ADULT PROTOCOL

BURNS

Airway / Breathing

Circulation / Shock

Cardiac

Medical

Trauma

UNIVERSAL PATIENT CARE PROTOCOL

CONSIDER SPINAL MOTION RESTRICTION PROCEDURE

AIRWAY PROTOCOL

OXYGEN

CAPNOGRAPHY PROCEDURE

If Chest, Neck, Face, Airway Involvement – Prepare for Invasive Airway Procedures
INTUBATION - only if evidence of airway compromise
CRICOTHYROTOMY - NEEDLE, KIT, or SURGICAL
As provided and trained
In rare circumstances for life saving measures only

Remove rings, bracelets, and other constricting items

See Rule of 9's chart at the end of this section

Thermal

If burn < 10% body surface area (using rule of nines)
Cool down wound with NORMAL SALINE

Cover burn with dry sterile sheet or dressings

IV / IO PROCEDURE
If Burns ≥ 20% then 80 drops / min (Macrodrip set) note to exceed 500 ml / hr - otherwise KVO

PAIN MANAGEMENT PROTOCOL

Chemical

Eye Injury
Continuous flushing with Normal Saline

Remove clothing and / or expose area

Flush area with NORMAL SALINE for 10 – 15 minutes

PAIN MANAGEMENT PROTOCOL

Initiate Trauma Alert

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Control where indicated
APPROPRIATE transfer of care

EMT Intervention	AEMT Intervention	PARAMEDIC Intervention	Online Medical Control

BURNS

HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL DIAGNOSIS
• Type of exposure (heat, gas, chemical) • Inhalation injury • Time of injury • Past medical history • Medications • Other trauma • Loss of consciousness • Tetanus / immunization status	• Burns, pain, swelling • Dizziness • Loss of consciousness • Hypotension / shock • Airway compromise / distress • Singed facial or nasal hair • Hoarseness / wheezing	• Superficial (1°) red and painful • Partial thickness (2°) superficial partial thickness, deep partial thickness, blistering • Full thickness (3°) painless and charred or leathery skin • Chemical • Thermal • Electrical • Radiation

KEY POINTS

- Exam: Mental Status, HEENT, Neck, Heart, Lungs, Abdomen, Extremities, Back, Neuro
- **Intubation is only required in cases with airway compromise.**
- Critical Burns: >25% body surface area (BSA); full thickness burns >10% BSA; partial thickness superficial partial thickness, deep partial thickness and full thickness burns to face, eyes, hand or feet; electrical burns; respiratory burns; deep chemical burns; burns with extremes of age or chronic disease; and burns with associated major traumatic injury. These burns may require hospital admission or transfer to a burn center.
- Potential CO exposure should be treated with 100% oxygen.
- Circumferential burns to extremities are dangerous due to potential vascular compromise partial thickness to soft tissue swelling.
- Burn patients are prone to hypothermia – Never apply ice or cool burns that involve >10% body surface area.
- Do not overlook the possibility of multiple system trauma.
- Do not overlook the possibility of child abuse with children and burn injuries.
- See appendix for rule of nines.

1. **Thermal (dry and moist):**
   a. Stop burning process: i.e. remove patient from heat source, cool skin, remove clothing
   b. If patient starts to shiver or skin is cool, stop cooling process.
   c. Estimate extent (%) and depth of burn (see chart). Determine seriousness (see chart) of burn, contact Medical Control and transport accordingly.
   Cover burn areas with sterile dressing.
2. **Radiation Burns:**
   a. Treat as thermal burns except when burn is contaminated with radioactive source, then treat as chemical burn.
   b. Wear appropriate protective clothing when dealing with contamination.
   c. Contact HAZ MAT TEAM for assistance in contamination cases.
3. **Chemical Burns:**
   a. Wear appropriate protective clothing and respirators.
   b. Remove patient from contaminated area to decontamination site (NOT SQUAD).
   c. Determine chemicals involved; contact appropriate agency for chemical information.
   d. Remove patient's clothing and flush skin.
   e. Leave contaminated clothes at scene. Cover patient over and under before loading into squad.
   f. Patient should be transported by personnel not involved in decontamination process.
   g. Determine severity (see chart), contact Medical Control and transport accordingly.
   h. Relay type of substance involved to Medical Control.
4. **Electrical Burns:**
   a. Shut down electrical source; do not attempt to remove patient until electricity is CONFIRMED to be shut off.
   b. Assess for visible entrance and exit wounds and treat as thermal burns.
   c. Assess for internal injury, i.e., vascular damage, tissue damage, fractures, and treat accordingly.
   d. Determine severity of burn, contact Medical Control and transport accordingly.
5. **Inhalation Burns:**
   a. Always suspect inhalation burns when the patient is found in closed smoky environment and / or exhibits any of the following: burns to face / neck, singed nasal hairs, cough and / or stridor, soot in sputum.
   b. Provide oxygen therapy, contact Medical Control and transport.

- Handle patients gently to avoid further damage of the patient's skin**.**
- If the patient is exposed to a chemical, whenever possible, get the name of the chemical, and document it on the patient run report. **DO NOT** transport any hazardous materials with the patient.
- Look for signs of dehydration and shock.
- Initiate early intubation for symptomatic patients with inhalation burns.
- Patients with major burns should be transported to the a Regional Burn Center.
- Patients with unstable airway or who are rapidly deteriorating should be transported to the closest appropriate facility.
- Patients with large surface burns lose the ability to regulate their body temperature. Avoid heat loss by covering the patient.