PROCEDURE

ORIGINAL DATE: 10/02
REVISED DATE: 02/08

SUBJECT: WOUND CARE – INFECTIONS

PURPOSE: To describe the process used by clinicians to identify individuals who are at risk for, or present with wound infections, to identify the signs and symptoms of infection, especially with regard to wounds and to report infections properly.

Rationale

All wounds, particularly chronic wounds, are contaminated. In order to limit contamination and prevent infection, the wound should be cleansed with each dressing change and devitalized tissue should be removed through one of the forms of debridement (autolytic, mechanical, enzymatic, sharp/surgical). Contamination does not cause problems with wound healing; however, colonization and infection impedes the healing process. In addition, infection may result in complications such as abscess formation, osteomyelitis or sepsis.

Procedure

1. Assess all individuals with wounds for developing wound infections at every visit.

2. Cleanse and/or debride wounds containing devitalized tissue according to physician orders.

3. Suspect wound infection if one or more of the following signs or symptoms occur:
    a. redness of the periwound tissue that is disproportionate to the wound size
    b. increase in wound bed or periwound temperature
    c. increase in quantity or significant change in quality of pain at the wound site or in the general area
    d. increase in edema
    e. change/increase in wound odor
    f. change in color/consistency and amount of exudates, onset purulent drainage
    g. change in the quality of granulation tissue (i.e. - bleeding easily, dullness)
    h. onset or increase of slough
    i. fever, chills, increased pulse rate and/or, in patients with diabetes, an increase in blood sugar
    j. increased wound size/new areas of breakdown

4. If an infection is suspected, contact the physician for discussion and to obtain an order for a wound culture if the physician deems appropriate. An order for a swab culture can be fulfilled in the home setting. A swab culture will identify organisms contaminating, colonizing and/or infecting a wound. Only a tissue culture will identify true infection. (Refer to HHVNA procedure – "*Obtaining a Swab Culture of a Wound*"). Culture results are documented in the patient's electronic record as they are received.

5. Ask the physician about changes to the plan of care due to the suspected wound infection. The physician may choose to begin a course of antibiotic treatment without the results of a wound culture or may wait for wound culture results to determine if antibiotic therapy is indicated and, if so, which antibiotic to prescribe.

    a. An order for a non-cytoxic antimicrobial dressing should be recommended to the physician and implemented once the order is obtained.
    b. If the clinician or physician recommends Dakin's solution cleansing or packing with Dakin's solution moistened gauze, this should be done with 1/4 strength Dakin's solution for 4 to 7 days only. The goal is to use Dakin's solution to decrease the bioburden in an infected wound. NOTE: long term use limits granulation formation and is discouraged. Exceptions must be documented, including the rationale for use of Dakin's solution for more than 7 days.
    c. Collaborate with the physician to address strategies for pain management if pain control is an issue for the patient.

6. If a wound infection is identified, the clinician will **document the infection in the palm under the "vitals" tab of the clinical record under "signs/sx of infection".**

Reference:

1. Bryant, R and Nix, D. Acute & Chronic Wounds: Current Management Concepts. Third Edition. Mosby, 2007, pp162-163, 277.

Approved Policy Committee: 09/13/05
Approved Policy Committee: 02/12/08