Care of burn patients in the hospital

Sheila Kavanagh, Alette de Jong
Nursing Committee of the International Society for Burn Injuries

Royal Adelaide Hospital, Adelaide, Australia
Rode Kruis Ziekenhuis, Beverwijk, The Netherlands

1. Introduction

In caring for the patient with a burn injury it is important to remember that many factors impact on the care that we are able to deliver. This is of particular relevance in the area of wound care. Access to costly wound products is not an option in many settings. In these situations, creativity and innovation have led to many excellent alternatives being developed. In some instances sophisticated products are available but lack of clinical experience makes them difficult to use. Wound care needs to be undertaken in the context of the local environment.

2. The burn wound

It is appropriate to highlight the functions of the skin as they underpin the management of the burn wound:

- Protection
- Immunological
- Fluid, protein and electrolyte homeostasis
- Thermoregulation
- Neurosensory
- Social—interactive
- Metabolism

A burn injury results in either the loss or disruption of some or all of these functions. The burns nurse must assess all of these factors when deciding on an appropriate nursing management plan.

2.1. Thermal energy effects

The three mechanisms that energy is transferred by: are conduction, convection and radiation. All of these mechanisms affecting heat transfer may deliver heat to, or away from, living tissues [1].

Sustained temperatures result in cellular dysfunction and early denaturation of protein [1]. As the temperature or the time of exposure increases, then cell damage increases.

Nguyen et al. [2] concur with other studies in demonstrating the beneficial effects of cooling on reducing tissue damage and wound healing time.

The question often asked, is how long after the burn injury, is it still worthwhile to commence cooling. Nguyen et al. [2] conclude from various authors that although immediate cooling is preferable, even a 30 min delay in application of cooling is still beneficial to the burn wound. The same authors do point out that the application of cooling 60 min after injury, does not demonstrate any benefit.

Impairment of blood flow in the zone of stasis can occur from shortly after the burn injury up to 48 h post-burn [1]. If blood flow is compromised, this may lead to the eventual necrosis of cells in this zone.

Clinical management that will promote the recovery of this zone includes:

- Wound dressing chosen to aid moist wound healing.
- The use of topical anti-microbial agents.
- Adequate fluid resuscitation/hydration.
- Elevation of burnt area to minimise oedema.
- Advising patient to avoid/minimise smoking.
- Management of systemic diseases such as diabetes-monitor and stabilise blood sugar levels.
2.2. *Burn wound oedema*

It is important to have an understanding of the timeframe of oedema development and resolution. The ability of the tissues to receive oxygen and nutrients is reduced during this time, while susceptibility to infection is increased [1].

The impact of this on clinical management is that strategies to aid recovery of the zone of stasis must extend until oedema resolution has occurred.

2.3. *Burn inflammation*

Inflammation becomes prominent at 7–10 days post-injury. It is at this time that blood flow in the burn wound is at its maximal level. Surgery, therefore, may be hazardous due to an increased risk of blood loss. This is one of the reasons that early burn wound excision is favoured by many burn surgeons [1].

2.4. *Burn wound depth*

Burn depth in Australia is most frequently described using the following classification system:

- Epidermal
- Superficial dermal
- Mid-dermal
- Deep dermal
- Full thickness

Other classification systems refer to 1st, 2nd and 3rd degree injury. This system, however, is subjected to personal interpretation of the classification. The advantage of the descriptive system is that it removes any ambiguity. This is especially useful when discussing burn wound management over the phone.

2.5. *The burn blister*

This is a subject still debated at length by various practitioners. A review of the literature by Flannagan and Graham [3] led them to conclude that ‘... empirical evidence over the last 50 years both supports and refutes the routine debridement of blisters’. Authors such as Williams [1], Pankhurst and Pochkhanawala [4] and Carrougher [5] conclude that small blisters can be let intact, but as a general rule, blisters should be debrided and the wound dressed.

How this translates into clinical practice is based on treating every patient individually. A variety of factors should be taken into consideration when deciding whether to de-roof blisters or leave them intact.

In the paediatric setting, blisters on the palm of the hand and sole of the foot are often left intact for a period of 48 h. In the adult, large blisters on the palm of the hand may impede function to a level that is unacceptable.

It has already been mentioned that the size of the blister should be taken into consideration.

2.6. *Factors affecting wound healing*

Both the very young and the elderly have very thin skin that makes them more susceptible to significant burn injury.

Other factors that affect wound healing include:

- Nutrition
- Infection
- Associated illnesses, such as diabetes mellitus, malignancy and vascular insufficiency
- Cytotoxic treatments

2.7. *Burn wound healing*

Factors that will enable healing to occur include wound care, good nutrition, maintenance of function, positive attitude and co-operation from the patient. Oedema reduction, prevention of burn wound infection and adequate analgesia will also contribute to optimal patient outcome.

The achievement of these goals involves the whole burn team. Every team member has a responsibility to maintain a high standard in relation to infection control strategies.

Care of the wound itself should be designed to:

- Promote spontaneous healing.
- Prevent further tissue loss.
- Prevent infection.
- Provide optimal conditions for surgery if required.
- Be as painless as possible.
- Be acceptable to the patient’s needs.

2.8. *Wound cleansing*

It is interesting to note that in the general wound care arena, there has been much discussion on the choice of wound cleansing solutions. Most studies have not looked at burn wounds. The Joanna Briggs Institute Best Practice information sheet ‘Solutions, techniques and pressure for wound cleansing’ [6] excluded studies that compared solutions for patients with burns.

Many authors including Carrougher [5], and Pankhurst and Pochkhanawala [4], report that in practice most burns units bath or shower their patients with tap water. Some centres use mild antiseptic impregnated sponges. Extreme caution should be exercised when using solutions that have been shown to be toxic to cells.

The maintenance of the temperature of the burn wound has been identified as beneficial by numerous authors. Methods of achieving this include:

- Warming cleansing solutions.
- Warm ambient temperature.
- Avoid lengthy dressing changes.
Avoid exposure of wet wound surfaces.

Ambulant patients, with minimal wound care needs, use independent showering. Burns units may use burn baths, portable shower trolleys, or a combination of both in their management of patients. The burns nurse will need to decide which is the most appropriate choice. Factors that need to be taken into consideration include:

- Age of patient.
- Patient ability to lie still.
- Extent of open burn wound.
- Presence of wound infection.
- Available equipment.
- Available space.
- Patients need for physical therapy.
- Wounds or dressings that may benefit from soaking.

Konop [7] states that the disadvantages of hydrotherapy include the risks of auto-contamination and electrolyte imbalance. Carrougher [5] warns against excessive immersion times over 30 min that may cause sodium and heat loss, in addition to pain and anxiety associated with prolonged exposure.

Cleansing and debridement should be careful, gentle and minimal. Body hair within the burn and to within 2.5 cm of the wound periphery should be shaved, with the exception of the eyebrows [5]. This will:

- Contribute to a decrease in the bacterial load on the wound surface.
- Make the application and integrity of occlusive dressings easier.
- Make the removal of occlusive dressings easier and less painful.

2.9. Mechanisms of wound debridement

There are five methods of wound debridement that may be utilised in wound management.

1. Autolytic—the use of moist dressing such as hydrogels or hydrocolloids may facilitate this.
2. Surgical—fascial, tangential or sharp debridement with scissors or scalpel.
3. Enzymatic—e.g. fibrinolysins (mashed papaya is used in Africa).
4. Mechanical—wet to dry dressings (danger of damage to new epithelium), pulse lavage, gentle washing.
5. Biological—larvae of *Lucilia sericata*.

2.10. Burn wound dressings

Various biologic, biosynthetic and synthetic wound dressings are used in burn care. Selection and use of these products depends on the condition of the wound bed, the inherent properties of the dressing and the goals of therapy [5]. In practice, different products seem to work for some centres and not for others. Patient population demographics and the local environment may all impact on the success or failure of certain dressing products.

Pankhurst and Pochkhanawala [4] summarise the ideal burn dressing as one that must:

- Protect the wound from physical damage and microorganisms.
- Be comfortable, compliant and durable.
- Be non-toxic, non-adherent, and non-irritant.
- Allow gaseous exchange.
- Allow high humidity at the wound.
- Be compatible with topical therapeutic agents.
- Be able to allow maximum activity for the wound to heal without retarding or inhibiting any stage of the process.

When selecting a suitable dressing, numerous factors need to be taken into consideration:

- Depth of the burn. (This determines the amount of exudate).
- Site of the burn.
- Extent of the burn.
- Type of first aid (cooling with dirty river water may increase the risk of infection).
- Cause of the burn (burns caused by flammable liquids or hot oil have a high potential for infection).
- Patients ability to manage dressing.
- Health professionals ability to manage dressing.
- Functional impact of dressing on patients lifestyle.
- Associated pain.
- Urgency of ‘time to healing’.
- Cost.

2.11. Management of the circumferential burn

In any circumferential burn, there is a risk of circulatory or respiratory compromise, depending on the site of the burn. Restriction normally occurs in full thickness burns, but may occur in deep dermal injury. If this compromise occurs, then an escharotomy must be performed. This is a longitudinal incision that runs the length of the burn. The incision should start in unburned skin and continue over into unburned skin at the distal end of the incision if possible. There will be some bleeding from the incision and a haemostatic alginate should be used on the escharotomy incision if full excision of the eschar is to occur at another time.

In any circumferential burn, care must be taken when applying dressings to ensure that:

- They are not constrictive in any way.
- They allow for full assessment of neurovascular or respiratory status.
2.12. **Management of the superficial burn**

In the very superficial burn with no epidermal loss, no dressing will be required. These burns are very painful and a topical analgesic cream may be useful. This can be followed by the use of a moisturising cream when the pain has eased.

The superficial burn can be treated by a variety of wound products. These should be chosen to protect the wound and encourage re-epithelialization. Product groups that are commonly used include polyurethane semipermeable films, hydrocolloids and retention dressings. If infection is present or there is a high risk of potential for infection to occur, an anti-bacterial dressing should be chosen.

2.13. **Management of the partial thickness burn**

The management of the partial thickness burn injury and the split thickness skin graft donor site is very similar. The donor site should have a low risk of infection and antibacterial dressings are not normally required. Product groups that may be considered for this depth of burn include:

- Hydrocolloids
- Polyurethane films
- Biologic dressings
- Biosynthetic dressings
- Alginates
- Polyurethane membrane supported gel
- Foams
- Anti-microbial products such as products containing silver
- Vaseline gauze (in Africa this is a dressing that nurses make themselves when dressings such as those listed above are not available. They have found this a great improvement on using plain dry gauze)

The use of temporary skin substitutes such as Biobrane™ and Transcyte™ have become more widely used in the treatment of mid- to deep-dermal burn injury. As these products do not have any anti-bacterial properties, meticulous wound cleaning must occur prior to application. Many centres give patients a general anaesthetic to allow for a thorough cleansing without causing undue distress to the patient. The use of re-tenitive tape to fix these substitutes instead of using staples minimises further painful episodes that are associated with staple removal.

As with the superficial burns, the presence or suspicion of infection will make the use of an anti-bacterial dressing obligatory.

2.14. **Management of the full thickness burn**

Full thickness burn injuries are treated with antimicrobial dressings. The most common dressing used in Australia and New Zealand have, until recently, been silver sulphadiazine cream and silver nitrate solution. There are now a wide variety of products containing silver available.

The choice of product can be guided by the same principles of choice for any dressing. There are advantages and disadvantages to all of the silver products. Factors to be considered in addition to those listed above, include:

- Likely time to surgery (pointless to use most expensive product if it is going to be removed in a very short period of time).
- Proximity of skin grafts or skin substitutes (creams may cause separation of substitutes or grafts).
- Presence of escharotomy site.
- Access required.
- Temperature of patient.
- Availability.

2.15. **Alternative dressings**

In some countries, the use of expensive commercially produced dressing products is not viable. Economic reality is a fact of life. Many centres have been very creative in the development of alternative dressings. The use of amniotic membrane, banana leaf dressing, honey, papaya and boiled potato peel bandage, have all been reported in the literature. What these reports have shown is that there are alternatives that may be very effective in the management of burn injuries.


2.16. **Burn itch**

Burn itch is still very common in many patients who have suffered a burn injury. There are many strategies used to minimise this. The following summary is provided by Demling and Desanti: Demling R, DeSanti L. The itching burn wound, 2002 [online]. http://www.burnsurgery.org/Modules/itch/p1/p1toc.htm [viewed: 7 July 2004].

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References


Further readings