Livewell Southwest

# Minor Surgery in Podiatric Practice Protocol

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**The policies and procedures page of LSW Intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.**

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# Minor Surgery in Podiatric Practice Protocol

## 1 Introduction

1.1 Health Professions Council (HPC) Podiatrists with appropriate annotation to use local anaesthetics may undertake minor surgical procedures as appropriate to their training, experience and competencies.

1.2 Therefore, the purpose of this document is to provide practical, evidence-based parameters for Podiatrists and Podiatry Assistants involved in the provision of minor surgical procedures to undertake such work for the Podiatry Service of Livewell Southwest.

## 2 Purpose

2.1 The objective of this document is to ensure consistency of care and best practice across all clinical staff employed by the Podiatry Service involved in the provision of minor surgical procedures. The document is comprehensive and written in such a style as to enable staff to access information in clear sections – hence some minor repetition has occurred but this means staff can refer easily to one part of the document and not have to re-read the entire text or search for specific information.

2.2 Clear procedural guidance and clinical information across a framework of relevant issues, will improve the quality of patient care.

2.3 There is a significant gap in the evidence pertaining to the complications of minor procedures in relation to some systemic diseases significant to Podiatry. However, consideration has been given to current practice within the profession, professional guidance and that from organisations such as the World Health Organisation (via the National Patient Safety Agency) and the National Institute for Health and Clinical Excellence.

## 3 Duties

3.1 The Podiatry Service Clinical Lead will be responsible for the implementation and monitoring of this protocol.

3.2 This document applies to all Podiatrists and Podiatry Assistants employed by the Podiatry Service of Livewell Southwest (Community Interest Company).

3.3 The use of minor surgical procedures by the academic staff and students of the University of Plymouth's Podiatry Programme working under honorary contracts within Livewell Southwest (Community Interest Company) is also governed by this and allied policies. The Head of the Podiatry Programme will be jointly responsible for the implementation of this document and ultimately the compliance of academic staff.

3.4 Qualified staff (HPC Registered Podiatrists) will retain responsibility and accountability for the actions of students under their supervision.

3.5 The terms “staff” and “podiatrist(s)” are used in this document to encompass all those individuals detailed in paragraphs 3.2 and 3.3. All such persons are responsible for engaging with and implementing the content of this document in their clinical practice.

# 4 Definitions

## 4.1 Abbreviations

| | |
|---|---|
| **CPD** | Continuing Professional Development |
| **HPC** | Health Professions Council |
| **KSF** | Knowledge and Skills Framework |
| **LA** | Local Anaesthetic |
| **NPSA** | National Patient Safety Agency |
| **LSW** | Livewell Southwest (Community Interest Company) |
| **SCP** | Society of Chiropodists and Podiatrists |
| **TNF** | Tumour Necrosis Factor |
| **WHO** | World Health Organisation |

## 4.2 Minor Surgery

a) Appropriately annotated HPC Registered Podiatrists are qualified to undertake a variety of localised minor surgical procedures, typically toenail avulsions but also blunt dissection and the removal of subungual exostoses - depending on training, experience and competencies.

b) In undertaking such procedures annotation is required to provide local anaesthetics which are used in a variety of nerve block techniques. Routine procedures for the majority of staff are limited to toenail avulsions using digital nerve block anaesthesia by virtue of their experience and scope of practice.

## 4.3 Toenail Avulsion

Either the partial or total removal of a toenail under local anaesthesia usually combined with the application of Liquefied Phenol B.P. to chemically destroy the nail matrix in order to permanently prevent re-growth of the nail plate. This procedure is typically used to treat amongst other pathologies, onychocryptosis – commonly referred to as an “in-growing toenail”.

# 5 Clinical and Governance Principles in Podiatric Minor Surgery

## 5.1 Quality

### 5.1.1 Broad Quality Considerations

LSW and other sources provide for a wide range of guidance on matters of clinical and corporate quality and performance. To further support ongoing quality improvements this document seeks to support best practice and audit.

### 5.1.2 Quality Standards in Clinical Practice

Appendix J details the broad quality concepts standards applied to the provision of minor surgery by the Podiatry Service. This, combined with procedural and clinical expectations, forms the basis of the peer review process regarding minor surgery and is considered in all audit tools used to measure the performance and clinical outcomes of this provision.

### 5.1.3 Peer Review and The Knowledge and Skills Framework

a) Appendix K details the peer review process for all staff involved in the provision of minor surgery as well as the key quality concepts for practice.

b) All staff providing minor surgery will be peer reviewed annually and this process is directly linked to the Knowledge and Skills Framework (KSF) to form a record of clear evidence regarding competency tied to the annual appraisal for each member of staff.

### 5.1.4 Audit

The provision of minor surgery will be subject to annual audit as part of the wider Service audit schedule. These audits will be registered and openly reported upon in line with current LSW policy amongst the Service and to the organisation.

### 5.1.5 Patient Satisfaction Surveys

This aspect of the service will be subject to the annual patient satisfaction survey process and registered and reported in line with current LSW policy.

### 5.1.6 Clinical Facilities

a) Only those purpose-built minor surgical facilities appropriate to the clinical needs of both patients and staff will be used for the provision of minor surgical procedures.

b) Currently, this facility is the Out-patients Minor Surgery Room at the Local Care Centre, Mount Gould Hospital, Plymouth. Use of the facility will be in accordance with arrangements made in advance with the Local Care Centre's, Service Development Manager.

c) All Podiatry staff working within the LCC will take responsibility for familiarising themselves with local fire and Health and Safety procedures. Service and LSW policies also apply.

d) Changes to the use of the facility by the Podiatry Service will be agreed by Service managers with the Local Care Centre Manager in advance and in writing.

e) Non-sterile examination gloves, plastic aprons, couch rolls, hard surface cleansing wipes and waste bags are supplied by Out-patients and the nursing staff on the unit should be contacted to arrange replenishment of stock.

f) Clinical waste will be disposed of via the Out-patient cleaning staff but service staff are still responsible for the correct use of the disposal streams for all waste generated and must follow standard practice as detailed in the relevant LSW and Service documentation.

#### 5.1.7 Workforce

a) Procedures will be undertaken by a Podiatrist, usually supported by a Podiatry Assistant or in certain circumstances another Podiatrist.

b) Podiatry students will be supervised by a qualified HPC registered Podiatrist at all times throughout all stages of the process.

#### 5.1.8 Value for Money

All aspects of the minor surgical care provided by the Podiatry Service will be considered in the Service's ongoing monitoring of expenditure and value. This will include the continuous development and review of patient care pathways and journeys to minimise Referral to Treatment Times and expenditure.

### 5.2 Supporting Clinical Practice

a) Information to support high quality clinical practice amongst Podiatrists is provided in the appendices of this document. It covers the significance of relevant medical conditions and medications and indicates considerations for caution and clinical contra-indications. This also aims to promote consistent decision making across the Podiatry Service.

b) The 1-2-1 line-management meeting process, clinical supervision, the Knowledge and Skills Framework (KSF) and Appraisal process will also be utilised to maintain standards of practice and staff competencies.

### 5.3 Training

a) It is professionally incumbent upon HPC Podiatrists to undertake identified Continuing Professional Development (CPD) and the

professional body recommends Local Anaesthesia and Minor Surgery as core modules. Staff will take responsibility for ensuring their own competence with, where appropriate and identified, support of LSW and Service – this may involve the Appraisal and Performance processes for example.

b) Competence will be monitored annually using the peer review audit system. Any resulting identification of training needs for individuals will be embedded in the Personal Development Plan of the Appraisal System.

c) The Podiatry Service also advises staff to seek peer and managerial support at any time they consider they have learning and development needs.

d) Training for Podiatry Assistants will be provided in-house by the Podiatry Service.

e) The University of Plymouth retains responsibility for the training of students in minor surgical and local anaesthetic skills and knowledge as well as the CPD needs of its academic staff.

f) Training in Basic Life Support and Anaphylaxis will be as per current LSW policy for LSW employees. Additional training as identified by changes for example, in practice, will be provided on an ad hoc basis to identified staff as required. The University of Plymouth is responsible for its staff and students in this respect. It also retains the responsibility to comply with this and all other LSW policies, procedures and guidelines.

## 5.4 Communication and Information

Current LSW and Service policy applies however the general principles are given below. Appendices J and K provide detailed information regarding the standards of communication expected and specific actions.

### 5.4.1 Patients

a) Staff will provide comprehensive clinical information and advice to patients verbally and in writing to ensure that patients, their partners and relatives and carers (as indicated) fully comprehend the cause of and treatment options for their condition and in particular the purpose, benefits and risks of any procedure undertaken in the management of the condition.

b) In addition, it is expected that staff will use excellent communication skills to manage patients and other attending lay-persons to meet their expectations and to address their concerns and anxieties throughout their care.

c) Staff must also ensure that patients leave assessment

appointments with a clear understanding of what will be happening to them and that when discharged patients have a clear understanding of any interventions provided by Podiatry Services and of any future events and care regarding any outstanding clinical needs.

d) If a patient requires minor surgery the Podiatrist, or in the case of students, the student in conjunction with the supervising Podiatrist, will ensure that the patient has been involved in any decision making and fully comprehends the treatment options and associated risks by:

- advising the patient of the treatment options including conservative methods and treatment options that are not available from Podiatry Services.
- explaining why a surgical procedure is necessary or recommended in preference to conservative care.
- explaining to the patient where and how the procedure is undertaken and its likely duration.
- explicitly explaining the potential presence and involvement of undergraduate Podiatry students who are training and of the patients right to choose not to be treated by them and that this will not compromise their care.
- advising the patient of the possible outcomes, risks and complications from such a procedure and the possibility of anaphylaxis, postoperative sepsis, and in the case of nail avulsions for example, the possibility of phenol burns, nail plate re-growth and the potential aesthetic results. These factors must be clearly entered onto the appropriate section of the consent form.
- explaining the post operative care, average healing time and discharge to their Practice Nurse and how to access Podiatry Services for further intervention if needed.
- ensure that informed consent is obtained and that consent forms are explained to the patient and completed correctly with the white copy offered to the patient.
- writing a care plan agreed with the patient within the patient records.
- issuing the current Podiatry Service Minor Surgery patient information leaflet to the patient.
- advising the patient that an appointment will be sent to them in due course if one is not given at the time of assessment.
- post operatively to verbally advise the patient on the return of normal sensation, possible post-operative problems such as haemorrhage, pain management, self-care including activity and mobility issues and to be clear on accessing emergency support.

### 5.4.2 Written Patient Information

a) Written information on minor surgical procedures will be issued to all patients and where appropriate, their partner, relatives or carers. All materials will conform to current LSW standards and ratification processes.

b) All written patient information will be procedure specific and detail:

- the reasons for a procedure.
- the known risks of any procedure.
- how the procedure is undertaken.
- what the patient will experience – the "patient journey".
- how to prepare for the procedure.
- what to do after the procedure.
- ongoing post-operative care.
- how to contact Podiatry Services for support and advice after the procedure.

### 5.4.3 Copying Letters to Patients

a) Staff are reminded to ask patients if they require a copy of any written correspondence which is entered into by Podiatry Services regarding their health.

b) Patients may change their mind on this matter at a future point and so it is prudent to clarify the patient's current considerations on a regular basis.

### 5.4.4 Informed Patient Choice and Consent

a) The principles of informed and consent and the right of patients to make informed choices about their care are paramount. Staff are referred to the current LSW policy documentation on consent for more detailed information.

b) "For consent to be valid, it must be given voluntarily by an appropriately informed person….. who has the capacity to consent to the intervention in question. Acquiescence where the person does not know what the intervention entails is not "consent" [6].

c) Confirm that the patient does in fact want to have the planned surgery. It is not appropriate to coerce the patient to make the choice for surgery when the clinical need is not obvious or when they are capable of making an informed decision. This is particularly important if there is an element of cosmetic surgery involved. This includes informing the patient of the options of no

treatment and conservative treatment. Patients who do not wish to have students involved in their care must not be coerced into accepting their presence even if this is purely in an observational capacity.

d) The potential risks and potential benefits should be explained. Guarantees cannot be offered that the patient will not have a regrowth of the nail plate for instance. All potential complications and outcomes must be discussed with the patient.

e) Patient consent, including their choices regarding student involvement, must be verbally confirmed at the time of surgery and recorded on the consent form and in the patient records. Likewise, it is appropriate to briefly reiterate the procedure details to the patient prior to this to doubly ensure informed and current consent.

f) Staff must also offer patients the opportunity to receive the "white" copy of their consent form at the time of formally consenting – usually at their assessment appointment.

### 5.4.5 Consent, Parental Responsibility and Mental Capacity

a) Staff are referred to their line managers and LSW policy for further information in respect of responsible persons signing on behalf of incapable adults and for consent issues involving children.

b) Staff should remember that patients deemed to have mental capacity are entitled to make decisions regarding their care which may be contrary to medical advice or opinion and which may lead to detrimental consequences for the patient. The right to choose is paramount and must be respected. Coercion is not acceptable practice.

c) "Capacity should not be confused with a health professional's assessment of the reasonableness of the patient's decision. The patient is entitled to make a decision which is based on their own religious belief or value system, even if it is perceived by others to be irrational, as long as the patient understands what is entailed in their decision. An irrational decision has been defined as one which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his or her mind to the question could have arrived at it" [1].

d) For this reason it is again vital to ensure patients are fully informed with regard to their care and that perceived detrimental choices by patients must be comprehensively recorded and communicated – such as to the referrer or

patient's General Practitioner.

### 5.4.6 Health and Social Care Professionals

Staff will provide comprehensive written and verbal information to other relevant health and social care workers as required to effectively discharge their duty of care to the patient. This communication will be timely and complete and at a minimum will require a written response to a referrer copying to the patient's General Practitioner as appropriate. A standard discharge information form is provided to be issued to the patient to give to the health professional who will manage their post-operative care – usually their GP's Practice Nurse.

## 5.5 Documentation

Podiatry Services will use a collection of fixed documentation to record the assessment, treatment and discharge of minor surgical patients in line with current LSW policy:

- LSW approved Service specific Consent Forms (based on the Department of Health Forms).
- Podiatry Service Toenail Avulsion Patient Information Leaflet.
- Podiatry Service Patient Record.
- Podiatry Service Surgical Checklist Form (NPSA/WHO compliant).
- Podiatry Service Nail Avulsion Post Operative Information for Health Professionals.

## 5.6 World Health Organisation Surgical Checklist[2, 9]

a) Podiatry Services has adopted the principles of the World Health Organisation's Surgical Safety Checklist as adapted and disseminated by the National Patient Safety Agency (NPSA).

b) "A core set of safety checks has been identified in the form of a WHO Surgical Safety Checklist for use in any operating theatre environment. The checklist is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications.

c) "Organisations are required to ensure the checklist is completed for every patient undergoing a surgical procedure (including local anaesthesia)". NPSA 2009.

d) To that end, the professionally relevant content of the NPSA documentation has been incorporated into Podiatry Services' clinical paperwork relating to the care of patients in receipt of local anaesthesia and minor surgical procedures.

## 5.7 Health and Safety

Staff are reminded of their legally binding employee and professional

duties and responsibilities to follow all and any instructions and guidance issued by their employer and of their personal duty to protect and manage their own health and safety and that of those around them.

Current LSW and Service policy stands.

### 5.7.1 Safe Systems of Work

a) Mandatory systems for the safe use of medical sharps and management of infection control etc are in place and must be followed at all times. Staff must only use equipment and devices supplied for the purpose they are intended for and where supplied to enable safer working, must use the equipment.

b) Staff are referred to the current Infection Control Manuals, Health and Safety Policies and other associated documentation for further information.

### 5.7.2 COSHH

Staff are referred to Service documents available in electronic and in hard copy formats for further information and to that for Liquefied Phenol BP in particular.

### 5.7.3 Personal Protective Equipment (PPE)

a) The use of Personal Protective Equipment (PPE) is mandatory.

b) For the purposes of undertaking minor surgical procedures the following items of PPE are supplied for use by staff:

- Staff Uniform – see current LSW and Service policy documentation.
- Disposable Plastic Aprons – single use.
- Disposable Face Visors – single use.
- Non-sterile examination gloves – latex free.
- Sterile surgical gloves – latex free.

### 5.7.4 Management of Surgical Instruments and Clinical Waste

a) Service and LSW policy stands and staff are referred to these documents for current information.

b) All clinical and surgical instruments will be managed through an appropriate decontamination and sterilisation process and be supplied pre-packed and sterile. The current process for labelling, tracking, packing and returning used (contaminated) instruments will be followed.

c) Separate clinical and domestic waste streams will be used and adhered to by staff.

## 5.8 Medical Emergencies during Podiatric Minor Surgical Procedures

### 5.8.1 Clinical Emergencies

a) Staff will utilise their mandatory training in Anaphylaxis and Basic Life Support and the use of oxygen to provide the initial management of clinical emergencies, patients who are taken ill or whom suffer an accident.

b) All clinical emergencies will be dealt with as indicated by the circumstances and the support of medical and paramedic support sought as appropriate.

c) When appropriate to the circumstances staff should use their training in the use of the defibrillator held on LCC reception to treat patients. Patients in cardiac arrest must not have the use of a defibrillator delayed in preference of deferring care to any medical or paramedic intervention which may have been summoned in the management of the emergency.

d) Oxygen (available at the Minor Surgery Room, Outpatients, Mount Gould LCC) should be administered at high flow rates of 10-15 litres per minute. Caution should be observed in its use and the correct procedure for administering oxygen followed at all times. In particular, it is crucial that the air bag attached to the mask is inflated with oxygen prior to placing the mask on the patient. This is achieved by placing a finger over the outlet valve of the bag.

e) In the event of an emergency requiring medical/paramedic support (for example cardiac arrest, myocardial infarction, anaphylaxis, unresponsive hypoglycaemia) staff are required to:

- Activate the emergency pull in the room (see below)
- Dial 2222 for the on-site medical emergency team
- Dial 9-999 to summon emergency paramedics

f) Activating the pull-alarm will NOT automatically trigger the summoning of the medical team or emergency paramedics.

g) Staff must inform a member of Service management as soon as is practicable of any serious medical emergency or incident. Staff are also reminded that they must complete an e-incident form in the event of any accident, untoward incident or “near miss” in any workplace situation.

### 5.8.2 Emergency Pull

a) The pull must only be used for life-threatening clinical emergencies.

b) When activated, alarm system will alert the staff on the LCC's Main Reception to an emergency and they (and/or a member of the out-patient's nursing staff) will attend the room to provide assistance as required.

c) The attending staff will not automatically summon medical or paramedic assistance, that responsibility remains with the Podiatry staff present.

d) It is incumbent on the attending podiatry staff to deal with any telephone calls to the emergency services in order to provide full and accurate clinical information to the Ambulance service. This task should not be devolved to clerical staff.

## 5.9 Administration and Reception Support

### 5.9.1 Role of the Podiatry Service Administration Staff

a) The Podiatry Service Administration staff will be responsible for all administration tasks regarding the provision of minor surgery. The Service administration staff will organise all appointments and the staffing of sessions.

b) The administration staff will also arrange for the patient records and three copies of the session list to be sent via the courier, "For The Attention of Podiatry (LCC, Outpatients), C/O Main Reception, Mount Gould LCC", appropriately in advance of each session.

c) The attending Podiatry staff will be responsible for collecting these items from Reception, providing copies of the list to the reception staff and those at the Nurses' Station in Out-patients and returning the patient records via the courier to the Podiatry Service Office at the end of each session.

d) All enquiries regarding the administration of the sessions will be directed to the Podiatry Service Office. The Podiatry Unit at the LCC is unrelated and should not be contacted in relation to the use of Outpatients by the Service.

### 5.9.2 Role of Mount Gould Local Care Centre (LCC) receptions

a) The main LCC Reception staff will provide a "meet and greet" service for patients attending for minor surgery and direct them to the Nurse's Station in Outpatients, where they will be met and showed to the waiting area.

b) The staff at both Reception and the Nurses' Station will be given printed copies of the patient list on the day of the session by the attending Podiatry staff.

c) LCC Reception and Outpatient Nursing staff will not be responsible for the administration of Podiatry sessions based in the Outpatients Department.

### 5.9.3 Additional Patient Facilities

a) In the event of excessive numbers of patients waiting in the Outpatient's Department, Podiatry patients will be asked to wait in the Interview Room in Outpatient's.

b) Whilst recovery facilities are not required for Podiatry patients undergoing minor procedures, patients requiring a quiet area to "recuperate" will be offered the use of a treatment room under the supervision of the Podiatry staff.

# 6 Guidance for the Management of Podiatric Minor Surgical Procedures

a) The physical skills and clinical knowledge required to undertake minor surgical procedures in practice are not within the scope of this document. However, local use of these procedures as a part of a commissioned service is supported through the content given below and in the Appendices. Staff must moderate and confine their practice to take account of the content of this document.

b) To support staff in achieving this, this section of the document and the appendices set the expected parameters of practice amongst Service Podiatrists and provides guidance to support clinical decision making.

## 6.1 Pre-operative Assessments

a) Minor surgery assessments may be completed by any Podiatrist or appropriately supervised Podiatry student. Patients should be assessed at the point of a need being identified and preferably not have this deferred to a separate, future appointment – excepting when the attending clinician is a Podiatry Assistant, who should refer the patient to a Podiatrist.

b) Assessments must clearly identify and demonstrate in the health record:

- the reason for referral.
- the presenting clinical condition and needs of the patient.
- an accurate medical, surgical and pharmacological history.
- the rationale for offering surgery to the patient – whilst considering

alternative options.

- the suitability of the patient for any proposed procedure - including a consideration of relevant social factor influences.
- that informed consent has been obtained.
- that a full and clear care plan has been established and is agreed with the patient.
- the agreed treatment has an identified clinical outcome set.

### 6.1.1 Rationale for the Decision to Offer Surgery

a) It must be clearly evident and recorded that there are sound clinical reasons for the patient to be offered surgical intervention. For instance, chronic pain not alleviated by other forms of treatment or infected onychocryptosis not responding to conservative treatment.

b) If there is not a clear reason to perform the surgery the patient should not be considered for the option and an alternative plan devised within the wider context of the service specification and current criteria.

c) Patients referred to surgery and who attend for it but do not have a clear rationale clearly stated in the clinical record and which still applies, will be advised on the day that surgery is inappropriate and treatment refused.

### 6.1.2 Medical Advice and Support in Decision Making

a) Circumstances will arise where due to a lack of clinical information for example, key medical practitioners involved in the care of the patient must be consulted – typically the patient's doctor or consultant.

b) Whilst seeking current and accurate information to support clinical decision making is valid and important, staff should not be under the misconception that seeking the approval of another health professional absolves the Podiatrist treating the patient from responsibility for their intervention where borderline decisions must be made.

c) The final decision as to whether or not to proceed with any intended intervention remains with the attending clinician on the day of surgery.

d) Therefore, it is prudent when seeking the input of another health professional, to be clear as to what information is being sought and for what purpose. It is good practice to advise patients that third parties will be contacted in support of their care.

e) Staff assessing patients must take responsibility for ensuring

that information they request is obtained and followed-up appropriately prior to any pre-booked surgical appointment or proceeding to arrange an appointment.

f) In addition to a patient's doctor staff are reminded that for specific conditions and situations the patient's consultant may be a more appropriate source of information.

g) Also advice can be sought from Specialist Podiatrists and the likes of the Pharmacy Lead – the latter being particular helpful in cases of concern regarding drug interactions and the administration of local anaesthetics.

h) Appendix I provides further indicators for appropriate routes of clinical support and advice.

### 6.2 General Presenting Clinical Indicators for Offering Nail Avulsions

a) Two types of nail avulsion are employed: partial and total nail avulsions. In the case of partial avulsions these may be bilateral in the sense that both sulci on the same digit are avulsed. Record keeping must be clear to avoid the term bilateral in this sense being confused with bilateral as in both feet.

b) Consideration must be given to the rationale for offering surgery as detailed above however these procedures may be used for treating:

- onychocryptosis
- onychauxis
- onychogryphosis
- onychomycosis
- involuted toenails
- cases of traumatic injury to the digit or nail plate

c) Patients experiencing difficulties with footwear which is considered inappropriate to good foot health or a contributing factor to the patient's presenting complaint or patients requesting intervention on the grounds of purely cosmetic appearance are generally not considered as having a suitable clinical need for providing a nail avulsion.

d) These latter patients should be provided with appropriate foot health education and discharged. In some rare instances this general principle may not be conducive to the welfare of the patient and professional discretion should be used and consideration given to providing a surgical intervention.

### 6.3 Special Consideration for Patients with Diabetes

It is inappropriate to undertake minor surgery on patients with diabetes if the clinical benefits are not clear.

### 6.3.1 General Points Regarding Diabetes

a) If the patient has diabetes ensure that they are fit for surgery and the wound has the best chance of resolution. This will entail good and consistent blood sugar control as well as adequate perfusion of the foot/toe. Check pedal pulses are present with a Doppler as well as by palpation and evaluate the patient's history.

b) Check the capillary blood sugar trend and the latest HbA1c – for which a value as near normal is desirable.

c) The HbA1C test should normally be undertaken every 3 months or thereabouts because of the life span of the glycated red blood cells, therefore ensure any results are current. Note that anaemic patients may show a low HbA1c because of low red blood count.

d) Consultation by the assessing Podiatrist with a Diabetes Specialist Podiatrist regarding suitability is expected and must be recorded in the patient record.

### 6.3.2 Nephropathy

It will be difficult to make decisions regarding patients with nephropathy without specialist tests. Kidney function may not be known by the patient. Those with overt, end stage nephropathy such as renal replacement therapy will be obvious and great care should be taken as they will by nature be complex patients with significant medical history. Liaison with the Specialist Diabetes Podiatrists, Diabetes Multi-disciplinary Team and the patient's General Practitioner will be required and must be evidenced in the patient record.

### 6.3.3 Neuropathy

a) "Denervated wounds delay macrophage and T-lymphocyte release, decrease their count and therefore delay significantly wound healing"[3].

b) "Denervation of skin in neuropathic patients can contribute to low inflammatory cell infiltration leading to chronicity of diabetic foot wounds"[4].

c) Whilst peripheral neuropathy in patients with diabetes does not contra-indicate a minor surgical procedure, due caution must be taken in deciding on the appropriate care plan for such patients. The rationale for surgical intervention must be clear and the benefit versus risk considered carefully. Consultation by the

assessing Podiatrist with a Diabetes Specialist Podiatrist regarding suitability is expected and must be recorded in the patient record.

### 6.4 Prophylaxis against Infective Endocarditis[5]

a) Regard people with the following cardiac conditions as being at risk of developing infective endocarditis:

- acquired valvular heart disease with stenosis or regurgitation.
- valve replacement.
- structural congenital heart disease, including surgically corrected or palliated structural conditions, but excluding isolated atrial septal defect, fully repaired ventricular septal defect or fully repaired patent ductus arteriosus, and closure devices that are judged to be endothelialised.
- hypertrophic cardiomyopathy.
- previous infective endocarditis.

b) Despite advances in diagnosis and treatment, infective endocarditis remains a life-threatening disease with significant mortality (about 20%) and morbidity.

c) Antibiotics have been offered routinely as a preventative measure to people at risk of infective endocarditis undergoing interventional procedures. However, there is little evidence to support this practice. Antibiotic prophylaxis has not been proven to be effective and there is no clear association between episodes of infective endocarditis and interventional procedures. Any benefits from prophylaxis need to be weighed against the risks of adverse effects for the patient and of antibiotic resistance developing.

d) As a result, this guideline recommends that antibiotic prophylaxis is no longer routinely recommended and patients should be advised of the importance of maintaining good oral health, symptoms that may indicate infective endocarditis and to seek expert advice.

### 6.5 Verification Assessments on the Day of Surgery

a) All patients will have their previous assessment verified for changes and complications on the day they attend for their procedure and this will be recorded in the health record.

b) The guiding principle is to ensure that no changes to the patients medical, surgical or pharmacological history or clinical needs have occurred which would alter the established care plan and/or suitability to undergo any minor surgical procedure. This will include verifying and recording current consent to proceed. The surgical checklist will support establishing the patient's current suitability.

c) Attention should be paid to establishing the patient's recent anaesthetic history as patients will often not associate other treatments with their attending purpose. Likewise, care should be taken to communicate well with the patient who may not perceive changes in medication or recent self-directed care for minor ailments as relevant.

### 6.6 Liquefied Phenol BP

a) Liquefied Phenol is used for the chemical matrixectomy of the nail bed during nail avulsion procedures and is an integral part of the process. Alternatives such as Sodium Hydroxide exist but they have their own hazards and concerns and it is still usual practice within the profession to use Phenol.

b) Liquefied Phenol BP is a toxic, corrosive substance that has anaesthetic properties when applied to the skin. It is rapidly absorbed through skin and may cause toxic effects as a result. There are reports of the toxic effect of phenol when used as a skin peel[6]. There is no evidence available of skin absorption toxicity following matrixectomy performed by Podiatrists.

c) There is no current evidence that the current method of use and quantity used in Podiatric practice constitutes being unduly hazardous or likely to result in long term health damage to patients or practitioners. The use of well ventilated rooms and the handling of the substance in a safe and controlled manner should be maintained.

d) There is some concern regarding the carcinogenicity, mutagenicity and teratogenicity of the substance. There is no clear evidence that the substance is likely to have any detrimental effect if it is used in the prescribed manner it is proposed.

e) Staff who are pregnant or likely to become pregnant should be aware of the current evidence and given the option to avoid contact with the substance as it is used by Podiatry Services. In practice the standard maternity risk assessment will cover this issue. Such staff are advised to contact their line-manager in the first instance.

f) By virtue of their exclusion from receiving local anaesthesia during the first trimester, pregnant patients during this phase will not be exposed to Phenol. However, whilst there is no clear evidence either way regarding Phenol and pregnancy it is considered appropriate to advise such patients not to undergo matrix phenolisation during pregnancy or when clinically imperative to undertake the procedure with clear and precise advice regarding the cautions. Avulsions without phenolisation after the first trimester are considered the option of choice when there is a clinical necessity to provide a procedure.

g) There is a possibility that phenol may enter breast milk and be

absorbed by babies. Therefore, for nursing mothers, it is advised that breast milk is discarded for 24 hours after phenol is used to avoid the risk of causing adverse effects in infants [10].

### 6.7 Local Anaesthesia

a) Current Service policy applies and staff are referred to the current documentation.

b) In essence Podiatry Services will only use plain solution local anaesthetics to achieve either localised anaesthesia via infiltration or a regional block such as a digital block.

c) Mepivacaine Hydrochloride 3% Plain Solution (PoM) (Scandonest) solution is the drug of choice and only this is available for use by staff. This product is covered by a Request for Use of Unlicensed Medicine by the LSW Medicines Governance Group (MGG) on (2nd August 2013) which permits its use in children and young people by the service aged 4 and over.

### 6.8 Conscious Sedation and General Anaesthesia

a) Cases requiring the use of general anaesthesia or conscious sedation must be dealt with on an individual basis in conjunction with the patient's doctor and consultant as appropriate. Staff should contact their line-manager in the first instance to discuss the management of such patients.

b) Conscious sedation for anxiety is commonly achieved through the use of midazolam – although this is known to have interaction issues with Mepivaciane Hydrochloride[10]. However, the Royal College of Anaesthetists is quite clear that "sympathetic patient management is the foundation of all clinical care"[7] and so pharmacological interventions are not an alternative to managing the patient's anxiety and fears.

c) Further, best practice involves the avoidance of sedation by supporting patients. An "explanation at each and every stage of any procedure is essential, particularly where sudden manoeuvres may disturb the patient acutely. Anxiety, discomfort and pain may still occur. They are inter-related, and each may increase the other. As a result, the procedure will become more difficult for all parties, but any drug treatment must be targeted specifically to each symptom.

d) "Often, anxiety can be alleviated by careful explanation, a sympathetic attitude and expert clinical management. Drug sedation should not be used for operator convenience, but as a supplement to behavioural management.

e) "In many situations, good analgesia and expert management suffice. The need for additional sedation should be related to the individual

patient's psychological and medical status because both affect the response to, and the need for, sedation. When conscious sedation is employed, the agents and doses chosen must be adjusted to the patient's requirements and ensure that verbal contact is possible at all times"[7].

f) In cases where general anaesthesia is unavoidable and/or the management of the patient is medically complex patients should be referred to their General Practitioner with a recommendation to refer on to orthopaedics for their care.

### 6.9 Post-operative Wound Care

a) In most instances patients will be discharged to their practice nurse or community nurse depending on their circumstances via the General Practitioner immediately following surgery, for the purposes of post-operative wound care.

b) Patients will only be retained for ongoing post-operative wound care management where there is a clearly defined clinical necessity that it is provided by Podiatry Services and that this is documented in the health record and care plan. This may be for example, a patient with significant peripheral vascular disease in which healing is compromised but surgery was necessary and the patient had existing foot pathology requiring the ongoing intervention of the Podiatry Service.

c) If in doubt staff should contact their line-manager or the Podiatry Clinical Lead for support as to the suitable provider of post-operative wound care.

d) The Podiatry Service does not provide patients with dressings or other healthcare products for the purpose of wound care by other services.

e) Patients requesting dressings are advised to consult with their General Practitioner when the circumstances are appropriate but should generally be encouraged and advised to self-source products from a public pharmacy.

f) When referring on to Community Nursing it is required that staff liaise with the nursing team in advance of surgery to obtain appropriate prescriptions in order to support their readiness to undertake the appropriate wound care.

### 6.10 Minor Surgical Procedures in the Domiciliary Setting

a) There is no defined provision to undertake minor surgical procedures in the community. Staff should seek to arrange or advise the patient to arrange suitable transport in the first instance, be it by ambulance or other appropriate means to facilitate surgical care for domiciliary patients at a clinical site.

b) Appropriate liaison with the Podiatry Service Administration staff regarding appointments and transport issues should also be made by the responsible Podiatrist.

c) The use of Local Anaesthetic drugs in the domiciliary setting is tightly restricted and must be avoided in all but the most pressing or controlled circumstances – Service management approval is required and must be sought and recorded in the patient's record.

## 7 Monitoring Compliance and Effectiveness

7.1 The Podiatry Service Clinical Lead will retain overall accountability and responsibility for the content, monitoring and implementation of this policy document.

7.2 Periodic clinical audit, patient satisfaction surveys and an annual peer review of staff compliance and competency will be included in the ongoing process to monitor quality, compliance and effectiveness.

7.3 Responsibility for undertaking the various review processes will be devolved by the Podiatry Service management to appropriate and capable members of staff.
.

7.4 Audits and patient satisfaction surveys will be registered, published and actioned in line with current LSW policy whilst peer reviews will be subject to internal scrutiny and a part of the KSF and annual appraisal processes.

7,5 Untoward incidents and inoculation injuries will be monitored by Service Management and the LSW Risk Management Team.

**All policies are required to be electronically signed by the Lead Director. Proof of the e-signature is stored in the policies database.**

**The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.**

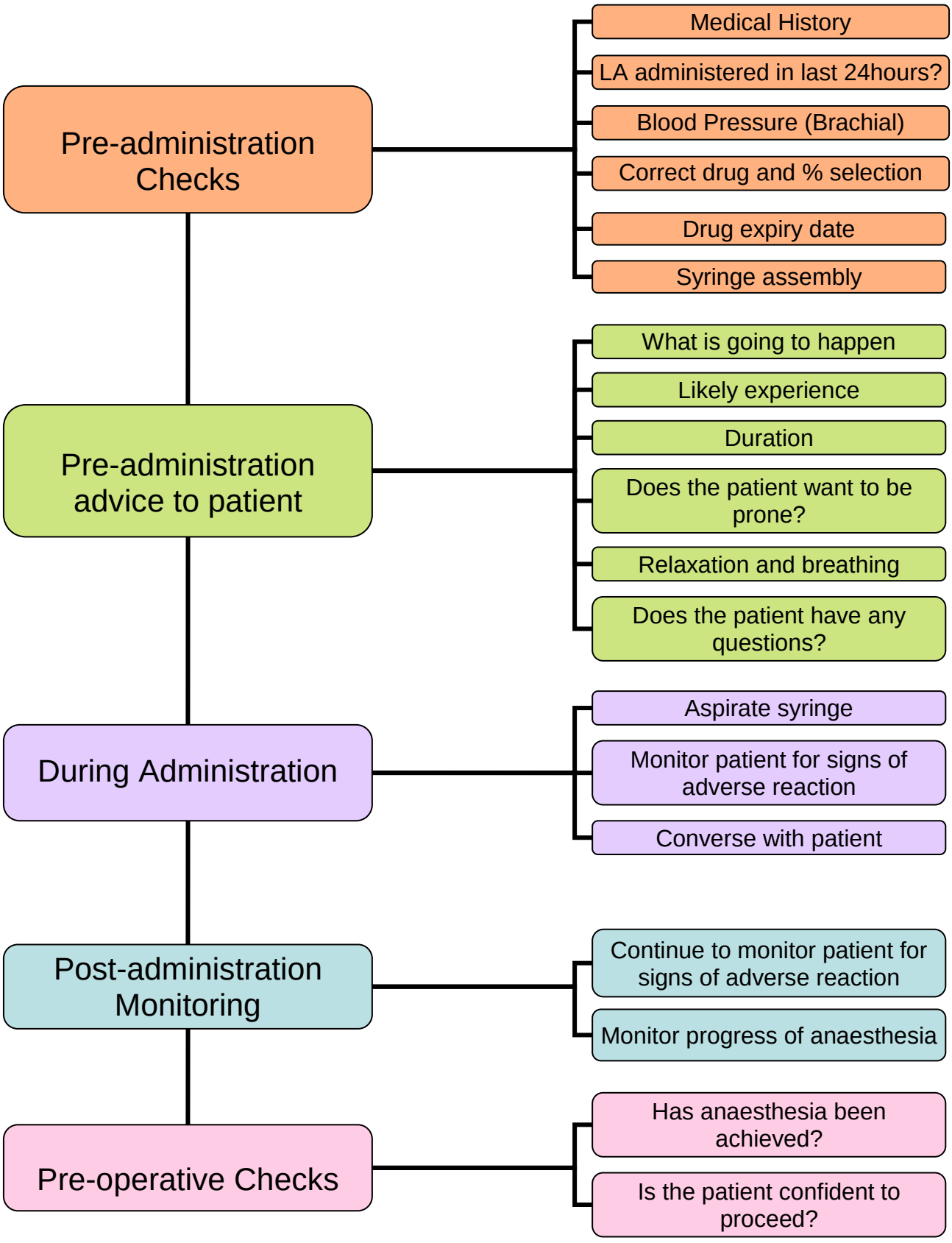
Signed: Director of Operations

Date: 25.03.2014

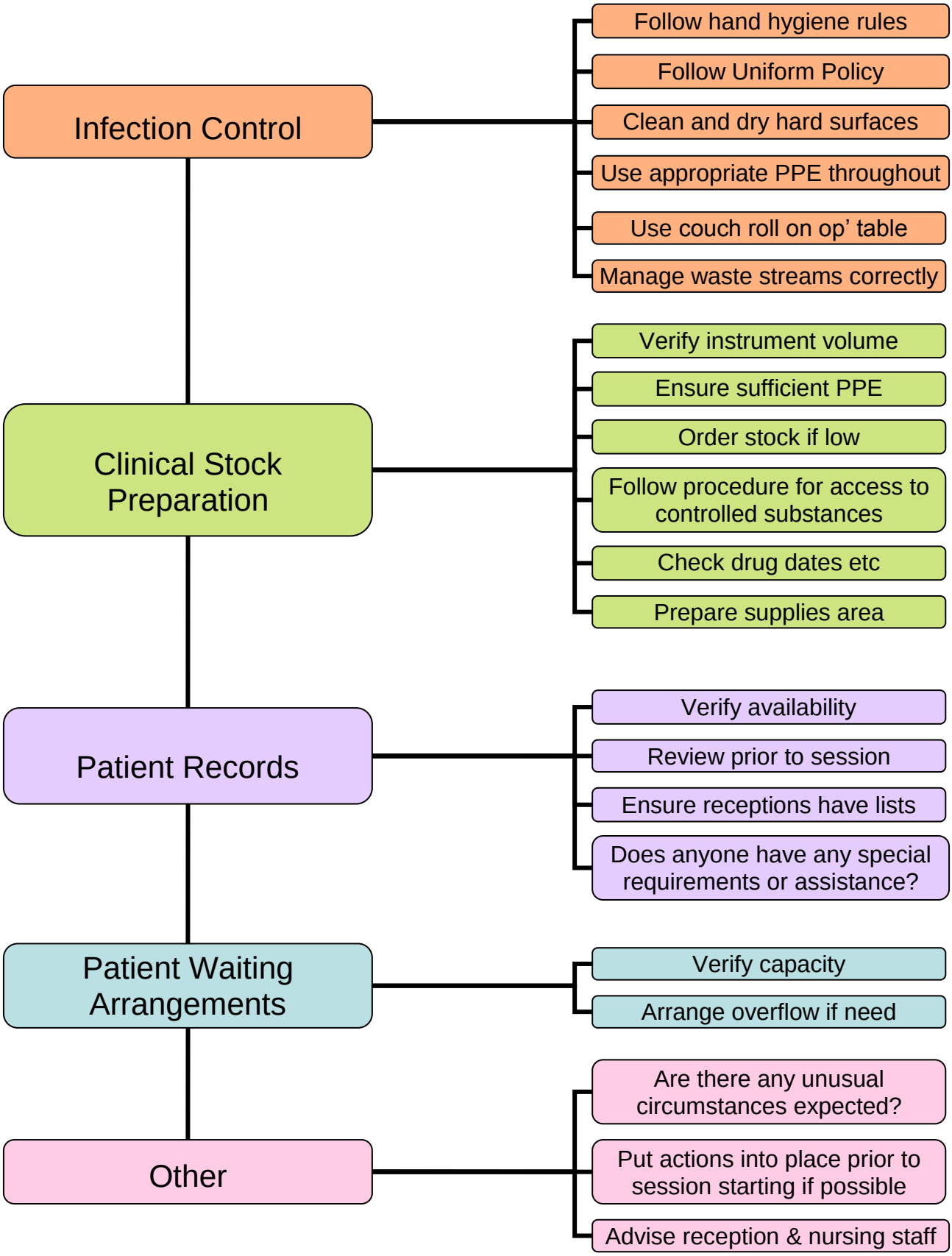
**Appendix F**

**Key Tasks: Minor Surgery Patient Assessment**

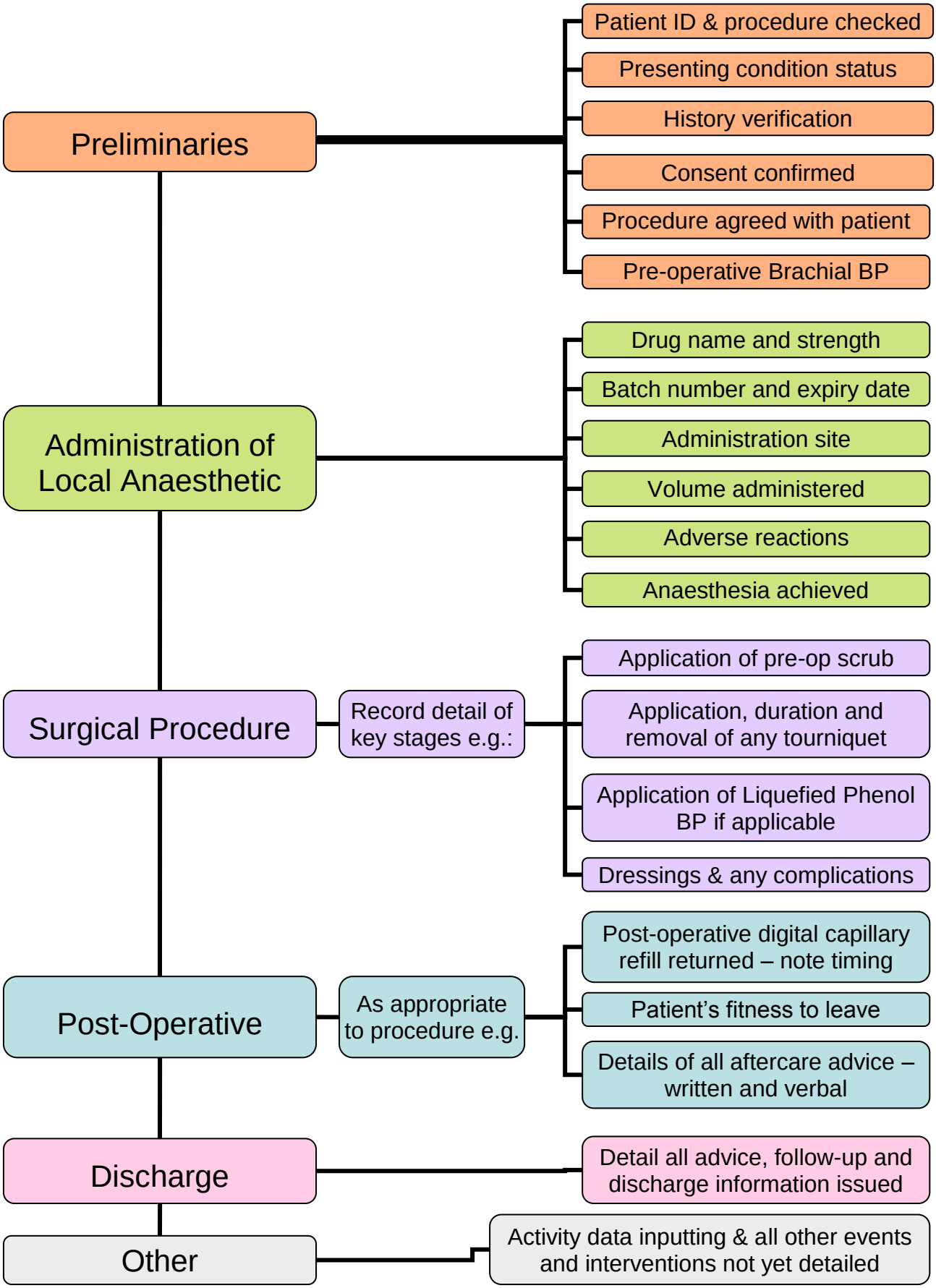
# Key Tasks: Administration of Local Anaesthetics



# Key Tasks: Minor Surgical Facility Preparation

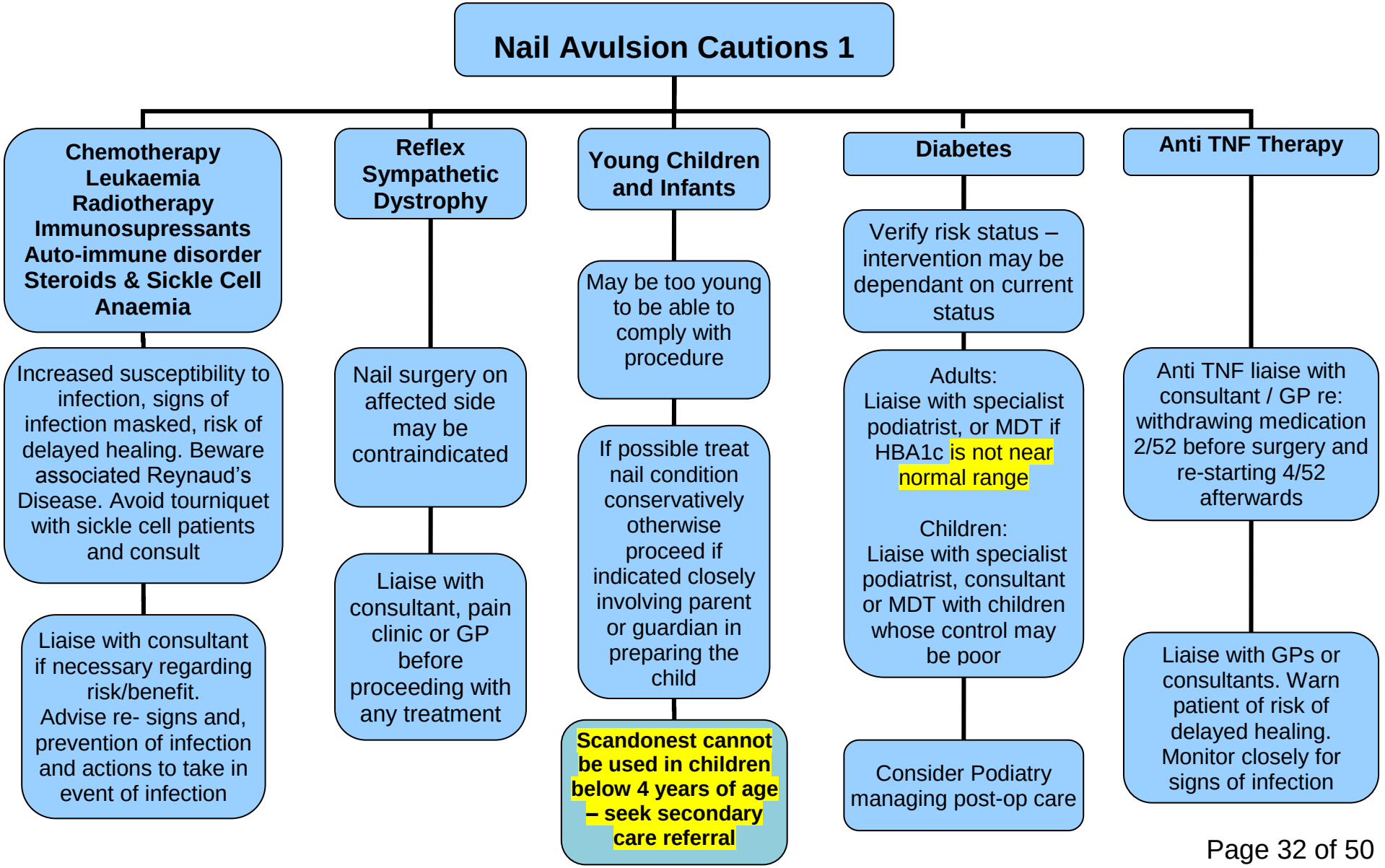


# Key Tasks: Minor Surgical Record Keeping - Core Entries

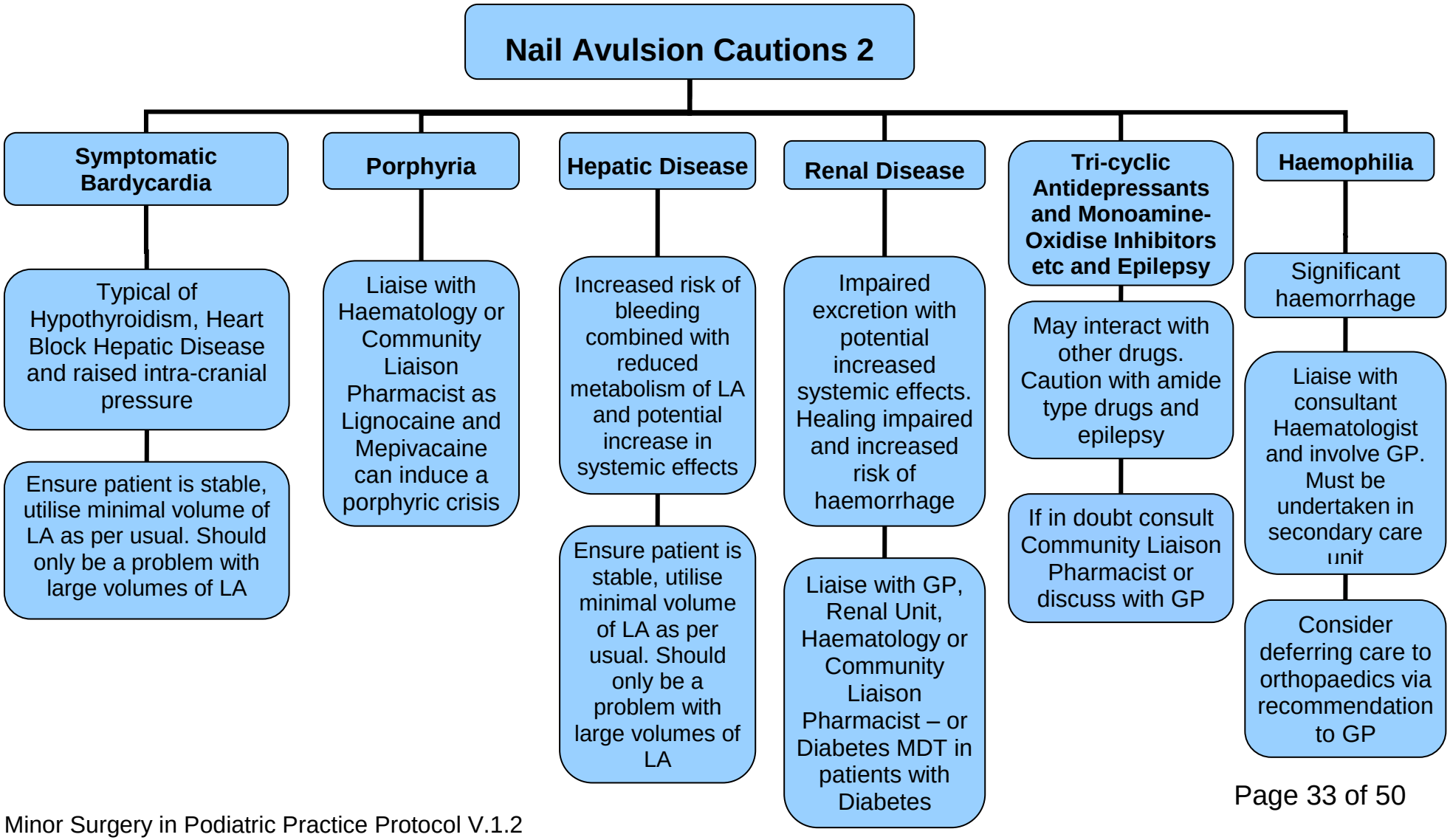


**Nail Avulsion Cautions 1**

**Appendix F**

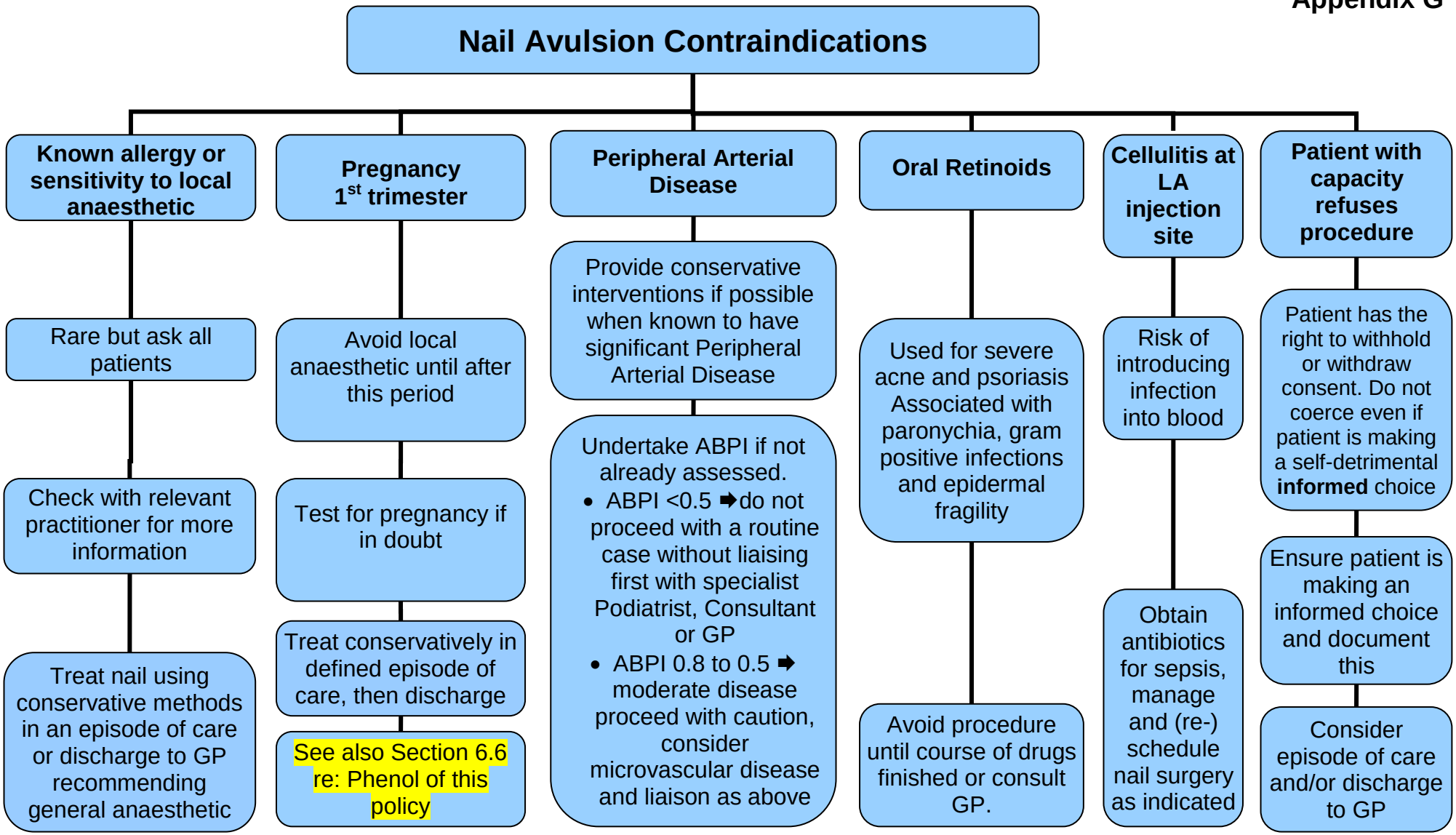


**Nail Avulsion Cautions 2**



**Nail Avulsion Contraindications**

**Appendix G**



# Podiatric Minor Surgery Clinical Guidance

## Appropriate Sources of Clinical Support and Advice in Clinical Decision Making

Podiatric Minor Surgery Clinical Guidance

# General Surgical and Medical Considerations

## Tourniquets

| | |
|---|---|
| • **Sickle Cell Anaemia:** | Tourniquets contraindicated – seek advice |
| • **Reynaud's and other connective tissue disorders:** | Caution with tourniquets - assess each case individually, treat when warm. Only consider surgery if other treatments prove ineffective. Always use minimum volumes of LA to minimise constriction from fluid encircling the digit.<br><br>NB: Caution with vaso-spastic disorders combined with a history of smoking especially amongst young men aged 20 - 45 |
| • **Steroids:** | Care with tourniquets and forceps not to damage skin |
| • **Atrophic skin:** | Care with tourniquets and forceps not to damage skin |

## Increased Risk of Haemorrhage

| | |
|---|---|
| • **Anticoagulants, anti-platelet medication**<br>• **Leukaemia**<br>• **Haemorrhagic disorders**<br>• **Liver & Kidney disease** | Check INR if between 2 and 3 is usually safe for surgery. Consult with GP, consultant or haematology for advice if delaying nail surgery or adjusting medication will be appropriate as Warfarin may need to be temporarily reduced. Warn patients of the risk of bleeding, apply extra protection, use haemostatic dressing and advice on keeping foot elevated and who to contact in an emergency. Dosages of 150mg aspirin are considered an anticoagulant dose but an acceptable parameter to proceed with minor procedures such as nail avulsions. |

## Risk of Infective Endocarditis

| | |
|---|---|
| • **History of infective endocarditis**<br>• **Prosthetic heart valves**<br>• **Heart valve damage, history of rheumatic fever** | See NICE Guidance CG 64 March 2008 Prophylaxis against infective endocarditis.<br><br>Warn patient to report to their GP if they suffer any minor illness in the month following nail surgery whether they had prophylaxis or not because infective endocarditis has an insidious onset and treatment may fail if diagnosis delayed. |

## Involuntary Movements

| | |
|---|---|
| • **Multiple Sclerosis, other neurological complaints e.g. Parkinson's Disease:** | Risks of inoculation injury, take all precautions necessary, warn patient of risks. |

## Increased Risk of Postural Hypotension/Syncope

| | |
|---|---|
| • **Diuretics,**<br>• **Beta blockers**<br>• **Hypotension**<br>• **Hypertension drugs:** | Susceptible to fainting – advise patient to lie prone<br><br>Monitor patient, sit up slowly after procedure |
| • **Addison's Disease:** | Liaise with GP prior to procedure - medication adjustment may be required |
| • **Bradycardia:** | Caution. Check pulses before procedure. LA contraindicated if heart block |

## False Positive Peripheral Circulation

| | |
|---|---|
| • **Ace Inhibitors:** | Assess carefully- warn patient that healing could be impaired |
| • **Angiotensin 2 Receptor Antagonists:** | Assess carefully- warn patient that healing could be impaired |
| • **Calcified blood vessels:** | Assess carefully- warn patient that healing could be impaired |

## Impaired Tolerance to Iodine

| | |
|---|---|
| • **Allergy, Thyroid conditions, pregnancy and breast feeding, Rx with Lithium:** | Avoid products containing iodine - use chlorhexidine as a pre-operative cleanser/scrub |

## Allergy to Latex

| | |
|---|---|
| • **Sufferers of spina bifida, food allergies and those who have undergone urino-genital tract operations are the most prone to latex allergy.**<br><br>• **Beware of sensitivity-v-true allergy** | Refer to Latex Policy – all clinical areas are latex-free<br><br>Book appointment at beginning of the day to avoid exposure to latex particles in the air.<br><br>Check dressings/equipment for presence of latex before use.<br><br>It is important to check for allergies before the procedure and ensure that this information is highlighted for the benefit of the operating podiatrist. |

**Appendix J**

## Quality Standard Concepts for Podiatric Minor Surgical Procedures

### 1 Infection Control and Safe Systems of Work

1.1 Only specifically designed fit-for-purpose facilities to be used for the provision of minor surgical procedures
1.2 Hand hygiene procedures enforced at all times – including between patients and all sections of each procedure
1.3 Clinical uniform to be worn and disposable single-use plastic aprons and all other personal protective equipment to be used when cleaning and treating patients as appropriate
1.4 All hard surfaces cleansed with appropriate product – repeated prior to each patient attending and at the end of each session
1.5 Disposable paper towel drapes to cover hard surfaces on operating table and clean disposable pillow cases used as indicated – repeated prior to each patient attending
1.6 Access and supplies to visors, goggles and other Personal Protective Equipment verified before each session
1.7 Keys to medicine cabinet returned to Out-patient Department nursing staff immediately after local anaesthetic drugs, needles and other secured items obtained
1.8 Aseptic technique always employed in the handling of sterile instruments and other items supported by the use of primary and secondary fields and metal surgical waste floor bin during procedures.
1.9 Surgical check-list completed fully and prior to any treatment and post-operative information fully completed after procedure
1.10 Safe systems of work followed in the handling of all sharps, medicines and substances subject to COSHH regulations
1.11 Clinical, pharmaceutical and domestic waste appropriately managed as per LSW policy
1.12 Supplied equipment to support the management of medical emergencies to be kept to hand
1.13 Working environment maintained in a clean and ordered manner
1.14 Stock levels checked and requirements reported as indicated
1.15 Adequate quantities of clinical supplies for the entire session verified
1.16 Surgical Instruments supplied in sterile packs, used and returned following tracking process – labels completed and returned with patient ID and corresponding labels retained in patient health record

### 2 Communication

2.1 Staff introduce themselves by name and designation to each patient and any relative, friend or carer attending with them
2.2 Staff to use excellent communication skills to manage patient expectations, concerns, fears and anxieties regarding their treatment
2.3 Patient identity confirmed by name, address and date of birth
2.4 Procedure to be undertaken confirmed and explained to patient's satisfaction and understanding
2.5 Post-operative advice given verbally to patient in support of previously issued written advice

2.6 Post-operative information sheet completed and issued to patient to give to their Practice Nurse/GP
2.7 Patient monitored and offered reassurance while L.A. is being administered and procedure undertaken
2.8 Staff to keep excellent communications with Out-patient Department Staff

## 3 Consent

3.1 Verbal consent to examine sought from patient
3.2 Informed consent to proceed confirmed with patient and recorded on consent form

## 4 Health Record Management and Data Collection

4.1 Patient Health Records Reviewed by Podiatrist prior to clinic commencing. Identified issues actioned
4.2 Record keeping – all documentation will be kept in accordance with current LSW and Service policies
4.3 Records to be returned to the Podiatry Office, Seventrees Clinic using the internal courier system
4.4 Enter activity data etc as required on e-system

## 5 Managing Untoward Incidents

5.1 Untoward incidents including all accidents, near-misses and clinical errors recorded and reported fully and openly (using an incident form) following LSW policy
5.2 Medical emergencies managed and reported as indicated

Podiatry Service
Livewell Southwest

## Minor Surgical Procedures Quality Peer Review – Practitioner Performance Assessment Form

PLEASE PRINT CLEARLY

Staff Name:

Peer Reviewer Name:

Staff Designation:

Peer Reviewer Designation:

Location of Review:

Date and Times:

Number of Patients seen during review:

### Notes:

- Reviewing Podiatrist should conduct the review as an observer and not seek to interject in proceedings or influence the actions of the attending staff
- A care of a minimum of four patients will be reviewed
- Completed paperwork to be sent directly to the reviewed member of staff's line-manager
- Copies of the paperwork to be held in staff's personnel folder and by the reviewed Podiatrist for their appraisal
- Formal Action Plan to be devised as appropriate to outcome of review at staff's next 1-2-1 meeting with their line-manager – unless change is needed and staff will be providing minor surgical care prior to next scheduled meeting

| Standards and Competencies | | KSF Dimensions | Was the standard completely achieved? | | | | | | | | | | | | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Yes | | | | No | | | | N/A | | | | |
| No. and Standard | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | |
| 1. | Uniform policy complied to | C3, C5, HWB7 | | | | | | | | | | | | | |
| 2. | Hand hygiene measures followed throughout the session | C3, C5, HWB7 | | | | | | | | | | | | | |
| 3. | Clinical environment and all hard surfaces cleaned using appropriate products and correct technique throughout the session | C3, C5, HWB7 | | | | | | | | | | | | | |
| 4. | Operating table covered using disposable paper couch roll | C3, C5 | | | | | | | | | | | | | |
| 5. | Staff introduces self and others to patient and others | C1, C5, HWB7 | | | | | | | | | | | | | |
| 6. | Patient identity confirmed | C1, C5, C6 HWB7 | | | | | | | | | | | | | |
| 7. | Procedure confirmed and discussed involving patient fully and appropriately taking account of their needs | C1, C3, C5, HWB7, HWB6 | | | | | | | | | | | | | |
| 8. | Current medical history verified for changes since assessment | C1, C3, HWB6, C5, | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 9. | Recent anaesthetic history verified | | | | | | | | | | | | | | |
| **Standards and Competencies** | | **KSF Dimensions** | **Was the standard completely achieved?** | | | | | | | | | | | | **Comments** |
| | | | **Yes** | | | | **No** | | | | **N/A** | | | | |
| **No. and Standard** | | | **1** | **2** | **3** | **4** | **1** | **2** | **3** | **4** | **1** | **2** | **3** | **4** | |
| 10. | Consent confirmed and recorded on consent form | C1, C3, C5, C6, HWB6 | | | | | | | | | | | | | |
| 11. | Baseline blood pressure taken and recorded prior to any treatment | HWB6 | | | | | | | | | | | | | |
| 12. | Verified and recorded baseline digital capillary refill time prior to any treatment | HWB6, HWB7 | | | | | | | | | | | | | |
| 13. | Correct site or digit or sulcus as appropriate marked on the patient prior to any treatment | C3, HWB6, HWB7 | | | | | | | | | | | | | |
| 14. | Anaesthetic drug name, strength and expiry date verified prior to administration | C3, HWB 6, HWB 7 | | | | | | | | | | | | | |
| 15. | Safe handling, use and disposal of syringe | C3 HWB7 | | | | | | | | | | | | | |
| 16. | Correct and compliant use of Personal Protective Equipment throughout procedure as appropriate | C3, C5, HWB 6, HWB 7 | | | | | | | | | | | | | |

| Standards and Competencies | | KSF Dimensions | Was the standard completely achieved? | | | | | | | | | | | | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Yes | | | | No | | | | N/A | | | | |
| No. and Standard | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | |
| 17. | Anaesthesia achieved and verified prior to proceeding with further care | C3, HWB 7 | | | | | | | | | | | | | |
| 18. | Sterile gloves and other PPE worn as indicated | C5, C3, HWB7 | | | | | | | | | | | | | |
| 19. | Correct handling of sterile instrument pack | C3, HWB 7 | | | | | | | | | | | | | |
| 20. | Primary and secondary fields established and used correctly | C3, HWB 7 | | | | | | | | | | | | | |
| 21. | Aseptic technique maintained throughout procedure | C3, HWB 7 | | | | | | | | | | | | | |
| 22. | Pre-operative scrub/cleanser used | C3, HWB 7 | | | | | | | | | | | | | |
| 23. | Tourniquet applied and timing noted and recorded | C1, C3, HWB7, | | | | | | | | | | | | | |
| 24. | Phenol handled and used in a safe manner | C3, HWB 7 | | | | | | | | | | | | | |
| 25. | Tourniquet removed | C3, HWB 7 | | | | | | | | | | | | | |
| 26. | Return of digital capillary circulation verified | C3, HWB 6, HWB 7 | | | | | | | | | | | | | |

| Standards and Competencies | | KSF Dimensions | Was the standard completely achieved? | | | | | | | | | | | | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Yes | | | | No | | | | N/A | | | | |
| No. and Standard | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | |
| 27. | Wound dressed correctly and appropriately | C1, C3, C5, HWB7 | | | | | | | | | | | | | |
| 28. | Verbal communication of comprehensive post- operative advice | C1, C3, C5, C6, HWB7 | | | | | | | | | | | | | |
| 29. | Contemporaneous record entry completed in full with instrument labels attached | C3, C1, C5, HWB 6, HWB 7 | | | | | | | | | | | | | |
| 30. | Discharge information sheet for health professionals completed and issued to patient | C1, C3, HWB7, C5 | | | | | | | | | | | | | |
| 31. | Correct disposal of waste into correct waste streams | C3 | | | | | | | | | | | | | |

**Further comments.** Please enter in the space below any comments or concerns not detailed above:

**Appendix L**

Podiatry Service
Livewell Southwest

## Minor Surgical Procedures Quality Peer Review
# Practitioner Action Plan

**PRIVATE AND CONFIDENTIAL**

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**Staff Name:** **Designation:**

**Line Manager:** **Designation:**

**Date of Relevant Peer Review:**

**Peer Reviewer Name and Designation:**

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| |
|---|
| **Principle Areas of Concern Identified in Peer Review** |
| **Action Points to Address Concerns –** including training and timescales for action |
| **Date Action Plan Progress to be Reviewed:** |

| | |
|---|---|
| **Staff Signature of Acceptance:** | |
| **Line Managers Signature:** | |
| **Progress Review of Actions Undertaken to Date –** note date of meeting if different to that previously agreed overleaf. | |
| **Outstanding Issues** | |
| **Further Actions –** (if any) including timescales | |
| **Date Action Plan Completed:** | |

| |
|---|
| **Staff Signature:** |
| **Line Managers Signature:** |

## References:


1) Reference Guide to Consent for Examination or Treatment, Department of Health (2001) (viewed at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006757?IdcService=GET_FILE&dID=29069&Rendition=Web, August 3rd 2009)

2) WHO Surgical Safety Checklist, National Patient Safety Agency - Patient Safety Alert Update, 26th January 2009 (viewed at http://www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/safer-surgery-alert, August 3rd 2009)

3) Richards A et al (1999), "Cellular changes in denervated tissue during wound Healing – Rat model", British Journal of Dermatology, 140, (6)

4) Galkowska H et al (2006), "Neurogenic factors in the Impaired Healing of Diabetic Foot Ulcers". The Journal of Surgical Research, 134, (2)

5) Prophylaxis against Infective Endocarditis, NICE CG64, 17th March 2008, (viewed at http://guidance.nice.org.uk/CG64, July 30th 2009)

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9) World Alliance for Patient Safety (2008) WHO Surgical Safety Checklist and Implementation manual Switzerland, World Health Organisation

10) Jenny Lawrence, Medicines Information, Plymouth Hospitals Trust email dated 06th January 2012.