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# A descriptive study to assess the awareness and practices regarding foot care among diabetic patients in selected hospitals of district Mohali, Punjab

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**Abstract**
When a person has diabetes, their blood sugar level is greater than usual. Because high blood sugar destroys the nerves and blood vessels in the feet, diabetics frequently have foot problems. Because diabetes can harm your feet—even a minor cut can have major repercussions—it is imperative that you take good care of your feet. Nerve damage brought on by diabetes may cause you to lose sensation in your feet. It may be more difficult for the feet to heal from an injury or fend off infection if diabetes lowers blood flow to them.
**Aim of the study:** The main purpose of the study is to assess the awareness and practices regarding foot care among diabetic patients in selected hospitals of District Mohali, Punjab.
**Design and Method:** A quantitative research approach, descriptive research design was adopted to conduct the study. Purposive sampling technique was used to select 60 sample to assess the awareness and practices regarding foot care among diabetic patients. In this study the population consist of diabetic foot patients. Data was collected by questionnaire and check list. Descriptive and inferential statistical methods were used to analyse the data.
**Result:** Based on the study, most awareness questions had less than 50% correct responses, particularly regarding critical diabetic foot care practices like proper footwear, hygiene, and warning signs. In practice-related items, participants performed relatively better, especially in daily foot inspection and cleaning practices, yet awareness did not translate into ideal behaviours in many cases.
**Conclusion:** The study reveals alarming levels of poor awareness regarding diabetic foot care, although practices are somewhat better. This mismatch calls for structured education programs, increased follow-up by healthcare providers, and community-based initiatives. Promoting awareness is essential to reduce the risk of complications, amputations, and improve the quality of life in diabetic patients.

**Keywords:** Diabetic foot care, Diabetes mellitus, Patient awareness, Foot care practices, Nerve damage, Peripheral neuropathy, Blood circulation, Amputation prevention

## Introduction
Diabetes mellitus is a metabolic condition characterized by high blood glucose levels brought on by the body's inability to effectively produce or use insulin. The Indian Council of Medical Research defines diabetes mellitus as a state marked by persistent hyperglycaemia and disruptions in the metabolism of proteins, fats, and carbohydrates due to deficiencies in either insulin secretion, insulin action, or both [1]. The hormone insulin, which is secreted by the pancreas, is crucial for regulating blood glucose levels. It appears when your body does not react well to insulin or when your pancreas does not generate any at all. Diabetes affects people of all ages. The majority of diabetes types are chronic, or long-term, diseases that are treated with medicine and/or lifestyle modifications. Carbohydrates are the primary source of glucose, or sugar, and are found in food and beverages. It is the main source of energy for your body. Your blood carries glucose, which is used as fuel by every cell in your body. To get glucose to the right place in the body, our blood needs assistance, much like a key. The hormone produced by the pancreatic gland behind or beneath the stomach is called insulin. Glucose accumulates in the bloodstream and causes

hyperglycaemia, or elevated blood sugar, when the body uses insulin incorrectly or the pancreas does not generate enough of it. Chronically producing hyperglycaemia, or increased blood sugar, over time can result in health issues such kidney damage, heart disease, and visual problems. Diabetes is referred to in medicine as diabetes mellitus. Another condition that is referred to as "diabetes" is diabetes insipidus, but it is distinct. Because they both result in increased thirst and frequent urination, they are referred to as "diabetes." Diabetes insipidus is far less prevalent than diabetes mellitus [2].

Among the most popular forms are: The period before type 2 diabetes is known as prediabetes. Although your blood glucose level is greater than usual, type 2 diabetes cannot be diagnosed because of it. Normal blood glucose levels are fewer than 140 mg/dl. Diabetes is diagnosed if the value is greater than 200 mg/dl. You are considered to have prediabetes if your reading is between 140 and 199 mg/dl. Diabetes risk can be decreased by reducing body weight by 5 to 10% with diet and exercise. Type 1 diabetes, sometimes referred to as insulin-dependent diabetes mellitus or juvenile-onset diabetes, is another kind of the disease. More than 90% of the insulin-producing cells in your pancreas are permanently killed in this autoimmune disease, which occurs when your immune system attacks and kills them for no apparent reason. Type 1 diabetes affects less than 10% of all diabetics. Type 1 diabetes usually affects a person before the age of thirty, while it can manifest later in life. The immune system destroys the pancreatic cells that produce insulin as a result of certain environmental variables, such as viral infections or dietary deficiencies in childhood or maturity. Type 2 diabetes, commonly known as adult-onset diabetes or non-insulin dependent diabetes mellitus, is brought on by either insufficient insulin production by the body or improper cell response to insulin. The pancreas's capacity to produce insulin declines as type 2 diabetes worsens. One of the most prevalent forms of diabetes is this one. Most often, it begins in people over thirty. Type 2 diabetes mellitus affects about 30% of those over 65 [3].

Any degree of glucose intolerance that develops during pregnancy is referred to as gestational diabetes. It happens when insulin resistance brought on by placental hormones raises blood sugar levels. Pregnant women who have gestational diabetes are more likely to have conditions associated with elevated blood pressure [4].

Increased thirst, increased urination, increased hunger, dry mouth, hazy vision, tiredness, nausea, poor stamina during exercise, and sluggish wound or sore healing are all signs of diabetes mellitus. The onset of symptoms in patients with type 1 diabetes is sudden and severe. Diabetic ketoacidosis is a dangerous condition. Symptoms of diabetic ketoacidosis include nausea, vomiting, exhaustion, and stomach pain, particularly in children. Before receiving a diagnosis, people with type 2 diabetes may go years or even decades without exhibiting any symptoms. A condition known as hyperosmolar hyperglycaemia state can occur when blood glucose levels get extremely high, causing severe dehydration that can cause mental confusion, drowsiness, and seizures [5].

Acute Complication of diabetes are hyperosmolar hyperglycaemic state and diabetic ketoacidosis. Chronic complications are retinopathy, foot problems, heart attack and stroke, nephropathy, neuropathy, gum disease and other mouth problems, related conditions like cancer, sexual problems in women and men [6]. Many organs can be affected like brain causing stroke, retinopathy cause blindness, kidney nephropathy causing chronic kidney disease, nerve nephropathy causing decreased sensation mainly in feet and legs [7].

A Diabetic foot disease is a condition that any aliment that arises directly from peripheral artery disease or sensory neuropathy that affects a diabetic foot is referred to as diabetic foot disease. Diabetes- related foot problems can be acute or long-term. Diabetes can cause peripheral artery disease and peripheral nerve dysfunction, which results in inadequate blood flow to the limbs. Nearly half of diabetic foot ulcer patients also have peripheral vascular disease.

Diabetic foot diseases include neuropathic osteoarthropathy, diabetic foot ulcers, and infections. These conditions are often referred to as diabetic foot syndrome. Patient's feel dry skin and diminished sense of pain as a result of advanced peripheral nerve damage linked to diabetes. Hence, little wounds could go unnoticed and eventually develop into a diabetic foot ulcer that is completely thick. Additionally, foot surgery can be performed without anaesthetics and is generally tolerated [8].

You might may not be aware of a cut, blister or ulcer on your foot if you are painless. A wound like that get effected. The infection may not heal properly because of the impaired blood flow in your foot caused by damaged blood vessels. Insufficient infection and blood flow can result to gangrene. In other words, the skin, muscles, and other tissues start to die. If you have gangrene or a foot ulcer that doesn't go away with medicine, you may need to have it amputated. Amputation of the lower limbs may be required in cases when wounds take a long time to heal and become infected, spreading to bones and joints. In individual with diabetes, foot trauma is the most frequent reason for non-traumatic amputation. Your damaged toe, foot, or leg portion will be amputated during this surgery. It could save your life and stop a dangerous infection from spreading. A diabetic foot disease can cause serious foot problems such as a bruise, cut, or blister on your foot that doesn't go better after a few days your feet's skin may be sore, red, or heated. Dried blood inside a callus the foot infection becomes dark, foul-smelling cause gangrene. An infected diabetic foot ulcer may lead to a painful build-up of abscess. The pus accumulated under the surface of the skin. Diabetic foot infection and long-term untreated diabetes can weaken the muscles and bones of the feet, causing deformity and foot amputation. Keeping blood sugar levels under control is the best defence for foot. This will help keep nerve end blood vessel damage from getting worse and keep the skin of the feet healthy, washing feet every day, trimming toe nails straight across with a clipper, protecting feet from heat and cold, keep the blood flow in feet, avoid going barefoot always wearing well fitted shoes to protect feet when walking, maintain a healthy weight, getting feet checked at your health care visits [9].

A recent meta-analysis found a 6.3% global prevalence of diabetic foot ulcer among adults with diabetes, which equals to approximately 33million people affected by diabetic foot ulcer [10].

International diabetes federation estimated that in 2019 around 463 million people had diabetes, and by 2045 this longer is expected to raise by 700 million. Additionally, it is predicted that between 2010 and 2030, the prevalence of diabetes will rise by 20% in developing countries and 69%

in underdeveloped ones [11].

Diabetic foot ulcers affect 6.2% of individuals with diabetes in India, indicating a significant health burden. Diabetic foot ulcers prevalence was consistent across India: East (9.5%), south (7.4%), and North (5.6%), showing a nationwide distribution [12].

In Punjab overall prevalence or diabetic foot ulcer was 16.83%. In rural areas, the prevalence was 13.91% with a female prevalence of 17.52% and a male prevalence of 15.48%, whereas in urban areas, the prevalence was 17.96%. Individuals 75 years and above had the highest prevalence of 66.67%. Therefore, the purpose of the present study is to create awareness and practices regarding foot care among diabetic patient [13].

**Need of Study**

Diabetes is like an iceberg. Non-insulin-dependent diabetes has become more commonplace globally, but it has become especially pronounced in poor and newly industrialized countries. Approximately 150 million people worldwide are thought to have diabetes at this time. By 2025, it is predicted that the number will have doubled. Up to 9% of people could have diabetes by 2030 [14].

Diabetic foot disease is the 13th biggest cause of over 350 illnesses worldwide, accounting for almost 2% of the total disease burden in 2024 [15].

An estimated 6.2% of people with diabetes in India is thought to have diabetic foot ulcers. About 25% of India's 62 million diabetics get diabetic foot ulcers; of them, 50% get infected and require hospitalization, and 20% need to have their feet amputated [16].

The researcher claims that diabetes mellitus is linked to numerous complications. The main cause of those issues is vascular system disruption, which can lead to insufficient circulation to the body's extremities. The foot is more susceptible to infection and ulcers as a result. One of the most dangerous and expensive side effects of diabetes mellitus is foot complications. Foot ulcers are among the symptoms of diabetes mellitus that the majority of patients are not completely aware of. Their inadequate understanding of proper foot care techniques and failure to take prompt action could lead to complicated issues, including potentially lethal outcomes. Whether the patient is in the hospital or at home, chronic complications of diabetes mellitus have significant implications for nursing care planning [17].

Diabetic foot disease is among the most dangerous consequences of diabetes mellitus. Infection, ulceration, and osseous deterioration of the diabetic foot are all included. Diabetic foot demands the highest level of care, and managing foot care effectively and efficiently is crucial [18].

As a result, diabetic foot ulcers are a very complicated problem that affects patients as well as society. According to a previous study, the incidence of diabetic foot ulcers and lower extremity amputations can be decreased by identifying high-risk individuals and treating risk factors early [19].

According to WHO estimates, around 180 million people worldwide suffer with diabetes. By 2030, these figures are probably going to more than double. An estimated 1.1 million deaths were attributed to diabetes in 2005. Nearly 80% of diabetes-related deaths take place in low- and middle-income nations. Nearly half of diabetes-related deaths occur in people under 70. Women account for 55% of diabetes-related deaths. Most significantly, it is predicted that between 2006 and 2015, the number of deaths from diabetes in upper-middle income nations will rise by more than 80%. Individuals with diabetes have a death rate that is at least twice as high as that of those without the disease. Diabetes and its complications have a major financial impact on people, families, nations, and health systems.

In the primary healthcare sector, there is an urgent need to raise awareness about diabetes management and associated consequences. It is imperative that primary healthcare practitioners get ongoing education on diabetes mellitus and its complications, and that their understanding of the disease be regularly evaluated. Diabetes screening is vital, but patient counselling and education are just as critical. The results of this study clearly show that patients lack the knowledge necessary to fully manage their illness. Therefore, in order to prevent co-morbidities that could affect their lifestyles and raise the burden on public health care, primary healthcare providers and other diabetic patients must be knowledgeable about diabetes [20]

**Problem Statement**

"A descriptive study to assess the awareness and practices regarding foot care among diabetic patients in selected hospitals of District Mohali, Punjab."

**Aim of the Study**

The aim of the study is to assess the awareness and practices regarding foot care among diabetic patients in selected hospitals of District Mohali, Punjab.

**Objectives of the Study**

- To assess the awareness regarding foot care among diabetic patients.
- To assess the practices regarding foot care among diabetic patients.
- To find out the association between the level of awareness and practices regarding foot care among diabetic patients with their selected socio-demographic variables.
- To disseminate the findings.

**Operational Definition**

- **Awareness:** Awareness refers to the level of knowledge and understanding that diabetic patients have about foot care, including the risk of foot complications, preventive measures, and the importance of regular foot hygiene.
- **Practices:** Practices refers to the actual actions and habits undertaken by diabetic patients to care of their feet.
- **Foot care:** Foot care encompasses the preventive and maintenance activities aimed at preserving foot health in diabetic patients.
- **Diabetic patients:** Diabetic patients are individuals suffering from a metabolic disease marked by elevated blood glucose level because of the body's incapacity to manufactural or utilize insulin efficiently.

**Assumptions**

- The diabetic patients had average or poor awareness regarding diabetic foot care.
- Most of them had limited practice level regarding diabetic foot care.

**Delimitations**

**The study was limited to the**

1. Diabetic foot patients who were present at the time of data collection.
2. Who were willing to participate in the study.

**Research approach**

A quantitative research approach was used to assess the awareness and practices regarding foot care among diabetic patients in civil hospital phase-6, Mohali.

**Research Design**

Research design is a functional or blueprint that includes the method and procedure use in collecting and analysing the needed information in research study. Descriptive research design was chosen for present study.

**Research Setting**

The study was conducted in civil hospital phase-6, Mohali. The reason for selecting this hospital were abundant of samples, investigation convenience and expected cooperation from head of department in getting permission for conducting the study.

**Target Population**

The target population of the study was comprised of diabetic foot patients of civil hospital phase-6, Mohali.

**Sample and Sampling Technique**

The sample consists of 60 diabetic foot patients. Convenient sampling technique was used to draw sample from the population.

**Inclusion Criteria**

1. Only diabetic foot patients of age 20-80 years of present in civil hospital phase-6, Mohali.
2. Willing to participate in the study.

**Exclusion Criteria**

1. Patient with surgery, cardiology problems and patient with sepsis.
2. Diabetic foot patients below 20 and above 80 years of age.

**Dependent Variable**

Foot care.

**Independent Variable**

Awareness and practices.

**Selection and Development of Tool**

Self-administered structured knowledge questionnaire and check list will be developed to assess the awareness and practice regarding foot care among diabetic patients. Extensive review of literature i.e. books, journals, expert opinion and the investigator's professionals experience provided basis for construction of the structured tool.

**Self-administered structured knowledge questionnaire**

It is divided into two sections:

**Part-A**

- Socio-demographic data
- Clinical profile

**Part-B**

- Self-structured knowledge questionnaire on awareness regarding foot care among diabetic patients.
- Check list on practices regarding foot care among diabetic patients.

**Description of Tool**

**Self-administered structured knowledge questionnaire was divided into two sections:**

**Part-A**

**Socio demographic data**

This section consists of variables to collect socio-demographic information such as age, gender, educational status, religion, occupation, socio-economic status, marital status, type of family, dietary habits and personal hygie.ne.

**Clinical profile**

This section consists of variables to collect clinical profile information such as diagnosis, type of admission, type of illness, previous illness (medical and surgical), lab reports and vital signs.

**Validity of Tool**

In order to measure the content validity. Research supervisor was consulted regarding content and language of the tool. The change was made as per guidance of experts after discussion with research supervisor, the tool was finalized.

**Reliability of Tool**

It is the degree of consistency or dependability with which an instrument measures the attributes. Reliability of tool was calculated by split half method and Kari Pearson method. Reliability of tool (r=0.79) for awareness score and (r=0.81) for practice score. The tool was found to be reliable and valid.

**Pilot Study**

The pilot study was conducted at civil hospital, Kharar. It was conducted on 10% of total sample size, self-structured knowledge questionnaire given to the group. The descriptive analysis was done in accordance with the objectives. The finding of the data revealed that study was feasible.

**Ethical consideration**

- Written permission was taken from the ethical committee of the Rayat Bahra College of Nursing, Mohali.
- Written permission was taken from the Director principal of the Rayat Bahra College of Nursing, Mohali.
- Written permission was taken from Senior Medical Officer of civil hospital phase-6, Mohali.
- Verbal and written consent will be taken from the participants of the study.
- Confidentiality and anonymity will be maintained throughout the study.

**Data Collection Procedure**

A formal written permission was obtained from the Senior Medical Officer of civil hospital phase-6, Mohali after discussing the purposes and objectives of the study with them. Also take permission from the diabetic patients prior

to the data collection was taken by the explaining the purposes the study and consent was taken from them. They were also assured about their confidentiality.

- Only pre-test will be taken by administering the self-structured knowledge questionnaire. They were instructed to go through the instruction before answering the questions. The instructions were also read out by the investigator.

**Plan of Data Analysis**

Data was analysed by using descriptive and inferential statistics.

**Section-A**

**Table 1:** Demographic Profile of Diabetic Foot Patients

| Socio Demographic Performa | | Frequency(F) | Percentage (%) |
|---|---|---|---|
| Age (In Years) | 20-35 years | 5 | 8% |
| | 36-50 years | 12 | 20% |
| | 51-65 years | 26 | 43% |
| | 66-80 years | 17 | 28% |
| Gender | Male | 27 | 45% |
| | Female | 33 | 55% |
| | Transgender | 0 | 0% |
| Education | Primary | 19 | 32% |
| | Secondary | 25 | 42% |
| | Graduate or above | 9 | 15% |
| | Illiterate | 5 | 8% |
| | No formal education | 2 | 3% |
| Religion | Sikh | 21 | 35% |
| | Hindu | 20 | 33% |
| | Muslim | 16 | 27% |
| | Christian | 3 | 5% |
| Occupation | Private employee | 13 | 22% |
| | Government employee | 28 | 47% |
| | Self-employee | 13 | 22% |
| | Unemployed | 6 | 10% |
| Socio-Economic Status (Per Month) | Below 2500 | 9 | 15% |
| | 2500-5000 | 10 | 17% |
| | 5001-10,000 | 20 | 33% |
| | 10,001-20,000 | 17 | 28% |
| | >20,000 | 4 | 7% |
| Marital Status | Married | 44 | 73% |
| | Unmarried | 12 | 20% |
| | Widow | 4 | 7% |
| | Separated | 0 | 0% |
| Type of Family | Joint family | 12 | 20% |
| | Nuclear family | 37 | 62% |
| | Extended family | 11 | 18% |
| Dietary Habit | Vegetarian | 19 | 32% |
| | Non-vegetarian | 34 | 57% |
| | Eggetarian | 7 | 12% |
| Personal Hygiene | By self | 32 | 53% |
| | Assisted | 20 | 33% |
| | Dependent | 8 | 13% |

**Table 2:** Clinical Profile of Diabetic Foot Patients

| Clinical Performa | | Frequency(F) | Percentage (%) |
|---|---|---|---|
| Diagnosis | Type 1diabetic mellitus | 27 | 45% |
| | **Type 2 diabetic mellitus** | **33** | **55%** |
| Type of Admission | Emergency | 27 | 45% |
| | OPD | 33 | 55% |
| Type of Illness | Acute | 32 | 53% |
| | Chronic | 28 | 47% |
| Previous History | Yes | 13 | 22% |
| | No | 47 | 78% |
| CBC | Normal | 49 | 82% |
| | Abnormal | 11 | 18% |
| Blood Glucose (Fasting) | Normal | 29 | 48% |
| | Abnormal | 31 | 52% |
| Blood Glucose (Postprandial) | Normal | 25 | 42% |
| | Abnormal | 35 | 58% |
| Glycated Haemoglobin (Hba1C) | Normal | 30 | 50% |
| | Abnormal | 30 | 50% |
| C-Reactive Protein | Normal | 53 | 88% |
| | Abnormal | 7 | 12% |
| Wound Swap Culture | Normal | 50 | 83% |
| | Abnormal | 10 | 17% |
| Blood Culture | Normal | 50 | 83% |
| | Abnormal | 10 | 17% |
| X-Ray of Foot | Normal | 53 | 88% |
| | Abnormal | 7 | 12% |
| BP | Normal | 8 | 13% |
| | Abnormal | 52 | 87% |
| Temperature | Normal | 55 | 92% |
| | Abnormal | 5 | 8% |
| Respiration | Normal | 58 | 97% |
| | Abnormal | 2 | 3% |
| Pulse | Normal | 57 | 95% |
| | Abnormal | 3 | 5% |
| Spo2 | Normal | 59 | 98% |
| | Abnormal | 1 | 2% |

**Section - B**

**Table 3:** Frequency & Percentage distribution of Awareness Scores. N=60

| Criteria Measure of Awareness Score | | |
|---|---|---|
| **Category Score** | **Frequency** | **Percentage** |
| Good (14-20) | 0 | 0.0% |
| Average (7-13) | 15 | 25.0% |
| Poor (0-6) | 45 | 75.0% |

Maximum Score=20
Minimum Score=0

The awareness scores are grouped into three levels:

- Good (14-20)
- Average (7-13)
- Poor (0-6)

None of the participant scored in the “good” range- nobody got more than 15 points. 25% of people scored in the “average” range, means they had a fair level of awareness. Most people, 75%, scored in the “poor” range, which means they had low awareness.

**Table 4:** Descriptive statistics of pre-test level of Awareness Scores. N=60

| Descriptive Statistics | Mean | SD | Median | Maximum | Minimum | Range | Mean % |
|---|---|---|---|---|---|---|---|
| Awareness Score | 5.85 | 2.43 | 5.00 | 13 | 0 | 13 | 29.3 |

Maximum Score=14
Minimum Score=0

The awareness score mean of 5.85, indicating the average score across all participants. The standard deviation (SD) is 2.43, suggesting moderate variability in the scores. The middle score (median) was 5.00, when the scores are arranged in order. The highest score achieved was 13, while the lowest score was 0, so the scores ranged from 0 to 13. The mean percentage is 29.3%, reflecting the average score of full score.

**Table 5:** Table Showing Association of Demographic Variables with awareness score regarding foot care among diabetic patients

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Age (In Years) | 20-35 years | 0 | 3 | 2 | 5.013 | 0.171 | 3 | 7.815 | Not Significant |
| | 36-50 years | 0 | 4 | 8 | | | | | |
| | 51-65 years | 0 | 4 | 22 | | | | | |
| | 66-80 years | 0 | 4 | 13 | | | | | |

**Table 5.1:** According to age, most diabetic patients were 51-65 years old. The obtained Chi-square value was 5.013, P value was 0.171 with df 3.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Gender | Male | 0 | 3 | 24 | 5.051 | 0.025 | 1 | 3.841 | Significant |
| | Female | 0 | 12 | 21 | | | | | |
| | Transgender | 0 | 0 | 0 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 5.2:** According to gender, the majority of the diabetic patients were females. The obtained Chi-square value was 5.051, P value was 0.025 with df 1.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Education | Primary | 0 | 2 | 17 | 4.376 | 0.357 | 4 | 9.488 | Not Significant |
| | Secondary | 0 | 8 | 17 | | | | | |
| | Graduate or above | 0 | 3 | 6 | | | | | |
| | Illiterate | 0 | 2 | 3 | | | | | |
| | No formal education | 0 | 0 | 2 | | | | | |

Hence it is concluded that mean score was statistically significant at <0.05.

**Table 5.3:** According to education, the majority of the diabetic patients had the secondary level of education. The obtained Chi-square value was 4.376, P value was 0.357 with df 4.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Religion | Sikh | 0 | 9 | 12 | 7.571 | 0.056 | 3 | 7.815 | Not Significant |
| | Hindu | 0 | 5 | 15 | | | | | |
| | Muslim | 0 | 1 | 15 | | | | | |
| | Christian | 0 | 0 | 3 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 5.4:** According to religion, the majority of the diabetic patients were Sikh. The obtained Chi-square value was 7.571, P value was 0.056 with df 3.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Occupation | Private employee | 0 | 4 | 9 | 4.308 | 0.230 | 3 | 7.815 | Not Significant |
| | Government employee | 0 | 7 | 21 | | | | | |
| | Self-employee | 0 | 1 | 12 | | | | | |
| | Unemployed | 0 | 3 | 3 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05

**Table 5.5:** According to occupation, the majority of the diabetic patients were government employee. The obtained Chi-square value was 4.308, P value was 0.230 with df 3.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Socio-Economic Status (Per Month) | Below 2500 | 0 | 3 | 6 | 2.886 | 0.577 | 4 | 9.488 | Not Significant |
| | 2500-5000 | 0 | 3 | 7 | | | | | |
| | 5001-10,000 | 0 | 3 | 17 | | | | | |
| | 10,001-20,000 | 0 | 4 | 13 | | | | | |
| | >20,000 | 0 | 2 | 2 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 5.6:** According to socio-economic status (per month), the majority of the diabetic patients had their income level between 5001-10,000. The obtained Chi-square value was 2.886, P value was 0.577 with df 4.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Marital Status | Married | 0 | 9 | 35 | 2.263 | 0.323 | 2 | 5.991 | Not Significant |
| | Unmarried | 0 | 4 | 8 | | | | | |
| | Widow | 0 | 2 | 2 | | | | | |
| | Separated | 0 | 0 | 0 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 5.7:** According to marital status, the majority of the diabetic patients were married. The obtained Chi-square value was 2.263, P value was 0.323 with df 2.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Type of Family | Joint family | 0 | 5 | 7 | 3.272 | 0.195 | 2 | 5.991 | Not Significant |
| | Female | 0 | 12 | 21 | | | | | |
| | Transgender | 0 | 0 | 0 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 5.8:** According to type of family, the majority of the diabetic patients were nuclear family. The obtained Chi-square value was 3.272, P value was 0.195 with df 2.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Dietary Habit | Vegetarian | 0 | 6 | 13 | 0.906 | 0.636 | 2 | 5.991 | Not Significant |
| | Non-vegetarian | 0 | 8 | 26 | | | | | |
| | Eggetarian | 0 | 1 | 6 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 5.9:** According to type of dietary habit, the majority of the diabetic patients were non-vegetarian. The obtained Chi-square value was 0.906, P value was 0.636 with df 2.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Personal Hygiene | By self | 0 | 8 | 24 | 0.933 | 0.627 | 2 | 5.991 | Not Significant |
| | Assisted | 0 | 6 | 14 | | | | | |
| | Dependent | 0 | 1 | 7 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table:** According to personal hygiene, the majority of the diabetic patients were by self. The obtained Chi-square value was 0.933, P value was 0.627 with df 2.

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6:** Table Showing Association of Clinical Variables with awareness scores regarding foot care among diabetic patients

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Diagnosis | Type 1 diabetic mellitus | 0 | 6 | 21 | 0.202 | 0.653 | 1 | 3.841 | Not Significant |
| | Type 2 diabetic mellitus | 0 | 9 | 24 | | | | | |

**Table 6.1:** According to diagnosis, the majority of the diabetic patients having type 2 diabetic mellitus. The obtained Chi-square value was 0.202, P value was 0.653 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Type of Admission | Emergency | 0 | 5 | 22 | 1.100 | 0.294 | 1 | 3.841 | Not Significant |
| | OPD | 0 | 10 | 23 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.2:** According to type of admission, the majority of the diabetic patients were coming in OPD. The obtained Chi-square value was 1.100, P value was 0.294 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Type of Illness | Acute | 0 | 7 | 25 | 0.357 | 0.550 | 1 | 3.841 | Not Significant |
| | Chronic | 0 | 8 | 20 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.3:** According to type of illness, the majority of the diabetic patients were acute. The obtained Chi-square value was 0.357, P value was 0.550 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Previous History | Yes | 0 | 4 | 9 | 0.295 | 0.587 | 1 | 3.841 | Not Significant |
| | No | 0 | 11 | 36 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.4:** According to previous history, the majority of the diabetic patients were no. The obtained Chi-square value was 0.295, P value was 0.587 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| CBC | Normal | 0 | 11 | 38 | 0.928 | 0.335 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 4 | 7 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.5:** According to CBC, the majority of the diabetic patients were normal. The obtained Chi-square value was 0.928, P value was 0.335 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Blood Glucose (Fasting) | Normal | 0 | 5 | 24 | 1.802 | 0.179 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 10 | 21 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.6:** According to Blood Glucose (Fasting), the majority of the diabetic patients were abnormal. The obtained Chi-square value was 1.802, P value was 0.179 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Blood Glucose (Postprandial) | Normal | 0 | 3 | 22 | 3.863 | 0.049 | 1 | 3.841 | Significant |
| | Abnormal | 0 | 12 | 23 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.7:** According to Blood Glucose (postprandial), the majority of the diabetic patients were abnormal. The obtained Chi-square value was 3.863, P value was 0.049 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Glycated Haemoglobin (Hba1C) | Normal | 0 | 6 | 24 | 0.800 | 0.371 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 9 | 21 | | | | | |

Hence it is concluded that mean score was statistically significant at <0.05.

**Table 6.8:** According to Glycated Haemoglobin (Hba1C), the majority of the diabetic patients were equal. The obtained Chi-square value was 0.800, P value was 0.371 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| C-Reactive Protein | Normal | 0 | 14 | 39 | 0.485 | 0.486 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 1 | 6 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.9:** According to C-reactive Protein, the majority of the diabetic patients were normal. The obtained Chi-square value was 0.485, P value was 0.486 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Wound Swap Culture | Normal | 0 | 11 | 39 | 1.440 | 0.230 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 4 | 6 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.10:** According to wound swap culture, the majority of the diabetic patients were normal. The obtained Chi-square value was 1.440, P value was 0.230 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Blood Culture | Normal | 0 | 12 | 38 | 0.160 | 0.689 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 3 | 7 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.11:** According to blood culture, the majority of the diabetic patients were normal. The obtained Chi-square value was 0.160, P value was 0.689 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| X-Ray of Foot | Normal | 0 | 11 | 42 | 4.367 | 0.037 | 1 | 3.841 | Significant |
| | Abnormal | 0 | 4 | 3 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.12:** According to X-ray of foot, the majority of the diabetic patients were normal. The obtained Chi-square value was 4.367, P value was 0.037 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| BP | Normal | 0 | 2 | 6 | 0.000 | 1.000 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 13 | 39 | | | | | |

Hence it is concluded that mean score was statistically significant at <0.05.

**Table 6.13:** According to BP, the majority of the diabetic patients were abnormal. The obtained Chi-square value was 0.000, P value was 1.000 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Temperature | Normal | 0 | 13 | 42 | 0.655 | 0.418 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 2 | 3 | | | | | |

Hence it is concluded that mean score was statistically significant at <0.05.

**Table 6.14:** According to temperature, the majority of the diabetic patients were normal. The obtained Chi-square value was 0.655, P value was 0.418 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Respiration | Normal | 0 | 14 | 44 | 0.690 | 0.406 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 1 | 1 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.15:** According to respiration, the majority of the diabetic patients were normal. The obtained Chi-square value was 0.690, P value was 0.406 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Pulse | Normal | 0 | 14 | 43 | 0.117 | 0.732 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 1 | 2 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.16:** According to pulse, the majority of the diabetic patients were normal. The obtained Chi-square value was 0.117, P value was 0.732 with df 1.

| Clinical Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Spo2 | Normal | 0 | 14 | 45 | 3.051 | 0.081 | 1 | 3.841 | Not Significant |
| | Abnormal | 0 | 1 | 0 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table:** According to spo2, the majority of the diabetic patients were normal. The obtained Chi-square value was 3.051, P value was 0.081 with df 1.

**Hence it is concluded that mean score was statistically not significant at <0.05.**

**Section - C**

**Table 7:** Frequency & Percentage distribution of Practice Scores N=60

| Criteria Measure of Practice Score | | |
|---|---|---|
| **Category Score** | **Frequency** | **Percentage** |
| GOOD (10-14) | 9 | 15.0% |
| AVERAGE (5-9) | 28 | 46.7% |
| POOR (0-4) | 23 | 38.3% |

Maximum Score=14
Minimum Score=0

The practice scores are grouped into three levels:

- Good (10-14)
- Average (5-9)
- Poor (0-4)

The 15% participant scored in the "good" range means they practice a lot. Most people, 46.7% scored in the "average" range, means they practiced a fair amount. 38.3% scored in the "poor" range, which means they practiced very little.

**Table 8:** Descriptive statistics of pre-test level of Practice Scores. N=60

| Descriptive Statistics | Mean | SD | Median | Maximum | Minimum | Range | Mean % |
|---|---|---|---|---|---|---|---|
| Practice Score | 6.47 | 3.22 | 6.00 | 14 | 0 | 14 | 46.2 |

Maximum Score=14
Minimum Score=0

The practice score had an average mean of 6.47, meaning that's what most people scored on average. The standard deviation was 3.22, which means the scores varied a lot. The middle score (or median) was 6.00. The highest score was 14, and the lowest was 0, so the scores ranged from 0 to 14. On average, people got 46.2% of the total possible points.

**Table 9:** Table Showing Association of Demographic Variables with practice scores regarding foot care among diabetic patients

| Demographic Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Variable** | **Options** | **Good** | **Average** | **Poor** | **Chi Test** | **P Value** | **DF** | **Table Value** | **Result** |
| Age (In Years) | 20-35 years | 1 | 3 | 1 | 1.468 | 0.962 | 6 | 12.592 | Not Significant |
| | 36-50 years | 1 | 6 | 5 | | | | | |
| | 51-65 years | 4 | 11 | 11 | | | | | |
| | 66-80 years | 3 | 8 | 6 | | | | | |

**Table 9.1:** According to age, most diabetic patients were 51-65 years old. The obtained Chi-square value was 1.468, P value was 0.962 with df 6.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Variable** | **Options** | **Good** | **Average** | **Poor** | **Chi Test** | **P Value** | **DF** | **Table Value** | **Result** |
| Gender | Male | 3 | 11 | 13 | 2.098 | 0.350 | 2 | 5.991 | Not Significant |
| | Female | 6 | 17 | 10 | | | | | |
| | Transgender | 0 | 0 | 0 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 9.2:** According to gender, the majority of the diabetic patients were females. The obtained Chi-square value was 2.098, P value was 0.350 with df 2.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Variable** | **Options** | **Good** | **Average** | **Poor** | **Chi Test** | **P Value** | **DF** | **Table Value** | **Result** |
| Education | Primary | 3 | 6 | 10 | 5.988 | 0.649 | 8 | 15.507 | Not Significant |
| | Secondary | 4 | 14 | 7 | | | | | |
| | Graduate or above | 2 | 5 | 2 | | | | | |
| | Illiterate | 0 | 2 | 3 | | | | | |
| | No formal education | 0 | 1 | 1 | | | | | |

Hence it is concluded that mean score was statistically significant at <0.05.

**Table 9.3:** According to education, the majority of the diabetic patients had the secondary level of education. The obtained Chi-square value was 5.988, P value was 0.649 with df 8.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Religion | Sikh | 4 | 10 | 7 | 5.474 | 0.485 | 6 | 12.592 | Not Significant |
| | Hindu | 3 | 12 | 5 | | | | | |
| | Muslim | 2 | 5 | 9 | | | | | |
| | Christian | 0 | 1 | 2 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 9.4:** According to religion, the majority of the diabetic patients were Sikh. The obtained Chi-square value was 5.474, P value was 0.485 with df 6.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Occupation | Private employee | 2 | 5 | 6 | 3.346 | 0.764 | 6 | 12.592 | Not Significant |
| | Government employee | 4 | 16 | 8 | | | | | |
| | Self-employee | 2 | 4 | 7 | | | | | |
| | Unemployed | 1 | 3 | 2 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 9.5:** According to occupation, the majority of the diabetic patients were government employee. The obtained Chi-square value was 3.346, P value was 0.764 with df 6.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Socio-Economic Status (Per Month) | Below 2500 | 1 | 4 | 4 | 3.742 | 0.880 | 8 | 15.507 | Not Significant |
| | 2500-5000 | 2 | 4 | 4 | | | | | |
| | 5001-10,000 | 2 | 8 | 10 | | | | | |
| | 10,001-20,000 | 3 | 10 | 4 | | | | | |
| | >20,000 | 1 | 2 | 1 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 9.6:** According to socio-economic status (per month), the majority of the diabetic patients had their income level between 5001-10,000. The obtained Chi-square value was 3.742, P value was 0.880 with df 8.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Marital Status | Married | 6 | 19 | 19 | 6.032 | 0.197 | 4 | 9.488 | Not Significant |
| | Unmarried | 1 | 7 | 4 | | | | | |
| | Widow | 2 | 2 | 0 | | | | | |
| | Separated | 0 | 0 | 0 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 9.7:** According to marital status, the majority of the diabetic patients were married. The obtained Chi-square value was 6.032, P value was 0.197 with df 4.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Type of Family | Joint family | 2 | 9 | 1 | 8.060 | 0.089 | 4 | 9.488 | Not Significant |
| | Nuclear family | 6 | 16 | 15 | | | | | |
| | Extended family | 1 | 3 | 7 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 9.8:** According to type of family, the majority of the diabetic patients were nuclear family. The obtained Chi-square value was 8.060, P value was 0.089 with df 4.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Dietary Habit | Vegetarian | 4 | 8 | 7 | 2.825 | 0.588 | 4 | 9.488 | Not Significant |
| | Non-vegetarian | 5 | 15 | 14 | | | | | |
| | Eggetarian | 0 | 5 | 2 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 9.9:** According to type of dietary habit, the majority of the diabetic patients were non-vegetarian. The obtained Chi-square value was 2.825, P value was 0.588 with df 4.

| Demographic Variables | | N= 60 | | | Association with Awareness Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Personal Hygiene | By self | 5 | 16 | 11 | 0.692 | 0.952 | 4 | 9.488 | Not Significant |
| | Assisted | 3 | 8 | 9 | | | | | |
| | Dependent | 1 | 4 | 3 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table:** According to personal hygiene, the majority of the diabetic patients were by self. The obtained Chi-square value was 0.692, P value was 0.952 with df 4.

**Hence it is concluded that mean score was statistically not significant at <0.05.**

**Table 10:** Table Showing Association of Clinical Variables with practice scores regarding foot care among diabetic patients.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Diagnosis | Type 1 diabetic mellitus | 6 | 12 | 9 | 2.079 | 0.354 | 2 | 5.991 | Not Significant |
| | Type 2 diabetic mellitus | 3 | 16 | 14 | | | | | |

**Table 10.1:** According to diagnosis, the majority of the diabetic patients having type 2 diabetic mellitus. The obtained Chi-square value was 2.079, P value was 0.354 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | df | Table Value | Result |
| Type of Admission | Emergency | 3 | 15 | 9 | 1.646 | 0.439 | 2 | 5.991 | Not Significant |
| | OPD | 6 | 13 | 14 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.2:** According to type of admission, the majority of the diabetic patients were coming in OPD. The obtained Chi-square value was 1.646, P value was 0.439 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Type Of Illness | Acute | 5 | 18 | 9 | 3.231 | 0.199 | 2 | 5.991 | Not Significant |
| | Chronic | 4 | 10 | 14 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.3:** According to type of illness, the majority of the diabetic patients were acute. The obtained Chi-square value was 3.231, P value was 0.199 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | df | Table Value | Result |
| Previous History | Yes | 1 | 7 | 5 | 0.774 | 0.679 | 2 | 5.991 | Not Significant |
| | No | 8 | 21 | 18 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.4:** According to previous history, the majority of the diabetic patients were no. The obtained Chi-square value was 0.774, P value was 0.679 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | df | Table Value | Result |
| CBC | Normal | 7 | 22 | 20 | 0.700 | 0.705 | 2 | 5.991 | Not Significant |
| | Abnormal | 2 | 6 | 3 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.5:** According to CBC, the majority of the diabetic patients were normal. The obtained Chi-square value was 0.700, P value was 0.705 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Blood Glucose (Fasting) | Normal | 5 | 15 | 9 | 1.276 | 0.528 | 2 | 5.991 | Not Significant |
| | Abnormal | 4 | 13 | 14 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.6:** According to Blood Glucose (Fasting), the majority of the diabetic patients were abnormal. The obtained Chi-square value was 1.276, P value was 0.528 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Blood Glucose (Postprandial) | Normal | 5 | 12 | 8 | 1.179 | 0.555 | 2 | 5.991 | Not Significant |
| | Abnormal | 4 | 16 | 15 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.7:** According to Blood Glucose (postprandial), the majority of the diabetic patients were abnormal. The obtained Chi-square value was 1.179, P value was 0.555 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Glycated Haemoglobin (Hba1C) | Normal | 6 | 11 | 13 | 2.677 | 0.262 | 2 | 5.991 | Not Significant |
| | Abnormal | 3 | 17 | 10 | | | | | |

Hence it is concluded that mean score was statistically significant at <0.05.

**Table 10.8:** According to Glycated Haemoglobin (Hba1C), the majority of the diabetic patients were equal. The obtained Chi-square value was 2.677, P value was 0.262 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| C-Reactive Protein | Normal | 8 | 26 | 19 | 1.290 | 0.525 | 2 | 5.991 | Not Significant |
| | Abnormal | 1 | 2 | 4 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.9:** According to C-reactive Protein, the majority of the diabetic patients were normal. The obtained Chi-square value was 1.290, P value was 0.525 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Wound Swap Culture | Normal | 7 | 23 | 20 | 0.446 | 0.800 | 2 | 5.991 | Not Significant |
| | Abnormal | 2 | 5 | 3 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.10:** According to wound swap culture, the majority of the diabetic patients were normal. The obtained Chi-square value was 0.446, P value was 0.800 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Blood Culture | Normal | 7 | 21 | 22 | 4.113 | 0.128 | 2 | 5.991 | Not Significant |
| | Abnormal | 2 | 7 | 1 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.11:** According to blood culture, the majority of the diabetic patients were normal. The obtained Chi-square value was 4.113, P value was 0.128 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| X-Ray of Foot | Normal | 7 | 25 | 21 | 1.195 | 0.550 | 2 | 5.991 | Not Significant |
| | Abnormal | 2 | 3 | 2 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.12:** According to X-ray of foot, the majority of the diabetic patients were normal. The obtained Chi-square value was 1.195, P value was 0.550 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| BP | Normal | 0 | 5 | 3 | 1.882 | 0.390 | 2 | 5.991 | Not Significant |
| | Abnormal | 9 | 23 | 20 | | | | | |

Hence it is concluded that mean score was statistically significant at <0.05.

**Table 10.13:** According to BP, the majority of the diabetic patients were abnormal. The obtained Chi-square value was 1.882, P value was 0.390 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Temperature | Normal | 9 | 25 | 21 | 1.030 | 0.598 | 2 | 5.991 | Not Significant |
| | Abnormal | 0 | 3 | 2 | | | | | |

Hence it is concluded that mean score was statistically significant at <0.05

**Table 10.14:** According to temperature, the majority of the diabetic patients were normal. The obtained Chi-square value was 1.030, P value was 0.598 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Respiration | Normal | 9 | 26 | 23 | 2.365 | 0.307 | 2 | 5.991 | Not Significant |
| | Abnormal | 0 | 2 | 0 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 10.15:** According to respiration, the majority of the diabetic patients were normal. The obtained Chi-square value was 2.365, P value was 0.307 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Pulse | Normal | 9 | 26 | 22 | 0.765 | 0.682 | 2 | 5.991 | Not Significant |
| | Abnormal | 0 | 2 | 1 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table 6.16:** According to pulse, the majority of the diabetic patients were normal. The obtained Chi-square value was 0.765, P value was 0.682 with df 2.

| Clinical Variables | | N= 60 | | | Association with Practice Score | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | Options | Good | Average | Poor | Chi Test | P Value | DF | Table Value | Result |
| Spo2 | Normal | 9 | 27 | 23 | 1.162 | 0.559 | 2 | 5.991 | Not Significant |
| | Abnormal | 0 | 1 | 0 | | | | | |

Hence it is concluded that mean score was statistically not significant at <0.05.

**Table:** According to spo2, the majority of the diabetic patients were normal. The obtained Chi-square value was 1.162, P value was 0.559 with df 2.
Hence it is concluded that mean score was statistically not significant at <0.05.

## Discussion

This chapter deals with the analysis and interpretation of data collected to assess the awareness and practices regarding foot care among diabetic patients in selected hospitals of district Mohali, Punjab.
This chapter relates the findings of the present study in accordance with the studies done earlier. The findings of the present study have been discussed under the objectives of this study.

## Organization of the data

The data collected were entered in master sheet. It was analysed and interpreted by using descriptive and inferential statistics. The data was organized and presented under the following section:
The first objective was to assess the awareness regarding foot care among diabetic patients.
None of the participant scored in the good range. 25% of people scored in the average range, means they had a fair level of awareness. Most people, 75%, scored in the poor range, which means they had low awareness.
The second objective was to assess the practice regarding foot care among diabetic patients.
The 15% participant scored in the good range means they practice a lot. Most people, 46.7% scored in the average range, means they practiced a fair amount. 38.3% scored in the poor range, which means they practiced very little.
The third objective was to find out the association between the level of awareness and practices regarding foot care among diabetic patients with their selected socio-demographic variables.
Mean awareness score was 5.85 (out of 20), indicating poor awareness overall. 75% of participants had poor awareness, and none achieved a good score. Significant association was observed between gender and awareness: females showed better awareness than males. Postprandial glucose level and foot X-ray results also showed a significant association with awareness — those with abnormal results surprisingly had higher awareness, possibly due to prior exposure to complications. Mean practice score was 6.47 (out of 14), falling in the average category.46.7% showed average practice, while only 15% practiced good foot care. No demographic or clinical variable showed statistically significant associations with practice scores. However, trends showed higher practice scores among females, graduates, those with better income, and participants from joint families.

## Summary

A descriptive study was conducted to assess the awareness and practices regarding foot care among diabetic patients in selected hospitals of District Mohali, Punjab.
The main objectives of the study were to assess the awareness regarding foot care among diabetic patients, to assess the practices regarding foot care among diabetic patients, to find out the association between the level of awareness and practices regarding foot care among diabetic patients with their selected socio-demographic variables, to disseminate the findings.
For the present study we followed purposive Sampling Technique and the sample size was of 60 diabetic foot patients from civil hospital phase-6, Mohali. Self-structured knowledge questionnaire was used to assess the awareness and practices regarding foot care among diabetic patients. A substantial majority (75%) of diabetic patients had poor awareness regarding foot care, with only 25% displaying average awareness. Notably, no participant scored in the 'good' category. The practice scores were comparatively better, with 46.7% scoring average, 38.3% showing poor practices, and 15.0% exhibiting good practices.
The data was analysed by using statistical and inferential test i.e., percentage, frequency, Mean, Median, Standard Deviation, Maximum Score, Minimum Score and Range. The data has been presented in the form of figures and

tables which helps to depict the findings.

**Conclusion**

The study reveals alarming levels of poor awareness regarding diabetic foot care, although practices are somewhat better. This mismatch calls for structured education programs, increased follow-up by healthcare providers, and community-based initiatives. Promoting awareness is essential to reduce the risk of complications, amputations, and improve the quality of life in diabetic patients.

**Implications**

The findings of the study can be implicated in different areas such as healthcare facilities (hospitals), primary health centres and community clinics, community health settings, non-governmental organizations and nursing homes or elder care centres.

**Nursing education**

Nursing education plays a vital role in enhancing patients' knowledge and promoting effective self-care practices. Nurses serve as frontline educators, guiding diabetic patients on the importance of proper foot care to prevent complications such as ulcers, infections, and amputations. Through health education sessions, counselling, and practical demonstrations, nurses help patients understand the significance of daily foot inspection, proper hygiene, suitable footwear, and timely reporting of any abnormalities. By assessing the existing awareness and practices among diabetic individuals, the study highlights the need for targeted nursing interventions to address knowledge gaps and encourage healthier behaviours. Ultimately, nursing education not only empowers patients to take charge of their foot health but also contributes to reducing the burden of diabetic complications on the healthcare system.

**Nursing research**

Nursing research plays a vital role in improving patient care by generating evidence-based practices. nursing research is used to explore and understand the level of knowledge and self-care behaviours of diabetic patients related to foot care. Since diabetic foot complications are a leading cause of hospitalization and amputation, this research highlights the importance of early education and preventive measures. Through systematic data collection and analysis, the study aims to identify gaps in awareness and current practices, providing valuable insights for nurses to develop targeted interventions, educational programs, and policies that promote better foot care and reduce complications in diabetic patients. This type of research strengthens nursing practice by ensuring that care is tailored to patient needs and grounded in empirical evidence.

**Nursing service**

Nursing service plays a crucial role in promoting health and preventing complications among diabetic patients. Nursing service involves providing direct care, education, and support to individuals with diabetes to improve their awareness and practices regarding foot care. Nurses are responsible for assessing patients' knowledge, identifying those at risk for foot problems, and delivering personalized health education focused on daily foot inspection, hygiene, proper footwear, and early recognition of warning signs. Through regular follow-up, counselling, and community outreach, nursing services contribute to reducing the incidence of diabetic foot ulcers and amputations. This study emphasizes how effective nursing services can empower patients to take charge of their foot health, ultimately enhancing their quality of life and preventing serious complications.

**Recommendations**

Based on the results of study, the following recommendations are made:

1. The study can be conducted on large sample to generalize the findings
2. The study can be done in different settings.
3. Apply a mixed method combine surveys (quantitative) with interviews (qualitative) for deeper study.
4. An experimental study can be done to determine the awareness and practices regarding diabetic foot care.

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