Developed by the British Columbia Provincial Nursing Skin & Wound Committee in collaboration with Wound Clinicians from:

Title | Guideline: Assessment, Prevention & Treatment of Wound Infection

| Practice Level | Nurses follow health authority/agency policy.  
|               | Nurses may take a culture and susceptibility swab (C&S) for suspected wound infection without a Physician’s order if this activity is within the nurse’s scope of practice and is supported by health authority/agency policy. 
|               | Swabs must be taken in accordance to the C&S Procedure to ensure good quality. 
|               | Clients with an actual or suspected wound infection require an interprofessional approach to provide comprehensive, evidence-based assessment and treatment. This clinical guideline focuses solely on the nurses’ role as one member of the interprofessional team providing client care. 

| Background | Wound infections are a challenging issue and are costly to the health care system. All wounds contain microbes, however the likelihood of a wound becoming infected is related to the number and virulence of the microorganisms and the ability of the client to resist infection. Risk factors which may contribute to a wound infection developing include poor vascular and tissue perfusion, poor nutritional status, localized edema, smoking, excessive alcohol use, and diseases and medications that compromise the immune system. 
|           | Wounds infections are classified on a continuum: contaminated, colonized, local infection, spreading infection, and systemic infection (sepsis). 
|           | For non-infected contaminated and colonized wound, monitor to ensure the wound progresses to closure. 
|           | For local and spreading wound infections, intervention is required to ensure wound closure and healing. 
|           | For spreading infections, it is important to probe the wound for bone, as chronic ulcers can lead to osteomyelitis if bone is exposed. 
|           | Local and spreading infections may transition to systemic infection and display signs and symptoms similar to other medical conditions. A comprehensive wound assessment is needed to differentiate whether the wound is the source of the infection or another condition is responsible (see Table 1 for Clinical Signs and Symptoms of Wound Infection). 
|           | Signs and symptoms (S&S) of infection may include poor healing and/or increased wound size, increased exudate, odour after wound cleansing, new or increasing pain, periwound erythema, induration and warmth/temperature, and/or increased necrotic tissue in the wound (see Table 1). 
|           | Signs and symptoms of inflammation include induration, erythema, pain, and increasing periwound temperature/warmth. 
|           | Clients living with diabetes mellitus (DM) have a condition associated with a prolonged inflammatory response. This includes delayed leukocyte migration to the wound bed and impaired leukocyte functioning. Clients with DM may have decreased vascular perfusion and a muted immune response decreasing the classical signs and symptoms of infection. 
|           | Gram positive and negative anaerobic and aerobic bacteria and Bacterial pathogens commonly found in wound infections include Staphylococcus aureus, Enterococcus spp., beta-hemolytic streptococci, and the Enterobacteriaceae (e.g., E. coli, Enterobacter spp., Klebsiella spp.), Pseudomonas aeruginosa and anaerobes (e.g., Peptostreptococcus, Bacteroides species) (see Appendix A). 
|           | In addition, toxin producing infections (e.g., Clostridia and some strains of Group A Streptococci and Staphylococcus aureus) cause wound infections, and for these an immediate consult to the surgeon is imperative. 
|           | Antibiotic treatment of wound infections should be guided by a C&S swab or tissue biopsy or needle aspiration. Growth of more than 10^5 organisms per gram of tissue is usually considered positive for a wound infection. Blood cultures are recommended if the client is febrile or hypotensive. 
|           | Biofilms, present in 60-90% of chronic wounds and in 6% of acute wounds delay wound healing and contribute to chronic inflammation. As biofilms cannot be seen and standard culture methods do not capture the true level of biofilm present, determination is based on clinical assessment. Wound cleansing, irrigation and debridement are essential to remove biofilm which will aid in wound healing and in preventing chronic inflammation. Maggot debridement therapy can also be used to assist in removing biofilm.

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January 2017
- Wound cleansing and/or irrigation in addition to the appropriate debridement method are required to remove eschar and necrotic tissue/slough from the wound thereby reducing the bacterial burden and the risk of infection.
- For local infection, a topical treatment using antiseptics or antimicrobial dressings is recommended. **Topical antibiotics are not recommended as they can increase the risk for an allergic response and the emergence of resistant microbes.**
- For spreading or systemic infections, a combination of topical antiseptics or antimicrobial dressings and systemic antibiotics (oral or intravenous) is recommended.

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<th>Indications</th>
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<td>This guideline is intended for acute and chronic wounds with suspected, or diagnosed, local infections or spreading infection. This guideline is not intended for acute surgical site infections healing by primary intention, or for systemic infections.</td>
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<table>
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<th>Definitions</th>
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| **Acute Wound** - A wound with an etiology that “occurs suddenly, either with or without intention, but then heals in a timely manner”
| **Acute inflammatory response** - A normal tissue reaction to injury that may include pain, swelling, itching, redness, and heat; caused when blood vessels dilate and leak fluid that contains leukocytes, plasma proteases and vasoactive amines such as histamine to stimulate healing.
| **Antimicrobials** - Antimicrobial is a general term for drugs, chemicals and other substances that either kill or slow microbe growth. Antimicrobial agents include antibacterial drugs, antiseptics, antivirals agents, and antiparasitic drugs (see Appendix B).
| **Antiseptics** - Antiseptics (topical) are antimicrobial agents that when applied to living tissue or skin, reduce the possibility of infection, sepsis and putrefaction. Antiseptics are distinguished from antibiotics by the latter’s ability to be transported through the lymphatic system to destroy microbes within the body and from disinfectants which destroy microorganisms found on non-living objects. Antiseptics with low toxicity e.g., 10% Povidone-iodine, silver-based products, honey, and chlorhexidine or its derivative polyhexamethylene biguanide (PHMB) may be used in wound care (see Appendix B).
| **Antibiotics** – Antibiotics (topical and systemic) are drugs used to treat bacterial infections.
| **Aseptic Technique** - Technique used to limit the transfer of microorganisms from one person to another by minimizing the microbe count and preventing cross contamination; includes sterile, no-touch, and clean technique. The technique chosen is based on the client clinical condition, the type, wound location and depth, procedure invasiveness, goals of care and agency policy.
| **Sterile Technique** - the use of sterile gloves, a sterile field, sterile tray, sterile instruments, sterile solution and sterile dressings. Only sterile gloved hands or instruments are used for direct contact with the wound.
| **No-Touch Technique** - the use of clean gloves and a sterile field, sterile tray, sterile instruments, sterile solution and sterile dressings. Only sterile instruments are used for direct contact with the wound.
| **Clean Technique** - the use of clean gloves (single client use, non-sterile), a clean field, a clean or sterile dressing tray, clean instruments (single client use), clean solution (single client use) and clean dressings. Clean gloved hands or instruments are used for direct contact with the wound. |
| **Autonomic Dysreflexia (AD)** - A potentially dangerous syndrome affecting persons with a thoracic spinal cord injury at or above the T-6. AD is characterized by uncontrolled hypertension, bradycardia, severe headaches, and pallor below and flushing above the cord lesions, and convulsions. May result from bowel/bladder distension, pain, pressure injuries, and/or infection.
| **Biofilm** - An invisible thin layer of microorganisms adhering to the surface of a structure, which may be organic or inorganic, together with the polymers that they secrete. Biofilms are present in 60% to 90% of chronic wounds and in 6% of acute wounds. Biofilms are characterized by “significant tolerance to antibiotics and biocides.” Biofilms lead to chronic inflammation and interfere with healing, and are not routinely detected in laboratory tests e.g., C&S swabs. \(^{24}\)
| **Chronic Wound** - A wound that is slow to progress through the healing phases due to intrinsic and extrinsic factors. Chronic non-healing wounds could be suggestive of biofilm. A holistic evaluation is needed to correct underlying factors (e.g., ischemia). \(^{47}\)
| **Chronic Wound Inflammation** - A condition in non-healing wounds characterized by high levels of inflammatory cytokines matrix metalloproteinases (MMPs), reduced growth factor activity, and diminished quantities and responses of proliferative cells. Chronic periwound inflammation is distinguished from chronic wounds as a guide to support nursing practice in British Columbia, however it is not a substitute for education, experience & the use of clinical judgment. **Note:** This is a controlled document. A printed copy may not reflect the current, electronic version on the CLWK Intranet (www.clwk.ca). Any document appearing in paper form should always be checked against the electronic version prior to use; the electronic version is always the current version. This DST has been developed as a guide to support nursing practice in British Columbia, however it is not a substitute for education, experience & the use of clinical judgment.
includes erythema, serous exudate, discomfort and warmth and can last for months to year.

**Client** - Recipient of care: community-client; residential care-resident; and in acute care-patient.

**Client/Family** - Two or more individuals who come together for mutual aid. Families are self-defined, and family is ‘who the client says their family is’; this is individualized.

**Conservative Sharp Wound Debridement (CSWD)** - The removal of nonviable wound tissue using a scalpel, scissors or curette to create a clean wound bed; several CSWD’s may be needed.

**Debridement** - The removal of non-viable tissue to support the development of granulation tissue which is necessary for healing to occur. There are several different debridement methods.

**Erythema** - Redness around the wound, may be painful and edematous.

**Eschar, dry stable** - Firm, dry necrotic tissue with an absence of drainage, edema, erythema or fluctuation. It is black or brown in color and is attached to the wound edges and wound base.

**Eschar, soft boggy** - Soft necrotic tissue - black, brown, grey, or tan in color may be firmly or loosely attached to the wound edges and wound base.

**Fluctuance** - Occurs when the wound has a ‘wave-like’ motion when it is palpated.

**Gangrene** - Several types of gangrene exist. Dry gangrene is characterized by dry, shriveled skin ranging from purplish-blue, black, and brown in colour and may occur in clients with peripheral arterial disease. Wet gangrene occurs when there is a bacterial infection in the affected tissue. Blistering, swelling and a ‘wet-appearance’ may occur (e.g., after frostbite or a severe burn).

**Gram negative bacteria** - This class of bacteria do not retain the crystal violet stain (Gram staining method), making positive identification possible; characteristic of bacteria that have a thin layer of peptidoglycan in their cell wall (see Appendix A).

**Gram positive bacteria** - This class of bacteria do retain the crystal violet stain (Gram staining method); characteristic of bacteria that have a thick layer of peptidoglycan their cell wall (see Appendix A).

**Induration** - Hardening of the periwound skin due to inflammation; may be secondary to infection.

**Pain Scales** - Pain is a multidimensional assessment, including physical, emotional, and functional domains. Pain assessment tools have been designed for various age groups and conditions:

- **CRIES Pain Scale** – Used by the neonatal clinician to rate the client’s pain by assessing crying, if the client requires oxygen greater than 95% (percent), noting increasing vital signs, facial expression, and sleeplessness.

- **FLACC** - Face, Legs, Arms, Cry, and Consolability is a behavioral pain scale used for the newborn to the age 3 year old client (based on nursing judgment).

- **Non-Communicative Patient’s Pain Assessment Instrument (NOPPAIN)** - Used to record the clinician’s observations and rating of pain behaviors in the client with dementia.

- **Numeric Rating Scale (NRS)** - The client rates their pain from 0-10 (0=no pain;10=worst pain).

- **Pain Assessment in the Advanced Dementia Scale (PAINAD)** - Used to rate pain for the client living with advanced dementia; rates the client’s pain after clinician observation of five minutes before scoring; the client may be observed at rest, during a pleasant activity, during care-giving, or after administration of pain medication.

- **Visual Analog Scale (VAS)** - Consists of a scale with face images depicting extremes of pain from no-pain to worst pain.

- **Wong-Baker FACES Pain Rating Scale** - A visual rating scale that asks the client to choose the face on the scale that best depicts the pain they are experiencing. The client rate their pain from 0 = does not hurt, to 10 = hurts as much as you can imagine.

**Personal Protective Equipment (PPE)** - Refers to protective gloves, gowns, and masks designed to protect the wearer from injury or infection.

**Product Information Sheet (PISheet)** - Product Information Sheet(s) are developed by the Provincial Nursing and/or Interprofessional Skin & Wound Committee. PISheets are found on the British Columbia Patient Safety and Quality Council's Connecting Learners With Knowledge website.

**Satellite wound** - Small peripheral open areas that are around a larger central wound.

**Slough** - Soft, moist necrotic tissue that is brown, tan, yellow or green in colour. It may be thin or thick and the consistency may be fibrous, stringy or mucinous. It may be firmly or loosely attached to the wound edges and base.

**Wound Infection Continuum** - Wounds can become contaminated or colonized by microbes which may lead to infections. Wound infections are classified on a continuum (see Table 1).
Assessment and Determination of Treatment Interventions

Assessment

1. Assess for Client Concerns
   a. Client/family level of understanding about risk factors for wound infection, the impact of infection on wound healing and the treatment of local infection, spreading and systemic wound infection.
   b. Impact of a wound infection on client’s daily life and body image.
   c. Social and financial concerns and availability of support systems to address concerns arising for the wound infection.
   d. Client/family preferences for treatment of the wound infection, risk factors and the goals of care.
   e. Acknowledge culture and traditions.
   f. Client/family ability and motivation to participate in the treatment plan for wound infection.

2. Assess for Risk Factors for Wound Infection
   a. Chronic medical conditions, especially those that compromise immune status, e.g., diabetes mellitus, venous insufficiency, arterial insufficiency, stroke, cancer and cancer-related treatments, cardiac disease, renal failure, autoimmune diseases, anemias, and rheumatoid arthritis.
   b. Advanced age.
   c. Impaired oxygenation status of skin and underlying tissue, e.g., chronic obstructive pulmonary disease, respiratory disease, heart failure, and anemia.
   d. Lifestyle factors such as cigarette and substance use and the motivation to quit.
   e. Poor personal hygiene (urine and/or fecal incontinence)
   f. Environmental hygiene (unsanitary shelter, water, waste disposal, or food sources).
   g. Medications that compromise the immune system e.g., antineoplastics, systemic corticosteroids, anticoagulants, and vasopressors.
   h. Elevated blood glucose (glycosylated haemoglobin - A1C) for clients living with diabetes.
   i. Impaired nutritional status:
      i. Low body weight, obesity, poor glycemic control, cachexia, hypovolemia/dehydration and prolonged nothing by mouth (NPO).
      ii. Adequacy of nutritional intake including percentage (%) of intake at meals, fibre intake, protein/calorie intake and fluid intake.
      iii. Possible causes of poor intake, e.g., difficulty swallowing, poor dentition, poor positioning for feeding, inability to feed self, gastrointestinal symptoms, and pain.
      iv. Assess renal function if increased protein is indicated for the client.
   j. Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-resistant enterococci (VRE) colonization, Extended Spectrum Beta-Lactamase (ESBL), or other Antibiotic Resistant Organisms (AROs), if known.
   k. Assess for other sites of infection, e.g., urinary tract infections, respiratory infections.

3. Assess for Pain Associated with Wound Infection
   a. New or recent changes in the character or severity of wound pain; type, location, quality of pain.
   b. Rate pain using client self-report and/or observation of non-verbal cues, for examples see Pain Scales definitions.
   c. Impact of pain on activity/mobility, sleep and mood and rate overall quality of life rated by the client e.g., Rate 1-10: 1 is poor quality of life, and 10 is healthy.
   d. Autonomic dysreflexia and/or increased spasticity in clients with a spinal cord injury.

4. Assess the Wound for Infection (Link to Wound Assessment & Treatment Flow Sheet)
   - Presence of undermining, sinuses/tunnels, and if the wound probes to bone.
   - Presence of slough and/or eschar, presence of a foreign body
   - The characteristic and amount of wound exudate.
   - Presence of odour, after cleansing.
   - Presence of satellite wounds on the periwound skin.
Wound Infection Continuum

**Contamination** - Wound contains low levels of non-proliferating microbes that typically do not impede wound healing.\(^2,21,44,47\)

**Colonization** - Wound contains “microbial organisms that undergo limited proliferation without evoking a host reaction”\(^47\)

**Local Infection** - Occurs when microorganisms invade the wound tissue and evoke a host response. “Local infection is contained in one location, system, or structure”.\(^47\) Subtle S&S of infection may evolve into more classic S&S of infection.\(^2,25,47\)

**Spreading Infection** - Occurs when the microorganisms invade the wound leading to classic S&S of infection. Microorganisms proliferate and spread beyond the wound border, this may involve deep tissue, muscle, fascia, organs or body cavities.\(^47\)

**Systemic Infection** - Occurs when the microorganisms invade the body and spread via the vascular and lymphatic system. Systemic inflammation, sepsis, organ dysfunction and death may result.\(^47\)

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### Table 1: Clinical Signs and Symptoms (S&S) of Wound Infection\(^2,13,32,38,44,47\)

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<thead>
<tr>
<th>Clinical Signs and Symptoms of Wound Infection</th>
<th>Vigilance Required</th>
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| **Contamination** Microorganisms are transient, wound closes | • There are no signs of infection, erythema, pain, or excess wound exudate.  
• The wound progresses to closure in a timely manner. |
| **Colonization** Microorganisms present without usually impeding wound healing | • There are no signs of infection, erythema, pain, or excess wound exudate.  
• The wound progresses to closure.  
• If microbial colonization increases, there may be subtle changes in the wound healing progression.  
• Biofilm may develop, interfering with the wound healing progression by contributing to chronic inflammation, and may lead to a localized infection. |
| **Local Infection** Microorganisms invade leading to healing impairment. Subtle S&S of infection may evolve into more classic S&S of infection. | • Increase and/or new onset of wound pain, or increasing pain.  
• Poor healing and/or wound enlargement: less than 10% change in wound measurements after 1 week of care or less than 30% healing in 3 weeks.  
• Friable granulation / hypergranulation / bright red granulation tissue in wound bed.  
• Epithelial bridging and pocketing in granulation tissue.  
• Increase in exudate and/or change in the exudate characteristic e.g., purulent.  
• Onset of, or increased, malodour after wound cleansing.  
• Periwound erythema, local warmth, and edema. |
| **Spreading Infection** Microorganisms invade with classic signs & symptoms of wound infection | • Increased wound size; and the presence of satellite, or new satellite wounds.  
• Periwound warmth 2 cm or greater and/or 2-3°F change in temperature with an infrared thermometer.  
• Periwound erythema extending and induration of 2 cm or greater.  
• Mild to moderate periwound swelling/edema. Wound crepitus.  
• Increasing malodour after wound cleansing.  
• Changes or increased blood glucose  
• Lymphangitis, general malaise/lethargy. |
| **Systemic Infection** Microorganisms invade with classic signs & symptoms of systemic infection | • Increasing general malaise/lethargy.  
• Fever, rigor and/or chills.  
• Change in behaviour or cognition e.g., delirium.  
• Change in blood glucose levels e.g., clients with diabetes mellitus.  
• Autonomic Dysreflexia in clients with T6 spinal cord injuries or above.  
• Rapid, elevated heart rate and respirations.  
• Elevated white blood cell (WBC) count.  
• Severe sepsis leading to septic shock leading to multi-organ failure and/or death. |

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a. If there are 2 or more clinical signs or symptoms of local infection and/or spreading infection consult with the Physician/NP and intervention is required.
b. If there are 2 or more clinical signs or symptoms of systemic infection present, consult with the Physician/NP and intervention is required.
c. Notify the Physician/NP if the wound probes to bone, or if exposed bone is visible.

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d. Biofilms are present in 60%-90% of chronic wounds and 6% of acute wounds, and can delay wound healing and contribute to chronic inflammation. Standard culture methods or clinical assessment alone do not identify biofilms.

e. Some wounds may be in a state of chronic inflammation as evidenced by the wound condition e.g., the presence of erythema, induration, warmth and pain. It is important to determine if there is a change in these indicators, e.g., increasing erythema which may be a sign of infection.

f. Clients with Diabetes Mellitus and a Wound
   i. For clients with diabetes mellitus, 1 or more signs and symptoms of infection, (local or systemic) especially if there is new or increasing pain, is sufficient to warrant consultation with the Physician/NP and doing a C&S swab.
   ii. Diabetes mellitus may mute visible evidence of local infection, due to compromised arterial blood flow, blunting of the inflammatory process, and diminished sensation.
   iii. Uncontrolled blood glucose levels may also indicate an infection (Link to Diabetic Ulcer DST)
   iv. Areas of wet gangrene and spreading or systemic infection in diabetic foot ulcer, especially if the wound probes to bone, are potentially limb or life threatening and require immediate Physician attention.

g. Arterial Wounds
   i. For clients with peripheral arterial insufficiency, 1 or more signs and symptoms of infection, especially if there is new or increasing pain, is sufficient to warrant consultation with the Physician/NP and doing a C&S swab.
   ii. Clients with arterial wounds are at greater risk to develop a wound infection and visible evidence of a local infection may be muted or non-existent due to compromised arterial blood flow and blunting of the inflammatory process (Link to Lower Leg DST).
   iii. Dry stable arterial wounds with eschar which may become moist and boggy at the edges or periwound redness may occur when the wound becomes infected.
   iv. Areas of wet gangrene and spreading or systemic infection in extremity arterial wounds, especially if the wound probes to bone, are potentially limb or life threatening and require immediate medical attention.

h. Venous Wounds
   i. Infected venous wounds may be characterized by newly formed ulcers, satellite wounds, or wound bed extension within the inflamed margins of pre-existing ulcers.
   ii. Venous wounds may exhibit periwound inflammation and warmth caused by venous dermatitis, allergic contact dermatitis or irritant contact dermatitis. Chronic inflammation may present as erythema, scaling, erosions, and/or excoriations (Link to Lower Limb DST).

i. Pressure Injuries
   i. Infection most often occurs in Stage 3, Stage 4, Unstageable (Stage X) pressure injuries, and in Deep Tissue Pressure Injuries (DTPI).
   ii. For pressure injuries that probe to bone, consider osteomyelitis.

j. Surgical Wounds healing by Secondary Intention
   i. Monitor for wound infection.

5. Investigations, where available:
   a. Recent hemoglobin A1C, blood glucose and toe pressures (if available) if the client has diabetes mellitus (Link to Diabetic Ulcer DST).
   b. Radiology studies to rule out osteomyelitis, if the wound probes to bone or if exposed bone is visible.
Determine Treatment Interventions

1. Infection strategies for prevention and intervention are determined and initiated based upon:
   a. The client’s overall assessment data.
   b. The presence/severity of wound infection - local infection, spreading infection, systemic infection.
   c. The wound healability (healable, maintenance, or non-healing).
   d. The client/family willingness to participate in the care plan.

Interventions

Develop a plan of care, in collaboration with the client/family and health care team that incorporates client care, treatment of risk factors, treatment goals, wound management, intended and unintended outcomes, client education and discharge plans.

Client Care Management

1. Address Client Concerns
   a. The care plan should address client/family concerns for the treatment of the infected wound.
   b. If receiving palliative/ end of life service, incorporate client/family wishes into the plan of care.
   c. Consult with Case Management to request additional home support as needed.
   d. Consult with Social Work, Facility Liaison, Aboriginal Health Representative, or Clinical Lead if there are psychosocial or financial concerns.
   e. Refer the client to the appropriate professionals to support improved health and wound healing, e.g., improved diet, access to food, medication management, and exercise plans.

2. Manage Risk Factors for Wound Infection
   a. Encourage the client to monitor any pre-existing illnesses or treatments that compromise the immune system or interfere with healing. Contact the Physician/NP if conditions deteriorate.
   b. Adhere to health authority/agency hand hygiene protocols and Personal Protective Equipment (PPE) recommendations before, during and after dressing changes.
   c. Support client to stop smoking and refer to a smoking cessation program with client consent.
   d. Refer for harm reduction/substance use management if the client consents.
   e. Support the client to achieve optimal glycemic control; hemoglobin A1C should be done every 3 months or more frequently if blood glucose control is unstable. (Link to Diabetic Ulcer DST)
   f. Encourage clients to take their medications as prescribed. Consult Pharmacist if necessary.
   g. Treat other sites of infection e.g., urinary tract infection, respiratory infection.
   h. Provide optimum nutrition to promote healing:
      i. Maximize the client’s nutritional status through adequate protein and calorie intake if compatible with goals of care.
      ii. Clients with chronic wounds should receive 35 kcal/kg of energy dense foods per day including 1.5 g of protein/kg. Assess renal function if increased protein intake is indicated.
      iii. Encourage 1500-2000 ml of fluid daily; or 30 ml or more per kg of body weight. Unless contraindicated e.g., renal, liver dysfunction or heart failure.
      iv. Offer fluids every 2 hours for adult clients with dehydration, fever, vomiting, profuse sweating, diarrhea or heavily draining wounds, unless contraindicated, e.g., heart, liver, or renal failure.
      v. Consult with a Registered Dietitian, if available, if the infection is not resolving or reoccurs or the client has one or more of the following:
         - Nutritional risk factors such as weight loss, dehydration, obesity, poor intake, poor glycemic control, Total Parenteral Nutrition (TPN) or tube feed.
3. Manage/Provide Pain Relief
   a. All new onset or worsening pain may be a sign of infection and requires immediate Physician/NP notification especially if the client has diabetes mellitus or arterial insufficiency.
   b. If the client has known wound pain, and/or CSWD is required, organize prn analgesic administration prior to commencement of CSWD to allow sufficient time for the analgesic(s) to take effect.
   c. If pain before, during and/or after dressing changes is not well controlled with oral medications consult with the Physician/NP and Pharmacist. Discuss use of topical anaesthetic creams, gels or sprays. Consider use an analgesic cover dressing. (Link to PI Sheet).
   d. Reassess wound pain at regular intervals and note any increase in severity or evidence of progressing infection.

Wound Care Management

1. Promote Strategies to Prevent Wound Infection: for Infection Control review
   a. Adhere to agency hand hygiene protocols before, during and after dressing changes.
   b. Aseptic technique is used to limit the transfer of microorganisms from one person to another by minimizing the microbe count and preventing cross contamination. The technique can be either sterile, no-touch or clean and is chosen based upon the:
      i. client’s clinical condition,
      ii. etiology of the wound
      iii. location of the wound
      iv. invasiveness of the procedure,
      v. goal of care, and the
      vi. agency policy.
   c. Clients who require sterile or no-touch technique include, but are not limited to:
      i. immune compromised,
      ii. client taking systemic corticosteroids or cancer medications,
      iii. wound with exposed bone or tendon, or wounds that probe to bone,
      iv. client with burns,
      v. wound at high risk for infection (arterial and diabetic wounds), and/or
      vi. client undergoing Conservative Sharp Wound Debridement (CSWD).
   d. Cleanse the wound bed with at least 100mls of cleansing solution and gently clean the wound with gauze with the goal of removing debris and slough from the wound bed. Removal of debris and slough reduces the risk that microbes will grow and helps prevent development of biofilms.
   e. Debride necrotic tissue using the most appropriate debridement method based upon the condition of the wound and the client setting (Link to Wound Bed Preparation DST):
      i. Autolytic debridement with semi-occlusive dressings can be used if the wound infection is being treated, although this not a preferred method as this is a slower process.
      ii. Mechanical debridement can be used to physically remove debris from the wound using a mechanical debridement device e.g., monofilament pad and forceps.
      iii. Maggot debridement therapy can be used to debride biofilm and necrotic debris in wounds that are colonized or infected (Link Maggot Debridement DST).
      iv. CSWD may be used to disrupt or remove biofilms and necrotic debris. Serial CSWD may be necessary for wounds that have large amounts necrotic tissue or biofilm (Link to be added).
      v. Surgical debridement may be required depending on client’s clinical condition and wound complexity (e.g., necrotizing fasciitis).
      vi. Debridement of biofilm should be followed by the use of antimicrobial dressings, topical antimicrobial agents or antibiotics to help reduce reformation of biofilm (see Appendix B).
      vii. A combination of debridement methods may also be necessary. Consult the Physician/NP and/or the Wound Clinician.
f. Take only the dressing supplies needed for the dressing change to the bedside or into the home; any supplies taken to the bedside or home cannot be returned to the dressing supply room/shelf.

g. For any acute care unit, residential facility or clinic area, client specific supplies must be labeled with the client’s name and kept together in a labelled brown paper bag to ensure easy, quick access to the supplies, to avoid cross-contamination and to protect dressings from light.

h. Supplies kept at the home must be kept secure from children or household pets.

i. Normal saline or sterile water containers must be used by only one client and must be dated and discarded within 24 hours of being opened.

j. Powders, ointments, pastes, gels and cleansing solutions/sprays are for single client use only and must be labelled with the client’s name and the date when opened.

k. Discard unused product as per the timeframe outlined on the PISheet or, if there are no instructions then discard when no longer indicated for use or the wound is closed/healed or product container empty. Discard if visibly contaminated.

l. Dressing supplies must be single client use only.

m. Use the smallest size of dressing that fits into or covers the wound. Wound contact layer dressings should be sized to fit the wound. Cover dressings should be sized to adhere to unbroken periwound skin and provide sufficient exudate absorption. Change cover dressings before leakage of exudate occurs. Leakage increases the risk that outside contaminants may enter the wound bed.

n. Saving Dressing Pieces¹:
   - When sterile technique is required for dressing changes, dressings must be sterile; saved dressings cannot be used.
   - When no-touch technique is used for dressing changes, dressings must be either sterile or appropriately saved dressing pieces.
   - If the dressing is larger than required to complete one dressing change, the unused piece(s) of dressing may be saved using the following process:
     i. In preparation for the dressing change, open the sterile package and place the dressing material onto the sterile dressing tray.
     ii. Use sterile forceps and sterile scissors to cut a piece of the dressing that fits into or covers the wound.
     iii. Use sterile forceps to place the remaining dressing piece into a new C&S container or a new re-sealable plastic storage bag (e.g., Ziploc bag). Each dressing needs its own container/storage bag.
     iv. Seal the container or bag correctly and label the container or bag with the client’s name, date and the name of the dressing.
     v. Note that once a sterile C&S container is opened to the air it is no longer considered sterile.
     vi. If using a dressing piece that has been saved:
         o In preparation for the dressing change, use sterile forceps to remove a dressing piece from the container or bag and place the dressing material onto the sterile dressing tray.
         o Use sterile forceps and sterile scissors to cut a piece of the dressing that fits into or covers the wound.
         o Use sterile forceps to place the remaining dressing piece back into the container or bag which has been labeled with the client’s name, date and the name of the dressing.
     vii. After saving dressings for 2 weeks, discard the container or bag and any remaining dressing pieces.
     viii. If saving another dressing piece, place it in a new C&S container or re-sealable plastic storage bag using the process described above.

¹ A literature review did not find any existing guidelines regarding how to appropriately save dressing pieces nor was literature found to refute this practice. An expert consensus process was used to develop this practice for British Columbia. These infection control strategies have been reviewed and approved by the British Columbia Provincial Infection Control Network Management Office.

Note: This is a controlled document. A printed copy may not reflect the current, electronic version on the CLWK Intranet (www.clwk.ca). Any document appearing in paper form should always be checked against the electronic version prior to use; the electronic version is always the current version. This DST has been developed as a guide to support nursing practice in British Columbia; however it is not a substitute for education, experience & the use of clinical judgment.
2. Promote Strategies to Treat **Local Infection, Spreading and/or Systemic Infection** in a Healable Wound:

   a. Use sterile or no-touch aseptic technique with dressing changes.
   
   b. Cleanse the wound bed: ([Link to Wound Cleansing Procedure](#))
      
      i. Wound cleansing/irrigation is one of the most effective strategies for removing necrotic debris and/or biofilm from infected wounds.
      
      ii. If using a topical antiseptic solution for cleansing wounds, monitor effectiveness of the slough/debris removal and discontinue antiseptic use once the infection is controlled and the wound bed is free of debris (see Appendix B).
      
   c. For the wound with 2 or more signs of **local infection**:
      
      i. Use a topical antimicrobial wound dressing. Antimicrobial treatment needs to be reassessed after 2 weeks of use with discontinuation of the treatment once the infection has resolved, bioburden is controlled or the wound shows evidence of healing.
      
      ii. Monitor frequently for improvement in the wound bed and assess the signs and symptoms of spreading infection.
      
      iii. If the wound infection has not improved after 7-14 days, collaborate with a Wound Clinician, Physician/NP and interdisciplinary team for consideration of other factors that could affect healing including but not limited to poor nutrition, the type of bacteria, ongoing pressure over the wound, poor blood supply or use of an inappropriate dressing and/or the need for a different antimicrobial (see Appendix B).
      
   d. For the wound with 2 or more signs of **spreading infection**:
      
      i. Notify the Physician/NP for consideration of a C&S swab and systemic antibiotics ([Link to C&S Procedure](#)).
      
      ii. Antimicrobial wound dressings may be used in conjunction with antibiotics for spreading wound infection. Assess the signs and symptoms of spreading infection and monitor frequently for improvement in the wound bed. Contact the Physician/NP if improvement is not seen within 72 hours of starting systemic antibiotics.
      
      iii. If wound infection does not show signs of improvement, consideration needs to be made of a different type of antimicrobial dressing and/or antibiotic.

   e. For the client with 2 or more signs and symptoms of a **systemic infection**:
      
      i. Notify the Physician/NP for consideration of a C&S swab and systemic antibiotics.
      
      ii. Antimicrobial wound dressings may be used in conjunction with antibiotics for systemic wound infection; monitor for signs of improvement and contact the Physician/NP if improvement is not seen within 72 hours of starting systemic antibiotics.
      
      iii. If the client’s infection does not show signs of improvement, consideration needs to be made of a different antibiotic.

   f. For the client with diabetes and/or arterial insufficiency with 1 or more signs or symptoms of local, spreading, or systemic infection:
      
      i. Notify the Physician/NP for consideration of a C&S swab and systemic antibiotics.
3. Promote Strategies to Treat Infection in an **Infected Maintenance** Wound  
   a. Use sterile or no-touch aseptic technique with dressing changes.  
   b. Maintenance wounds, where a spreading or systemic infection is present, are to be treated to resolve the infection (see Interventions in 2d & 2e).  
   c. For a dry, small maintenance wound that is locally infected, paint with a topical antiseptic solution (povidone iodine or chlorhexidine without alcohol) (See Appendix B). Paint the entire wound and 2.5 cms of the periwound skin (1 inch). If no improvement is seen in the wound in 7-14 days, consult a Wound Clinician or Physician/NP.  
   d. Debride the wound only if directed by a Wound Clinician or ordered by a Physician/NP.  
   e. For local infection in larger maintenance wounds, see Interventions in 2c.

4. Promote Strategies to Treat Infection in the **Infected Non-Healable** Wound  
   a. Non-healable wounds where infection is present should be treated as per overall care goals (e.g., palliative care/end-of-life care directives).

5. Reassess the wound at every dressing change for signs of improvement or deterioration in the wound infection.

6. Notify a Wound Clinician or Physician/NP if the following occur:  
   a. Acute onset of pain or increasing pain;  
   b. Wound now probes to bone, indicating risk of osteomyelitis;  
   c. Signs of local infection do not resolve within 7-14 days of antimicrobial dressing; and/or  
   d. Signs of spreading or systemic infection do not resolve within 3 days of starting antibiotics.  
   e. Clients who are immune compromised, and/or those with diabetes mellitus should be closely monitored as diabetes-related wounds may rapidly deteriorate. Contact a Physician/NP at the first signs of wound deterioration.

**Client Education**

1. If the client has diabetes mellitus and has not previously participated in a Diabetic Education Program, discuss participation and refer with client consent.

2. Based on the client’s knowledge and understanding about wound infection, discuss the following:  
   a. Signs and symptoms of bacterial burden and local and systemic infection.  
   b. Hand hygiene protocols and infection control prevention strategies.  
   c. Personal hygiene, bathing, showering, if necessary.  
   d. Additional signs of wound infection, such as uncontrolled blood sugars and/or increased pain or wound drainage.  
   e. Healthcare professionals to contact if signs and symptoms of infection occur or increase.  
   f. Strategies to prevent infection from reoccurring.  
   g. Proper dressing technique, if client/family member will be changing dressing.

3. Provide educational material to support and reinforce teaching.

**Discharge Planning**

1. Discharge planning, including when discharge is anticipated, should be initiated during the first client encounter and should support timely discharge and optimal client independence.

2. If the client’s care is being transferred across sectors (acute care, community care or residential care), ensure that the receiving agency is provided with a current wound care plan that outlines the client care, wound management strategies, management of the wound infection, and any completed client education.
British Columbia Provincial Nursing Skin & Wound Committee
Guideline: Assessment and Treatment of Wound Infection

Client Clinical Outcomes

1. Intended - Healable Wounds
   a. The client’s wound does not become infected and closes in a timely manner.
   b. There is early recognition of the risk of developing a wound infection.
   c. Interventions are implemented to prevent or limit wound infection.
   d. If a wound infection develops, appropriate strategies are implemented to assess, treat, and manage the wound infection.

2. Intended - Maintenance Wound (Slow-to-heal)
   a. The client’s wound is maintained and is infection free.

3. Intended - Non-healable Wound
   a. The client’s wound is monitored/managed to be infection free, as long as possible.

4. Unintended
   a. The client’s wound becomes infected.
   b. There was not early recognition of the risk of developing a wound infection.
   c. Interventions were not implemented to prevent or limit wound infection.
   d. A wound infection occurred, and appropriate strategies were not implemented to assess, treat, and manage the wound infection.

Documentation

1. Document prevention strategies for clients at risk (e.g., immuno suppressed, elderly clients).

2. Report wound infection as per agency policy.

3. If wound infection suspected or present:
   - Notify Physician/NP.
   - Document the current treatment care plan as per health authority/agency policy.

References/Bibliography


**Document Creation/Review**

This guideline is based on the best information available at the time it was published and relies on evidence and avoids opinion-based statements where possible. It was developed by the Provincial Nursing Skin and Wound Committee and has undergone provincial stakeholder review.

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<th>Created By</th>
<th>British Columbia Provincial Nursing Skin and Wound Committee in collaboration with Wound Clinicians from all Health Authorities</th>
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<td>Revision Date(s)</td>
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## APPENDIX A: Examples of Microorganisms Commonly Found in Wounds

(Updated from Centers for Disease Control, May, 2016. [www.cdc.org](http://www.cdc.org))

<table>
<thead>
<tr>
<th>Gram Stain</th>
<th>Micro-organisms</th>
<th>Description</th>
<th>Aerobic / Anaerobic</th>
</tr>
</thead>
</table>
| Gram positive | Beta-Hemolytic Strep - Group A | Group A *streptococcus* bacteria can cause a wide range of infections. Clients may also carry group A strep in the throat or on the skin and have no illness symptoms. Group A strep infections are relatively mild illnesses - "strep throat" or impetigo - a skin infection. Occasionally these bacteria can cause serious and even life-threatening diseases.  
- These bacteria spread through direct contact with mucous -nose or throat of people who are sick or through contact with infected wounds or skin sores.  
- Illnesses caused include: Serious illness such as pneumonia (lung infection), necrotizing fasciitis, or streptococcal toxic shock syndrome (STSS). | Aerobic |
| Gram positive | Beta-Hemolytic Strep - Group B (Streptococcus agalactiae) | Rates of serious group B *strept* infections are much higher among newborns than among any other age group, serious group B *strept* infections occur in other age groups in both men and women.  
- Common problems caused by group B *strept* in adults are: bloodstream infections; pneumonia (infection in the lungs); skin and soft-tissue infections; or bone and joint infections. Rarely in adults-group does B *strept* cause meningitis.  
- The source of infection for adults is unknown. Since group B *strept* is a common organism in the GI tract of men & women, this may be a source of some infection. | Anaerobic |
| Gram positive | Clostridium | *Clostridium* species inhabit soils and the intestinal tract of animals, including humans. *Clostridium* is a normal inhabitant of the healthy lower reproductive tract of women. It is spore forming, rod shaped - has multiple strains but *Clostridium Perfringens* is the main pathogen associated in wet gangrene and is capable of producing many different toxins.  
- Symptoms of invasion include severe pain, edema, tissue necrosis or separation of the skin into paper thin black/purple layers along with strong pungent odour. If unchecked can progress to gas gangrene which can be limb and/or life threatening. | Anaerobic |
| Gram positive | Coagulase negative *staphylococcus* (CoNS) | CoNS are regarded as a pathogenic but they are increasingly recognized as causing of clinically significant bloodstream infections. CoNS are part of the normal flora of human skin and mucous membranes. CoNS are the most common cause of bacteremia related to indwelling devices and most of these infections are hospital-acquired.  
- Important infections include central nervous system shunt infections, native or prosthetic valve endocarditis, urinary tract infections and wound infections.  
- Risk factors for CoNS infection include the presence of foreign devices (such as intravascular catheters) and immune compromise.  
- Treatment of CoNS infections can be challenging given limitations of antimicrobial resistance and the frequent presence of foreign material. | Aerobic |
| Gram positive | Corynebacterium | Corynebacterium species occur commonly in soil, water and food products. The genus contains the species Corynebacterium diptheriae and the nondiphtherial corynebacteria, collectively referred to as diphtheroids. Nondiphtherial corynebacteria are increasingly recognized as pathogenic, especially in immunocompromised hosts.  
- *Nondiphtherial Corynebacterium* species can be found in the mucosa and normal skin flora of humans.  
- Common infection with these organisms is bacteremia in association with infections involving devices e.g., heart valves, catheters, and neurologic shunts. They are also found in wounds. | Aerobic & can also survive in an anaerobic environment |
| Gram positive | Peptostreptococcus | *Peptostreptococcus* are found predominantly in the mouth, skin, gastrointestinal, vagina and urinary tracts, and compose a portion of the bacterial gut flora. Under immunosuppressed or traumatic conditions these organisms can become pathogenic, as well as septicemic, harming their host. *Peptostreptococcus*:  
- Can cause brain, liver, breast, lung abscesses, and soft tissue (wound) infections.  
- Are the 2nd most frequently recovered anaerobes and account for approximately one quarter of anaerobic isolates found.  
- Grows slowly which makes them increasingly resistant to antimicrobials. | Anaerobic |
| Gram positive | Staphylococcus Aureus – S. Aureus | *Staphylococci* (staph): A common type of bacteria that live on the skin and mucous membranes (e.g., in the nose) of humans. *S. aureus* is the most important of these bacteria in human diseases. They are only able to invade via broken skin or mucous membranes; hence, intact skin is an excellent human defense. However, damage to the skin or other injury may allow the bacteria to overcome the body’s natural protective mechanisms of the body, leading to infection. *S. aureus*:  
- Is capable of causing various infections of the skin and other organs.  
- Infections are common with frequent skin injury, particularly if the skin is dry.  
- Most commonly found in wounds, especially diabetic foot ulcers (DFU). They are generally very hardy organisms. | Aerobic |
<table>
<thead>
<tr>
<th>Gram Stain</th>
<th>Micro-organisms</th>
<th>Description</th>
<th>Aerobic / Anaerobic</th>
</tr>
</thead>
</table>
| Gram negative | *Bacteroides fragilis* | Bacteroides are 1% to 2% of the normal colonic bacterial microbiota in humans. They are significant pathogens and commonly found in most anaerobic infection. Bacteroides maintain a generally beneficial relationship with the host when retained in the gut, but when they escape they can cause significant pathology, including bacteremia, soft tissue and wound infections.  
- The species *B. fragilis* is an opportunistic human pathogen causing infections of the peritoneal cavity, gastrointestinal surgery, and in wounds.  
- Bacteroides fragilis is resistant to a wide variety of antibiotics — β-lactams, aminoglycosides, and recently many species have acquired resistance to erythromycin and tetracycline. | Anaerobic |
| Gram negative | *E. Coli (Enterobacteriaceae)* | Usually occurs later in the course of wound deterioration and in deeper wounds. *E. Coli* lives in the digestive tracts of humans. While many *E. Coli* are normal gut flora, some strains are human pathogens, and are known as the most common cause of urinary tract infections, gastrointestinal disease (ranging from simple diarrhea to dysentery-like conditions), as well as other infections such as wound infections.  
- Potential sources of exposure are contaminated food or water and person-to-person contact. People who have weakened immune systems are more likely to become ill from *E. Coli*. | Anaerobic |
| Gram negative | *Extended-Spectrum Beta-Lactamase (ESBL) producing bacteria* | ESBL is a gram-negative bacteria that produces an enzyme; beta-lactamase has the ability to breakdown commonly used antibiotics, such as cephalosporins and penicillins and make them ineffective for treatment. Clients colonized with the bacteria carry the ESBL producing bacteria that cause infection without any signs or symptoms.  
- *Escherichia coli* and *Klebsiella pneumoniae* (see below) are the most common forms.  
- ESBL producing organisms are commonly isolated from urine, wound or skin, feces and have also been found in blood and the respiratory tract.  
- ESBLs are usually spread via direct and indirect contact with colonized/infected clients and contaminated environmental surfaces.  
- ESBLs are most commonly spread via unwashed hands of health care providers. | Anaerobic |
| Gram negative | *Klebsiella (Enterobacteriaceae)* | *Klebsiella* species are routinely found in the human nose, mouth, and GI tract as normal flora; however, they can also behave as opportunistic human pathogens.  
- *Klebsiella* organisms can lead to a wide range of disease states, notably pneumonia, urinary tract infections, sepsis, meningitis, diarrhea, and soft tissue (wound) infections. Infections are more common in the very young, very old, and those with other underlying diseases, such as cancer.  
- *Klebsiella* usually occurs later in the course of wound deterioration and in deeper wounds.  
- The principal pathogenic reservoirs for transmission of *Klebsiella* are the GI tract and the hands of hospital personnel. | Anaerobic |
| Gram negative | *Proteus mirabilis* | *P. mirabilis* causes 90% of all Proteus infections in humans. It is widely distributed in soil, water and is commonly found in the intestinal tracts of humans.  
- *Proteus* is also found in multiple environmental habitats, including LTC facilities and hospitals. In hospital settings, it is not unusual for *Proteus mirabilis* to colonize both the skin and oral mucosa of both clients and hospital personnel. Infection primarily occurs from these reservoirs.  
- *Proteus vulgaris* and *Proteus penneri* are also easily isolated from clients in LTC facilities, hospitals and from clients with underlying diseases or compromised immune systems. | Anaerobic |
| Gram negative | *Pseudomonas aeruginosa* | *Pseudomonas* infection is caused by strains of bacteria found widely in soil, water and on the skin. The most common type causing infections in humans is called *Pseudomonas aeruginosa*.  
- *Pseudomonas aeruginosa* is a common bacterium that usually occurs later in the course of wound deterioration. It is also commonly found in diabetic foot ulcers. Because it thrives on moist surfaces, this bacterium is also found on medical equipment, including catheters.  
- Serious *Pseudomonas* infections usually occur in clients in the hospital and/or with weakened immune systems.  
- *Pseudomonas* infections, like those caused by many other hospital bacteria, are becoming more difficult to treat because of increasing antibiotic resistance. | Aerobic |
| Gram negative | Veillonella | *Veillonella* is a normal bacterium in the intestines and respiratory tract. It is a small, coccus that is part of the normal flora of the mouth, GI tract, and vagina in humans.  
- When isolated from clinical specimens, *V. parvula* is often regarded as a contaminant or commensal, but it has been implicated as a pathogen in infections of the sinuses, lungs, heart, bone, and soft tissue. | Anaerobic |
## Appendix B: Topical Antimicrobials Products

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Product with link to PISheets</th>
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<tbody>
<tr>
<td><strong>Antimicrobial Dressings</strong></td>
<td>Cadexomer Iodine ointment or paste dressing</td>
<td>Iodosorb</td>
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<tr>
<td></td>
<td>Povidone Iodine dressing</td>
<td>Inadine</td>
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<tr>
<td></td>
<td>Povidone Iodine solution</td>
<td>Povidone Iodine for Wound Care</td>
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<tr>
<td></td>
<td>Honey - Gel and impregnated dressing</td>
<td>Medihoney Antimicrobial Medical Honey</td>
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<td></td>
<td>Honey - Calcium Alginate Honey</td>
<td>Medihoney Apinate</td>
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<tr>
<td></td>
<td>Methylene Blue / Gentian Violet Foam dressing</td>
<td>Hydrofera Blue</td>
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<td>Silver Alginate dressing</td>
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<td>Silver Foam</td>
<td>Biatin AG</td>
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<td>PHMB Antimicrobial Foam w Border</td>
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<td>Polyhexamethylene Biquanide (PHMB) Foam</td>
<td>PHMB Antimicrobial Foam</td>
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<tr>
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<td>Polyhexamethylene Biquanide (PHMB) Gauze</td>
<td>PHMB Antimicrobial Foam w Top Sheet</td>
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<td></td>
<td>Chlorhexidine Dressing</td>
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<td>Acetic Acid (0.25%, 0.5%, and 1% solutions)</td>
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<td>Sodium hydrochloride</td>
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<td>Chlorhexidine solution</td>
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Appendix C: Topical Antibiotic Products available for Treating Wounds (Under development)