Appendix 2

Scottish Ropper Ladder for Infected Wounds

Guidelines for identifying infected wounds and when to start and stop using topical Antimicrobial Wound Dressings (AWD)

NHS SCOTLAND

Each stage builds on the previous signs noted

Each stage builds on the previous treatment

***Refer to local guidance**

Stage 4 - when 1 or more signs of systemic infection present: May lead to sepsis if not treated

- Spreading cellulitis
- Pus/abscess
- Patient systemically unwell
- Pyrexia
- Raised white cell count/CRP
- Wound breakdown+/-satellite lesions.

Stage 4 - Treatment

1 Swab wound*.
2 Consider: SEPSIS 6*; other source; blood cultures.
3 Start systemic antibiotics* and monitor patient.
4 If rapid deterioration immediate referral for urgent medical advice.
5 Consider topical AWD*. *
6 Monitor wound progress*, review at 2 weeks – see Stage 2, point 4, for actions.

Stage 3 - When 2 or more signs of spreading infection present: Wound deteriorating

- Localised cellulitis/erythema
- Pain increasing
- Exudate: thick, haemopurulent or purulent
- Localised oedema
- Malodour increasing.

Stage 3 - Treatment

1 Swab wound*.
2 Start topical AWD*.
3 Consider starting systemic antibiotics*.
4 Monitor wound progress*, review at 2 weeks – see Stage 2, point 4, for actions.
5 *If signs of systemic infection, go to Stage 4.*

Stage 2 - when 2 or more signs of local infection present: Healing not progressing normally

- Exudate - high volumes
- Malodour
- Pain in or around wound
- Hypergranulation tissue
- Discoloured or bleeding granulation tissue
- Slough/necrosis.

Stage 2 - Treatment

1 DO NOT SWAB.
2 Consider biofilm disrupting cleansing solution.
3 Consider topical AWD*.
4 Monitor wound progress*, review at 2 weeks:
  a 'If no signs of infection, STOP and return to Stage 1, point 4 for actions
  b If improving, continue and review weekly until no signs of infection
  c If static, review AWD* choice.
5 *If signs of spreading infection, go to Stage 3.*

Stage 1 - when 2 or more signs of Contamination/ Colonisation present Healing progressing normally

- Exudate - low to moderate volume
- Pain - minimal
- Odour - minimal
- Slough/necrosis.

Stage 1 - Treatment

1 DO NOT SWAB.
2 Identify aetiology of the wound and refer if any concerns e.g. vascular, lymphoedema.
3 Refer all diabetic wounds to diabetic podiatry/MDT.
4 Optimise wound healing with debridement and dressings*.
5 If no progress after 2 weeks review wound management plan.
6 *If signs of local infection go to Stage 2.*

START

In certain patients, some signs and symptoms of infection might be masked e.g. diabetes, vascular, immunocompromised. Clinical judgement should be used to determine when AWDs should be used.

References:
International Wound Infection Institute (IWII), Wound Infection in clinical practice. Wounds International 2016
Wounds UK Best Practice Statement. The use of topical antimicrobial agents in wound management. London: Wounds UK, 2013 (3rd Ed)
European Wound Management Association (EWMA). Position Document: Management of wound infection. London: MEP Ltd 2006
European Wound Management Association (EWMA). Position Document: Identifying criteria for wound infection. London: MEP Ltd 2005
Care of deteriorating patients. Edinburgh: SIGN; 2014.

Adapted from Ruth Ropper Lothian Ladder Version 2 by SLWG for Antimicrobial Wound Dressings consisting of Health board and speciality representatives.
1st Edition: September 2017; Review: September 2020
Medical Photography Service, NHS Lothian,October 2017

Ruth Ropper
Lead Nurse, Tissue Viability, NHS Lothian
Email: ruth.ropper@nhslothian.scot.nhs.uk