BURN WOUND CARE: DONOR SITE CARE

PURPOSE
Donor site care is provided to patients following skin graft harvesting for both split thickness and full thickness grafts and is performed to keep the area of the donor site clean and moist and to promote wound healing.

Expected outcomes of donor site care include:
- donor site heals without complications and minimal scarring
- donor site remains free from infection

POLICY STATEMENTS
Aseptic technique is an integral component of wound care.

SITE APPLICABILITY
Patients with burns are cared for in the Pediatric Intensive Care Unit (PICU), inpatient unit 3R, Medical Day Unit and the BCCH Plastics Clinic.

PRACTICE LEVEL/COMPETENCIES
At BCCH, a staff member who has completed advanced burn care education through attendance at Care of Burn Survivors workshop or has related experience and training may participate in burn wound management.

The Registered Nurse who participates in burn care attains and maintains the following competencies through education and practice:
- Perform comprehensive assessment focusing on:
  - burn wound care including escharotomies
  - pain
- Able to distinguish between normal and abnormal findings with relation to burns (scalds, chemical, flame, electrical, radiation)
- Plan, implement and evaluate care for patients with burns
- Individualize and modify standard careplan based on assessment findings
- Identify equipment, supplies and monitoring to provide care for patients requiring burn wound care
- Provides patient and family teaching specific to burn care

EQUIPMENT
- Donor site dressings and supplies (i.e. Tegaderm, Jelonet, Viscopaste or Acticoat)
- Sterile scissors
- Appropriate analgesics or anxiolytics per prescriber’s order
- Cleansing agent (warm sterile water and 2% Chlorhexidine diluted in bath or basin, Normal saline)
- Dressing tray
- Sterile burn gauze or sterile linen for cleansing and drying
- Staple or suture removal kit as indicated
- Splinting materials as required
- Clean and sterile gloves
- Culture swabs as required (for foul smelling or abnormal coloured drainage)

PROCEDURE

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<tr>
<th>PROCEDURE</th>
<th>Rationale</th>
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<tr>
<td>1. DETERMINE that you have the relevant competencies to perform burn wound care.</td>
<td>Relevant competencies developed through attendance at Care of Burn Survivors workshop and/or related experience and training.</td>
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<td>2. IDENTIFY patient and EXPLAIN procedure. ENSURE patient and family understand procedure and questions are answered.</td>
<td>May serve to reduce patient and family’s anxiety. Evaluates and reinforces understanding of previously taught information.</td>
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3. **PERFORM** hand hygiene. **GATHER** needed equipment, supplies and involved health care providers.  
   *Routine Infection Control Practices; reduces transmission of microorganisms. Facilitates completion of tasks in a timely manner.*

2. **PREPARE** a warm environment (at 31-32°C) that minimizes exposure to hypothermia and keeps patient normothermic (37 - 38°C).  
   *Preservation of patient’s body temperature is important for maintenance of hemodynamic and metabolic stability.*

   **NOTE:** may require additional heat source (warmer) if unable to raise room temperature sufficiently.

   *Ambient room temperature of 31-32°C reduces radiant heat loss. Morbidity increases significantly with each degree drop in patient temperature below normal.*

5. **OBTAIN** assistance of second nurse and involved health care providers.  
   *Donor site care requires 2 nurses plus other health providers for wound care, positioning, range of motion, pain management, etc.*

6. **TRANSPORT** patient to procedure location if necessary. **PROVIDE** for appropriate privacy and position patient to promote comfort and facilitate procedure.  
   *Promotes patient’s comfort during procedure; ensures adequate pain and anxiety control; promotes compliance with future procedures.*

   **NOTE:** may require additional heat source (warmer) if unable to raise room temperature sufficiently.

7. **ASSESS** patient’s pain and anxiety level; **PREMEDICATE** with analgesics and anxiolytics per prescriber’s orders.  
   *Privacy is an important consideration for school-aged children and adolescents.*

Considerations: Child Life Specialist may be helpful in working with the patient to use non-pharmacological pain and anxiety control techniques.

8. **ENSURE** appropriate cardiorespiratory monitoring throughout donor site care.  
   *Analgesic and anxiolytic medications, especially when given together, may adversely affect patient’s hemodynamic and respiratory status.*

9. **PERFORM** hand hygiene; **DON** personal protective equipment (clean gloves, gown, and mask) as indicated for the specific procedure.  
   *Routine Infection Control Practices; reduces transmission of microorganisms and protects health care provider.*

10. **ASSEMBLE** equipment aseptically.  

10. **ASSESS** donor site covering for adherence of dressing, leakage, collection of secretions, foul odour, abnormal colour, or cellulitis.  
   *The presence of loose dressing or leakage necessitates dressing reinforcement. The presence of foul odour, abnormal colour and collection of secretions could be signs of donor site infection that require different interventions.*

11. **PROVIDE** wound care as per the below considerations:

**CONSIDERATIONS**

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<tr>
<th>Dressing Type</th>
<th>Indications</th>
<th>Maintenance and Care</th>
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| Tegaderm occlusive dressings  | Small donor sites    | • Assess for fluid collection under Tegaderm dressing. If present, swab Tegaderm with 2% Chlorhexidine and 70% Alcohol and leave to dry X 30 seconds. Aspirate fluid with small needle and syringe or needless IV catheter (Jelco) taking care to keep needle tip away from skin. Apply a small Tegaderm dressing over aspiration site.  
• For leaking dressings, cleanse donor site dressing and |
**BURN WOUND CARE: DONOR SITE CARE**

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<tr>
<th>Exposed Jelonet</th>
<th>Large surface area donor sites (usually trunk or thighs)</th>
<th>Patient arrives from OR with Jelonet on donor site and wrapped with N/S compresses. Plastic surgeon will direct removal of outer N/S compress upon arrival on unit.</th>
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<td>Leave jelonet adherent to donor site, it will incorporate into a crust on top of wound and separate spontaneously in 7 – 10 days. If donor sites are on back, placing patient on a pad of Jelonet ‘runners’ on top of back pad will prevent sticking to linens.</td>
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<td>Monitor for foul smell, drainage or cellulitis. Bed cradles will prevent linens from sticking to exposed site.</td>
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<th>Viscopaste</th>
<th>Donor sites where circumferential wrap is most practical</th>
<th>Assess for shift in dressing position, foul smell or drainage. It is expected that some drainage will seep through dressing and will look yellow.</th>
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<td>Can be left on donor site up to 7 days if no signs of infection. Replace dressing if becomes soiled by feces, etc. May be applied directly to donor site or may be applied over an antibacterial dressing (e.g., Acticoat). Do not use saran wrap under or over the Viscopaste as it retains its own moisture.</td>
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<td>Wrap circumferentially, but each wrap must have either a switch in direction of a wrap or a small fold back of excess to allow for expansion. This type of dressing does not stretch and may cause circumferential compression if not applied carefully. Cover with Kling gauze.</td>
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<td>Removal is easily achieved by cutting wrap or simply unwrapping.</td>
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<tr>
<th>Acticoat</th>
<th>Donor sites at high risk for infection</th>
<th>As per burn dressing change policy and procedure.</th>
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<th>Biobrane</th>
<th>Temporary biosynthetic skin dressing used on superficial and partial-thickness wounds and donor sites.</th>
<th>Applied similarly to a skin graft. Do initial dressing change at Day 2 post application to check if it has adhered to the wound bed – <strong>DO NOT PEEL OFF THE BIOBRANE</strong>.</th>
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<td>If there is exudate, dress with a dry dressing as needed. If wound is dry, may leave open to air. Biobrane will peel off on its own as the donor site re-epithelializes under it.</td>
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<tr>
<th>Lotion</th>
<th>Healed donor sites</th>
<th>Applied for moisture and massage of healed areas. Can use any unscented lotion.</th>
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12. If dressing is loose, reinforce as needed. **WRAP** reinforced dressing with compression bandage or tubigrips. Consult OT if new tubigrips are needed. **Promotes adherence of colloidal dressing.**

13. If foul odour is present, consult with physician about the need for culture swabs and a dressing change. **Reinforces information regarding procedure.**

14. If dressing change is needed, **REINFORCE** education surrounding procedure and reasons for removal of the donor site dressings. **ANSWER** questions that patient or family may have. **Reduces anxiety in family or patient.**

15. **PERFORM** hand hygiene. **ADD** culture swabs to prepared dressing tray. **Routine Infection Control Practices; reduces transmission of microorganisms.**

16. **REMOVE** donor site dressings and discard in appropriate receptacle. **Aseptic technique used; contact is made with openings in the skin.**

17. **REMOVE** clean gloves, **PERFORM** hand hygiene and **DON** sterile gloves. **Wound care that is done too aggressively may damage newly formed epithelial cells and delay wound healing.**

18. Gently **CLEANSE** wounds with sterile normal saline, using circular motions and a gauze pad. **Topical preparations may be difficult to apply if wounds are wet.**

19. **RINSE** wound beds with sterile water or sterile normal saline and **PAT** dry in preparation for new dressing. **Culture is obtained after cleansing to ensure debris contamination is not cultured.**

20. **OBTAIN** culture if required. **Reduces cross contamination of wound.**

21. **REMOVE** contaminated gloves; **PERFORM** hand hygiene; **DON** a new pair of sterile gloves. **Standard precautions; reduces transmission of microorganisms.**

22. **APPLY** new dressing as required. **Return to room signals end of procedure.**

23. **DISCARD** used supplies and equipment in appropriate receptacle. **Return to room signals end of procedure.**

24. **REMOVE** personal protective equipment and wash hands. **Return to room signals end of procedure.**

25. **RETURN** patient to his/her room if procedure performed in treatment room. **Return to room signals end of procedure.**

**DOCUMENTATION**

- **DOCUMENT** on appropriate records (burn wound flowsheet, careplan, nurses notes):
  - patient and family education
  - pain and anxiety control and effectiveness of medications/interventions
  - location and appearance of wounds
  - procedures performed
  - topical agents and dressings applied
  - team members participating in burn wound care
  - unexpected outcomes and related treatment
  - any other pertinent actions or observations

**REFERENCES**

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