Original Research

Paediatric Burns – A Single Institution Experience and Suggested Algorithm for School Return

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Abstract

Introduction. Paediatric burns account for almost 40,000 visits to UK emergency departments annually. Following a burn, patients often remain off school – this has educational and social impacts on children, plus financial implications for caregivers. The risk of infection, the commonest cause of morbidity, is highest in the first week post-burn. Currently, there are no formal guidelines regarding school return following a burn, and the recent cost of living crisis in the UK prompted a review into how school return could be facilitated. This study aimed to propose criteria to guide school return if no clear difference in complications was seen between patients returning school before versus after complete wound healing, and to reassess complication rates after implementing a trial in which select patients would return to school early.

Methods. A retrospective review of all referrals between January-June 2023 was performed. A set of criteria to guide school return was implemented, and following a 6-month trial period between February-July 2024, another retrospective review was done.

Results. 241 children were referred between January-June 2023; after exclusion, 113 cases were reviewed. 8 (7.08%) developed complications; 2/19 (10.53%) of those remaining off school, 2/77 (2.60%) with unclear school return, and 4/17 (23.53%) of those attending school before complete wound healing, with infection developing in all 3 with delayed initial hospital presentation. During the 6-month trial with guided school return, 238 children were referred. 28 children attended school prior to wound healing as per the agreed criteria; patients were followed up until discharge, and none developed complications.

Discussion and Conclusions. Delay in presentation, and

return to school immediately post-burn, with an associated delay in specialist burn care, appeared to be biggest risk factor for infection in the cohort reviewed. Findings also supported that other risk factors for burn wound complications include burn depth and disturbance to NPWT. Risk of complications did not seem to increase when school return was guided by the proposed criteria, with predictors for uncomplicated early school return appearing to be small burn size (≤1% TBSA), burn location (hands, trunk or limbs), and superficial partial thickness depth. Children remaining off school following a burn can have psychosocial, educational and monetary impacts upon the patient and their caregivers; allowing them to return before complete wound healing may help to diminish these effects, and has been shown to be safe when guided by the proposed criteria.

Keyword: Burns, Paediatrics, Children, Wound Healing, School, Management, Infection

Introduction

Paediatric burns are defined as injuries to the skin through thermal (hot or cold), chemical, electrical or radiation mechanisms in those under the age of 18. These burns account for a large number of hospital attendances, with almost 40,000 visits to UK emergency departments annually.[1]

Within the North of England, including North Wales and the Isle of Man, there are 3 burn centres, 2 burn units, and 2 burn facilities providing specialist services for paediatric patients.[2] The regional burns unit in Sheffield Children's Hospital (SCH) covers a wide area in Yorkshire, accepting paediatric patients with burns up to 30% TBSA (total body surface area).[3] Patients referred to this unit for burns not requiring admission, or those following discharge, are typically followed up as outpatients until the wounds have healed.

Infection is the commonest, and one of the biggest causes of morbidity in paediatric burns.[4,5,6] Not only can burn wound infection impair wound healing, with a prolonged recovery time, but it may also lead to other complications such as sepsis.[4,7] The risk of developing wound infection post-burn is highest in the first week,[8, 9] with scald injuries, the most frequently encountered burn mechanism in paediatric patients,[6] developing infection after only 2 days,[10] highlighting the importance of timely management.

In view of infection risk, local protocol in SCH was to advise all children to remain off school until complete wound healing i.e. no longer requiring dressings. This has numerous implications on both patients and their caregivers. Aside from missing education and interacting with their peers, which has been shown to impact upon children's mental health,[11, 12] children may lose routine, which can particularly affect those with learning difficulties;[13] these psychosocial issues may exacerbate, and/or be worsened by, the mental health problems and social isolation already found in school-aged children with burns.[11, 14, 15, 16]

With children needing to stay at home whilst off school, parents or other caregivers may need to take time off work, or arrange alternative childcare, both of which have a financial implication. Other added costs to families include bills, such as extra food and heating, whilst the child is at home; caregiver anxiety associated with these alterations in work and outgoings, possibly worsened by the recent cost of living crisis in the UK,[17,18] may further negatively impact upon the child.[16]

Currently, there are no formal guidelines regarding school return in children who have suffered a burn. This study aimed to compare complication rates in paediatric burns patients, between those returning to school before versus after complete wound healing, and to review complications during a trial in which select patients would return to school early.

Subsequently, this paper proposes a set of criteria to guide which patients may be suitable to return to school prior to complete wound healing, in order to minimise the educational, psychosocial and financial implications to both patients and caregivers, of keeping them off school.

Method

In order to gain insights into experiences with cases of children returning to school early, and guide decision-making in terms of trial criteria, an anonymous online survey, created by the authors, was sent to members of the burns team involved with patient follow up (nursing staff and therapists). The survey included the following questions:

1. Do you know how long children are advised to take off school following a burn?
2. Do you advise all parents/children to take this length of time off school?
3. Have you seen cases where a child has gone to school before complete wound healing?
4. If yes to the above, what were the reasons for this?
5. In your experience, do you think there are cases in which a child would be safe to return to school sooner?
6. Do you think it is appropriate for the child to return to school following a burn, provided they are well, and the burn/wound covered with a dressing?
7. Have you seen any cases in which a child has developed a complication because they went to school too early?
8. Which do you think are the biggest issues faced by families, whilst a child is recovering at home/staying off school?

Following the survey, a retrospective case-control study was performed on burns referrals from January to June 2023. Inclusion criteria included nursery/school age, burns requiring ongoing dressings, and follow up at SCH until discharge. Exclusion criteria included patients not attending nursery/school, patients going abroad, missing documentation, failed attendance at follow up appointments, care transferred to another hospital, and patient discharged on first review or burn already healed/erythema upon initial review. Records for included cases were reviewed for data on the burn, management, school return and complications.

Complications included wound breakdown (loss of epithelialisation), graft loss, local wound infection (diagnosed as per traditional criteria)[19], and systemic infection i.e. sepsis secondary to wound colonisation.

School return was deemed unclear in cases where records did not include mention of the child returning to school, or of school altogether.

Findings were discussed at the SCH burns interdisciplinary meeting, attended by consultants, nursing staff, therapy staff (physiotherapists and occupational therapists) and psychologists, and a set of criteria deemed appropriate for early school return was agreed upon (Figure 3).

Following this, a 6-month clinical trial was performed from February to July 2024, with retrospective data collection on burn data, school return and complications performed during and after the trial. Inclusion criteria were age ≥5, children requiring ongoing burn management, school attendance, patients followed up until complete wound healing, and clear documentation of school return prior to discharge. Exclusion criteria were as above, along with burn characteristics (size >10%; location on feet/face), complex cases (polytrauma/ management for other injuries/social issues), and unclear school return date. Inclusions and exclusions were not limited to those in the "Criteria for early school return" (Figure 3) in order to capture patients fallen outside of these criteria, who did attend school prior to complete wound healing.

Results

Survey

The survey received 12 responses; answers to their respective questions are listed below.

1. Do you know how long children are advised to take off school following a burn?
   - Yes – 100%
2. Do you advise all parents/children to take this length of time off school?
   - Yes – 41.7%
   - No – 8.3%
   - Advice dependent on factors such as burn location, child age, mental wellbeing – 50%
3. Have you seen cases where a child has gone to school before complete wound healing?

- Yes – 83.3%
- No – 16.7%

4. If yes to the above, what were the reasons for this?
   - Teenagers with exams (41.7%)
   - Parents unable to take time off work/ arrange childcare (25%)
   - Children requiring structure + routine for mental health/behavioural reasons (16.67%)
   - Burn small/well covered e.g. leg (16.7%)
   - Families choosing not to follow advice (8.3%)
   - Parents not informed (8.3%)
   - Child safety i.e. being fed at school (8.3%)
5. In your experience, do you think there are cases in which a child would be safe to return to school sooner?
   - Yes – 100%
   - Common themes within reasoning:
     - Burn factors – small, superficial, nearly healed; dressings at home
     - Patient factors – older age, sensible, able to keep clean/safe; children requiring routine
     - School can accommodate – no sports; child can leave lessons early to avoid busy corridors
6. Do you think it is appropriate for the child to return to school following a burn, provided they are well, and the burn/wound covered with a dressing?
   - Yes – 58.3%
   - Maybe – 41.7%
   - No – 0%
7. Have you seen any cases in which a child has developed a complication because they went to school too early?
   - No – 66.7%
   - Yes – 16.7%
   - N/A – 16.7%
8. Which do you think are the biggest issues faced by families, whilst a child is recovering at home/staying off school? (figure 1)

Burn referrals

In the periods evaluated (January-June 2023, and February-July 2024), the average time from burn to complete healing for all patients managed by SCH (n=479), excluding those transferred elsewhere or not attending appointments, was 18.3 days (SD = 14.0). The majority of cases had burns of <1% TBSA (55.9%), superficial partial thickness depth (53.7%), and the hands/wrists were the most commonly affected body parts (42.0%).

First cycle – retrospective case-control study

Between January-June 2023, a total of 241 children were referred to the burns unit; after exclusions (Figure 2), 113 cases were reviewed. Of these, 17 children were clearly documented to have attended school prior to complete wound healing; reasons for this included delayed presentation to hospital (n=3), patients being informed school was fine to attend by A&E (n=2), parents unable to arrange childcare (n=1), unclear reasoning (n=3) and as advised by the burns team (n=8). Children were advised to attend school early when requiring routine e.g. autism (n=3), when the child had a prolonged time off school i.e. 3+ weeks (n=4) and unclear in one case (n=1). These cases, with associated complications, are detailed in Table 1. Average

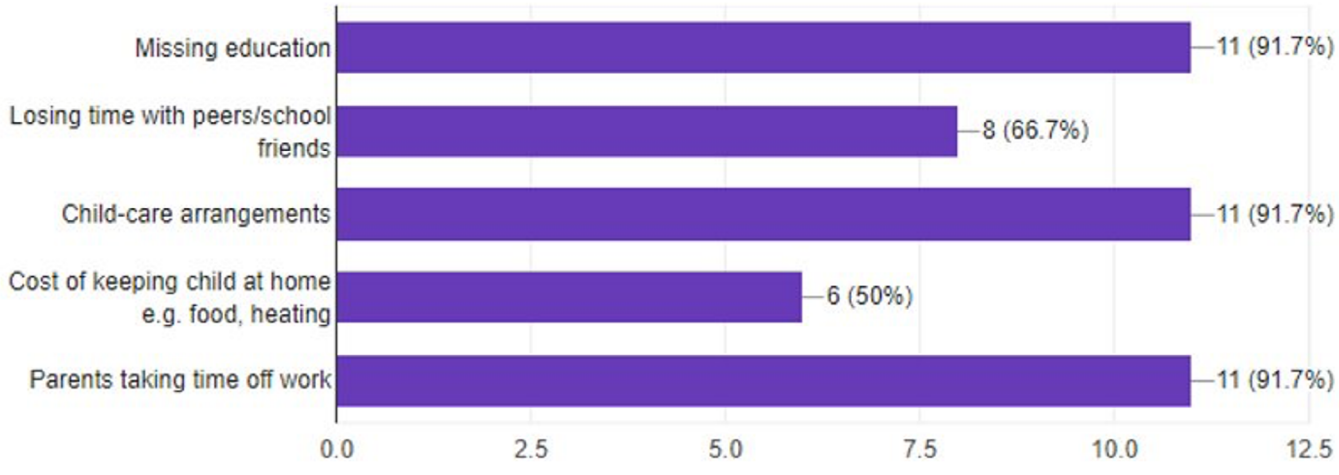

Figure 1. Family challenges during school absence after burn injury.

length of time from injury to complete wound healing was 17.1 days (SD = 11.4).

Complications were seen in 8 patients (7.08%). Of those returning before wound healing, 4/17 (23.53%) children developed complications; all 3 with delayed hospital presentation (and subsequently attending school prior to specialist burn care) developed infection. The only other complication in this group was a case with long (95 days) healing time; the patient returned to school due to prolonged time off, and developed wound infection and associated breakdown a few weeks after returning. A Fischer's test was performed to assess the association between delayed hospital presentation and infection; there was a significant increase in infections with delayed presentation ($p = 0.0059$).

In the group who remained off school, 2/19 (10.53%) developed complications (sepsis; graft failure due to negative pressure wound therapy (NPWT) dressing failure). Of those with unclear school return, 2/77 (2.60%) developed complications (infection, wound breakdown). These are detailed in Table 2.

Another Fisher's test was completed to compare the groups returning to school before and after wound healing; this showed that children who returned to school before wound healing had a higher chance of developing complications (odds ratio = 2.62, 95% CI [0.38, 18.2]), but the findings were not statistically significant ($p = 0.38$, two-tailed).

Criteria for early school return

- Patient age 5+
- Burn size max 1% TBSA
- Burn location – limbs/trunk
- Patient can avoid activities that risk dirtying wound
- Patient's family aware of signs of infection + what to do
- School will accommodate + allow for regular reviews at SCH

Also consider allowing patient to return to school/nursery if:

- Patient requires routine e.g. ADHD, mental health diagnosis
- Patient wanting to return to school/preparing for exams
- Parent/guardian will struggle to have patient at home
- Other burn locations/larger burns that can be easily dressed + kept clean

Figure 3. Proposed criteria for early school return following paediatric burn injury.

After presenting initial findings to the burns multidisciplinary team, a set of criteria was agreed for patients felt to be appropriate for early school return (Figure 3).

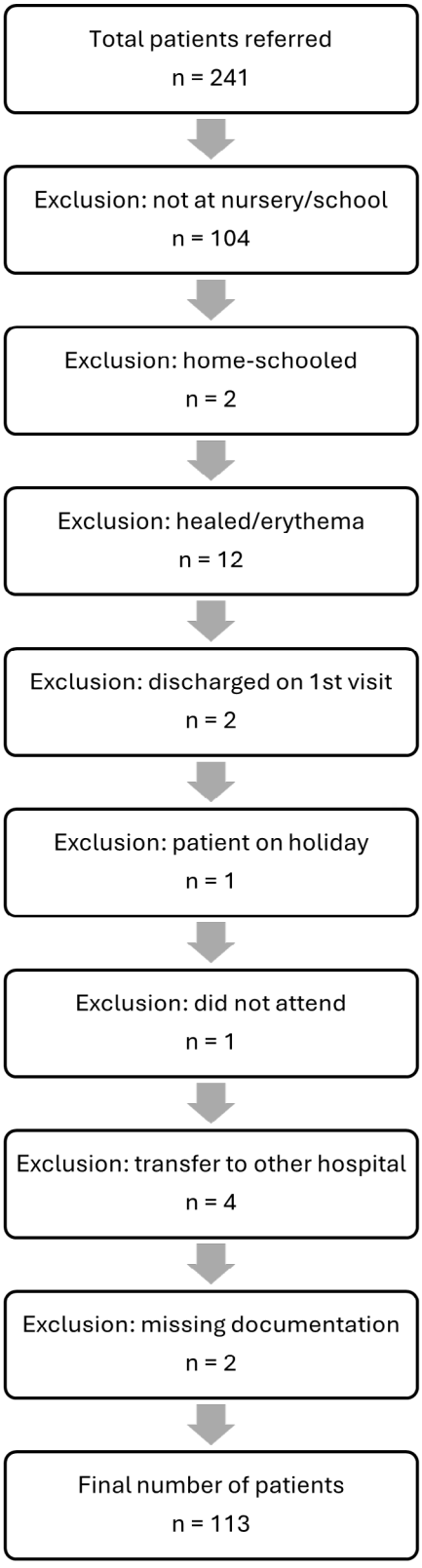

Figure 2. Study flow diagram of patient selection (first cycle).

Table 1. Characteristics and outcomes of patients returning to school before complete wound healing (first cycle).

Reason for return to school	Age	TBSA	Depth	Site	Days to heal	Complications/other
Told school fine to attend by A&E	5	<1%	SD	Face	14	Told by A&E school fine; advised to stay off by SCH when seen
	10	<1%	SD	Left hand	11	Not informed to stay off by Barnsley; advised can return to school by no PE/busy breaktimes by SCH when seen
Delayed presentation to hospital	14	1.5%	FT	Arm	57	Wound infection
	• Self-inflicted/DSH; did not tell parents + attended school post injury - Told someone at school day 4 post burn; seen at SCH day 7 with cellulitis (started on Abx 3 days prior) - more Abx day 26; debridement + graft day 36; healed by day 57 - Unclear if returned to school in meantime					
	12	<1%	SD	Leg	30+	Wound infection
	• Delayed presentation to hospital; given Abx by DRI - Seen by SCH 2+ weeks post injury - Picked scabs whilst healing; healed by 30+ days					
	9	<1%	DD-FT	Right foot	30+	Wound infection
	• Did not attend A&E after injury • PO Abx for infection day ?15 • Agreed by PT/OT can return to school (on ?day 18)					
Advised by SCH team	11	3-4%	SD-DD	Thigh/ groin	54	Advised can return to school day 48 (18 days post FTSG) - burn healed 1 week later
	14	<1%	SD	Left foot		Advised day 10 – no PE/playing outside 2/52 after healing
	7	1.5%	SD-FT	Face + thigh	95	Wound infection (Abx day 66) + breakdown Psychology referral
	• Day 22 – excision FT burn + closure right thigh + PICO – advised no PE with PICO 1 month later					
	7	<1%	SD-DD	Right hand	15	Special education needs requiring routine
	14	<1%	SD	Right hand	11	Mental health problems – on reduced timetable already
	5	<1%	SD	Right thumb	20	Given 1/52 Abx by GP; seen by SCH day 8 post burn? ADHD - patient needing routine
	9	<1%	DD-FT	Right hand	27	Advised could return to school day 22
	8	2-3%	SD-MD	Chest, face, left hand	32	
	• Burn sustained on holiday – seen day 2 + started on Abx due to mechanism • Cleaned + dressed in theatre day 3; discharged day 4 • Off school 5 weeks before agreed to return but no PE/playing outside					
Parents unable to stay home	1	3%	SD-MD	Chest + arm	16	
Unclear	14	<1%	SD	Hand	12	
	11	1%	DD	Leg	27	Prophylactic oral Abx given day 27 for group A strep on swab
	8	<1%	SD	Hand	11	Unclear if advice r.e. school given

Legend. SD = superficial dermal; MD = mid-dermal; DD = deep dermal; FT = full-thickness; Abx = antibiotics

Table 2. Characteristics and complications of patients who remained off school or had unclear school return (first cycle).

Age	TBSA	Depth	Site	Days to heal	Complications/other
7	<1%	DD-FT	Forehead	19	Wound infection (Abx day 4) Seen at SCH day 6
7	<1%	FT	Right foot	49	Graft loss (as PICO dressing broke) Overgranulation
	• Debridement + SSG in theatre day 17 • Returned to school when wound healed				
9	<1%	MD-DD	Food	25	Wound breakdown – patient removing dressings at home
6	<1%	SD	Right hand	21	Admitted day 8 with sepsis

Legend. SD = superficial dermal; MD = mid-dermal; DD = deep dermal; FT = full-thickness; Abx = antibiotics

Second cycle – trial implementation

Between February-July 2024, 238 children were referred to and reviewed by the burns unit. Average length of time between injury and complete wound healing was 19.5 days (SD = 16.1). Patients were excluded (n=205) according to previous exclusion criteria, as well as trial criteria (Figure 4). School return was unclear in 5 cases.

During this period, 28 children attended school prior to wound healing (as agreed by parents/guardians). Ages ranged between 5 year 6 months, and 14 years 10 months. 24 cases had burns fulfilling checklist criteria; the majority were small burns with TBSA <1% (n=20), and the remainder TBSA 1% (n=4). Depths included SD (n=14) SD-MD (n=2), SD-DD (n=2), S-FT (n=1), MD-DD (n=1), DD (n=5), DD-FT (n=2) and FT (n=1). The commonest burn location was the hands (n=12; 42.9%). Average healing time in this cohort was 22.4 days (SD = 12.1).

The remaining 4 (Table 3) were patients with larger burns, who were advised to return in view of age, and ease of keeping the burn covered/protected; the patient with 6% TBSA burns was advised to return following MDT discussion. All patients were advised to stay off PE and remain indoors during breaktimes. Patients were followed up until discharge, and none developed any complications.

Table 3. Trial cohort returning early to school.

Age	TBSA	Depth	Site
10y8m	1.5%	SD	R arm
10y2m	2%	SD	Arm/abdomen
8y2m	3%	SD	Abdomen + b/l thigh
12y10m	6%	SD-DD	Left thigh/hip

Legend. SD = superficial dermal; MD = mid-dermal; DD = deep dermal; FT = full-thickness

Discussion

This study reviewed complication rates in paediatric burns patients returning to school before complete wound healing during two cycles; the first, in which these patients were compared to those only returning to school after total wound healing, and the second, during which select children were advised to return to school as per trial criteria.

Time to complete wound healing was 17.1 days in the first cycle, versus 19.5 days in the second cycle; the reason for this is unclear, however may be in part due to, on average, a larger TBSA (2 vs 2.57%) and deeper burns (i.e. deep dermal to full thickness; 15.4% vs 17.2%) in the second cohort. This would explain the increase in time to healing to 22.4 days in the trial cohort, with this average being skewed by the three patients with the most prolonged healing times; these included a 6% TBSA burn, with the longest healing time of 52 days, and two small (<1% TBSA) but deep (DD-FT) burns on the hand and leg/ankle. Though there is evidence to strongly suggest that burn healing time is increased by burn depth,[20, 21, 22] as well as the location of deeper burns being on the extremities,[23] TBSA has not been shown to be a significant risk factor for prolonged wound healing,[24] so it is unclear whether the act of returning to school early, or other factors, contributed to these findings in the trial cohort.

A total of 8 complications were seen in patients referred between January-June 2023, with

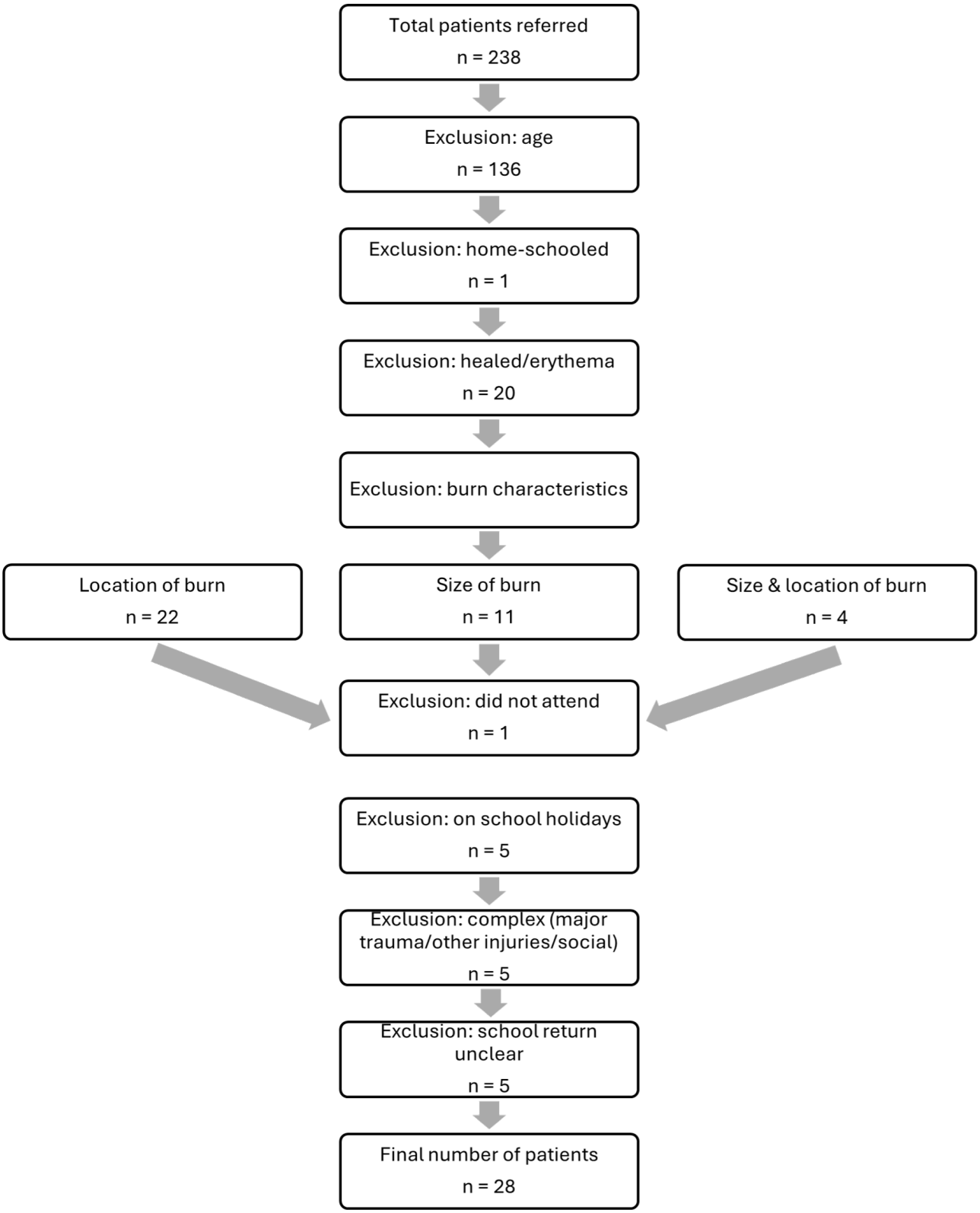

Figure 4. Study flow diagram of patient selection (first cycle).

infection affecting 5 of these. Complication rates were highest in those who clearly returned to school prior to wound healing (23.53%), however, all three patients with delayed initial hospital presentation (and therefore delayed review by the SCH burns team) developed infection. Excluding these, there was 1 complication in the early return group (7.14%), compared to 2 in the group remaining off school (10.53%), and 2 in those with unclear school return (2.60%).

Of these 8 cases, 6 patients had burns of <1% TBSA, with the other two only 1.5%. 5 patients

were partially/completely full thickness, with 4 developing infection, and another deep dermal; though burn depth is also a known risk factor for infection,[25,26] a possible explanation for these findings, 2 of these cases, however, were related to potential causative events; wound complications have been shown to result from NPWT failure,[27] but there is little evidence to support the link with inappropriate removal of dressings. Though only small numbers of patients, these findings are consistent with evidence that delayed burn care increases the risk of infection.[26,28,29] No complications were seen in the trial cohort, despite a range of burn depth, TBSA, and location, highlighting that early management by a burns team may be a key protective factor against burn wound infection and breakdown. There has been no research commenting on burn complications and their association with school return for these findings to be compared to.

Reviewing all children who returned to school before wound healing, both those in cycle 1, and the trial cohort in cycle 2, predictors for uncomplicated early school return appear to be small burn size (≤1% TBSA), burn location on hands, trunk or limbs, and superficial partial thickness depth; this aligns with previous studies reviewing factors that may impact upon school return,[30] though it must be noted that studies reporting factors that can increase the duration off school are typically based on patients requiring hospital admissions with large burns,[31, 32] unlike the majority of the SCH burn patients. Staley et al,[31] did however show that, despite a long length of time away from school, children did not have a negative impact upon their behaviour or education upon their return, unless these problems existed prior to the burn. Based on these findings, it may be argued that children may not face any issues if remaining off school until complete wound healing in the majority of SCH cases, with healing times being far less than the time off school in these studies, but as per earlier discussion, many other factors must be considered when a child is remaining at home, such as their safety i.e. being fed and kept warm, caregiver availability, added costs to families, and how caregiver stress/anxiety may impact upon the child, and issues revolving around these may be prevented or reduced by facilitating early school return.

This trial has shown that the risk of wound complications does not appear to be increased when early school return is guided by the specialist burns team, provided patients are of an appropriate age, the burn is an appropriate size and can be easily managed, and sports/busy activities at school can be avoided.

Limitations

The authors acknowledge the limitations of this study which should be considered when interpreting the results, in particular, the small sizes of the populations being reviewed may lead findings to not be generalisable to the wider population. The low numbers are mostly due to unclear or a lack of documentation regarding school return, which also limited review of the length of time between burn injury and school return. A sample size calculation was not performed as patient cohorts were reviewed retrospectively.

Conclusion

Delay in presentation to emergency health services and return to school immediately after burn injury, with an associated delay in specialist burn care, appeared to be biggest risk factor for developing infection in the cohort reviewed, and is a known risk factor for developing burn wound infection. No complications, including wound infections, were seen in any of the burns patients who returned to school before complete wound healing, when guided by the SCH criteria, or after discussion in MDT.

Allowing children to return to school is beneficial to both patient and families/caregivers – not only does this allow for minimal disruption to the child's education, routine, and socialising with peers, but also the routine for others. Whilst the patient is at school, caregivers do not need to take time off work/arrange childcare, nor are additional outgoings required for food, electricity, gas, or water which may be needed if the child were at home.

This study proposes the above criteria as a guide for decisions regarding return to school following a burn, after initial review by the specialist burns team, to help minimise issues arising from time off school, whilst limiting the risk of burn complications.

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