**Guideline for the use of Antimicrobial Wound Care Products**

(*Burns patients undergoing treatment from the NUH Burns Unit are excluded from this guideline)*

**Step 1. Wound assessment**

**Holistic wound assessment** to establish wound characteristics, underlying aetiology and factors which could delay healing. Use aseptic non touch technique for wound care.

**Assess wound for signs of infection**

**Classic signs of Infection**
- Erythema
- Swelling
- Localised heat
- Increase or change in exudate
- Abscess formation / pus
- Offensive or worsening odour
- Systemic signs e.g. pyrexia

**Additional / subtle signs of infection**
- Delayed healing
- Wound breakdown
- Pocketing at wound base
- Epithelial bridging
- Friable granulation tissue
- Discolouration of wound bed
- Increased or unexpected pain

Any of the above signs present?

- **Yes**
  - Continue to Step 2 (see overleaf) - management of wounds showing signs of infection

- **No**
  - Antimicrobial dressing not indicated. Provide wound care dressing as recommended in wound care formulary.

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**Prophylactic** use of antimicrobial dressings will be dependent upon the cause of the wound or risk of infection i.e. burns, bites, dirty traumatic wounds, patients who have reduced immunity, diabetes or poor arterial circulation, unsterile foreign bodies causing trauma. If any of these become clinically infected, despite local treatment then follow the pathway. Diabetic foot wounds should be referred to a specialist centre and closely monitored. Advice on severe burns should be sought from the Burns Unit.

**The Tissue Viability Team may be** contacted for advice or referral at any stage during this process. However this is essential if prolonged antimicrobial treatments are being applied.

**INFECTED WOUNDS SHOULD BE RE-ASSESSED CONTINUOUSLY WITH FORMAL ASSESSMENT EVERY 14 DAYS TO ASSESS EFFECTIVENESS OF MANAGEMENT PLAN**
Step 2. Management of wounds that are showing two or more signs of infection

Send swab for analysis and commence antimicrobial dressing for minimum of 2 weeks.

Initial Treatment
- Inadine (1st line), Flamazine (2nd line), Atrauman AG (3rd line) for flat/ shallow wounds.
- Cavity wound antimicrobial packing- see wound care formulary i.e. Aquacel Ag ribbon. (Suprasorb A + Ag flat may be used for cavity wound packing only where the nature of the wound means that it is less expensive than Aquacel Ag ribbon). Inadine, Flamazine, Aquacel Ag ribbon, Atrauman AG and Suprasorb A + AG should be used for these indications ONLY.

Is infection spreading into surrounding tissues i.e. is redness extending?
Yes= commence empirical systemic antibiotic therapy prior to swab result as per local antimicrobial guidelines.
No= review swab result when available to check sensitivity and if still required prescribe appropriate antibiotic.

Wound assessment should be continued with formal assessment at least every 14 days

Positive microbiology result and clinical signs of infection.
Commence or check antibiotic therapy according to sensitivities, antimicrobial prescribing guidelines and wound symptoms. To evaluate if initial treatment is effective

Antibiotic therapy completed.

Clinical signs of infection persist.
Re-swab wound and consult Microbiology regarding appropriateness of treatment. Review wound process i.e. aseptic non touch technique. Further patient assessment of factors affecting healing and ensure aetiology established.

Secondary Treatment
Consider changing systemic antibiotic according to swab result and consider changing topical antimicrobial according to formulary and treat for 14 days.

Wound Re-assessment of antimicrobial wound dressing at 14 days

No improvement signs of infection/ critical colonisation persist.
Discuss with GP/ microbiology and check FBC + CRP. Refer for specialist advice e.g Tissue Viability Team.

Review underlying cause of infection and delay in healing with specialist e.g. Tissue Viability Team and follow advice for appropriate antimicrobial dressing and wound technique.

The inclusion of silver containing dressings for wound packing is due to the absence of an alternative antimicrobial dressing. There is no quality evidence that has demonstrated the effectiveness of silver containing dressings.

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