

PEDIATRIC MINOR BURNS

1 STOP THE BURNING PROCESS

- + Remove all clothing, diapers, jewelry, metal and restrictive garments.
- + Do not place ice or cold water on burns.
- + Obtain patient's medical history.
- + Check tetanus status and give tetanus if last immunization was more than five years ago.

2 BURN CENTER REFERRAL CRITERIA*

Burn injuries that should be referred to a burn center include:

1. Partial-thickness burns greater than 10% total body surface area (TBSA).
2. Burns that involve the face, hands, feet, genitalia, perineum or major joints.
3. Third-degree burns in any age group.
4. Electrical burns, including lightning injuries.
5. Chemical burns.
6. Inhalation injuries.
7. Burn injuries in patients with pre-existing medical disorders that could complicate management, prolong recovery or affect mortality.
8. Any patient with burns and concomitant trauma, such as fractures, in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit. Physician judgment will be necessary and should be in concert with the regional medical control plan and triage protocols.
9. Burned children in hospitals without qualified personnel or equipment for the care of children.
10. Burn injuries in patients who will require special social, emotional or rehabilitative intervention.

For questions regarding a burn injury, regardless of size, call **855-863-9595**.

* American Burn Association

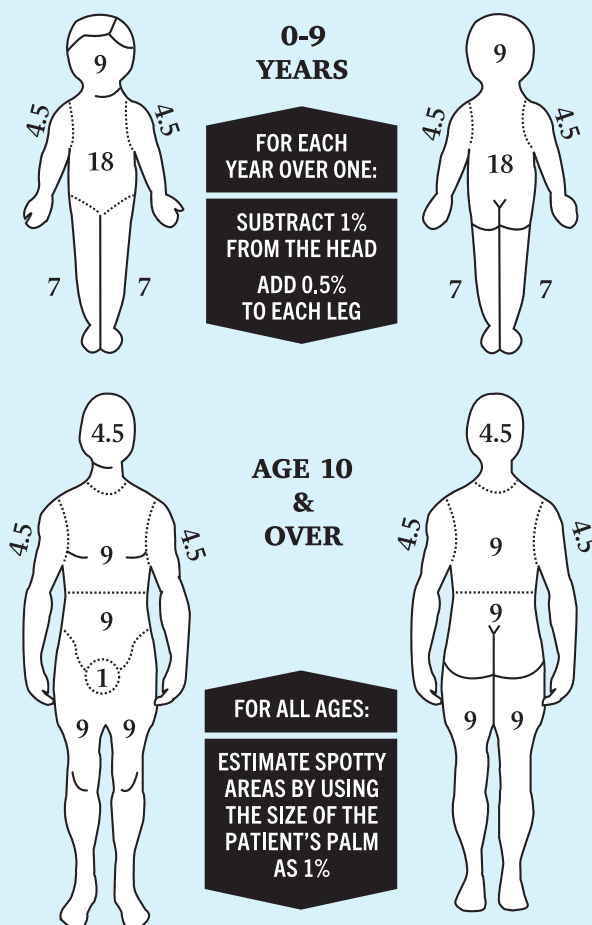


BURN AND RECONSTRUCTIVE CENTERS OF AMERICA



TOTAL BODY SURFACE AREA BY PERCENTAGE

RULE OF NINES



3 ESTIMATE DEPTH OF BURN INJURY

First-degree burns:

- + Are marked by red, pink or darkened skin.
- + Are painful and warm to touch.
- + No blisters or skin sloughing present.
- + Not included in TBSA calculation.

Second-degree (partial thickness) burns:

- + Are moist, reddened, blistered and painful to touch.
- + Blanch to touch.
- + Are at risk of developing into a third-degree burn. Regularly reassess second-degree burns to ensure the injury has not converted to a third-degree burn.

Third-degree (full thickness) burns:

- + Are dry/tight/leathery, brown/tan/waxy or pearly white.
- + Are devoid of blanching or capillary refill.
- + Are relatively pain-free, devoid of blisters and may initially appear as second-degree.
- + Need skin grafting to heal.

4 TREAT MINOR BURN WOUNDS

- + Medicate for pain before wound care.
- + Remove all blisters and devitalized tissue.
- + Clean the wound with antibacterial soap and low-pressure, room-temperature water.
- + Apply antibacterial ointment.
- + Wrap the wound with light gauze.
- + Inform patient that they may follow up at one of our clinics.

5 WATCH FOR POSSIBLE COMPLICATIONS

Complications include:

- + Infection of the burn or wound.
- + Localized cellulitis.
- + Fever, chills or nausea.
- + Development of eschar.
- + Uncontrollable pain.

SIGNS OF CHILD ABUSE

IF ABUSE/NEGLECT IS SUSPECTED,
CONTACT THE LOCAL AUTHORITIES
AS SOON AS POSSIBLE.

- + UNEXPLAINED BURN
- + IMPLAUSIBLE HISTORY
- + INCONSISTENT HISTORY
- + DELAY IN SEEKING MEDICAL CARE
- + FREQUENT INJURIES AND/OR ILLNESSES
- + CHILD ACCUSES AN ADULT
- + ONE PARENT ACCUSES THE OTHER PARENT
- + ALLEGED SELF-INFLICTED

- + ALLEGED SIBLING-INFLECTED
- + PATTERN OF BURN
- + IMMERSION OF BURNS
- + RIGID CONTACT BURNS
- + CAREGIVER ABSENT AT TIME OF INJURY
- + OTHER SIGNS OF ABUSE AND/OR NEGLECT
- + PRIOR INVOLVEMENT OF LOCAL AUTHORITIES

855-863-9595 • www.burncenters.com •  
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