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Review

Canadian Patient Perspectives on Facilitators and Barriers to Diabetic Foot Ulcer Care: A Scoping Review

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Key Messages

- Patients and caregivers experience barriers to diabetic foot ulcer care, such as referral delays, limited education, emotional distress, and systemic gaps.
- Facilitators to diabetic foot ulcer care include education, peer support, access to offloading devices, and community programs supporting self-management.
- Improved outcomes require education, interdisciplinary, and culturally safe care, and national strategies for underserved populations.

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ABSTRACT

Our aim in this study was to review Canadian patient and caregiver perspectives on the facilitators and barriers to diabetic foot ulcer (DFU) care. We conducted a scoping review in collaboration with a patient partner, following the PRISMA-ScR guidelines. Grey literature and primary studies from MEDLINE, CINAHL and Embase were searched from inception to February 2024. Studies of adults with active or healed DFUs and their caregivers were included. Data were independently screened and extracted by 2 reviewers and key themes were synthesized collaboratively. Twenty-two studies representing 400 patients or caregivers were included, with most individuals living in Ontario (n=15 articles, 68.1%). Five overarching themes capturing facilitators and barriers to DFU care were identified: Prevention, Access to Care, Patient Education, Wound Care, and Patient Impact. Reported barriers included emotional distress, limited mobility, low awareness of self-management strategies, and delayed referrals, while key facilitators involved caregiver and community support as well as education from health care providers. Canadian diabetic foot screening and DFU treatment (preservation) programs should focus on improving access, empowering patients through education, and leveraging community support partners to promote self-management and amputation prevention.

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Mots-clés:
Pied diabétique
ulcère du pied
dépistage du pied
participation des patients
préservation des membres
prévention des amputations

R É S U M É

Objectif : Passer en revue les points de vue des patients et des proches aidants canadiens sur les facteurs favorables et les obstacles aux soins des ulcères du pied diabétique (UPD).
Méthodologie : Nous avons mené une revue exploratoire en collaboration avec un patient partenaire, conformément aux lignes directrices PRISMA-ScR (*Preferred Reporting Items for Systematic Reviews*). La littérature grise et les études primaires issues des bases de données Medline, CINAHL et EMBASE ont fait l'objet d'une recherche couvrant la période allant de leur date de création jusqu'en février 2024. Les études portant sur des adultes présentant des UPD actives ou cicatrisées et leurs proches aidants ont été incluses. Les données ont été examinées et extraites de manière indépendante par deux évaluateurs, et les thèmes clés ont été synthétisés de manière collaborative.
Résultats : Vingt-deux études représentant 400 patients ou aidants ont été incluses, la plupart des personnes vivant en Ontario (n = 15 articles, 68,1 %). Cinq thèmes généraux reflétant les facteurs favorables et les obstacles aux soins des UPD ont été identifiés et comprenant : prévention, accès aux soins, éducation des patients, soins des plaies et impact sur les patients. Parmi les obstacles rapportés figuraient la détresse émotionnelle, la mobilité réduite, la faible connaissance des stratégies d'autogestion et les retards dans l'orientation vers des spécialistes, tandis que les principaux facteurs favorables comprenaient le soutien des aidants et de la communauté ainsi que l'éducation dispensée par les professionnels de santé.
Conclusions : Les programmes canadiens de dépistage du pied diabétique et de traitement (préservation) des UPD devraient se concentrer sur l'amélioration de l'accès aux soins, l'autonomisation des patients par l'éducation et la mobilisation des partenaires communautaire de soutien afin de promouvoir l'autogestion et la prévention des amputations.
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Introduction

Over their lifetime, up to 34% of individuals living with diabetes risk developing a diabetic foot ulcer (DFU) and facing lower extremity amputation. DFUs are the result of multiple factors. Biologic and comorbidity-related factors include diminished protective sensation from peripheral neuropathy, foot deformities, and impaired wound healing attributable to peripheral arterial disease [1]. These intersect with health system capacity gaps, such as lack of regular foot screening and delays in guideline-aligned wound care, which collectively contribute to amputation risk [2].

DFU care can be considered in 2 phases. First, prevention of new or recurrent DFUs (i.e. comprehensive foot screening) requires periodic foot examination, footwear assessment, treatment of high-risk features (i.e. callus debridement), and patient education. Second, DFU healing to prevent amputation (i.e. limb preservation) requires interdisciplinary care that addresses arterial insufficiency, infection, wound dressings, debridement, and offloading, as well considers contributory social determinants of health [3,4].

Improving Canadian care pathways for DFU care is an urgent need [5], yet major gaps persist between best and actual practice [2]. Underrecognition of patient voices and lack of patient involvement in chronic disease pathway development may be hindering DFU care quality improvement [2,3]. Studies have collected quantitative Canadian data on risk factors for amputation among patients with diabetes [6], yet no study has synthesized Canadian patient and caregiver perspectives on barriers and facilitators to DFU care and amputation prevention. This review addresses that gap to inform patient-centred foot screening and limb preservation initiatives across Canada.

Methods

We conducted a scoping review adhering to the Preferred Reporting Items for Systematic Reviews (PRISMA) Extension for Scoping Review (PRISMA-ScR) and Guidance for Reporting Involvement of Patients and the Public Checklists (GRIPP2; Supplementary Table 1) [7,8]. A patient partner (T.W.) contributed to protocol development, thematic synthesis, results interpretation, and manuscript review to ensure patient-centred framing. Inclusion and exclusion criteria were structured using the following framework:

Population: Adults with type 1 or 2 diabetes in Canada, with active or prior DFUs (defined according to the International Working Group on the Diabetic Foot [IWGDF] [9]), and caregivers (any non–health care individuals assisting these patients).

Intervention: Any form of DFU care, defined *a priori* to include preventive strategies for new or recurrent DFUs (i.e. comprehensive foot screening and risk reduction activities such as callus debridement, footwear assessment, and patient education) or treatment of active DFUs (i.e. wound management and limb preservation measures such as debridement, offloading, etc) was considered eligible.

Comparator: Not applicable.

Outcomes: Qualitative or narrative perspectives (via interview or focus groups) on the facilitators and barriers to DFU care.

Studies with quantitative survey/questionnaire data without any narrative or qualitative findings were excluded. All primary studies, reviews, case reports, and grey literature (i.e. government report, health technology assessments [HTAs]), from 1946 to February 27, 2024, were included if they contained direct patient or caregiver perspectives (verbatim quotations, open-ended survey responses, case narratives, or documented patient/stakeholder consultation). Eligible sources were written in English and drew from any health care setting.

The search strategy was developed with a clinical librarian and run through MEDLINE, Embase (all via the OVID

platform), and CINAHL electronic databases, which collectively capture clinical, allied health, and nursing literature relevant to diabetic foot care. Grey literature was retrieved via Overton and reference hand-searching (Supplementary Tables 2, 3, and 4).

Two independent reviewers (S.F. and R.P.) screened the titles, abstracts, and full texts. Discrepancies were resolved by discussion and input from the principal investigator (C.d.M.). Data were extracted using a standardized form that included publication details, setting, study design, sample size, patient demographics (age, sex, amputation status, Indigenous status), and patient perspectives categorized by Health Quality Ontario (HQO) DFU quality statements. The HQO is a set of 12 measurable statements developed by consensus of clinicians and people with lived experience, which guide the expectations for comprehensive DFU care in Ontario (risk assessment, education, specialist referral, vascular/infection management, offloading and wound care, and care transitions) across care settings (Supplementary Table 5) [5]. Additional categories were added for impact on mental health, finances, and activity levels.

A mixed inductive–deductive thematic synthesis was completed. Team members' clinical, methodologic, and lived-experience perspectives were discussed throughout the analysis to support reflexivity. We first extracted original authors' interpretations, labelled themes, and participant quotations where available. Two reviewers (S.F. and R.P.) then independently open-coded these extracts, all of which were double-checked for consistency, with discrepancies resolved in consensus team meetings. Coding and extraction were managed with Microsoft Excel, and an audit trail documenting coding decisions was maintained. The HQO statements were used as a prespecified deductive framework where relevant; data not captured by the framework underwent open inductive coding to generate higher order categories. For practical relevance, we attempted to map inductive categories

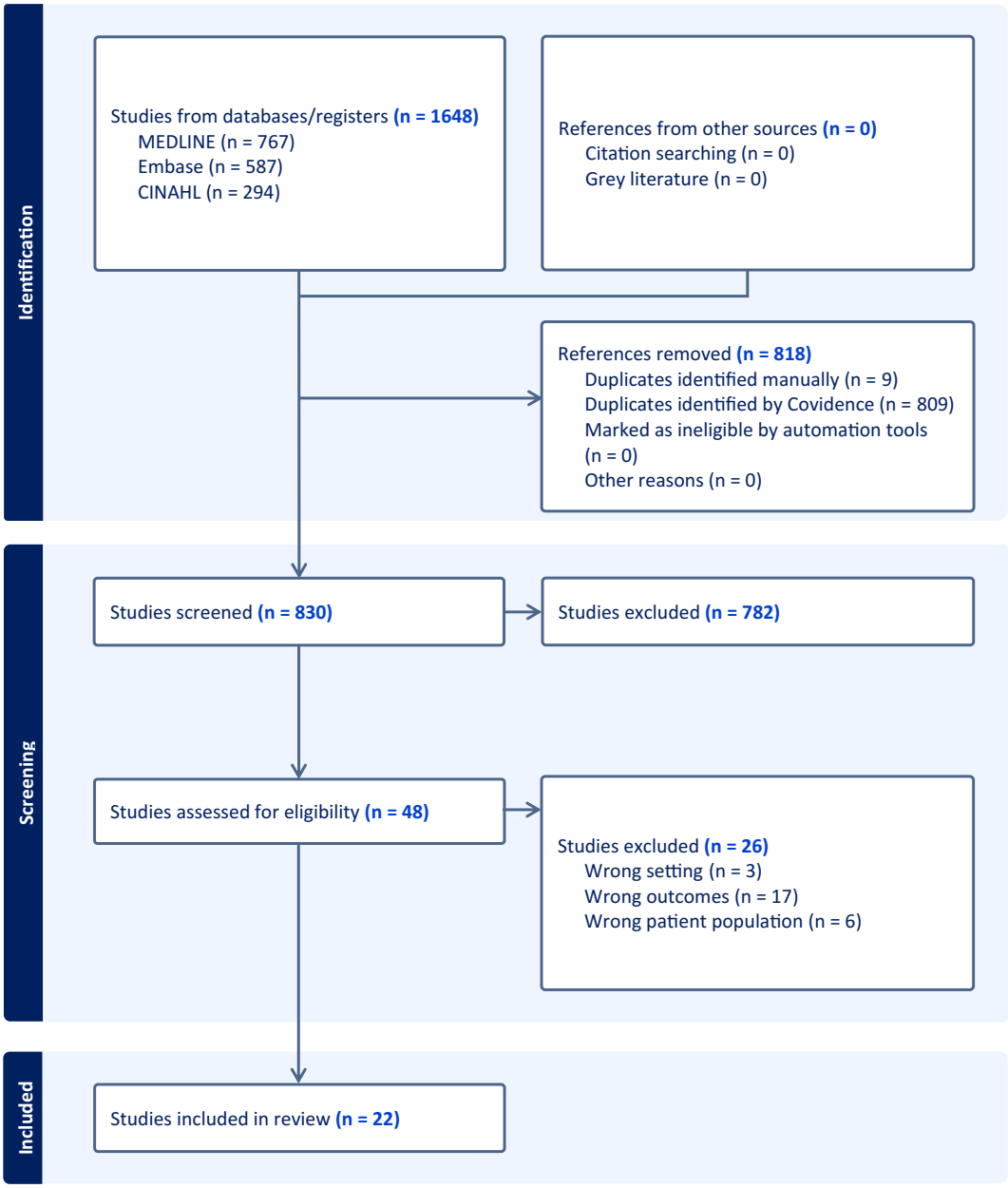


Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram summarizing inclusion and exclusion of studies.

Table 1
Characteristics of included literature

Ref no.	Article information							Patient demographics			
	Author group	Year	Location	Design	Primary question/aim	Study qualitative method/framework	Sample size	Mean/median age (years)	Sex (% female)	Previous amputation (%)	Population subgroup (if applicable)
[21]	Adams et al	2014	Southwestern Ontario	Qualitative case study	Understand the process of creating and operating a community-based interprofessional team for DFU care and the factors that support or hinder team formation	Serial semistructured interviews with team members (3 time-points) and brief patient interviews; qualitative/case analytic approach	9	N/R	N/R	N/R	N/R
[10]	Blanchette et al	2023	Canada	Scoping review	Map the literature on diabetes-related foot complications among Indigenous peoples in Canada	Not a primary qualitative study, but synthesizes qualitative and mixed-methods evidence using narrative/thematic synthesis; includes critical appraisal and Indigenous stakeholder consultation	N/R	N/R	N/R	>0 *	Indigenous peoples
[22]	Boodoo et al	2017	Toronto	Qualitative, interview-based study	To explore views of individuals with DFU about technology and mHealth for DFU monitoring and prevention	Face-to-face semistructured interviews; inductive thematic analysis; coding done by 2 researchers; used Dedoose software	8	53.5	28.6	N/R	N/R
[18]	Bryce and Surkhab Peerzada	2013	Toronto	Case report	Narrative/case description of an individual's journey with diabetes-related foot complications	Theoretical framing N/R; personal narrative/case description (patient voice/experience)	1	N/R	0	0	N/R
[23] *	Costa et al	2023	Southeast Ontario	Constructivist grounded-theory study	To examine processes of engagement in information-seeking behaviours among individuals with DFU	Primary qualitative study with iterative grounded-theory analytic procedures	30	<65 (12 participants), >65 (18 participants)	33	20	N/R
[24] *	Costa et al	2023	Southeast Ontario	Constructivist grounded-theory study	To identify and explore the impact of DFU on individuals' lives and daily routines	Semistructured interviews; social constructivism and symbolic interactionism reported; qualitative thematic/constructivist analysis	30	<65 (12 participants), >65 (18 participants)	33	20	N/R
[25] *	Costa et al	2022	Southeast Ontario	Constructivist grounded-theory study	To identify/explore the meaning of "diabetes" for people who develop a DFU	Data collected via one-to-one semistructured interviews; constructivist/interpretive thematic analysis (social-constructivist/symbolic interactionism lens)	30	<65 (12 participants), >65 (18 participants)	33	20	N/R
[26] *	Costa et al	2018	Southeast Ontario	Constructivist grounded-theory study	To identify patients' perceptions of their role in managing their DFU (degree of ownership/leadership in self-care	Reporting findings from the larger Costa qualitative program; based on semistructured interviews and analyzed using constructivist/interpretive approaches	30	<65 (12 participants), >65 (18 participants)	33	20	N/R
[27] *	Costa et al	2022	Southeastern Ontario	Constructivist grounded-theory study	To understand patients' reasons for delayed help-seeking at DFU onset	One-to-one semistructured interviews, purposive/theoretical sampling, iterative coding, and constant comparative analysis	30	<65 (12 participants), >65 (18 participants)	33	20	N/R
[28] *	Costa et al	2021	Southeastern Ontario	Constructivist grounded-theory study	How do patients progress through a "journey to engagement" toward active self-management of a DFU (what phases/processes explain engagement)?	Semistructured interviews, iterative memoing and theoretical sampling to develop a phased explanatory model	30	<65 (13 participants), >65 (17 participants)	33	0	N/R
[29] *	Costa et al	2020	Ontario	Constructivist grounded-theory study	To understand how do socioeconomic factors (cost, insurance, income) influence engagement with DFU self-management and access to offloading devices	Semistructured interviews; iterative inductive coding	30	<65 (13 participants), >65 (17 participants)	33	N/R	N/R
[30]	Goodridge	2004	Winnipeg, Manitoba	Cross-sectional, comparative design	Examining how does HRQoL differ between adults with current vs healed DFUs	Structured questionnaires and interviews; quantitative comparisons of HRQoL supplemented by qualitative interview material described in thesis form (not a primary qualitative study)	104	63.9	31.7	0	N/R

[15]	Health Quality Ontario	2017	Ontario	HTA	Evaluate clinical benefits/harms, cost-effectiveness, and budget impact of fibreglass total contact casting, removable cast walkers, and irremovable cast walkers for diabetic neuropathic foot ulcers; also to collect patient experience data	Patient interviews were included; used an inductive/modified grounded-theory approach for analyzing interview transcripts and used NVivo for coding	16	N/R	N/R	N/R	N/R
[16]	Health Quality Ontario	2017	Ontario	HTA	Assess the safety, clinical effectiveness, and cost-effectiveness of standard wound care plus HBOT vs standard wound care alone for DFU; also to investigate patients' preferences, perspectives, and lived experience of HBOT	Purposive sampling for patient recruitment, performed phone/in-person interviews and an anonymous online survey to capture lived experience, and analyzed interview transcripts and survey responses using a modified grounded-theory/inductive constant-comparative approach	21	N/R	N/R	N/R	N/R
[17]	Kabali et al	2021	Ontario	HTA	Assess clinical effectiveness, harms, cost-effectiveness, budget impact, and patient experiences/preferences for skin substitutes used to treat DFU and venous leg ulcers	For the qualitative component the HTA team selected a modified grounded-theory approach and used NVivo for coding (patient interview transcripts)	2 †	N/R	N/R	>0 ‡	N/R
[20]	Kong et al	2021	Montreal, Québec	Case report	Describe management of chronic DFU using a remote wound-care smartphone app and experience implications	Single patient report with narrative reflections	1	57	Male	100	N/R
[12]	Kuhnke et al	2014	10 Canadian provinces	Descriptive qualitative study	What are peer leaders' perspectives on the value, implementation challenges, and community impact of a peer-led limb-preservation/education program?	Peer-leader interviews and program documents; descriptive thematic reporting	12	N/R	N/R	N/R	Indigenous peoples
[11]	McIntyre et al	2007	Manitoba	Retrospective and prospective cohort study with narrative material	Prevalence/clinical features of foot and ankle problems among Aboriginal/non-Aboriginal patients with diabetes receiving hemodialysis; explore access/service differences	Not a primary qualitative study but includes descriptive patient-level summaries	127	59	43	27	Indigenous peoples, hemodialysis patients
[14]	Meatherall et al	2005	Manitoba and northwestern Ontario	Descriptive/mixed-methods study (questionnaire and hospital medical record review)	To understand the disability and quality of life profile in Canadian Aboriginal non-Aboriginal patients with diabetes and lower extremity amputations	Not a primary qualitative study, but a qualitative analysis of responses to 5 open-ended, non-cued questions was done; categorized and analyzed content of narratives describing each participant's experience; principal themes were identified, and axial coding was used to identify additional themes	44	64	24	100	First Nations (North American Indians) and Métis peoples
[19]	Raizman and Gavish	2020	Scarborough, Ontario	Case series	Outcomes and feasibility/acceptability of an at-home self-applied photobiomodulation device for DFU	Clinical case descriptions with author and patient reflections; not a formal qualitative framework	4	72.5	0	25	N/R
[31]	Stevens et al	2021	Newfoundland and Labrador	Interpretive description	Patient, support-person, and HCP perspectives on personal challenges to foot self-management for adults with diabetes	Semistructured interviews with multiple stakeholder groups (patients, supporters, HCPs); thematic/interpretive descriptive analytic approach	11	64.6	54.5	N/R	N/R
[13]	Wees et al	2023	Saskatchewan	Community participatory research design	To understand barriers to preventive diabetic foot care in First Nations communities and identify community-driven solutions	Focus groups/interviews with community members and stakeholders; participatory analysis with Indigenous engagement and co-interpretation	10	>45	44	N/R	First Nations peoples

DFU, diabetic foot ulcer; *HBOT*, hyperbaric oxygen therapy; *HCP*, health care provider; *HRQoL*, health-related quality of life; *HTA*, health technology assessment; *N/R*, not reported.

* Multiple Costa et al studies [23–29] derive from the same/similar primary sample (n=30) recruited from a southeastern Ontario wound clinic; these articles are retained separately because each presents a distinct research question and analytic focus (i.e. information-seeking, daily routine impact, meaning of diabetes, socioeconomic barriers, delay to help-seeking, journey to engagement, or role perception). The participants were *not* double counted in our overall synthesis.

† Exact number of caregivers not provided.

‡ Exact number of patients with amputations not provided.

back to the HQO framework where applicable. Through team deliberation, including T.W. (patient partner), codes were iteratively regrouped *post hoc* into 5 overarching themes, enhancing clarity and real-world applicability (Supplementary Table 5).

Results

Study selection and characteristics

A total of 1,648 records were identified through a systematic search; 830 records were screened after duplicate removal, of which 22 studies met the inclusion criteria (Figure 1). Together, they represented 400 patients and caregivers, with mean ages of 53.5 to 72.5 years.

Included studies were published between 2004 and 2023, with 17 of the 22 (77.3%) being published after 2017. Ontario was the most common location (15 of 22, 68.2%), followed by Manitoba (3 of 22, 13.6%) and pan-Canadian studies (2 of 22, 9.1%). One study originated from Québec and 1 from Newfoundland and Labrador. Five studies (22.7%) specifically included Indigenous peoples [10–14]. Study designs included HTAs [15–17], case studies or series [18–20], qualitative interviews [12,14,21–31], a scoping review [10], a cohort study [11], and a focus group study [13].

Thirteen studies (59.1%) included patients with previous amputations [10,11,14,17,19,20,23–29], although exact counts were inconsistently reported. Full study characteristics are presented in Table 1.

Thematic synthesis

The synthesis identified 5 key themes that capture the barriers and facilitators to DFU care (Figure 2):

1. *Prevention*—Pre-DFU care.
2. *Access to Care*—Support patients with DFUs receive from health care providers (HCPs).
3. *Patient Education*—Understanding the disease and self-management.
4. *Wound Care*—Correct and consistent wound-cleaning and offloading.
5. *Patients*—Emotional, mental, and financial burdens, plus activity participation.

Key facilitators and barriers for each theme, along with illustrative patient and caregiver quotations, are summarized in Table 2.

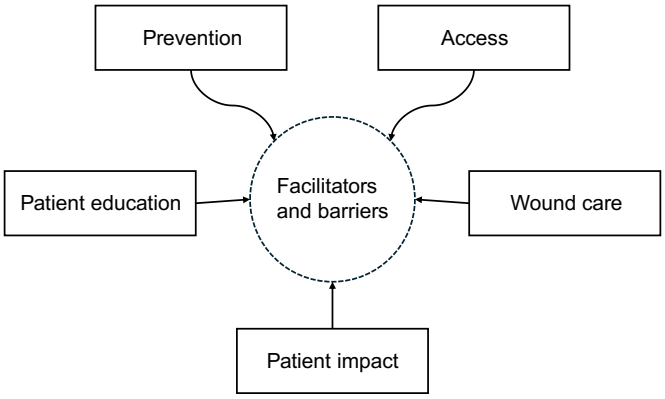


Figure 2. Five themes derived from postextraction data synthesis categorizing facilitators and barriers to care of diabetic foot ulcer.

Prevention

Prevention-related findings appeared in 10 articles (5 identified facilitators, 7 identified barriers). Facilitators included patient understanding that wounds can lead to amputations, which motivated more regular surveillance and earlier presentation [12,28], along with caregiver support [29] and use of smartphone applications that increased connectedness and early reporting of changes [20].

Barriers included nonadherence to diabetes medications, missed wound surveillance, and failure to make lifestyle changes [18,22,23,25,27,29]. Limited education regarding the natural history of DFUs led several participants to underestimate the early foot changes and delayed help-seeking [23,27,29]. Several participants expressed feelings of helplessness regarding living with diabetes, viewing the diagnosis and its complications as inevitable [23,25]; this outlook reduced motivation to engage in preventive behaviours. Finally, comorbidities such as limited mobility or visual deficits limited self-monitoring ability, and at times made clinic attendance more difficult, creating a practical pathway from functional limitation to delayed detection and presentation [22,29].

Access

Access was discussed in 11 articles (8 identified facilitators, 7 identified barriers). Facilitators included coordinated multidisciplinary teams [21], positive educational interactions with HCPs [13,31], timely referrals to wound-care services [28–30], and involvement in volunteer-led diabetic foot care workshops (i.e. the Ontario-based “Diabetes, Healthy Feet, and You,” formerly PEP Talk) [12].

Barriers included delayed, administratively complicated, or incomplete referrals; participants described repeated referral forms, unanswered referral requests, and the need to involve a friend or clinician advocate to have a referral processed. They also reported having no regular family physician and long specialist waitlists, which further created practical delays [17,27–29]. Other barriers included self-treatment of DFUs delaying timely care [28] and differing provider approach (i.e. treating DFUs as cellulitis or with trial-and-error wound care) [27]. Geographic distance and limited home-care services compounded process barriers, especially for Indigenous patients [11,14,29].

Patient education

Education and self-management were discussed in 15 included articles (10 identified facilitators, 11 identified barriers). Facilitators included patients’ knowledge of DFU wound-care principles [15,28], learning from HCPs [11,29,31], family, and peer-led workshops [12,18,23]. Patients’ confidence in performing wound care improved self-efficacy and supported continued engagement in management tasks [26,28].

Identified barriers included limited knowledge on DFU treatment options [17] and unclear or vague HCP guidance translated into concrete uncertainties for patients about how often to change dressings, when to seek escalation, and how to apply and use offloading devices; authors reported that this uncertainty undermined patients’ confidence and adherence to wound-care routines [13,15,16,23,25–27,29,31]. In some samples, patients also reported unfamiliarity with smartphone monitoring applications, posing a barrier in the adoption of such technologies for diabetic foot surveillance [22].

Table 2
Key findings and illustrative quotations on facilitators and barriers to DFU care, organized by 5 identified themes

Theme		Key findings and illustrative quotes	Subgroup
Patient Education		"I would read online or I'd type in diabetes, or symptoms, or things like that." [23]	Patients—urban
		"I have cousins who have been diabetic for a long time and type 2 as well so we chatted a bit … She was a good resource. I could call her…" [23]	
	Barriers	"I didn't know [skin substitutes were] an available option. I knew that there had been research … I didn't think [they were] publicly accessible." [17]	Patients/caregivers—urban
		"Through my diabetic education, they don't mention ulcers." [27]	Patients—urban
		"Not much more than take care of your feet. It was a very simple instruction …" [27]	
		"Nothing else, in the diabetes class they just said, 'Watch what you eat.' That was about it. As I say, I haven't seen a dietitian in years." [23]	
Prevention	Facilitators	"Well, for one thing, you have to be self-aware. If you think for one second that you've got a sore on the bottom of your foot, don't wait 'til it breaks out, go and have it looked at now … when you do have a sore, be aware of what it looks like." [28]	Patients—urban
	Barriers	Concept that the lack of adherence to medication and exercise programs led to development of DFUs. [19]	Patients—urban
		"Life tends to get in the way." [19]	
		"Diet, exercise, sleep, drinking, all of that other stuff, and controlling blood sugar. The best way to put it is, when I was first diagnosed, I didn't get much information and I made a lot of the mistakes just simply through ignorance." [29]	
Access	Facilitators	"They emphasized there were ten members of the [interprofessional] team, and I was one of them ... Everyone knew their specialty, and they all worked together ... It's great." [21]	Patients—urban
		"Most participants were receptive to the idea of being able to communicate with and send physiological readings to their HCP via a mobile phone app. Specifically, they liked the idea of being able to send images of their feet or DFU and receiving an alert of its status." [22]	
		"A common pattern was that patients and support persons valued positive communication with their HCP. One patient talked about being able to call or e-mail their diabetes educator." [31]	Patients/caregivers—urban/rural
	Barriers	"[The physician] filled out a form … I waited and didn't get a response. There's no contact information. I called a central line. They didn't process the form, and then I was sent another form. And then it got to the point where I had to get a friend who was a GP [general practitioner] to call … That was another set of paperwork." [17]	Patients/caregivers—urban
		"And it's kind of hard to find someone to drive you to Regina for $57 with the cost of gas." [13]	Patient—Indigenous
Wound Care	Facilitators	"If I watch how they prepare the bandage, I can prepare it the same way." [28]	Patient—urban
	Barriers	"I didn't perceive it as a really big problem. You know, it's a, um—you know, it was tiny then, tiny little black spot. I was … Eh, it was gonna heal sometime." [27]	Patients—urban
		Some participants felt unable to perform advanced wound care tasks like packing a wound and needed assistance.	
		"If it was just an Iodine I could put that on myself. But if it was a packing I didn't feel comfortable packing it in there …" [29]	

(*continued on next page*)

Table 2 (*continued*)

Theme		Key findings and illustrative quotes	Subgroup
Patient Impact	Facilitators	"I had absolutely no cost myself at all. All the bandages and supplies they give you at the clinic to do this at home were excellent." [17]	Patients/caregivers—urban
		"Well that's why I want this to get better, 'cause I wanna be able to get back to doing what I was doing before this like riding my bike, go for walks with the wife, go back to the gym … That's why I wanna heal it, that's why I'm coming here. That's why I am wearing this cast. I want this healed so I can get back to doing that." [29]	Patients—urban
		"My family adapts. They're on me all the time, because sometimes, I'm not always in the boot, and if they come in and they see it, they lose their crap… For me it is good to know that she cares about me and brings more hope for those days that I feel down." [29]	
	Barriers	"It's not easy losing a limb. It was the hard part, and when I woke up, I was not a happy person. I wasn't sure how this prosthetic thing worked, or who paid for it, or anything." [17]	Patients—urban
		"I feel guilty over that I've caused the wound myself." [28]	
		"I'm afraid to lose my foot or leg." [28]	
		"… I can't go in the pool now, I can't walk on concrete, can't go to the beach …" [24]	
		"I didn't want to go visit people because I didn't want to take my shoes off in their house." [24]	
		"We have a dietitian, she gives us the foods but I have a problem a lot other people in the community have the same problem … It's really hard for the people to follow the diet because of financial issues." [13]	Patient—Indigenous

Wound care

Wound care was discussed in 13 articles (8 identified facilitators, 9 identified barriers). Facilitators included effective offloading devices and footwear [15,19,20,28,31], early glycemic control, antibiotic therapy, dressing changes [18,28], access to supplies [29], and absence of wound odour [31].

Barriers included pain associated with dressing changes and ambulation, leading some participants to avoid/delay clinic attendance and physical activity that support diabetes care [15,17,23,30,31]. Wound leakage and malodour were described as socially embarrassing and led some participants to limit outings or to avoid removing footwear in social situations [15,23,30,31]. Prolonged DFU healing time and recurrence was also described as frustrating and demoralizing [15]. Lack of knowledge about offloading devices reduced their effective use and practical benefit [15], and authors reported that infection management carried an emotional burden for some participants, which could interfere with wound care [24]. Ineffective self-management [11,27,29], and inadequate footwear among Indigenous patients further reinforced cycles of delayed healing and poorer outcomes [11,14].

Patient impact

Seventeen studies described patient impact (7 articles identified facilitators, 16 articles identified barriers). Facilitators limiting the burden of DFU care on patients included low/no-cost access to supplies [17], supportive family members [16,29], satisfaction with offloading therapies [16], adherence driven by amputation avoidance and daily activity participation [14,29], and high awareness of peer-led programs [12].

Barriers exacerbating the burden of DFU care on patients included emotional responses such as anxiety, guilt, regret, and depression, particularly around amputation and perceived personal failure; these emotional states were both consequences of DFUs and factors that reduced motivation for appointments and self-care, thus delaying wound healing [10,17,18,24,25,28]. Functional limitations disrupted participation in vocational and home activities [16,28,32] and financial burden restricted access to offloading devices and supplies, thereby limiting adherence to wound-care regimens [11,12,16,17,29–31]. Indigenous populations cited intergenerational trauma, financial constraints, geographic isolation, and inadequate housing or caregiving support as compounding factors [11,13,14].

Discussion

In this scoping review we have consolidated Canadian patient and caregiver perspectives on DFU care through 5 major domains (Figure 2). These findings are of importance to consider in the scale-up and development of robust DFU care and limb preservation pathways.

Barriers

Barriers included difficulties implementing lifestyle recommendations, delayed access to specialized wound care, inadequate knowledge of wound-care practices, discomfort with treatment, and the financial burden of DFUs.

The patient impact theme identified self-reported emotional distress—that is, worry, anxiety, and low mood, and revealed how these emotions both followed from having a DFU but also altered how patients engaged with care; patients had reduced capacity to sustain care regimens and restricted outings due to embarrassment about the state of their feet. This is supported by a prospective cohort study from the United States showing that

depression is associated with incident DFUs [33]. A recent Indonesian randomized controlled trial (RCT) also demonstrated that a 3-month self- and family-management program incorporating motivational interviewing significantly improved wound size and perceived family support [34]. Canadian patients described similar emotional burdens of DFUs with concerns about infection, mobility loss, and amputation acting as strong psychological stressors [24]. Conversely, some patients in the identified studies accounted fear of amputation to increased vigilance and earlier presentation. This suggests there may be a bidirectional relationship, in which DFUs commonly generate emotional distress and, in some patients, distress modifies care engagement and social participation.

This emotional burden intersected with other barriers including physical limitations and lack of knowledge, creating a compounding cycle that impeded effective DFU management. For example, pain associated with dressing changes, prohibitive costs, and wearability concerns for offloading devices may reduce use and adherence to prescribed regimens or devices [15,17,29]. Taken together, this suggests that inconsistent adherence and incomplete device uptake will reduce the benefit of wound-care regimens and offloading. Having patients understand the importance of early offloading and general diabetic foot care are important components to effective DFU care [35].

Another major barrier was patients' limited wound-care knowledge, which was primarily attributed to inadequate communication from HCPs during initial visits. Some HCPs may avoid early education to prevent overwhelming newly diagnosed patients [31], whereas Canadian qualitative studies suggested that patients prefer early education on diabetes-related complications [36,37]. Meta-analyses have not consistently shown that educational interventions reduce DFU incidence [38], but those studies often reflected single-session interventions. Multimodal holistic interventions with group-based learning, demonstrations, and written materials have demonstrated effectiveness [39] and are supported by IWGDF guidelines [4]. One RCT from the United Kingdom showed that 1 or 2 diabetes-related education sessions alone were insufficient to prevent ulcer recurrence [40]. These findings highlight the need for layered, patient-centred education that ensures comprehension and promotes self-efficacy.

Last, Indigenous patient perspectives identified unique challenges, including intergenerational trauma, geographic isolation, limited home services, and economic hardship that amplify both clinical and psychosocial burdens and reduce access to limb-preservation care [13]. These findings align with Australian research where Aboriginal and Torres Strait Islander populations faced higher rates of DFUs and lower extremity amputations due to historical social exclusion and limited access to care [41]. The same principles apply within Canada, where Indigenous voices may be underrepresented due to exclusion by Western-centric research methodologies [10]. This underscores the need for culturally safe, community-engaged, and patient-centred management plans.

Facilitators

Facilitators of DFU care include family support, education from trusted HCPs, positive experiences with mechanical offloading devices, access to supplies and care, community programs, and smartphone applications. These facilitators operated through distinct but complementary processes. Family members provided practical assistance with foot inspection, wound care, and transportation, thus reducing logistical barriers to adherence and enabling continuity of care. Clear education from trusted HCPs increased patients' confidence and skill in wound self-management, and community peer-led programs acted similarly to normalize self-care practices and providing locally accessible instruction and social support.

Access to mechanical offloading devices was emphasized as they promote rapid healing and protection while maintaining mobility. Total contact casting (TCC) was associated with improved ulcer healing and was preferred over removable cast walkers (RCWs) in the 2017 Ontario HTA [15]. However, patients highlighted that device effectiveness in routine practice depends on availability, affordability, wearability, and practical training: cost and access barriers limit uptake and some patients substitute less effective devices for pragmatic reasons [27]. These observations point to 2 implementation priorities: 1) ensure equitable access to the most effective devices, and 2) pair device provision with hands-on training and follow-up to optimize correct use.

Community and peer-led programs, such as "Diabetes, Healthy Feet, and You" (formerly PEP Talk), were also highly valued, with positive responses from participants and peer educators [12]. Nevertheless, barriers remain, such as challenges recruiting patients, and lack of reliable transportation for Indigenous members [42]. Since 2014, the program has been established across local health integration networks in the Greater Toronto Area [12], but there remains a paucity of data on their long-term impact and implementation in other provinces. In the United States, the 2022 National Standards for Diabetes Self-Management Education and Support document delineates the delivery and evaluation of such programs [43]. In Canada, Diabetes Canada's own self-management guidelines [44], and a trial using social media–based self-education programs show promise, with improved foot self-care and preventive practices amongst patients [45]. In the future, such self-management programs should be strengthened while also ensuring they are scalable, equitable, and have measurable outcomes.

This need for targeted and inclusive education programs ties into the role of interdisciplinary teams in managing DFUs. Patients often emphasized the importance of accessing specialized diabetes educators given that their physicians often have limited time [21]. Systematic reviews have shown that team-based care reduces amputation risk. One study reported an 89% relative reduction in above-ankle amputation rates (odds ratio 0.11) [46], whereas another meta-analysis showed a 55% reduction in the risk of major lower extremity amputations [47]. These results underscore the importance of policy responses, extending interdisciplinary DFU teams and improving referral pathways can have a measurable impact on limb preservation at a population level.

Limitations

This review has a few limitations. First, only English-language articles were included, which may exclude Francophone or other language perspectives. Second, most studies were from Ontario, limiting national representativeness. Despite 5 studies including Indigenous populations' perspectives, there remains an urgent need for research that reflects the diversity and unique barriers faced by Indigenous communities. Experiences within the specific patient populations discussed in this scoping review are likely heterogeneous, including among Indigenous peoples and rural residents; however, the available literature did not provide sufficient detail for further subgroup analysis. Finally, although we did involve one patient partner, we were unable to involve additional ones due to logistical constraints, and the time required to build partnership. This underscores the need for further research that actively engages this population to evaluate its impact on care and health decisions.

Implications

This scoping review has significant implications for improving DFU care in Canada. Consolidating patient perspectives highlighted multiple actionable targets for change. Our partnership with T.W. ensured recommendations for education and support pathways are practical and patient-centred.

Clinically, patients reported vague messaging from HCPs, highlighting the need for tailored education tools and shared decision-making [4]. Improved referral systems are essential to mitigate delays and ensure care continuity. However, access challenges persist, given podiatry is often outside Canada's publicly funded system, creating financial barriers and reinforcing health inequities [47,48].

Accessing interdisciplinary wound care or limb preservation programs is essential. For instance, some Québec clinics integrate family physicians, nurses, podiatrists, and surgeons onsite, enabling timely escalation of care, although such models are not widespread [49,50]. Ontario's Lower-Limb Preservation Strategy is a promising initiative aiming to implement standardized multidisciplinary pathways to reduce preventable amputations and improve equity in lower limb care [51].

At the systems level, geographic and financial barriers must be addressed. Community-based and peer-support programs can empower patients and enhance treatment adherence. Future research should explore the experiences of rural, remote, and Indigenous populations. Moreover, longitudinal studies on peer-led programs are needed to assess their impact, sustainability, and support for those living with or at risk of DFU/lower extremity amputation, and their care partners. As technology becomes more integrated into care, understanding how patients use wound-management applications is also essential to addressing access barriers across income and location.

In conclusion, in this scoping review of 22 articles we have identified 5 themes around barriers and facilitators to DFU care in Canada. Notable barriers were inadequate patient education and the emotional burden of living with a DFU, whereas key facilitators included access to mechanical offloading that promotes wound healing while maintaining mobility as well as valuable community- or peer-led support programs that enable DFU self-management. These results highlight potential areas for improvement, such as national comprehensive guidelines that advocate for data capture, program evaluation, and continuous quality improvement of DFU care initiatives implemented in communities across Canada. They can also inform future policy decisions and guide further research into Canadian patient perspectives on DFU care and limb preservation.

Supplementary Material

To access the supplementary material accompanying this article, visit the online version of the *Canadian Journal of Diabetes* at www.canadianjournalofdiabetes.com.

Author Disclosures

Conflicts of interest: None.

Author Contributions

All authors meet the 4 criteria for authorship as outlined by the International Committee of Medical Journal Editors.

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Supplementary Table 1
GRIPP2 short form checklist

Section and topic	Item	Reported on page no.
1: Aim	Report the aim of PPI in the study.	2
2: Methods	Provide a clear description of the methods used for PPI in the study.	2
3: Study Results	Outcomes—Report the results of PPI in the study, including both positive and negative outcomes.	6
4: Discussion and Conclusions	Outcomes—Comment on the extent to which PPI influenced the study overall. Describe positive and negative effects.	10
5: Reflections/Critical Perspective	Comment critically on the study, reflecting on the things that went well and those that did not, so others can learn from this experience.	9

GRIPP2, Guidance for Reporting Involvement of Patients and the Public Checklists; *PPI*, patient and public involvement.

Supplementary Table 2
Ovid MEDLINE (all) database from 1946 to February 27, 2024

No.	Concept	Search strategy keywords	No. of results
1	Diabetic Foot	Diabetic Foot/ or (diabet$ and (feet$1 or (low$ adj3 (extrem$ or limb$)) or foot$ or ankle$1)).mp.	33,784
2	Amputation/Ulcer	exp Amputation, Surgical/ or (amput$ or hemipelvectom$ or disarticulation$ or ulcer$ or ulcus or gangrene$).tw,kf,kw.	313,083
3	Chronic Wound Care	((chronic$ and (care adj3 wound$)) or (leg$1 adj2 (ulcer$ or infection$))).tw,kf.	10,693
4	Amputation/Ulcer combined	or/2-3	314,654
5	Diabetes Mellitus Type 2	exp *Diabetes Mellitus, Type 2/ or exp Diabetes Mellitus, Type 2/co	157,554
6	Diabetes Mellitus Type 2 (free text)	(dm2 or t2dm or (diab$ and DM) or MODY or niddm or iidm or non insulin depend$ or noninsulin depend$ or noninsulindepend$ or non insulin?depend$ or type 2 diab$ or type ii diab$ or type 2 DM).tw,kf.	233,339
7	Combined Diabetes	or/5-6	264,058
8	Lower Extremity	exp Lower Extremity/ or Diabetic Foot/ or (leg$1 or (feet$1 or (low$ adj3 extrem$) or foot$ or ankle$1)).tw,kf,kw.	567,840
9	Amputation and Diabetes and Extremity	4 and 7 and 8	2,959
10	Combined Diabetic Foot/Amputation	1 or 9 [Diabetic Foot OR Diabetic Amputation Foot /Leg/Low Extrem]	33,884
11	Diabetes Complications	exp Diabetes Complications/pc or exp *Diabetes Complications/ or exp Diabetes Mellitus, Type 2/co	148,519
12	Diabetes Complications and Extremity	8 and 11	17,127
13	All Diabetic Foot Concepts	1 or 9 or 12	34,818
14	Qualitative/Survey Terms	exp 'Surveys and Questionnaires'/ or exp qualitative research/ or focus groups/ or interviews as topic/	1,357,852
15	Qualitative/Survey Free Text	(survey$ or questionnaire$ or nonrespondent$ or (randomized adj3 response$) or adj3 techniq$) or respondent$ or qualitative$ or (focus$ adj2 group$) or interview$ or quantitative$ or inventory$).mp.	3,061,561
16	Qualitative Methods	(ethnograph* or phenomenol* or ethnonurs* or (grounded and theor*) or (purposive and sample) or hermeneutic* or heuristic* or semiotics or (lived and experience*) or narrative* or (life and experience*) or (cluster and sample) or (action and research) or (observational and method) or (content and analysis) or (thematic and analysis) or (constant and comparative and method) or (field and stud*) or fieldwork or (field and work) or (key and informant) or (theoretical and sample) or (discourse and analysis) or discussion* or (ethnological and research) or ethnomethodolog* or (mixed and method*) or (mixed and model*) or (mixed and design*) or (multiple and method*) or multimethod* or triangulat*).tw,kf.	2,417,527
17	Self-Care/Management	exp Home Care Services/ or (home$1 care$ or homecare$).tw,kf,kw. or exp self care/ or Self Efficacy/ or Self-Management/ or (self-efficac$ or self-care$ or self-manag$).tw,kf,kw. or self$.ti. or self$.ab. /freq=2	563,033
18	Patient-Reported Outcomes	(patient adj reported adj (experience$ or outcome$ or data)).tw,kf,kw.	41,836
19	Patient Attitudes	exp Patient Satisfaction/ or Consumer Behavior/ or "Patient Acceptance of Health Care"/ or exp Attitude to Health/ or patient preference/ or "Quality of Life"/	751,518
20	Patient Perspectives Free Text	exp Patient Satisfaction/ or Consumer Behavior/ or "Patient Acceptance of Health Care"/ or exp Attitude to Health/ or patient preference/ or "Quality of Life"/	809,475
21	Perceptions/Compliance	(opinion$ or attitude$ or satisfaction$ or satisfy$ or complian$ or cooperat$ or refusal$ or noncomplian$ or non-complian$ or preference$ or accept$ or utili$).tw,kf,kw. or (perspective$ or perception$ or perceiv$ or community$).mp.	4,144,274
22	Combined Qualitative/Perspective Concepts	or/14-21	8,778,731
23	Final Combined Results	13 and 22	12,586
24	Canada	exp Canada/ or (Canada or Canadian or Alberta$ or British Columbia$ or Manitoba$ or New Brunswick$ or (Newfoundland$ adj2 Labrador$) or Northwest Territor$ or Nova Scotia$ or Nunavut or Ontario$ or Prince Edward$ Island$ or Quebec$ or Saskatchewan$ or Yukon$ Territor$).af.	1,454,173
25	Final Combined with Canada	13 and 22 and 24	500
26	English Language Filter	limit 25 to English language	498

Supplementary Table 3
Embase (Classic + Embase) database from 1947 to February 27, 2024

No.	Concept	Search strategy keywords	No. of results
1	Diabetic Foot	diabetic foot/ or (diabet$ and (feet$1 or (low$ adj3 (extrem$ or limb$)) or foot$ or ankle$1)).tw,kw.	53,566
2	Amputation/Ulcers	amputation/ or foot amputation/ or leg amputation/ or below knee amputation/ or exp foot ulcer/ or *leg ulcer/co or exp gangrene/co or (amput$ or hemipelvectom$ or disarticulation$ or ulcer$ or ulcus or gangrene$).tw,kf,kw.	475,140
3	Wound Care	((chronic$ and (care adj3 wound$)) or (leg$1 adj2 (ulcer$ or infection$))).tw,kw.	13,868
4	Amputation or Wound Care Combined	or/2-3	477,049
5	Diabetes	non insulin dependent diabetes mellitus/ or diabetic complication/	354,923
6	Diabetes Free Text	(dm2 or t2dm or (diab$ and DM) or MODY or niddm or iidm or non insulin depend$ or noninsulin depend$ or noninsulindepend$ or non insulin?depend$ or type 2 diab$ or type ii diab$ or type 2 DM).tw,kw.	368,651
7	Combined Diabetes	or/5–6	463,438
8	Lower Limb Terms	*lower limb/ or *leg/ or exp *ankle/ or exp *foot/ or diabetic foot/ or (leg$1 or (feet$1 or (low$ adj3 extrem$) or foot$ or ankle$1)).tw,kf,kw.	679,382
9	Diabetes + Amputation + Lower Limb	4 and 7 and 8	5,440
10	Diabetic Foot Combined	1 or 9	53.893
11	Diabetes Complications	non insulin dependent diabetes mellitus/co or *diabetic complication/	9,514
12	Lower Limb + Diabetes Complications	8 and 11	688
13	Full Diabetic Foot/Amputation Set	1 or 9 or 12	53,938
14	Qualitative and Survey Terms	exp health survey/ or health care survey/ or exp questionnaire/ or exp qualitative research/ or exp interview/	1,588,522
15	Survey/Qualitative Free Text	(survey$ or questionnaire$ or nonrespondent$ or (randomized adj3 response$) or (response$ adj3 techniq$) or respondent$ or qualitative$ or (focus$ adj2 group$) or interview$ or quantitative$ or inventory$).tw,kw.	3,731,055
16	Qualitative Methodologies	(ethnograph* or phenomenol* or ethnonurs* or (grounded and theor*) or (purposive and sample) or hermeneutic* or heuristic* or semiotics or (lived and experience*) or narrative* or (life and experience*) or (cluster and sample) or (action and research) or (observational and method) or (content and analysis) or (thematic and analysis) or (constant and comparative and method) or (field and stud*) or fieldwork or (field and work) or (key and informant) or (theoretical and sample) or (discourse and analysis) or discussion* or (ethnological and research) or ethnomethodolog* or (mixed and method*) or (mixed and model*) or (mixed and design*) or (multiple and method*) or multimethod* or triangulat*).tw,kw.	3,630,860
17	Self-Care and Home Care	home care/ or (home$1 care$ or homecare$).tw,kf,kw. or exp self care/ or exp self concept/ or (self-efficac$ or self-care$ or self-manag$).tw,kf,kw. or self$.ti. or self$.ab. /freq=2	846,210
18	Patient-Reported Outcomes	(patient adj reported adj (experience$ or outcome$ or data)).tw,kf,kw.	67,248
19	Patient Attitudes	exp patient attitude/ or consumer attitude/ or attitude to health/ or exp "quality of life"/	1,264,779
20	Patient Perspectives Free Text	((patient$ or consumer$ or parent$ or father$ or mother$ or famil$) adj3 (satisf$ or value$ or prefere$ or attitude$ or perspectiv$ or perce$ or expectation$ or view$ or choice$ or (quality$ adj2 life$) or QoL or HRQoL or refus$ or report* or feedback$)).tw,kf,kw.	1,268,853
21	Attitudes and Satisfaction	(opinion$ or attitude$ or satisfaction$ or satisfy$ or complian$ or cooperat$ or refusal$ or noncomplian$ or non-complian$ or preference$ or accept$ or utili$).tw,kf,kw. or (perspective$ or perception$ or perceiv$ or community$).tw,kw.	5,109,435
22	Qualitative Combined	or/14-21	11,419,820
23	Full Relevant Set	13 and 22	21,571
24	Canada	exp Canada/ or (Canada or Canadian or Alberta$ or British Columbia$ or Manitoba$ or New Brunswick$ or (Newfoundland$ adj2 Labrador$) or Northwest Territor$ or Nova Scotia$ or Nunavut or Ontario$ or Prince Edward$ Island$ or Quebec$ or Saskatchewan$ or Yukon$ Territor$).tw,kw,in.	1,726,739
25	Canada Combined	13 and 22 and 24	719
26	English Only	limit 25 to English language	711
27	Limit to Embase	limit 26 to embase	404

Supplementary Table 4
CINAHL database (complete)

No.	Concept	Search strategy keywords	No. of results
1	Diabetic Foot	(MH "Diabetic Foot") or (TX (diabet* N5 (feet or (low* N3 (extrem* or limb*)) or foot or ankle*)))	13,973
2	Complications	(TX (amput* or hemipelvectom* or disarticulation* or ulcer* or ulcus or gangrene*)) OR (TX ((chronic* and (care N3 wound*)) or (leg* N2 (ulcer* or infection*))))	84,773
3	Diabetes	TX ((diab* and (dm2 or t2dm or DM)) or type 2 diab* or type ii diab* or type 2 DM)	98,562
4	Anatomical Focus	TX (leg or legs or (feet* or (low* N3 extrem*) or foot* or ankle or ankles))	179,781
5	Complication Filter	TX complication*	768,201
6	Combined Foot, Complications, Diabetes, Anatomy	S2 AND S3 AND S4 AND S5	951
7	DFU (combined)	S1 OR S6	14,217
8	Study Design/Methodology	TX (survey* or questionnaire* or nonrespondent* or (randomized N3 response*) or (response* N3 techniq*) or respondent* or qualitative* or (focus* N2 group*) or interview* or quantitative* or inventory*)	1,413,639
9	Qualitative Terms	TX (ethnograph* or phenomenol* or ethnonurs* or (grounded and theor*) or (purposive and sample) or hermeneutic* or heuristic* or semiotics or (lived and experience*) or narrative* or (life and experience*) or (care and experience*) or (cluster and sample) or (action and research) or (observational and method) or (content and analysis) or (thematic and analysis) or (constant and comparative and method) or (field and stud*) or fieldwork or (field and work) or (key and informant) or (theoretical and sample) or (discourse and analysis) or discussion* or (ethnological and research) or ethnomethodolog* or (mixed and method*) or (mixed and model*) or (mixed and design*) or (multiple and method*) or multimethod* or triangulat*)	1,101,336
10	Self-Management	TX (self-efficac* or self-care* or self-manag*)	116,201
11	Patient Values	TX (((patient* or consumer* or parent* or father* or mother* or famil*) N3 (satisf* or value* or prefere* or attitude* or perspectiv* or perce* or expectation* or view* or choice* or (quality* N2 life*) or QoL or HRQoL or refus* or report* or feedback*))	454,142
12	Patient Attitudes	TX (opinion* or attitude* or satisfaction* or satisfy* or complian* or cooperat* or refusal* or noncomplian* or non-complian* or preference* or accept* or utili*) or (perspective* or perception* or perceiv* or community*)	1,760,703
13	Patient-Centred Concepts Combined	S8 OR S9 OR S10 OR S11 OR S12	2,999,002
14	Combined Clinical + Patient	S7 AND S13	5,079
15	Canada Filter	TX (Canada or Canadian or Alberta* or British Columbia* or Manitoba* or New Brunswick* or (Newfoundland* N2 Labrador*) or Northwest Territor* or Nova Scotia* or Nunavut or Ontario* or Prince Edward* Island* or Quebec* or Saskatchewan* or Yukon* Territor*)	477,998
16	With Canada	S14 AND S15	295
17	Language Filter	Limiters—English Language	8,477,170
18	Final Result	S16 AND S17	294

Supplementary Table 5
Codebook

Primary theme	Secondary theme	Subtheme (code)	Definition	Example verbatim quote or authors interpretation/labelled theme	Source [reference]	Deductive vs inductive → HQO
Access	Transitions/ coordination	Collaborative team/service organization	Organization of interprofessional teams and pathways affecting access and coordination of DFU care.	"They emphasized that there were 10 members of the team and I was one of the 10 … I love the team approach … Everybody knew his or her specialty and they all worked together …" (participant).	Adams et al, 2014 [21]	Deductive → HQO 03, HQO 12
Wound care	Access	Skin substitutes/advanced therapies (HTA)	Assessment of skin substitutes and advanced therapies for DFU management and implications for availability.	HTA patient input/summary: patients/stakeholders reported generally positive views of skin substitutes but consistently raised limited availability across Ontario, low awareness/knowledge, and cost/out-of-pocket as access and acceptability barriers.	Kabali et al, 2021 [17]	Deductive → HQO 07, HQO 10
Wound care	Access	Offloading/casting (HTA)	Comparative effectiveness and access implications for TCC, RCWs, and irremovable cast walkers.	HTA evidence/patient section summaries: variability in device availability and concerns regarding wearability/ adherence, as practical barriers to use.	Health Quality Ontario, 2017 [15]	Deductive → HQO 05, HQO 06
Wound care	Access	Hyperbaric oxygen (HTA)	Effectiveness and access considerations for hyperbaric oxygen therapy in DFU.	HTA: Inconsistent evidence for major-amputation reduction but improved ulcer healing in some trials; patient stakeholders report access barriers and out-of-pocket costs.	Health Quality Ontario, 2017 [16]	Deductive → HQO 07, HQO 08, inductive → HQO 11
Access	Patient impact/ equity	Indigenous perspectives synthesis	Geographic, systemic and cultural drivers of worse DFU outcomes for Indigenous peoples (transportation, cultural safety, marginalization).	Scoping review: Higher burden of diabetes-related foot complications/lower extremity amputations among Indigenous peoples; need for culturally safe, equity-focussed approaches.	Blanchette et al, 2023 [10]	Deductive → HQO 03, HQO 11, HQO 12
Prevention	Access/technology	mHealth for monitoring/ prevention	Patient views on using mobile health apps to monitor and prevent DFUs.	"I found the app useful for checking my wound" and "the app made me feel more connected" (participants).	Boodoo et al, 2017 [22]	Deductive → HQO 02, HQO 05, HQO 12
Patient impact	—	Personal journey/narrative case	Individual case narrative illustrating lived experience and psychosocial impact from DFU.	Case text narrative emphasizes fear, disruption to identity/ daily life, social isolation, and emotional burden of DFU.	Bryce, 2016 [18]	Inductive → HQO 04
Prevention/ patient education	Patient impact	Engagement in information seeking	Processes of engagement in seeking DFU-related information and resources.	Participants described active information-seeking (Internet, family), reasons for delay ("thought it would heal on its own"), and a journey to self-management.	Costa et al, 2023 [23]	Deductive→ HQO 01, HQO 02
Patient impact	Prevention/ education	Impact on daily routine/ meaning	How DFU affects daily life and routines (social roles).	Participants described a "sense of life change," reduced outings/leisure, and emotional fluctuation tied to DFU.	Costa et al, 2023 [24]	Inductive → HQO 04
Prevention/ patient education	Patient impact	Illness meaning	How patients interpret "diabetes" in the context of developing a DFU.	Authors note in Results/Discussion, there are differing illness meanings (personal failure vs biomedical complication) that influence help-seeking and self-management behaviour.	Costa et al, 2022 [25]	Inductive → HQO 02
Patient education/ prevention	Patient impact	Perceived role in management	Participants' self-described roles and preferences for involvement in DFU care (how confident/active they are in daily self-management).	Authors report 3 role typologies in the abstract: "follower of provider instructions, leader of their self-care ('I am the boss'), and advocator of own health care."	Costa et al, 2018 [26]	Deductive→ HQO 02
Prevention	Access	Delay reasons	Perceived reasons for delaying help-seeking at DFU onset.	"I burnt my toe on a heater" and "It was tiny, tiny little black spot." Author themes: Limited knowledge about foot care; unaware of diabetic foot problems; underestimation of ulcer presentation; "I thought I could fix it myself"; inaccurate diagnosis; trial-and-error by nonspecialized provider.	Costa et al, 2022 [27]	Deductive → HQO 01, HQO 02, HQO 12
Prevention/ patient education	Patient impact	Journey to self-management	Process by which patients engage in self-management of DFU over time.	Authors report: "Engagement phases: perception of illness; noticing foot changes; realizing seriousness; beginning to learn self-management; engaging in self-management"; authors describe factors like self-confidence, social/formal supports and access to resources as drivers of progression.	Costa et al, 2021 [28]	Deductive → HQO 01, HQO 02
Access/wound care	—	Cost barriers to devices	Socioeconomic factors limiting access to off-loading boots and devices and the downstream impact on self-management.	"I can't afford offloading boots. And disability wouldn't cover that. But, they're expensive … Last pair I wanted to get was $710"; "I was told I am supposed to wear a special shoe but I can't afford it" (participants).	Costa et al, 2020 [29]	Deductive → HQO 06, inductive HQO 05, HQO 11

Patient impact	—	Quality of life comparison (current vs healed DFU)	Health-related QOL differences in patients with current vs healed DFU.	Author reports differences in health-related QOL between those with current and healed DFU; "Active DFU associates with lower physical functioning, social participation, and emotional well-being compared with healed DFU."	Goodridge, 2004 (thesis) [30]	Inductive → HQO 04
Prevention/ access	Patient education/ continuity / technology	Smartphone app for wound care	Use of remote patient-facing wound care apps enabling monitoring and clinician contact.	Authors report through case summary that the patient was successfully managed using the app. Patient found the app "educational and empowering."	Kong et al, 2021 (case report) [20]	Deductive → HQO 02, HQO 05, HQO 12
Patient education	Patient impact	Peer-led programs	Peer leader perspectives and program utility for limb preservation and education.	Peer leaders reported program benefits for community education and limb preservation but noted implementation/practical considerations: "The workshop was very informative. As a diabetic, I was told to watch my feet but I didn't know what to watch for until I attended this workshop …" (participant).	Kuhnke et al, 2014 [12]	Deductive → HQO 02, HQO 12
Access	Patient impact/ equity	High amputation prevalence/access issues	Foot and ankle problems in Aboriginal and non-Aboriginal diabetic patients with ESRD; access implications.	Manuscript/Table 1 indicates high prevalence of foot problems and access implications for Aboriginal patients; system and geographic factors exacerbate access barriers.	McIntyre et al, 2007 [11]	Deductive → HQO 03, HQO 11, HQO 12
Patient impact	Access/equity	Disability and QOL in Aboriginal amputees	Disability, QOL and social impact among Aboriginal and non-Aboriginal amputees with diabetes.	Paper documents higher functional/disability burdens and QOL impacts among amputees, disparities exist by Indigenous status.	Meatherall et al, 2005 [14]	Inductive → HQO 04
Wound care	Access/technology	Photobiomodulation at-home devices	Case series describing outcomes of at-home photobiomodulation devices for DFU.	Cases reports describe wound responses to the home device, noting feasibility/acceptability.	Raizman and Gavish, 2020 [19]	Deductive → HQO 07, HQO 10
Patient education	Patient impact	Interpretive descriptions of self-management challenges	Patient, support-person, and HCP perspectives on personal challenges in foot self-management (including practical, emotional, and knowledge barriers).	Results summarize personal challenges reported by patients, support persons, and HCPs to foot self-management.	Stevens et al, 2021 [31]	Deductive → HQO 02, inductive → HQO 04
Access	Patient education/ transitions	Community participatory identification of barriers	Community-driven identification of barriers to preventive care among First Nations people.	Authors note barriers included limited primary care access, inadequate diabetes management, geographic isolation, racism, and poor urban–rural coordination; participants suggested stronger partnerships, education, and culturally safe care.	Wees et al, 2023 [13]	Deductive → HQO 03, HQO 11, HQO 12

DFU, diabetic foot ulcer; *ESRD*, end-stage renal disease; *HCP*, health care practitioner; *HQO*, Health Quality Ontario; *HTA*, Health Technology Assessment; *QOL*, quality of life; *RCW*, removable cast walker; *TCC*, total contact casting.
Health Quality Ontario Statements in Brief*

1. Risk Assessment: People with diabetes are assessed for their risk of developing a diabetic foot ulcer when they are diagnosed with diabetes and at least once a year thereafter. Patients at higher risk are assessed more frequently. All risk assessments are performed using standard, validated tools.
2. Patient Education and Self-Management: People with diabetes and their families or caregivers are offered education about diabetic foot care and complications, including basic foot care; how to prevent foot complications and monitor for the signs and symptoms of foot complications; and who to contact in the event of a concerning change.
3. Referral to an Interprofessional Team: People with a diabetic foot ulcer are referred to an interprofessional team that delivers ongoing, coordinated, integrated care. If they have major complications, they are seen within 24 hours by a team that delivers emergency services and then referred to an interprofessional team for ongoing care.
4. Comprehensive Assessment: People with a diabetic foot ulcer or foot complications undergo a comprehensive assessment that informs their individualized care plan and includes evaluation of vascular status, the presence of infection, and pressure redistribution to determine the healing potential of the wound.
5. Individualized Care Plan: People with a diabetic foot ulcer or foot complications have a mutually agreed-upon individualized care plan that identifies patient-centred concerns and is reviewed and updated regularly.
6. Pressure Redistribution: People with a diabetic foot ulcer or foot complications are offered pressure-redistribution devices as part of their individualized care plan.
7. Wound Debridement: People with a diabetic foot ulcer have their wound debrided if it is determined as necessary in their assessment, and if it is not contraindicated. Debridement is carried out by a trained health care professional using an appropriate method.
8. Local Infection Management: People with a diabetic foot ulcer and a local infection receive appropriate treatment, including antimicrobial and non-antimicrobial interventions.
9. Deep/Surrounding Tissue Infection or Systemic Infection Management: People with a diabetic foot ulcer and a suspected deep/surrounding tissue infection or systemic infection receive urgent assessment (within 24 hours of initiation of care) and systemic antimicrobial treatment.
10. Wound Moisture Management: People with a diabetic foot ulcer receive wound care that maintains the appropriate moisture balance or moisture reduction in the wound bed.
11. Health Care Provider Training and Education: People who have developed or are at risk of developing a diabetic foot ulcer or foot complications receive care from health care providers with training and education in the assessment and management of diabetic foot ulcers and foot complications.
12. Transitions in Care: People with a diabetic foot ulcer or foot complications who transition between care settings have a team or provider who is accountable for coordination and communication to ensure the effective transfer of information related to their care.

From Health Quality Ontario, Ontario Ministry of Health [5].

Supplementary Table 6

■ ■ ■

Health Quality Ontario Statements in Brief*
1. Risk Assessment: People with diabetes are assessed for their risk of developing a diabetic foot ulcer when they are diagnosed with diabetes and at least once a year thereafter. Patients at higher risk are assessed more frequently. All risk assessments are performed using standard, validated tools.
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* From Health Quality Ontario, Ontario Ministry of Health [5].