The Assessment and Management of Bacterial Loading in Wounds Tool (AMBL)

Oxford Health NHS
NHS Foundation Trust

		Wound Bed Contamination Patient's immune system is maintaining bacteria at safe levels Healing / patient not compromised	**Wound Bed Colonisation** Multiplying bacteria has the ability to tip patient and wound defences Healing compromised	**Local Wound Bed Infection** Patient's defences are overwhelmed Healing *and* patient compromised	
LOCAL SIGNS & SYMPTOMS [4]	*Wound bed*	Wound surface area has reduced in size by 40% at 6 weeks. Positive granulation/ epithelialisation	Healing has slowed /or stopped (non-progressing wound). Sloughy/necrotic tissue may be present	Healing has stopped *or* Wound has deteriorated / extended	
	Exudate Levels	Normal exudate for patient/wound type	Increased exudate (sometimes mild odour)	Malodorous / Copious / purulent exudate	
	Pain	No change	Increased / changed pain	Acute / changed pain	
	Erythema	Erythema not usually present [1]	Erythema not usually present [1]	**Local Wound bed Infection** Erythematous border <2cm	**Systemic infection** Erythematous border >2cm
SYSTEMIC SIGNS & SYMPTOMS[4]		None	None	Abnormal/changed odour Discoloured/friable Tissue/ Pocketing Bridging/Necrosis slough	Pyrexia Tachycardia General malaise Raised WBC & CRP Soft tissue infection
MANAGEMENT	*Systemic antimicrobials (antibiotics)*	No	No	No	Yes
	High Risk patient? [4]		consider antibiotics in line with local prescribing protocols/guidelines	Yes	
	Wound Swabs for M, C & S	No [2]	No [2]	No [2]	Yes
	Topical Antimicrobial dressing	Standard formulary dressing	1st Line Honey-impregnated dressing 2nd Line Iodine-based dressing	1st Line Honey-impregnated dressing 2nd Line Iodine-based dressing	
	Other actions	Debride sloughy/necrotic tissue[3] Treat / optimise co-existing morbidities Assess wound for colonisation/ wound bed infection at every dressing change	Consider referral to Tissue Viability Treat/optimise co-existing morbidities Assess wound for infection at every dressing change Debride sloughy/necrotic tissue[3]	Refer to Tissue viability if support needed Treat / optimise co-existing morbidities	

[1] *Some wounds (if chronic or < 72 hours old or) may have an erythematous border due to the inflammatory processes of wound healing; the erythematous border should be < 1cm*

[2] *Wound swabbing is only indicated where systemic antibiotic therapy is required to treat systemic infection and soft tissue infection such as Cellulitis*

[3] *Do not attempt to debride lower limb wounds until vascular integrity has been explored in line with a holistic patient assessment. A lower limb assessment (Palpate Pedial Pulses, capillary refill, skin assessment etc) plus a Doppler (where appropriate) should be clearly documented.*

[4] *Note that high risk patients (including those with diabetes or compromised immune / circulatory systems) may not display the signs & symptoms of colonisation or infection described below and may present with more subtle signs.*

This diagnostic tool has been adapted by kind permission from Gill Wicks of Great Western Hospital NHS Foundation Trust Community Services.

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The Management of Bacterial Loading in Wound Beds Pathway