Heels are Special

• Because heels have a small surface it is difficult to redistribute the pressure and need extra protection

• Suspending or Offloading the heels is the best intervention
Heel Pressure Ulcers

• Heel composed of the largest bone in the foot, the calcaneus

• Skin overlying the heel has an average thickness of 3.8 mm

• Major cause of heel pressure ulcer is unrelieved pressure

• Heel is second most frequent site for pressure ulcers to develop

• Heel is most common location for DTI pressure ulcers to occur
Risk Factors for Pressure Ulcer Development

- > age 70
- Impaired mobility
- Smoker
- Low BMI/ High BMI
- Malnourished
- Urinary and Fecal incontinence
- Restraints
- Alcohol/Drug Abuse
- Immunosuppressive and Chemotherapeutic Agents
- Uncontrolled excess local pressure

Disease conditions:
- Malignancy
- Diabetes
- CHF
- Pneumonia
- Fever
- Sepsis
- Hypotension
- Renal Failure
- Dry Skin
- Hx of PU
- Anemia
- Hypoalbuminemia
- Lymphopenia
Prevention of Heel PU

- Frequent skin assessments
  - During bathing
  - When repositioning/turning
  - When applying/removing socks/ted hose
  - When patient complains heels are burning or are painful

- Offloading/Float heel s is important
  - Your hand should slide easily under the heel when

- Use of heel protective devices
  - Heel boots
  - Pillows

- Frequent repositioning = at least every 2 hours

- Apply Skin prep to heels at least daily to intact skin

- Minimize friction and shear – use draw sheet or lifting device to reposition in bed
Heel Pressure Ulcer Treatment

- **No pressure ulcer present:**
  - Offload/float heels
  - Skin prep daily
  - If heels are severely dry and cracked, apply Sween Cream daily

- **Stage 1**
  - Offload/float heels
  - Skin prep daily

- **Stage 2- Stage 4; Unstageable**
  - Offload/float heels
  - If PU present, apply single layer of Vaseline gauze secured with dry dressing until seen by ET or MD recommendations

- **DTI**
  - Offload/float heels
  - Skin prep daily

- **Eschar, Hard:**
  - Offload/float heels
  - Skin prep daily
  - Keep area dry

- **Eschar, Soft:**
  - Offload/float heels
  - Keep area dry
  - Vaseline gauze with dry dressing until seen by ET or MD recommendation
Documentation

- Educate patient and family importance of elevating heels
  - IPOC
  - Comment section in skin assessment section of eRecord
Document in eRecord:

- Heels elevated
- Use of heel boots/pillows for offloading/floating
- Skin prep applied
- Amount patient consumed during meals and snacks
Documentation in eRecord

- Document interventions in eRecord in the Skin Assessment section:
  - Heels elevated on pillows
  - Skin prep applied
  - Status of heels, for example:
    - Intact
    - Mushy
    - Red
    - Open area

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Documentation in eRecord - PU found

• Document in eRecord in the **IView** in the **Physical Assessment Section** in the **Skin Section** under **Pressure Ulcer**

• Documenting in the Pressure Ulcer section will automatically trigger an ET Nurse consult
Nutrition

- Assess patient’s food intake
- Document in eRecord
- Poor nutrition places a patient at risk for pressure ulcer development by contributing to:
  - Reduced muscle strength, function, and fatigue
  - Inactivity
  - Poor skin turgor
  - Decreased albumin
References

