



Standards of Physiotherapy and Occupational Therapy Practice in the Management of Burn Injured Adults and Children

Devised by the Burn Therapy
Standards Working Group, 2005

Endorsed by the
Burn Therapists' Interest Group
British Burn Association
National Burn Care Group

CONTENTS

Pg 2:	Introduction
Pg 4:	Acute Phase of Rehabilitation:
	Standard 1: A. General Criteria
Pg 6:	Standard 1: B. Respiratory Criteria
Pg 8:	Standard 1: C. Rehabilitation Criteria
Pg 11:	Standard 2
Pg 13:	Intermediate Phase of Rehabilitation:
	Standard 3
Pg 16:	Re-integration Phase
	Standard 4
Pg 19:	Later Phase of Rehabilitation:
	Standard 5
Pg 23:	Reconstructive Phase:
	Standard 6
Pg 24:	Standard 6: A. Pre-operatively
Pg 25:	Standard 6: B. Post-operatively
Pg 26:	Core Professional Standards
Pg 28:	Appendix I
Pg 29:	Appendix II & III
Pg 30:	Acknowledgements
Pg 31 - 32:	References

Documentation policy currently varies between Physiotherapy and Occupational Therapy Departments in both the same hospital and between hospitals. This document assumes that all burn therapists document patient assessments / treatments in individual patient Physiotherapy and Occupational Therapy notes, referred to in this document as “therapy notes”. These may be combined therapy notes or separate Physiotherapy and Occupational Therapy notes. It is acknowledged that it is also acceptable to document in the patient’s medical notes, nursing notes and where utilised, in combined multi-disciplinary patient notes / care pathways.

INTRODUCTION

Approximately 250 000 people experience burn injuries in the UK each year, varying from small burns requiring minimal treatment to major burns which require intensive and prolonged hospital care (1). A burn injury often has a significant impact upon the individual, both physically and psychologically, which in turn affects their family and those close to them.

Physical, functional, psychological and aesthetic rehabilitation must be commenced immediately post burn in order to achieve optimal outcome (1). The ultimate goal of burn rehabilitation is to assist the individual in their return to their pre-injury status (2). The nature of some burn injuries may make this impossible and in such cases, the focus is on returning the individual to as near their pre-morbid status as possible. For some individuals, in particular those who have sustained major burns or have complex additional needs, the entire rehabilitation process may last for many years (1).

It is essential that burn rehabilitation is multi-disciplinary, co-ordinated, individualised and holistic. The affected individual will require the services of a team of highly specialised, dedicated health care professionals, indeed, the concept of an integrated multi-disciplinary team approach is widely accepted and used in burn care today (3). The Physiotherapist and Occupational Therapist (referred to in this document as the burn therapist, unless otherwise specified) play a vital part in the burn care team, with their roles often overlapping and changing in emphasis during the different phases of the rehabilitation process (4).

Burn patients need to be treated by the individuals with the greatest knowledge base and the most experience to ensure that they receive the best possible care (5). It is therefore essential that specialised burn therapists are not only placed in specialist burn centres, but in burn units and facilities throughout each regional burn care network (1). It is vital

that therapists with less experience, knowledge or exposure to burn patients seek advice and guidance from more experienced colleagues in order to ensure optimal patient management.

This document is a development of “Standards for Physiotherapy and Occupational Therapy Practice for the Management of People Following Burn Injury”, published in 2000 (6). These standards were designed to assist and guide Physiotherapists and Occupational Therapists who are involved in the care of adult and / or paediatric burn patients.

A UK burn therapy standards audit (7) was conducted during 2003, to establish therapy compliance with these standards. Following analysis of the results and evaluation of the evidence base, burn therapists across the UK unanimously agreed that the standards could be further developed. It is hoped that the revised standards in this document accurately reflect the work of burn therapists working across the UK today.

The six standards cover all aspects of burn therapy assessment, treatment and management, commencing with the acute phase, then progressing through the stages of intermediate rehabilitation and re-integration and finally onto later rehabilitation and reconstruction. It is acknowledged that not all of the standards are relevant to all patients – this is dependant upon the size, depth and location of the burn injury as well as other physical and psychosocial factors. The burn therapist must therefore determine the relevant standards for each individual patient at a given time.

It is imperative that this document is used in conjunction with relevant documents produced by the Chartered Society of Physiotherapy (8,9) and the College of Occupational Therapy (10,11), and alongside the multi-disciplinary “Standards for Burns Care” (12). In addition, relevant guidelines and standards produced by other Clinical Interest Groups should also be considered where appropriate.

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ACUTE PHASE OF REHABILITATION

In the acute phase, many burn patients require intensive medical care, particularly those with a large burn surface area and / or an inhalation injury. The burn injury will be in the early stages of wound healing: undergoing frequent dressing changes and often requiring surgical intervention.

The individual may present with a wide range of signs and symptoms potentially affecting all of the major systems in the body including the respiratory, neurological, orthopaedic and cardiovascular systems. Many patients will also be affected psychologically although this may not be apparent until later.

STANDARD 1

The therapeutic management of the burn patient is determined by thorough assessment and formulation of a detailed list of problems / treatment goals and a detailed treatment / management plan. The patient is subject to regular, on-going therapeutic re-assessment and review with subsequent changes to the problem list / treatment goals and management plan.

A. GENERAL CRITERIA

A.1.1

The following **information is gathered and documented clearly and concisely**. Where information is not available / accessible then this should be indicated.

HISTORY OF PRESENT CONDITION

- Location of incident (home, work etc)
- Date, time and cause of burn
- Exposure to smoke or other respiratory irritants
- Additional injuries (eg, fractures, head injury)
- % TBSA, area of burn, depth of burn (to include a Lund & Browder chart)
- Treatment at scene
- Date of admission (for in-patients only)
- Treatment to date
- Surgery to date: to include details of operative procedures, date of surgery and name of surgeon
- Relevant medication that patient is currently on (in particular – analgesia, cardiovascular drugs, sedatives, paralysing agents)

PAST MEDICAL HISTORY

- Include relevant PMH such as previous chest, cardiac, neurological, orthopaedic or psychiatric problems

DRUG HISTORY

- Medication that patient was on prior to admission
- Allergies / precautions

SOCIAL HISTORY

- Hand dominance (for upper limb burns only)
- Smoker / ex-smoker / non-smoker
- Type of accommodation and who patient lives with
- Pre-burn level of support from family , friends , carers
- Pre-burn level of mobility (use of walking aids) and functioning
- Pre-burn developmental stage (paediatric patients only)
- Occupation / schooling and hobbies
- Religion
- Child protection issues (paediatric patients only)

Note: it is often not possible to establish all of the above details initially. Documentation should indicate where this is the case.

B. RESPIRATORY CRITERIA

Note: The following respiratory criteria (B) are **specific to Physiotherapists only**. The Physiotherapist must follow these criteria if:

- Patient has a suspected / known inhalation injury
- Patient has been intubated and ventilated
- Patient has pre-existing respiratory problems
- Patient has other respiratory problems as a result of the burn injury (eg, pulmonary oedema)

It is acknowledged that it is relevant for the **Occupational Therapist** to **document the ventilatory status and conscious level** of the patient.

B.1.1

A **respiratory assessment is conducted** to determine the immediate treatment needs of the patient. This assessment is **carried out and documented within 24 hours** of the patient's admission.

B.1.2

The **subjective and objective respiratory assessment is conducted and documented in line with ACPRC guidelines** (13 – Appendix I, standards 4 & 5). Additional information is documented specific to the burn patient:

- Presence of facial / neck / chest burns and / or oedema
- Presence of stridor / hoarse voice
- Carboxyhaemoglobin level
- Bronchoscopy results
- Presence of carbonaceous sputum / bronchial casts
- Patient's ability to maintain a clear airway (ability to cough)
- Respiratory drugs

B.1.3

Following the initial assessment, a **list of problems / treatment goals and treatment plan** is **formulated and documented in line with ACPRC guidelines** (13 – Appendix II, standards 7 & 8).

Wherever possible, this is formulated **in partnership with the patient**.

For those patients who are unconscious, very young, have poor cognition or those with significant psychological / psychiatric impairment, this is formulated in partnership with the family / carers, wherever possible.

The list of problems / treatment goals and treatment plan should provide **sufficient detail for another physiotherapist to replicate the treatment**.

B.1.4

There is evidence that **additional injuries / complications** have been **documented** (as in Criteria A.1.1) and **considered** when planning treatment.

B.1.5

There is **written evidence** that **daily liaison** has occurred with relevant **MDT members** re: the patient's respiratory status and management.

B.1.6

There is **written evidence** that the patient's **respiratory status** is **reassessed / reviewed at least once a day**, and the **list of problems / treatment goals and treatment plan amended** according to individual need. Such amendments should be clearly recorded and dated.

C. REHABILITATION CRITERIA

C.1.1

A **musculoskeletal assessment** is conducted to determine the immediate treatment needs of the patient. This assessment is **carried out and documented with-in one working day of admission** (week-ends and bank holidays excluded).

C.1.2

A **detailed subjective and objective assessment is conducted and documented.** The patient's level of consciousness should be clearly recorded at the start of this assessment.

CONSCIOUS, NON-PARALYSED PATIENT

- Patient's perception of their pain. If patient is unable to express this (eg, too young, ET tube in situ) then the nurses perception of the patient's pain level should be recorded
- Current cardiovascular observations / temperature
- Patient position
- Presence of drips, drains, catheter, NG tube etc
- Appearance of exposed wounds
- Presence of dressings
- Presence / location of oedema
- Resting position of hands (upper limb burns)
- Active ROM (to include approx range in degrees)
- Passive ROM (to include approx range in degrees)
- Transfer / gait assessment
- Basic functional assessment (feeding, toileting)
- Impression of psychological status
- Other assessments / issues relevant to patient (eg, neurological status)

UNCONSCIOUS, PARALYSED OR HEAVILY SEDATED PATIENT:

- The assessment will be based on the structure outlined above, however active ROM, gait, function and the psychosocial assessment will not be possible at this time.

It is acknowledged that it is not always relevant or appropriate to conduct all of the above at the initial assessment. Where this is the case, the therapist should state N/A or “unable to assess due to.....” on the assessment form. The therapist must then ensure that, where relevant, these points are addressed and recorded at future assessment.

C.1.3

Following the initial assessment, a **list of problems / treatment goals and treatment plan is formulated and documented.**

Wherever possible, this is formulated **in partnership with the patient** (assuming the patient is conscious and able to comprehend). For those patients who are unconscious, very young, have poor cognition or those with significant psychological / psychiatric impairment, this is formulated in partnership with the family / carers, wherever possible.

The list of problems / treatment goals and treatment plan should provide **enough detail for another burn therapist or other suitably trained physiotherapist / occupational therapist to replicate the treatment** (it is acknowledged that the week-end and bank holiday therapy service may not always be delivered by a specialised burn therapist).

C.1.4

There is evidence that **additional injuries / complications** have been **documented** (as in criteria A.1.1) and **considered** when planning treatment.

C.1.5

There is **written evidence** that **regular liaison / discussion** has occurred with relevant **MDT members** re: the patient's condition and progress. Discussion at ward rounds and MDT meetings should be clearly documented.

Therapy referral to other MDT members (eg, to the psychotherapist or social worker) is **clearly documented**.

C.1.6

There is **written evidence** that the patient's **musculoskeletal status** is **reviewed and reassessed regularly**, and that the **list of problems / treatment goals and treatment plan are amended** according to individual need. Such amendments should be clearly documented and dated.

C.1.7

All **episodes of surgical intervention are recorded clearly and promptly**, to include date of surgery, details of operative procedure, post-operative instructions / plan and name of surgeon.

STANDARD 2

An individualised acute treatment / management programme is implemented, based on patient assessment. Wherever possible, this programme is developed in conjunction with the patient and / or their family and carers.

This programme will typically include some / all of the following therapeutic treatment techniques and modalities: chest physiotherapy, limb elevation, correct positioning, splinting, active and passive exercises, functional / purposeful / play activities and patient / family education and support.

2.1

The treatment / management plan is implemented in a timely and effective manner and is documented clearly and concisely, with sufficient detail for another burn therapist to replicate the treatment. Respiratory treatment is implemented in line with the ACPRC guidelines (13 – Appendix III, standard 9).

2.2

The patient and / or their family / carers (according to patient age, state of consciousness and comprehension) are educated regarding all aspects of the therapeutic treatment programme (including purpose / benefits of treatment and risks of non-compliance) and this is documented in the therapy notes.

Where possible and appropriate, written information is given to supplement verbal advice and this is evidenced in the notes.

2.3

There is **written evidence** that the **burn therapist has considered / addressed psychological and social support for the patient and their family / carers. Referral to expert sources of psychosocial support** should be made **promptly** and **documented** clearly, including the date of referral and name of person accepting the referral.

2.4

Referring back to Standard 1, criteria B.1.6 and C.1.6: the **treatment plan is subject to continual change** depending upon the findings of reassessments / reviews. **New treatment modalities / techniques are implemented promptly** and **recorded accurately**, with sufficient detail for another burn therapist to replicate the treatment.

INTERMEDIATE PHASE OF REHABILITATION

The transition from acute to intermediate rehabilitation is variable for each patient, according to many factors such as burn size, severity and involvement of other body systems. Many patients (for example those with a small % BSA) will enter this phase almost immediately whereas others may take several weeks or even months to become medically stable and thus appropriate for intermediate rehabilitation. This phase of therapy management may be delivered on an in-patient and / or out-patient basis and will vary dramatically in intensity, according to patient need.

During this stage the main therapeutic focus is on function and purposeful activities. Where appropriate, the therapy sessions will often be based in the gymnasium, occupational therapy workshops and activity areas.

Significant wound healing will have taken place / will be taking place at this stage and scar management will therefore usually commence at this stage of rehabilitation

STANDARD 3

Working as an integral part of the burns multi-disciplinary team, the therapist assists, co-ordinates and where appropriate leads the planning, implementation and review of the patient's on-going care / management.

3.1

The **burn wounds / scars** are **fully assessed** and findings are **documented at least once a week** (as specified below) for in and out-patients. If the out-patient is attending less regularly then burn wound / scar assessment and documentation should be made at each visit:

- Wound location & appearance (if wounds are uncovered) Detailed description.
Presence of wound infection.
Swabs results (if applicable)
- Scar location & appearance Detailed description
Objective measure, eg, Vancouver scar scale
Digital photography (where this facility is available)

3.2

Physical and cognitive factors are **assessed and documented at least once a week** (as specified below) for in and out-patients. If the out-patient is attending less regularly than once a week then assessment and documentation should be made at each visit. For each factor, an **objective measure** should be used and this will be based upon individual therapy dept policy:

- Pain Subjective interview and objective measure
- Itch As above
- Hypersensitivity Subjective interview
- Sensory loss Objective measure
- Active ROM Goniometer measurement
- Passive ROM Goniometer measurement
- Exercise tolerance Objective measure
- Strength Objective measure
- Function Objective measure
- Cognition / perception Objective measure
- Developmental stage (paeds) Objective measure

It is acknowledged that it is not always relevant or appropriate to assess all of the above, depending upon the site / extent of the burn injury, age / compliance of the patient and presence of other diseases / injuries.

3.3

The following **psychosocial factors are assessed and documented** at a frequency deemed appropriate by the individual therapist:

- Psychological status of patient and family Subjective interview
Objective tool (where this is usual practice for the therapist to perform this)

- Social status of patient: hobbies, work school, leisure Subjective interview

Where the patient is unable to answer for themselves (eg, very young patient) then family members / carers should be interviewed to provide the above answers, wherever possible.

3.4.

There is **written evidence that regular liaison** has occurred with relevant **MDT members** re: the above. **Copies of written referrals and reports** are kept in the therapy notes.

RE-INTEGRATION PHASE

Re-integration usually falls into the intermediate phase of rehabilitation and the focus is on the patient's return to society and their gradual return to maximal level of functioning and independence. Individuals with a major burn injury and / or complex psychosocial problems will often require a high level of MDT assistance / involvement in their integration back into society whereas others (particularly those with less severe injuries) may require little or no assistance during this phase.

STANDARD 4

Working as an integral part of the Burns MDT, the therapist co-ordinates and facilitates the planning and implementation of the patient's return to society. Wherever possible (according to patient age, compliance, psychological state etc) the patient is encouraged to take the lead in this re-integration process.

4.1

There is **written evidence** that the **patients home environment** has been **thoroughly assessed** (through verbal interview with patient / family / carers), considered and **appropriate action** taken to **facilitate a safe discharge**. This should include risk assessment to ensure that the environment is safe and habitable.

Where indicated and where **local policy allows**, a **home visit is conducted and documented** for those patients with predicted issues at home (eg, elderly patients, patients with complex injuries who live alone).

Where local policy will not allow a home assessment and the patient has predicted issues, there is written evidence that the therapist has initiated the process of patient transfer to local hospital (refer to 4.6).

4.2

For patient's with **complex burns and / or psychosocial problems**, the therapist attends an **in-patient MDT discharge planning meeting**. There is **detailed documentation** of this meeting including plans for provision of out-patient therapy (to include frequency, location etc)

4.3

Where deemed necessary by the therapist, the **therapist liaises with relevant community services** eg, community social worker, home care services, and community therapists. There is **written evidence of such liaison** and a **copy of any report** sent is filed in the therapy notes.

4.4

Prior to discharge, the **patient undergoes a full physical and psychosocial therapy assessment** (as detailed in Standard 3: 3.1, 3.2, 3.3) and this is fully **documented**. Details of this assessment are included in any report sent to community or local therapists.

4.5

Prior to discharge the patient's **list of problems / treatment goals are fully re-evaluated** (in conjunction with the patient / family / carers) and **documented**. These should include the patient's goals with relation to return to work / school (where relevant) and return to leisure activities. Details of this should be included in any report sent to community or local therapists.

4.6

Where the **patient is to be transferred to their local hospital** for in / out-patient therapy or the patient is to receive therapy in the community, a **telephone referral** is made and a **detailed written report** is forwarded to the appropriate therapist. **Documentation of telephone calls and a copy of the report is filed** in the therapy notes.

4.7

Prior to discharge, the **patient and their family / carers** are provided with **individualised advice and written information** (as deemed appropriate by the therapist) re: the following:

- A home therapy programme consisting of specific advice relevant to the individual patient (exercise regime, splinting regime, functional activities, scar management regime)
- A named therapy contact / telephone number
- Out-patient therapy appointment
- Contact details for national and / or local burn support groups
- Details re: appropriate leisure / recreational facilities, eg, local gymnasium or swimming pool
- Details re: specific equipment / adaptation resources available locally
- Advice and discussion re: return to work / school

4.8

Where deemed necessary by the therapist, the **therapist liaises with the patient's employer, disability employment advisor or the patient's school / nursery** (this may be pre or post discharge) to **advise upon the patient's return** and, where required, **organise a re-integration programme**. There is **written evidence of such liaison** and a **copy of any report** sent is filed in the therapy notes. It is acknowledged that this role may be fulfilled by another member of the MDT and this should be documented where this is the case – eg, play specialist or nursery nurse may conduct a school visit.

LATER PHASE OF REHABILITATION

In the later phase of rehabilitation, the burn wounds will usually be fully healed and the emphasis is on burn scar management, return to maximal function / independence and continued psychosocial support. For individuals with significant scarring and / or complex psychosocial problems, the late phase of rehabilitation can continue for many months and often years (particularly for children). Individuals with minimal or non-problematic scarring and minimal / no psychosocial problems will usually require very little input at this stage.

STANDARD 5

The burn therapist provides on-going assessment, treatment, advice and psychosocial support to the patient and their family / carers through-out the burn scar maturation period and, where necessary, post scar maturation.

The therapist implements a wide range of scar management modalities / techniques based on individualised assessment, including scar massage, pressure therapy, use of silicon products, splinting and stretching.

5.1

The burn out-patient has a named burn Physiotherapist and / or Occupational Therapist (documented in the therapy notes) and their contact details. This therapist takes responsibility for ensuring smooth co-ordinated follow-up and review of the patient during, and where necessary post scar maturation.

5.2

Frequency of patient review / re-assessment is at the discretion of the therapist, and is **determined following discussion** with the patient and / or their family / carers. The agreed plan for frequency of patient review is **documented in the therapy notes**.

5.3

The following **physical factors are assessed / acknowledged and documented at each review**. An **objective measure** should be used for each factor and this will be based upon individual therapy dept policy:

- Pain Subjective interview and objective measure
- Itch As above
- Scar appearance Detailed description
Objective measure, eg, VSS
Digital photography
- Hypersensitivity Subjective interview
- Sensory loss Objective measure
- Active ROM Goniometer measurement
- Passive ROM Goniometer measurement
- Exercise tolerance Objective measure
- Strength Objective measure
- Function Objective measure
- Cognition / perception Objective measure
- Developmental stage (paeds) Objective measure

It is acknowledged that it is not always relevant or appropriate to assess all of the above, depending upon the site / extent of the burn injury, age / compliance of the patient and presence of other diseases / injuries.

5.4

Where deemed appropriate by the therapist, the following **psychosocial factors are assessed and documented at each review**:

- Psychological status of patient and family Subjective interview
Objective tool (where this is usual practice for the therapist to perform this)

- Social status of patient: hobbies, work school, leisure Subjective interview

5.5

Where **specialist advice / treatment is needed** (beyond the remit of the burn therapist), then the **therapist refers** the patient to another appropriate members of the **MDT**, eg, to psychologist / counsellor, cosmetic camouflage team, social worker, disability employment advisor etc. This **referral is documented** in the therapy notes.

5.6

The patient and their family / carers are provided with **individualised advice and written information** (as deemed appropriate by the therapist) regarding each scar management modality employed. There is **documentation to support that this has occurred**.

5.7

If the patient is receiving their regular therapy at a local hospital or in the community (eg, at home or in school), then the **burn therapist maintains appropriate communication with the local therapist**, particularly when there is significant change in the patient's condition. Telephone conversations and / or reports between the two therapists are documented in the therapy notes.

5.8

The **therapist liaises with the Burns Consultant / Surgeon** re: patients with complex scarring issues. Where service provision permits, the **therapist and surgeon jointly assess the patient** and where indicated, in conjunction with the patient and / or their family / carers, reconstructive surgery is planned. Details of this liaison and assessment are **documented in detail in the therapy notes** (refer also to Standard 6).

5.9

On **final discharge** from the burn therapy service, the **therapist liaises** with both the **patient's GP and their Burn Consultant**. This should be documented in the patients therapy notes, and, where standard practice, in the patient's medical notes. **Copies of reports sent to the GP / Consultant should be filed in the therapy notes.**

RECONSTRUCTIVE PHASE

The reconstructive phase occurs during the later phase of rehabilitation. Burn patients with the following problems will usually be offered reconstructive surgery:

- **Cosmetically unacceptable scar**
- **Unstable / hypersensitive / painful burn scar**
- **Burn scar causing significant joint contracture**
- **Burn scar causing significant functional limitation**

Many children with major burn injuries will undergo reconstructive surgery at regular intervals throughout their childhood. There is no limitation on the timing of reconstruction. Indeed, some patients elect to undergo reconstruction many years after their initial burn injury.

STANDARD 6

Following burn reconstruction, an individualised treatment / management programme is formulated and implemented by the burn therapist. This is based on thorough pre and post-operative assessment and formulation of a detailed list of problems / treatment goals and treatment / management plan.

Wherever possible, this programme is developed in conjunction with the patient and / or their family / carers.

A. PRE-OPERATIVELY

A.6.1

A **detailed pre-operative physical assessment is conducted and documented**, as in Standard 5, Criteria 5.3.

A.6.2

A **detailed pre-operative assessment or relevant psychosocial issues is conducted and documented**, as in Standard 5, Criteria 5.4. This should also include details of the home environment / situation and the patient's expectations of the surgery.

A.6.3

The **operative procedure and post-operative therapy regime are explained** in detail to the patient and / or their family / carers. Where available, **written information is also given**, and this is **documented** in the therapy notes.

A.6.4

Pre-operative liaison occurs between the **therapist, the Burn Consultant / Surgeon** (as in Standard 5, 5.8) and other relevant members of the **MDT** and this is **documented** in the therapy notes.

B. POST-OPERATIVELY

B.6.1

The **operative notes and post-operative instructions** (to include details of the procedure, date of surgery and name of surgeon) are **copied** into the **therapy notes**.

B.6.2

Following reconstructive surgery, the patient will progress again through all the stages of rehabilitation, requiring varying amounts of therapy assistance / input according to the extent of the surgery. Documentation in the therapy notes should provide evidence of the following:

- **Thorough assessment and formulation of a detailed list of problems / treatment goals and treatment / management plan:** refer to **Standard 1, C Rehabilitation Criteria**. If the patient has pre-existing or post-operative respiratory problems then the physiotherapist must also follow **Standard 1, B Respiratory Criteria**.
 - **Implementation of an individualised treatment / management programme:** refer to **Standard 2**.
 - **Review of on-going care:** refer to **Standard 3**.
 - **Reintegration into Society:** refer to **Standard 4**.
 - **On-going assessment, treatment, advice and psychosocial support:** refer to **Standard 5**.
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CORE PROFESSIONAL STANDARDS

In addition to the specialist standards described in this document, it is imperative to highlight that the burn therapist is ethically and legally obliged to maintain ALL professional standards laid down by their relevant professional body (Chartered Society of Physiotherapy or the College of Occupational Therapy, references 8-11).

The following core standards have been written, not to suggest they are more important than other existing core professional standards, but because they are of particular relevance to the burn therapist.

A - INDIVIDUALISED APPROACH

The burn injured child / adult will be respected and treated as an individual by their burn therapist.

- Core Standards of Physiotherapy Practice (8): Standard 1
- Code of Ethics and Professional Conduct for Occupational Therapists (10): Section 2.1

B - INFORMED CONSENT

The burn therapist will follow the standards laid down by their professional body and other relevant professional bodies relating to informed consent.

- Core Standards of Physiotherapy Practice (8): Standard 2
- Professional Standards for Occupational Therapy Practice: Consent Standards 1-5 (11)
- Seeking Consent – Working with Children (14)
- Good Practice in Consent Implementation Guide: Consent to Examination or Treatment (15)
- Local Trust Policy

C - CONFIDENTIALITY

The burn therapist is ethically and legally obliged to treat all information relating to the burn patient in the strictest confidence.

- Core Standards of Physiotherapy Practice (8): Standard 3
 - Code of Ethics and Professional Conduct for Occupational Therapists (10): Section 2.3
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APPENDIX I

ACPRC / CSP (2002)Emergency Respiratory On Call Working Guidance for Physiotherapists, Information Paper no.53

Standard 4 (page 6) – Assessment

In order to deliver effective care, information relating to treatment options is identified, based on the best available evidence.

Standard 5 (page 6 & 7)– Information Collection

Information relating to the patient and his / her presenting problem is collected:

- Chest X-Rays
- Arterial blood gases
- Observation charts
- Ventilator settings
- Intracranial pressure monitoring
- Glasgow Coma Scale monitoring
- CVS / fluid balance charts
- Oxygen and humidification requirements
- Information from other members of the MDT

The physical examination of the patient should include a thorough review of their respiratory status, which may include specific observation of:

- Chest shape
- Respiratory pattern
- Evidence of respiratory distress
- Position of patient and ease of movement
- Other injuries / incisions
- Method of ventilation
- Presence of peripheral oedema
- Patient colour

Further examination should include auscultation and palpation of chest movement.

APPENDIX II

ACPRC / CSP (2002)Emergency Respiratory On Call Working Guidance for Physiotherapists, Information Paper no.53

Standard 7 (page 7 & 8) – Analysis

Following information gathering and assessment, analysis will be undertaken in order to formulate a treatment plan.

Standard 8 (page 8) – Treatment Planning

A treatment plan is formulated in partnership with the patient.

Please refer to the original document for more specific details re: standards 7 and 8.

APPENDIX III

ACPRC / CSP (2002)Emergency Respiratory On Call Working Guidance for Physiotherapists, Information Paper no.53

Standard 9 (page 8) - Implementation

The treatment plan is delivered in a way that benefits the patient.

Please refer to the original document for more specific details re: standard 9.

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