Nursing Foot Care

Practice Direction

College of Licensed
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Practice directions assist practical nurses in understanding their responsibilities and legal obligations, enabling them to make safe and ethical decisions within their practice. Practical nurses are expected to comply with the information disseminated in practice directions. Failure to do so may result in investigation for misconduct and/or an audit of the nurse's practice.

Purpose

This practice direction provides licensed practical nurses (LPNs), employers, and the public with information about the professional expectations of LPNs who engage in nursing foot care practice in Manitoba.

Scope of Foot Care Practice

Basic Foot Care: The nursing care components of basic foot care do not require formal post-basic education. The competencies needed to carry out basic foot care, including assessment, hygiene, and patient teaching, are entry-level competencies for LPNs in Manitoba.

Toenail cutting is also a component of basic foot care for all clients. However, even if the client is not experiencing any lower leg or foot issues, the mere presence of certain diseases (e.g., diabetes, peripheral vascular disease) increases the risk associated with cutting toenails. LPNs are expected to use their professional judgment as they prepare to cut the toenails of a client with such medical issues. The more the client's lower leg and foot are impacted by disease, the more likely the LPN should possess post-basic foot care competencies to prevent, anticipate or manage any complications which may be associated with cutting toenails.

Post-Basic Nursing Foot Care: Performing post-basic nursing foot care interventions requires: specialized knowledge, skill, and judgment; completion of the CLPNM-approved post-basic education program; and current competence.

Post-basic nursing foot care practice includes:

- assessment of past medical history including, but not limited to, Diabetes Mellitus, Peripheral Vascular Disease, or Peripheral Neuropathy
- assessment of circulation
- assessment of skin integrity, foot, and nail structure
- determining and implementing a plan of nursing foot care that is consistent with recognized standards of practice that may include:
  - hygiene and shortening of toenails for client with, or at high risk for, disease or pathology affecting the lower leg or foot
  - debridement (manual or mechanical) and buffing or reducing of corns and calluses to the level of the dermis that may require the use of a grinder with a sanding disc or drum
  - evaluation of client status and effectiveness of the plan of nursing foot care, and
  - client referral for treatment of a disease or complication and/or corrective footwear devices.

Differences Between Basic and Post-Basic Nursing Foot Care [1]

Basic Foot Care	Post Basic Nursing Foot Care
Knowledge • anatomy and physiology of the feet and lower extremities • common microorganisms of the feet • asepsis and infection control • complications of diabetes and its effect on the feet • education of client and caregiver	**Knowledge** • basic foot care knowledge, and • pathophysiology as it relates to chronic disease and the feet (e.g., diabetes and peripheral vascular disease) • changes in the feet because of chronic disease(s) • best practices in infection control related to cleaning and sterilizing instruments • footwear assessment • the scope of practice of other foot health providers

Skill
• assessing and inspecting of the foot
• performing of non-invasive foot-care procedures:
  • cleansing
  • moisturizing
  • toenail trimming
• educating clients and caregivers
	Skill
	• basic foot care skills, and
	• adhering to the principles, applications, and contraindications of padding and offloading
	• operating of a rotary file
	• performing interventions for the common pathologies of the feet (e.g., corns, calluses, dystrophic nails)

Judgment • making practice decisions based on assessing the client without disease or pathology affecting the lower leg or foot • taking appropriate action when assessment findings are not as expected • documenting and reporting appropriately • taking appropriate action when a client's needs exceed their scope of practice or individual competence, such a referring to another health care provider	**Judgment** • basic foot care judgment, and • making practice decisions based on assessing a client with or at high risk for disease or pathology affecting the lower leg or foot • taking appropriate action when assessment findings are not as expected • documenting and reporting appropriately • taking appropriate action to refer the client to the appropriate foot health care provider

Use of Sharps in Nursing Foot Care

LPNs practising post-basic nursing foot care may encounter clients with lower extremity wounds. While there is an overlap in the components of foot care and wound care, the focus of post-basic nursing foot care is on wound prevention, not wound treatment [2].

In particular, clients with diabetes who develop a foot ulcer must be referred to, and treated promptly by, an interprofessional healthcare team with expertise in treating foot ulcers to prevent recurrent foot ulcers and amputation [3].

The LPN must recognize a situation where the client's needs are outside of their individual scope of practice, experience, or competency level and appropriately seek guidance or refer the client.

The competence needed to perform conservative sharp wound debridement (CSWD), and/or to remove or reduce hyperkeratotic lesions (i.e., corns and calluses) using a scalpel or another sharp instrument, is not taught in the CLPNM-approved post-basic nursing foot care program. Use of sharps in nursing foot care may only be executed by an LPN who has acquired additional education and training in sharps use for CSWD and/or sharp reduction and has submitted proof of successful completion to the CLPNM.

The additional education required to perform CSWD and/or sharp reduction to remove or reduce hyperkeratotic lesions must equip the LPN with the knowledge, skill, and judgment required to perform the procedure and to address and manage any adverse outcomes. Any acceptable education must also include evaluation and confirmation of competence by an experienced, competent and authorized healthcare professional.

Educational Requirements for Post-Basic Nursing Foot Care

LPNs must complete the CLPNM-approved nursing foot care program to practice post-basic nursing foot care in Manitoba. This program equips the LPN with theoretical knowledge and clinical competency in:

- changes in the foot due to age and chronic diseases
- common foot pathology and related nursing interventions
- foot and lower extremity anatomy and physiology
- footwear assessment
- infection control
- nursing assessment of the foot and lower extremity
- structure and function of the foot and nail, and
- use of instruments commonly used in nursing foot care.

Assiniboine Community College (ACC) delivers the only CLPNM-approved nursing foot care program. The ACC program comprises 116 hours of theory and 32 hours of clinical practice. The CLPNM does not approve foot care programs outside of Manitoba.

Proof of Eligibility to Practise Post-Basic Nursing Foot Care

The LPN must arrange for ACC to submit an official transcript to the CLPNM denoting successful completion of the CLPNM-approved foot care education program before they may practise post-basic foot care in Manitoba. The CLPNM will make an internal notation on the LPN's registration, confirming they have attained the necessary education. This information is not displayed on the CLPNM public register but is considered public information and is shared if the CLPNM receives an inquiry.

Barring any other registration related restrictions or conditions, after an LPN has

completed the CLPNM-approved post-basic nursing foot care program and has confirmed that the CLPNM has received the required documentation as outlined above, they are then authorized to practise post-basic nursing foot care. The LPN may provide nursing foot care to clients in multiple settings, including hospitals, personal care homes, community health clinics, and private homes.

The Practice of Post-Basic Nursing Foot Care

Licensed practical nurses provide nursing foot care services within the parameters of their CLPNM approved education, training, and experience, and as per *The Licensed Practical Nurses Act* CCMS L125 (2001), the CLPNM Standards of Practice, the CLPNM Code of Ethics, and any other related CLPNM Practice Direction.

Principles of Infection Control

Foot care devices have been associated with infections and outbreaks; therefore, *each client interaction requires a sterile set of foot care equipment and devices* [4, 5].

LPNs providing nursing foot care are responsible for ensuring that the client is not placed at risk of infection when reusing any foot care equipment/devices during the provision of care [4].

Reprocessing reusable foot care equipment/devices shall meet manufacturers' instructions for use, current national guidelines such as the Canadian Standards Association (CSA), the Public Health Agency of Canada (PHAC/Health Canada), Infection Prevention and Control Canada (IPAC), and regional standards [2, 4-7].

Medical equipment/devices used to provide foot care must be approved or licensed for medical use and designed for humans, specifically, feet (e.g., rotary sanding device and accessories) [4].

Policies and Procedures

Whether an LPN practising foot care is self-employed (i.e., independent practice) or works for an organization, policies, and procedures must provide clear direction on all aspects of nursing foot care. Nursing foot care policies and procedures must also be consistent with the CLPNM Entry-level Competencies, the Nursing Competencies for Licensed Practical Nurses in Manitoba, the Standards of Practice, the Code of Ethics, any other related CLPNM practice direction, and best practice guidelines.

LPNs who practice nursing foot care as employees of an organization must advocate for policies and procedures to guide safe nursing foot care practice and must collaborate with the employer, as needed, to develop policies and procedures.

Examples of foot care policies and procedures include, but are not limited to:

- billing processes
- care planning
- confidentiality of personal health information
- documentation and record retention
- health history and lower limb assessment
- infection prevention & control
- nail splinting
- obtaining informed consent
- reduction of corns & calluses
- referrals

Self-Employment and Nursing Foot Care

LPNs who practice nursing foot care in a self-employed capacity must establish and annually review and revise their policy and procedure documents to reflect current legislation, standards, and best practice guidelines. [10] Self-employed LPNs who employ others must

ensure that their staff has a working knowledge of the policies and procedures.
LPNs who provide post-basic nursing foot care services in a self-employed capacity are also expected to comply with the CLPNM Practice Direction on Self-Employed Practice.

Risks Associated with Post-Basic Nursing Foot Care [11]

The context of practice greatly influences the level of risk involved in providing post-basic foot care. Context of practice determines the appropriate application of LPN practice with the collective consideration of client conditions or factors affecting the status and needs of the client, the abilities and attributes of the individual LPN, and the characteristics and resources of the environment.

The context of practice guides individual decision-making in specific practice settings or situations.

Context of Practice and Levels of Risk in Post-Basic Nursing Foot Care

Lowest Risk

The lowest level of risk in providing post-basic nursing foot care to clients is when the LPN works as an employee and regularly provides nursing foot care services.

- This might be in a personal care home or community health centre, or any area where an authorized professional qualified to diagnose and prescribe treatment (physician, podiatrist, nurse practitioner) is readily available for consultation.
- In these settings, the LPN is employed by the agency or facility. There is often regular oversight of the LPN's practice by a manager, and other healthcare professionals who provide care to the client are present for collaboration and referral.
- There are employer policies and procedures related to foot care services. While collaboration and client-centered care is expected, these policies and procedures are the employer's responsibility, not the individual LPN.
- The employer is responsible for putting in place policies and physical, technical, and administrative security safeguards that are necessary to protect client confidentiality. The LPN is responsible for following health record creation, retention, confidentiality, and security policies that the employer establishes.
- The employer is likely to carry liability insurance that provides some degree of coverage for their staff, in addition to the liability insurance the LPN holds as an individual practitioner.
- The risk of infection transmission is more easily managed when the employer provides access to equipment and facilities necessary to adhere to infection prevention and control regulations.

Moderate Risk

When the environment shifts into a practice setting with increasing independence, the risks shift to a more moderate level.

- The LPN might provide post-basic foot care services as an employee of a home care program or be employed by another regulated nurse operating nursing care services. In these scenarios, the LPN's supervisor/manager may not directly oversee the LPN's practice.
- There may be no manager or interprofessional team immediately available to the LPN for guidance and support.
- The risk of infection transmission may be more difficult for the LPN to manage, as the LPN may have more difficulty accessing the equipment and facilities necessary to adhere to infection prevention and control regulations.

Highest Risk

The most significant risks exist in providing post basic foot care as a solo and/or self-employed practitioner.

- If the LPN receives payment for services directly from a client (or another payee), the LPN is self-employed. All the risks normally managed by the employer, in the low and moderate risk scenarios above, now become the responsibility of the LPN who is self-employed. In these conditions, there can often be significant additional responsibilities and risks.
- The LPN is solely responsible for equipment management, infection control, obtaining informed consent, liability coverage and risk mitigation, referral practices, and for developing and implementing policies to guide their practice.
- Services are often provided via a mobile service model and in inconsistent and uncontrolled environments.
- Patients may be less able to assess the quality of services they receive.
- Referral resources may be limited.
- LPNs are responsible for maintaining a transparent fee schedule and accurate records.
- The LPN is responsible for the creation and maintenance of a health record system, and for maintaining its security and confidentiality.
- There is no manager or team available for consultation therefore the LPN must establish their own network for support and guidance to improve the quality of their practice.
- There is no manager to recommend or arrange access to education and training that may assist the LPN in keeping their skills up to date.

As the risk level associated with the LPN's practice context increases, the LPN requires a higher level of individual competence and resources to appropriately manage the risks. Whether services are provided in self-employed or an employer/employee model, all LPNs are accountable for providing safe, ethical, and competent care, and are accountable for their practice and their decisions.

Titles and Abbreviations

The CLPNM does not authorize the use of titles, signatures, or abbreviations that convey that an LPN has attained a specialized foot care credential either directly or by implication. This includes, but is not limited to, the use of:

- the term *certified* concerning nursing foot care, such as the title *Certified Foot Care Nurse*
- any abbreviation that implies certification in nursing foot care, such as *CFCN*
- the title foot care nurse as part of the nurse's signature, or
- any abbreviation that implies a specialized foot care credential or designation, including but not limited to the abbreviation *FCN*.

Using such titles and abbreviations provides the impression that a formal foot care credential has been conferred or that a higher level of academic certification was achieved. Therefore, it may mislead the public.

For clarity, it is acceptable, when describing the nurse's practice, to identify that the nurse practices *nursing foot care* or that the nurse is a *foot care nurse*, just as it is appropriate for a nurse working in primary care to identify themselves as a *primary care nurse*. Such descriptions provide information about the nurse's area of practice. When not used in conjunction with *certified* or as part of the nurse's signature, they do not imply a professional designation. It is also acceptable for a nurse who has done so to communicate that they have completed Assiniboine Community College's Nursing Foot Care program.

Professional Development and Continuing Competence

To maintain competence, LPNs who practise post-basic nursing footcare are responsible for practising regularly and for completing at least one learning plan related to their nursing footcare practice each year in connection with CLPNM's Continuing Competence Program. Refer to the CLPNM's Practice Direction on the Continuing Competence Program for more information.

In addition, LPNs who practice nursing foot care in a self-employed capacity must also ensure that they meet all requirements in the CLPNM's Practice Direction on Self-Employed Practice, including the requirement to practise a minimum of 250 hours of foot care, per year, to maintain their competence, as a requirement of ongoing registration.

LPNs who take a short period of time away from their nursing foot care practice must, prior to their returning to nursing foot care practice conduct a self-assessment, identify any gaps in their knowledge, skill, and judgment, and develop and implement a plan to restore their competence before resuming foot care practice. In these circumstances, to restore competence, the LPN may need to undertake learning activities beyond completing the learning plans required for the CCP. As an example, the LPN might request to shadow or to be mentored by another nurse, for a period of time, who practises nursing foot care.

LPNs must recognize that taking long periods away from nursing foot care practice may lead to competence gaps that can only be addressed by undertaking the CLPNM-approved Nursing Foot Care program anew. LPNs are expected to

demonstrate insight and prudent judgement when assessing their own competence.

Post-basic nursing foot care is practised with a high degree of independence. LPNs practising post-basic nursing foot care must critically appraise their own nursing foot care practice to identify opportunities to enhance their knowledge, skill, and judgment. This includes engaging with colleagues and peers in providing and obtaining mutual mentoring and support to improve the quality of practice. Nurses practising foot care are also expected to use current knowledge and evidence-informed clinical practice standards and guidelines.

Recommended topics to remain up to date on related to nursing foot care include, but are not limited to:

- chronic disease management including diabetes management
- footwear assessment
- infection control
- preventative healthcare
- health record, storage, retrieval, and security, and
- cultural competence and health equity.

For More Information

Visit our website at www.clpnm.ca for more information and resources.

Contact us with questions at
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About the CLPNM

The CLPNM is the governing body for the licensed practical nursing profession in Manitoba. Mandated to govern its members in a manner that serves and protects the public interest, the CLPNM establishes practice requirements for the provision of safe and effective nursing care.

Resources

Resources relevant to nursing foot care and LPN practice in Manitoba, include:

CLPNM Resources

Entry-Level Competencies for the Licensed Practical Nurse in Manitoba

Nursing Competencies for Licensed Practical Nurses in Manitoba

Determining Appropriate LPN Practice: A Guide to Decision-Making

CLPNM Code of Ethics

CLPNM Standards of Practice

CLPNM Practice Direction - Interprofessional Collaborative Care

CLPNM Practice Direction – Self-Employed Practice

These resources can be accessed from the CLPNM website at: https://clpnm.ca/for-registrants/practice-supports/practice-directions-and-guidance/

Education and Practice Resources

Assiniboine Community College - Continuing Studies https://assiniboine.net/programs/cs

Canadian Association of Foot Care Nurses https://cafcn.ca/

Diabetes Canada – Clinical Practice Guidelines http://guidelines.diabetes.ca/cpg

Infection Prevention and Control Canada (IPAC) - Guidelines & Standards
https://ipac-canada.org/evidence-based-guidelines.php

Manitoba Association of Foot Care Nurses
https://mafcn.ca/

Wounds Canada – Best Practice Guidelines
http://www.woundscanada.ca/bprs

References

The following documents were consulted during the development of this practice direction.

1. College of Licensed Practical Nurses of Prince Edward Island. *Practice directive: Foot care*. 2019; https://clpnpei.ca/wp-content/uploads/2019/11/Practice-Directive-Foot-Care-February-2019.pdf.

2. Gallagher, D., *The certified foot care nurse and the importance of comprehensive foot assessments.* J Wound Ostomy Continence Nurs, 2012. 39(2): p. 194-6.

3. Embil, J.M., et al., *Foot Care.* Canadian Journal of Diabetes, 2018. 42: p. S222–S227.

4. Infection Prevention and Control Canada. *Reprocessing of critical foot care devices (Position statement)*. 2019; https://ipac-canada.org/photos/custom/Members/pdf/Position%20Statement%20%20_ReprocessingCriticalFootCare_RevisedJuly2019.pdf.

5. Centers for Disease Control and Prevention, *Healthcare-associated hepatitis b and c outbreaks (≥ 2 cases) reported to the centers for disease control and prevention (CDC) 2008-2017* 2018: Atlanta, GA.

6. Winnipeg Regional Health Authority, *Nursing foot care infection prevention & control management in community health services (Policy #90.00.020)*. 2013: Winnipeg, MB.

7. Canadian Standards Association, *Canadian medical device reprocessing (CAN/CSA-Z314-18)*. 2018: Toronto, ON.

8. College of Podiatrists of Manitoba. *Standard 4: Infection control guidelines*. 2007; https://www.copom.org/legislation/Infection%20Control%20Guidelines.pdf.

9. Public Health Agency of Canada, *Infection control guidelines: Foot care by health care providers.* Canadian Communicable Disease Report, 1997. 23S8 (Supplement): p. 2-iii - 2-6.

10. Canadian Association of Foot Care Nurses. *National competencies for advanced nursing foot care in Canada*. 2017; https://cafcn.ca/wp-content/uploads/CAFCN-National-Competencies-for-Advanced-Nursing-Foot-Care.pdf.

11. Saskatchewan Association of Licensed Practical Nurses. *Practice guideline: Basic foot care and advanced foot care*. 2020; https://salpn.com/wp-content/uploads/Foot-Care-2021.pdf.