Heel pressure ulcers accounted for >50% of all hospital-acquired pressure ulcers. From June 2000 through July 2003, heel ulcers, with the exception of one survey, accounted for more than half of our hospital acquired pressure ulcer prevalence rate. We were inconsistently using a rigid, heavy, pressure-relieving boot that sometimes damaged the dorsum of the foot, leaving the nurses and physicians reluctant to use them.

In September 2003, a Task Force was convened consisting of:
- Risk Manager
- Critical Care Physician
- Podiatrist
- WOC (ET) Nurses
- Clinical Informatics Analyst
- Chief Medical Officer
- Chief Nursing Officer
- Managers of Central Distribution, Education, Operating Room, Critical Care

We decided to switch to the HEELIFT® Smooth Boot, a smooth lightweight foam. Our IT Department was able to link an automatic order for the boots as well as a consult to the WOC Nurses for all patients placed on a ventilator or on hemodialysis. The WOC Nurses monitored compliance with the boots’ use. We continued to monitor prevalence every six months among all adult inpatients with our usual exceptions of new mothers and those admitted to Behavioral Health.

At our next prevalence rounds in January 2004, our hospital acquired heel pressure ulcer rate was down to 1.9%. In July 2004, the heel ulcer rate was 1.3%. Our prevalence rounds in January 2005 showed the heel ulcer rate was down to 1%, down to 0% in July, and averaged 1.2% in 2006*.

Instituting an IT System that automatically generates orders for an easy to use and effective boot as well as an automatic consult to the WOC (ET) Nurse for two groups of patients who are at high risk for developing pressure ulcers dramatically reduced the prevalence of hospital acquired heel pressure ulcers in our hospital. Before beginning the study, heel pressure ulcers represented 63% of all pressure ulcers (July 2003). By January 2005, heel pressure ulcers represented only 23% of all pressure ulcers. This represents an almost 66% decrease in the prevalence of hospital acquired heel pressure ulcers 16 months after our Action Plan was initiated.