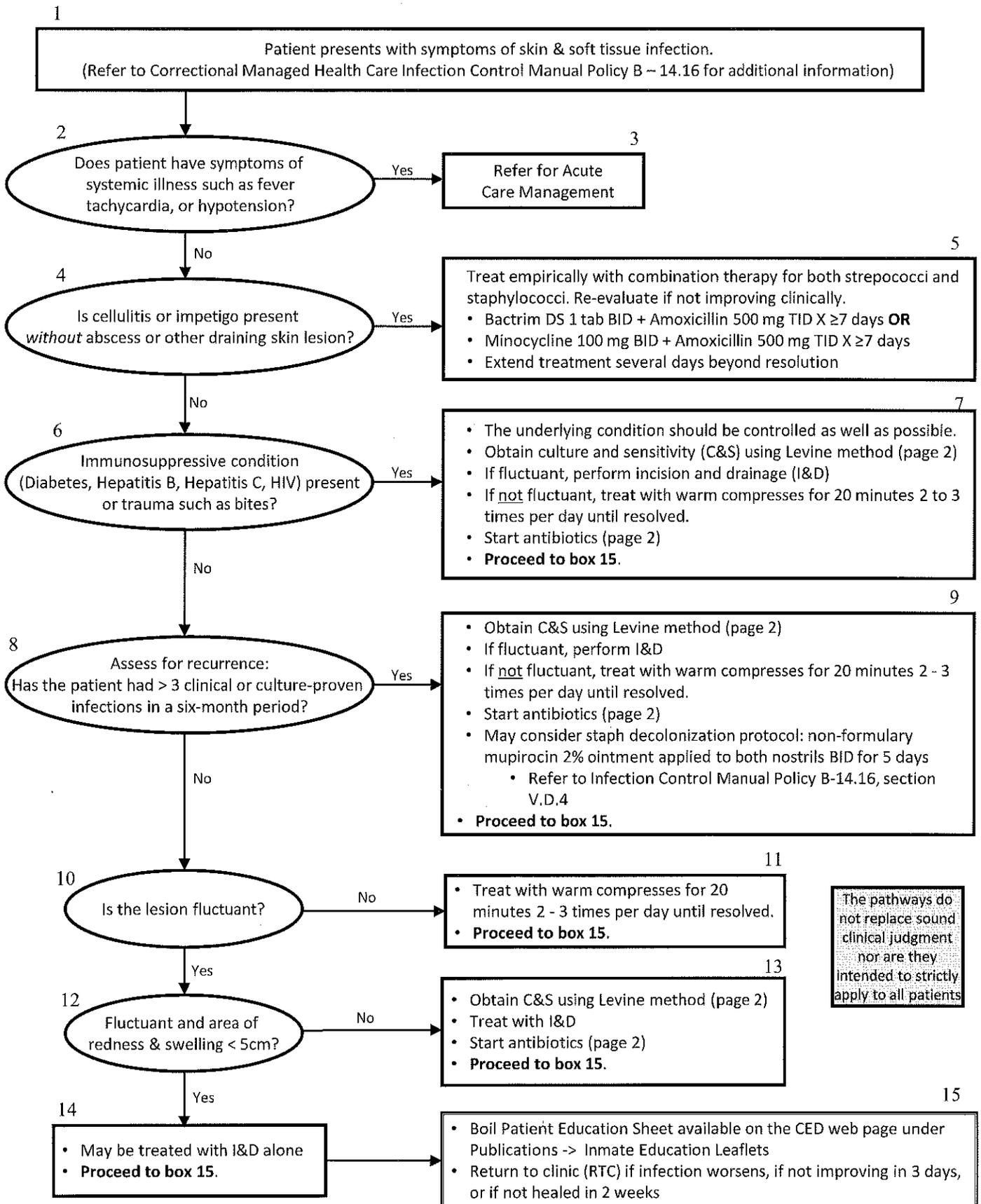


SKIN AND SOFT TISSUE INFECTION



The pathways do not replace sound clinical judgment nor are they intended to strictly apply to all patients

Nurses: DMGs are to assist providers in making treatment decisions and are not to be confused with or viewed as Nursing Standing Delegated Orders (SDOs). As such, **treatment recommendations in DMGs cannot be implemented independently by nursing staff without an order from a provider.**

Culture Using the Levine Method

- Cleanse the wound with sterile water or normal saline to wash away any slough, necrotic tissue or dried exudate.
- Moisten the culture tip. If the wound is moist, a sterile swab can be used straight from the packaging. If the wound is dry, then the swab tip should be moistened with sterile water to increase the chances of recovering organisms from the site.
- Collect in a zig-zag motion – the swab should be moved across the wound surface in a zig-zag motion, at the same time, being rotated between the fingers.
- Send to lab – immediately following the collection, the swab should be returned to its container (placed into the transport medium) and accurately labeled.

Antibiotic Selection

- If possible, begin after C&S results available. May treat with soaks or dressing changes pending results.
- If empiric therapy must be started, begin empiric therapy with Bactrim DS.
- If allergic or failure on treatment, consider referral to higher level of care for recommendations.
- Antibiotic therapy **should be guided by C&S** results once available. All cases of methicillin sensitive *Staphylococcus aureus* (MSSA) and methicillin resistant *Staphylococcus aureus* (MRSA) must be reported to the Office of Public Health by the facility Infection Control Nurse (ICN). Refer to the Infection Control Policy Manual (B-14.16 Attachment B).
- Duration generally at least 7 days and should extend several days past clinical resolution.
- Empiric therapy to avoid: rifampin alone, flouoroquinolone, cephalosporin, clindamycin, or erythromycin.