Initial assessment and treatment of burns in Elderly

Specialist Burn Nurse

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Predisposition to Burn Injury

- Age (Elderly and Children)
- Alcohol/drug misuse
- Epilepsy
- Diabetes
- Pre-existing psychiatric disorders

Burns Numbers in Uk

- In the United Kingdom about 250 000 people are burnt each year

- 10% of burns occur in people aged over 65. Various effects of ageing (such as immobility, slowed reactions, and decreased dexterity) mean elderly people are at risk from scalds, contact burns, and flame burns.

First aid in the community

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STOP

First Aid for burns and scalds

S **Strip** hot clothes and jewellery if possible.

T **Turn on cold tap** (never use ice). Run the burn under cool water for 10-20 minutes. Keep the rest of the person warm.

O **Organise** medical assistance. Contact NHS 24 – dial 111, attend A&E or dial 999.

P **Protect** burn with cling film or clean cloth (**NO** dressings, fluffy cloth, creams/lotions). **Give Painkillers.**

Frist Aid in the nursing Home

- Remove the residence clothes as soon as burn is noticed .
- Applied cold water look to get patient into the shower or apply cold water.
- Review the Burn and assess the size and Depth
- Apply appropriate dressing for the burn and if required refer to other services for advice

Important Information when reviewing the burn wound

- Require comprehensive history of burn injury
- How it happened
- Why it happened
- Initial First aid undertaken when they had the burn if you were not present when it happened

- Is the Burn
- Circumferential
- Inhalation
- Chemical
- Electrical

- Patient past medical history

Burn Types

Scald injury

Electrical Burn

Contact Burn

CHEMICAL BURNS

NHS Greater Glasgow

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- The Depth of burn wound is the most important assessment method in the management of the burned patients

Classification of Burns Depth

Superficial Burn

Partial Thickness Burn

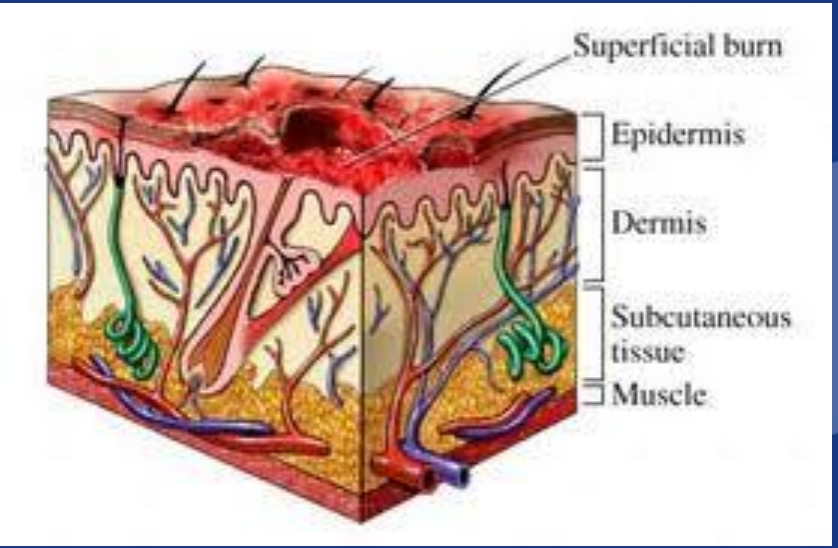
Full Thickness Burn

Superficial Burn

Injury to the top layer of skin the epidermis.

Normally heals within 5 to 7days.

Heals usually with no scarring but there can be permanent colour change



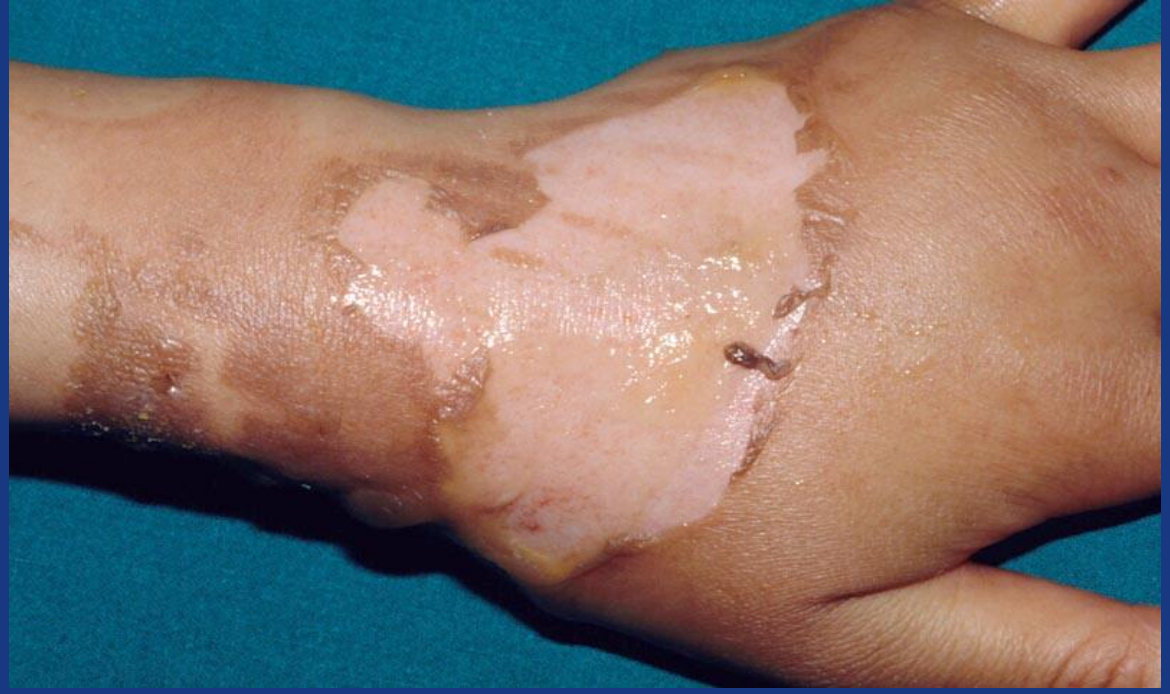
Superficial Burn :- may appear bright pink or red in colour (erythema). Blisters may or may not be present. The texture is normal or firm and the area is very painful and hypersensitive to touch. On pressure the burn area will blanch and capillary return will be brisk.

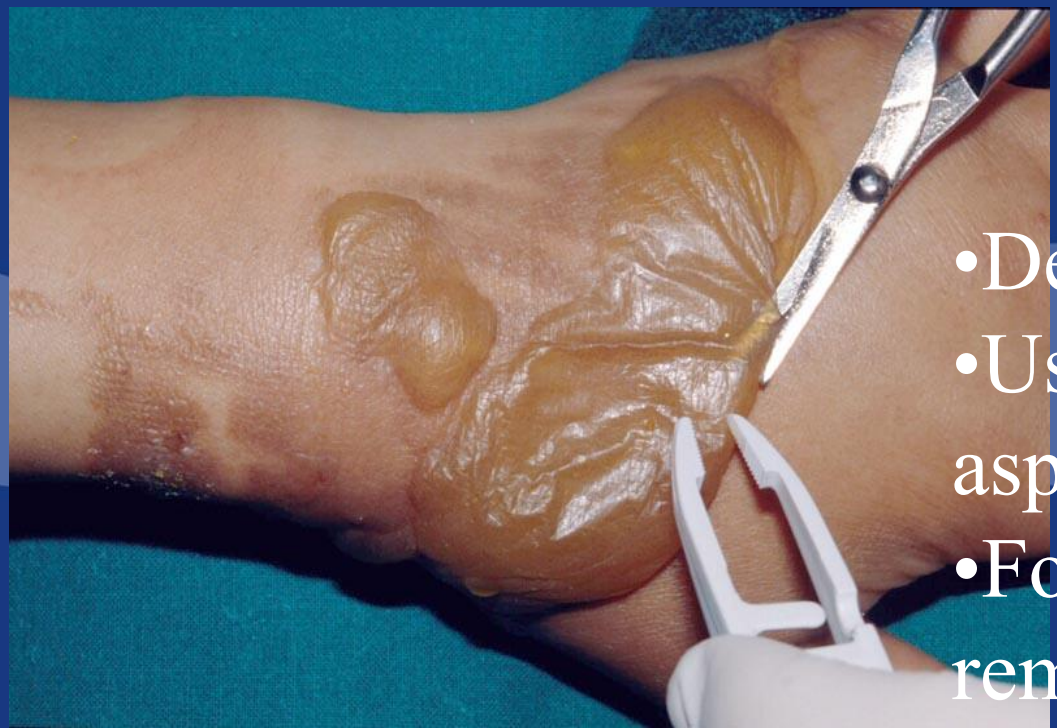
Cleanse area

Remove all blisters

Apply a non –adherent dressing

Follow on care would be Nurses in care home with support from care home liaison team
If a large area /over joints is involved
Please refer for advice to the *Burns* clinic, Outreach service or Burns Unit when out of hours .





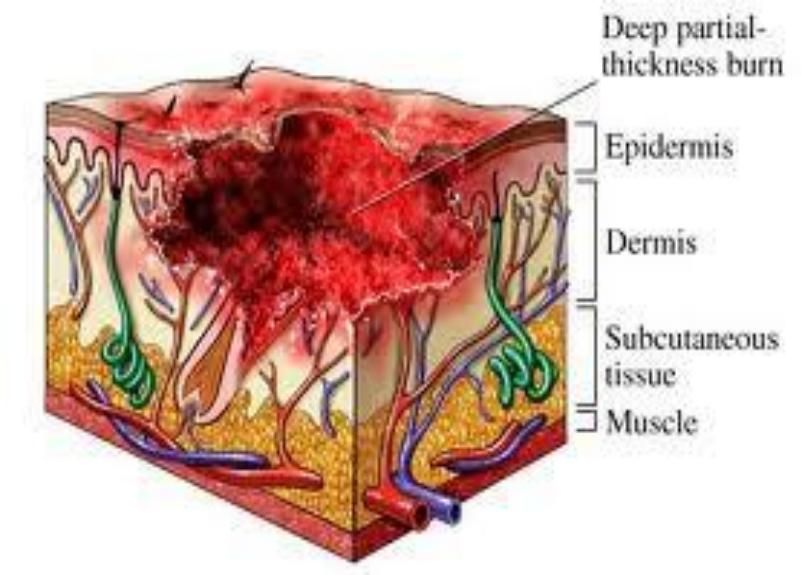
- De-roof blisters
- Use sterile needle to aspirate or
- Forceps and scissors to remove non viable tissue

Partial Thickness Burn

Injury to the second layer of skin the dermis

Normally heals within 7-14 days but if a deep partial thickness can be more than 4 weeks

It heals within two to three weeks no scarring should be present. If longer healing time scarring will be apparent



Partial Thickness Burn :- characterised by a creamy coloured base which is mottled in appearance. Sensation is present. On pressure burn area will blanch and capillary return slow.

Cleanse area

Remove all blisters

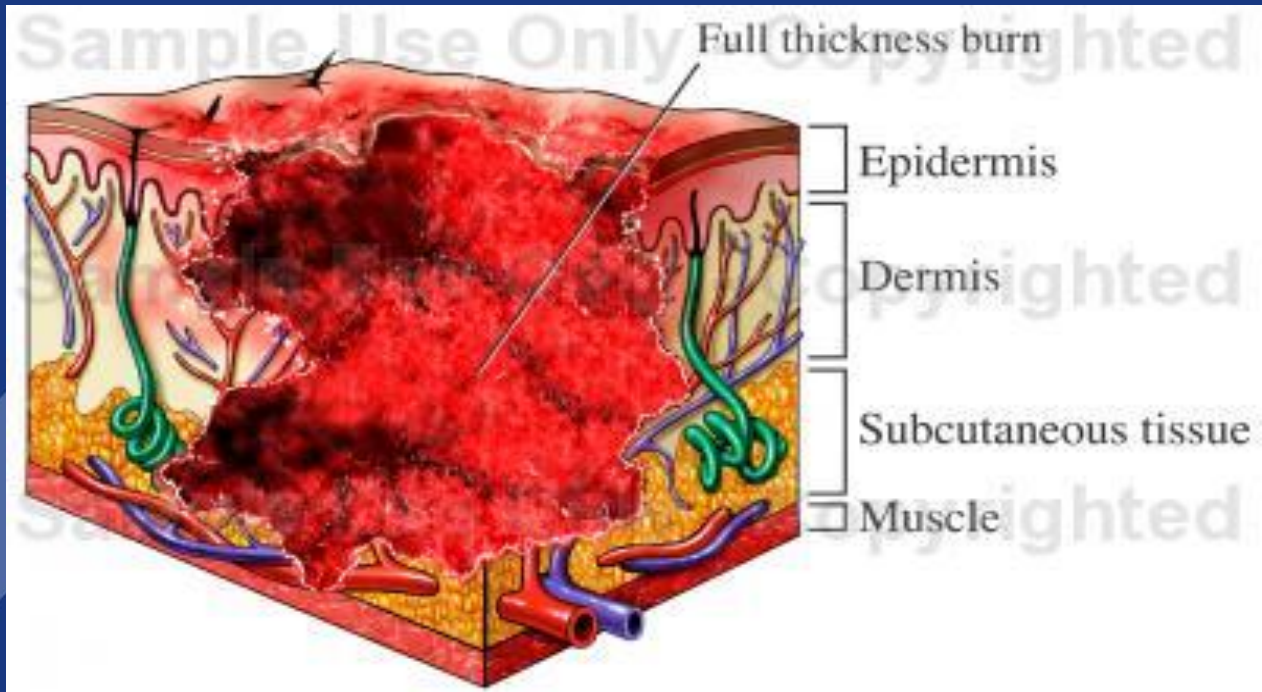
Apply a non –adherent dressing

Discuss further management with Outreach service /Out of hours Burns Unit

Full Thickness Burn

Injury which destroys all three layers of skin and can extend into underlying tissues (ligaments and muscle)

Due to the damage sustained, these burns do not heal without surgical intervention. In certain circumstances surgery is not a option as this depends on patients co- morbidities



Full Thickness Burn:- characterised by its whitish leather appearance. It can also be brown, cherry red or charred black. It is firm and leathery in texture. Few, if any, blisters are present. Those blisters that are present are thin walled and break easily. Areas will not blanch under pressure. Initially, nerve sensation is greatly diminished or lost completely when the injury is sustained.

Cleanse area

Remove blistering

Apply a loose non-adherent dressing

All this depth of burn requires referral to the Burns team.

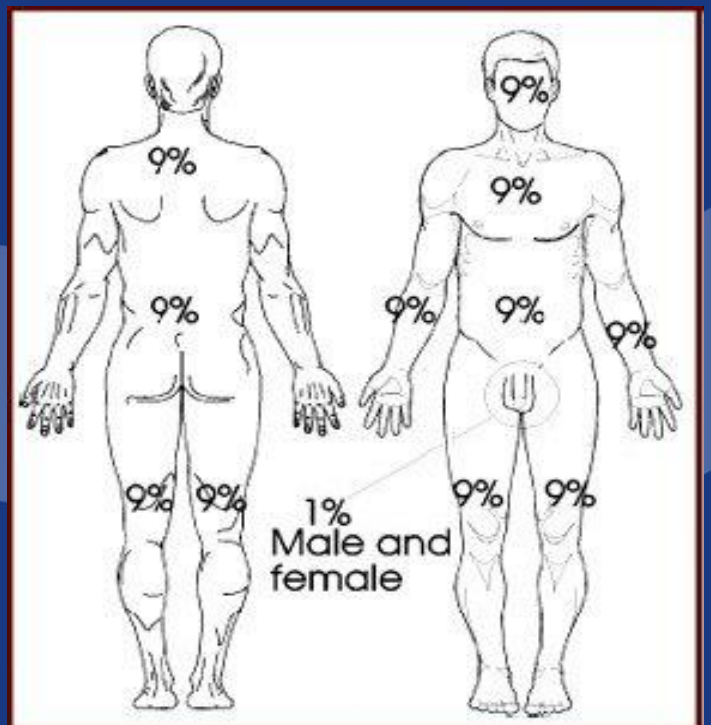
Methods of assessing size of Burn wound

The "rule of palm" is a quick way to estimate the size of a burn. The palm of the person who is burned (not fingers or wrist area) is about 1% of the body this is used to give a percentage of burn injury. This method is better used on small burns.

For an accurate measurement Wallace Rule Of Nines Assessment Chart for Adults only.

Wallace Rule of Nines

This is a good, quick way of estimating size in medium to large burns in adults. The body is divided into areas of 9%, and the total burn area can be calculated. It is not accurate in children. Watchel (2000) states that the rule of nines technique overestimates the burn size.



Burns common in care home

- Scalds
- Tea/Coffee
- Soup
- Hot food

- Contact
- Radiators

Scalds

- Reasons
- Cognitive issues
- Poor mobility

- Risk of Burns going deep
- Due to cognitive issues

(patient declining any intervention)

- Poor mobility

(Patient requires hoisted to remove clothes not enough staff)

- Patient does not tell staff the have burned them selves
- Patient who are elderly have fragile skin

Contact Burn

- Reasons
- Mobility high risk of falls
- Area not risked assessed

- Risk of burns going deep
- Mobility (unable to move away from hot surface)
- Cognitive issues(patient not able to contact staff after falling)
- Fragile skin

Burns Outcomes

- Heal the wound
- Restore and maintain function
- Reducing infection
- Minimising Scaring

WOUND PRODUCTS USED IN BURN INJURY

Ideal Dressing For Burns

- Easy to apply
- Maintain moist wound environment
- Allow gaseous exchange
- Control bacteria
- Comfortable
- Allows range of movement

Why a Non-adherent dressing?

- Available in large sizes
- Allows exudate to permate
- Cost effective
- Ease of application for patients and staff
- Does not macerate surrounding skin
- Does not mask the depth of the Burn
- Can be soaked for easy removal

Infection in Burns

Burns have high risk of infection especially in feet and groin burns. Also patient with cognitive issues

If any clinical indictors of infection please apply a silver base dressing to wound and swab the wound

Think may require antibiotics

Case studies to discuss

Mr Thomas

82 yr old gentleman

Pmh:- Cognitive issues

Burn:- Patient manage to get to hot water urn and opened the tap. He sustained scald burn to both upper thighs

Mrs White

85yr old lady

Pmh:- Cognitive issues

Burns:- Patient slipped between bed and radiator . She sustained a contact burn to abdominal area

Mrs Brown

97 yr old lady

Pmh-Poor mobility , cardiac issues and mild cognitive issues

Burn:- Given a hot cup tea not in her normal cup. Patient slipped tea causing scalp to both upper thighs

Require steps if a resident sustains a burn

- First Aid
- Assess the depth and size of the burn
- Photograph burn
- Apply appropriate dressing
- Complete wound chart
- Inform manager
- Inform relatives
- Commence investigation and API is done
- Inform the care home liaison nurse
- Refer to Burns Outreach if appropriate

How to refer

- ggc.burnsandplasticoutreach@ggc.scot.nhs.uk (Mobile Number 075342285670
- Patient details with telephone number
- History of burn
- Photograph of Burn

- Burns Outreach is available 8-4 Mon-Fri emails sent outside these hours will reviewed next day If urgent discussion required then contact service on phone if outside these hours contact Plastic Trauma Team at GRI

Further Education

www.cobis.scot.nhs.uk

www.britishburnassociation.org

NHS Greater Glasgow

Thank You for listening