NHS National Services Scotland

Care of Burns in Scotland
National Managed Clinical Network

TRANSITIONAL CARE FOR INDIVIDUALS INJURED BY BURNS

PAEDIATRIC

Reviewed by Mr Stuart Watson, NHS GG&C September 2020;
On behalf of the COBIS Steering Group
To be reviewed September 2023

INTRODUCTION

The transition between childhood and adulthood is recognised to be a challenging time for all individuals. For patients with lifelong conditions such as diabetes and epilepsy, good communication between health care professionals, and patient involvement, participation and co-operation is known to be associated with better health outcomes.

Many burn injured individuals will sail through adolescence with no more issues than the average person. However, it is recognised that some who injure themselves during adolescence, or who bare the scars from childhood injury, may develop specific issues which may be ameliorated by careful consideration and intervention by health care professionals and by voluntary sector organisations involved in burn care support.

Issues which may develop during this transitional phase in life may pertain to interactions with health services. However, issues and difficulties may also develop which relate to interaction with the wider community particularly if post burn scarring is associated with disability of perceived deformity.

In the following sections recommendations are made which may alleviate patient's difficulties both in their experience of hospitals but also their wider experience in the community.

ACUTE ADMISSIONS FOR BURNS DURING ADOLESCENCE

1. All acute burns requiring admission (see COBIS REFERAL GUIDELINES) should be admitted to a burn unit or facility with appropriate infrastructure specific to the needs of their injury. This includes appropriate nursing, medical and paramedical skill mix.
2. The environment of the admission facility should be appropriate to the patient's developmental maturity and not necessarily fixed to a rigid age cut off. Staff assessing patients in accident and emergency should be given latitude to make an assessment of the patient's maturity and to direct them to the facility they consider most appropriate under the circumstances. A guideline age cut off for patients who should be referred to adult services is 16 years of age, however, this is at the discretion of the referring and receiving hospitals.
3. When patients of borderline age are admitted to a facility, all reasonable efforts should be made to create an atmosphere in their immediate environment appropriate to their age and level of maturity.
4. Consideration should be given, during the course of the admission, to transferring transitional patients to a more appropriate age specific facility when this is compatible with their health care needs and infection control requirements.
5. During their inpatient stay, consideration should be given to the patient's psychosocial needs and a plan for delivering these should be documented. This may include the involvement, after discharge, of voluntary sector organisations such as the Scottish Burn Children's Club and Changing Faces.
6. Patients and if appropriate parents should be involved in all discussions pertaining to the site and nature of health care delivery.

ADMISSION FOR RECONSTRUCTIVE SURGERY

The points documented in the previous section have relevance to reconstructive admissions and should be followed. In addition:

1. At outpatient assessment discussion should be had with patients and, as appropriate parents, as to the most appropriate healthcare facility to which the individual should be admitted. It is recognised that on occasion specific health care requirements may dictate that patient are admitted to a particular facility.
2. At pre-admission clinic, adolescent patients should be treated in a manner appropriate to their age. Respect and consideration should be given to their opinions and requirements. Extra time should be allotted to assess their needs. For example, some mature adolescents may wish to be entirely independent and to make their own healthcare decisions. Others of the same age may equally require the almost continuous presence and support of their parents. These requirements must be respected and allowances made to accommodate the patients' wishes within reason.
3. It may be appropriate, at pre-admission clinic to take time to show patients around the facility so that they will be familiarised and not surprised on the day of admission.

OUTPATIENT CLINICS AND THERAPY APPOINTMENTS

The points documented in the previous sections have relevance to reconstructive admissions and should be followed. In addition:

1. At dressing clinic appointments, it should be recognised that adolescents may have specific pain management requirements. Extra time maybe required for discussion and for dressing care. The use of age appropriate distraction equipment should be facilitated/provided.
2. Some pain management techniques which were not appropriate at a younger age such as ENTONOX, may become relevant.
3. All therapy and outpatient attendances should occur in an age appropriate environment whilst taking into consideration specific geographical and health care related constraints.

CARE AFTER DISCHARGE

1. As above during all points of contact with health professionals, consideration should be given to the patients psychosocial requirements after discharge. In particular opportunities to introduce patients to the wider support networks in the community including voluntary sector organisations such as changing faces and the Scottish Burned Children's Club.
2. In all contacts health care professionals should emphasise the open door nature of our services and invite patients to return for further care or discussion at any point they consider that necessary. The pivotal role of general practice services should be emphasised, and GPs should have a very low threshold to re-refer patients to the burn service should difficulties be encountered.

COBIS in collaboration with voluntary sector organisations should give consideration to rendering the service and information more accessible by utilising new methods of communication such as the internet, Facebook and Twitter. All such efforts must be consistent with health service communications and data protection

NOTE
This guideline is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guideline recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is advised, however, that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.