

S-FC04: Basic assessment of a foot wound and provide basic/bridging intervention

Scope and objectives of clinical task

This CTI will enable the health professional to:

- classify a foot wound using the University of Texas Wound Classification System (UTWCS)
- provide basic wound care including removal and re-application of the dressing, cleansing of the wound, dressing prescription and application, education for ongoing wound management and monitoring of normal healing
- develop and implement a plan to manage the wound. This may include application of a basic dressing, provision of an off-loading strategy, referral to a high-risk foot service for a non-healing wound, debridement, or for specialised wound care management.

VERSION CONTROL

Version: 1.0

Endorsed: (Professional)	Queensland Hospital and Health Service Podiatry Steering Committee	Date approved:	19/3/2019
Approved: (Operational)	Chief Allied Health Officer, Allied Health Professions' Office of Queensland	Date approved:	9/4/2019
Document custodian:	Chief Allied Health Officer, Allied Health Professions' Office of Queensland	Review date:	9/4/2022
Acknowledgements:	Mackay Hospital and Health Service, Metro North Hospital and Health Service		

The CTI reflects best practice and agreed process for conduct of the task at the time of approval and should not be altered. Feedback, including proposed amendments to this published document, should be directed to AHPOQ at: allied_health_advisory@health.qld.gov.au.

This CTI should be used under a skill sharing framework implemented at the work unit level. The framework is available at: <https://www.health.qld.gov.au/ahwac/html/calderdale-framework.asp>

Please check <https://www.health.qld.gov.au/ahwac/html/clintaskinstructions.asp> for the latest version of this CTI.

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Note 1: The purpose of a bridging intervention is to provide timely care as part of the management plan to address wounds identified on the skill shared assessment. It is intended to support comprehensive wound management prescribed by the podiatrist or wound service which may be part of a collaborative practice service delivery model.

Note 2: This CTI uses the UTWCS as the primary method to assess the wound. Health services may use other tools to complement this task e.g. PEDIS or SINBAD. If this is the case, the alternative tool should be integrated into the training and competency assessment plan for the skill share-trained practitioner and be recorded on the Performance Criteria Checklist.

Requisite training, knowledge, skills and experience

Training

- Mandatory training requirements relevant to Queensland Health/HHS clinical roles are assumed knowledge for this CTI.
- Complete the following CTIs:
 - CTI S-FC01: Assess the risk of foot complications
 - CTI S-FC02: Doppler ultrasound of the foot and ankle
 - CTI S-FC03: Calculate an Ankle Brachial Pressure Index (ABI) and Toe Brachial Pressure Index (TBI)
 - And application of an off-loading strategy is within the scope of the local implementation complete CTI S-FC05: Prescribe, fit, train and review of an off-loading strategy for foot protection.

Note: A wound management course can provide the knowledge content required e.g. training opportunities provided by product suppliers, workplace based wound care courses or on-line training with [Wound Healing Institute Australia \(WHIA\)](#) or [Wounds Australia](#). Equivalent learning may be obtained through readings/independent study of resources and training with the lead professional.

Clinical knowledge

To deliver this clinical task a health professional is **required** to possess the following theoretical knowledge:

- understanding of the key differences between an acute and chronic wound and implications for care
- risk factors for a foot wound including trauma, peripheral neuropathy or peripheral arterial disease
- basic understanding of the physiology and functions of the skin including factors that may alter skin integrity such as dryness, age, nutrition, deformity; and common preventative strategies such as regular inspection, use of moisturisers and off-loading devices
- basic understanding of the physiology of wound healing including general principles for supporting wound healing e.g. tissue debridement, treating infection and inflammation, and moisture balance
- common signs of infection, distinguishing features of local and spreading infection and a basic understanding of principles for their management
- rationale and components of a wound assessment including the use of the UTWCS and any other tools planned for use within the local service
- common wound dressings available for use at the local service including indications and limitations for use, application and disposal process and client access options including eligibility criteria for provision by the local service or funding schemes, or the availability at a local pharmacy
- principles, rationale, indications and limitations of common strategies used to off-load foot wounds.

The knowledge requirements will be met by the following activities:

- review of the 'Learning resource'
- receive instruction from the lead health professional in the training phase
- read and discuss the following references/resources with the lead health professional at the commencement of the training phase:
 - manufacturer guidelines for the use of wound care products available in the local service
 - local guidelines and processes for accessing wound care products including the provision of products to clients
 - if providing care via a collaborative telehealth model, relevant local workplace procedures and service model documents e.g. use and booking of telehealth equipment.

Skills or experience

The following skills or experience are not specifically identified in the task procedure but support the safe and effective performance of the task or the efficiency of the training process and are:

- **required** by a health professional in order to deliver this task:
 - competence in measurement of clinical observations relevant to foot care where this is relevant to the healthcare setting and client group. This may include blood pressure, heart rate and pain scales
 - if required for the local setting, skill or the ability to acquire skill in medical photography of a foot wound.
- **relevant but not mandatory** for a health professional to possess in order to deliver this task:
 - scar management.

Indications and limitations for use of a skill shared task

The skill share-trained health professional shall use their independent clinical judgement to determine the situations in which he/she delivers this clinical task. The following recommended indications and limitations are provided as a guide to the use of the CTI but the health professional is responsible for applying clinical reasoning and understanding of the potential risks and benefits of providing the task in each clinical situation.

Indications

- The client presents with a foot wound and a basic foot care risk assessment has been completed e.g. CTI S-FC01: Assess the risk of foot complications. The client presentation may include having a dressing to the foot or lower limb, awareness of a known wound or the identification of an unknown wound on assessment.

Limitations

- The client has a foot wound and is already under a wound management plan e.g. via a specialised wound care service/nurse, podiatrist or GP. Note the management plan in place including previous and forthcoming attendances. If necessary liaise with the service to confirm the management plan and ongoing review requirements and timeframes.
- The wound requires debridement e.g. devitalised necrotic, sloughy wound bed, black or hyperkeratotic borders are evident. Cover the wound with an appropriate dressing (refer to the

-
- ‘Learning resource’). Facilitate the client to be reviewed by a health professional with expertise in debridement e.g. high-risk foot service, wound nurse, podiatrist or medical practitioner.
- The wound appears to be inflamed or infected e.g. spreading cellulitis, yellow, brown, black or grey exudate, offensive odour, or the foot feels hot to touch compared to the unaffected site. Cover the wound with an appropriate dressing (refer to the ‘Learning resource’). Determine if the infection is local or spreading. Facilitate the client to be reviewed by a medical practitioner for management i.e. a GP (local infection) or emergency department (spreading infection).
 - The client requires application of a wound dressing product that the local health service has determined to be out of scope of this skill sharing CTI or that the individual health professional has not been trained and assessed as competent to implement e.g. silver, collagen or silicon based dressings. Facilitate the client to access the required dressing using local referral pathways.
 - The wound extends above the ankle. Implement local processes for management of leg wounds.
 - The wound involves a foreign body e.g. splinter, glass, wire or nail. Facilitate the client to be reviewed by a medical practitioner for removal of the foreign body i.e. a GP or emergency department.
 - The client has known peripheral arterial disease (Doppler or ABI indicate venous or arterial insufficiency). Complete the UTWCS, provide a basic wound dressing and liaise with the local high-risk foot service for ongoing management and/or the medical practitioner for vascular review.
 - The client has significant ischaemia to the foot or lower limb including pain, pallor, pulseless, paraesthesia, paralysis (foot-drop) and poikilothermia. The client should be reviewed on the same day at a high-risk foot service or if unavailable, an emergency department for assessment and management.
 - The client reports significant pain with the wound and/or dressing removal and re-application. Liaise with the medical team for appropriate pain management and wound management options.

Safety and quality

Client

The skill share-trained health professional shall identify and monitor the following risks and precautions that are specifically relevant to this clinical task:

- the client has a known or suspected allergy to wound dressing products including iodine, silver, silicone and adhesives e.g. micropore tape. Liaise with a health professional with expertise in wound dressings for alternative products
- the client reports financial hardship and is unable to afford the required wound management products. Consider alternative products and associated costs. Implement local processes for access to product supplies including funding schemes and online suppliers e.g. [Independence Australia](#), [Bright Sky Australia](#)
- the client is unable to reach the dressing area or manipulate products for ongoing self-management of the wound. This may be due to problems with low back pain, finger dexterity or cognitive issues. Determine if the client has a carer to assist and educate the carer to the required wound management. If a carer is unavailable or unable to provide assistance, arrange an alternative management plan e.g. a GP practise nurse or non-government organisation
- clients who have suspected deep wounds (probe to tendon, joint or bone) or an acute Charcot Neuroarthropathy or an acute “Charcot foot” (peripheral neuropathy, rocker bottom foot appearance, warmth to touch, redness in the foot, swelling in the area and pain or soreness) should be assessed by a high-risk foot service on the same day. If this service is not available clients should attend the

emergency department for assessment with a follow up arranged at the high-risk foot service as part of ongoing management

- clients who are screened at high risk of a foot wound and present with areas of callus or hyperkeratosis should be prescribed an off-loading device and be reviewed for debridement as part of the management plan. Ongoing review of the off-loading device should be negotiated between the skill share-trained health professional and the high-risk foot service.

Equipment, aids and appliances

- Check products are within their use by dates and remain sterile i.e. packaging is not broken or pierced.
- The dressings available that the skill share-trained health professional has been trained and assessed as competent to apply are not suitable for the wound e.g. excessive exudate or size of wound. Apply a dressing to cover the wound e.g. to absorb exudate and prevent cross infection. Arrange for urgent review and follow up with a relevant health professional for ongoing wound care.

Environment

- The environment must allow for a general aseptic field to be established.

Performance of Clinical Task

1. Preparation

- Gloves and dressing pack/supplies including a blunt sterile probe
- Gown, goggles and mask if risk of spray or splash
- Access to appropriate receptacles for disposal of dressings, bed linen, probes and gloves
- Local UTWCS recording form
- If required for the local service, camera and photo consent form
- Prepare the general aseptic environment by wiping surfaces with a disinfectant.

2. Introduce task and seek consent

- The health professional checks three forms of client identification: full name, date of birth **plus one** of the following: hospital UR number, Medicare number, or address.
- The health professional introduces the task and seeks informed consent according to the Queensland Health Guide to Informed Decision-making in Health Care, 2nd edition (2017).

3. Positioning

- The client's position during the task should be:
 - lying or sitting supported in a supine position with legs outstretched on a height adjustable bed/chair.
- The health professional's position during the task should be:
 - seated directly opposite the client with the feet at mid-trunk level.

4. Task procedure

- The task comprises the following steps:
 1. Determine the history of the foot wound using the 'Guide to conducting a foot wound history' in the 'Learning resource'.
 2. Perform hand hygiene and set up the dressing pack/items next to the examination area.
 3. Don disposable gloves and if a dressing is in situ, remove the dressing as per the manufacturer's instructions. If the risk of spray or splash back exists, wear a gown, goggles and mask.
 4. Dispose of solid dressings and gloves in the appropriate receptacle.
 5. Perform hand hygiene and don a clean pair of disposable gloves.
 6. Cleanse the wound by irrigating with saline and rubbing with a clean gauze to disrupt the wound biofilm and remove surface debris.
 7. With a blunt sterile probe, gently assess the wound by probing across the wound base and around the borders. Check for sinuses, deeper structure involvement and foreign objects. See the 'Limitations' and the 'Safety and quality' sections.
 8. Assess the wound using the UTWCS, including depth, signs of infection and ischaemia. See 'Learning resource'.
 9. Determine the wound stage and grade and record.
 10. If required for the local service, complete the photo consent form and photograph the wound.
 11. Determine an appropriate management plan referring to the 'Limitations' section, wound management decision making flowchart and Table 6: Wound management dressing guide from Wounds international (2013) in the 'Learning resource'.
 12. Discuss the proposed management plan with the client, making any required adjustments. See the 'Safety and quality' section.
 13. Perform hand hygiene and don a clean pair of disposable gloves.
 14. Apply the required dressing to the wound according to the manufacturer's guidelines.
 15. Educate the client (and carer) regarding ongoing wound management including access to dressings, application of the dressing (if relevant), timeframes for dressing changes and review by a health professional. Include education on wound healing expectations, signs of infection and an action plan for safety.
 16. Dispose of bed linen, probe and gloves in the appropriate receptacles.
 17. Wipe all used surfaces with a disinfectant i.e. bed, chair and table.

5. Monitoring performance and tolerance during the task

- Common errors and compensation strategies to be monitored and corrected during the task include:
 - difficulty removing the dressing. This may be due to:
 - adhesive sticking to the surrounding skin. Apply adhesive removal wipes.
 - the dressing being adhered to the wound bed. Soak the dressing with saline to moisten and loosen the dressing from the wound.
 - the wound appears to have an undermining edge. Use the sterile probe to determine the extent of the undermining. Note the depth and location on the recording form. Complete the assessment and dress the wound. If a plantar surface wound and in scope for the skill share trained health professional implement CTI S-FC05: Prescribe, fit, train and review an off-loading strategy for foot protection, and implement local service processes for urgent access to a high-risk foot service

- the wound is observed to be non- or slow-healing i.e. less than a 50% reduction in 4 weeks. These wounds should be seen by a health professional with expertise in wound management e.g. wound care nurse, high-risk foot service or medical practitioner.
- monitor for adverse reactions and implement appropriate mitigation strategies as outlined in the ‘Safety and quality’ section above.

6. Progression

- Task progression strategies include:
 - as the wound progresses, the dressing will change to match the exudate volume, size and appearance. If the wound is improving in appearance it should continue to be reviewed every 10-14 days until resolved. This should be arranged as per local service models. If the wound is non-healing or deteriorating, the skill share-trained health professional should implement local processes for the client to be reviewed by a health professional with expertise in wound management.
 - for foot wounds, dressings should be worn for a minimum of two weeks post wound healing to provide protection for newly epithelised skin.
- The client may require further assessment if wound dressing goals change or factors impacting the wound dressing change e.g. lack of stock, hospital admission, change in assistance available, acute injury to the limbs, illness or surgery.

7. Document

- Document the outcomes of the task as part of the skill share-trained health professional’s entry in the relevant clinical record, consistent with documentation standards and local procedures. For this task:
 - if a dressing was removed and whether irrigation with sterile saline or water was undertaken
 - wound features and characteristics including description of the size and depth of the wound, surrounding skin, wound edge and base, amount and type of exudate, odour, presence of sinuses, deeper structure involvement and foreign objects
 - presence of neuropathy including location and size of area
 - presence or signs of infection or ischaemia e.g. redness, heat/coolness, purulence, odours, worsening pain, increasing exudate
 - The UTWCS rating score and if relevant the name and score for any additional tools used
 - product to cleanse the wound, the dressing/s applied, treatment goal for the product used and products used to retain the dressing to the wound e.g. tubular dressing, adhesive or bandage. Including any factors that impacted on decision making e.g. product availability, costs, carer support
 - the wound management plan including who and where re-dressing will be undertaken, frequency of dressing changes and planned review date
- The skill shared task should be identified in the documentation as “delivered by skill share-trained (insert profession) implementing S-FC04: Basic assessment of a foot wound and provide basic/bridging intervention” or similar wording.

References and supporting documents

- Queensland Health (2017). Guide to Informed Decision-making in Health Care (2nd edition). https://www.health.qld.gov.au/_data/assets/pdf_file/0019/143074/ic-guide.pdf
- National Association Diabetes Centres (2018). NADC Collaborative Interdisciplinary Diabetes High Risk Foot Service Standards. Available at: <https://nadc.net.au/wp-content/uploads/2018/08/HRFS-Standards-FINAL-9.7.18.pdf>
- Procedure: University of Texas Staging System for Diabetic Foot Ulcers (2015). DFU Staging Procedure: South West Regional Wound Care Program. Available at: <http://swrwoundcareprogram.ca/Uploads/ContentDocuments/Procedure-UniversityofTexasStagingSystemforDiabeticFootUlcers.pdf>

Assessment: Performance Criteria Checklist

S-FC04: Assess a foot wound and provide basic bridging intervention

Name:

Position:

Work Unit:

Performance Criteria	Knowledge acquired	Supervised task practice	Competency assessment
	Date and initials of supervising AHP	Date and initials of supervising AHP	Date and initials of supervising AHP
Demonstrates knowledge of fundamental concepts required to undertake the task through observed performance and the clinical reasoning record.			
Identifies indications and safety considerations for the task and makes appropriate decisions to implement the task, including any risk mitigation strategies, in accordance with the clinical reasoning record.			
Completes preparation for the task including collecting equipment (gloves, dressing pack/supplies, UTWCS recording form and camera if required) and prepares the aseptic environment.			
Describes the task and seeks informed consent.			
Prepares the environment and positions self and client appropriately to ensure safety and effectiveness of the task, including reflecting on risks and improvements in the clinical reasoning record where relevant.			
<p>Delivers the task effectively and safely as per the CTI procedure, in accordance with the 'Learning resource'.</p> <ol style="list-style-type: none"> Clearly explains and demonstrates the task, checking the client's understanding. Determines the foot wound history using the 'Guide to conducting a foot wound history' in the 'Learning resource'. Correctly performs hand hygiene and sets up the dressing pack/items. Dons disposable gloves and protective equipment. If a dressing is in situ, correctly removes and disposes of the dressing and gloves in the appropriate receptacle. Performs hand hygiene and dons a clean pair of disposable gloves. Cleanses the wound to disrupt the wound biofilm and remove surface debris. With a blunt sterile probe gently assesses the wound. Correctly determines and records the wound stage and grade using the UTWCS matrix. If relevant correctly applies additional wound tools. If required for the local service, completes the photo consent form and photographs the wound. 			

<p>k) Determines an appropriate management plan referring to the “Limitations” section and the ‘Learning resource’.</p> <p>l) Discusses the proposed management plan with the client, making any required adjustments.</p> <p>m) Performs hand hygiene and dons a clean pair of disposable gloves.</p> <p>n) Correctly applies the required dressing to the wound.</p> <p>o) Educates the client (and carer) regarding ongoing wound management.</p> <p>p) Disposes of bed linen, probe and gloves in the appropriate receptacles.</p> <p>q) Wipes all used surfaces with a disinfectant i.e. bed, chair and table.</p> <p>r) During the task, maintains a safe clinical environment and manages risks appropriately</p>			
Monitors for performance errors and provides appropriate correction, feedback and/or adapts the task to improve effectiveness, in accordance with the clinical reasoning record.			
Documents in the clinical notes including a reference to the task being delivered by the skill share-trained health professional and the CTI used.			
If relevant, incorporates outcomes from the task into an intervention plan e.g. plan for task progression, interprets findings in relation to care planning, in accordance with the clinical reasoning record.			
Demonstrates appropriate clinical reasoning throughout the task, in accordance with the ‘Learning resource’.			

Notes on the scope of the competency of the health professional

The health professional has been trained and assessed as competent to deliver the following wound scales:

- The UTWCS
- _____

And dressing products:

- _____
- _____
- _____
- _____

Comments:

Large empty rectangular area for entering comments.

Record of assessment competence:

Assessor name:	Assessor position:	Competence achieved: / /
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Scheduled review:

Review date: / /

S-FC04: Assess a foot wound and provide basic/bridging intervention

Clinical Reasoning Record

- The clinical reasoning record can be used:
 - as a training resource, to be completed after each application of the skill shared task (or potential use of the task) in the training period and discussed in the supervision meeting
 - after training is completed for the purposes of periodic audit of competence
 - after training is completed in the event of an adverse or sub-optimal outcome from the delivery of the clinical task, to aid reflection and performance review by the lead practitioner.
- The clinical reasoning record should be retained with the clinician's records of training and not be included in the client's clinical documentation.

Date skill shared task delivered: _____

1. Setting and context

- insert concise point/s outlining the setting and situation in which the task was performed, and their impact on the task

2. Client

Presenting condition and history relevant to task

- insert concise point/s on the client's presentation in relation to the task e.g. presenting condition, relevant past history, relevant assessment findings

General care plan

- insert concise point/s on the client's general and profession-specific/allied health care plan e.g. acute inpatient, discharge planned in 2/7

Functional considerations

- insert concise point/s of relevance to the task e.g. current functional status, functional needs in home environment or functional goals. If not relevant to task - omit.

Environmental considerations

- insert concise point/s of relevance to the task e.g. environment set-up/preparation for task, equipment available at home and home environment. If not relevant to task - omit.

Social considerations

- insert concise point/s of relevance to the task e.g. carer considerations, other supports, client's role within family, transport or financial issues impacting care plan. If not relevant to task - omit.

Other considerations

- insert concise point/s of relevance to the task not previously covered. If none - omit.

3. Task indications and precautions considered

- insert concise point/s on the indications present for the task, and any risks or precautions, and the decision taken to implement/not implement the task including risk management strategies.

4. Outcomes of task

- insert concise point/s on the outcomes of the task including difficulties encountered, unanticipated responses

5. Plan

- insert concise point/s on the plan for further use of the task with this client including progression plan (if relevant)

6. Overall reflection

- insert concise point/s on learnings from the use of the task including indications for further learning or discussion with the lead practitioner
-

Skill share-trained health professional

Lead health professional (trainer)

Name:

Name:

Position:

Position:

Date this case was discussed in supervision: / /

Outcome of supervision discussion e.g. further training, progress to final competency assessment

Assess a foot wound and provide basic/bridging intervention: Learning resource

Early assessment of a foot wound is essential to ensure timely and appropriate management and prevent further complications. This CTI provides basic assessment skills and basic/bridging intervention for a foot wound. There are several key factors in appropriate treatment of a foot wound:

- prevention of infection
- taking the pressure off the area, called off-loading
- removing dead skin and tissue, called debridement
- applying medication or dressings to the wound
- managing other health conditions e.g. glycaemic control for diabetes, fluid overload for heart failure.

Required reading

Infection

- International Wound Infection Institute (IWII). Wound infection in clinical practice. Wounds International 2016. Available at: <http://www.woundinfection-institute.com/wp-content/uploads/2017/03/IWII-Wound-infection-in-clinical-practice.pdf>
- Table 2: Infectious Diseases Society of America and International Working Group on the Diabetic Foot Classifications on Diabetic Foot Infection. In Lipsky BA, Berendt AR, Cornia PB, Pile JC, Peters EJG, Armstrong DG, Gunner Deery H, Embil JM, Joseph WS, Karchmer AW, Pinzur MS, Senneville E (2012). 2012 Infectious Diseases Society of America Clinical Practice Guideline for the Diagnosis and Treatment of Diabetic Foot Infections, *Clinical Infectious Diseases*, 54(12) p. e132–e173. Available at: <https://academic.oup.com/cid/article/54/12/e132/455959>

Wound assessment

- Diabetic Foot eLearning course. Available through iLearn at: <https://central.csd.s.qld.edu.au/central/courses/176>
 - Module 8: Ulcer assessment and diagnosis
 - Ulcer assessment
 - Ulceration management

Note: for the modules listed above quizzes should be completed and results recorded.

Wound classification

- Forss J, Till D (2014). Calculating diabetic foot ulceration healing times using the Texas wound classification system. *Journal of Foot and Ankle Research* 7 (Suppl 2): A3. Available at: <https://footankleres.biomedcentral.com/articles/10.1186/1757-1146-7-S2-A3>

Management

- National Association of Diabetes Centres (2018). NADC Collaborative Interdisciplinary Diabetes High Risk Foot Services (HRFS) Standards V1.1. Available at: <https://nadc.net.au/wp-content/uploads/2018/08/HRFS-Standards-FINAL-9.7.18.pdf>

- Kavitha KV, Tiwari S, Purandare VB, Khedkar S, Bhosale SS, Unnikrishnan AG (2014). Choice of wound care in diabetic foot ulcer: A practical approach. World Journal of Diabetes 2014 Aug 15; 5(4): 546-556. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4127589/>
- International best practice guidelines: wound management in diabetic foot ulcers. Wounds International 2013. Available from: http://www.woundsinternational.com/media/best-practices/_/673/files/dfubestpracticeforweb.pdf
- Sussman G (2014). Ulcer dressings and management. Wounds and ulcers. Australian Family Physician 43(9): 588-592. Available at: <https://www.racgp.org.au/afp/2014/september/ulcer-dressings-and-management/>
- World Union of Wound Healing Societies: Position Document (2016). Local management of diabetic foot ulcers. Living with a diabetic ulcer: the patient's perspective. p12-15. Available at: http://www.wuwhs2016.com/files/WUWHS_DFUs_web.pdf

Decision support tools

- Australian Government, Department of Veterans' Affairs (2012). Wound identification and Dressing Selection Chart. Available at: <https://www.dva.gov.au/sites/default/files/files/providers/woundcare/woundchart.pdf>
- Review Module 9: Decision support tools in iLearn
 - Wraights clinical pathway tool (slide 6)
 Note this is revision from CTI S-FC01: Assess the risk of foot complications

Optional reading

- South West Regional Wound Care Program. Teaching resources. Available at: http://www.swrwoundcareprogram.ca/49/Teaching_Resources/

Guide to conducting a foot wound history

If as part of CTI S-FC01: Assess the risk of foot complications, presence of a wound is determined, information regarding the client's wound history is required. This may be obtained from the client's medical record and during subjective examination. The following questions are provided as a guide in conducting a foot wound history.

- Is the client aware that they have a wound on their foot?
 - If no
 - Does the client perform daily foot inspections? If the client does not perform daily foot inspections, problem solve with the client how daily foot inspections can occur e.g. integration into daily hygiene program, carer education, use of a mirror or provision of reminder poster.
 - If the client does perform daily foot inspections, discuss the features of the current wound and determine the duration of presence.
 - If yes
 - Does the client know when and how the wound occurred e.g. trauma or noticed as part of daily foot inspection? This will assist in determining the client's self-management skills and monitoring the progress of the wound. See the 'Monitoring' section above and review progress in the task.
 - Is the client able to describe how the wound has changed in appearance since first noting its presence? Including whether they are satisfied with the healing. This will assist in determining if

the wound is healing, non- or slow healing or extending. See the 'Monitoring' section above and review progress in the task.

- Is there a dressing plan in place for the wound?
 - If no, in consultation with the client develop a dressing plan. Refer to decision support tools.
 - If yes, is the client adhering to the dressing plan? If not, why not? This may assist in identifying issues. Refer to Kavitha et al (2104) in the required reading. Liaise with the dressing prescriber regarding wound dressing problems.
- Does the client have an off-loading device?
 - If yes, see the 'Limitations' section above. Determine if the client is wearing the off-loading device and if not, why not. Liaise with the off-loading device prescriber regarding off-loading device problems.
- Does the client have any pain associated with the wound? If yes, rate the pain using a pain rating scale e.g. 0-10. Determine the aggravating, relieving factors and the diurnal pattern. If the client is having difficulty managing pain or significant functional issues associated with pain, liaise with a health professional with expertise in pain management strategies e.g. a GP, nursing staff on the ward.

Management of foot wounds

Clients with a foot wound require a management plan. At a minimum the wound will need to be cleaned and covered prior to being referred to a wound service. For non-complex wounds management primarily consists of preventing further trauma and facilitating and monitoring normal healing. For wounds at risk management may include application of a simple foam dressing and consideration of an offloading strategy. For complex wounds, including those with signs of infection and/or those with involvement of deeper anatomical structures, referral to high-risk foot service and/or wound service is required. Figure 1 provides the skill share-trained health professional with a decision-making support tool for the risk profile rating and assessment findings, to guide the clinical reasoning on suitable additional interventions for client care and management. This should be discussed in conjunction with the 'Learning resources', local workplace instruction and model of care documents as part of the training process.

Figure 1 Wound management clinical decision-making flowchart

