

# DRY BLACK HEEL GUIDE

Once healed take measures to prevent recurrence

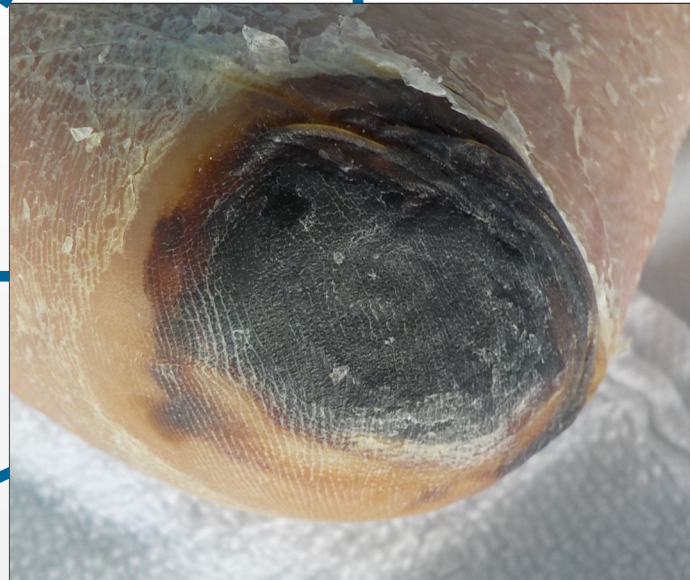
Use offloading devices to reduce or remove pressure on heel e.g.

Non ambulatory— heel protection boots

Ambulatory—pressure relief ankle foot orthotic shoe

Consider x-ray or MRI scan if osteomyelitis is suspected

**Do not debride**



Observe daily for signs of softening, erythema\*, tenderness, purulence\*, fluctuance\* and/or odour

Complete datix/incident report

Keep dry and exposed if no exudate

Obtain photographs of heel

Do not apply dressings which create a moist environment e.g. Gels, ointments or foams

**If the dry black necrosis becomes soft, moist, exuding and breaking down with or without surrounding erythema then the necrosis should be removed/debrided, application of appropriate dressing and refer to the relevant speciality**

**Peripheral arterial disease (PAD)**

Refer to [Vascular](#)

**Diabetic patient**

Refer to [Diabetic foot clinic](#)

**If no PAD or Diabetes**

Refer to [Tissue Viability](#)

\*Erythema = redness; Purulence = pus; Fluctuance = moving in waves, moveable compressible due to abscess/infection; Induration = Localized hardening of soft tissue

# Dry Black Heel Guide

## An area of “black” necrotic eschar or “shell” on the heel

A multidisciplinary team (MDT) approach should be taken to manage all black heels. An agreed plan should be formulated, implemented and reviewed regularly by the MDT.

### Assessment:

Black heels should be described to facilitate communication amongst staff and to accurately monitor the progress or deterioration of the lesion.

To ensure this, the clinician should describe the location and history of the wound, accurately measure and the note tissue types present.

All information should be recorded on the wound assessment chart/Trak.

### Management:

**1) Relief of pressure and/or shear:** Correct moving and handling is essential: gliding sheets should be used at all times which must be long enough to incorporate heels in the manoeuvre. Heel protection devices which elevate the heels from the mattress should be used.

**2) Debridement:** Heel wounds, which have a dry eschar and no oedema, no erythema\* or fluctuance\*, **do not** require aggressive intervention (i.e. any dressings) but continuous assessment is essential as the management plan may change.

If there is oedema, erythema, fluctuance or drainage, then the eschar should be removed, as this necrotic material will provide an optimal environment for bacterial growth. There are several methods of wound debridement available. The wound may appear larger after debridement.

**3) Infection:** All black heels will be colonised with bacteria but are not necessarily clinically infected. If bone is exposed or can be probed, an X-ray should be performed to rule out osteomyelitis.

**4) Dressing Selection:** Dressing choice will depend upon the type and condition of the underlying tissue, the level of exudate, the odour, and condition of the surrounding skin and the depth of the wound. For further information, please refer to the LJJ dressing selection chart.

### Reassessment:

Regular monitoring is essential . It should be a frequent and consistent process, with accurate documentation. Deterioration in the patient’s physical status will also be influential.

A black heel with adequate sensation and vascular supply should show evidence of improvement within 2 to 4 weeks.

While healing is the preferred goal, there are cases, for example in the terminally ill, where the maintenance of comfort is the more realistic or appropriate goal.

### Acknowledgements / References

Fania Pagnamenta–Nurse Consultant (Tissue Viability) Newcastle upon Tyne Hospitals NHS Foundation

Northern Board Guidelines for the Management of Black heels: a multidisciplinary approach 2003.

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Prevention and treatment of pressure ulcers; quick reference guide. Washington DC; National Pressure Ulcer Advisory Panel; 2009.