

Transfer Guidelines For Patients with Burn Injuries

1. Stop the burning process

2. Airway management

- Raise the head of bed if appropriate to decrease airway edema
- Administer 100% oxygen with suspected carbon monoxide or cyanide poisoning and /or inhalation injury
- Consider early oral intubation with largest ETT possible (size 8 preferred)
 - Upper airway patency is threatened
 - Gas exchange or lung mechanics inadequate
 - Airway protection compromised by mental status
 - Concern for progressive edema during transport
 - Stridor or raspy breath sounds

3. Circulation

- Secure large bore IV cannula or establish IO (required for patients with burns >20%)
- IV/IO may be placed through burned skin if needed
- In burns >30% TBSA, 2 large bore IV line are preferred
- Remove restrictive jewelry/clothing if possible
- Lactated Ringers (LR) is fluid of choice (0.9% NS may be used if LR unavailable)
- Initial management (adjust after TBSA is calculated)
 - <5 y/o; LR @ 125mL/hr
 - 6-13 y/o; LR @ 250mL/hr

- >14 y/o; LR @ 500mL/hr

4. Consult UofL Hospital – Burn Center for a burn TeleConsultation visit if process is established

5. Physical exam

- Assess for associated injuries
- Calculate % TBSA using the Rule of Nines (only include partial and full thickness injuries)
- Obtain glucose on pediatric patients
- Electrical burn patients will require cardiac monitoring

6. Fluid resuscitation (after TBSA calculation)

- Deliver ½ over first 8 hrs and remaining over next 16 hrs

Adult: LR 2mL/kg/%TBSA

Children: (<14 yrs or <40kg): LR 3mL/kg/%TBSA

Infants: <10kg; Add D5LR at maintenance rate to IVF resuscitation

Electrical Burns: LR 4mL/kg/%TBSA

7. Cover burns with DRY dressings. Utilize blankets and warm transport vehicle to prevent hypothermia.

8. Administer pain medication per system protocol