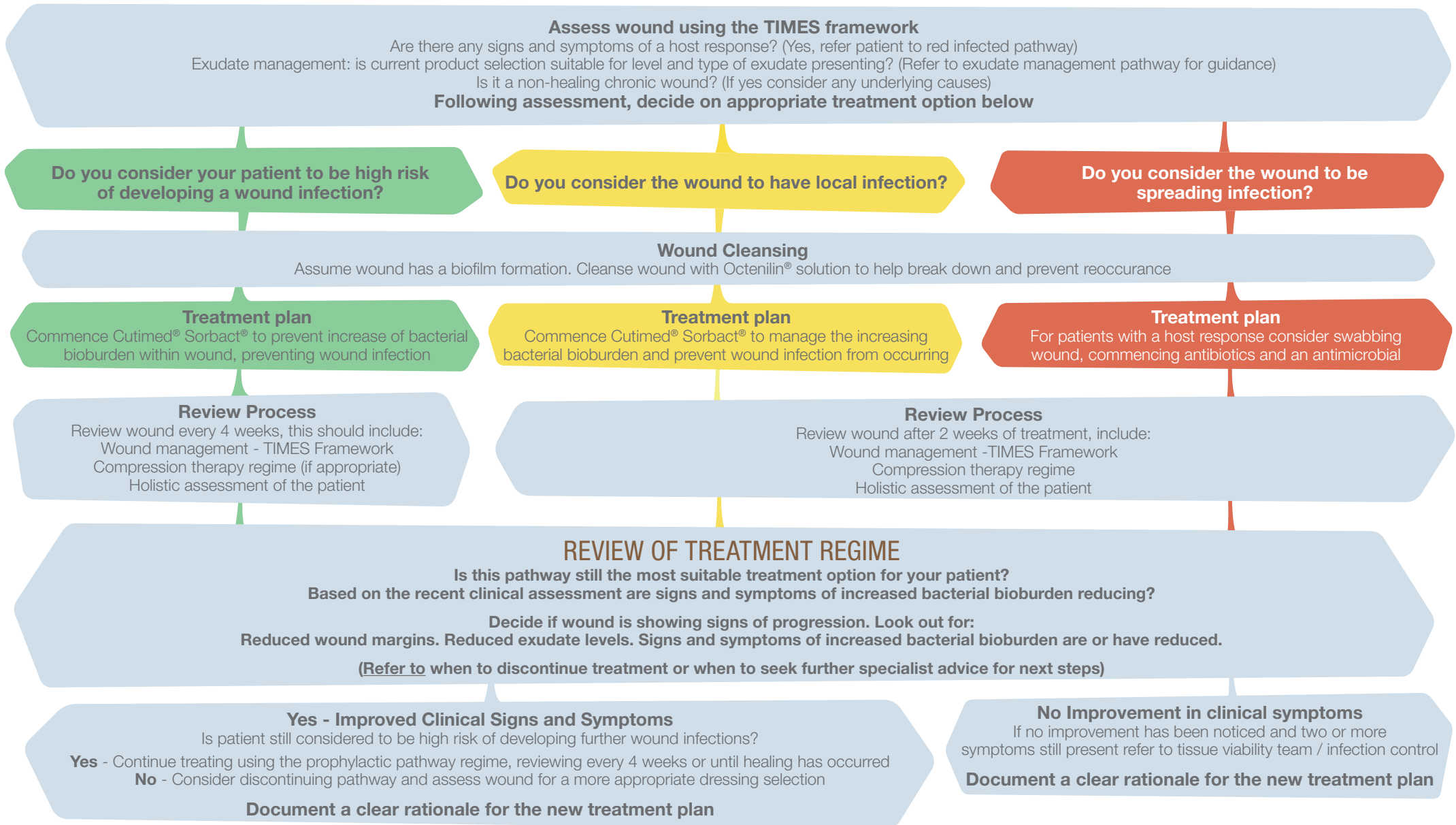


# PREVENTING AND MANAGING WOUND INFECTION



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# PREVENTING AND MANAGING WOUND INFECTION

## SUPPORTING INFORMATION

### What is a High Risk Patient?

- Co-morbidity that alters a patient's immune response
- Patient who has had 2 or more infections within the same wound previously within a 6 month period
- Medications that can alter a patient's immune response (Chemotherapy)

### Holistic Assessment of the Patient

Consider the following:

- Nutritional status including fluid intake
- Co-morbidities - are they being managed effectively?
- Medication regimes
- Compliance with the treatment - is there anything that is preventing compliance?

### Wound Assessment - TIMES Framework

- T** - Tissue type - viable-continue as healthy granulation tissue present. Non-viable-consider debridement options before continuing
- I** - Inflammation or Infection - review pathway if wound is infected
- M** - Moisture levels - aim for a moist wound healing environment refer to Exudate Pathway for appropriate dressing selection
- E** - Edge of the wound is epithelisation present? If no progress observed please review the wound starting at T of TIME
- S** - Surrounding skin - assess the cause and manage hyperkeratosis / eczema / dry skin / oedema / skin damage. Protect the skin for further damage

### Signs and Symptoms of Local infection

- Increased exudate levels
- Wound progression slows down (static wound)
- Erythema not exceeding 2cm
- Alteration in pain levels

### Signs and Symptoms of Spreading Infection

- Erythema extending 2cm
- Pain
- Heat
- Swelling
- Increased Exudate
- Malodour

### Suspected biofilm in the chronic wound - are any of the following present?

- Absence of healing progression, even though all obvious comorbidities and wound management issues have been addressed
- Visible, slimy, gel-like and shiny material on the surface of the wound bed, which detaches easily and atraumatically from the wound bed
- Re-forming of slough quickly, despite debridement
- An increase in the production of exudate
- Poor quality granulation tissue - possibly fragile and/or hypergranulation
- Signs of local infection (as biofilm is a precursor to infection) e.g. heat, redness, swelling, pain, odour

### Systemic Infection

All of the signs and Symptoms of Spreading infection but including a host response (high temperature and generally unwell)

### Cellulitis Guidelines

Diagnosis will include an assessment of the patient highlighting the following:

- Painful, hot, swollen, and tender skin, that spreads rapidly. Skin may have a glossy tight appearance, blisters may also be present
- Look for a skin break where the infecting organism may have entered
- Mark it with a pen to monitor for spreading infection
- GP to commence 7 days oral antibiotics
- Monitor for signs of sepsis - if suspected admit to acute hospital to follow sepsis pathway (the sepsis six)

Cellulitis can often be misdiagnosed and could be:

- Lipodermatosclerosis - hardened, tight, red or brown skin, typically affecting the inner aspect of the calf
- Venous eczema - red, scaly or flaky skin, which may have blisters and crusts on the surface
- Exclude DVT - refer to policy (Venous Thromboembolism in Adults available on intranet)

### Signs of Sepsis

- Class I - there are no signs of systemic toxicity and the person has no uncontrolled co-morbidities
- Class II - the person is either systemically unwell or systemically well but with a co-morbidity (for example peripheral arterial disease, chronic venous insufficiency, or morbid obesity) which may complicate or delay resolution of infection
- Class III - the person has significant systemic upset such as acute confusion, tachycardia, tachypnoea, hypotension, or unstable co-morbidities that may interfere with a response to treatment, or a limb-threatening infection due to vascular compromise
- Class IV - the person has sepsis syndrome or a severe life-threatening infection such as necrotising fasciitis

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