 

**NADC Collaborative**

**Interdisciplinary Diabetes**

**High Risk Foot Services (iHRFS)**

**Gap Analysis Template**

**Version 2.0 Nov 2023**



**DEFINITIONS**

**Access to:** Ability to contact directly for opinion and to provide clinical handover, either offsite or onsite. The underlying principle is that a patient/person with diabetes attending the iHRFS can expect that the iHRFS will be able to coordinate services and to provide on-site the majority of key services required for standard, evidence-based management of their foot problem. While it may not be practical to provide every specific service function on-site, it is anticipated that the service will work closely with other providers to ensure treatment is delivered in a coordinated manner according to agreed treatment protocols. Examples of off-site services would include:

* + hospital in the home for IV antibiotics
  + specialised total contact casting for Charcot's neuroarthropathy

**Dedicated to:** have allocated time available to provide care for patients/people with diabetes attending the iHRFS within their health care professional scope of practice and that this is recognised by their employer/manager as part of their duties/roles and responsibilities. Attends iHRFS team meetings.

**Definition of Meeting the Standards:** To be accredited the iHRFS needs to meet *each* of the standards, to the appropriate level.

**Diabetes Foot Disease:** Infection, ulceration or destruction of tissues of the foot, associated with neuropathy and/or peripheral artery disease (PAD) in the lower extremity of people with diabetes

**iHRFS:** Interdisciplinary High-Risk Foot Service, reflecting that the foot disease being managed places the patient/person with diabetes at high risk of foot complication such as initial or further, amputation

**On-site:** Located at the geographic physical site dedicated to the iHRFS

\*\*Note the iHRFS Standards: also includes management of people with foot complications who may have similar aetiology but not diabetes such as PAD, Neuropathy of other causes.

**Application Section**

The application section is designed to provide information about the service undergoing accreditation and what areas they HRFS excel in. The following will allow assessors an insight into your service and provide the necessary background.

* Provide Statistical information regarding your Interdisciplinary Diabetes HRFS including an estimate of patient numbers per month
* Provide an overview of your iHRFS contribution to research over the last two years
* Provide information about the different sorts of clinical services your iHRFS provides
* Provide an outline of the health professional education provided by your iHRFS over the last two years
* What areas does you iHRFS excel in
* Please list an programs, initiatives, tools or experiences that are examples of Best Practice that your iHRFS shares, or could share, with other iHRFS
* Outline your iHRFS data collection/auditing/quality improvement methods
* Provide a iHRFS and overall Organisational structure
* Provide a detailed timetable of clinics, including number of appointments available per clinic
* Describe and detail your services patient journey
* Provide a synopsis of your service and funding arrangements

**Standard 1: Interdisciplinary Approach**

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| **CORE SERVICE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| * Patient management is provided by a co-located interdisciplinary team with experience in the management of diabetes foot disease. |  |  |  |  |  |
| * The minimum Core iHRFS staffing is: a senior consulting diabetologist/endocrinologist/physician, a senior podiatrist, and a credentialled diabetes educator. |  |  |  |  |  |
| * All core iHRFS team members have dedicated time allocated to provide care for patients/people with diabetes attending the iHRFS within their scope of practice and this is recognised by their employer/manager as part of their duties/roles and responsibilities. |  |  |  |  |  |
| * Patients of the iHRFS should have access to (or clear documented referral pathway to) a Vascular surgeon, or specialist with expertise in peripheral arterial disease, and access to peripheral revascularisation procedures. |  |  |  |  |  |
| * A HRFS interdisciplinary clinic is conducted to a frequency of at least one session of 3.5 hours (morning or afternoon) per week, where each core member has dedicated time allocated to the session. |  |  |  |  |  |
| * iHRFS key strategic and planning meetings are attended by all core staff members at least once per year. |  |  |  |  |  |
| * All relevant members of the iHRFS team and the patient/person with diabetes-related foot disease, family members or carer (where appropriate) have contributed to the individualised patient management plan. |  |  |  |  |  |
| * Interdisciplinary case conferences are held as required for complex cases, with all core staff members and the patient/person with diabetes-related foot disease present and the conference detail is documented within medical records, including short and long-term management plans. |  |  |  |  |  |
| * iHRFS staff adopt a person-focused and mutually agreed goal-orientated approach. |  |  |  |  |  |
| * Where relevant service providers are not available on-site, rapid access referral pathways directed to required off-site specialists are documented in the model of care, and are supported by local guidelines and policies and utilised in the management of patients/people with diabetes. |  |  |  |  |  |
| **CENTRES OF EXCELLENCE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| Meets all Core Service indicators AND: |  |  |  |  |  |
| * Dedicated staffing as described in the core standard with *access to* regular consultation with the following *additional* health care professionals: * Endocrinologist * Infectious diseases specialist * Orthotist and/or pedorthist * Wound nurse specialist (optional) |  |  |  |  |  |
| * Patients of the iHRFS should have access to one or more specialist that has interest and expertise in foot correctice surgery, * Orthopaedic surgeon * Podiatric surgeon |  |  |  |  |  |
| * As required for relevant patient care, the *additional* health care professionals can be physically present at least fortnightly in the interdisciplinary clinic. |  |  |  |  |  |
| * A iHRFS maintains a podiatry service 5 days a week in business hours. |  |  |  |  |  |
| * The service to have access to other health professionals/support services who *may make an important contribution to patient care and/or the operation of the service* include: * Diabetes Nurse Practitioner (who may also undertake the role of a consulting physician in rural/regional setting) * The referring General Practitioner (GP)/primary care service/Health Professional (HP) * Dietitian * Psychiatrist and/or Psychologist * Social worker/counsellor * Cardiologist * Radiologist * Rehabilitation/Amputee specialist * Plastic Surgeon * Renal Specialist / nephrologist * Indigenous health worker * Exercise Physiologist and/or Physiotherapist * Neurologist / Chronic Pain Specialist/Team * Allied health assistant / nurse assistant * Geriatrician * Family/carers * NDSS information and support services |  |  |  |  |  |

**Standard 2: Physical Environment, Coordination and Administration**

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| **CORE SERVICE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| * An iHRFS member is appointed as the HRFS Coordinator to provide overall coordination of the iHRFS team, ensuring adherence to these standards and a coordinated approach to clinical care of the patient/person with diabetes-related foot disease. |  |  |  |  |  |
| * The iHRFS Coordinator: * has the scope of their authority clearly defined as outlined in a position description and recruited at an appropriate leadership level/grade; * has dedicated time to fill this role; * organises regular iHRFS team meetings and has documented the minutes of such meetings including to facilitate case conferences and dissemination of information to all iHRFS team members; * ensures processes for patient triage, management, bookings and follow-up are defined and occur; * ensures processes for communication with other relevant health professionals are defined. |  |  |  |  |  |
| * iHRFS-dedicated administration processes: * Adequate administrative time commensurate to clinical load is allocated to support functions including meeting bookings, patient triage and bookings, communication, follow-up care, and continuous quality improvement. * Dedicated administrative staff, are included in local businesses cases and models of care and can be accessed by the entire clinical team to support patient care, as defined by the Coordinator. |  |  |  |  |  |
| **CENTRE OF EXCELLENCE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| Meets all Core Service indicators AND: |  |  |  |  |  |
| * A iHRFS member is appointed as the iHRFS Clinical Leader (who may or may not be the HRFS Coordinator), who actively promotes and advocates for the iHRFS, its funding, resources, quality improvement and development, research quality, and has a lead role in articulation of the HRFS clinical and strategic direction / plan, plus development of local business cases/models of care as required. |  |  |  |  |  |
| * The iHRFS team Clinical Leader has the following:   + - demonstrated experience and expertise in diabetes foot management including evidence of continuing education, research or post-graduate qualification in the field of diabetes or wound management;     - demonstrated attributes and accomplishments consistent with being a strong clinical leader. |  |  |  |  |  |
| * + - Administrative staff assist with dedicated iHRFS quality assurance activities, including data collection and support for research and education. |  |  |  |  |  |

**Standard 3: Evidenced-Based Clinical Management**

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| **CORE SERVICE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| * Clinical staff have identified and agreed upon treatment guidelines and protocols which are based on published evidence-based best practice guidelines (EBPG) which should include:  1. Holistic assessment of the individual, including psychosocial factors, diabetes management, co-morbidities, and whenever able, documenting patient goals in care. 2. Foot disease assessment and management protocols with specific references to: 3. neurovascular assessment 4. revascularisation 5. Sharp debridement and surgical debridement 6. infection management 7. pressure offloading including orthotics and footwear 8. surgery (e.g. debridement, corrective surgery, need for amputation) 9. wound dressings 10. Patient education - what they know and what they need to know about diabetes and management of their foot complication(s). |  |  |  |  |  |
| * The iHRFS develops and documents hospitalisation avoidance pathways. |  |  |  |  |  |
| * All aspects of patient management are appropriately documented using a standardised approach that is aligned to the minimum dataset. \*\*Note wound severity, infection and perfusion status should each be graded using a validated grading system. |  |  |  |  |  |
| * It is evident in the medical record that clinical staff adhere to the agreed published EBPG for the management of patients with diabetes foot disease. |  |  |  |  |  |
| * Formal review and updating of guidelines and protocols according to current research and evidence occurs at least every 4 years or when new high level evidence is published or when relevant EBPG are published. |  |  |  |  |  |
| **CENTRE OF EXCELLENCE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| Meets all Core Service indicators AND: |  |  |  |  |  |
| * The iHRFS leads change in implementation of EBPG through education and development of local policies in their hospital, region or beyond. |  |  |  |  |  |
| * The iHRFS has strong communication and connection with the primary health network, GPs and primary care system to maximise early intervention and prevention. |  |  |  |  |  |
| * The iHRFS sets clear goals and monitors its achievement in terms of reducing the number of major amputations and the service focus is saving and preserving limbs. |  |  |  |  |  |
| * The iHRFS leads change through research, translational research and quality improvement which is published in peer review journals or reports which are available to other health professionals. |  |  |  |  |  |

**Standard 4: Access and Defined Intake Criteria**

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| **CORE SERVICE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| * Evidenced-based iHRFS intake criteria are clearly defined and articulated to referrers for both urgent and non-urgent referrals. |  |  |  |  |  |
| * The Coordinators have dedicated time and should undertake triage for referrals on the business day of receipt. |  |  |  |  |  |
| * Patients/people with diabetes with urgent referrals are assessed on the same day within business hours, that is for patients/people with diabetes where foot ulcers are suspected to be deep (probe to tendon, joint or bone), for those with spreading cellulitis, or with critical limb ischaemia, or patients with known or suspected acute Charcot neuroarthropathy. |  |  |  |  |  |
| * If there is no iHRFS capacity to see urgent patient referrals on the same day, the HRFS is to recommend Emergency Department attendance, with subsequent iHRFS follow-up as per Standard 5. |  |  |  |  |  |
| * Non-urgent referral for patients/people with diabetes foot disease who have less acute, yet superficial, and nonischaemia foot ulcers will receive treatment within 5 business days of referral, with optimal management management of the majority (80%) of the patients referred with urgent diabetes foot disease to be seen within 2 business days of referral. |  |  |  |  |  |
| * The iHRFS provides culturally appropriate services and has access to interpreter services where required. |  |  |  |  |  |
| **CENTRE OF EXCELLENCE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| Meets all Core Service indicators AND: |  |  |  |  |  |
| * Intake criteria are clearly defined and articulated to referrers, including if possible a web page. |  |  |  |  |  |
| * 80% of the patients referred with non-urgent diabetes foot disease are seen in the iHRFS within 2 business days of referral. |  |  |  |  |  |
| * Target for prevention of major amputations. |  |  |  |  |  |
| * The iHRFS has the capacity to, and process for, accepting clinically appropriate referrals from outside their geographical zone when there is no suitable iHRFS locally or when the patient’s condition is complex and requiring a higher level of service than is available locally. |  |  |  |  |  |
| * Provides information and general advice as requested by other iHRFS and community services, including assessment methods and care protocols and patient educational materials. |  |  |  |  |  |
| * Provides consulting telehealth services to outreach areas occurs when necessary and clinically appropriate. |  |  |  |  |  |

**Standard 5: Continuity of Care and Communication**

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| **CORE SERVICE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| * The patient’s management plan is to be developed in consultation with the patient/person with diabetes (and, where relevant, their family/carers). |  |  |  |  |  |
| * Management plans, (including wound care plans and updates) are communicated (i.e. via correspondence/letter and with SINBAD communication tool, plus other wound classification method as appropriate) in a timely manner (within 5 business days) to the referrer and all relevant health professionals involved in the patient’s care including the GP, following:   + initial consultation   + any new diagnosis or significant clinical change such as would warrant hospitalisation or significant change in treatment   + discharge |  |  |  |  |  |
| * In cases where peripheral arterial disease is present, prior to any amputation being undertaken, there is a referral pathway for vascular surgical services consultation, in order to facilitate consideration of revascularisation and/or limb salvage procedures. |  |  |  |  |  |
| * The iHRFS must have iHRFS discharge criteria and a related healthcare management pathway system with strategies for prevention of ulcer recurrence included. |  |  |  |  |  |
| * Defined individualised patient pathways post-iHRFS discharge are clearly identified and communicated via the SINBAD communiation tool (plus other wound classification method as appropriate), with the patient, referrer and the patient’s GP, with clinical handover processes in place to ensure continuity of care. |  |  |  |  |  |
| * The Emergency Department has a local guideline in place to contact to iHRFS regarding any patients presenting to ED or admitted into hospital with diabetes foot disease, who meet iHRFS referral criteria. |  |  |  |  |  |
| * For inpatients, with diabetes foot disease the iHRFS team provides recommendations in care for both inpatient and post-hospital care. |  |  |  |  |  |
| * The iHRFS team member is contacted in business hours, when non-admitted patients with foot complications present to the Emergency Department, for review and management plan update. |  |  |  |  |  |
| * A formal mechanism exists to identify and refer non-admitted patients with diabetes foot disease that present to the Emergency Department after hours e.g. by phone message, written referral or fax within one business day. |  |  |  |  |  |
| **CENTRE OF EXCELLENCE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| Meets all Core Service indicators AND: |  |  |  |  |  |
| * Patient education is supported with written information, pictorial or digital media and covers key topics such as self-care for their foot, footwear and pressure offloading devices. |  |  |  |  |  |
| * Processes are in place for inpatients who present with diabetes and a foot wound to be screened for suitability for iHRFS care and the iHRFS is to be notified of these patients with iHRFS consultation, treatment, management and/or involvement in the discharge process being provided as needed. |  |  |  |  |  |
| * Patients presenting to the Emergency Department, who have been screened as suitable for iHRFS care, can be directly referred to the outpatient iHRFS, avoiding a hospital admission. |  |  |  |  |  |
| * There is a pathway for patients seen in the iHRFS for direct admission to inpatient care, avoiding the Emergency Department. |  |  |  |  |  |
| * For patients being considered for non-emergency major amputation, there is a referral pathway to a pre-amputation clinic to a rehabilitation clinic specialist prior to amputation being undertaken. |  |  |  |  |  |
| * The iHRFS offers a shared care model or step-down clinic post iHRFS discharge, with various providers, such as community health services, private podiatrists, or general practices. |  |  |  |  |  |

**Standard 6: Equipment**

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| **CORE SERVICE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| * There is allocated space for the iHRFS to operate, that meets infection control and workplace health and safety requirements |  |  |  |  |  |
| * There is an appropriate chair, including bariatric chairs, available for all patients treated in the iHRFS which has height adjustment and positioning for the patient’s/person with diabetes’ legs. |  |  |  |  |  |
| * Instruments and equipment essential for the assessment and treatment of patients are available and include, but are not limited to:   + nail clippers, files, scalpel handles, curettes, forceps, scissors, probes   + tools for the assessment of vibratory perception and protective sensation including a 10g monofilament, tuning fork and/or biothesiometer   + hand held Doppler onsite   + Onsite ultrasound equipment for the detection of ankle and toe pressure (ankle brachial indices and toe pressures). |  |  |  |  |  |
| * On-site pressure offloading modalities including all of the following: * removable ankle and knee-high devices (including the capacity to be rendered non-removable) * removable ankle-high devices (offloading shoe, cast shoe) * post-operative/ healing sandals * paddings * prefabricated foot orthoses |  |  |  |  |  |
| * A referral pathway exists for on-site or off-site total contact casting. |  |  |  |  |  |
| * Written patient education and training is provided for the appropriate use of devices. |  |  |  |  |  |
| * A pathway exists for the timely prescription of footwear and footwear modifications, which may include prescription by either an on-site trained podiatrist or qualified pedorthist or off-site services. |  |  |  |  |  |
| * Timely access (within one month of referral) to on site or off site pedorthic services exists. |  |  |  |  |  |
| **CENTRE OF EXCELLENCE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| Meets all Core Service indicators AND |  |  |  |  |  |
| * On site or ready off-site access to in shoe plantar pressure to evaluate pressure offloading. |  |  |  |  |  |
| * Access to negative pressure wound therapy. |  |  |  |  |  |
| * Access to an orthotic laboratory to make adjustments and repairs to orthoses or pedorthic footwear and access to onsite basic equipment for the manufacture of chairside offloading and modification of devices (such as grinder etc.). |  |  |  |  |  |
| * Access to an ambulatory care service for administration of intravenous antibiotics exists, thus avoiding hospital admission or expediting discharge. |  |  |  |  |  |
| * Equipment and staff for application and removal of total contact casts. |  |  |  |  |  |
| * Use of photography for tracking of wounds, with informed consent of the patient/person with diabetic foot disease. |  |  |  |  |  |
| * Dedicated funding for patients to access medical grade footwear for prevention of ulcer recurrence (for clients where there are gaps in State or Commonwealth funding for the provision of devices). |  |  |  |  |  |

**Standard 7: Wound Care**

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| **CORE SERVICE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| * A local guideline is in place for the removal of slough, necrotic tissue and surrounding callus of a diabetic foot ulcer with sharp debridement |  |  |  |  |  |
| * There is access to a variety of consumables to treat wounds, including all of the following: * Absorbent dressings * Foam dressings * Antimicrobial dressings |  |  |  |  |  |
| * Local guidelines are in place, taking into consideration the wound exudate, comfort and the cost for the selection of appropriate dressings. |  |  |  |  |  |
| * A documented wound care plan is completed in the patient record for every patient per visit. |  |  |  |  |  |
| * A documented pathway for referral for wound care in between appointments exists for each patient and is communicated to the patient/person with diabetes-related foot disease or their designated carer. |  |  |  |  |  |
| * Wound management education is provided to patients or their designated carers to help them to manage their wounds between HRFS appointments. |  |  |  |  |  |
| **CENTRE OF EXCELLENCE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| Meets all Core Service indicators AND: |  |  |  |  |  |
| * Evidenced-based advanced wound healing products and modalities are available, e.g. forms of skin grafting, application of platelet rich plasma, in inpatient and ambulatory care settings. |  |  |  |  |  |

**Standard 8: Quality Improvement**

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| **CORE SERVICE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| * The iHRFS utilises the Australian Diabetes iHRFS Database or maintains a database aligned with the minimum dataset to enable national audits and collaboration |  |  |  |  |  |
| * The iHRFS develops key performance indicators used to assess safety and efficacy of the clinical service assist with the allocation of resources and service improvement. |  |  |  |  |  |
| * The iHRFS undertakes an annual audit that includes the indicators (on at least 80% of all patients seen annually, or 30 consecutive patients). |  |  |  |  |  |
| * Data and/or reports are shared with the clinical team and the NADC annually (facilitated by the Austalian Diabetes iHRFS Database) to identify areas of improvement, and a strategic plan is developed to address these areas. |  |  |  |  |  |
| * There is a quality improvement cycle in place at least annually that occurs and responds to audit outcomes, including for serious adverse events. |  |  |  |  |  |
| * Routine and ongoing education and professional development in high-risk foot care is provided for all iHRFS staff. |  |  |  |  |  |
| Data recorded should include the following (detailed minimum dataset with field coding available on request:   1. **Demographics**    1. DOB, and/or age, gender, ethnicity    2. Indigenous status 2. **Service**     1. Date of referral    2. Date of first appointment offered    3. Date of initial assessment    4. Date of first interdisciplinary assessment    5. Referral service    6. Outpatient or inpatient    7. Referrer    8. Patient postcode    9. Telehealth 3. **Clinical/Biomedical**     1. Diabetes type    2. Diabetes duration    3. Macrovascular complications    4. Microvascular complications    5. History of previous foot ulceration    6. History of previous amputation and extent    7. HbA1c    8. Comorbidities    9. Smoking Status    10. Kidney function (eGFR) and dialysis 4. **Ulcer Assessment**    1. Date assessed    2. Side, location and aspect    3. Date of onset    4. Precipitant    5. Recurrent    6. Initial area    7. Initial depth    8. Type    9. WIfI (preferred) or Texas classification    10. SINBAC classification 5. **Management**    1. Interdisciplinary input    2. Pressure offloading    3. Systemic antibiotics    4. Hospitalisation and cumulative length of stay    5. Amputation and extent    6. Patient disposition    7. Data of separation 6. **Ulcer Outcome**    1. Status    2. Date of healing or amputation |  |  |  |  |  |
| An annual i**HRFS audit** should include:   * The iHRFS uses electronic methods to collect the same data as other like services so that data can be aggregated or compared for benchmarking through the national iHRFS audit. * At least 80% of patients or 30 consecutive patients in a 12-month period. * Number of episodes of care, patients and ulcerations audited/ * Casemix (patient and ulceration characteristics as detailed above) * Process outcomes (according to whether an inpatient or outpatient when referred):   + Time from ulcer occurrence to initial review   + Time from referral to appointment being offered   + Time to referral to initial review   + Time from referral to interdisciplinary review of % of patients receiving interdisciplinary review   + % of patients with ischaemic ulceration who received vascular consultation. * Ulceration Outcomes   + % of ulceration healed at 12 weeks and at 20 weeks   + Time to healing   + % of patients ulcer free at 12 weeks and at 20 weeks   + Time to being ulcer free   + % of patients with ulceration recurrence and time to recurrence   + % of patients admitted and cumulative time as inpatient   + Reason of admission, % of patients requiring amputation & amputation extent * Disposition   + % of patients discharged or transferred per episode of care and destination   + % of patients deceased   + Time in service |  |  |  |  |  |
| **CENTRE OF EXCELLENCE INDICATORS** | **Met** | **Partially Met** | **Not Met** | **Comments/Supporting Evidence/Document Links** | **Quality Improvement Plan** |
| Meets all Core Service indicators AND: |  |  |  |  |  |
| * Evidence of attendance at continuing education and scientific / conference meetings for iHRFS staff. |  |  |  |  |  |
| * Annual audit includes all patients seen in the iHRFS with diabetes-related foot ulcers and all patients seen with Charcot neuroarthropathy. |  |  |  |  |  |
| * The iHRFS is involved in research studies of the diabetes foot. |  |  |  |  |  |
| * The HRFS routinely audits inpatient data to identify number of referrals to the iHRFS and the number of non-iHRFS patients admitted with a foot ulcer. |  |  |  |  |  |

**ACCREDITATION**

In response to the development of the NADC Collaborative Interdisciplinary Diabetes HRFS Standards the NADC, with the collaborative support of the Kellion Diabetes Foundation (KDF), have commenced a pilot NADC Collaborative Interdisciplinary Diabetes High Risk Foot Service (iHRFS) Accreditation Program.

The accreditation process for iHRFS will aim to:

* + - Improve iHRFS nation-wide by promoting standards of excellence within iHRFS
    - Improve outcomes for people at high risk of foot disease
    - Promote knowledge sharing, with iHRFS able to leverage knowledge from other accredited centres to improve service delivery
    - Provide opportunity for iHRFS to benchmark performance against peer centres
    - Encourage iHRFS improvement – with the service having the opportunity to utilise the evidence gained from the accreditation process to lobby for increased funding and resourcing in areas where the service can be enhanced, to promote better health outcomes for consumers

On completion and evaluation of the pilot the accreditation program will become available to all iHRFS within Australia and further information can be found at <https://nadc.net.au/hrfs-accreditation/>.

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