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OASIS Alert

Diabetic Ulcers: PUT YOUR BEST EFFORT INTO DIABETIC ULCER ID AND PREVENTION

Simply saying a wound is a diabetic ulcer isn't enough.

Diabetic ulcers hurt the patient, your outcomes and your bottom line. When you admit a diabetic patient, add diabetic foot care to the care plan. Don't wait until the discharge or transfer OASIS, when you have to answer M2250 (Does the physician ordered plan of care include diabetic foot care, including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care?).

Recognizing and preventing diabetic ulcers can be a challenge, but one that you can master with a few key pointers.

For one, realize that simply saying a wound is a diabetic ulcer doesn't give you enough information, explains **Dorothy Doughty**, a wound care expert at **Emory University**. "You need to know if it's a neuropathic ulcer, an ischemic ulcer -- or a combination," she says.

Evaluating a diabetic ulcer requires a couple of considerations.

Look to diagnoses: To have a diabetic neuropathic ulcer, the patient must have a documented diagnosis of both diabetes mellitus and peripheral neuropathy, notes **Elizabeth Ayello**, a nursing professor at **Excelsior College** in Albany, N.Y. But documentation labeling an ulcer diabetic doesn't tell you enough.

What to do: Ask the physician to define the underlying etiology of the ulcer, advises **Rena Shephard**, president of **RRS Healthcare Consulting** in San Diego. "For example, is it ischemic and then affected by pressure and diabetes-related factors such as decreased sensation?" Shephard notes that "any time a person has an ulcer, you need to carefully assess what role pressure may have played in causing the wound or in affecting how it heals."

Also, obtain an X-ray of the patient's foot to see if the ulcer is close to the bone and could be osteomyelitis, says **Michael Miller**, a wound care expert in Linton, Ind. An ultrasound can identify arterial insufficiency.

First Clue: Location, Location, Location

Patients can "have autonomic neuropathy that makes their feet dry and cracked," creating an opening in the skin, Doughty adds. Or the person may scratch his foot, causing a small wound. Motor neuropathy can also occur, causing damage to the nerves that control the muscles affecting foot contour, she says. As a result, the person develops "'hammer toes' that tend to rub against the shoe more."

When the shoe doesn't fit: Sensory neuropathy -- where the person doesn't feel repetitive trauma caused by his shoes -- is responsible for about 60 percent of diabetic ulcers, Doughty notes.

Ischemic ulcers alone comprise about 20 percent of ulcers in people with diabetes mellitus, Doughty says. "Location is a huge indicator in telling the difference," she notes. Look for a neuropathic diabetic ulcer on the bottom of the foot or its periphery -- "or somewhere where the foot is typically in contact with the shoe." By contrast, an ischemic ulcer will appear on the distal toes or distal foot, adds Doughty. Or the person may have injured his foot and the wound became bigger and bigger because the wound didn't get enough blood flow to heal or fight infection. "You can also have a wound that started out due to neuropathy and ended up as a non-healing wound due to ischemia," Doughty says.

Prevention is key: "If a diabetic has a foot callous, send her to a podiatrist for a good foot exam," advises **Evonne Fillinger**, a consultant with **Boyer & Associates** in Brookfield, Wis. "People with diabetes should have a foot exam

frequently, and be seen regularly by a physician," she adds. "Inspect the person's feet daily, and make sure the person has excellent fitting shoes and wears cotton socks. Synthetic materials tend to hold the moisture in and make the person more prone to fungal infections of the feet," she adds.