

High Risk Foot & Nail Assessment & Management Plan Documentation Guide

This provincial document guides the documentation process, either electronic health record or paper, of a Foot Care Nurse’s assessment and care planning for patients, clients, residents.

Assessment and care planning to be done within the first two visits. If a change in the patient’s, client’s, resident’s condition should occur while under the care of a FCN, then a reassessment is to be done, and the management plan adjusted as needed.

The table below lists the parameters and the frequently used findings. A **parameter** is a ‘question’ used to ensure a comprehensive assessment or documentation. **Findings** are terms used as an ‘answer(s)’ for a parameter.

Assessment – Foot	
Parameter	Findings
Skin/Nail Integrity	
<p>Foot</p> <p>Bold and green highlighted findings are normal or usual</p>	<p>For both right and left, choose all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Normal for age/No concern <input type="checkbox"/> Dry skin <input type="checkbox"/> Fragile/thinning <input type="checkbox"/> Healed wound/scar <input type="checkbox"/> Tyloma <input type="checkbox"/> mild <input type="checkbox"/> mod <input type="checkbox"/> heavy (if checked, indicate level of buildup) <input type="checkbox"/> Heloma <input type="checkbox"/> mild <input type="checkbox"/> mod <input type="checkbox"/> heavy (if checked, indicate level of buildup) <input type="checkbox"/> Reddened pressure point(s) <input type="checkbox"/> Maceration <input type="checkbox"/> Edema +1, +2, +3, +4, NP (if checked, circle amount of pitting, NP = non-pitting) <input type="checkbox"/> Circumference: Midfoot _____cm (enter measurement in centimeters) <input type="checkbox"/> Shiny, hair loss <input type="checkbox"/> Moist/waxy <input type="checkbox"/> Woody <input type="checkbox"/> Papillomatosis (lymphedema) <input type="checkbox"/> Verruca <input type="checkbox"/> Hemorrhagic callus <input type="checkbox"/> Anhydrosis (very dry skin) <input type="checkbox"/> Fissures (deep cracks) <input type="checkbox"/> Hyperhidrosis <input type="checkbox"/> Itching areas <input type="checkbox"/> Rash <input type="checkbox"/> Weepy <input type="checkbox"/> Blister(s) <input type="checkbox"/> Wound(s) # _____ (enter number of wounds noted) <input type="checkbox"/> Odour <input type="checkbox"/> S&S of Infection
<p>Toes</p>	<p>For both right and left, choose all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Normal for age/No concern <input type="checkbox"/> Dry skin <input type="checkbox"/> Fragile <input type="checkbox"/> Healed wound/scar <input type="checkbox"/> Tyloma <input type="checkbox"/> mild <input type="checkbox"/> mod <input type="checkbox"/> heavy (if checked, indicate level of buildup)

	<ul style="list-style-type: none"> <input type="checkbox"/> Heloma <input type="checkbox"/> mild <input type="checkbox"/> mod <input type="checkbox"/> heavy (if checked, indicate level of buildup) <input type="checkbox"/> Reddened pressure point(s) <input type="checkbox"/> Maceration between toes <input type="checkbox"/> Edema +1, +2, +3, +4, NP (if checked, circle amount of pitting, NP = non-pitting) <input type="checkbox"/> Positive Stemmer Sign <input type="checkbox"/> Negative Stemmer Sign <input type="checkbox"/> Clubbing <input type="checkbox"/> Shiny, hair loss <input type="checkbox"/> Moist/waxy <input type="checkbox"/> Thickened skin <input type="checkbox"/> Verruca <input type="checkbox"/> Anhydrosis (cracks btw toes) <input type="checkbox"/> Itching areas <input type="checkbox"/> Rash <input type="checkbox"/> Weepy <input type="checkbox"/> Blister(s) <input type="checkbox"/> Dry eschar <input type="checkbox"/> Wound(s) # _____ (enter number of wounds noted) <input type="checkbox"/> S&S of infection
<p>Nails</p>	<p>For both right and left, choose all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Well-groomed/correct length <input type="checkbox"/> Appropriate free nail edge <input type="checkbox"/> Attached to nail bed <input type="checkbox"/> Missing: GT, 2nd, 3rd, 4th, 5th (if checked circle missing toe, GT = great toe) <input type="checkbox"/> Unkempt <input type="checkbox"/> Length too long <input type="checkbox"/> Loose/broken/splitting <input type="checkbox"/> Thickened <input type="checkbox"/> Shredding of nail/flaking <input type="checkbox"/> Pitting <input type="checkbox"/> Transverse ridging <input type="checkbox"/> Koilonychia (spoon shaped) <input type="checkbox"/> Onychogryptosis (Ram's Horn) <input type="checkbox"/> Involuted <input type="checkbox"/> Onychocryptosis (ingrown nail) <input type="checkbox"/> Bleeding/weeping (bed/fold) <input type="checkbox"/> Cuticle edge inflamed <input type="checkbox"/> Subungual ulcer/abscess <input type="checkbox"/> S&S of infection
<p>Skin/Nail Colour</p>	
<p>Foot</p> <p>Bold and green highlighted findings are normal or usual</p>	<p>For both right and left, choose all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Colour as per limb <input type="checkbox"/> Pallor in dependent position <input type="checkbox"/> Pallor with 30° elevation: (if checked then choose one) <ul style="list-style-type: none"> <input type="checkbox"/> Less than 30 secs <input type="checkbox"/> 30 secs or greater <input type="checkbox"/> Dependent rubor <input type="checkbox"/> Red <input type="checkbox"/> Bluish/purple <input type="checkbox"/> Black <input type="checkbox"/> Blanchable <input type="checkbox"/> Mottled <input type="checkbox"/> Hyperkeratosis

<p>Toes</p>	<p>For both right and left, choose all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Colour as per foot <input type="checkbox"/> Pallor in dependent position <input type="checkbox"/> Pallor with 30° elevation: if checked then choose one) <ul style="list-style-type: none"> <input type="checkbox"/> Less than 30 secs <input type="checkbox"/> 30 secs or greater <input type="checkbox"/> Dependent rubor <input type="checkbox"/> Red <input type="checkbox"/> Bluish/purple <input type="checkbox"/> Black <input type="checkbox"/> Blanchable <input type="checkbox"/> Mottled
<p>Nails</p>	<p>For both right and left, choose all that apply. If checked, circle the toe(s) of concern; GT= Great Toe</p> <ul style="list-style-type: none"> <input type="checkbox"/> Colour as per toes <input type="checkbox"/> White: GT, 2nd, 3rd, 4th, 5th <input type="checkbox"/> Yellow: GT, 2nd, 3rd, 4th, 5th <input type="checkbox"/> Red/black: GT, 2nd, 3rd, 4th, 5th <input type="checkbox"/> Green: GT, 2nd, 3rd, 4th, 5th <input type="checkbox"/> Rust: GT, 2nd, 3rd, 4th, 5th <input type="checkbox"/> Other: enter colour that was noted
<p>Skin Warmth</p>	
<p>Foot</p> <p>Bold and green highlighted findings are normal or usual</p>	<p>For both right and left, choose all that apply</p> <ul style="list-style-type: none"> <input type="checkbox"/> Warm as per limb <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Cold <input type="checkbox"/> IRD check: ____°C (IRD = Infrared Device) <p>Pulses by Palpation: Circle if pulse was noted: P = Present D = Diminished A = Absent</p> <p>Posterior Tibial: P D A Dorsalis Pedis: P D A Peroneal: P D A</p> <p>Pulses by Doppler: If pulse present (P= pulse present) then circle score and phase.</p> <p>Posterior Tibial: <input type="checkbox"/> P Score: 2 1 0 (2 = Expected 1 = Diminished 0 = Absent) Phase: Tri, Bi Mono</p> <p>Dorsalis Pedis: <input type="checkbox"/> P Score: 2 1 0 (2 = Expected 1 = Diminished 0 = Absent) Phase: Tri Bi Mono</p> <p>Peroneal: <input type="checkbox"/> P Score: 2 1 0 (2 = Expected 1 = Diminished 0 = Absent) Phase: Tri Bi Mono</p>
<p>Toes</p>	<p>For both right and left, choose all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Warm as per foot <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Cold <input type="checkbox"/> IRD check on GT: ____°C (IRD = Infrared device, GT = Great Toe) <input type="checkbox"/> Cap Refill: less than 3sec <input type="checkbox"/> Cap Refill: 3sec or greater
	<p>For Ankle Brachial Pressure Index (ABPI) use worksheet to record findings from the test, enter the score for right and left foot.</p> <p>ABPI Score:</p> <p>For Toe Brachial Pressure Index (TBPI) use worksheet to record findings from the test, enter the score for right and left foot.</p> <p>TBPI Score:</p>
<p>Movement</p>	
<p>Foot</p>	<p>For both right and left, choose all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> No bone deformities

<p>Bold and green highlighted findings are normal or usual</p>	<p>Good ankle ROM (Range of Motion)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Forefoot amputation <input type="checkbox"/> Foot amputation <input type="checkbox"/> ↓ Ankle ROM _____ degree (enter degree noted) <input type="checkbox"/> Dorsiflexion/plantar flexion <input type="checkbox"/> Inversion/eversion <input type="checkbox"/> Abduction/adduction <input type="checkbox"/> Dropped metatarsals heads <input type="checkbox"/> Sx hardware Insitu (Sx = Surgical) <input type="checkbox"/> Sx hardware exposed (Sx = Surgical) <input type="checkbox"/> Rocker foot (if checked check one) <ul style="list-style-type: none"> <input type="checkbox"/> Acute Charcot <input type="checkbox"/> Chronic Charcot <input type="checkbox"/> Plantar fasciitis/heel spur <input type="checkbox"/> Metatarsalgia <input type="checkbox"/> Morton's neuroma
<p>Toes</p>	<p>For both right and left, choose all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> No bone deformities <input type="checkbox"/> Good Hallux ROM <input type="checkbox"/> Non-painful bunion <input type="checkbox"/> Non-painful bunionette <input type="checkbox"/> Toe amputation: <ul style="list-style-type: none"> GT, 2nd, 3rd, 4th, 5th (circle toe missing; GT = Great Toe) <input type="checkbox"/> Painful bunion <input type="checkbox"/> Painful bunionette <input type="checkbox"/> Painful joint(s) <input type="checkbox"/> ↓ Hallux ROM _____ (degree) <input type="checkbox"/> Overlapping digits <input type="checkbox"/> Dropped metatarsal heads <input type="checkbox"/> Hammer toes <input type="checkbox"/> Clawed toes <input type="checkbox"/> Mallet toes <input type="checkbox"/> Cocked toes
<p>Mobility</p>	<p>For both right and left choose appropriate finding:</p> <p>Weight Bearing: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> None</p> <p>Calf Muscle: <input type="checkbox"/> Normal <input type="checkbox"/> Impaired</p> <p>Assess person's overall:</p> <p>Balance: <input type="checkbox"/> Steady <input type="checkbox"/> Unsteady</p> <p>Proprioception: <input type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p>Mobility Aids</p>	<p>Select the mobility aids the person is currently usings</p> <ul style="list-style-type: none"> <input type="checkbox"/> None needed <input type="checkbox"/> Wheelchair bound <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker; If checked, indicate number of wheels <input type="checkbox"/> None <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Scooter <p>Mobility Supports</p> <p><input type="checkbox"/> Splint <input type="checkbox"/> Brace <input type="checkbox"/> Prosthesis; if checked, indicate the type: _____</p>
<p>Gait & Arch Analysis</p>	<p>Use Gait & Arch worksheet to guide assessment.</p> <p>Gait: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (slightly wide, moderately wide) <input type="checkbox"/> Other: _____</p> <p>Stride Length: <input type="checkbox"/> Normal <input type="checkbox"/> Reduced <input type="checkbox"/> Other: _____</p> <p>Arch: <input type="checkbox"/> Normal Arch <input type="checkbox"/> High Arch <input type="checkbox"/> Flat Foot <input type="checkbox"/> Severe Flat Foot</p>
<p>Footwear</p>	<p>Assess both indoor and outdoor footwear:</p> <p>Type: _____ <input type="checkbox"/> Normal wear <input type="checkbox"/> Abnormal wear <input type="checkbox"/> Causing trauma</p> <p>Type: _____ <input type="checkbox"/> Normal wear <input type="checkbox"/> Abnormal wear <input type="checkbox"/> Causing trauma</p> <p>Type: _____ <input type="checkbox"/> Normal wear <input type="checkbox"/> Abnormal wear <input type="checkbox"/> Causing trauma</p>

	<p>Socks: <input type="checkbox"/> Clean & dry <input type="checkbox"/> Other: _____</p> <p>Orthotics: (pads, lifts, straps, etc.,) Free Text _____</p>
Compression Stockings	<p><input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both</p> <p><input type="checkbox"/> To knee Type: _____</p> <p><input type="checkbox"/> Full leg Type: _____</p> <p><input type="checkbox"/> Other garments: _____</p> <p><input type="checkbox"/> Prescribed: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date (mth/yr) last ordered: _____</p>
Sensation	
<p>Foot</p> <p>Bold and green highlighted findings are normal or usual</p>	<p>Client able to verbally or non-verbally participate in this assessment Y (Yes) N (No)</p> <p>For both right and left, choose all that apply:</p> <p><input type="checkbox"/> No pain day or night</p> <p><input type="checkbox"/> Normal sensation</p> <p><input type="checkbox"/> Ache</p> <p><input type="checkbox"/> Knife-like</p> <p><input type="checkbox"/> Intermittent</p> <p><input type="checkbox"/> Shooting</p> <p><input type="checkbox"/> Continuous</p> <p><input type="checkbox"/> Mild intensity</p> <p><input type="checkbox"/> Moderate to severe intensity</p> <p>Pain Scale 0-10 _____ (if above pain descriptor(s) checked, enter number re level of pain)</p> <p><input type="checkbox"/> Pain during day</p> <p><input type="checkbox"/> Pain at night</p> <p><input type="checkbox"/> Pain at rest</p> <p>Pain relieved: (choose one of the following)</p> <p><input type="checkbox"/> With rest <input type="checkbox"/> When limb up <input type="checkbox"/> When limb down</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Burning</p> <p><input type="checkbox"/> Crawling</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Plantar fasciitis/heel spur(s)</p>
Toes	<p>For both right and left, choose all that apply:</p> <p><input type="checkbox"/> No pain day or night</p> <p><input type="checkbox"/> Normal sensation</p> <p><input type="checkbox"/> Ache</p> <p><input type="checkbox"/> Knife-like</p> <p><input type="checkbox"/> Continuous</p> <p><input type="checkbox"/> Intermittent</p> <p>Pain Scale (0-10) _____ (if above pain descriptor(s) checked, enter number re level of pain)</p> <p><input type="checkbox"/> Pain during day</p> <p><input type="checkbox"/> Pain at night</p> <p><input type="checkbox"/> Pain at rest</p> <p><input type="checkbox"/> Pain relieved: choose one of the following)</p> <p><input type="checkbox"/> With rest <input type="checkbox"/> When limb up <input type="checkbox"/> When limb down</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Burning</p> <p><input type="checkbox"/> Crawling</p>
	<p>For Tuning Fork Vibration Screening: use worksheet to record findings from the test, enter the score for right and left foot _____/_____ (8/8)</p> <p>For Monofilament Testing use worksheet to record findings from the test, enter the score for right and left foot. _____/_____ (10/10)</p>
Signature	<p>Date: _____ Signature including designation: _____</p>

Assessment – Client Health

Medical conditions	<p>Choose all that apply:</p> <p><input type="checkbox"/> Diabetes Mellitus: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2</p> <p><input type="checkbox"/> Elevated blood glucose level: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Elevated A1C: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Neuropathy (sensory, motor, or autonomic): <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> CVA <input type="checkbox"/> MS <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Lower limb condition: <input type="checkbox"/> Venous Insufficiency <input type="checkbox"/> Peripheral artery disease <input type="checkbox"/> Mixed arterial/venous <input type="checkbox"/> Lymphedema <input type="checkbox"/> Lipedema</p> <p><input type="checkbox"/> Impaired oxygenation: <input type="checkbox"/> Chronic obstructive pulmonary disease</p> <p><input type="checkbox"/> Heart failure</p> <p><input type="checkbox"/> Auto-immune disease/immunosuppression: <input type="checkbox"/> Chemotherapy</p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> HIV/AIDs <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Crohn’s Disease</p> <p><input type="checkbox"/> Lupus <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Organ Failure: Kidney disease <input type="checkbox"/> Dialysis <input type="checkbox"/> Liver disease</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Hemorrhagic/bleeding conditions <input type="checkbox"/> Anticoagulation/antiplatelet therapy <input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Hormonal changes: <input type="checkbox"/> Thyroid changes <input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Menopause <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Mental health concerns</p> <p><input type="checkbox"/> Advanced age</p>
Contributing factors:	<p>Choose all that apply:</p> <p><input type="checkbox"/> Sedentary</p> <p><input type="checkbox"/> Occupation (sit/stand long periods)</p> <p><input type="checkbox"/> Smoking <input type="checkbox"/> Substance use</p> <p><input type="checkbox"/> Poor nutrition intake</p> <p><input type="checkbox"/> Body image concern (nails)</p>
Barriers to care:	<p>Choose all that apply:</p> <p><input type="checkbox"/> Cost for treatment</p> <p><input type="checkbox"/> Cost of correctly fitted footwear</p> <p><input type="checkbox"/> Food insecurity</p> <p><input type="checkbox"/> Travel distance to care</p> <p><input type="checkbox"/> Health literacy</p>
Signature	<p>Date: _____ Signature including designation: _____</p>

Management Plan

To be developed at the first assessment and updated whenever a change is needed.

Goals of Care	<p>Choose all that apply:</p> <p><input type="checkbox"/> Nail reduction</p> <p><input type="checkbox"/> Tyloma reduction</p> <p><input type="checkbox"/> Heloma reduction</p> <p><input type="checkbox"/> Verruca reduction</p> <p><input type="checkbox"/> Skin care</p> <p><input type="checkbox"/> Teaching</p> <p><input type="checkbox"/> Other: _____</p>
Referrals	Free text; indicate to reason for the referral and to whom
Care Plan	Free text; write out details of care plan
Frequency of visit	Indicate how often FCN visits to be done
Signature	<p>Date: _____ Signature including designation: _____</p>

