

PROTECTIVE FOOTWEAR

Suitable footwear plays an important part in protecting insensitive feet against injury. Even where this is not available, patients should learn to avoid harmful footwear which can itself injure the foot.

It is not possible in this booklet to write about specially moulded footwear for deformed feet or to describe how footwear is made.

The purposes of this section are to outline important qualities looked for in basic, protective footwear, and possible sources of protective footwear.

1. IMPORTANT QUALITIES OF BASIC, PROTECTIVE FOOTWEAR FOR INSENSITIVE FEET

1.1 A soft insole to cushion against walking pressures

This cushioning needs to be about 1 cm thick. Its softness is known in some rubber or plastic factories as "15 shore".

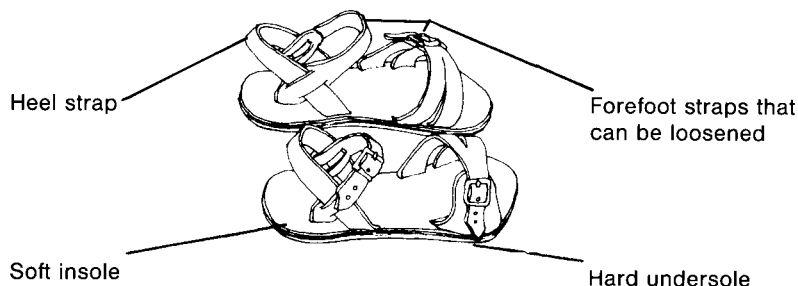
Insole material may be obtainable through your leprosy control programme office. If choosing insole material from a shop or factory, take your shoes off and try jumping or hopping on samples! *Your feet should sink into it but you should not feel the ground through it.* Buy just a few sheets at first, make some sandals and test these for wear and tear and check that it does not wear through too easily.

1.2 A hard undersole that cannot be pierced by thorns and stones or other sharp objects likely to be on the ground in your area. Car tyre is often used for this purpose and lasts very well.

1.3 An upper that:

- fits well, having plenty of room for clawed toes,
- has straps or laces over the forefoot that can be loosened to make room for a bandage or for foot swelling, and
- includes a heel-strap or filled in heel. This is necessary so that the patient does not claw his toes up more in order to keep the footwear on his foot. If your patients insist in *not* using the heel-strap, then make the uppers reach high up (near to the ankle) over the forefoot.

A common type of protective footwear used in hot countries



1.4 Footwear suitable for local conditions, for example:

- enclosed footwear where skin cracking is a serious problem (patients with open footwear should try to use socks),
- footwear with a cap or straps over the toes in stony areas where toes are likely to be injured,
- strongly-attached, wide straps or an enclosed upper in muddy conditions,
- and footwear that can safely be repaired locally and replaced promptly.

1.5 Footwear that the patient is willing, and if possible happy, to wear

Acceptability is important. Do try really hard to help the patient find protective footwear that he really likes and can afford to replace year after year.

Protective footwear that is not worn will not protect the foot!

Try to offer a choice of styles and colours where possible and helpful. Try using trimmings if the patient likes these and they are available locally – horizontal trimmings help to make the extra thickness of the sole less obvious.

These individual touches and styles are extra important in younger patients and where acceptance is a problem because the footwear has become known locally as “leprosy footwear”.

If a patient is still not really happy with the footwear, despite your best efforts, try to help him understand:

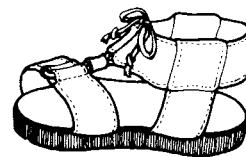
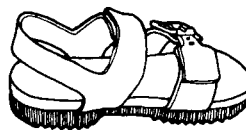
- the usefulness of the footwear in protecting against wounds, and
- the importance of avoiding the first or next wound, because each extra wound makes it more difficult to avoid a following wound.

2. POSSIBLE SOURCES OF PROTECTIVE FOOTWEAR INCLUDE THE FOLLOWING:

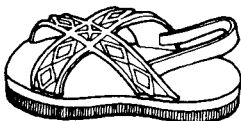
- a) Sports footwear that incorporates good insole cushioning



- b) Modified shop sandals
Straps lengthened and soft insole added



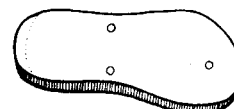
- d) Heel strap added to house slippers



- c) Footwear can be deepened by 1 cm and a soft insole added by: local shoe makers, factories, hospital-workshop



Note. Soft slipper sole, with straps removed and the holes plugged with the same material, can be used as insoling material.



Use of protective, cushioned footwear by the majority needing it is the priority. Patients should be encouraged to buy their own unless destitute, using suitable local shop footwear. Where this is not available it may be necessary to organise distribution of footwear for sale to patients, through district leprosy supervisors. Where special shoe workshops exist, their staff can focus attention on modifying footwear for patients whose wounds recur with the simpler footwear.

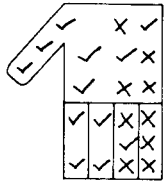
FOLLOW-UP DISABILITY RECORDS NEEDED FOR FEEDBACK

1. RECORDING CHANGES IN NERVE FUNCTION

Repeat the sensation and strength tests used for the baseline disability record if you think that these may have changed. Test sensation at extra sites if there is partial sensation loss, and not only at dot sites. Record the test date, and any changes noticed on the Individual Patient Form (IPF).

Example:

4.1.87	Full recheck of sensation and strength – no change since the baseline record.
2.2.87	<p>Full recheck of sensation and strength: Eyes, left hand and feet no change. Right hand: new sensory loss and weakness, noticed by patient last week. Little finger in – patient cannot now close fully, minimal little finger clawing. Slight tenderness of ulnar nerve above elbow.</p>



Right palm

2. RECORDING CHANGES IN WOUNDS, OPEN CRACKS AND BONE SHORTENING

2.1 IPF record

1. Draw in all new or recurred wounds, open cracks or shortening on a new hand or foot map.

(Do not draw a later second map to show change in the *same* wound.)

It is a good idea to draw all such maps on the right-hand side of the page so that they can easily be compared with one another.

2. Add brief wound comments regarding:

- wound cause,
- size and condition,
- history: date of the first wound at the site and length of time for which it recently stayed healed
- treatment, including removal of any dead bone,
- healing date.

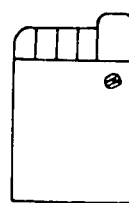
2.2 Wound notebook or page

Avoid filling up the IPF with detail that has only short-term importance.

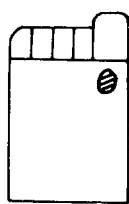
Record this sort of information in a notebook or page that can be thrown away . . . *after* important information on it has been summarised on the IPF, and when healing is complete.

Example: Rt sole

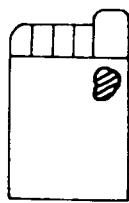
1.9.85
1 x 1 cm clean and shallow.
(Seen healed 22.9.85)



14.8.86
2 x 2 cm (x 3 mm deep)
Septic.
(Seen healed 30.9.86)



3.1.87
3 x 3 1/2 cm.
Shallow, infected

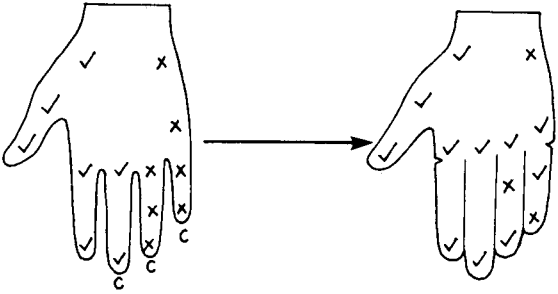
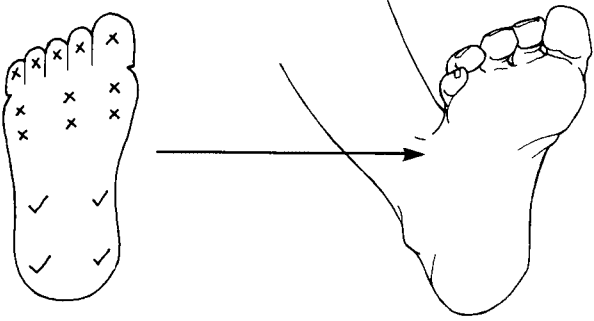
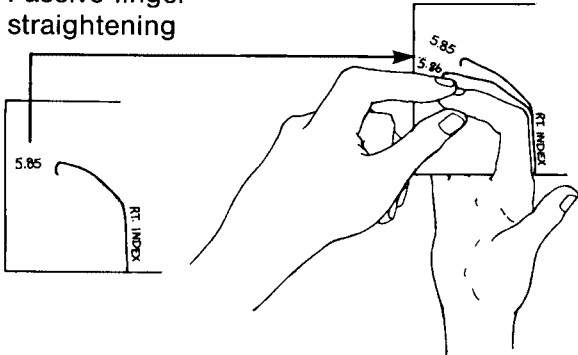
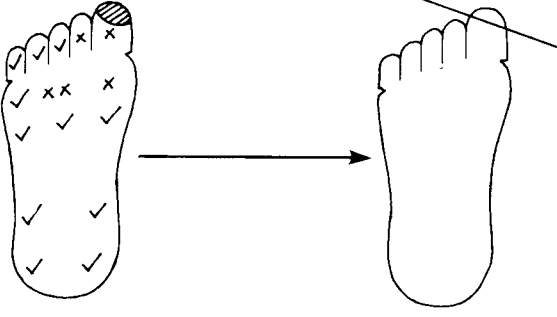


A wound notebook is especially useful for recording fortnightly changes in wound size and condition in patients in hospital with slow-to-heal wounds. Refer to it during ward rounds when discussing healing progress and plans with patient and co-workers.

Sample page of a wound notebook

PATIENT: John Eket. No. 1243. Work: farmer.			
		Wound history: first wound same site 4 years and last stayed healed only 3/12. Cause: walking pressures, sandal worn out. Plan: new sandals self-care of wound plan to avoid recurrence.	
DATE 1987	SIZE in mm Front/back Side/side	COMMENTS	ASSESSOR
Jan. 3	30 35	Shallow but infected.	JMW
Jan. 8	30 35	Much cleaner after soap soaks. Uses stick well. Has new, protective sandals.	JMW
Jan. 16	20 23	Doing well.	JMW
Jan. 23	20 25	Getting careless and fed-up . . . walking too much – went to see football match nearby.	JMW
Jan. 30	10 15	Patient saw that healing stopped when walked more . . . more careful now. Doing well again.	JMW
Feb. 6	– –	Healed but tender on pressure. To keep stick for home use whenever is tender.	JMW

FIVE EXAMPLES OF FEEDBACK USING DISABILITY RECORDS

<p>BASELINE RECORD → FOLLOW-UP</p>	<p>FINDINGS</p>
<p>1.</p> 	<p>Level 1 disability feedback: nerve function <i>improving</i>. (Sensation and clawing are recovering.)</p>
<p>2.</p> 	<p>Level 2 disability feedback: wounds and open cracks, <i>successfully avoided</i>.</p>
<p>3. Passive finger straightening</p> 	<p>Level 2 disability problem: stiffness <i>getting worse</i>.</p>
<p>4. Vision record: counting fingers possible in good light: Rt: 3 metres → Rt: 5 metres Lt: 6 metres → Lt: 6 metres</p>	<p>Level 3 disability feedback: right eye vision <i>improved</i>.</p>
<p>5.</p> 	<p>Level 3 disability feedback: big toe shortening occurred following wound neglect = <i>worsening</i>.</p>

TEACHING THAT ENCOURAGES CARING

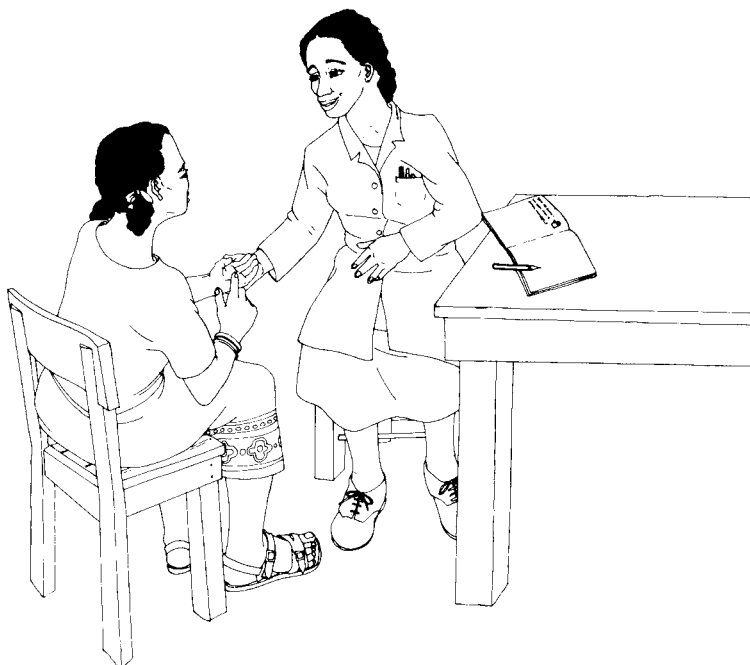
“HOW something is taught is just as important as WHAT is taught. And the most important part of HOW something is taught is the CARING, RESPECT AND SHARED CONCERN that go into it.”

Health teaching cannot be swallowed like tablets so that we and others “do what we are told to do for our own good”. As adults we decide whether or not to act on advice that we are given. Our response depends a great deal on factors such as how we feel, what we think of the person giving the advice, whether or not we really understand and believe what we are told and whether or not suggestions made are practical.

It is important that as staff we recognise that the way in which we offer teaching has a great effect on whether or not patients act on what we advise. It is important also that we remember that patients can teach us as much as we can teach them!

BE WELCOMING . . . AND TAKE TIME TO LISTEN

It feels good to be welcomed, listened to, cared for and respected. These attitudes in staff are likely to encourage listening and caring in patients and co-workers.



Take extra time to listen quietly to patients who seem “stubborn” or who always challenge or joke about your teaching.

Such patients are often worried people with longterm problems:

- perhaps feeling despairing because their wounds never seem to stay healed,
- perhaps fearing lest you embarrass them in front of other patients when you see that their wound has re-opened.

As you listen to a patient you will probably come to understand him better.

Beware of giving easy-sounding answers for difficult problems . . . of saying for example “you have not been careful” when a patient’s wound recurs. Maybe the patient’s tissues have been so damaged that the wound now recurs even though he *has* been careful. Maybe the patient *cannot* give the wound the rest that it needs and at the same time work to feed his family.

¹ Reference. *Helping Health Workers Learn*, David Werner and B. Bower, 1982, USA, Hesperian Foundation.

SHOW A REAL CONCERN FOR SMALL AND EARLY PROBLEMS

If you set an example of regular and careful inspection of insensitive areas, and if you show real concern over early problems such as neglected skin and warm spots that warn of build-up injury . . . then you will encourage patients to do likewise.

If on the other hand you fail to inspect and fail to notice early problems, or if you notice these problems but pay little attention to them . . . then you will encourage similar neglect in patients.

Neglected small problems turn into big problems. Neglected, dry skin for example may develop an open crack.

The neglected, small wound may become infected and cause severe tissue damage.



Teach concern by showing concern

SHOW CONFIDENCE IN THE SELF-CARE THAT YOU TEACH

1. Avoid unnecessary intervention

Don't, for example, do skin and wound care for a patient who could do it just as well himself . . . even if more slowly. Instead teach him, show him that you have confidence that he can do it and encourage him to persevere. The patient who, under caring instruction, gets his own wound healed through self-care . . . has learnt confidence in self-care and will be encouraged to care for his next wound early at home.

2. Practise what you teach

Because you teach patients always to soak and oil dry skin daily:

- when you are doing wound dressings, make sure that your patients *oil* their skin after soaking,
- make sure that patients attending an exercise class *soak* before they oil their hands, even if only for a few minutes.

3. Make provision for hospital patients to carry out the daily routine of care that you teach.

Check that needed bowls, water, oil, soap and mirrors are available . . . and that patients who cook extra food for themselves have needed protection so that they can cook safely.

See that the patient admitted for a wound on one foot also cares for his hands and his other foot if insensitive. See that the patient admitted for reaction *also* cares daily for his eye which does not close fully.

LET PATIENTS LEARN SELF-CARE BY PRACTISING IT

This is important. Studies have shown that people remember what they *do* better than what they only hear about or observe. As patients practise:

- help them to care *correctly*, for example to rub off the hard skin areas carefully,
- discuss with them *how* they will manage at home, for example what oil they will use, and
- discuss with them *why* the self-care is needed. It is important that patients have a clear idea of what to expect as a result of self-care.

Only to talk about self-care is NOT ENOUGH



**Prepared to help out-patients
practise needed self-care**