Person—foot ulcer indicator (history), code N

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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 attributes

Identifying and definitional attributes

Data element concept:	Person—foot ulcer indicator
METEOR identifier:	304022
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has a foot ulcer on either foot.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	Foot ulcer indicator

Value domain attributes

Identifying and definitional attributes

Value domain:	Yes/no/not stated/inadequately described code N
METEOR identifier:	301747
Registration status:	Australian Teacher Workforce Data Oversight Board, Recorded 25/10/2022 Children and Families, Standard 22/11/2016 Community Services (retired), Standard 14/02/2006 Disability, Standard 07/10/2014 Early Childhood, Standard 21/05/2010 Health, Standard 21/09/2005 Homelessness, Standard 23/08/2010 Housing assistance, Standard 10/02/2006 Independent Hospital Pricing Authority, Standard 01/11/2012 Indigenous, Standard 13/03/2015 Tasmanian Health, Standard 08/11/2023
Definition:	A code set representing 'yes', 'no' and 'not stated/inadequately described'.

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
	Value	**Meaning**
Permissible values:	1	Yes

	2	No
Supplementary values:	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.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

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) NBPDS
Health, 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.