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# Burns Management in the Emergency Department

(Referral Pro-forma)

**WEIGHT in KG**

**Adult**

**Paediatric**

**Actual Time of Injury**

|  |  |
| --- | --- |
| **Date of admission** |  |
| **Time of Admission** |  |
| **Year of admission** |  |
| **Age of patient** |  |

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| **AIRWAY** |

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| **Is the patient presenting with any of the following. Please circle Y / N.** | | |
| Stridor / change in voice | Y | N |
| Injury in enclosed space. | Y | N  Is there any suggestion the patient has sustained an **Airway / Inhalation injury?**    **Yes / No**  If **yes** please seek senior anaesthetic review immediately.  Intubation may be required. If indicated use an uncut ETT to allow for facial oedema |
| Singed nasal hair | Y | N |
| Facial burn / burns to mouth | Y | N |
| High carboxyhaemoglobin. | Y | N |
| Brassy cough/ change in voice | Y | N |
| Carbonaceous sputum. | Y | N |
| Circumferential /semi circumferential neck burns | Y | N |
| Administer high flow oxygen if required | Y | N |

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| **BREATHING** |

Has this patient any of the following which may suggest a breathing impairment?

**(Please circle Y/N)**

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| Circumferential chest burns: **Needs immediate discussion with local burns service.** | Y | N |
| O2 saturation lower than expected | Y | N |
| Respiratory rate outside expected limits | Y | N |
| Any other evidence of Broncho-pulmonary or chest wall injury | Y | N |
| Consider Carbon Monoxide / Cyanide poisoning, especially burns occurring in enclosed spaces (Bloods available with ABGs)  Treat as departmental policy. | Y | N |
| Elevated lactate, arrhythmias, reduced GCS and reduced arterial-venous oxygen saturation difference: Consider Cyanide poisoning. Use of antidote recommended. | Y | N |

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| **CIRCULATION** |

Has the patient any of the following which may suggest circulation impairment?

**(Please circle Y/ N)**

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| Tachycardia | Y | N |
| Tachypnoea | Y | N |
| Reduce level of consciousness | Y | N |
| Central and peripheral capillary refill time >2 seconds | Y | N |
| Cool peripheries / Circumferential limb burn. | Y | N |



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| **POINTS TO NOTE**  **All patients requiring fluid resuscitation should have:**   * Two large-bore intravenous cannulas and through the burn if necessary. * An indwelling urinary catheter attached to an hourly urine collection bag. (Discuss with receiving burns service) * IV fluid resuscitation should be commenced as per ATLS protocol   .   * If this does not improve parameters repeat primary survey looking for causes of shock. | Y  Y  Y  Y | N  N  N  N |
| Please take bloods for the following**;**    FBC (Inc. Haematocrit ) U&E, | Y | N |
| ABG, | Y | N |
| G&S | Y | N |
| CK | Y | N |
| Clotting screen | Y | N |
| BHCG | Y | N |
| Absence of peripheral pulses requires immediate contact with local burns service as ***ESCHAROTOMIES*** may be required .Please follow directions below | Y | N |

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| **IF PATIENT REQUIRES ESCHAROTOMY PLEASE FOLLOW DIRECTIONS BELOW** |

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| Contact to be made with the Burns and Plastic Surgery team.  Consultant or SpR grade if the need for escharotomy is suspected. |
| Escharotomies are performed by plastic surgeons in the operating theatre. |
| Diathermy **MUST** always be immediately available when any escharotomy procedure is carried out |
| In immediate escharotomy situations, only carry out chest incisions, until satisfactory ventilation is achieved, then **STOP.** |
| Local anaesthetic and adrenaline infiltration along incision lines will reduce blood loss and improve comfort. |
| Escharotomy wounds should be dressed with appropriate haemostatic dressings, e.g. calcium alginate e.g. kaltostat dressings with overlying absorbent dressings.  Avoid tight dressings as will further restrict. |
| An escharotomy may cause bleeding and damage to underlying structures. |
| Do **NOT** perform a fasciotomy. |

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| **DISABILITY** |

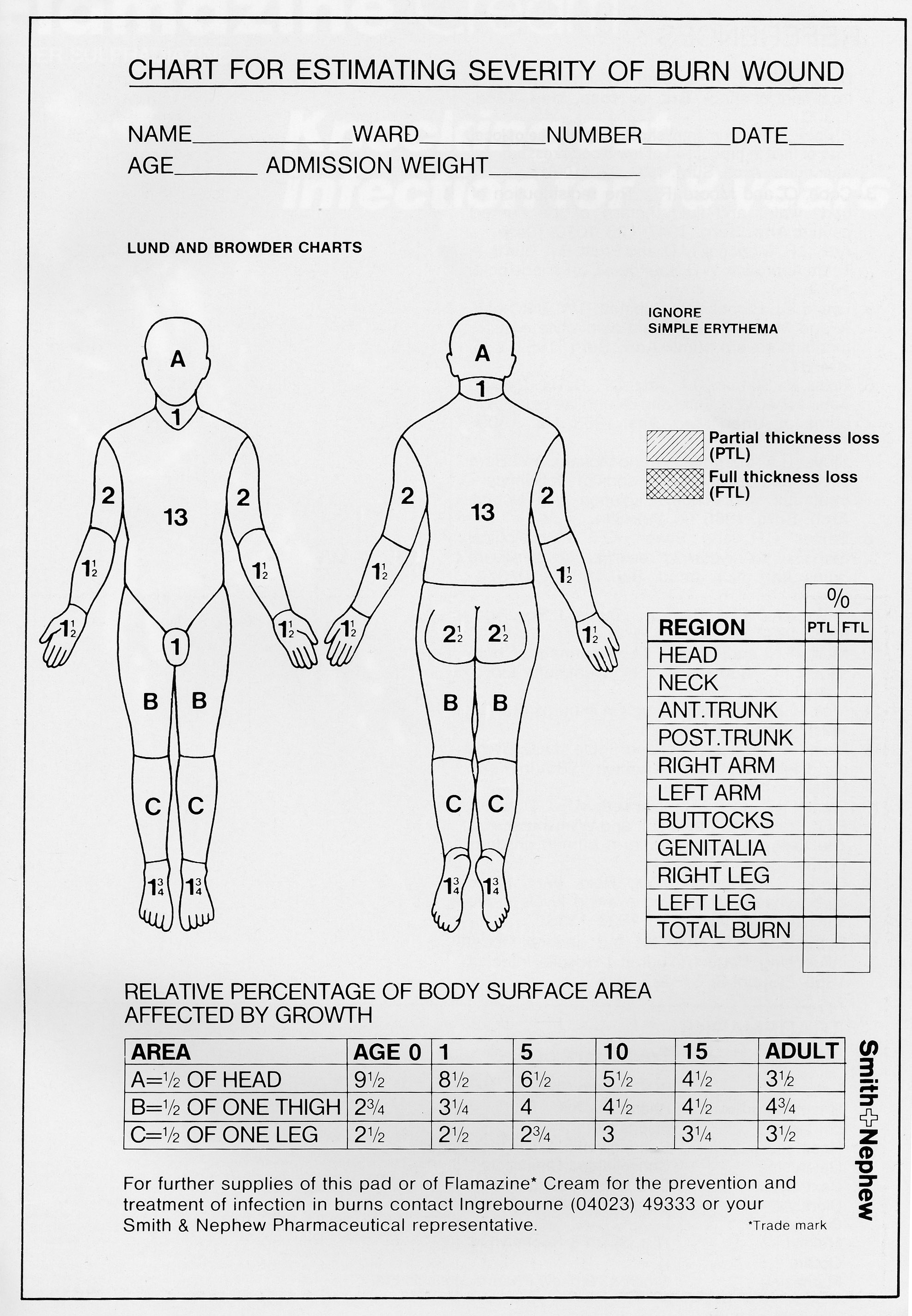
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| --- | --- | --- |
| Does the patient have a GCS <9? Please indicate. | GCS …. / 15 | |
| Pupils equal and reacting to light? Please indicate. | Reactive | Unreactive |
| **CONSIDER** | | |
| Toxic exposure?  Carbon monoxide and hydrogen cyanide | Y / N  Blood results | |
| Any associated trauma?  Limbs  Chest  Abdominal  Head  Other  None | IDENTIFY OTHER TRAUMA | |
| Ensure ABG’s normalised | ABG Results | |
| Notable comments | | |

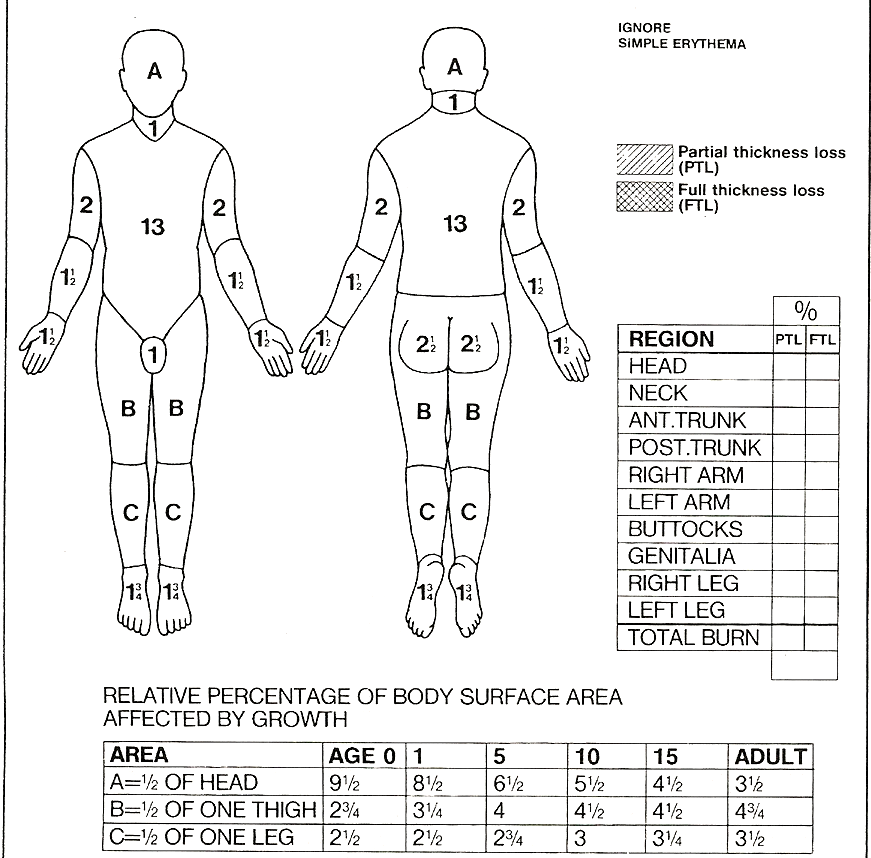
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| **EXPOSURE, ENVIRONMENT AND EVALUATION** |

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| Measure core temperature and maintain >36C | Current Temp  \_\_\_\_\_\_\_\_\_\_\_C |
| **Assess Total Burn Surface Area. ( TBSA) %.**   * Use Lund and Browder chart below to document findings.      * The patients whole hand including fingers = 1%.      * Ignore simple erythema * Total Burn Size =……….%.TBSA      * Partial thickness: = ………% TBSA * Full thickness: = ……… % TBSA * Total: =………..% TBSA * Revised Baux Score = …..   \*\*(Revised Baux Score: Age + % TBSA and add on 17 if severe smoke inhalation (SSI) present \*\* | **\_\_\_\_\_\_\_\_\_\_\_\_**% |
| Question to ask = does burned skin and unburnt skin = 100% |  |
| Be as clear and accurate as is possible |  |





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| **FLUID RESUSCITATION WITH HARTMAN’S SOLUTION** |

**ADULT >15% OF TBSA burned require IV fluid resuscitation = (Major Burn)**

**CHILDREN >10% OF TBSA burned require IV fluid resuscitation = (Major Burn)**

**re - confirm the ACTUAL TIME OF INJURY this ensures correct fluid management.**

Use the **Parkland Formula** (**see below**) to calculate the amount of fluid required in the first 24 hours post burn injury. This should be given in the form of a balanced electrolyte solution (Hartman’s / Plasmalyte). Fluid requirement for the first 24 hrs is always calculated from ***time of injury.***

**2 -4 mls fluid x %TBSA burn x weight (kg) = Total Fluid Volume (TFV) over 1st 24hrs from time of injury.**

**Resus fluid is given in two parts: 50% of TFV for 8 hours + 50% given in next 16 hours.**

***Fluid for 1st 8hrs = 50% of TFV***

***Fluid for 9 – 24hrs = 50% of TFV***

Give half of fluid in first 8hrs from time of injury and half in next 16 hrs

Percentage TBSA Burned = times

Weight in kg = times

**Urine output target**

**Adults**0.5 ml/ kg/hr

**Children**

**And**

**Infants**1- 2 ml/ kg/hr

**Does the patient require catheterisation?**

**PLEASE DISCUSS WITH RECEIVING BURNS SERVICE**

**Catheterise and attach an hourly urine device**

**Maintenance fluids**

**Adult*s***

No maintenance fluids

**Children.**

Calculate as normal with

0.9% saline +5% Dextrose

**FLUID RESUSITATION IS ONLY A GUIDE AND INFUSION RATES SHOULD BE ADJUSTED AND TITRATED TO DELIVER APPROPRIATE URINE OUTPUT**

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| **WOUND COVER AND AMBULANCE TRANSFER** |

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| Is the burn patient fit for transfer? Please indicate.  . | Y | | N |
| * Is the patient critical and do they require ITU / PICU? * If transferring, does the patient require critical care on route? * If transferring does the patient require standard care on route? * Do they require burns centre treatment and require care on route? | Y  Y  Y  Y | | N  N  N  N |
| * Cover the burn wounds in loose cling film prior to transfer. * If transfer is to be delayed, clean the burn wounds then cover with a non-adherent dressing e.g. Silflex / Atrauman | | | |
| All ambulance transfers for resuscitation burns must be performed by crews who can and will continue to provide:   * on-going fluid resuscitation * thermal regulation * monitoring throughout transfer | | | |
| Please attach any X-rays and blood results to the patient’s notes. | Y | N | |
| **COMPLETE AMPLE:**   * Allergies * Medicines * Past medical history * Last meal * Events | Y  Y  Y  Y  Y | N  N  N  N  N | |
| **NO** antibiotics required in E/D. | | | |

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* In the first instance ED’s should contact their local burn service for advice.
* If a burn bed is required and one is not available in the Network region the Burn clinician/service will advise ED departments to contact the National Burn Bed Bureau to find one.
* Contact with the burns service should be maintained for further advice/support until a bed is found.

**NATIONAL BURN BED BUREAU TELEPHONE NUMBER = 01384 679036**

**The local burns service will provide support and guidance with burn injured patients admitted to Emergency Departments. This will help ensure burn injured patients are directed to the correct level of burns care service.**