HOME AND COMMUNITY CARE SUPPORT SERVICES
North East

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

PARTIAL THICKNESS BURNS CLINICAL PATHWAY

Partial Thickness Burns (PTB): PTB can involve the epidermis and dermis and are characterized by pain, redness, edema & blistering. PTB can be life-threatening depending on age, comorbidities and the extent of the body surface involved. These burns can often be managed safely in the community or out-patient setting and may require hospitalization from time to time.

Full Thickness Burns: Destroy the epidermis, dermis and capillary network. Skin grafting may be required. They are typically managed in an acute care burn unit setting.

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* Date/Initial:	✓ **where applicable; (N/A) where not applicable**			
COMPREHENSIVE ASSESSMENT				
Complete a comprehensive patient history and assessment including: mechanism of burn (i.e. thermal, electrical, etc.), comorbidities, medications, immune status, nutritional status, and age.				
Perform and document a weekly comprehensive wound assessment identifying wound dimensions, wound bed appearance (need for debridement), exudate (type and amount), peri-wound appearance. Assess for bone exposure (report immediately to Primary Care Practitioner [PCP]). Record percentage of weekly healing.				
Assess wound for signs and symptoms of infection: induration or edema, increased pain, increased exudate, unusual odour, delayed healing, friable or discoloured granulation tissue, peri-wound erythema greater than 2 cm, fever, changes in cognition and general malaise. Report concerning findings to Primary Care Provider (PCP). *Monitor wound for areas of full thickness skin loss; infection is the most common cause of partial thickness burn converting to full thickness.*				
Record percentage body surface area burned using Rule of Nines. See Appendix A for child and adult parameters.				
Perform and document a complete pain assessment.				
Assess for dehydration and ensure adequate fluid intake.				
Determine Tetanus immunization status.				
Complete nutritional assessment screening tool.				
Assess, determine and emphasize importance of patient adherence to individualized treatment plan.				
Photo image upload at initial visit, monthly and with wound deterioration.				
GOALS				
Wound will progress through the healing process.				
Wound will be protected from further complications.				

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Patient factors contributing to infection will be addressed and mitigated (i.e. nutritional support, glycemic control, restoration of balance between host resistance and microorganisms).				
Patient will have acceptable pain management.				
Encourage patient/caregiver participation in developing individualized treatment plan and exploring self-management.				
Maintenance of adequate fluid intake to compensate ongoing fluid loss from burn and oral intake to support healing.				
Encourage mobility if appropriate to reduce risk of contractures.				
WOUND TREATMENTS				
Cleanse gently with lukewarm potable water. Shower with mild soap and water for wound with larger surface area.				
Clean and pat peri-wound dry and apply a protective barrier to prevent maceration if indicated.				
Remove loose debris (slough). Refer to appropriate clinician for additional debridement if required.				
Select dressing that contours to the wound base, supports moist wound healing, does not restrict functional movement, and controls exudate. Splint joint in position of function if required. Consider dressing that requires infrequent changes.				
Cover with silver impregnated hydrofibre (i.e. Aquacel Ag) covered with an absorbent dressing appropriate for exudate management. Reassess in 1 week. At the 1 week dressing change, remove any loose product. Leave any adherent product and trim loose edges. Silver impregnated hydrofibre may be left in place up to 14 days. Adherent dressings may be removed by soaking. Cover fragile epithelialized areas with non-adherent dressing (i.e. Adaptic or Jelonet) and apply dry dressing. Silver sulfadiazine is an appropriate alternative dressing, however, early collaboration with the ordering physician to initiate silver hydrofibre protocol is encouraged (as appropriate).				
Facial burns: Cleanse with soap and water then apply Polysporin ointment. Patient to self-manage. Reduce nursing visits to monitor if indicated.				
Blisters should remain intact. Larger blisters that are at risk of rupturing may be aspirated using aseptic technique.				
Moisturize epithelialized (new) skin with unscented moisturizer.				
Medical follow up indicated if wound has not reepithelialized after 14 days.				

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Consider if the wound meets the definition of a Chronic Maintenance wound: Wounds that fail to progress normally through the repair process (are present for at least 12 weeks and have not responded to wound specific pathway), frequently caused by vascular compromise, chronic inflammation, repetitive insults to the tissue or patient lifestyle choices. These wounds fail to close in a timely manner or fail to result in durable closure. Please refer to Chronic Maintenance Clinical Guideline.				
Document Variance Report for deviation from clinical pathway i.e. frequency greater than q. 3 days.				
MEDICATIONS				
Complete medication reconciliation.				
Initiate systemic antibiotic/topical therapy as per PCP order.				
PAIN				
Support use of pre-procedural analgesic to manage pain.				
Review non-pharmacological techniques such as repositioning, relaxation, rest, time outs.				
SELF-MANAGEMENT & EDUCATION				
Review signs and symptoms of infection and delayed healing.				
Showering is encouraged for mechanical debridement. **Bathing and/or soaking of wound is discouraged.** Follow PCP protocol.				
Promote safe activity (per PCP) and rest, smoking cessation and appropriate analgesic use.				
Encourage daily intake to meet recommendations of Canada's Food Guide, focusing on regular balanced meals and adequate fluid intake (1.5-2L/day) unless contraindicated.				
Involve patient and family in care planning and wound management.				
REFERRALS (if indicated)				
PHYSIOTHERAPY: Request consult for Physiotherapist to assess for proper exercises, mobilization, ambulation techniques and gait assessment. Request specific intervention in the physiotherapy referral.				
OCCUPATIONAL THERAPY: Request consult for Occupational Therapist to assess education regarding position strategies, mobility strategies and therapeutic services. Please accompany referrals with wound stage, location, size and duration of the wound.				
DIETETICS: Request consult for Dietitian assessment if nutritional status implicates delayed wound healing and/or energy- protein malnutrition and/or identified need for diabetic diet teaching/monitoring. Include height, weight and wound descriptors with referral. Consider referral to Complex and Diabetes Education Program.				

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NURSE SPECIALIZED IN WOUND, OSTOMY AND CONTINENCE: Refer according to wound/ostomy escalation process, which includes initial escalation to SPO Wound and Ostomy Care Champion PRIOR to NSWOC referral.				
SOCIAL WORK: Request consult for socioeconomic challenges such as ineffective coping, financial issues, and assistance with resources.				
DISCHARGE PLANNING				
Provide appropriate patient handbook and review appropriate teachings to support wound healing. Facilitate community referrals as indicated.				