

# Heel Pressure Ulcers: A to Z

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Q & A

Diane Langemo, PhD, RN, FAAN gave a comprehensive presentation on heel pressure ulcers that included the basics of a pressure ulcer, new NPUAP/EPUAP guidelines, CMS "never events" and prevention and treatment options including the necessary features of a pressure-relieving device.

Following her presentation, Dr. Langemo answered questions raised during the live event.

**1. 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 or 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's all you have temporarily, that is fine. But it is a short term solution.

**2. I have seen ulcers on the side of the ankle. Are there any tips for off-loading them? Heel off-loading boots don't work well in my experience.**

Malleolar ulcers are often seen in patients who have external rotation and in patients who are bariatric. They can also be seen in disoriented or non-alert individuals. A more rigid boot could keep the heel, foot and lower extremity in-place. One example would be the Heelift<sup>®</sup> Suspension Boot; that would work well in this instance. There are other more rigid boots available as well.

There is also the bariatric boot or the petite Heelift 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 with the Heelift boot, in the foam, is on the side you can actually cut out some of the bump surrounding the ankle to take pressure off of that area. Then remember that the Heelift 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 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 the Heelift is really quite a versatile boot that has been manufactured.

**3. 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 not very good 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 Heelift 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 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.

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**3.** 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.

**4. 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 there lower extremity and heel down on it that it totally compresses. So 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.

**5. Tips for off-loading heels in patients with contractures? Would the Heelift allow some possibilities of adjusting where the pressure is off-loaded?**

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.

**6. 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.

**7. Is a deep tissue injury that isn't open staged as Stage I 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 dermis and therefore it is a full thickness Stage III or Stage IV injury. So the question then, until it is opened, you would still stage it as a Stage I on the MDS 2.0.

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. With the MDS 2.0 currently there are only the four stages that are able to be documented, I through IV. 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 I 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, 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.

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

I would also say the National Pressure Ulcer Advisory Panel has a website – [www.npuap.org](http://www.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.

8. **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.

9. **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 TEDs 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 that they are clean and applied properly.

10. **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 a 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.

11. **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. 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.

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**11.** I have seen patients even who have previously had, for example, a fem pop bypass that has now occluded and they develop an ulcer. 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.

**12. Can negative pressure wound therapy be use on the heel ulcer?**

Yes, it can but it really rarely fits very well. Therefore, it isn't used and it would prevent the individual unless you are able to capably bridge the tubing 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.

**13. Please say more about Stage II versus DTI? Is a clear-fluid filled blister on the heel a Stage II?**

Yes, it is if it is partial thickness, fluid-filled and not blood-filled. And, as I said before, the presence of the blood indicates a full thickness injury.

**14. We are using Silvadene and a dry dressing on the heel ulcer. We have ulcer used calcium alginate, Santyl 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 and not until the ulcer heals. They are used primarily to treat the infection that is present.

If an 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 an eschar on a heel ulcer, it is often done when there are signs and symptoms of infection present with it.

**15. The WOCN 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, off-load the pressure but second protect it. And the dressings also help with protecting the area from friction and shear.

**16. 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.

**17. What is the preferred treatment for DTI?**

As I just mentioned, first of all, totally off-load 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 off-loaded and these actually go on to heal without opening up.

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**18. 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 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.

**19. 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.

**20. 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.