

Surname: _____		First Name: _____	
CHRIS #: _____		Date of Birth (DD/MM/YYYY): _____	
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HCN: <input type="text"/>			Version Code <input type="text"/> <input type="text"/>

WOUND - DIABETIC/NEUROPATHIC FOOT ULCER PATHWAY

Diabetic Foot Ulcer (DFU): A DFU is a partial or full-thickness penetration of the dermis. It is a complication of either Type I or Type II diabetes. Cracks, fissures or ulcers that may be a result of acute trauma, callous formation (pressure from structural foot deformity or buildup of callous from inappropriate footwear or repeated persistent trauma. Patients may or may not have feeling (neuropathy) or pain, but show signs of an open wound with or without discharge.

<p style="text-align: center;">To be completed at least once weekly and/or with change in patient condition <i>*This tool is used only as a guide and does not replace clinical judgment</i></p>	<input checked="" type="checkbox"/> where applicable; (N/A) where not applicable			
	Date/Initial	→		
COMPREHENSIVE ASSESSMENT				
Complete a comprehensive physical assessment and history with particular attention to feet/shoes. i.e. age of wound, previous history of wound, comorbidities, medications, immune status, vascular status and nutritional status.				
Perform and document a weekly comprehensive wound assessment identifying wound dimensions, wound bed appearance (need for debridement), exudate (type and amount), periwound appearance. Assess for tunneling, undermining, sinus tracts, bone exposure or ability to probe to bone (report immediately to Primary Care Provider (PCP)). Record percentage of weekly healing.				
Visually inspect foot for colour, calluses, skin conditions (dryness, rashes, signs of fungal or yeast infestations), toenail condition and structural deformities. Visually inspect shoes, and gait for abnormalities in wear or positioning. Check temperature of feet and signs of dependent edema, redness or rubor. Identify presence of peripheral neuropathy. Assess for gait and pressure areas.				
Perform and document a complete pain assessment.				
Complete lower leg assessment including ABPI , with initial assessment, every 4-6 months and with wound deterioration, forward to NE LHIN. Possible false high ABPI include patients with diabetes, renal failure or edema.				
Assess glycemic control, review glucometer readings and history.				
Assess wound for signs/symptoms of infection: induration, increased exudate, unusual odour, delayed healing, friable or discoloured granulation tissue, periwound erythema greater than 2 cm and report to PCP. Abscess, cellulitis, gangrene or osteomyelitis requires immediate referral to PCP - <i>Infection in a diabetic patient must be treated immediately. An infected foot ulcer in a diabetic patient has a high amputation rate</i>				
Complete nutritional assessment screening tool.				
Assess, determine and emphasize importance of patient adherence to individualized treatment plan.				
Photo image upload at initial visit and monthly and with wound deterioration.				

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GOALS				
Encourage patient/caregiver participation in developing individualized treatment plan. Explore self-management.				
Patient will have acceptable pain management and report a decrease in pain intensity if applicable				
Glycemic control will be optimal to promote healing (HbA1c less than or equal to 7%)				
Patient will demonstrate healing within a reasonable time frame (greater than 20% in 3 weeks)				
Patient will demonstrate adequate nutrition to promote glycemic control and meet energy, protein and fluid requirements				
Wound is protected from further damage, infection, contamination and periwound skin remains intact				
WOUND TREATMENTS				
Address causative factors such pressure and shear by considering appropriate offloading devices (e.g. TCC, Aircast XP, appropriate footwear, and positioning)				
Cleanse wound with potable water				
Clean & pat periwound dry and apply a protective barrier to manage periwound maceration if indicated				
Early and frequent debridement of necrotic tissue and thick keratinized tissue (callous) around periwound. Do not debride black eschar until arterial status is confirmed.				
<i>Manage bioburden</i> , fill dead space, undermining and tunnels loosely with antimicrobial dressing: Exudating wound: including but not limited to silver calcium alginate, Cadexomer Iodine, Gentian Violet or PHMB Non-exudating wound: Nanocrystalline silver moistened with sterile water or hydrogel Apply secondary dressing: Foam/Absorbent dressing Non-exudating/ dry eschar with arterial insufficiency: iodine based product and gauze cover dressing				
<i>Manage bleeding</i> in an exudating wound: Ag Calcium Alginate				
Change dressing every 3-7 days depending on type of dressing used and amount of exudate.				
If chronic inflammation is suspected, consider protease inhibitor. Consider NSWOC consult.				
Document variance if deviation from Clinical Pathway.				
MEDICATIONS				
Complete medication reconciliation.				
Provide analgesics PRN.				
Initiate systemic antibiotic/topical therapy as per PCP order.				
PAIN				
If dressing changes are painful (procedural) ensure patient takes analgesic before dressing changes				
Use non-pharmacological techniques such as repositioning, relaxation, rest, time outs				
Assess carefully for signs of infection. Pain is an indicator for infection particularly in an insensate foot.				
Encourage comfortable proper fitting footwear				

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SELF-MANAGEMENT & EDUCATION				
Teach patient/family: <ol style="list-style-type: none"> 1. Pathophysiology of diabetic foot ulcers and contributing factors of neuropathy, arterial compromise, pressure, friction and shearing 2. Examine feet daily, and have PCP examine your feet during every visit, PCP to consider referral to chiropodist 3. Keep feet clean and dry, (special attention between toes) avoid soaking feet 4. Avoid scratching dry or itchy skin to avoid abrasions and trauma 5. Protect feet, wear properly fitted shoes in and out of home, don't use a heating pad or hot water bottle to warm feet-just warm socks 6. Use prescribed positioning and offloading devices 7. Promote increased mobility and activity as tolerated 8. Encourage light coloured socks to monitor the appearance of blood stains. Encourage to report any noted staining 9. Encourage daily intake to meet recommendations of Canada's Food Guide with focus on diabetes management and regular balanced meals. 				
REFERRALS				
PHYSIOTHERAPY: Request consult for Physiotherapist to assess for proper exercises, mobilization, ambulation techniques and gait assessment. Request specific intervention in the physiotherapy referral.				
OCCUPATIONAL THERAPY: Request consult for Occupational Therapist to assess the source and cause of pressure injury, education regarding position strategies, mobility strategies and therapeutic services. Please accompany referrals with wound stage, location, size and duration of the wound.				
DIETETICS: Request consult for Dietitian assessment if nutritional status implicates delayed wound healing and/or energy-protein malnutrition and/or identified need for diabetic diet teaching/monitoring. Consider referral to Diabetes Education Program.				
ENTEROSTOMAL THERAPY: Refer according to wound/ostomy escalation process. Detailed wound assessment and clinical images must be submitted with referral.				
SOCIAL WORK: Request consult for socioeconomic challenges such as ineffective coping, financial issues, assistance with resources.				
CHIROPODY: Determine need for chiropody referral for debridement and assistance with resourcing offloading devices.				
DISCHARGE PLANNING				
Provide 'Diabetic Foot Ulcer Patient Handout' and review appropriate teachings for prevention of further injury.				
Refer to self-management if appropriate				