

Wound Care Enabler Series

Enabler # 5 ASSESSING FOR WOUND INFECTION

1. Assess for clinical signs Superficial Wound Infection

Superficial Infection → 3 or more NERDS¹ = No swab + Antimicrobial Dressing

Non-Healing wound:	Wound is not healing in 2-4 weeks
Exudate is increased:	You notice more exudate on dressing
Red friable tissue:	Granulation tissue is not healthy and bleeds easily
Debris:	You see slough and/or eschar in the wound
Smell:	Still smelly after you clean it



2. Assess for clinical signs of Deep & Surrounding Wound Infection

*Deep & Surrounding Infection → 3 or more STONEES¹ = Swab + antimicrobial dressing + antibiotics

Size is bigger:	Wound measurements show wound is larger
Temperature is increased:	Increased peri-wound temp > 3° F compared to 2 mirror image areas
Os:	Wound probes to bone/exposed bone in wound
New breakdown:	New/Satellite areas of breakdown
Exudate is increased:	You notice more exudate on dressing
Erythema/Edema:	You note peri-wound to be red +/- swollen
Smell:	Still smelly after you clean it

Intervention: ^{1, 2}

- Antimicrobial dressings: 2 week challenge
- Antibiotic per protocol
- Re-evaluate infection using NERDS and STONEES at each dressing change

*Special Considerations in Diabetes: ³

- Deep & surrounding foot infections lead to limb loss
- Red flags: In addition to STONEES, pain in an insensate foot, flu-like symptoms, erratic glucose control

1. Woo, K.Y., & Sibbald, R.G. (2009). A cross-sectional validation study of using NERDS and STONEES to assess bacterial burden. *Ostomy Wound Management*, 55(8), 40-48.

2. Edwards-Jones, V., Flanagan, M., & Wolcott R. (2015). Technological advancements in the fight against antimicrobial resistance. *Wounds International*, 6(2), 47-51.

3. Registered Nurses' Association of Ontario (2013). *Assessment and Management of Foot Ulcers for People with Diabetes* (2nd ed.). Toronto, ON: Registered Nurses' Association of Ontario