Person—foot ulcer indicator (history), code N

Identifying and definitional attributes

Metadata item type: Data Element

Short name: Foot ulcer (history)

METEOR identifier: 302819

Registration status:
- Health, Standard 21/09/2005

Definition: Whether person has a previous history of ulceration on either foot, as represented by a code.

Data Element Concept: Person—foot ulcer indicator

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes
Record if person has a previous history of ulceration on either foot.

CODE 2 No
Record if person has no previous history of ulceration on either foot.

Collection methods: Ask the individual if he/she a previous history of foot ulceration. Alternatively obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: Supersedes Person—foot ulcer history status, code N

- Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) NBPDSHealth, Standard 21/09/2005

DSS specific information:

Past history of foot ulceration, peripheral neuropathy and foot deformities have been associated with increased risk of foot ulceration and lower limb amputation for patients who suffer from diabetes. The aim is to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration.

Following the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, individuals with a 'high-risk foot' or a significant active foot problem should be examined every six months or at every visit.

Assessment:

- ask patient about previous foot problems, neuropathic symptoms, rest pain and intermittent claudication
- inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'
- assess footwear
- check peripheral pulses
- examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.