



**Treatment Protocol: BURNS**

**Ref. No. 1220-P**

**Base Hospital Contact: Required for burns meeting Trauma Center criteria, 2<sup>nd</sup> or 3<sup>rd</sup> degree burns  $\geq$  10% TBSA.**

1. Assess airway and initiate basic and/or advanced airway maneuvers prn (*MCG 1302*)  
If evidence of inhalation injury, treat in conjunction with *TP 1236-P, Inhalation Injury*
2. Administer **Oxygen** prn (*MCG 1302*)  
If carbon monoxide exposure suspected, provide **high-flow Oxygen 15 L/min** and treat in conjunction with *TP 1238-P, Carbon Monoxide Poisoning ①*
3. Assess for signs of trauma  
If traumatic injury suspected, treat in conjunction with *TP 1244-P, Traumatic Injury*
4. Remove jewelry and clothing from involved area
5. Apply blanket to keep patient warm ②
6. For ELECTRICAL burns  
Cover with dry dressing or sheet, treat in conjunction with *TP 1221-P, Electrocutation*
7. For THERMAL burns ③  
Cover with dry dressing or sheet  
Consider cooling with water for burns isolated to less than 5% BSA
8. For CHEMICAL burns  
If dry, brush and flush with copious amounts of water  
If liquid, flush with large amounts of water ④  
If eye involvement, irrigate eye with **Normal Saline 1L** during transport; allow patient to remove contact lenses if possible, treat in conjunction with *TP 1240-P, HAZMAT*
9. Establish vascular access prn (*MCG 1375*)  
  
For IO placement in alert patients administer **Lidocaine 2% 0.5mg/kg (20mg/mL) slow IO push**, dose per *MCG 1309*, may repeat once for infusion pain at half initial dose
10. For partial/full thickness burn >10% body surface area or poor perfusion (*MCG 1355*):  
**Normal Saline 20mL/kg IV/IO rapid infusion** per *MCG 1309*  
**CONTACT BASE** for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV/IO**
11. Elevate burned extremities as able for comfort
12. For pain management: refer to *MCG 1345, Pain Management*  
Dose per *MCG 1309*



**SPECIAL CONSIDERATIONS**

- ❶ Consider potential for carbon monoxide and/or cyanide toxicity in closed space fires. Pulse oximetry is not accurate in carbon monoxide poisoning. (*TP 1238-P, Carbon Monoxide Poisoning*)
- ❷ Infants and small children are at high risk for hypothermia due to their large surface area to body mass ratio, reduced ability to shiver, and limited body fat.
- ❸ EMS Personnel are mandated reporters of child abuse and neglect, and a report should be made when suspected as per *Ref. 822*. Communicate suspicion for child abuse and/or neglect to accepting ED staff when home suggests children could be at risk for harm (e.g., unkept home, evidence of drug or alcohol abuse, unsafe living conditions, known or suspected domestic violence), when the history does not match with the severity of physical findings (e.g., child posturing after a roll off the couch), when patterned injury or burns or noted (e.g., circular burns as from a cigarette, whip marks on the skin, burns of both hands or feet), or when child reports physical or sexual abuse. Children < 3 years of age and those with developmental delay are at increased risk of abuse. This must also be accompanied by notification to the Department of Children and Family Services (DCFS).
- ❹ Observe for hypothermia; cooling large surface area burns (>10% body surface area) may result in hypothermia.