**Trauma scenario 3: Burn (2 pages)**

A patient was cooking when the kerosene stove exploded. They have blisters to the face, lips, neck and chest.

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| **ASSESSMENT** | **FURTHER INFORMATION** | **KEY POINTS** | **YES** | **NO** |
| A | Airway: patent  Voice hoarse | Recognises emergency nature of burns to face and lips |  |  |
| Must recognise airway emergency and ask for help |
|  | No C-spine risk | Communicates no C-spine risk |  |  |
| B | Respiratory rate: 32 | Counts respiratory rate for 30 seconds and x2 |  |  |
| Oxygen saturations: 92% | Administers oxygen |  |  |
| Inspection: burns to neck and chest. Not circumferential. | Asks about bruising, wounds, deformity |  |  |
| Auscultation: chest clear | Correct auscultation technique |  |  |
| Percussion: resonant (normal) | Correct percussion technique |  |  |
| Palpation: no surgical emphysema. Chest wall movement symmetrical | Correct palpation technique |  |  |
| C | Hands: well perfused | Hands assessed correctly |  |  |
| Skin Temperature: warm | Skin temp. assessed correctly |  |  |
| Radial pulse: strong, regular | Radial pulse palpated |  |  |
| HR 95 | Pulse assessed for 30 secs x 2 |  |  |
| BP 110/82mmHg | BP assessed correctly |  |  |
| CRT: 3 seconds | CRT assessed correctly |  |  |
| Skin turgor (peripheral, unable to assess sternum): normal | Skin turgor assessed correctly |  |  |
| Abdo: soft, non-tender, no bruising | Inspects and palpates abdomen |  |  |
| Pelvis: symmetrical | Inspects pelvis |  |  |
| Long bones: no deformity or bruising | Inspects and palpates long bones bilaterally |  |  |
| External bleeding: none | Asks about external bleeding |  |  |
|  | IV access |  |  |
| Blood tests |  |  |
| 500mls crystalloid and reassesses for response.  Plans to give further crystalloid to replace fluids lost through burns |  |  |
| D | AVPU: Alert | Determines correct AVPU score |  |  |
| Pain: severe | Gives analgesia |  |  |
| Covers wounds with clingfilm or wet dressing |  |  |
| E | Temperature 35.2 | States will keep patient warm |  |  |
| No burns or injuries posteriorly | Rolls patient to side |  |  |
| Plan | Needs transfer to a centre that can manage advanced airways  Needs significant fluid replacement | Must suggest higher airway management  Oxygen and close monitoring of vital signs  Fluid replacement |  |  |
| Wound dressings |  |  |
| Analgesia |  |  |

**Diagnosis: inhalation injury and burn**

**Equipment (if available)**

* Mannequin
* Stethoscope
* Sphygmomanometer
* Oxygen mask

**Learning objectives:**

* Confident primary survey conducted using an ABCDE approach
* Recognition of emergency nature of presentation and risk of airway obstruction
* Recognition of requirement for fluid replacement
* Pain management with analgesia AND wound dressing
* Recognition of need for transfer due to risk of airway deterioration

**Debrief:**

Responses to the debrief questions are meant to reflect learning; they require more than yes or no answers. Reflect on this discussion for your logbook.

1. How do you think that went?
2. What did you think was happening with the patient?
3. Do you think your interventions were helpful? Describe how. If not, explain why.
4. Did the team members communicate effectively with each other? Provide examples.
5. Did the team members communicate effectively with the patient? Provide examples.
6. What aspect of this scenario can you apply in your clinical practise?