Superficial Dermal <3% TBSA

Superficial dermal burn wounds <3% should be treated as follows:-

1. Deroof blisters and debride loose skin
2. Cleanse with warmed normal saline or tap water
3. Obtain wound swabs
4. Apply a non-adherent dressing (as per local wound formulary). Use an anti-microbial dressing if required.
5. Apply a secondary dressing of gauze/burns swabs and crepe bandage if required
6. Reassess wounds after 24-48 hours and redress as above
7. Further dressing changes should be carried out as dressing application guidelines dictate or if exudate strikes through or infection is present. Wounds should be redressed until area is completely re-epithelialised.
8. Apply moisturiser and massage healed skin 3-4 times daily.

Superficial Dermal >3% TBSA

Superficial dermal burn wounds >3% should be treated as follows:-

1. Deroof blisters and thoroughly debride loose skin
2. Obtain wound swabs
3. Cleanse with saline/tap water
4. Where possible apply Biobrane biosynthetic dressing as per application guidelines
5. Consider cover with prophylactic antibiotics e.g. Co-Amoxyclov and / or anti-microbial dressings as per local guidelines
6. Apply a secondary dressing of gauze swabs and crepe bandage.
7. Inspect wounds 24-48 hours after application of Biobrane. Treat any pockets of fluid as per Biobrane guidelines.
8. Inspect wounds again at 72 hours post application and remove method of fixation
9. When Biobrane is well adhered and no exudate is evident allow the patient to bathe (no sooner than 5 days) and apply tubifast over the wound
10. Trim loose areas of Biobrane as the wound heals. Apply moisturiser to healed skin 3-4 times daily.
11. If it is not possible to use Biobrane then follow wound care guidelines above.
Deep Dermal

Deep dermal burn wounds should be treated as follows:-

1. Deroof blisters and debride loose skin
2. Cleanse with warmed saline/tap water
3. Obtain wound swabs
4. Apply an anti-microbial, non-adherent dressing (as per local wound formulary)
5. Apply a secondary dressing of gauze swabs and crepe bandage
6. Re-assess the wound within 24-48 hours
7. If the wound is not for surgical management continue to dress with an anti-microbial, non-adherent dressing until healed.
8. After wound healing has occurred moisturise and massage the wound 3-4 times daily.
9. Deep dermal burn wounds will most likely scar and will need review in the scar management/pressure garment clinic.

Full Thickness <1%TBSA

Full thickness injuries should be treated as follows:-

1. Debride loose skin from wound
2. Cleanse with warmed saline/tap water
3. Obtain wound swabs
4. Apply an anti-microbial, non-adherent dressing (as per local wound formulary)
5. Apply a secondary dressing of gauze swabs and crepe bandage if required
6. A prompt referral to the burns/plastics clinic should be made for a surgical assessment to take place.
7. If the patient does not require surgical intervention then continue to dress the wounds as above until healing has taken place.
8. After wound healing has occurred the skin should be moisturised and massaged 3-4 times daily
9. Refer the patient to the scar management/pressure garment clinic.
Full Thickness >1% TBSA

Full thickness injuries >1% TBSA should be treated as follows:-

1. Admit to the appropriate ward for surgical/plastics review
2. Debride loose skin
3. Cleanse with warmed saline/tap water
4. Obtain wound swabs
5. Apply an anti-microbial, non-adherent dressing (as per local wound formulary)
6. Apply a secondary dressing of gauze/burns swabs and crepe bandage if required
7. A further surgical review should be carried out within 24 hours
8. The wounds will continue to be dressed as above until surgical intervention can occur

NB If the injury is full circumferential an urgent surgical referral to assess the need for escharotomy should be carried out.

Facial wounds

Facial wounds will not have a dressing applied. They will be nursed exposed in a heated cubicle. If the wound does not require surgical management the treatment would be as follows:-

1. Ensure cubicle is warm
2. Deroof blisters and gently debride loose skin
3. Cleanse wound with warmed saline or tap water
4. Obtain wound swabs
5. Apply topical ointments if prescribed
6. Repeat wound care 2-3 times daily
7. Nurse the child in an upright position to reduce swelling
8. When the crusts have lifted moisturise and massage the healed skin 3-4 times daily
Hand/feet wounds

Burn injuries to hands or feet should be treated as follows:

1. Deroof blisters and debride loose skin
2. Cleanse with warmed saline or tap water. The hand or foot may be placed into a basin of warm water for cleansing
3. Obtain wound swabs
4. If the digits are affected apply individual dressings to each digit
5. Dress with a non-adherent anti-microbial dressing
6. Apply a secondary dressing of gauze swabs. Bandage hands/feet into a position which will preserve function.
7. Reassess wounds within 24-48 hours
8. If no surgical intervention is required redress wounds as above until wound healing has occurred
9. After wound healing has occurred the skin should be moisturised and massaged 3-4 times daily
10. Refer to the scar management/pressure garment clinic for assessment

NB All injuries which involve a joint should be assessed by the physiotherapist.

Perineal wounds

Perineal wounds should be treated as follows:-

1. Deroof blisters and debride loose skin
2. Cleanse with warmed saline/tap water
3. Consider the need for a urinary catheter
4. Obtain wound swabs
5. Apply topical ointment as prescribed
6. Apply a non-adherent wound dressing and burns swabs. If the child wears a nappy then put the nappy on over the dressings.
7. Renew dressings as child soils or exudate dictates
8. Cleanse and redress areas at least twice daily
9. Continue with this regime until wound has healed
10. After wound healing has occurred the skin should be moisturised and massaged 3-4 times daily
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