Ontario
North East Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Est

Surname:	First Name:
CHRIS #:	Date of Birth (DD/MM/YYYY):
HCN:	Version Code

PARTIAL THICKNESS BURNS CLINICAL PATHWAY

- Partial Thickness burns can be life-threatening depending on age, comorbidities and the extent of the body surface involved.
- These are the only types of burns that can be managed safely in the community or out-patient setting and may require hospitalization.
- Partial Thickness burns can involve the epidermis and dermis characterized by pain, redness, edema & blisters.

Full thickness burns destroy the epidermis, dermis and capillary network. Skin grafting may be required for these types of burns. They are typically managed in an acute care burn unit setting.

Name: **BRN#:**

To be completed at least once weekly and/or with change in patient condition ****This tool is used only as a guide and does not replace clinical judgment*** **ASSESSMENT** **Check ✓ where applicable; (N/A) where not applicable**	✓ Date/Initial	✓	✓	✓
Complete a comprehensive patient history and assessment including: Partial Thickness Burn , mechanism of burn (eg steam, electrical, hot water, flame, enclosed space, duration of contact, etc.), comorbidities, medications, and nutritional status, age.				
Percentage body surface area burned (rule of nines) 9% head and neck, 18% anterior trunk, 18% posterior trunk, 18% upper limbs, 36% lower limbs, 1% genitalia and perineum				
Perform and document a complete pain assessment				
Assess for dehydration and ensure adequate fluid intake				
Determine Tetanus immunization status				
Assess wound for signs and symptoms of infection: inflammation, increased exudate, unusual odour, delayed healing, friable or discoloured granulation tissue. Monitor the edge. Refer back to Plastic/General Surgeon who is treating the patient.				
Notify MD if signs of systemic infection (i.e. fever, changes in cognition)				
Assess patient adherence and understanding of treatment plan				
GOALS				
Wound will be protected from infection, insulated and supported in a moist wound healing environment				
Patient will have acceptable pain management and report any increase in pain intensity				
Patient will demonstrate progression towards healing within a reasonable time frame (typical wound closure within 4 weeks)				
Patient factors contributing to infection will be corrected (i.e. nutritional support, glycemic control, restoration of balance between host resistance and microorganisms)				
Maintenance of adequate oral intake to compensate ongoing fluid loss from burn				
Monitor wound for areas of full thickness skin loss (infection is the most common cause of partial thickness burn converting to full thickness)				
WOUND TREATMENTS				
Cleanse and protect the peri-wound. May cleanse small burns with lukewarm tap water and mild soap (liquid Dove soap recommended). Shower				

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with soap and water with larger surface areas. Make sure water is potable, otherwise use saline.				
Removal of loose debris (slough). Refer to appropriate clinician for additional debridement if required				
Select dressing to prevent desiccation that contours to the wound but does not restrict functional movement, splint joint in position of function where possible, controls exudate and avoids maceration of peri-wound area. Consider dressing that requires infrequent changes once determined it is a Partial Thickness Burn.				
Partial Thickness Burns: Cover with silver impregnated hydrofibre eg Aquacel Ag covered with a dry absorbent dressing of sufficient thickness to prevent leak through. Reassess in 1 week. At the 1 week dressing change, remove any loose product. Leave any adherent product and trim loose edges. ***DO NOT USE ANY LIQUID TO MOISTURIZE THE DRESSING IN ORDER TO REMOVE IT. ADHERENT DRESSINGS SHOULD BE LEFT INSITU.*** Cover any remaining areas with non-adherent dressing (Adaptic or Jelonet) and dry dressing.				
Silver Sulphadiazine is an appropriate alternative dressing. Collaborate with ordering practitioner.				
Facial burns: Cleanse with soap and water then apply Polysporin. Teach patient to apply, nurse to monitor.				
Blisters should remain intact. Larger blisters are at risk of bursting and may be aspirated using aseptic technique. Report to MD/NP				
Trim dressing Q7 days				
Moisturize epithelialized (new) skin with moisturizer				
Document Variance Report for deviation from clinical pathway				
NUTRITION				
Encourage regular meals throughout the day. Encourage meal plan to meet recommendations of Canada's Food Guide				
Encourage adequate fluid intake (1.5-2L/day) unless contraindicated				
MEDICATIONS				
Provide analgesics PRN				
Initiate systemic antibiotic/topical therapy as per MD order				
Medication Reconciliation for medications that delay wound healing eg. steroids, anti-inflammatories, methotrexate				
PAIN				
Encourage mobility if appropriate				
Dressing changes are painful (procedural) ensure patient takes analgesic before dressing changes				
Use non-pharmacological techniques such as repositioning, rest – State:				
Cleanse wounds gently using warm water or saline				
Involve patient in pain procedural choices (what helps, what doesn't) (e.g. time outs) – State:				
Take analgesics as prescribed (using WHO guidelines for analgesic)				
TEACHING AND PSYCHOSOCIAL SUPPORT				
Teach patient: Factors contributing to infection, delayed healing and signs and symptoms of infection				
Involve patient and family in care planning where appropriate				
Provide patient and family with information that will enhance knowledge and skills necessary to promote recovery and improve function				
Provide patient with information on follow up care and accessing community resources				
REFERRALS				
Request consult for Physiotherapist for proper exercises, mobilization and ambulation techniques, falls prevention assessment if appropriate *see*				

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below for specific interventions				
PT REFERRAL/INTERVENTION				
1. **2.**				
Request consult for Occupational Therapist to assess positioning and/or transfers to make appropriate device recommendations. *see below for specific interventions*				
OT REFERRAL/INTERVENTION				
1. **2.**				
Request consult for Dietitian for energy protein assessment if nutritional status implicates delayed wound healing. Complete nutritional assessment screening tool. Based on result – automatic referral (Dietitian to amend) *see below for specific interventions*				
DIETITIAN REFERRAL/INTERVENTION				
1. **2.**				
Request referral for Enterostomal Therapist/Wound Care Specialist/Nurse Practitioner/Physician (i.e. wound deterioration, if < 20% healing following 3 to 4 weeks of appropriate treatment, further surgical intervention required)				
ET/WCS/APN/NP/MD REFERRAL/INTERVENTION				
1. **2.**				
Request consult for ineffective coping, financial issues, etc. State: _____ *See below for effective interventions*				
SOCIAL WORK REFERRAL/INTERVENTION				
1. **2.**				
DISCHARGE PLANNING				
Assess patient/caregivers adherence and understanding to treatment plan				
Discharge patient: Community referrals as required				
Refer to self-management if appropriate				

Print Name	Signature	Initials	Date