Dr. Diane Langemo: Thank you for tuning into the webinar and we will now address the questions that were submitted. We have many excellent questions. The first one, why aren't well-positioned pillows under the calves considered appropriate for long term use?

They are not considered appropriate for long term use for a variety of reasons. First of all, with a pillow no one can guarantee the pressure redistribution ability or effect that it will have on the heels. Pillows don't stay in place, especially in individuals with dementia, Alzheimer's who just are not alert. They tend to kick them around and move their lower extremities off of them. So they just don't stay in place. If it is all you have temporarily, that is fine, but it is a short term solution.

Next question. I have seen ulcers on the side of the ankle. Are there any tips for offloading them? Heel offloading boots don't work well in my experience.

Okay, these Malleolar ulcers are often seen in patients who have external rotation and in patients who are bariatric patients they can also be seen in disoriented or non-alert individuals. A more rigid boot could keep the heel, foot, lower extremity in place and one example would be the heel-lift suspension boot; that would work well in this instance. There are other more rigid boots available as well.

Or there is also the bariatric boot, heel-lift boot or the petite heel-lift boot for the smaller framed patient. And these work well to try to address the pressure on the Malleolar areas of the medial lateral ankle. What you can do is in the heel-lift boot in the foam that is on the side you can actually cut out some of the bump surrounding the ankle to take pressure off of that area. And then remember that the heel-lift boot comes with an extra pad that can be placed on either side to which the leg is rotating and that also helps keep it from rotating and also the pressure off of the ankle area.

If there is a patient with a foot drop problem then the pad can be placed in a vertical position behind the sole of the foot. So it is really quite a versatile heel-lift boot that has been manufactured.
Number three – please comment on heel-lift devices causing ulcers to the Achilles area as well as the top of the foot from the straps, especially when staff is (inaudible) about checking them. First of all you need to have checking the boot fit as part of the policy for use of the boots in your agency. Second, the heel-lift boot has an extra pad that comes with the boot to help customize the fit of the boot to address some of these issues. Check to make sure that the boot that you are able to – that with the boot you are able to place your finger between the heel opening and the bed. The boot should not move freely about the leg.

Another thing you can do is to cut a v-shape out of the fixed pad that is in the boot and that will help relieve some of the pressure over the Achilles area. So there are a variety of things that you can do to address this. Next, what about floating heels on gloves filled with water. Does this increase or decrease risk? It actually increases risk because, again, you cannot accurately estimate or maintain the redistribution ability of this device and unfortunately what happens is many patients put their lower extremity and heel down part enough on it that it actually totally compresses it so that the heel is, again, lying on the surface of the bed.

The same is with the pillows. They don’t stay in place; they get kicked around and they are just not recommended.

Tips for offloading heels in patients with contractures, would the heel-lift allow some possibilities of adjusting where the pressure is offloaded?

Yes, it would. Moving the extra pad around as I have mentioned previously can allow you to address this problem. You may need to use boots plus pillows and/or wedges to help keep the heels off the bed and the lower extremity in correct alignment from internally or externally rotating.

Next question. You indicate not to use synthetic sheepskin. Is it your assertion that real sheepskin redistributes pressure?

No, it does not redistribute pressure but it prevents the sweating that you see when synthetic sheepskin is in place. Sheepskin may provide minimal redistribution pressure ability but overall it is primarily just a comfort intervention.
Next, is a deep tissue injury that isn't open staged as stage 1 on MDS 2.0 even if it contains blood? Very good question because in a deep tissue injury if it does contain blood it does mean that it is deeper than the dermas and therefore it is a full thickness stage 3 or stage 4 injury. So the question then, until it is opened you would still stage it as a stage 1 on the MDS 2.0. Then when it opens and you are able to see the base of the wound and determine the level or the depth of the injury, then you can stage it accordingly.

What you do – with the MDS 2.0 currently there are only the four stages that are able to be documented, 1 through 4. So if you have a deep tissue injury with a blood blister that is present or there is blood under the tissue, then you do stage it as a stage 1 until it opens up.

There is a new MDS 3.0 coming out in October of 2010. And we have worked with the CMS and they have added on to that in section [M] the unstageable and the DTI categories. So starting October of 2010 you will be able to correctly stage this on the MDS 3.0.

Because you have to stage it as a stage 1 until it opens up what you do then because you have quoted it as a stage 1, in your narrative notes it is vital that you put in there your description of the area so that it is clear that even though it was staged as a stage 1 in the section M that this actually was assessed by you to be a full thickness injury.

And I would also say the National Pressure Ulcer Advisory Panel has a website NPUAP.org. And on that website is a position statement that NPUAP developed for staging of DTI on the MDS 2.0. And it also gives very nice examples of the narrative that you can write on that. And that is available as a free download.

Next question. You mentioned that high-risk pressure ulcer patients often have end-stage disease yet this term isn't in the QIQM Technical Manual. That is correct; it is not in there. It is a term that is in the literature. It is a term that is commonly being used but it does not appear in the QIQM Technical Manual. And really it merely refers to the fact that many patients these days have multiple co-morbidities that increase their risk for pressure ulcer development, including the patients who may be end-stage chronic lung disease, end-stage renal failure, etc. But especially when we are talking about end-stage disease processes we know that the risk is significantly higher and the ability to avoid that pressure ulcer development may not be available.
Next question, are Ted hose appropriate when patients are at home? My understanding is that once they are up and around they either need higher compression like [Jobst] but not the Ted.  

First of all the primary care providers ordered these and they ordered the amount of compression that they do want. But Ted’s definitely can be used at home and that is why they are sent home with the patient. Again, the patient needs to be instructed to follow the same directions about removing them at least twice a day, checking the leg and the ankle, making sure hat they are clean and applied properly.

Next, is it recommended to not debride intact eschar on the heel?

Correct. It is recommended to not debride eschar on the heel if it is stable, dry, intact adherent eschar without signs of inflammation or infection. That eschar is a natural biological protection for the body and overall should be left alone.

Next, in individuals with decreased circulation is a round localized purple/black area over the calcaneus considered a vascular or a pressure ulcer?

Another, as the rest, a very good question. These individuals often have arterial and/or venous problems and the ulcers are often of mixed origin. I have seen – so that you would need to, the primary care provider would need to diagnose it as to the origin and the type of the ulcer that it is. And frequently what you see in these in individuals is that it is a mixed arterial/pressure, mixed/venous pressure, mixed diabetic-neuropathic/pressure ulcer.

I have seen patients even who have previously had, for example a fem pop bypass that the bypass has now occluded. And they develop an ulcer and there are those individuals, I guess especially plaintiff attorneys who want to call them a pressure ulcer when in fact they really are arterial ulcer – there is just no blood supply to that portion of the lower extremity.

Next, can negative pressure [wound] therapy be use on the heel ulcer? Yes, it can but it really rarely fits very well and so therefore it isn't used and it would prevent the individual unless you are able to capably
bridge the tubing to be able to ambulate at all. And again remember that the negative pressure wound therapy is not used in the presence of infection unless the infection is appropriately being addressed.

Next, please say more about stage 2 versus DTI? Is a clear fluid filled blister on the heel a stage 2? Yes, it is. If it is partial thickness it is fluid filled and not blood filled. And as I said before the presence of the blood indicates a full thickness injury.

Next, we are using Silvadene and a dry dressing on the heel ulcer. We have used Calcium Alginate, [Santol] and [Bactrim] in the past. The center of the ulcer is covered with eschar. Any suggestions for treatment?

Well actually the purpose of this webinar was not to get into specifics like that. But I would say Silvadene is a silver based preparation. It is an excellent product. However, if there are no signs or symptoms of infection present probably the Silvadene isn't needed at that point. Remember, silver products are only used for a limited period of time, not until the ulcer heals. They are used primarily to treat the infection that is present.

If eschar is present as was stated here it may need to be debrided but more than likely it is best to leave that alone until it falls off. When they do debride eschar on a heel ulcer it is often done when there are signs and symptoms of infection present with it.

Next, WOC on guidelines speak to wound care also. Is it appropriate for nurses to apply dressings on a reddened heel that is not open?

Yes it is. Any way that you can protect that area – first of all offload the pressure but second protect it. And the dressings also help with protecting the area from friction and shear.

Next, should a heel blister be drained or unroofed? No, as I said before you do not unroof or drain those. It is best to leave them alone; they are a normal biological protection.
Next, what is the preferred treatment for DTI? As I just mentioned, first of all totally offload the area, cleanse it and protect it and wait for the area to evolve. There are many instances where a DTI is assessed, the area is completely offloaded and these actually go on to heal without opening up.

Next, how can we find the source for breaking the Braden Scale by individual sub-scales to individual the risk factors? I actually looked for that reference quickly. I wasn't able to find it. But, one of the individuals, two of the individuals that worked on that were at the University of Nebraska Medical Center in Omaha and they are Dr. Janet Cuddigan and Ellen Didier. And those two individuals could be contacted for further information on that.

In determining an in-house pressure ulcer rate is it the number of pressure ulcers or the number of individuals with a pressure ulcer that is counted?

It is the number of individuals regardless of how many pressure ulcers that individual has.

And last question – what type of pad is appropriate for a patient on a low air loss or alternating pressure mattress?

Again this needs to be individualized but it would need to be a very thin pad that would not interfere with the pressure redistribution properties of the low air loss or the alternating pressure mattress. And I would refer you to the new 2009 NPUAP EPUAP International Pressure Ulcer Guidelines for more information on that.

Thank you very much for the excellent questions, your time and attention. And I will turn it back over to Kristy Shelly.

Kristy Shelly: I would like to thank Dr. Diane Langemo for her assistance with this program. And thank the medical audience for their participation. We would also like to thank DM Systems for their support of this program and we hope we have answered your questions and contributed to your knowledge of heel pressure ulcers. Thank you and we hope you all have a great day.