BURN WOUND CARE

Poster 2 Supporting the Northern Burn Care Network (NBCN) Guidelines

BURN Unit contact numbers.

Royal Preston: Tel:01772 522244 Fax: 01772 523694
Wythenshawe Manchester: Tel: 0161 2916314 Fax: 0161 2916315
Manchester Childrens: Tel: 0161 701 8100 Fax: 0161 276 1234

See guidance for referral criteria for

- **Complex burns**
- **Complex non-burns**
- **Non-complex burns**

For cases that do not meet the criteria for referral:

Initiate and continue local care and give advice to observe signs for infection. Refer on if wound unhealed at 14 days adults / 7 days paediatrics

Discharge when wound healed, with written advice to moisturise and protect from sun until healed skin loses pink colour

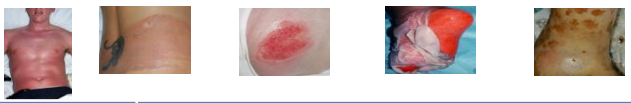
Infection in children: *Toxic Shock Syndrome / Burn Sepsis Syndrome*

Observe for 2 of the following;

- Temperature >38 °C
- General malaise
- Rash
- Hypotension
- Diarrhoea and vomiting
- Not eating or drinking
- Tachycardia / tachypnoea

This is a medical emergency and rapid transfer to the nearest emergency department is vital.

1 2 3 4 5



Classification of Wound	Treatment Options SEE NBCN GUIDANCE FOR RATIONALE AND AIMS
1.Erythema	• Atrauman under light dressing • Actiform cool **Un-perfumed moisturising cream instead of dressing, this may be sufficient to alleviate pain without a dressing required.**
2.Superficial/ Epidermal	• Adaptic touch under absorbent dressing • Allevyn Gentle • Actiform cool
3.Superficial Dermal	• Adaptic touch under absorbent dressing • Allevyn Gentle **Antimicrobial if at increased risk of infection:-** • Cutimed Sorbact Gel (hydrogel sheet)
4.Deep Dermal	• Atrauman under absorbent dressing • Allevyn Gentle **Antimicrobial if dirty or infection suspected:-** • Actilite • Cutimed Sorbact Gel
5.Full Thickness	• Cutimed Sorbact Gel • Flamazine cream
Special areas	
Face	• Chloramphenicol ointment to eyes if eyelids involved • Olive oil
Hands and Feet	• Atrauman under absorbent dressing • Clear bags secured at wrist / ankle over padding **Antimicrobials as above**

N.B. Once Flamazine (silver sulphadiazine) cream has been used then the appearance of the burn will be masked by a whitish layer this must be cleaned off when re-assessing.

Full NBCN guidelines and forms are kept in this department: (indicate where)

Liz White Tissue Viability Nurse Specialist ELHT 11/2012

Burn wound assessment

The burn area must be cleaned. All blisters and loose skin removed. Where the burn is over hair the hair is shaved to enable the area to be kept clean, this includes the scalp.

Limbs and digits need assessment of circulation and sensation.

Burn wound cleansing

The aim of burn wound cleansing is to help create the optimum local conditions for wound healing by removal of debris, exudates, foreign and/or necrotic material and other microorganisms (Dougherty & Lister 2007). This will also assist in assessment of burn size and depth. These solutions are currently used:

NaCl 0.9%

Physiologically balanced solution that has a similar osmotic pressure to that already present in living cells and thus compatible to human tissue (Herndon 2007)

Tap water and Soap

Soap and water is used by most Burns Units and is cited by the European Working Party of Burns Specialists as a solution of choice for burn wound cleansing, (Alsbjorn et al 2007).

Soap should be un-perfumed to prevent skin/tissue irritation.

Blister Management

There is conflicting evidence within international burns literature concerning best practice for the management of blisters. However consensus leans towards the conclusion that blisters should be debrided as their presence will impede wound depth assessment, limit function and increase the potential for infection.

Guidelines for Blister Management: adapted from Sargent (2006)

Blister size

< 1cm: can be left intact as unlikely to rupture spontaneously or impede healing.

> 1cm: should be debrided as more likely to rupture spontaneously

Blister type:

- *Thin walled blisters:* should be debrided because a) they are prone to rupture and b) they occur on hair lined skin surfaces which are of increased infection risk.
- *Thick walled blisters:* Thicker skin occurs on hands and feet. If 1cm or below and not limiting function and/or mobility they can be left intact. If larger they are more likely to limit these actions and thus should be debrided

Special Areas

FACES Keep exposed with a topical application olive oil or similar. This keeps the area flexible and prevents the cracking that happens if the face dries and scabs over. The face is washed and the oil re-applied at least 4 times a day.

EARS Coated in Silver sulfadiazine cream to form a protective barrier and minimise risk of the cartilage becoming infected.

Please remember to insert foam or cotton wool into the entrance of the ear to prevent it becoming blocked by the cream and exudate.

HANDS To enable movement, the patients independence and the observation of the peripheral circulation clear plastic bags are used to cover the hands if large areas involved.

Bags are changed daily unless there is a build up of exudate then they are changed more frequently.

Small areas on hands can be dressed ensuring minimal restriction of movement.

Elevate and commence physiotherapy as soon as possible.

FEET These are treated in the same way as hands.

Education Post Healing

Trauma and friction will cause skin blistering and breakdown

The new skin may have damaged sebaceous glands so frequent application of a perfume free moisturising cream will be required.

Itching may be a problem and may be helped by moisturising creams and massage.

Occasionally a prescription of an antihistamine is required especially if the itching is disturbing sleep.

Burns that have taken longer than 14 days to heal commonly produce hypertrophic scar tissue. Silicone Gel and pressure garments are the first line treatment.

Protection from the sun is very important, the use of a total sun block for at least 2 summers is recommended.