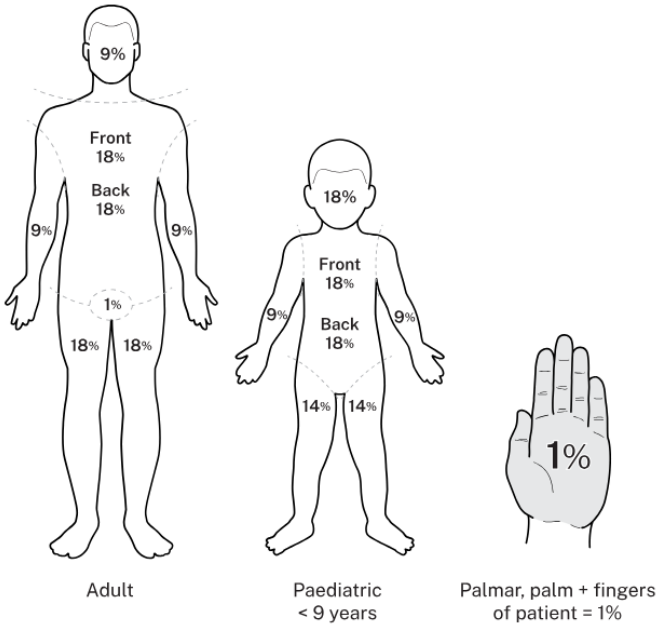
| BURNS | |
|---|---|
| **ADULT** | **PEDIATRIC (≤34 KG)** |
| **BLS** | |
| • **Universal Protocol #601**<br>• Pulse Oximetry<br>- O2 administration per Airway Management Protocol #602<br>• Remove burning, smoldering, or constrictive clothing and jewelry.<br>• **All burns (excluding electrical burns) < 30% BSA AND no inhalation injury**: stop the burning process by applying cool running water (CRW) over the burn. The goal is a cumulative (bystander and first responder) application of CRW for 20 minutes.<br>• **Thermal Burns:** Stop the burning process. Do not break blisters. After CRW, cover the affected body surface with a dry, sterile dressing or sheet<br>• **Chemical Burns:** Brush off dry powder, if present. Remove any contaminated or wet clothing.<br>• **Tar Burns:** do not remove tar.<br>• **Electrical Burns:** Turn off the power source and safely remove the victim from the hazard area. Cover the affected body surface with a dry, sterile dressing or sheet.<br>• Additional skills as approved by SLOEMSA<br>• Consider Policy #155: EMS Helicopter Operations for direct transport out of county to a burn center for those patients who meet burn center referral criteria (see notes).<br>• Determination of Death on Scene: Refer to SLOEMSA Policy #125 - Determination of Death/Do Not Resuscitate (DNR)/End of Life Care. | **Same as Adult** |

| ALS | |
|---|---|
| • Protocol #603: Pain Management<br><br>• For wheezing, **Albuterol** 2.5-5 mg via HHN/Mask/CPAP/BVM with adjunct over 5-10 min<br><br><u>Combined with:</u><br>• **Ipratropium Bromide** 500 mcg via HHN/Mask/CPAP/BVM with adjunct over 5-10 min<br>- Repeat once after 20 minutes<br><br>• **Consider Normal Saline up to 500mL IV/IO**<br>- May repeat x1 for persistent hypotension.<br>- May repeat x1 based on ALS provider discretion for normotensive patients. | • Protocol #603: Pain Management<br><br>• For wheezing **Albuterol** 2.5-5 mg via HHN/Mask/BVM with adjunct over 5-10 min<br><br><u>Combined with:</u><br>• **Ipratropium Bromide** 250 mcg via HHN/Mask/BVM with adjunct over 5-10 min<br>- Repeat once after 20 minutes<br><br>• **Consider Normal Saline up to 20mL/kg IV/IO, not to exceed 500 mL**<br>- May repeat x1 for persistent hypotension.<br>- May repeat x1 based on ALS provider discretion for normotensive patients. |
| **Base Hospital Orders Only** | |
| • As needed | • As needed |
| **Notes** | |
| • **Procedure #717: Endotracheal intubation remains the gold standard** for airway management in burn patients due to the rapid and often unpredictable progression of upper airway edema following thermal injury or inhalation of superheated gases. Facial burns, singed nasal hairs, carbonaceous sputum, stridor, or voice changes may signal impending airway obstruction. | |



- **For reference, burn center referral criteria are:**
  - Partial-thickness burns of greater than 10 percent of the total body surface area.
  - Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
  - Third-degree burns in any age group.
  - Electrical burns, including lightning injury.
  - Chemical burns.
  - Inhalation injury.
  - Burn injury in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
  - Burns and concomitant trauma (such as fractures) when the burn injury poses the greatest risk of morbidity or mortality. If the trauma poses the greater immediate risk, the patient's condition may be stabilized initially in a trauma center before transfer to a burn center. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
  - Burns in children; children with burns should be transferred to a burn center verified to treat children. In the absence of a regional pediatric burn center, an adult burn center may serve as a second option for the management of pediatric burns.
  - Burn injury in patients who will require special social, emotional, or rehabilitative intervention