TREATMENT PROTOCOL FOR NEUROPATHIC & DIABETIC FOOT ULCER (DFU)

Initiate Wound Record

****Confirm that patient with DFU has been referred to a vascular specialist for assessment.****

☐ Photograph wound and file as per regional policy

☐ Initiate wound record

CLIENT INFORMATION

Name

Date

Laboratory

Follow Home Care policy for sending a wound swab for C & S and inform most responsible practitioner if a lab test is sent in client's name and why. ☐ Swab C&S: date:

Wound Management:

**** See formulary for current Health Pro product selection****

☐ Cleanse and moisturize peri-wound and intact skin lower limb/feet/foot

☐ Cleanse wound with 60-100mls of normal saline or alternative at the appropriate psi (4-15) at least room temperature

☐ Gently remove loose debris/yellow slough/crusting with gauze

☐ Protect peri-wound skin from moisture damage, use skin sealant or barrier

☐ Identify infection or suspected infection (see Lower Leg Assessment Form for additional infection guidelines)

**** Do not underestimate the severity of infection in a diabetic foot.****

If any of these signs/symptoms are present contact the most responsible provider.

☐ Greater than 2 cm of redness ☐ Foul odor ☐ Probe to bone

☐ Local inflammatory response (warmth, swelling) ☐ Increased pain ☐ Wound breakdown

☐ Increased amount of exudate ☐ Friable granulation tissue

☐ For a high risk or infected ulcer apply an antimicrobial contact layer (refer to formulary or contact wound specialist nurse for advice on product selection): _____

☐ For a non-infected ulcer apply absorbent dressing: _____

☐ Apply a non-occlusive cover dressing if required:_____

☐ Confirm ABPI/TBPI score before application of compression: Right _____ Left: _____

**** If ABPI is greater than or equal to 0.5 and less than 0.8, nurses with advanced education (SK Polytechnic CE 4021 or equivalent) may initiate compression if appropriate. Other nurses contact most responsible provider for orders.****

**** If ABPI is less than 0.5 or greater than 1.3 consult most responsible provider. Note: ABPI is only part of a broader assessment; when in doubt defer to clinical judgment of referring provider, and request written order.****

☐ Apply modified compression bandaging (0.5-0.79): _____ ☐ Right leg ☐ Left leg ☐ Bilateral

☐ Apply high compression bandaging (0.8-1.3): _____ ☐ Right leg ☐ Left leg ☐ Bilateral

**** Always apply modified compression if client has altered cognition or loss of protective sensation. ****

**** Compression may be modified initially and gradually increased based on client comfort/tolerance. ****

**** Risk for pressure injury is always present. Plan for timely reassessment after initiating compression.****

☐ Arrange regular debridement/callus management (specialist or other regional resources)_____

☐ Arrange assessment for pressure offloading (specialist or other regional resources) _____

☐ Initiate dressing change 3x per week and adjust frequency as appropriate. Frequency: _____

☐ Reassess the wound at every dressing change. Complete a full wound reassessment weekly, including wound measurements, and update wound record.

**** Use wound record to monitor change in wound depth and surface area, and contact wound clinician nurse for advice/reassessment if required. (Target 50% reduction in surface area within 4 weeks.)****

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Counseling provided

☐ Establish wound care goals with client:_____

_____

☐ Provide client/caregiver with instructions for care & management: _____

_____

CLIENT INFORMATION

Name

Date

☐ Educate client/family/caregiver about compression, exercise & limb elevation. Explain warning signs and how to remove compression wrapping if necessary. _____

☐ Address client concerns: _____

☐ Other: _____

Date	Coordination of care (arrange consults if physician/NP has not already done so)
	Glycemic Control: ☐ Diabetes education centre ☐ Other:
	Offloading footwear: ☐ Podiatry ☐ Orthotist ☐ Other:
	Vascular disease (specialist): via ☐ Primary care provider
	Foot care & maintenance: ☐ Home Care ☐ Podiatry ☐ Other:
	Fit for compression hosiery if appropriate: ☐ OT/PT ☐ Wound clinician nurse ☐ Other:
	Client concerns: ☐ Dietician ☐ Social work ☐ Other:
	Risk factor reduction:
	Other:

Individualized care plan

Signature: Date:

Communications

☐ Provide summary of assessment and recommended treatment to referring Physician/NP. Use LEW Pathway form **"Communication with Referring Physician/NP."** Attach lower leg assessment form if appropriate.

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Date/Time	Treatment Change & Progress Note	CLIENT INFORMATION: Name: Date: