Summary of Recommendations

RECOMMENDATION		*LEVEL OF EVIDENCE
Practice Recommendations		
Patient Empowerment and Education	**1.0** All patients with diabetic foot ulcer(s) (PWDFU) or caregivers should have an understanding of their condition and the resources available to optimize their general health, diabetes management and ulcer care.	Ia
	1.1 Education is essential as an empowerment strategy for diabetes self-management and prevention or reduction of complications.	IV
	1.2. Education is based on identified individual needs, risk factors, ulcer status, available resources and ability to heal.	IV
Holistic Assessment	**2.0** Complete and document a health history, including diabetes management, allergies, medications, functional assessment and physical examination (vascular status, infection, callus, neuropathy, foot deformity/pressure, ulcer).	Ib – IV
Vascular Status	**2.1** Clinically assess bilateral lower extremities for vascular supply and facilitate appropriate diagnostic testing.	IIb – IV
Infection	**2.2** Assess all patients with diabetic foot ulcers for signs and symptoms of infection and facilitate appropriate diagnostic testing and treatment.	IIa
Neuropathy	**2.3** Identify peripheral neuropathy by assessing for sensory, autonomic and motor (S.A.M.) changes.	II – IV
Foot Deformity and Pressure	**2.4** Assess for foot pressure, deformity, gait, footwear and devices. Facilitate appropriate referrals.	Ia – IV
Foot Ulcer Assessment	**3.0** Describe and document the ulcer characteristics.	IV
	3.1 Identify the location, length, width, depth and classify the ulcer(s).	Ia – IV
	3.2 Assess ulcer bed, exudate, odour and peri-ulcer skin.	IV
Goals of Care	**4.0** Define goals based on clinical findings, expert opinion and patient preference.	IV
	4.1 Determine the potential of the ulcer to heal.	IV
	4.2 Develop goals mutually agreed upon by the patient and healthcare professionals.	IV
Management	**5.0** Identify and optimize systemic, local and extrinsic factors that can influence wound healing.	IV
Systemic Factors	**5.1** Modify systemic factors and co-factors that may interfere with or impact on healing.	IV
Local Factors	**5.2** Provide local wound care considering debridement, infection control and a moist wound environment.	Ia-III
Extrinsic Factors	**5.3** Provide pressure redistribution.	IIa

*See page 12 for details regarding "Interpretation of Evidence".

	RECOMMENDATION	LEVEL OF EVIDENCE
Non-healing diabetic foot wounds	**5.4** Evaluate and implement treatment options for non-healable wounds.	IV
Evaluation	**6.0** Evaluate the impact and effectiveness of the treatment plan.	IV
Reassess	**6.1** Reassess for additional correctable factors if healing does not occur at the expected rate.	III-IV
Other therapies	**6.2** Consider the use of biological agents, adjunctive therapies and/or surgery if healing has not occurred at the expected rate. Review each specific modality for recommendations.	Ia-IV
Education Recommendations		
Continuing Professional Development	**7.0** Nurses and other members of the interdisciplinary team need specific knowledge and skills in order to competently assess and participate in the treatment of diabetic foot ulcers.	IV
Curriculum Support and Resources	**8.0** Educational institutions are encouraged to incorporate the RNAO Nursing Best Practice Guideline *Assessment and Management of Foot Ulcers for People with Diabetes* into basic RN, RPN, MD and allied health professional curricula.	IV
Organization & Policy Recommendations		
System Support	**9.0** Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes: ■ An assessment of organizational readiness and barriers to education. ■ Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process. ■ Dedication of qualified individual(s) to provide the support needed for the development and implementation process. ■ Ongoing opportunities for discussion and education to reinforce the importance of best practices. ■ Opportunities for reflection on personal and organizational experience in implementing guidelines. In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *Toolkit: Implementation of Clinical Practice Guidelines,* based on available evidence, theoretical perspectives and consensus. The RNAO strongly recommends the use of this *Toolkit* for guiding the implementation of the best practice guideline on *Assessment and Management of Foot Ulcers for People with Diabetes*.	IV
Resources	**9.1** Organizations are encouraged to develop policies that acknowledge and designate human, material and fiscal resources to support the nurse and the interdisciplinary team in diabetic foot ulcer management.	IV
Team Development	**9.2** Organizations are encouraged to establish and support an interdisciplinary, inter-agency team comprised of interested and knowledgeable persons to address and monitor quality improvement in the management of diabetic foot ulcers.	IV

	RECOMMENDATION	LEVEL OF EVIDENCE
Partnerships	**9.3** Organizations are encouraged to work with community and other partners to develop a process to facilitate patient referral and access to local diabetes resources and health professionals with specialized knowledge in diabetic foot ulcer management.	IV
Financial Support	**9.4** Organizations are encouraged to advocate for strategies and funding to assist patients in obtaining appropriate pressure redistribution devices.	IV
Advocacy	**9.5** Organizations are encouraged to advocate for an increase in the availability and accessibility of diabetic foot ulcer care for all residents of Ontario.	IV

Interpretation of Evidence

Levels of Evidence

Ia	Evidence obtained from meta-analysis or systematic review of randomized controlled trials.
Ib	Evidence obtained from at least one randomized controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization.
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.