SESLHD PROCEDURE COVER SHEET

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FUNCTIONAL GROUP(S)	Infection Control Surgery, Perioperative and Anaesthetic
KEY TERMS	Antimicrobial Wound Antiseptic Silver dressings Medical honey Chlorhexidine Cadexomer Iodine Polyhexamethelene Biguinide (PHMB)
SUMMARY	This document outlines the use of antiseptic dressings and has a criteria and algorithm regarding when these dressings should be utilised.

1. POLICY STATEMENT

To ensure that antiseptic dressings are appropriately prescribed, utilised and monitored whilst providing safe and effective wound care for patients. Where uncertainty about the use of an antiseptic dressing exists, a clinician must seek the expertise of a recognised wound care expert within their facility.

2. BACKGROUND

The aim of this policy is to:

- Provide patients with safe effective wound care
- Facilitate appropriate use of antiseptic dressing products
- Ensure adherence to manufacturer's instructions

2.1 Types of Antiseptic / Antimicrobial dressings

Includes any dressing product with the following ingredients:

- Cadexomer Iodine
- Chlorhexidine
- Medical honey
- Polyhexamethelen Biguinide (PHMB)
- Betaine/polyhexanide
- Silver dressings

3. DEFINITIONS

Ankle Brachial Pressure Index (ABPI)	The ankle–brachial index is the ratio of the highest systolic blood pressure measured at the ankle to that measured at the brachial artery (Donnou et al, 2018)
Antiseptic / Antimicrobial dressings	These dressings are applied topically. All antiseptic dressings are antimicrobial. These dressings reduce bacterial burden and suppress the biofilm formation and reformation. The dressings do not impact on the wound healing process that continues to take place (Leaper,2015). Recommended to use for 2 weeks and re-evaluate. (Erikkson et al, 2021)
Biofilm	Biofilms are defined as an aggregate of bacteria tolerant to treatment and the host defences (Wound International, 2017). Wound biofilms are associated with impaired wound healing and signs and symptoms of chronic inflammation (IWII 2022)
Chronic wounds (also known as **Hard to Heal Wound** due to delayed wound healing)	These wounds fail to progress through an orderly process of healing where an anatomical and functional result is not achieved within an appropriate length of time (Zhao et al, 2016)

Infection	There is a presence of multiplying microbes leading to inflammation, redness, swelling, warmth, pain and possibly a fever (Alves, 2020)
Localised infection previously known as critical colonisation	Compromised by microbes whereby delayed healing without signs and symptoms associated with clinical infection (Alves et al,2020)
Wound Care Expert	A person with advanced training in wound management and recognised within the facility for example, CNC/CNS 2 wound care, CNC/CNS 2 Stoma and wound care, Clinical Nurse Educators, Nurse Educators, Podiatrist and in ED this would include a Nurse Practitioner or CNS with wound portfolio

4. RESPONSIBILITIES

5.1 Registered/Enrolled Nurses will:

Ensure that they work within their scope of practice and attend relevant education related to this procedure and use products appropriately as outlined by the product guidelines/instructions.

5.2 Line Managers will:

Ensure all clinical staff are given the opportunity to attend wound management education and that all clinicians work within this procedure and have appropriate resource and stock items to implement the recommendations within this procedure.

5.3 Allied Health and Medical staff will:

Ensure that they work within their scope of practice and attend relevant education related to this procedure and use products appropriately as outlined by the product guidelines/instructions.

5. PROCEDURE

- The clinician must seek the expertise of a recognised wound care expert within their facility to ensure appropriate use of all antiseptic dressings.
- Prior to commencement of an antiseptic dressing a complete wound assessment must be carried out and documented (as per Documentation)
- Allergies should be checked and documented prior to commencement of an antiseptic dressing e.g. allergy to iodine if this type of dressing is being considered
- Criteria for antiseptic dressing (refer to Appendix A) is to be used to assess the need for an antiseptic dressing
- Sterile water or a betaine/polyhexanide solution (e.g. Prontosan) should only be used to clean wounds prior to using silver dressings (Xu, 2021).
- Preparation of the wound bed is essential prior to application of antiseptic dressings e.g. debridement prior to using silver dressings. Silver products do not penetrate

through Biofilm and require debridement or betaine/polyhexanide solution (e.g. Prontosan) soak prior to application when Biofilm suspected on wound bed.

- All wounds where antiseptic dressings are being utilised require re-assessment of antiseptic dressing product/s every 2 weeks to determine if antiseptic dressings are still appropriate for the wound. Refer to the Antiseptic Algorithm (refer to Appendix B)
- It is recommended that the same antiseptic dressing product/s is used for two weeks unless clinical complications occur from the use of the dressing product (refer to Appendix B)
- Re-assessment of wound base and use of antiseptic dressing product/s every 2 weeks to determine if antiseptic dressings are still appropriate for the wound. Refer to Appendix B)
- After 2 weeks if the wound has not responded and it is determined that an antiseptic dressings is still required change the type of antiseptic dressings.
- The clinician must assess the exudate volume before selecting the type of antiseptic product to be used as the effectiveness of any antiseptic dressing is influenced by the level of wound exudate.
- Document the assessment findings and outcome and document in the patient's medical records.

- **Silver dressings must be removed prior to patient going into the MRI scanner.**

6. DOCUMENTATION

In the patient's medical record document as per SESLHD requirements.

Use the eMR wound template when available or appropriate wound care paper-based form.

Examples of wound documentation include both eMR and paper forms

- Community Health-Wound Assessment Treatment Evaluation Plan (WATEP)
- eRIC wound template for ICU patients
- Wound Assessment and Management form (SE1060.118)

7. AUDIT

N/A

8. REFERENCES

1	Alves, P. J., Barreto, R. T., Barrois, B. M., Gryson, L. G., Meaume, S., & Monstrey, S. J. (2021). Update on the role of antiseptics in the management of chronic wounds with critical colonisation and/or biofilm. *International Wound Journal*, *18*(3), 342-358.
2	Donnou, C., Chaudru, S., Stivalet, O., Paul, E., Charasson, M., Selli, J. M., ... & Mahé, G. (2018). How to become proficient in performance of the resting ankle–brachial index: Results of the first randomized controlled trial. *Vascular Medicine*, *23*(2), 109-113.
3	Eriksson, E., Liu, P. Y., Schultz, G. S., Martins-Green, M. M., Tanaka, R., Weir, D., ... & Gurtner, G. C. (2022). Chronic wounds: Treatment consensus. *Wound Repair and Regeneration*, *30*(2), 156-171.
4	Leaper, D., Assadian, O., & Edmiston, C. E. (2015). Approach to chronic wound infections. *British Journal of Dermatology*, *173*(2), 351-358.
5	Xu, D., Chu, T., & Tao, G. (2021). Clinical Study on the Efficacy of Silver Ion Dressing Combined with Prontosan Gel Dressing in the Treatment of Diabetic Foot Ulcers and the Effect on Serum Inflammatory Factors. *Evidence-Based Complementary and Alternative Medicine*, *2021*.
6	Zhao, R., Liang, H., Clarke, E., Jackson, C., & Xue, M. (2016). Inflammation in chronic wounds. *International journal of molecular sciences*, *17*(12), 2085.
7	International Wound Infection Institute (IWII), Wound Infection in Clinical Practice Wounds International (2022)

Internal Wound Care Policies, Procedures and Business Rules

#	Document number	Document title
1	POWH CLIN151	Wound: Cellulitis, Care of the Patient with
2	POWH/SSEH CLIN134	Wound: Fungating Wound Management
3	POWH/SSEH CLIN012	Wound: Larval therapy in wound management
4	POWH/SSEH CLIN029	Wound: Moist Wound Healing and the Use of Dressing Products
5	POWH/SSEH CLIN027	Wound: Split Skin Graft (SSG) and Donor Site Dressings
6	POWH/SSEH CLIN022	Wound: Skin Tear Management Guidelines
7	SESLHDPR/297	Wound: Assessment and Management
8	SESLHDPR/285	Wound: Clinical Digital Photography

9. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
May 2010	DRAFT	Area Wound Care Committee
July 2010	DRAFT	Area Patient Safety and Clinical Quality Committee
July 2010	DRAFT	Area Clinical Council
Sept 2010	0	Published
Nov 2011	1	Rebadged in SESLHD template - Michelle Bonner Acting Policy Officer
Dec 2011	2	Comment left in policy removed by Michelle Bonner Acting Policy Officer with approval of Lisa Graaf and Trish Morgan
May 2017	3	SESLHD wound Committee
November 2022	4	Minor review by ISLHD and SESLHD Wound Committees. References and definitions updated, additional information included regarding silver products. References and links updated, minor changes to wording. Conversion to procedure template – SESLHDPR/750
December 2022	4	Approved by Executive Sponsor
February 2023	4.1	Published by SESLHD Policy team following formatting changes and advice that Drug and Therapeutic Committee approval not required.

Appendix A: Criteria for Antiseptic Dressing

Criteria
A. Acute or post-acute burn injury (if Yes immediately commence Antiseptic / Antimicrobial dressings). Contact Concord Hospital Burns Unit if further advice is required.
B. Meets 2 or more of the following criteria :
High risk patients (e.g. palliative care / ICU / High Dependency / diabetic, immunosuppressed and/or patients with complex wounds / exposed bone)
History of Repeated infections which are investigated and treated
Wound size not reduced by 30% within 2 weeks
Exudate has **increased** or become purulent
Odour present or increased
Debris or necrotic tissue present (consider removal)
Erythema, Oedema and Increased Temperature or change in wound bed colour
Hypergranulation tissue present
Friable granulation (bleeds on contact)
Tissue bridging / rolled wound edges / pocketing / induration
Alteration in pain from wound not associated with procedural pain e.g. increased or new pain
And the following has taken place:
Investigation/s and treatment of other possible causes of delayed wound healing. **Examples for investigations include:** Wound biopsy, Ankle Brachial Pressure Index, x-ray, wound swab etc.
Patient has agreed to follow a **comprehensive wound management** program
Valid prescription / documentation/initiation of Antiseptic Dressings
Prior to commencement of an antiseptic dressing a complete wound assessment must be carried out and documented on an authorised wound care management plan paper form or eMR as appropriate in your local health care district.

Appendix B: Antiseptic Dressing Algorithm (Used in conjunction with Appendix A)