

# HOME AND COMMUNITY CARE SUPPORT SERVICES

North East

Surname: _____		First Name: _____	
CHRIS #: _____		Date of Birth (DD/MM/YYYY): _____	
HCN: _____		Version Code _____	

## WOUND - DIABETIC/NEUROPATHIC FOOT ULCER CLINICAL PATHWAY

**Diabetic Foot Ulcer (DFU):** DFU is a complication of diabetes mellitus characterized by a partial or full-thickness open wound with or without discharge. Cracks, fissures, or ulcers form as a result of acute trauma, callous formation, or repeated/persistent trauma. DFU may be complicated by pain and/or neuropathy.

**Neuropathic Foot Ulcer:** Neuropathic foot ulcers can occur in the absence of diabetes.

<p style="text-align: center;"><b>To be completed at least once weekly and/or with change in patient condition</b>  <i>*This tool is used only as a guide and does not replace clinical judgment</i></p>	<input checked="" type="checkbox"/> where applicable; <input type="checkbox"/> (N/A) where not applicable			
	Date/Initial:			
<b>COMPREHENSIVE ASSESSMENT</b>				
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), peri-wound 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.				
Assess wound for signs/symptoms of infection: induration or edema, increased exudate, unusual odour, delayed healing, friable or discoloured granulation tissue, peri-wound erythema greater than 2 cm, fever, or general malaise, and report to PCP. Pain is an indicator of infection particularly in an insensate foot. Abscess, cellulitis, gangrene or osteomyelitis requires immediate referral to PCP – <i>DFU infection may not display classic signs of infection, Infection in a diabetic patient must be treated immediately. An infected foot ulcer in a diabetic patient has a high amputation rate.</i>				
Complete lower leg assessment including <b>ABPI</b> , with initial assessment, every 4-6 months and with wound deterioration, forward to Home and Community Care Support Services – North East. Inaccurate ABPIs may occur in patients with diabetes, renal failure or				
Assess glycemic control, review glucometer readings and history, review available HbA1c results (target less than 7%).				
Perform and document a complete pain assessment.				
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.				
<b>GOALS</b>				
Wound will progress through the healing process				
Wound is protected from further complications through use of offloading strategies.				

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Patient will have acceptable pain management.				
Patient will demonstrate adequate nutrition to promote glycemic control and meet energy, protein and fluid requirements.				
Encourage patient/caregiver participation in developing individualized treatment plan and exploring self-management.				
<b>WOUND TREATMENTS</b>				
Address causative factors such as pressure and shear by considering appropriate offloading devices (e.g. total contact casting, removable cast, appropriate footwear, and positioning). Note that healability is compromised in the absence of pressure offloading.				
Cleanse wound with potable water.				
Clean & pat peri-wound dry and apply a protective barrier to manage peri-wound maceration if indicated.				
Early and frequent debridement of necrotic tissue and thick keratinized tissue (callous) around peri-wound. Do not debride black eschar until arterial status is confirmed.				
<i>Manage bioburden</i> , fill dead space, undermining and tunnels loosely with antimicrobial dressing: <b>Exudating wound:</b> including but not limited to silver calcium alginate, cadexomer iodine, or PHMB <b>Non-exudating wound:</b> Nanocrystalline silver moistened with sterile water or hydrogel Apply secondary dressing: Foam/absorbent dressing <b>Non-exudating/ dry eschar with arterial insufficiency:</b> iodine based product and gauze cover dressing.				
Manage bleeding in an exudating wound: 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 and/or NSWOC consult.				
Consider if the wound meets the definition of a Chronic Maintenance wound: Wounds that fail to progress normally through the repair process (are present for at least 12 weeks and have not responded to wound specific pathway), frequently caused by vascular compromise, chronic inflammation, repetitive insults to the tissue or patient lifestyle choices. These wounds fail to close in a timely manner or fail to result in durable closure. Please refer to Chronic Maintenance Clinical Guideline.				
Document variance if deviation from Clinical Pathway i.e. frequency greater than 3 days.				
<b>MEDICATIONS</b>				
Complete medication reconciliation.				
Initiate systemic antibiotic/topical therapy as per PCP order.				
<b>PAIN</b>				
Support use of preprocedural analgesic to manage pain.				
Review non-pharmacological techniques such as repositioning, relaxation, rest, time outs.				

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SELF-MANAGEMENT & EDUCATION				
Review with patient/family the pathophysiology of DFU and contributing factors for neuropathy, arterial compromise pressure, friction and shearing.				
Review the following choices to promote healing and decrease recurrence: <ul style="list-style-type: none"> <li>Examine feet daily, and have PCP examine your feet at each visit</li> <li>Keep feet clean and dry, pay special attention between toes, avoid soaking</li> <li>Avoid scratching dry or itchy skin, avoid abrasions and trauma</li> <li>Protect feet, wear properly fitted shoes in and out of home, and use socks to keep feet warm (not heating pads or hot water bottles)</li> <li>Use positioning and offloading devices as prescribed</li> <li>Use light coloured socks to easily note blood stains (report bleeding)</li> </ul>				
Promote increased activity and mobility as tolerated.				
Encourage daily intake to meet recommendations of Canada's Food Guide with focus on diabetes management and regular balanced meals, as well as adequate fluid intake (1.5-2L/day) unless contraindicated.				
Involve patient and family in care planning.				
REFERRALS				
<b>PHYSIOTHERAPY:</b> Request consult for Physiotherapist to assess for proper exercises, mobilization, ambulation techniques and gait assessment. Request specific intervention in the physiotherapy referral.				
<b>OCCUPATIONAL THERAPY:</b> Request consult for Occupational Therapist to assess the source and cause of injury, education regarding position strategies, mobility strategies and therapeutic services. Please accompany referrals with wound stage, location, size and duration of the wound.				
<b>DIETETICS:</b> 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.				
<b>NURSES SPECIALIZED IN WOUND, OSTOMY &amp; CONTINENCE:</b> Refer according to wound/ostomy escalation process, which includes initial escalation to SPO Wound and Ostomy Care Champion PRIOR to NSWOC referral.				
<b>SOCIAL WORK:</b> Request consult for socioeconomic challenges such as ineffective coping, financial issues, and access to resources.				
<b>CHIROPODY/PODIATRY:</b> Determine need for referral for debridement and assistance with resourcing offloading devices.				
DISCHARGE PLANNING				
Provide appropriate patient handbook and review appropriate teachings to support wound healing. Facilitate community referrals as indicated and provide teachings for prevention of further injury including offloading strategies.				