide both individual and group-based learning activities in the area of foot care

Key Functions

The key function of this role is to develop, implement and evaluate Aboriginal-specific health promotion programs within the Healthy Deadly Feet (HDF) multidisciplinary team, according to qualification level. Additional scope consists of:

- Assisting the community to understand the HDF program
- Helping patients and families understand the various roles of the HDF Podiatrist and team members
- Supporting individual and community understanding of the risk factors related to DRFD
- Aiding patients and families to understand the services which are available and the referral pathways to specialised support teams or services, such as a Diabetes Educator.

Aboriginal Health Education will be available to individuals, families and communities who self-identify as having Aboriginal ancestry or as being part of an Aboriginal family.

Provide agreed education to Aboriginal individuals, families and community members to promote and education on the issues of:

- Diabetes
- Footcare
- Smoking and vascular disease
- DRFD
- Exercising safely
- HDF program

This may also include informing the community about related tools and programs used within the LHD/SHNs.

Supervision and Mentoring

Within this role, supervision and mentoring are crucial to provide support and safety for the person providing the health education. It is recommended that clinical supervision, cultural mentoring and operational management are engaged when preforming this role.

Clinical Supervision

Clinical supervision facilitates the process of reflective practice which supports the individual to develop the knowledge and skills required to enhance the quality and safety of care. The purpose of clinical supervision is to ensure the delivery of high-quality care and treatment through accountable decision making and clinical practice. It is also to facilitate learning and professional development.

Clinical Supervision is ordinarily undertaken by the HDF Podiatrist.

Cultural Mentoring

Cultural mentoring creates a space for dialogue about life and work experiences, cultural identity, expectations, understandings and perceptions, cultural obligations and reciprocity and how culture informs professional practice and career development.

Cultural Mentoring may be undertaken by arrangement or agreement by an Aboriginal person within the health services, for example the: Aboriginal Health Team Leader; Aboriginal Chronic Disease Program; Senior Aboriginal Health Worker.

Operational management

Operational management is a relationship designated to coordinate workload. It is dependent on:

- service delivery needs and settings
- skill and knowledge
- level of training and qualification.

Operational management elements can include but are not limited to; operational line management; consultation; performance management; and performance appraisal.

Operational supervision/ line management within the HDF team should be locally determined.

HEALTHY DEADLY FEET

Scope of role

The scope of this role is determined by the local health service. It is important to define the scope in relation to the HDF setting based on local cultural/expectations and competence of the person performing in the role. The following table is based on some of the skills sets within the Certificates of Aboriginal Primary Health Care and Allied Health Assistance. It is to be utilised as a guide to develop the scope of the role within each LHD/SHNs.

PROVIDE INFORMATION AND STRATEGIES IN HEALTH CARE
Consider identified community and individual client needs in determining priorities and potential areas to be addressed
Provide accurate information about the nature, incidence and potential impacts of health conditions in relation to Aboriginal communities
Provide accurate information about the importance of regular health checks, compliance with treatment regimens and medications, and the need to follow-up and monitor problems
Provide health information in plain language, using visual aids where appropriate
Discuss risk factors relating to specific health problems in the context of local, cultural, community, family and individual issues
Provide practical advice relating to maintaining good health in line with individual and community needs and organisational guidelines
Provide support for clients with common health problems in Aboriginal communities
Provide guidance about health issues in line with community needs
Use culturally appropriate educational resources for health programs
Provide information about resources available in the community and state in relation to addressing health issues
Support clients to take a self-care approach to maintaining health in line with identified individual needs
Organise follow-up care for clients with health problems using computer – and/or paper-based registers
Identify clients who are overdue for health care checks and employ active-recall strategies
Identify social and environmental factors that impact on health problems and address them in partnership with the community and other agencies
Promptly report any notifiable health problems detected or suspected in line with organisational and regulatory requirements

HEALTHY DEADLY FEET

PROVIDE INFORMATION AND STRATEGIES IN CHRONIC CONDITION CARE
Consider identified community and individual client needs in determining priorities and potential areas to be addressed by chronic condition health promotion
Identify primary, secondary and tertiary prevention strategies for prevalent chronic conditions across the lifespan
Provide accurate information about the nature, prevalence and potential impacts of chronic conditions in relation to Aboriginal communities
Provide health information in plain language, using culturally appropriate and safe communication skills, and visual aids where appropriate
Discuss risk factors relating to specific chronic conditions in the context of local, cultural, community, family and individual issues
Explain and/or demonstrate practices for early detection of specific chronic conditions
Provide information about available resources in relation to addressing chronic conditions
Equip clients with common chronic conditions to make effective decisions about their health
Assist clients with chronic conditions to actively participate in the development of multidisciplinary care plans
Use culturally appropriate educational resources for chronic condition programs
Provide information about resources available in the community and state in relation to addressing chronic condition issues
Support clients to take a self-care approach to maintaining health in line with individual needs
Make appropriate referrals for clients with chronic conditions in accordance with organisation procedures and policies
Maintain confidentiality to reflect community and organisation guidelines
Offer brief interventions for smoking cessation as required, using motivational interviewing and other relevant techniques
Identify patterns of alcohol consumption and offer brief interventions as required
Identify clients with chronic conditions who are overdue for health care checks and engage follow-up and active recall strategies according to organisation procedures and policies
Identify social and environmental factors that impact on chronic conditions and address them in partnership with the Aboriginal community and other agencies

HEALTHY DEADLY FEET

PROVIDE INFORMATION AND STRATEGIES IN CHRONIC CONDITION CARE
Identify the person's chronic disease conditions and seek information about its possible impacts on health, well being and ability to achieve maximum performance in everyday situations
Determine current treatments, and other inputs and supports by seeking information from the person or other health professionals
Determine the level and type of support and assistance required by the person within scope of own role
Adjust services and support to meet the specific nature of the chronic disease
Actively involve the person in the development of strategies to self manage their chronic disease
Discuss with the person, their family and other carers, the full range of issues that could have an impact on their well being
Respond to the range of issues in an integrated way
Support the person to understand their chronic disease condition
Facilitate the person to self manage through provision of advice and resources
Identify and discuss any unmet needs and requirements and make appropriate referral
Maintain awareness of current contribution of other agencies and professionals in supporting the person
Identify the level and type of contribution made by family and other carers and the effects it has on the person
Identify and meet communication and reporting responsibilities within the support system and own role
Respond to variations in the person's needs in the context of a coordinated service approach
PLAN, DEVELOP AND EVALUATE HEALTH PROMOTION AND COMMUNITY DEVELOPMENT PROGRAMS
Consult community representatives and key people to identify community health needs and concerns
Assess information to identify key stakeholders, community health trends and ethical considerations
Undertake appropriate research and identify community development opportunities
Consider and respect community values and beliefs, gender roles and taboos in researching community health needs
Identify and access relevant existing resources (human, financial and physical) for use in health promotion and community development programs

HEALTHY DEADLY FEET

Create a process for key representatives of the community and any related agencies or organisations to be consulted in the plan development
Ensure health promotion and programs have a holistic, culturally sensitive approach and support the community in taking a self-determination approach to health
Prepare proposals (or submissions) as required to address any additional resource requirements, including funding
Identify evaluation processes and criteria to be used for critiquing health promotion programs
Develop health promotion strategies in partnership with key representatives of the community and any related agencies or organisations
Develop goals, actions and key performance indicators for health promotion and community development activities
Identify appropriate delivery strategies according to the needs of the target group, location and health issues
Provide relevant information to health services, work team and community
Access, adapt or develop resources (human, financial and physical) as required to suit the needs of the health issue, audience and program delivery context
Provide health care and community development programs to the community in ways that are consistent with Aboriginal community values and beliefs
IIntegrate and implement health screenings in own practice to enhance understanding of the work team and community needs, concerns and resources available, surveillance and education activities into the programs
Provide information in plain language to clients about health problems common to their particular client group, using culturally appropriate and safe communication skills
Refer common health problems identified as part of the program to professionals and support services
Support clients and families in accessing health care services and associated benefits as required
Provide guidance, support and assistance to individuals and families coping with social and emotional issues according to identified needs and cultural protocols
Reflect on own practice to enhance understanding
Evaluate health promotion and community development program against criteria that reflect identified community health objectives
Monitor and evaluate community health outcomes

HEALTHY DEADLY FEET

Collect, document and interpret data to contribute to the evaluation of health programs
Seek to identify program strengths as well as areas for improvement as a basis for continual enhancement of health outcomes
Communicate outcomes of the evaluation to relevant stakeholders to guide future activities in the delivery of health promotion and health services to the community
Seek feedback on program effectiveness and provide to community and organisational representatives
Prepare reports from data collected and provide to management in line with organisational guidelines
Maintain client and community confidentiality in line with organisational and community requirements
Support ongoing community development strategies
CONDUCT GROUP SESSIONS FOR INDIVIDUAL CLIENT OUTCOMES
Obtain information about the purpose of the group sessions from an allied health professional and the desired individual client outcomes
Identify requirements outside scope of role and responsibilities as defined by the organisation and discuss with allied health professional
Identify and confirm impact of the program's contribution to the clients' overall care plan
Determine client availability according to organisation protocols
Determine client appropriateness according to client profile
Plan group activities that are consistent with client needs and recognise physical abilities and limitations of each client
Plan group activities that are consistent with the interests, preferences and beliefs of the clients
Plan group activities with consideration of the clients' pace and timing requirements
Plan group activities according to the size and composition of the group
Plan group session to maximize the involvement of all group members
Establish a balance between tasks to be accomplished and the group process
Identify possible risk to successful group activities and adjust the plan to minimise risk
Confirm group session plan with allied health professional

HEALTHY DEADLY FEET

Gather and/or prepare materials and equipment required for the group session and check for safety and suitability
Arrange the environment to encourage full participation by all group members
Seek agreement on the purpose, process and intended outcomes of the group activity with the group
Discuss the group activity with the group to encourage as much participation as possible
Work with the group to establish ground rules
Provide each group member with the necessary information, materials and support to participate in the group activity
Ensure that the manner, level and pace of communication is appropriate for each group member
Communicate with clients in a manner most likely to promote co-operation, dignity and self-esteem and encourage participation
Use group skills to ensure the involvement of all group members
Identify potential conflict within the group and manage to ensure ongoing involvement of individuals in group activities
Seek assistance when client presents with needs or signs outside limits of own authority, skills and/or knowledge
Report client difficulties to the supervising allied health professional for advice before continuing the program
Participate in supervision processes with the treating allied health professional in accordance with organisation protocol

HEALTHY DEADLY FEET

HEALTHY DEADLY FEET

Domain 3
Foot Screening and Early Intervention Guideline

NSW GOVERNMENT

Healthy Deadly Feet

This domain involves both screening and the provision of basic foot care in partnership with a Podiatrist.

The Healthy Deadly Feet (HDF) worker working in this domain will:

- Prepare for and perform basic foot hygiene (excluding scalpel work)
- Apply padding and cushioning (as described in this guideline)
- Assist with support and advice to clients in the selection of footwear
- Assist with cutting and filing toenails of very low risk feet (as described in this guideline)
- Complete basic foot screening (as described in this guideline)
- Conduct basic dressing (as described in this guideline)
- Conduct basic first aid if required

The professional development that will assist the HDF worker to complete the tasks in this domain would include the podiatry skillset – Assist with basic foot hygiene from HLT43015 Certificate IV in Allied Health Assistance or CHCCCS013 Provide basic foot care. First aid training along with both Workplace Health and Safety and Infection control would also need to be covered.

Suggested Units of Competency are:

HLTAHA006 – Assist with basic foot hygiene

or

CHCCCS013 – Provide basic foot care

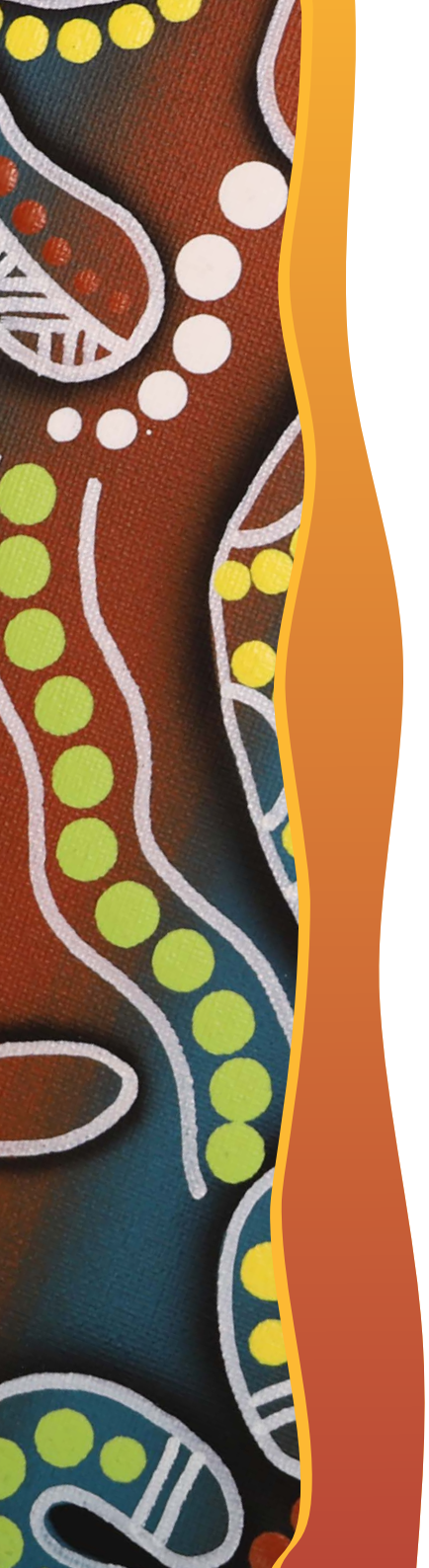
HLTWHS002 – Follow safe work practices for direct client care

or

HLTINF001 – Comply with infection prevention and control policies and procedures

HLTWHS001 – Participate in workplace health and safety

HLTAID003 – Provide first aid



Healthy Deadly Feet project

The NSW Ministry of Health developed the Healthy Deadly Feet (HDF) Project with the aim to increase the Aboriginal workforce in foot care and podiatry in NSW Health and improve Diabetes Related Foot Disease (DRFD) outcomes for Aboriginal people in NSW. The HDF team includes HDF workers – Aboriginal Health Workers (AHWs), Aboriginal Health Practitioners (AHPs), Aboriginal Allied Health Assistants (AAHAs) and Allied Health Assistants (AHAs) and podiatrists who clinically supervise the HDF workers.

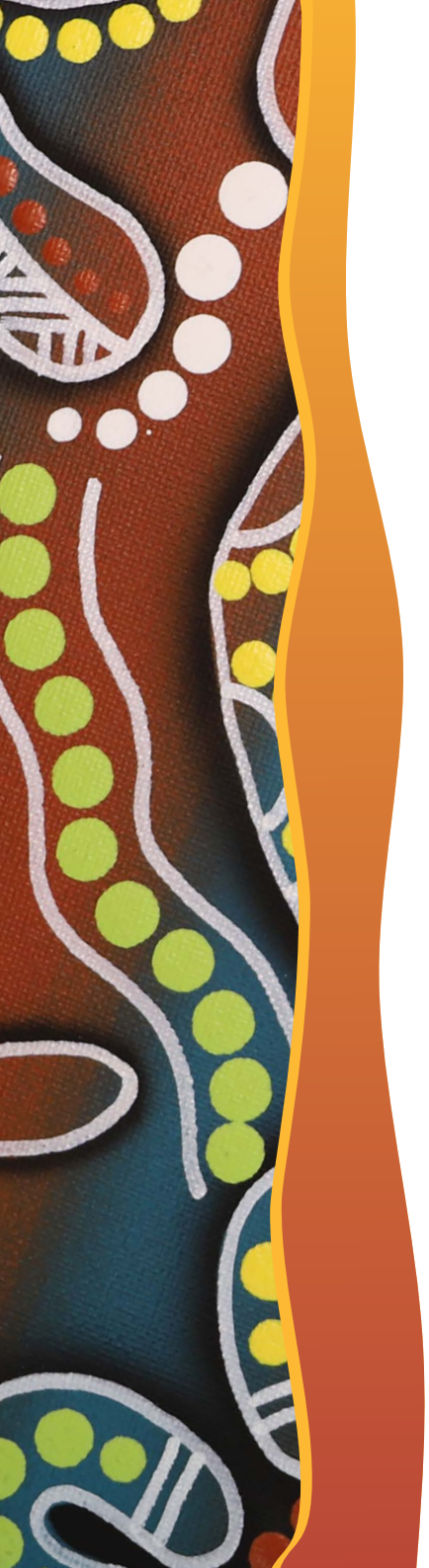
The HDF team will work with Aboriginal people of all ages across NSW who have or are at risk of developing diabetes and DRFD, as well as their families and communities. The HDF team will raise awareness in the Aboriginal community of the risk factors for diabetes and DRFD, strategies for prevention, and the treatment options and care facilities available.

The HDF team will support Aboriginal people in their communities across three domains of care:

1. Cultural care navigator

2. Health promotion and education

3. Foot Screening and early intervention



Foot Screening and Early Intervention

1. Introduction

This guideline has been developed to support the third domain – Foot screening and early intervention. It will outline appropriate management for people who may require foot care, and support best practice for the prevention and management of foot complications.

2. Aims and Expected Outcomes of this Guideline

Aims

- Patients will have their foot care needs screened and managed appropriately.

Outcomes

- Foot screening completed and action plan developed.
- Appropriate referrals made and foot care program commenced if applicable.

3. Scope

This guideline applies to all trained clinicians with at least the unit of competency of either HLTAH006 - Assist with basic foot hygiene or CHCCCS013 - Provide basic foot care. These clinicians must also be able to perform foot screening and management* including:

- Aboriginal Health Practitioners
- Allied Health Assistants

4. The Aboriginal Foot

An assessment of 127 people with Aboriginal ancestry found a tendency for increased pressure on the front of the foot when walking or running. This is thought to be related to the way the bones and ligaments have developed over generations which improve athleticism. The formal term for this biomechanical change is equinus which reduces movement of the ankle meaning that the foot points slightly more downwards. This places more pressure on the forefoot, which can contribute to skin changes like calluses and corns. In turn this can increase the risk of ulceration and amputation, especially as people get older, gain weight or are living with diabetes and peripheral neuropathy.

While this study is too small to generalise, the findings indicate more research needs to be done in the field . More information is available in the 2018 research article from Dr James Charles.

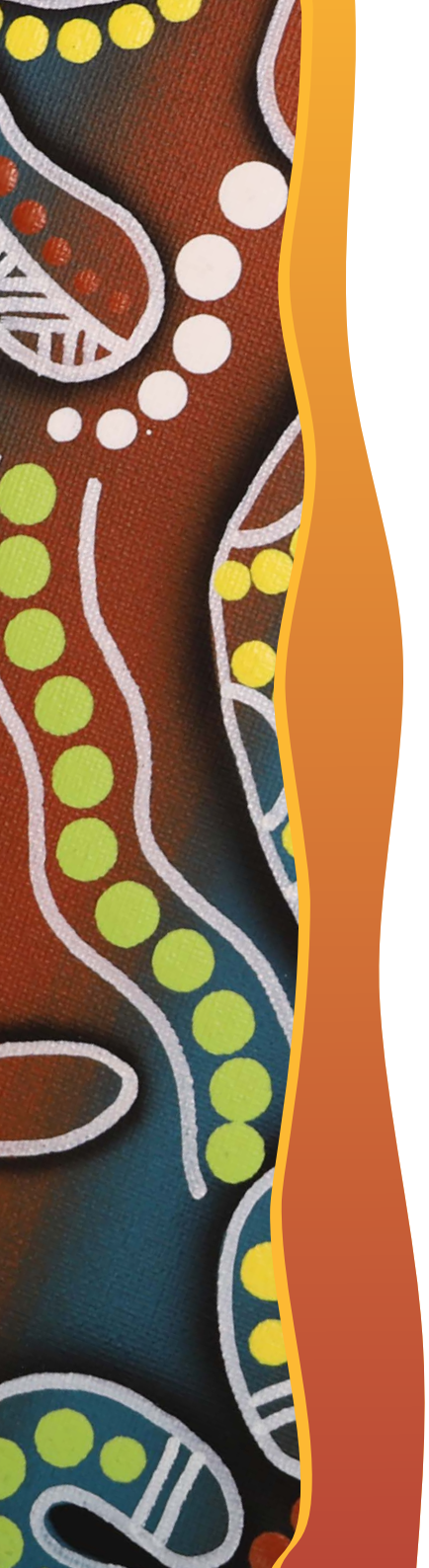
5. Foot Screening

Foot screening forms the basis for planning essential foot care and appropriate referral. A foot screening identifies:

- **Foot problems** – which may be causing discomfort, putting the foot at risk of complications
- **Change in circulation** – (see section 5.1.1) peripheral artery disease (PAD) can be limb threatening if not identified early and vascular consultation may be indicated when at risk
- **Change in nerve function** – peripheral neuropathy provides information to assist not only in assessing risk but also implementing pressure relief strategies as patients will be unable to provide reliable feedback regarding pain.
- **Self-care capacity** – consider whether a patient will require basic foot care assistance

The Figure 1 Diabetes Foot Screening Tool may be used when screening a patient's feet. This tool will screen for PAD and peripheral neuropathy, to direct clinical decisions related to their foot care needs.

* Basic foot hygiene under the direction of a podiatrist, including skin and nail care and applying dressings, padding and cushioning (excluding scalpel work).



5.1 Risk Factors

5.1.1 Peripheral Arterial Disease – change in circulation

Peripheral Arterial Disease interferes with skin integrity and a person's ability to heal if they develop a wound. Debridement or aggressive nail reductions in these patients may not always be indicated until review by a Vascular surgeon is able to establish adequacy of circulation to heal. During screening the dorsalis pedis and posterior tibialis pedal pulses should be palpated. If pulses are not palpable and the skin integrity is compromised a referral to the patient's general practitioner (who may refer to a vascular specialist) should be considered.

5.1.2 Peripheral Neuropathy – change in nerve function

Peripheral Neuropathy interferes with a person's ability to feel pain. In combination with callus or corns overlying a deformity this increases a person's risk of developing an ulcer.

Screening for peripheral neuropathy may include use of a 10g monofilament* (if available) or the Light Touch Test (also known as the Ipswich Touch test).

Table 1: Risk factor screening

RISK FACTOR SCREENING	
Diabetes-related peripheral neuropathy or loss of protective sensation (LOPS)	Unable to feel 10g monofilament* under the hallux, 1st or 5th MPJ with eyes closed Or unable to feel light touch on the 1st, 3rd, or 5th toes
Peripheral arterial disease or signs	Unable to palpate at least one pedal pulse
Calluses or corns	Very thick skin over a joint or on the heels that could result in foot ulceration

5.1.3 Diabetes Mellitus

There is no single condition that places the foot at risk of developing foot complications, instead it is a combination of factors. Diabetes mellitus does not require a Podiatrist to cut nails that are simply long, if the patient has no risk factors for foot ulceration/amputation.

* A 10g monofilament is a strand of nylon used to assess sensation in peripheral nerves by exerting 10g of pressure. If one or more locations on the bottom of the foot cannot be felt by the patient it is considered diagnostic of peripheral neuropathy.

HEALTHY DEADLY FEET

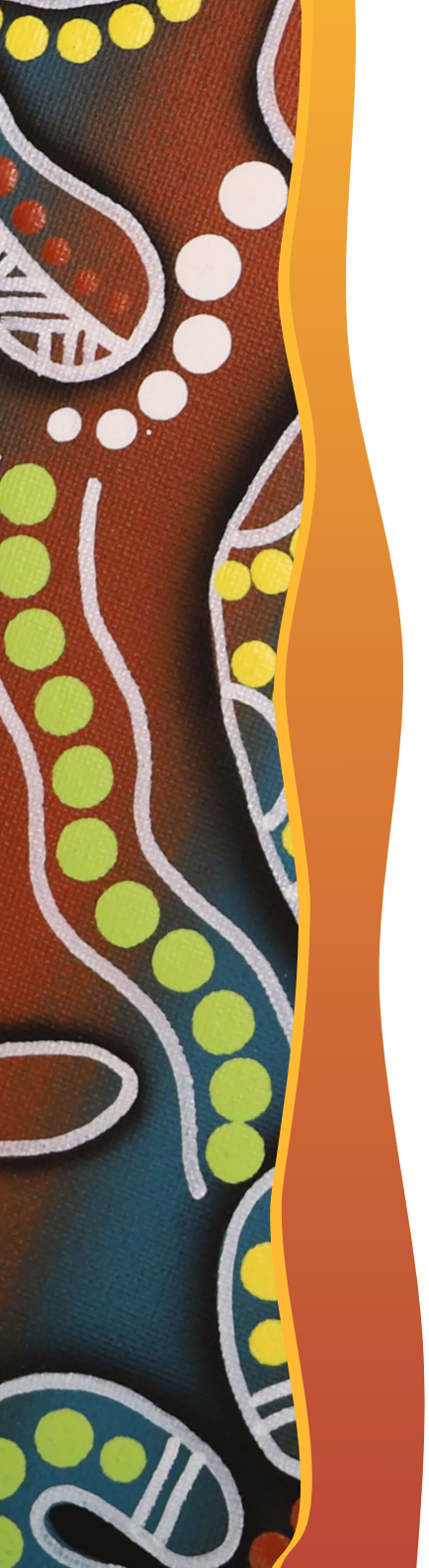
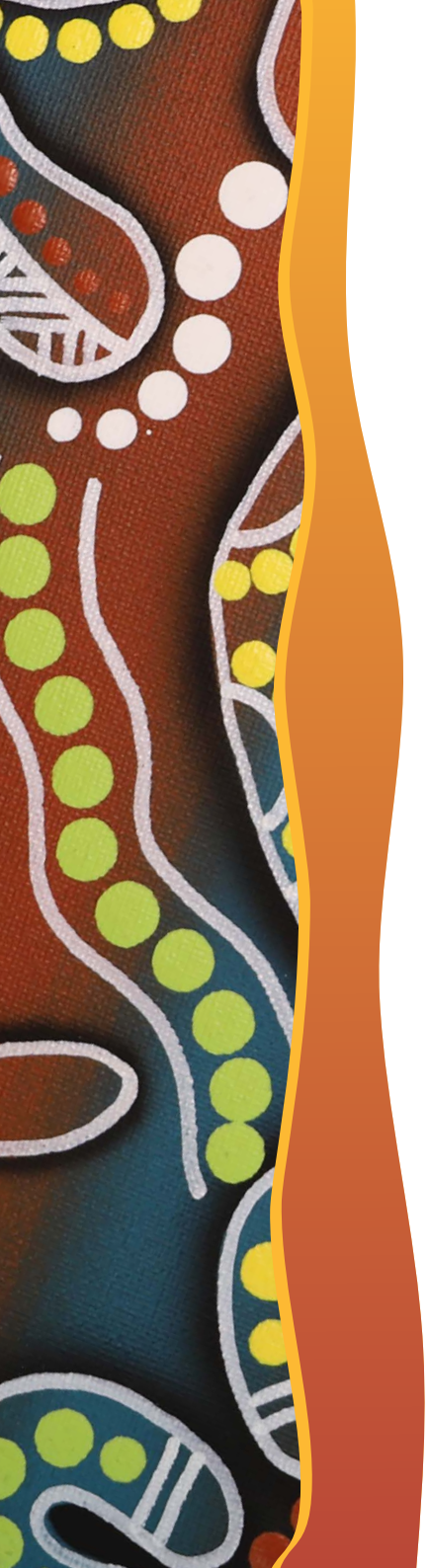


Figure 1. Diabetes Foot Screening Tool

PODIATRY HISTORY				
1	Do you currently see a Podiatrist?		☐ Yes ▶ ☐ No	If Yes, when did you last see a Podiatrist?
IDENTIFY FOOT PROBLEMS				
Foot problem		**Description**		
2	Current foot ulcer	Present for> 1 month and below the ankle	☐ Yes ▶ ☐ No	If Yes, refer to Podiatrist, High Risk Foot Clinic (HRFC) or GP
3	Infection	Bacterial infection with cellulitis, discharge, swelling or other sign of infection	☐ Yes ▶ ☐ No	If Yes, refer to GP or HRFC, then Podiatrist
4	Amputation	Lower extremity amputation (minor or major)	☐ Yes ▶ ☐ No	If Yes, refer to Podiatrist
5	Foot deformity	Bunion, hammer/claw toe, Charcot joint, prominent bone	☐ Yes ▶ ☐ No	If Yes, refer to Podiatrist
6	Previous foot ulcer	Present for> 1 month prior to healing and below the ankle	☐ Yes ▶ ☐ No	If Yes, refer to Podiatrist
7	Calluses or corns	Very thick skin over a joint or on the heels	☐ Yes ▶ ☐ No	If Yes, refer to Podiatrist
8	Skin breaks	Damage to the skin on the foot	☐ Yes ▶ ☐ No	If Yes, refer to Podiatrist
9	Nail disorders	Ingrown, painful, very thick	☐ Yes ▶ ☐ No	If Yes, refer to Podiatrist



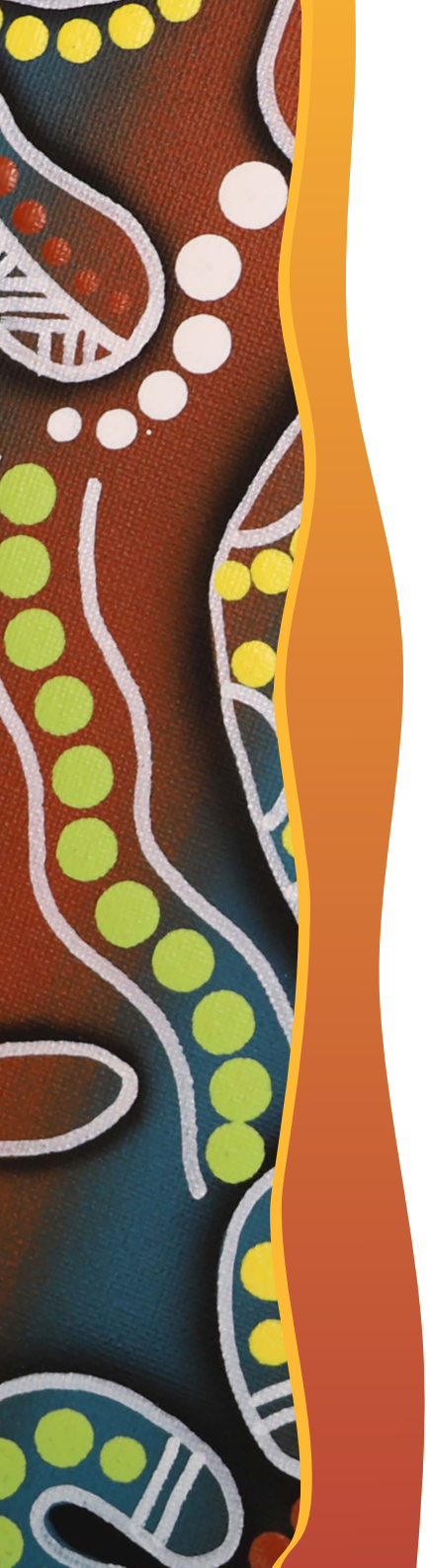
Diabetes Foot Screening Tool (continued)

IDENTIFY CHANGE IN CIRCULATION – IF CIRCULATION IS ABSENT PERIPHERAL ARTERY DISEASE (PAD) NEEDS TO BE CONSIDERED		
10 Left foot dorsalis pedis pulse felt	☐ Yes ☐ No ▶	If No, refer to GP and/or Podiatrist
11 Left foot posterior tibial pulse felt	☐ Yes ☐ No ▶	If No, refer to GP and/or Podiatrist
12 Right foot dorsalis pedis pulse felt	☐ Yes ☐ No ▶	If No, refer to GP and/or Podiatrist
13 Right foot posterior tibial pulse felt	☐ Yes ☐ No ▶	If No, refer to GP and/or Podiatrist
14 Vascular symptoms –intermittent claudication (cramping with exercise, relieved with rest)	☐ Yes ▶ ☐ No	If Yes, refer to GP and/or Podiatrist
IDENTIFY CHANGE IN NERVE FUNCTION – FOR PEOPLE WITH DIABETES WITH SUSPECTED LOSS OF PROTECTIVE SENSATION (LOPS)		
15 Left foot 10g monofilament felt (or light touch test)	☐ Yes ☐ No ▶	If No, refer to Podiatrist
16 Right foot 10g monofilament felt (or light touch test)	☐ Yes ☐ No ▶	If No, refer to Podiatrist
17 Neuropathic symptoms – burning, numbness, tingling, sharp shooting pain	☐ Yes ▶ ☐ No	If Yes, refer to Podiatrist
IDENTIFY SELF-CARE CAPACITY		
18 Does the person have normal vision?	☐ Yes ☐ No ▶	If No, consider foot care by Podiatrist or HDF worker and provide foot health education
19 Can the person reach their own feet for safe self-care?	☐ Yes ☐ No ▶	If No, consider foot care by Podiatrist or HDF worker and provide foot health education

Diabetes Foot Screening Tool (continued)

IDENTIFY SELF-CARE CAPACITY (CONTINUED)		
20 Are there any other factors influencing the person's ability to safely care for their own feet?	☐ Yes ▶ ☐ No	If Yes, consider foot care by Podiatrist or HDF worker and provide foot health education
IDENTIFY EDUCATION NEED		
21 Does the person understand the effects of diabetes on foot health?	☐ Yes ☐ No ▶	If No, provide foot health education
22 Can the person identify appropriate foot care practices?	☐ Yes ☐ No ▶	If No, consider foot care by Podiatrist or HDF worker and provide foot health education
23 Are the person's feet adequately cared for?	☐ Yes ☐ No ▶	If No, consider foot care by Podiatrist or HDF worker and provide foot health education
CHECK FOOTWEAR		
24 Is the **style** of footwear good?	☐ Yes ☐ No ▶	If No, provide foot health education
25 Is the **condition** of footwear good?	☐ Yes ☐ No ▶	If No, provide foot health education
26 Is the **fit** of the footwear good?	☐ Yes ☐ No ▶	If No, provide foot health education

HEALTHY DEADLY FEET

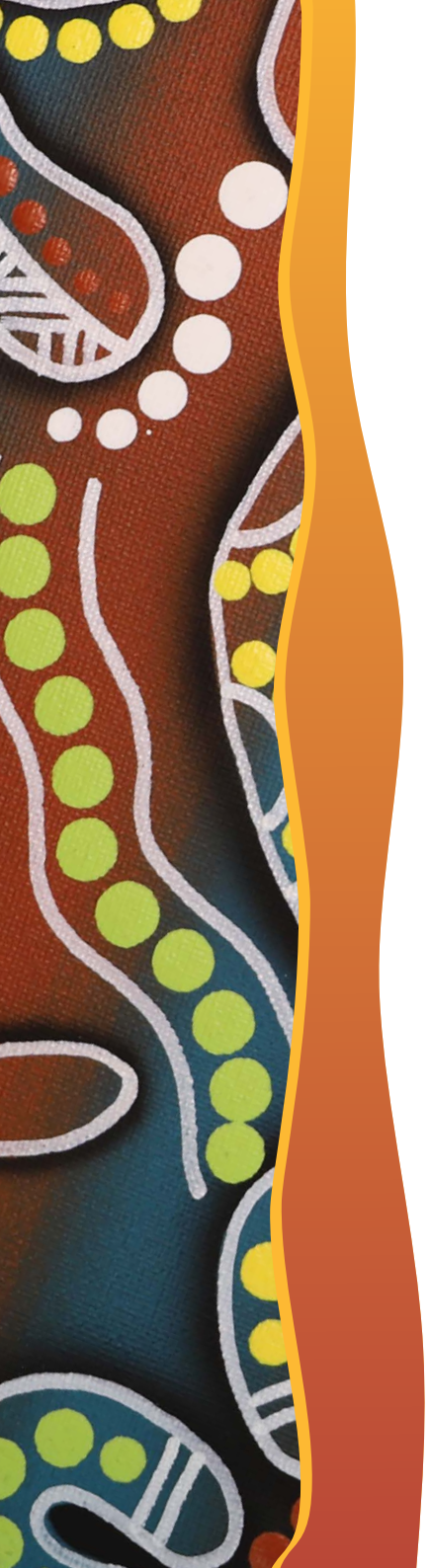


Action Plan

Following completion of the screening tool use this form to record actions

ACTIONS NEEDED	REASON FOR REFERRAL	DATE REFERRAL MADE
Refer to Podiatrist		
Refer to High risk foot clinic		
Refer to GP *Consider Chronic Disease management program referral		
Foot care health education		
Provide basic foot care		

HEALTHY DEADLY FEET



6. Basic Foot Care

The provision of basic foot care is a normal activity of daily living. There are instances when an individual is unable to attend to their own foot care due to illness, age or disability and assistance will be required to help with foot hygiene.

When an individual is identified as 'Low Risk' (see table Foot Risk Stratification) or does not have a pathology that requires specialist care, the Health Practitioner Regulation National Law Act 2009 allows for the provision of basic foot care by health practitioners regulated under the act, this includes but is not limited to

- Aboriginal Health Practitioner (AHP)*
- Allied Health Assistant (AHA)*.

Patients or family members may be encouraged and supported in providing basic foot care.

Foot hygiene or basic foot care includes but is not limited to:

- Washing
- Drying
- Applying moisturisers
- Cutting and filing non-pathological nails
- Cleaning of superficial dead skin/material between the toes

6.1 Equipment

Use of **Disposable foot care** kits is encouraged as it reduces the risk of infection and negates the need to sterilise sets in cases where a sterilisation facility is not available. The Susol Basic kit includes 1x Nipper, and 1x Nail File, double sided fine and medium

- Suppliers include: Orthopaedic Appliances & Briggate Medical Company
- NSW Health HIMF* code 548979

6.2 Cleansing and Moisturising

- Feet should be washed with warm water and soap during normal showering/cleansing routine
- After cleansing, feet should be dried with a towel, especially between the toes
- After drying, apply emollient on soles and top of feet – do not put moisturiser between toes as it may encourage maceration and tinea.

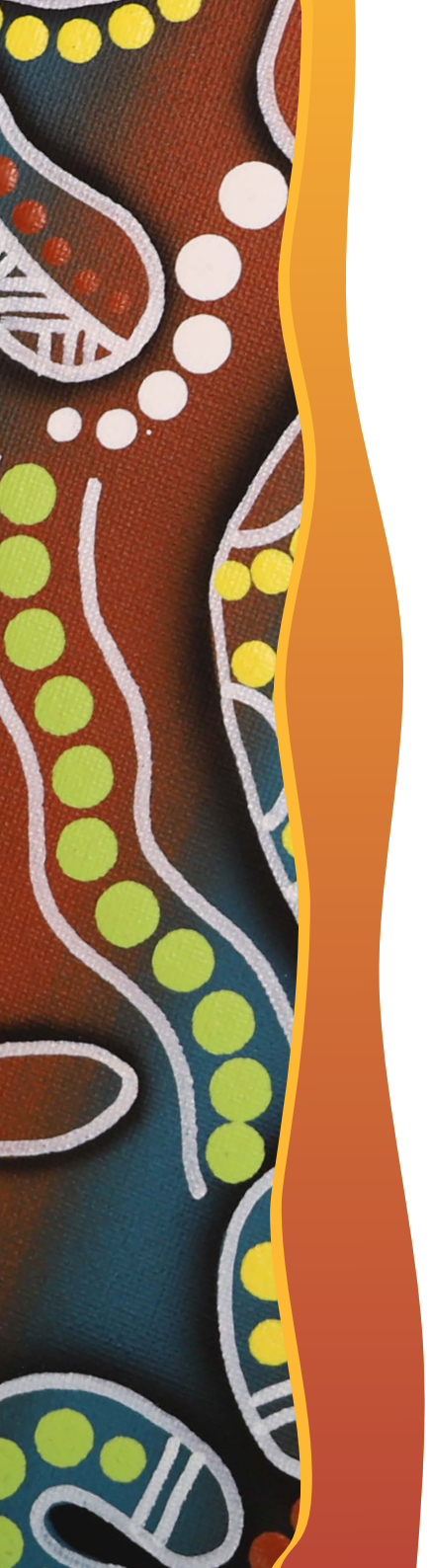
6.3 Cutting Nails

- Place a bluey under the patients feet to collect nail debris and trimmings
- Prior to cutting nails, cleanse/wipe feet, including between toes, with gauze and skin cleanser, check between toes for lesions, maceration or tinea and examine heels for fissures, pressure areas or callus.

* With the unit of competency HLTAH006 Assist with basic foot hygiene or CHCCCS013 – Provide basic foot care as a minimum from the Certificate IV in Allied Health Assistance (Podiatry) – National Course Code: HLT43015

** The Health Item Master File (HIMF) is a list of generically described products that are procured by HealthShare NSW for Local Health Districts and other Public Health Organisations.

HEALTHY DEADLY FEET



- Use the sterile clippers to trim the nails, following the natural curve of the nail line, and taking small, successive snips rather than trying to cut in one large clip.
- Keep thumb over the top of the clipper to avoid the toenail clipping from causing you injury
- File sharp edges over the end of nails from the top down (not across or along the cut edge)
- Remove bluey and all nail debris which might otherwise injure a patient's skin
- Dispose of clippers into contaminated sharps container.

6.4 Documentation in the Medical Record

All foot care given should be appropriately documented and provided within the requirements of infection control practice and legislation. Any foot care provided should be documented in the medical record.

6.5 Common Procedures

Under the delegation of the podiatrist, these procedures may be appropriate. The skills and knowledge to conduct these procedures are included in the unit of competency HLTAHA006 – Assist with basic foot hygiene or CHCCCS013 – Provide basic foot care. Verbal and written education should be provided to the client to support their understanding and allow for monitoring and adjustment if required.

6.5.1 Applying Cushioning and Padding

Cushioning is used to relieve foot pain when the normal fat pad or tissue over bony prominences (joints & bones) has been lost. This can happen due to age, progressive joint diseases such as arthritis &/or bunion development, cortisone injections or genetics. Clients will often feel pain in these areas and in some cases develop hard skin or callus. Cushioning materials are used (in conjunction with footwear education) to protect and reduce the amount of force being exerted and thus reduce pain.

Padding is used to relieve foot pain or pressure that causes corns or more focal areas of pressure. Padding materials are used to redistribute focal areas of pressure and the force to other areas of the foot, so that it does not all go into one area.

6.5.2 Basic Dressing/Wound Care

If a client has a wound the HDF worker should follow the delegated instructions for dressing the wound, escalating any concerns if there are any changes or deterioration as per local protocols.

If a patient presents with a wound not previously noted or in the delegated instructions, the HDF worker should discuss with the delegating Podiatrist or Registered Nurse before dressing the affected area.

HEALTHY DEADLY FEET

7. Delegation of Tasks

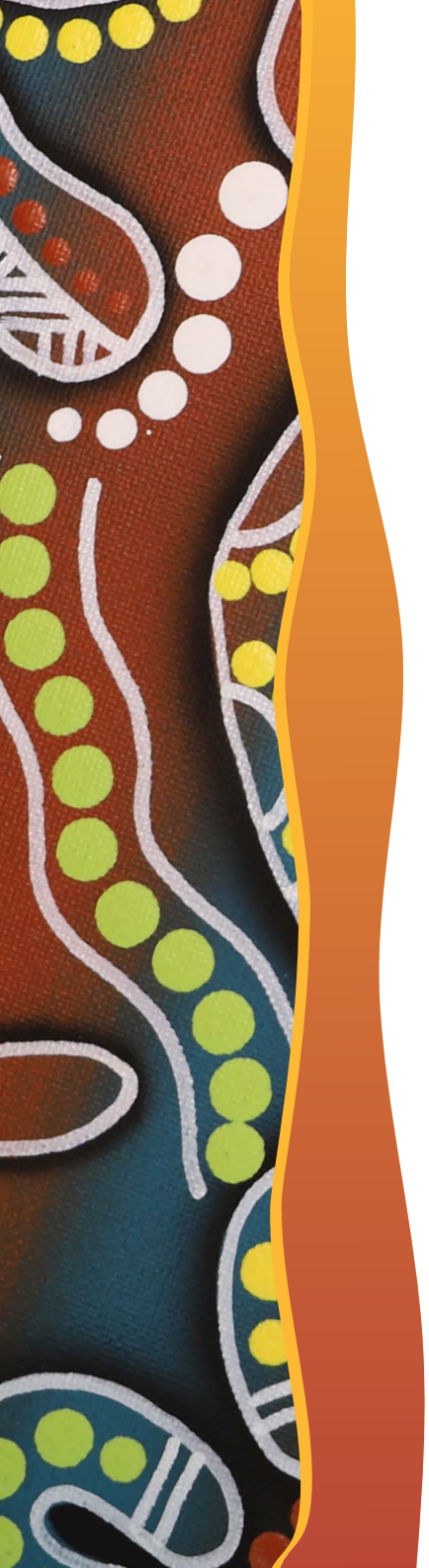
Delegated tasks are those tasks that fall within the scope of the Podiatrist but which the Podiatrist delegates to the HDF worker to complete on their behalf. Delegated tasks are patient related and this delegation needs to be documented in the patient notes. An allocated task is a task that is specifically included in the scope of the HDF worker and is not patient specific. Determining which tasks will be allocated to the HDF worker will need to be determined locally in the context of the environment and the local clinical need.

Patient related tasks, relating to specific patients, included in this guideline will be delegated by the podiatrist or health care professional, as identified in local clinic protocols. Tasks that are not specific to an individual patient may be completed by the HDF worker without specific delegation from the podiatrist. For example, the HDF worker might complete a basic foot screen and conduct foot care education for all Aboriginal patients presenting to a particular ward or community centre, this becomes an allocated task. Allocated tasks do not include delegation from the Podiatrist.

For patient related tasks, the delegating health professional will identify the task, delegate using clear communication and demonstration if required, document the task and review the task for each patient, including any changes from the usual task processes and expected outcomes.

The HDF worker undertaking the task should review the medical record and liaise with medical, nursing or any other appropriate staff, if relevant, to determine whether there are any new medical issues which may impact on the suitability for foot care and notify the delegating Podiatrist of any reported changes.

HEALTHY DEADLY FEET



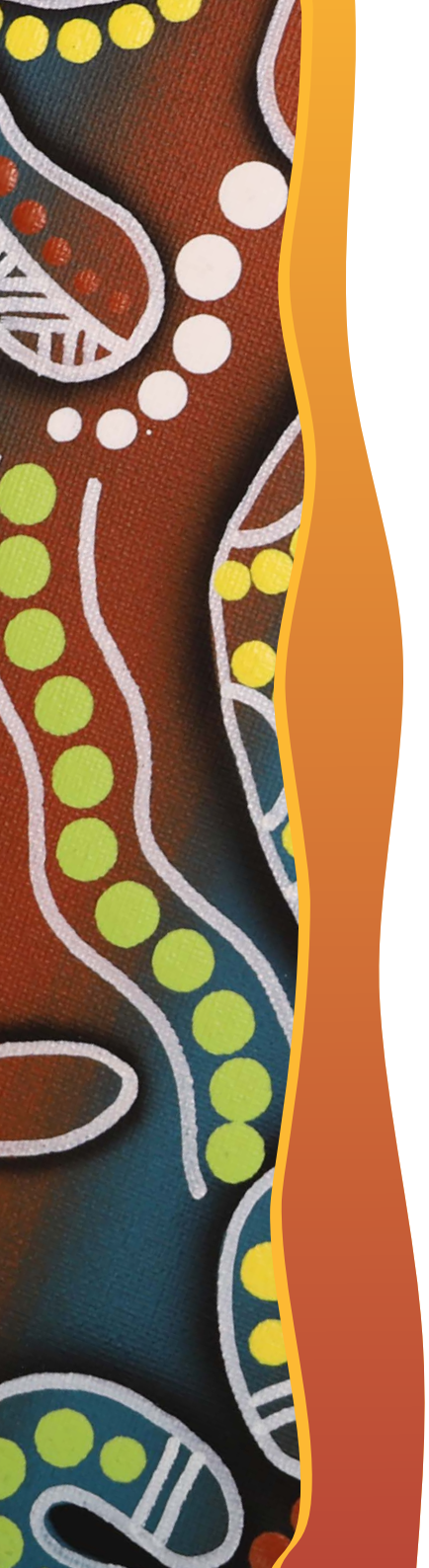
8. Foot Risk Stratification

Risk stratification refers to the assessment of a person's risk of developing foot complications such as diabetic foot ulcers. Foot risk stratification will be completed by the Podiatrist and used for service planning. This foot risk stratification has been adapted to the context of the HDF program from Foot Forward for diabetes program

Many foot conditions are ongoing and could be managed on a regular basis by the HDF worker. If, however, there is a risk level of high or moderate, this indicates that a podiatry referral is required.

RISK LEVEL	DEFINITION	ACTION
HIGH RISK	LOPS or PAD, and one or more of the following: • History of foot ulcer • A lower-extremity amputation (minor or major) • End-stage renal disease • Aboriginal*	• Refer to the persons GP and/or Podiatrist or High risk foot service if available, within 2-3 weeks • Provide foot care education, outline treatment expectations and reason for referral to the podiatrist • Include as part of the general practice annual cycle of care, schedule and inspect all areas of the feet **every 1 – 3 months**
MODERATE	LOPS + PAD, or LOPS + Foot Deformity or LOPS + Foot Pathology PAD + Foot Deformity or PAD + Foot Pathology	• Refer to the Podiatrist for ongoing care, within 6-8 weeks. • Provide foot care education, outline treatment expectations and reason for referral to the podiatrist • Include as part of general practice annual cycle of care, schedule and inspect all areas of the feet **every 3 – 6 months**
LOW	LOPS or PAD	• Engage person/family/carers and undertake opportunistic foot checks during medical, nursing, AHW etc appointments. • Referral for routine preventable foot care: - Podiatrist if a person with diabetes has PAD - HDF worker with relevant training if a person with diabetes has LOPS only • Address modifiable risk factors, such as smoking and diabetes management • Include as part of general practice annual cycle of care, schedule and inspect all areas of the feet **every 6 – 12 months**
VERY LOW	No LOPS and No PAD	• Address modifiable risk factors • Include as part of general practice annual cycle of care, schedule and inspect all areas of the feet **every 12 months**

* Until adequately assessed, all Aboriginal people with diabetes are considered to be at high risk of developing foot complications and therefore will require foot checks at every clinical encounter and active follow-up.



Education

- When foot screening is complete, the person with diabetes should be advised of their risk status and the information provided should reflect the person's risk status
- The person with diabetes risk status should be communicated to all members of the healthcare team
- Emergency contact numbers should also be provided to the person with diabetes, along with education regarding when to seek medical assistance

***Consider**

If pedal pulses are not palpable, which may suggest PAD:

- GP should be promptly advised of the outcome of the foot screening
- Referral for duplex ultrasound and/or vascular review, (if person with diabetes has had no previous intervention) may be indicated
- Some chronic ischaemic feet in people with diabetes may actually appear pink and well perfused initially due to autonomic neuropathy.

If the person cannot feel the 10g monofilament or the touch test, this may suggest LOPS:

- If foot screening is not conducted by a general practitioner (GP), the person with diabetes' GP should be promptly advised of the outcome of the foot screen

DEFINITIONS	AS PART OF FOOT SCREENING/ASSESSMENT IN PRIMARY CARE
AHA (Allied Health Assistant)	Allied Health Assistants who have completed an accredited foot care course, can safely perform a basic foot care assessment, determine foot care requirements and use essential equipment and a range of topical medications where the services of a professional podiatrist are not required.
AHW (Aboriginal Health Worker)	Aboriginal Health Workers who have completed an accredited foot care course, can safely perform a basic foot care assessment, determine foot care requirements and use essential equipment and a range of topical medications where the services of a professional podiatrist are not required.
LOPS (Loss of Protective Sensation)	Loss of Protective Sensation is assessed using either a 10g monofilament or the Light Touch test (refer to training module for further information).
PAD (Peripheral Artery Disease)	Peripheral Artery Disease is assessed through palpating pedal pulses
Modifiable Risks	Identifying risks that may be reduced or eliminated, for example; if a person smokes, they may benefit from smoking cessation to assist them in quitting, consistently high glycated haemoglobin test levels (HbA1c) should be addressed etc.
Foot Deformity	A change in foot type/shape that makes it difficult to fit a standard shoe as assessed by a trained health professional. Further training by local podiatry teams may be indicated.
Foot Pathology	These include corns, calluses, tinea pedis, thickened toenails (+/- fungal infection), heel fissures.
Aboriginal People	Consider that Diabetic Foot Ulcer presentations are at a younger age, hospital presentations and amputations are higher, suggesting that when people are seeking help when their disease is more advanced.[1] "Until adequately assessed, all Aboriginal people with diabetes are considered to be at high risk of developing foot complications and therefore will require foot checks at every clinical encounter and active follow-up".[2]

1. Defining the gap: a systematic review of the differences in rates of diabetes-related foot complications in Aboriginal and Torres Strait Islander Australian and non-indigenous Australians. West, M., Chuter, V., Muneaunu, S. & Hawke, F. (2017) Journal of Foot and Ankle Research, 10 (48).
2. National Evidence-Based Guideline on Prevention, Identification and Management of Foot Complications in Diabetes (Part of the Guidelines on Management of Type 2 Diabetes) 2011. Melbourne Australia