Developed in collaboration with the Wound Care Champions, Wound Care Specialists, Enterostomal Nurses, and South West Regional Wound Care Program (SWRWCP) members from Long Term Care Homes, Hospitals, and South West Community Care Access Centre contracted Community Nursing Agencies in the South West Local Health Integration Network.

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<th>Procedure: University of Texas Staging System for Diabetic Foot Ulcers</th>
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| Background | • Classification systems grade wounds according to the presence and extent of various wound characteristics, i.e. wound size, depth, appearance, etc.\textsuperscript{1}  
• Classification systems can help with the planning and monitoring of interventions and in predicting outcomes, and are also helpful for research and auditing purposes\textsuperscript{1,2}  
• A single diabetic foot ulcer classification system should be used consistently amongst all members of a person’s wound care team, and should be recorded appropriately in medical records\textsuperscript{1}  
• The “University of Texas Staging System for Diabetic Foot Ulcers” is one of the most well-established, commonly used classification systems for diabetic foot ulcers\textsuperscript{3–5}. It was developed in the mid-1990’s based on the shortcomings of the Wagner Classification System  
• Using a matrix of four grades and four stages, the “University of Texas Staging System for Diabetic Foot Ulcers” assesses:  
  o Ulcer depth  
  o Presence of infection  
  o Presence of lower-extremity ischemia  
• This system has been validated and is generally predictive of outcomes, i.e. the higher a diabetic foot ulcer is graded and staged using this system, the higher their risk is for amputation |
| Indications | This procedure is intended to be used by front line registered health care providers, to assist with their assessment and management of individuals admitted with or presenting with a diabetic foot ulcer. |
| Procedure | NOTE: The use of the “University of Texas Staging System for Diabetic Foot Ulcers” is but one part of the holistic assessment of an individual admitted with or presenting with a diabetic foot ulcer. |

**Assessment**

1. Review the person’s medical chart for:  
   a. Any previous diabetic foot ulcer staging documentation  
   b. A completed “Initial Wound Assessment Form” \( \rightarrow \) this form will contain needed information re active infections (i.e. wound infection) and comorbid conditions (i.e. ischemia)  
   c. A completed “Interdisciplinary Diabetic/Neuropathic Foot Assessment Form” \( \rightarrow \) this form will contain needed information re diabetes related complications (i.e. peripheral arterial disease), history of previous diabetic foot ulcers, and quality of lower limb circulation (i.e. ankle-brachial index
results, signs of arterial/venous disease, etc.)

d. Current wound care orders

2. This procedure should be used in conjunction with the “Guideline: The Assessment of People with Diabetic/Neuropathic Foot Ulcers”

### Planning

1. **Expected outcomes:**
   
   a. Information from your assessment allows for the proper staging of the person’s diabetic foot ulcer using the “University of Texas Staging System for Diabetic Foot Ulcers”
   
   b. The person reports minimal discomfort associated with the dressing change and wound assessment
   
   c. Registered nursing staff, in collaboration with other involved health care disciplines and the person with the wound or their substitute decision maker (SDM)/power of attorney for personal care (POA C) (if applicable), are able to use the assessment information, in conjunction with your holistic person and wound assessment, to initiate/modify and implement an appropriate, person-centered, interdisciplinary plan of care which contains clear directions to staff and others who are providing the person with direct care

2. **Explain the dressing change and wound assessment procedure and purpose to the person and/or their SDM/POA C (if applicable) and obtain verbal or implied consent**

3. **Assess the need for pre-procedure pain medication as removal of dressings and/or the dressing change procedure itself can be painful. The person may require pain medication before the dressing change/wound assessment, and if so, they **must** be allotted enough time to allow the drug’s peak effect to take place BEFORE initiating the dressing change/assessment**

### Implementation

1. **Provide for privacy and ensure the person is in a comfortable position to facilitate assessment of the wound**

2. **Wash your hands and attend to the person with your assessment tools and dressing supplies**

3. **If the person is in bed, raise the bed (if you are able to) to an appropriate ergonomic working position to facilitate ease of assessment. Otherwise position yourself in an appropriate ergonomic position to allow for the wound assessment while preventing self-injury**

4. **Ensure adequate lighting**

5. **Don clean disposable gloves, and expose the person’s wound by removing the existing wound dressing as per the manufacturer’s instructions. You may consider the application of gown, goggles, and/or a mask if the risk for spray or splash back exists**

6. **Dispose of soiled dressings in the appropriate receptacle**
7. Remove your gloves and dispose of them in the appropriate receptacle
8. Put on a new pair of clean disposable gloves and cleanse the wound as ordered or as per the “South West Regional Wound Care Program’s Dressing Selection and Cleansing Enabler – HEALABLE” or “South West Regional Wound Care Program’s Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE”, as indicated. Gently pat the wound dry with gauze (if needed)
9. Assess the wound using the “NPUAP PUSH Tool 3.0” (see “Procedure: NPUAP PUSH Tool 3.0”)
10. Assess the ulcer depth (grade) using the “University of Texas Staging System for Diabetic Foot Ulcers”:
   a. If the ulcer is closed, i.e. it is completely covered with epithelium, you have a Grade 0 ulcer
   b. If there is partial or full-thickness loss of the dermis without exposure of tendon, capsule or bone, then you have a Grade 1 ulcer
   c. If there is full thickness tissue loss with visible tendon or capsule but NO visible bone, then you have a Grade 2 ulcer
   d. If there is full thickness tissue loss with visible bone, then you have a Grade 3 ulcer
11. Assess the ulcer for signs of infection and ischemia and stage using the “University of Texas Staging System for Diabetic Foot Ulcers”. **NOTE:** you will require information from the lower limb assessment portion of the “Interdisciplinary Diabetic/Neuropathic Foot Assessment Form” to determine the ulcer stage:
   a. If the ulcer has no signs of infection or ischemia, you have a Stage A ulcer
   b. If the ulcer has signs of infection and NO signs of ischemia, you have a Stage B ulcer
   c. If the ulcer has signs of ischemia and NO signs of infection, you have a Stage C ulcer
   d. If the ulcer has both signs of infection and ischemia, you have a Stage D ulcer
12. Document the ulcer stage and grade in the allocated spots on the “University of Texas Staging System for Diabetic Foot Ulcers” matrix on the “Interdisciplinary Diabetic/Neuropathic Foot Assessment Form”
13. Apply a new dressing as per the person’s medical order or as per the “South West Regional Wound Care Program’s Dressing Selection and Cleansing Enabler – HEALABLE” or “South West Regional Wound Care Program’s Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE”, using clean technique unless otherwise indicated, i.e. unless the wound is considered acute
14. Assist the person to a comfortable position as needed
15. Lower the person’s bed to an appropriate height (if applicable), and ensure the person’s safety, i.e. apply side rails, personal alarms,
restraints, etc. as per the person’s care plan/medical orders
16. Clean reusable equipment/surfaces touched during the procedure
   with warm soapy water or detergent wipes and dry thoroughly to
   prevent cross infection, returning reusable equipment to the
   appropriate places. Dispose of any personal protective equipment
   and soiled dressing supply materials in the appropriate receptacle
17. Remove and dispose of your gloves in the appropriate receptacle and
   wash your hands
18. Discuss your findings and the implications of those findings with the
   person and/or their SDM/POA C, i.e. the higher the grade/stage of the
   person’s diabetic foot ulcer as per the “University of Texas Staging
   System for Diabetic Foot Ulcers”, the greater their risk for amputation
19. Share the results of your assessment with the interdisciplinary
   members of the person’s wound care team
20. Complete documentation as required, i.e. document initial and on-
   going “NPUAP PUSH Tool 3.0” scores on the designated form
   according to your organization’s policy, and document the persons
   “University of Texas Staging System for Diabetic Foot Ulcers” ulcer
   stage/grade in their medical records
21. Utilize the findings of your assessment in conjunction with your
   holistic person and wound assessment, to complete/update and
   implement an interdisciplinary, person-centered plan of care. NOTE:
   The “University of Texas Staging System for Diabetic Foot Ulcers”
   matrix, found on the SWRWCP website
   (www.swrwoundcareprogram.ca), has suggested interventions
   based on the ulcer stage

Evaluation
1. Unexpected Outcomes:
   a. The wound is not staged/graded as per “University of Texas
      Staging System for Diabetic Foot Ulcers” guideline, and/or
      appropriate interventions are not implemented
   b. The person complains of intolerable pain during your wound
      assessment/dressing change

References
1. International best practice guidelines: Wound management in
   www.woundsinternational.com
2. Frykberg RG. Diabetic foot ulcers: pathogenesis and management.
   classification system. The contribution of depth, infection, and
5. Lavery LA, Armstrong DG, Harkless LB. Classification of diabetic foot
| Related Tools (NOTE: these tools and their instructions can be found on the SWRWCP’s website: swrwoundcareprogram.ca) | • University of Texas Staging System for Diabetic Foot Ulcers  
• Initial Wound Assessment Form  
• Interdisciplinary Diabetic/Neuropathic Foot Assessment Form  
• Guideline: The Assessment of People with Diabetic/Neuropathic Foot Ulcers  
• South West Regional Wound Care Program’s Dressing Selection and Cleansing Enabler – HEALABLE  
• South West Regional Wound Care Program’s Dressing Selection and Cleansing Enabler – MAINTENANCE/NON-HEALABLE  
• NPUAP PUSH Tool 3.0  
• Procedure: NPUAP PUSH Tool 3.0 |

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