Integrated Diabetes Foot Care Pathway

Diabetes Foot Risk Stratification and Triage

Risk of Developing Foot Disease

Risk Level	Risk Factors	Rescreen and Referral	Foot Action Plan
3 **High**	**LOPS** or **PAD** **and one or more of the following:** • History of foot ulcer • A lower-limb amputation (minor or major) • ESRD	1-3M Enact action plan and rescreen every **1 - 3 months** 2-4W Initial podiatry referral within **2 - 4 weeks**	Review footwear Provide structured foot care education Optimise diabetes holistic management including modifiable risk factors Organise referrals and recall date for re-screening based on risk classification
2 **Moderate**	**LOPS + PAD** or **LOPS + Foot deformity** or **PAD + Foot deformity**	3-6M Enact action plan and rescreen every **3 - 6 months** 6-8W Initial podiatry referral within **6 - 8 weeks**	
1 **Low**	**LOPS** or **PAD**	6-12M Enact action plan and rescreen every **6 - 12 months**	
0 **Very low**	**No LOPS** and **No PAD**	12 M Screen every **12 months**	Develop self-management plan that supports preventative self-care behaviours

Advise all members of the healthcare team of any change in risk status

Aboriginal and Torres Strait Islander people should be considered "High Risk" until assessed otherwise – consider cultural safety when conducting a foot assessment and providing foot care advice.

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Diabetes Foot Risk Stratification and Triage

Risk of foot disease

Risk of foot disease: Assessing all people with diabetes and stratifying their risk of developing foot complications assists in reducing ulceration as well as limb-loss and mortality. Foot assessment is performed by any suitably trained healthcare professional to identify the at-risk foot and implement an appropriate Foot Action Plan.

Re-screening frequency needs to be individualised and it may change in a patient if their risk factors for foot complications change.

Structured foot care education should include

- ✔ Foot ulceration and the consequences
- ✔ Preventative foot self-care behaviours, such as:
  - Seeking professional help in a timely manner after identifying a foot problem
  - Not walking barefoot, in socks without shoes or in thin soled slippers
  - Wearing adequately protective footwear
  - Undergoing regular foot checks
  - Practicing proper foot hygiene

Abbreviations

ESRD: End stage renal disease

LOPS: Loss of Protective Sensation (a sign of diabetic peripheral neuropathy) – once LOPS is diagnosed repeating assessment at each re-screening is not necessary

PAD: Peripheral Artery Disease

Definitions

Modifiable risk factors: Behaviours or exposures that can raise or lower a person's risk of developing foot complications. For instance: smoking, poor diet, blood glucose targets, blood lipids, and weight management.

Pre-ulcerative lesions: Includes corns, callus, tinea pedis, thickened toenails (+/- fungal infection), heel fissures. Treatment should be undertaken by a podiatrist (or similarly competent foot practitioner).

References

International Working Group Diabetic Foot Guidelines – 2019: https://iwgdfguidelines.org/guidelines/guidelines/

Identification and Management of Foot Complications in Diabetes (Part of the Guidelines on Management of Type 2 Diabetes) 2011. Melbourne Australia

Diabetic foot problems: prevention and management NICE guideline (NG19): https://www.nice.org.uk/guidance/NG19

D-Foot International fast track pathway: https://d-foot.org/projects/fast-track-pathway-for-diabetic-foot-ulceration

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Integrated Diabetes Foot Care Pathway

Active Foot Disease Pathway

Active Foot Disease

	Presentation	Action Plan
Acute Limb Ischaemia	Sudden Acute Foot Pain, Pallor or coldness present over hours or days and impalpable foot pulses	Refer immediately to ED
Chronic Limb-Threatening Ischaemia	**PAD with either:** Pain on rest Gangrene Lower-limb ulceration	Same day referral to a vascular specialist
Foot Ulcer	**Severe infection** Foot infection associated with systemic features (SIRS)	Refer immediately to ED
Foot Ulcer	**Infection present without systemic signs or symptoms** Mild infection - <2cm erythema periwound involving skin & subcutaneous tissue Moderate infection - >2cm erythema periwound involving deeper structures (i.e. tendon/bone)	Referral to iHRFS for wound care and offloading (pressure management): • Same day referral, to iHRFS or similar service (if no iHRFS exists locally) Refer to Practice Points to implement standard of care Initiate appropriate antibiotic therapy and collection of microbiology specimens For moderate infections complicated by co-morbidities, refer to ED for assessment
Foot Ulcer	**No infection in a superficial ulcer**	If not greater than 50% reduction by 2-4 weeks, refer to iHRFS or similar service (if no iHRFS exists locally) Refer to Practice Points to implement standard of care
Charcot Foot	Clinical signs of inflammation (redness, heat, swelling) present in the neuropathic foot. Pain may be present despite neuropathy. No evidence of a portal of entry (i.e. ulcer) to suggest infection.	Same day referral to iHRFS (or similiar service is experience managing Charcot foot) Refer to Offloading in Practice points to implement standard of care.

Practice Points

Address infection if present

Score ulcer (use SINBAD plus other classification system as appropriate) to assess progress and facilitate faster triage

Local wound care: sharp debridement and ulcer dressing to absorb exudate

Optimise perfusion, diabetes holistic management and modifiable risk factors

Offloading the ulcer or charcot foot, consider immobilising the affected leg with knee-high cast/boot and/or wound care. Discuss options with local iHRFS

Advise all members of the healthcare team of any change in risk status

Aboriginal and Torres Strait people are recognised as a high risk group for foot ulceration and amputation.

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Active Foot Disease Pathway

Active foot disease

Foot complications as a result of diabetes significantly impact a person's quality of life and they are a significant burden to morbidity and mortality. Treatment delay is a risk factor for increased frequency of lower limb amputation and is associated with longer treatment time, increased wound size and worse outcomes.

Thus, in the presence of active foot disease it is incumbent on the primary care team to ensure timely referral to appropriate services, either interdisciplinary high-risk foot services, specialist vascular care, or in the most severe cases, hospitalisation.

Abbreviations

ED: Emergency department

iHRFS: Interdisciplinary High Risk Foot Service or Foot Clinic

LOPS: Loss of Protective Sensation

PAD: Peripheral Artery Disease

SINBAD: Site (Ulcer), Ischaemia, Neuropathy (LOPS), Bacterial infection, Area, Depth

SIRS: Systemic Inflammatory Response Syndrome (refer to local guidelines)

Definitions

Comorbities: The presence of one or more additional conditions co-occurring with a primary disease. While many people with diabetes + foot infection may not require hospitalisation, comorbidities, such as renal failure or an immunocompromised state, may benefit from admission.

References

International Working Group Diabetic Foot Guidelines – 2019: https://iwgdfguidelines.org/guidelines/guidelines/

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D-Foot International fast track pathway: https://d-foot.org/projects/fast-track-pathway-for-diabetic-foot-ulceration

NADC Collaborative Interdisciplinary Diabetes HRFS Standards 2018: https://nadc.net.au/wp-content/uploads/2019/07/HRFS-Standards-FINAL-9.7.18.pdf