

# Person—foot ulcer history status, code N

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# Person—foot ulcer history status, code N

## Identifying and definitional attributes

<b>Metadata item type:</b>	Data Element
<b>Short name:</b>	Foot ulcer - history
<b>Synonymous names:</b>	Foot ulcer - history
<b>METEOR identifier:</b>	270159
<b>Registration status:</b>	<a href="#">Health!</a> , Superseded 21/09/2005
<b>Data Element Concept:</b>	<a href="#">Person—foot ulcer history status</a>
<b>Value Domain:</b>	<a href="#">Foot ulcer history code N</a>

## Value domain attributes

## Representational attributes

<b>Representation class:</b>	Code
<b>Data type:</b>	Number
<b>Format:</b>	N
<b>Maximum character length:</b>	1

	<b>Value</b>	<b>Meaning</b>
<b>Permissible values:</b>	1	Yes - history of foot ulceration
	2	No - no history of foot ulceration
<b>Supplementary values:</b>	9	Not stated/inadequately described

## Collection and usage attributes

<b>Guide for use:</b>	Record whether or not the person has a history of foot ulceration.
<b>Collection methods:</b>	Ask the individual if he/she a previous history of foot ulceration. Alternatively obtain this information from appropriate documentation.

## Data element attributes

## Source and reference attributes

<b>Submitting organisation:</b>	National diabetes data working group
<b>Origin:</b>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

## Relational attributes

<b>Related metadata references:</b>	Has been superseded by <a href="#">Person—foot ulcer indicator (history), code N</a> <a href="#">Health!</a> , Standard 21/09/2005
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***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.