

Plastics education series – part one: Burns management in primary care

This webinar will start soon.

Plastics education series – part one: Burns management in primary care

Zoom webinar – Tuesday 7 July 6.30pm - 8pm

Acknowledgement of traditional owners

We acknowledge the Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we are meeting today. We pay our respects to Elders past and present.

We would also like to acknowledge Aboriginal people who are joining us today.



Some housekeeping



Tonight's webinar is being recorded:
<https://learning.primaryhealthtas.com.au>



Please use the Zoom Q&A feature to ask questions



Please don't forget to register for your next webinar at:
<https://www.primaryhealthtas.com.au/for-health-professionals/events/>



Evaluation Survey

Evaluation survey Plastics education series – Burns management in primary care



Learning Outcomes



Identify burns requiring referral to a specialist service in line with the Tasmanian HealthPathways



Discuss wound management options in primary care



Recognise when escalation is required when managing burns in primary care



Assess and accurately estimate burn depth

Presenter



Dr Nanda Kandamany

Plastic and reconstructive
surgeon, Royal Hobart Hospital
and Senior Lecturer at the
University of Tasmania.

Mr Nanda Kandamany MBChB, MRCS, FRCS (Plast), FRACS

Consultant Plastic & Reconstructive Surgeon - Royal Hobart Hospital

Clinical Senior Lecturer - UTAS

Director - Tasman Plastic Surgery

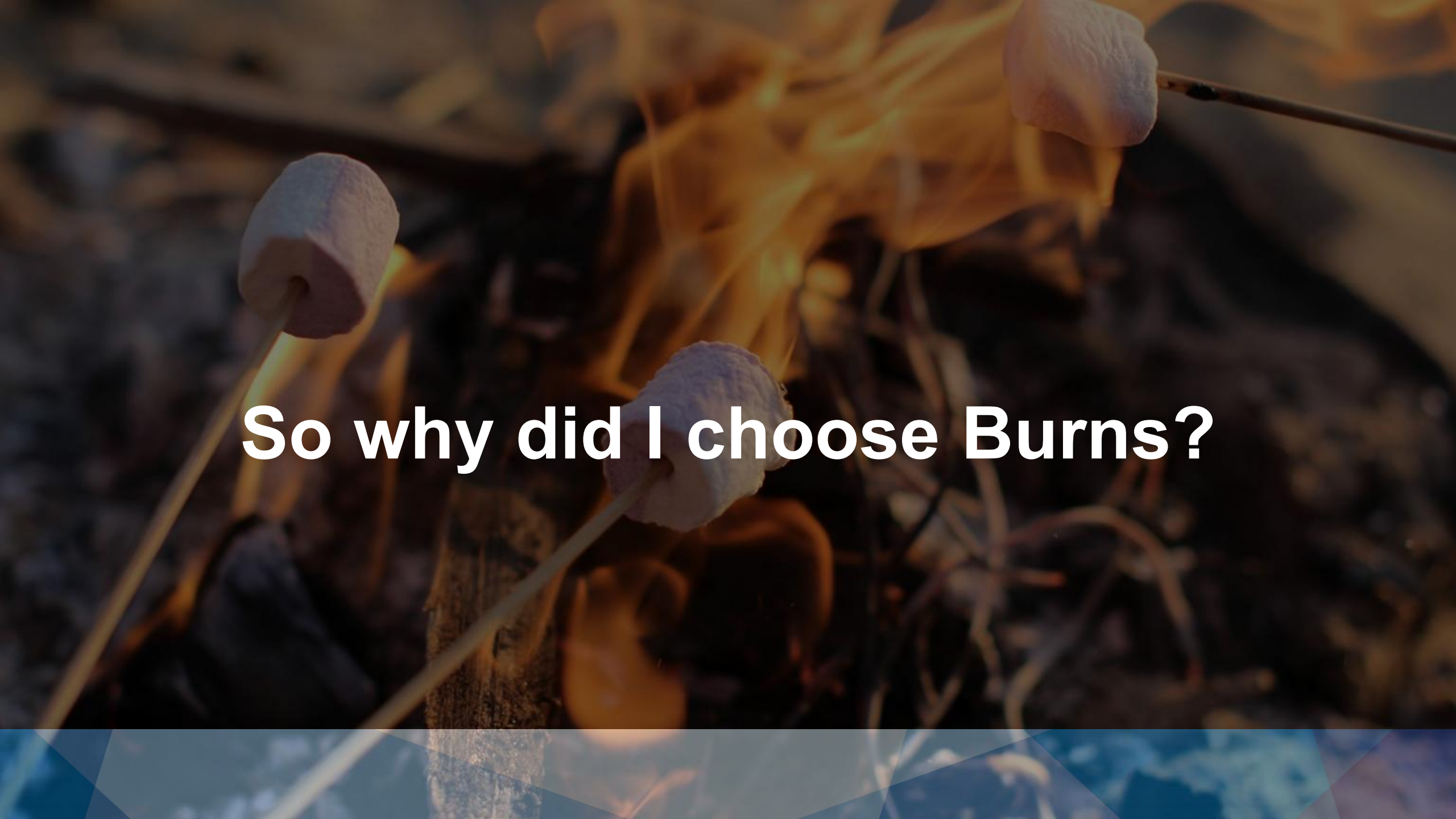
Aims

- History of burns
- Pathophysiology
- Aetiology
- Acute management- assessing burn depth and size
- Recognise when escalation is required
- Late management-reconstructive options
- Clinical cases-apologies for the visual slides

About me....

- Plastic Surgeon-UK trained
- Dual accredited FRCS(Plast) and FRACS
- England- Research MD in Wound Healing + laser fellowship
- Perth WA -Fellowship Burns (Fiona Wood) & Hand Surgery
- Consultant - Royal Hobart Hospital 2017
- 2020: Joined Simon Thomson - 295 Macquarie St, Hobart
- Established Tasman Plastic Surgery 2021
- Subspeciality interests: breast reconstruction, cosmetic surgery, gender affirmation, lasers, skin cancer, hand surgery, head & neck, burns...and everything else!



A close-up photograph of a campfire with marshmallows being roasted on sticks. The fire is bright orange and yellow, with flames rising from a pile of sticks and leaves. Three marshmallows are visible, each on a stick. The background is dark and out of focus. The text "So why did I choose Burns?" is overlaid in white, bold, sans-serif font in the center of the image.

So why did I choose Burns?

- Bradford City stadium fire 1985
- 56 dead, hundreds injured
- Prof. David Sharpe- set up the Bradford Burns Research Unit
- Research Fellow at Bradford Burns Research Unit 3 years
- In vitro wound healing



News > UK > Home News

Bradford City stadium fire: The untold stories of the 1985 fire that devastated Valley Parade

Thirty years after football's 'forgotten tragedy', the truth of what exactly happened when 56 people died in a fire at Bradford City's Valley Parade stadium remains elusive

Ian Herbert • Tuesday 12 May 2015 09:06 BST • [Comments](#)



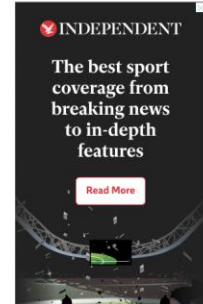
Fans flee to the pitch to avoid the flames in the wooden main stand (Rex Features)

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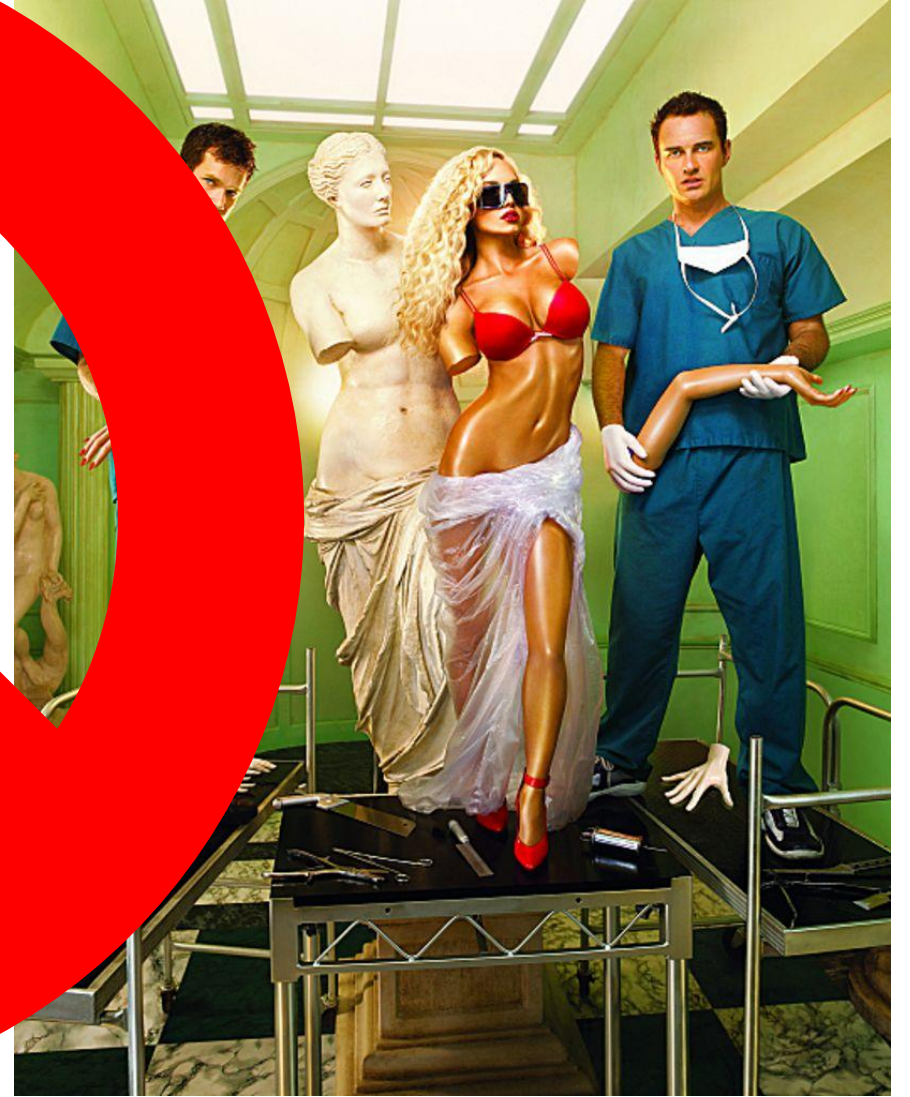
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"Thank you. Thank you for telling this," said the woman, who was perhaps 60 or so, to one of the young people whose stage play, based on football's Bradford disaster, had just concluded on the small theatre space behind her. And only after she had gone – vanished into the kind of warm Bradford Saturday night on which wives, children, parents and friends first learned that they were the bereaved, 30 years ago next week – did the significance of her gratitude become clear. She was Hazel Greenwood – the mother whose children, 13-year-old Felix and 11-year-old Rupert, had been ushered away from the flames of the stadium fire all those years ago by a traffic warden, seeking to shelter them under his tunic. He and the children all perished, along with the boys' father. The children were still nestled under the





- Bali bombing 2002
- 202 killed, 209 injured, 88 Australians
- Prof. Fiona Wood- Australian of the Year 2005
- Pioneer of “spray-on-skin”
- Burns Fellow WA Adult and Children Burns Service 1 year







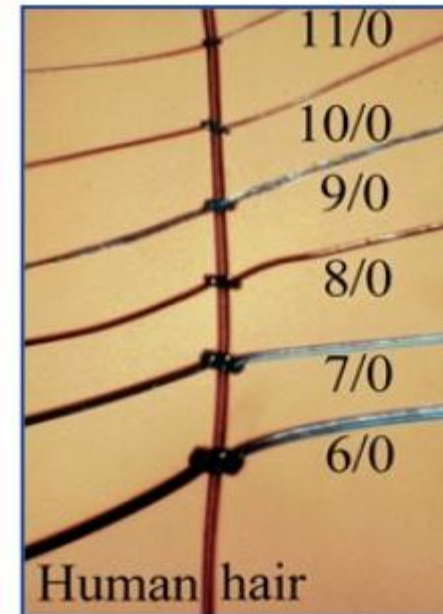
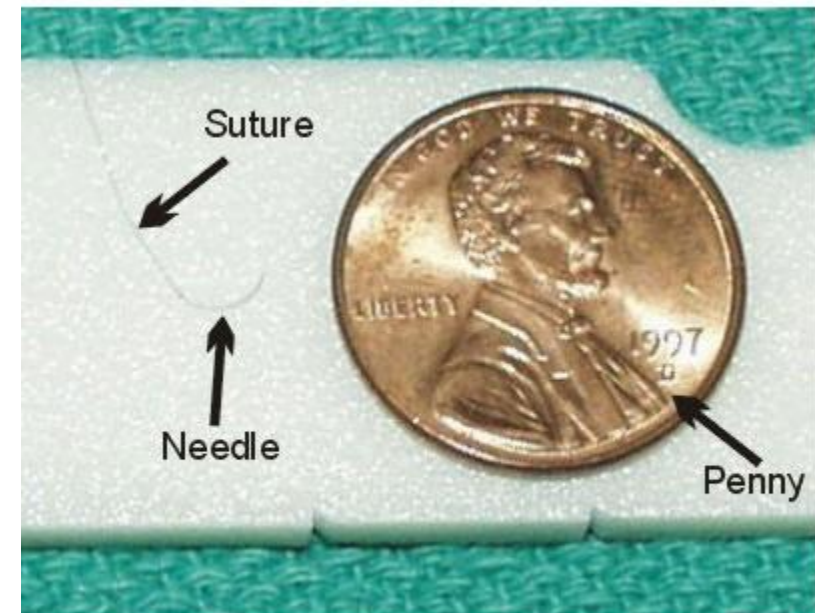






Microsurgery

T



Burns

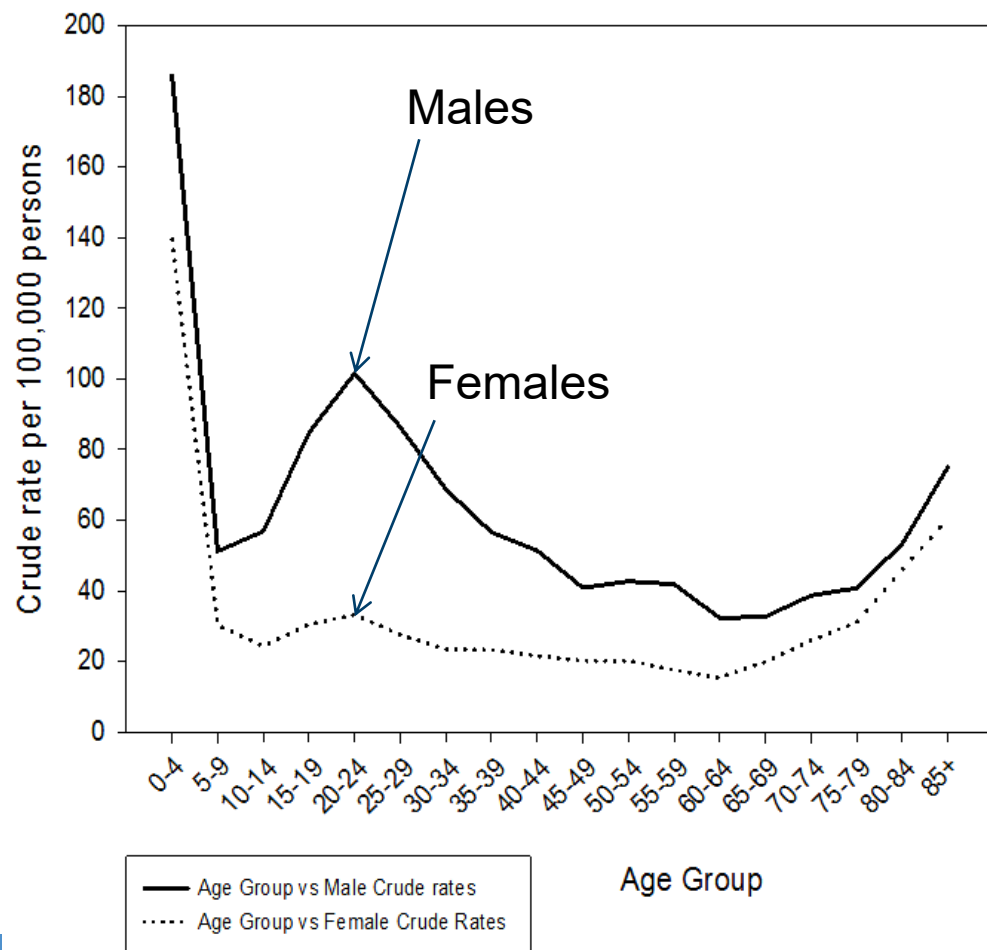
Mechanisms of injury

- Thermal
 - Scalds
 - Flame
 - Contact
 - Sunburn
 - Frostbite
- Electrical
 - Low voltage
 - High voltage
 - Flash
- Chemical
 - Acids
 - Alkali

Who gets burnt?

- Young children – scalds from hot liquids/baths
- Older children – illicit activities
- Working age – flame burns, 30% work related
- Elderly – scalds, contact burns and flame burns

Incidence with age

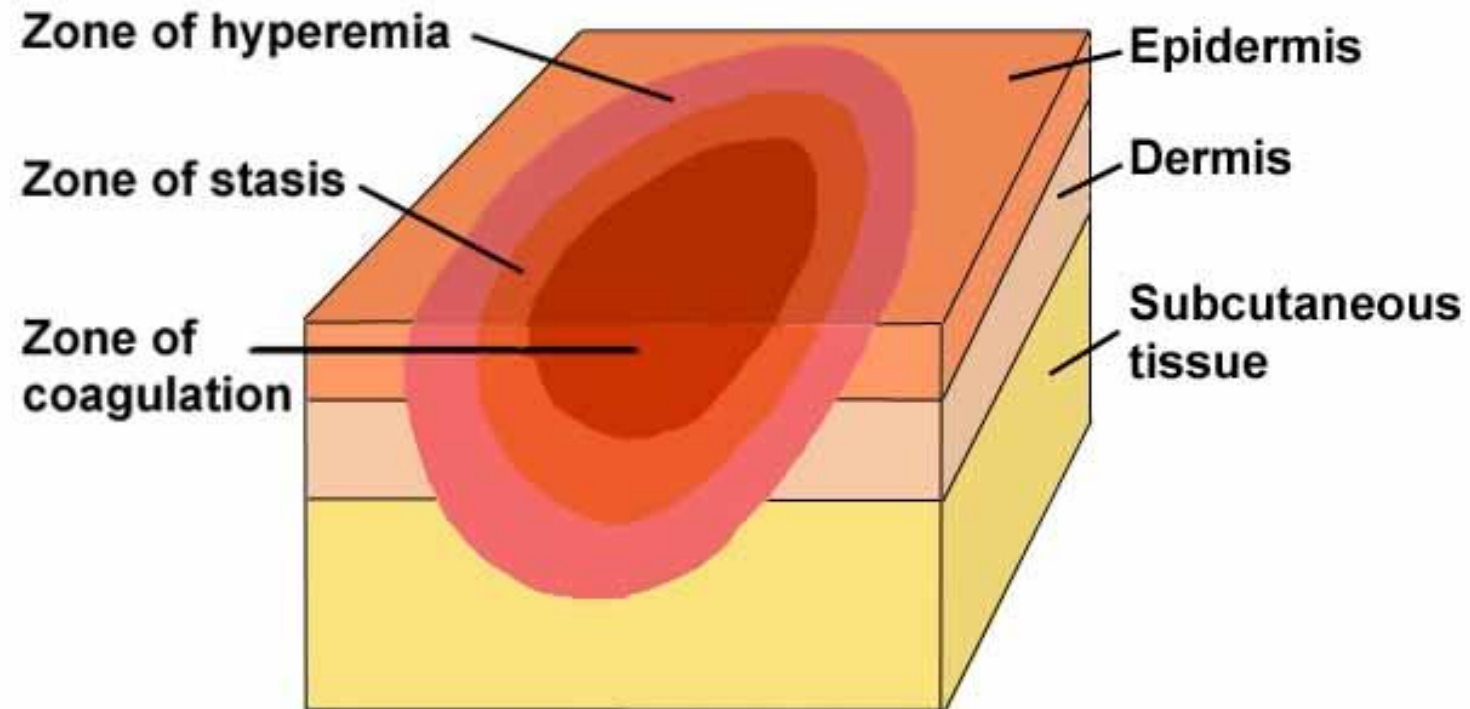


- High incidence in burns in under 5s
- 2nd peak in incidence in young men
- Rising incidence in older people

What happens when you have a burn?

- Area of tissue necrosis
- Inflammatory reaction set on overdrive
- Swelling
- Systemic inflammatory leak
- Stress response - hormones (catecholamines, catabolism)

Jackson Burn Model

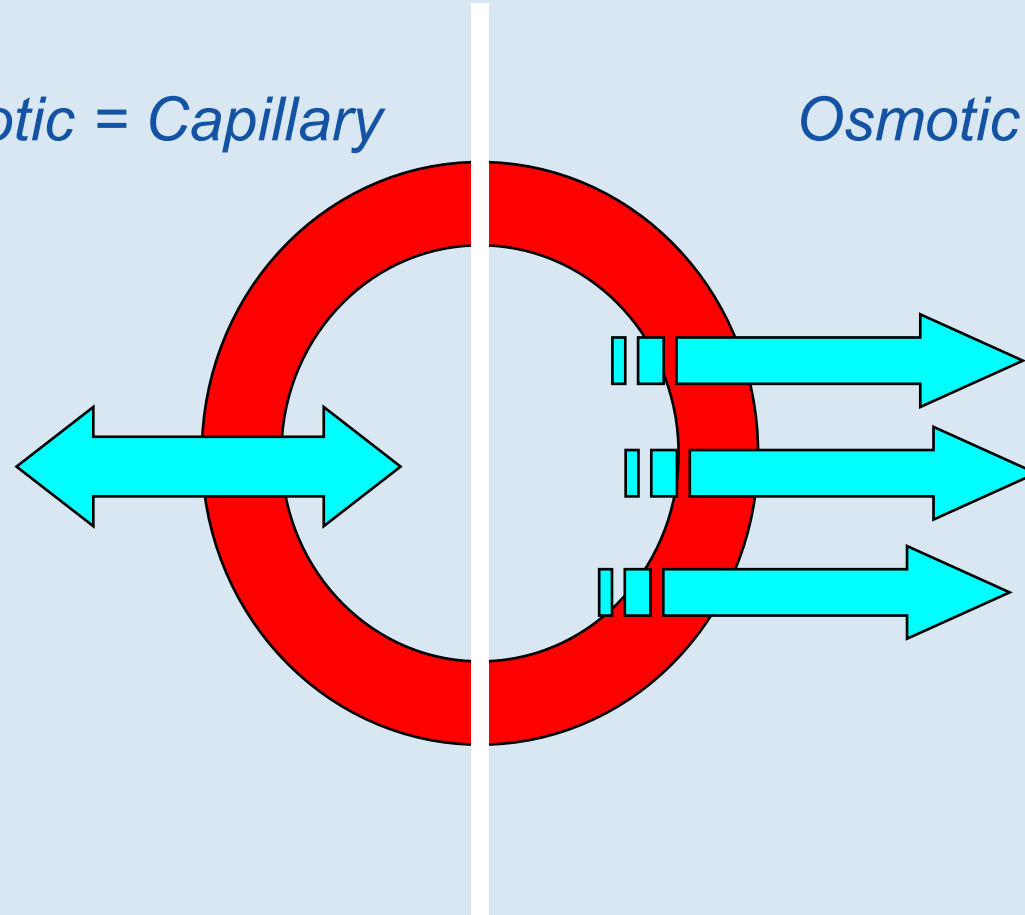


Normal

Burn

Osmotic = Capillary

Osmotic > Capillary



Acute management

- **Rescue**
- Resuscitate
- Retrieve
- Resurface
- Rehabilitate
- Reconstruct
- Review

First aid



reduction in need for skin
graft if 1st aid applied at
time of injury

• burning process
and roll
• remove clothing
• burn wound
• water 15 C °
• running water
• minutes

- Up to 3 hours post injury

Management

- Rescue
- **Resuscitate**
- Retrieve
- Resurface
- Rehabilitate
- Reconstruct
- Review

Primary survey

- **A**irway maintenance with cervical spine control
- **B**reathing and ventilation
- **C**irculation with haemorrhage control
- **D**isability and neuro status
- **E**xposure / Environmental control
- **F**luid resuscitation

Who to fluid resuscitate

- Adults $> 20\%$ BSA
- Children $>10\%$ BSA
- Oral resuscitation for smaller burns

Why fluid resuscitate

- Barrier to fluid loss
- Insensible losses
- Shock/hyperdynamic circulation



Fluid resuscitation

- 2 large bore peripheral cannula – preferable through unburnt skin
- Estimate burn area
- Calculate fluid requirement
- Half in first eight hours FROM INJURY
- Remaining over next 16 hours

Parkland formula

2 – 4 mls Hartmanns / kg body weight / %
burned

Clinical Monitoring

- **Urine output** 0.5mls/kg/hr adults, 1ml/kg/hr children
- Patient's conscious state
- Temperature
- (BP and pulse)

Other

- X-ray
- Pain relief
- NG tube
- Catheter
- Tetanus
- Bloods – Hb, U&E, Drug screen
- ABG
- ECG
- Carboxyhaemoglobin
- BM

Secondary Survey

- A – Allergies
- M - Medications
- P – Past Illnesses
- L – Last meal
- E – Events/ Environment related to injury
- Top to toe examination



DURATION OF
EXPOSURE



TYPE OF CLOTHING
WORN



TEMPERATURE/
NATURE OF FLUID IF
SCALD



FIRST AID

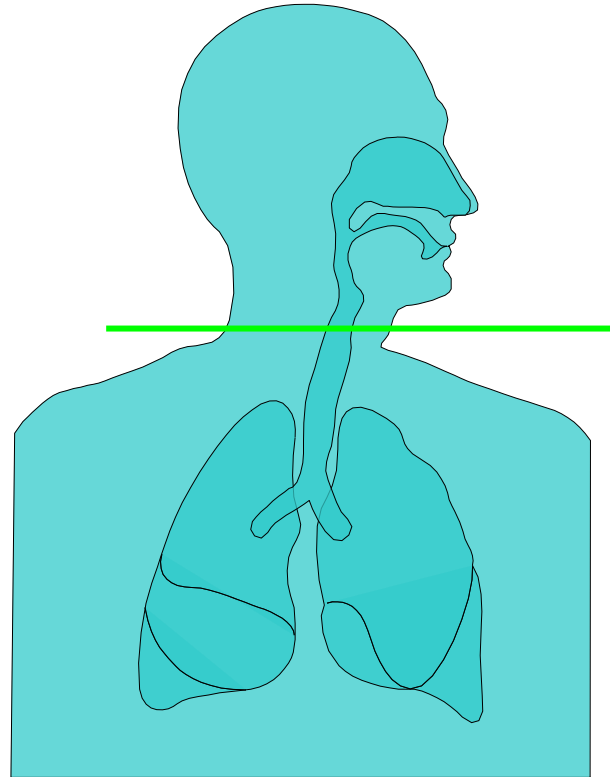
Inhalational injuries

Heat damage

Above the larynx

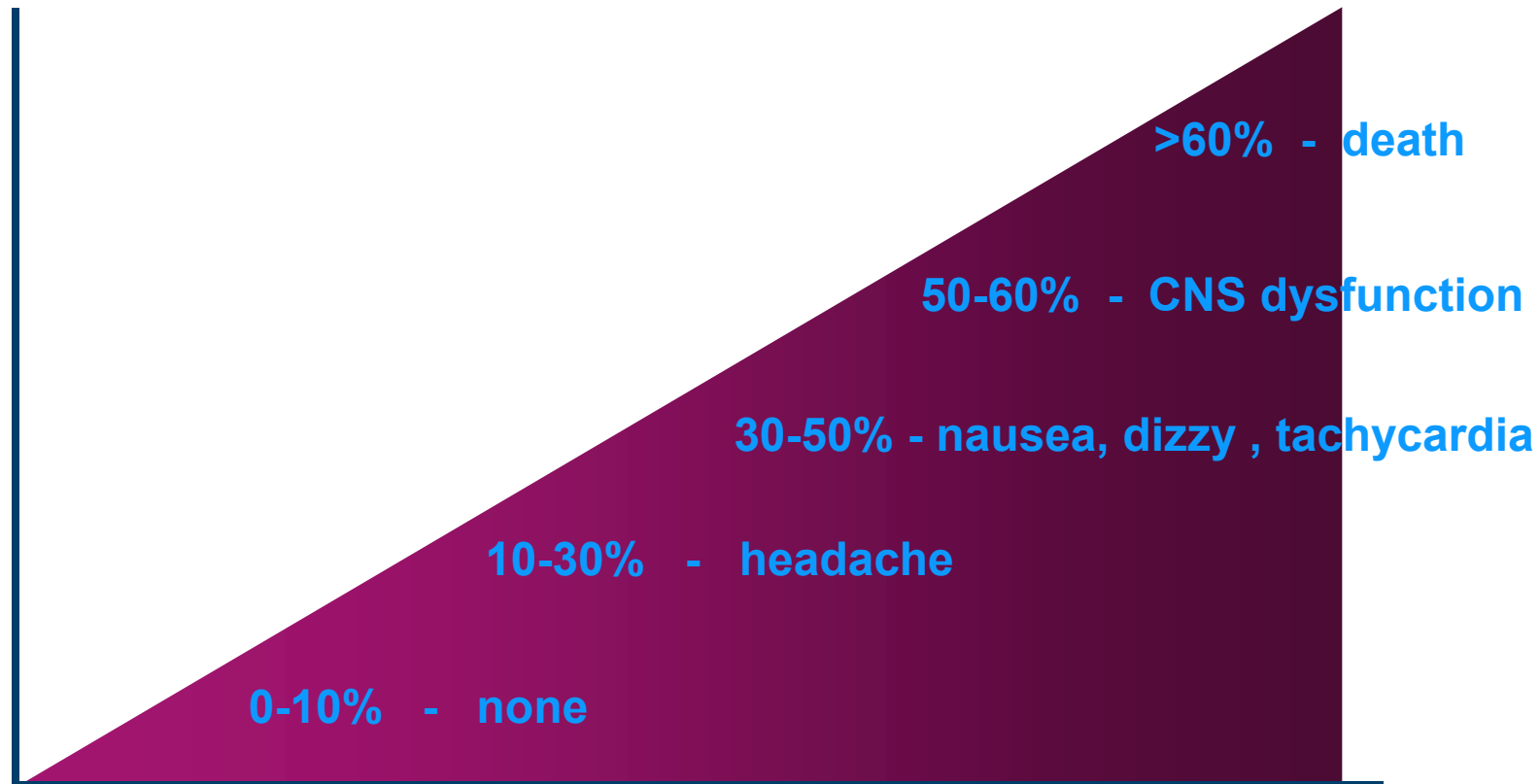
Chemical injury

Below the larynx



Systemic Intoxication Injuries

Clinical signs of CO poisoning



Diagnosis of inhalational injury

- History
 - Enclosed space
 - House
 - Motor vehicle
 - Aeroplane
 - Explosion
 - Petrol or gas fire
 - Bomb



HAND



WALLACE RULE
OF NINES



LUND & BROWDER
CHART

Burn size estimation

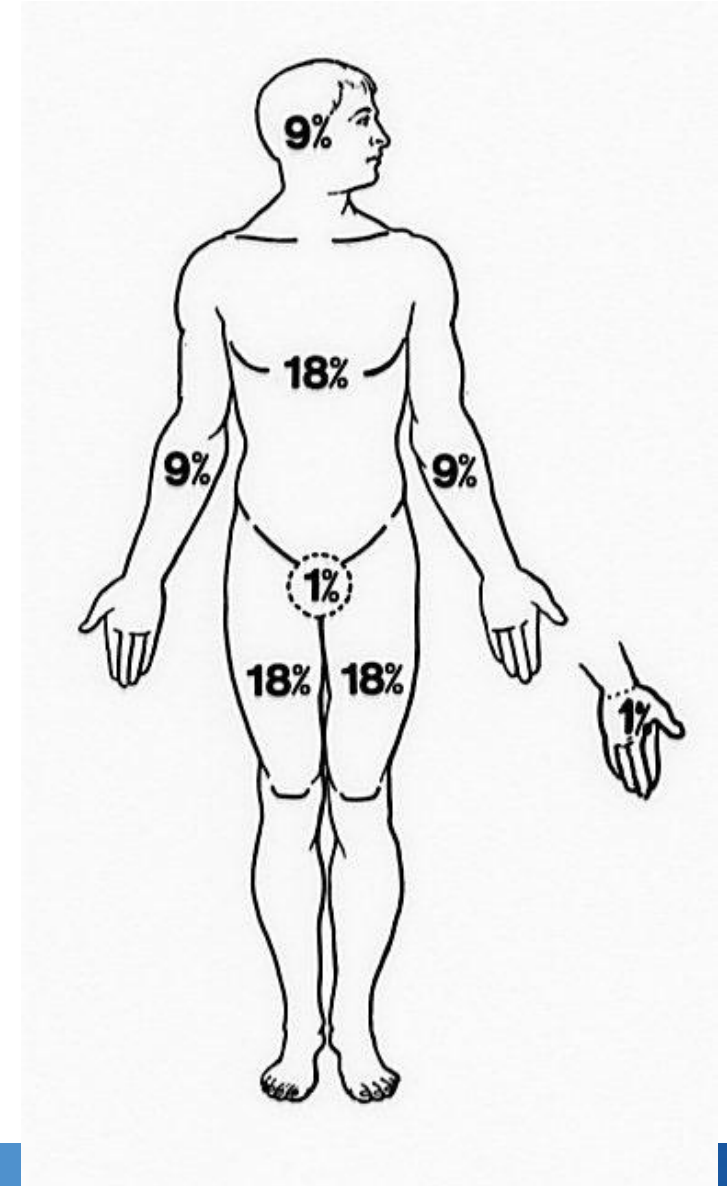
- Palm
 - Patient's palm
 - Approx. 1% of body surface area



Burn size estimation

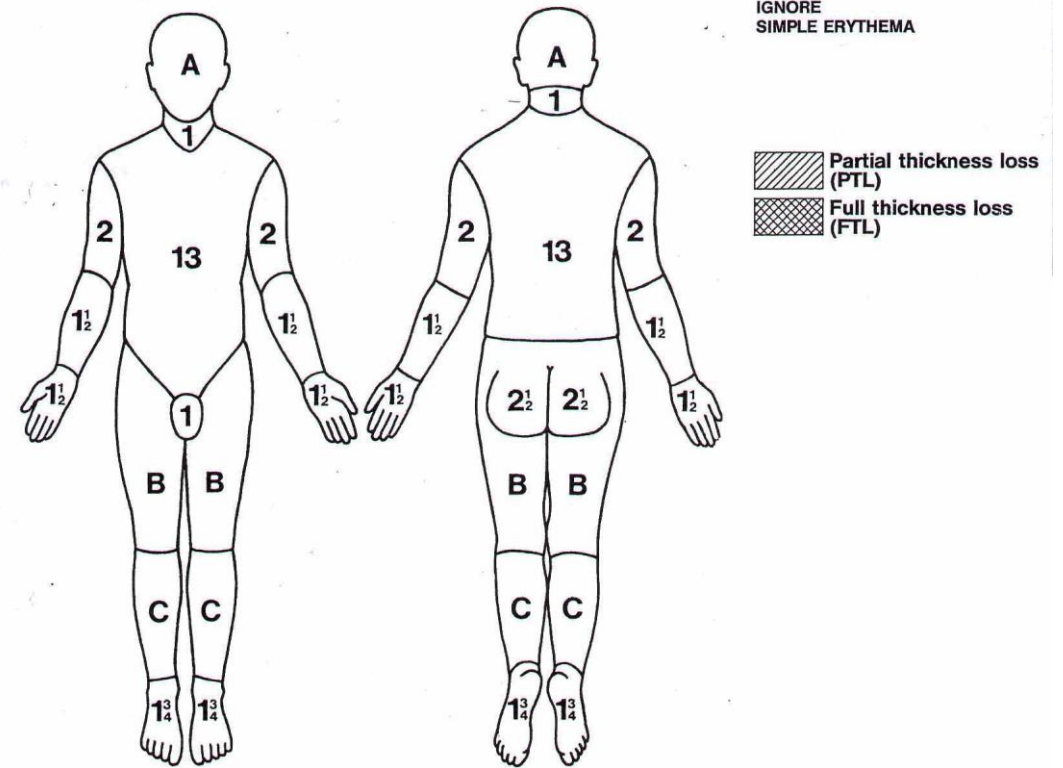
Rule of nines

- Applies to adults
- Areas of body divided into areas of 9%
- Perineum 1%



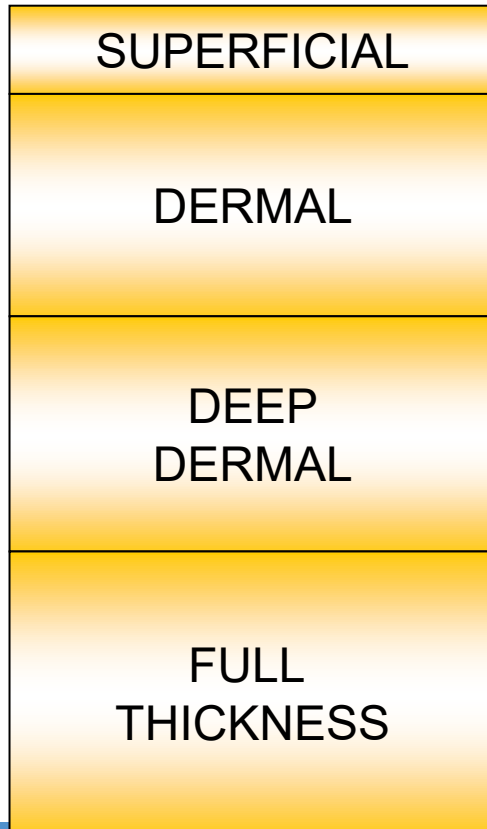
RELATIVE PERCENTAGE OF BODY SURFACE AREA
AFFECTED BY GROWTH

AREA	AGE 0	1	5	10	15	ADULT
A= $\frac{1}{2}$ OF HEAD	$9\frac{1}{2}$	$8\frac{1}{2}$	$6\frac{1}{2}$	$5\frac{1}{2}$	$4\frac{1}{2}$	$3\frac{1}{2}$
B= $\frac{1}{2}$ OF ONE THIGH	$2\frac{3}{4}$	$3\frac{1}{4}$	4	$4\frac{1}{2}$	$4\frac{1}{2}$	$4\frac{3}{4}$
C= $\frac{1}{2}$ OF ONE LEG	$2\frac{1}{2}$	$2\frac{1}{2}$	$2\frac{3}{4}$	3	$3\frac{1}{4}$	$3\frac{1}{2}$



Depth of burn

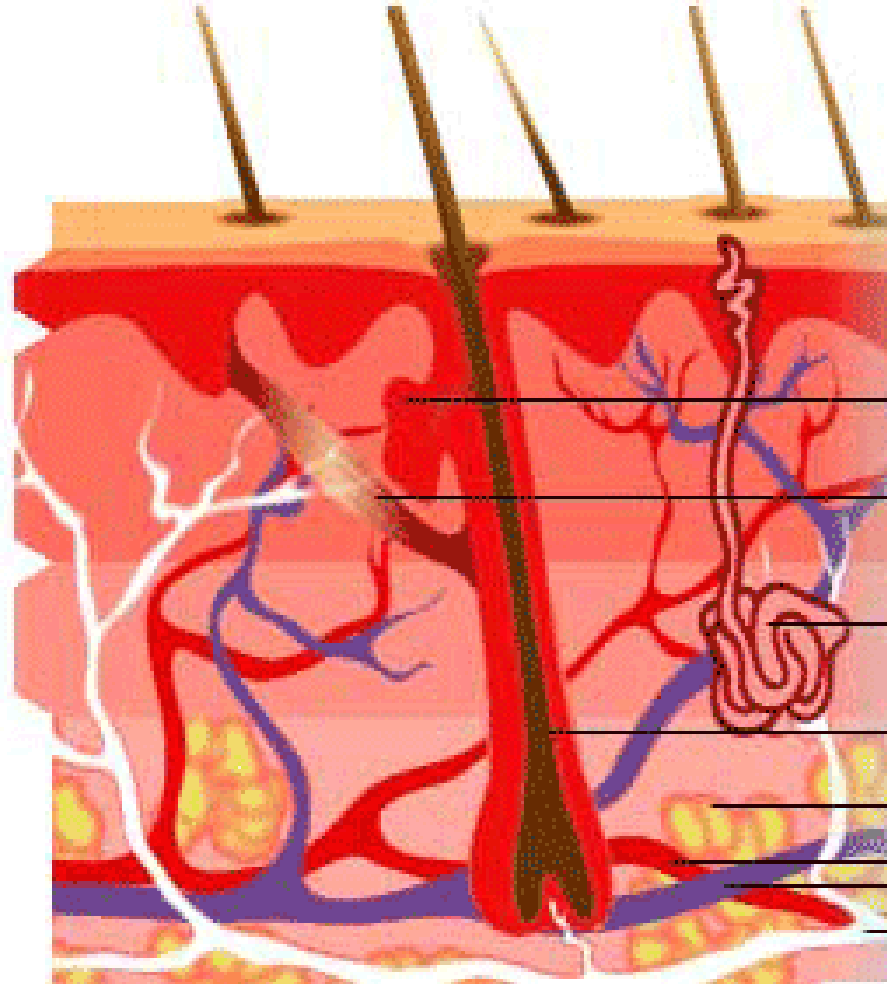
1st , 2nd 3rd degree burn terminology no longer used



Epidermis

Papillary Dermis

Reticular Dermis



Oil Gland

Muscle

Sweat Gland

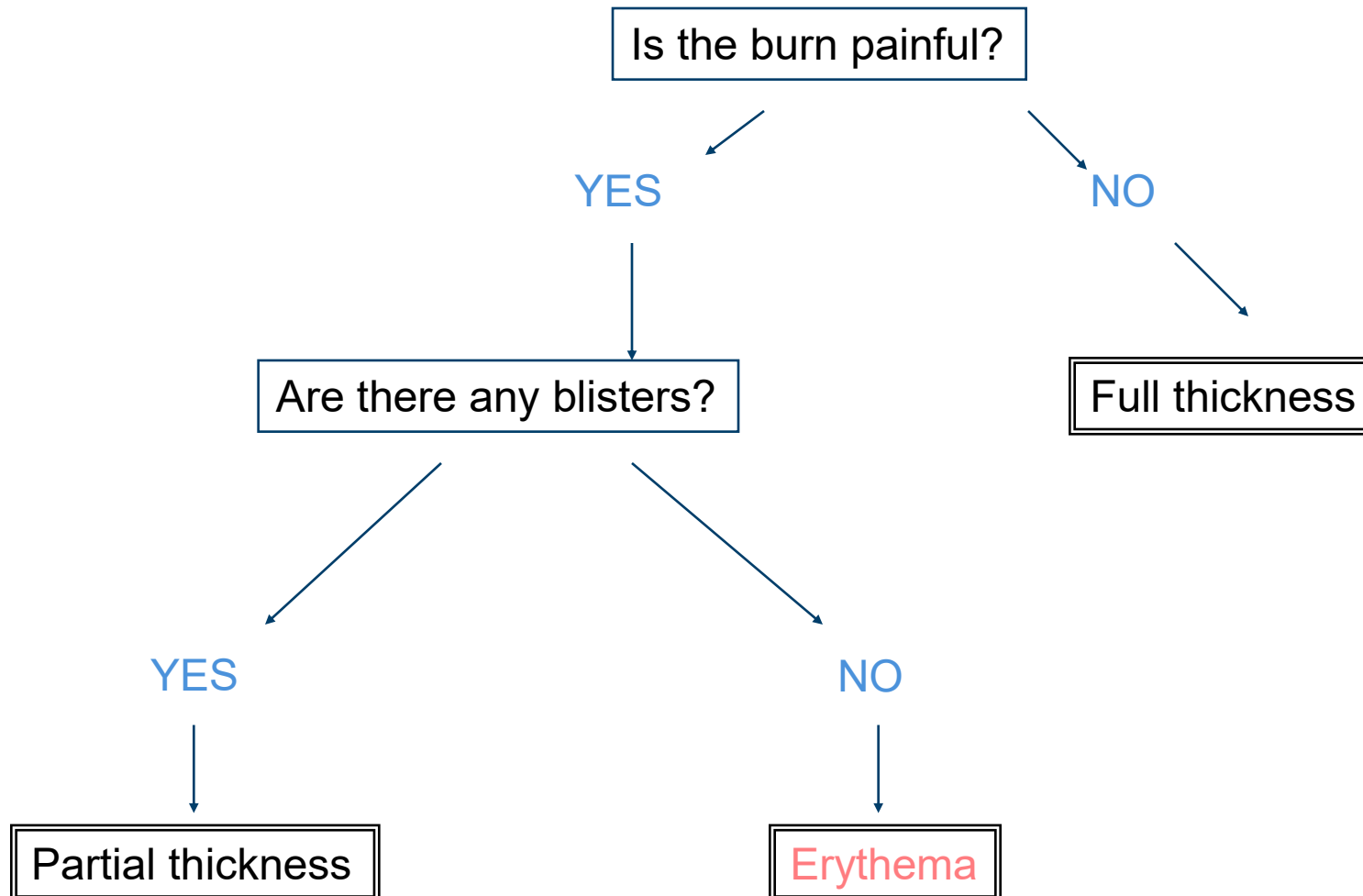
Hair

Fat tissue

Blood vessel

Nerve

How to identify burn depth



	Appearance	Description	Capillary refill?	Sensation?
Epidermal		Bright red/pink Heals within 7 days.	Present (fast)	Yes
Superficial Dermal		Pale pink. Often blistered. Heals within 14 days	Present	Yes – very painful
Mid-Dermal		Dark pink	Sluggish	May be present or absent
Deep		Blotchy red (from haemoglobin that has leaked out of damaged capillaries)	Absent	Absent
Full Thickness		White, waxy or leathery appearance	Absent	Absent

Management of the small burn



Acticoat

Nanocrystalline impregnated silver mesh, sustained released

For **ALL** burns in first 48 hours



Acticoat dressings

Moisten Acticoat with
Water

OR

A water-based hydrogel onto it eg. Intrasite

Secondary dressing

Wet gauze, Jelonet, Dry gauze, Bandage/Tubigrip

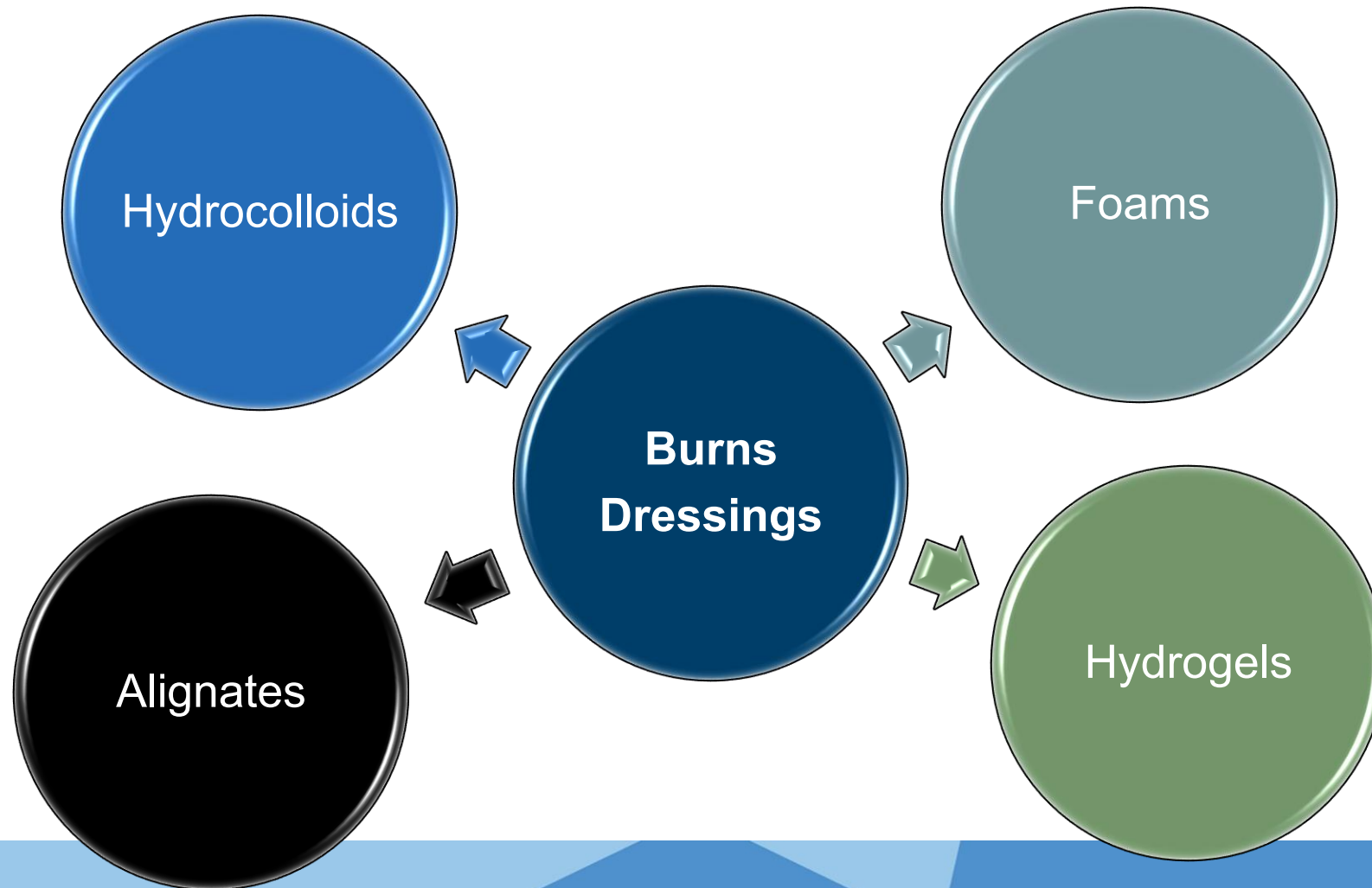
OR

Duoderm

CGF (adults)

Extra thin (children)

Dressings after FIRST 48 hours





- Moist granulating tissue
- Haemostasis following escharotomies
- Moderately to highly exudative sloughy wounds
- Becomes a gel on contact with wound exudate
- Oil to remove



Hydrocolloids

- Low/moderate exudating wounds
- Appropriate for all burn depths
- Water repellent and conformable
- Thin hydrocolloids for scar management only in adults
- Paediatrics can use thin



Hydrocolloids

Offensive exudate can be mistaken for infection



Foams

- Come in plain and silver
- Absorb exudate therefore help to manage and prevent hypergranulation
- Help prevent and manage maceration



Hydrogels



- Aids autolytic debridement
- Rehydrates dry slough or eschar
- No harm to granulation tissue or epithelialisation



Hand dressings

- Low profile
- Conformable
- Allow movement
- Not restricting movement of digits
- Functional
- Comfortable



Management

- Rescue
- Resuscitate
- **Retrieve**
- Resurface
- Rehabilitate
- Reconstruct
- Review

- >10% TBSA in adults, >5% TBSA in children
- Special areas – face, hands, feet, genitals, major joints
- Full-thickness burns >5% TBSA
- Electrical / chemical burns
- Burns with inhalation injury
- Extremes of age
- Pre-existing medical disorders
- Associated trauma

Preparation for transfer



Continue with oxygen



?Endotracheal intubation



Continue fluids



Clean and cover burn



Pain relief

- Full thickness burn loses ability to expand as oedema progresses
- Surgical release of skin
- Circumferential burns to chest
 - May decrease compliance of chest wall
 - Reduce ventilation
 - Requires escharotomy
- Indication in Limbs
 - Circumferential full thickness burn
 - Deep pain at rest
 - Pain on passive movement
 - Loss of distal circulation
 - Numbness
 - Decrease saturation on pulse oximetry

Burns in children

- Difference in body size and proportions
- Thinner skin, assessment more difficult
- Require resuscitation fluids and maintenance fluids
- Prone to hypoglycaemia, fluid overload and hyponatraemia

Chemical injuries

- Industry
 - Alkalis
 - cement
 - Acids
 - Hydrofluoric acid (glass etching)
- Military
 - phosphorous
- Household
 - Alkalis
 - Drain cleaners, paint removers
 - Phenols
 - Sanitizers, disinfectants
 - Sodium hypochlorite
 - Disinfectants, bleaches
 - Sulphuric acid
 - Phosphorous
 - Fireworks, insecticides
 - fertilizers



Chemical burns

- Tissue destruction continues until agent is removed or inactivated
- Acids produce a coagulative necrosis
- Alkalis produce a liquefactive necrosis – penetrates deeper than acids



Management of Chemical Burns

- IRRIGATION (except sodium, potassium or lithium)
- Continue until pH returns to normal



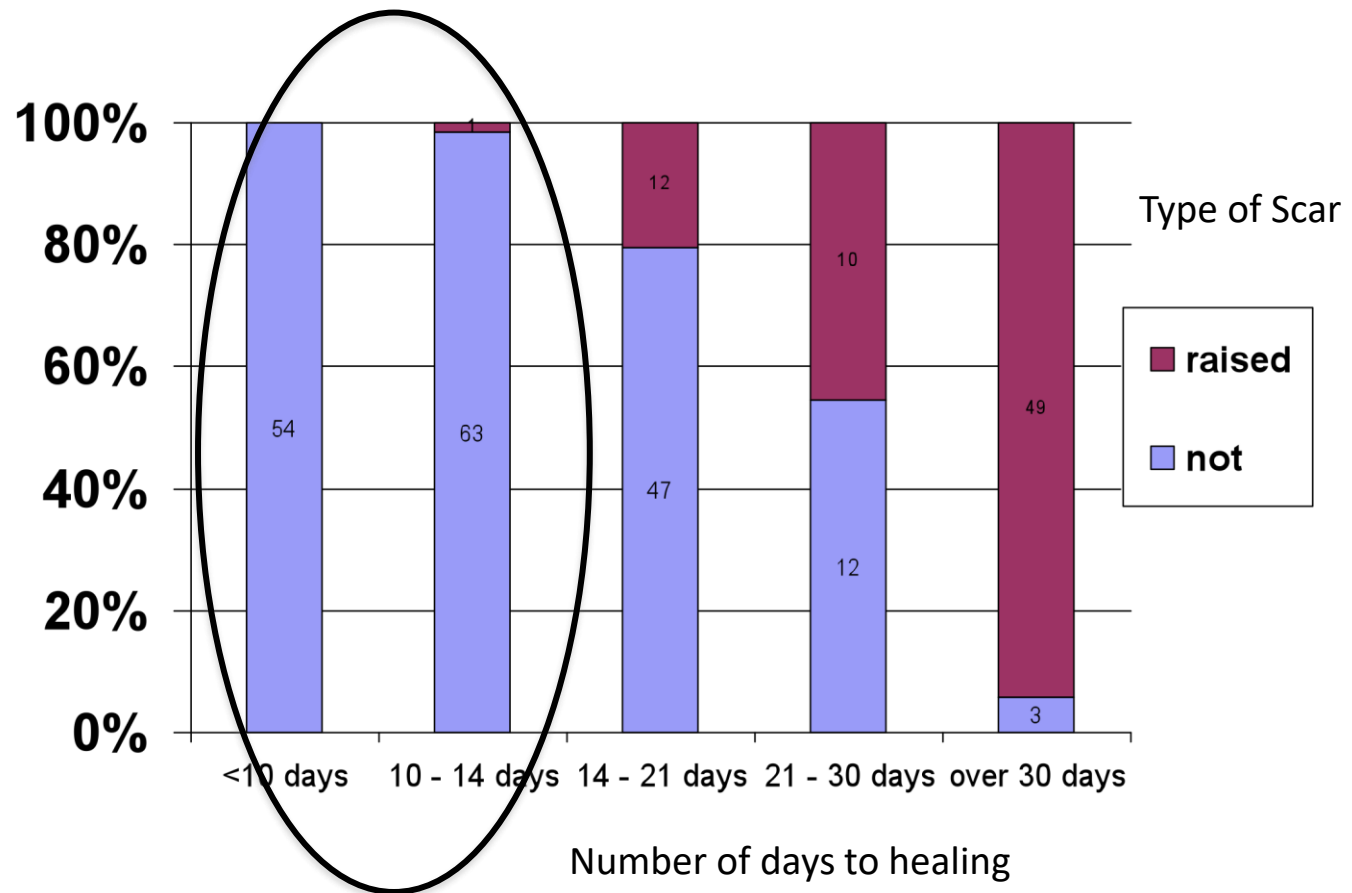
Hydrofluoric acid burns

- 2% BSA can be fatal
- Fluoride ions bind to calcium
- Causes hypocalcaemia
- Treatment:
 - Irrigation
 - Trim fingernails
 - Topical calcium gluconate gel
 - 10% calcium gluconate injection
 - Early excision



Management

- Rescue
- Resuscitate
- Retrieve
- **Resurface**
- Rehabilitate
- Reconstruct
- Review



Biobrane

- Biosynthetic temporary skin substitute
- Two layers:
 - Outer silicone layer
 - Small pores
 - Inner nylon mesh
 - Porcine collagen
- Reduces pain and hospital stay *Burns 24 (1998) 49-53*



Recell

- Small thin skin graft harvested
- Skin cells are extracted
 - Keratinocytes
 - Fibroblasts
 - Melanocytes
- Suspension of cells sprayed onto wound



- Available from skin banks
- Donors are screened for transmissible diseases
- Preserved in 15% glycerol with antimicrobials
- Frozen at -80°C
- Disadvantages
 - Risk of disease transmission e.g. CMV HIV
 - Rejection

Integra™

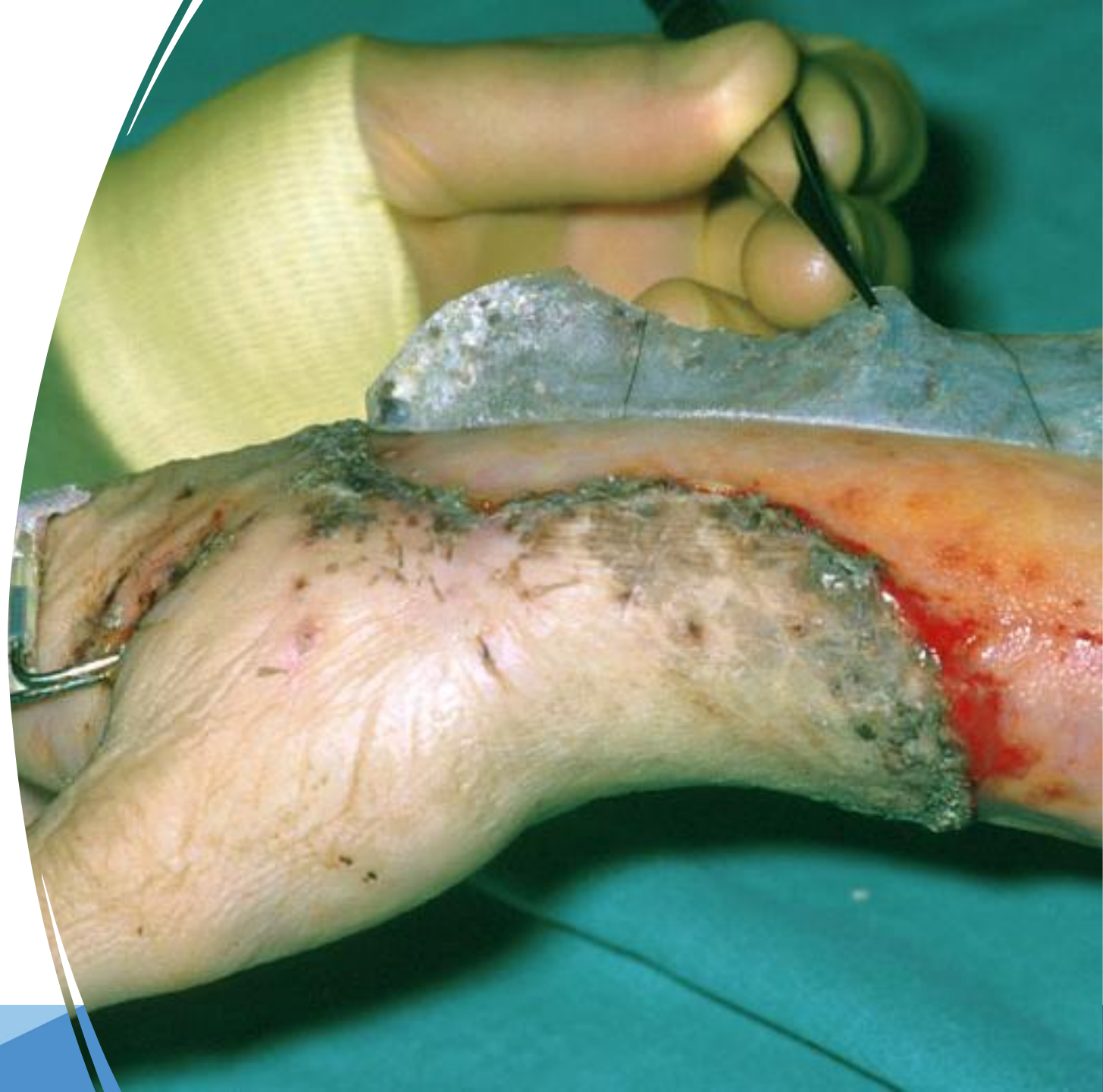
- Biosynthetic dermal substitute
- Outer silicone layer
- Inner layer
 - Cross linked bovine collagen
 - Shark chondroitin 6-sulphate



Integra™

Two stages

- Initially Integra applied to wound
- Allow 3 weeks for dermis to integrate into wound
- Second stage
 - Removal of silicone outer layer
 - Application of thin SSG +/- Recell



Integra™

T



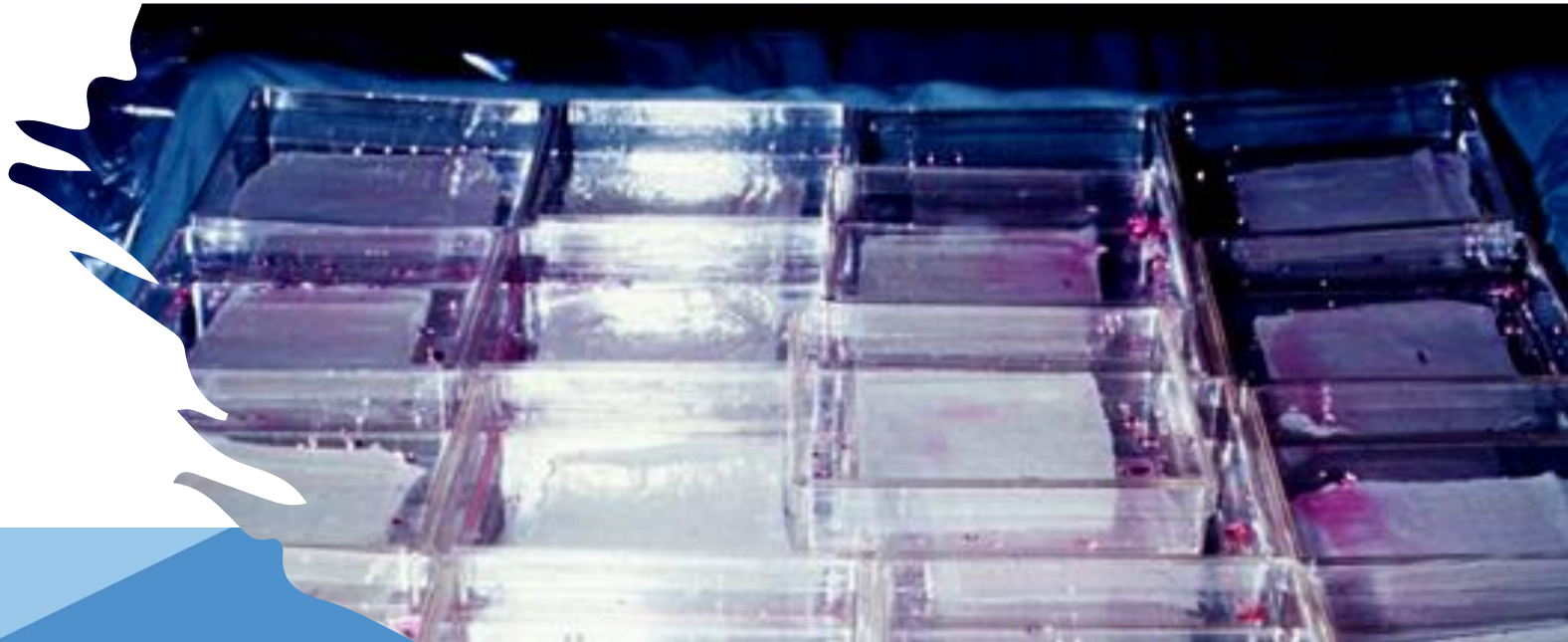
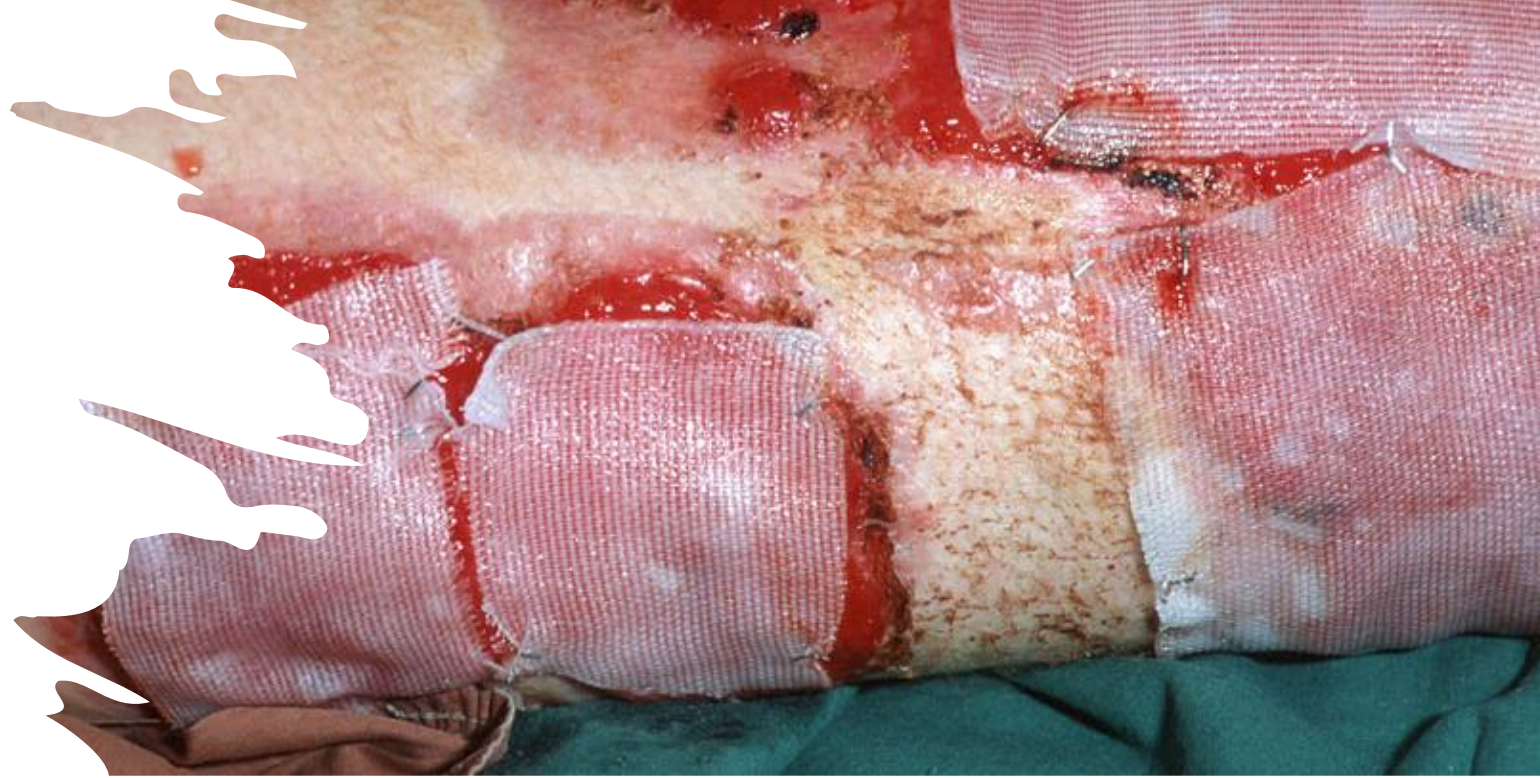


Cultured epidermal autografts

- Small skin graft taken
- Sent off to labs
- Culture cell sheets

Disadvantages

- Provides epidermal cover only
- Takes several weeks to produce
- Very expensive

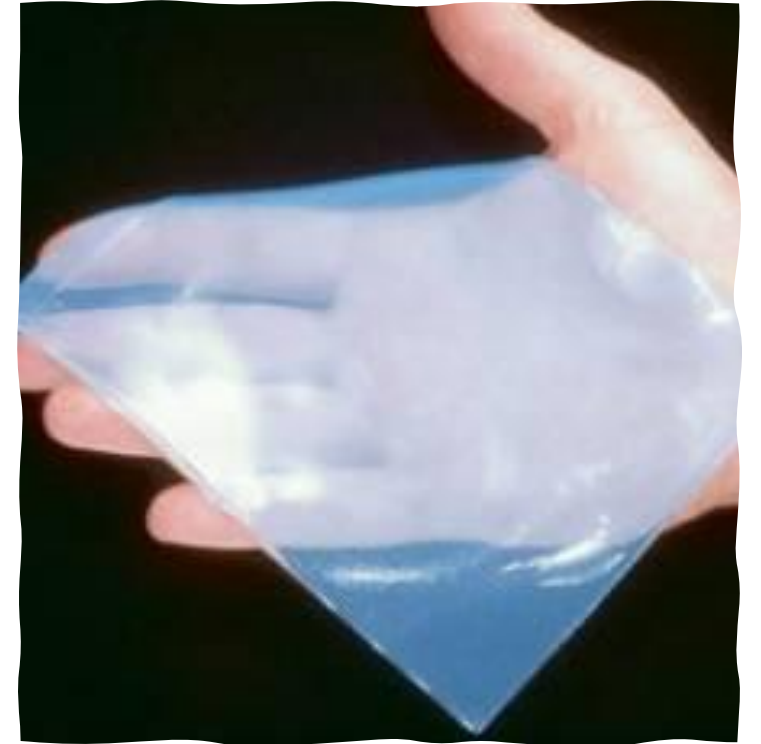


Management

- Rescue
- Resuscitate
- Retrieve
- Resurface
- **Rehabilitate**
- **Reconstruct**
- **Review**

Scar therapy

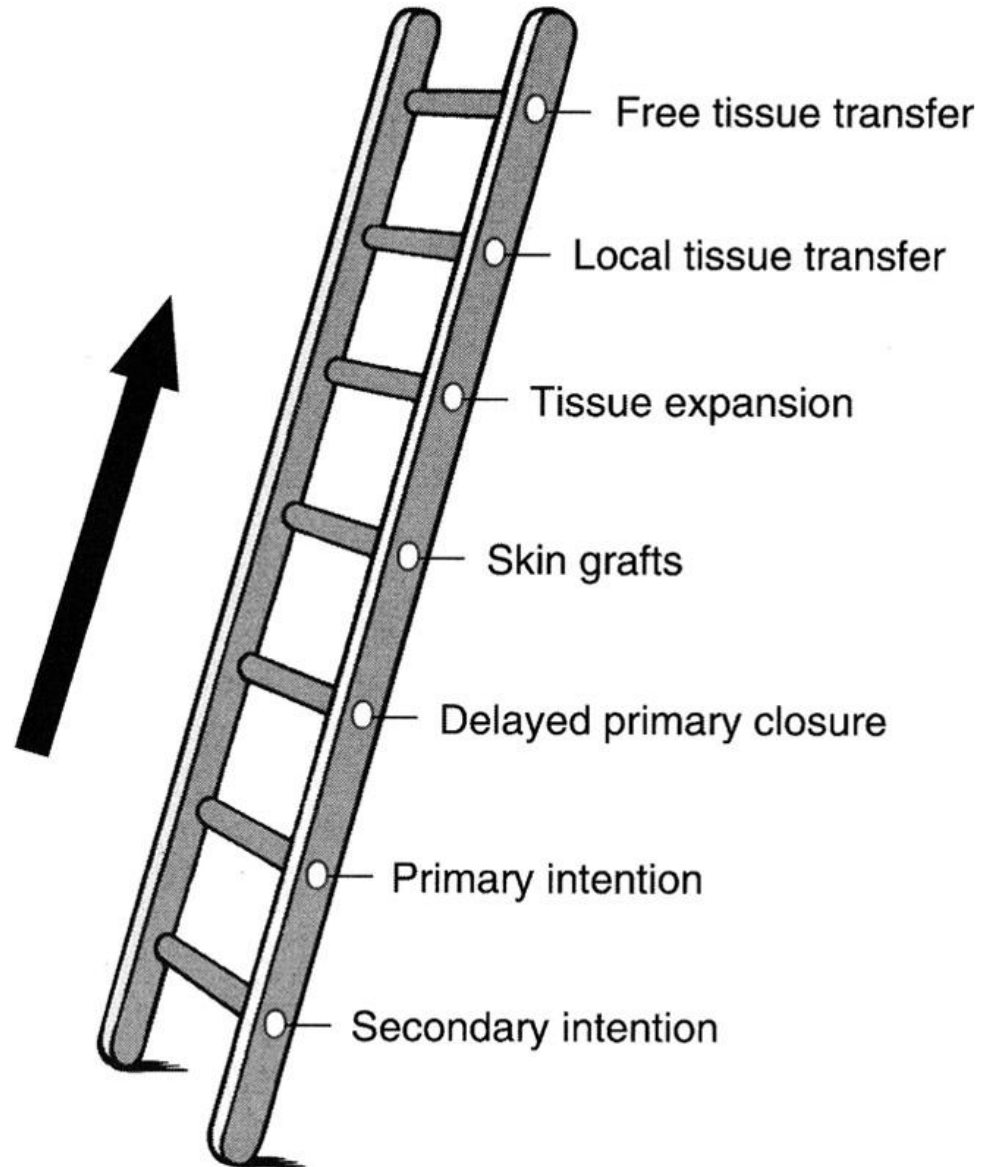
- Topical silicone
- Pressure garment
- Splints
- Face mask
- Steroid injections
- Cosmetic camouflage



Rehabilitation

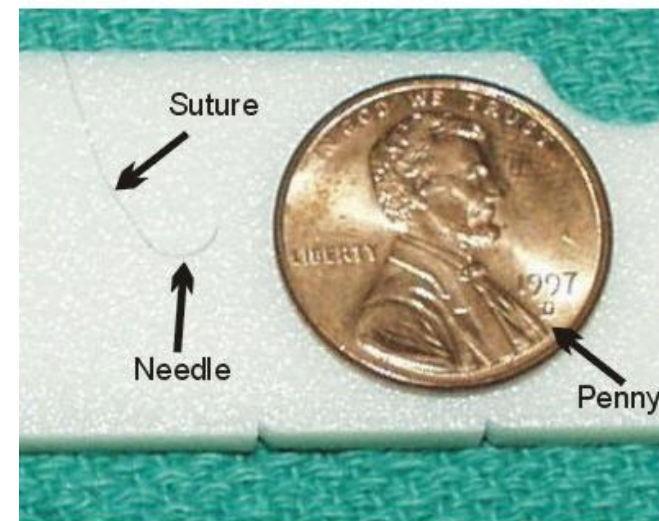
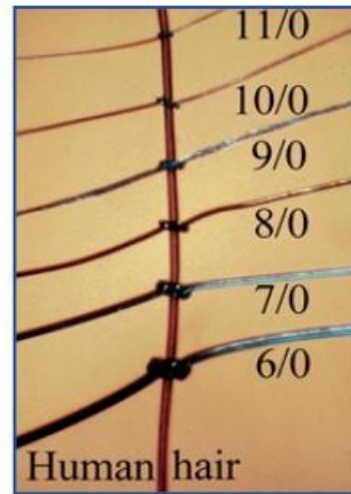
Lifestyle Issues

- Return to home environment
 - home visits - equipment
 - reintegration into daily activities
 - return to hospital for ongoing follow up
- Return to work
 - graded return
 - type of job i.e.: indoors vs outdoors
 - driving - what options are there??
 - retraining
- Return to play / sport



Techniques

- Excision and primary closure
- SSG
- FTSG
- Z-plasty
- Local flaps – random, axial, perforator
- Tissue expansion
- Free flaps



On going needs

Dressings

Pain

Itch

Pressure garments

Scar management

Physiotherapy

Nutrition

Further Surgery

Psychological Issues

Social Issues

Financial Issues

Legal Issues

Summary

Structure of EMSB Approach							
L O O K	A I R W A Y	B R E A T H I N G	C I R C U L A T I O N	D I S A B I L I T Y	E X P O S U R E	FLUIDS	A.M.P.L.E. History
						ANALGESIA	Head to Toe Examination
						TESTS	Tetanus
						TUBES	Documentation
D O	C-spine control	Supplemental O ₂	Haemorrhage control & I.V. access	AVPU & Pupils	Environmental Control (& Estimate TBSA)		Referral
	Primary Survey					Check First Aid	Secondary Survey _{MT2}
							 2021

Further Training?



Emergency Management of Severe Burns Course (EMSB)
1 day course

More details at www.anzba.org.au/education/emsb

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Questions?

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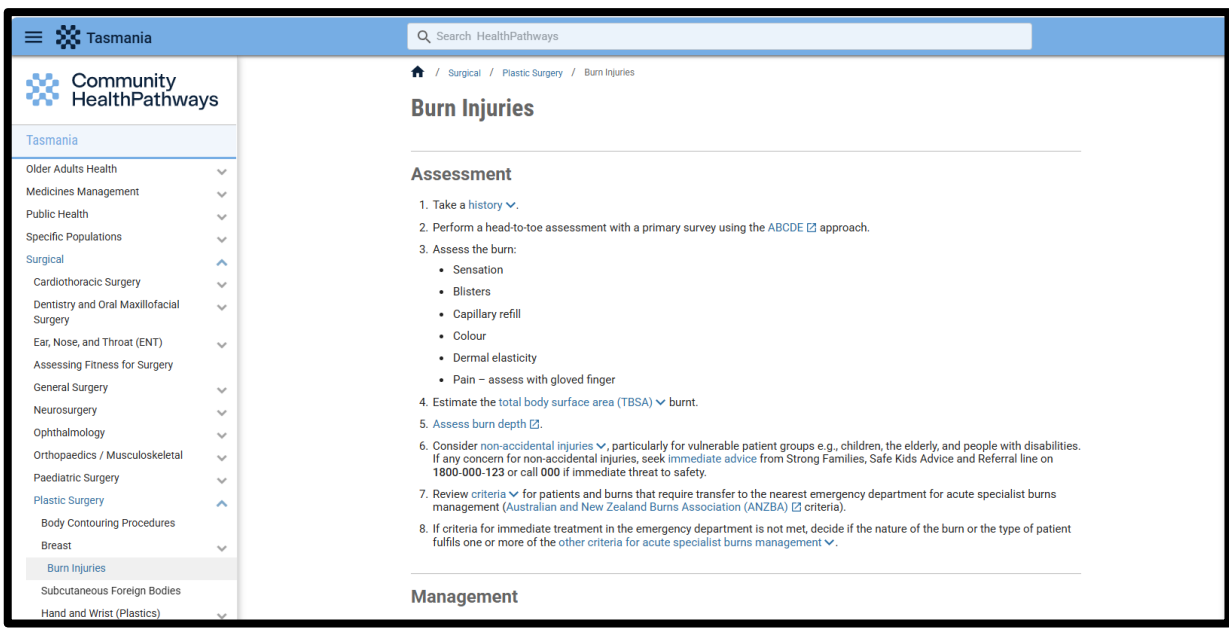
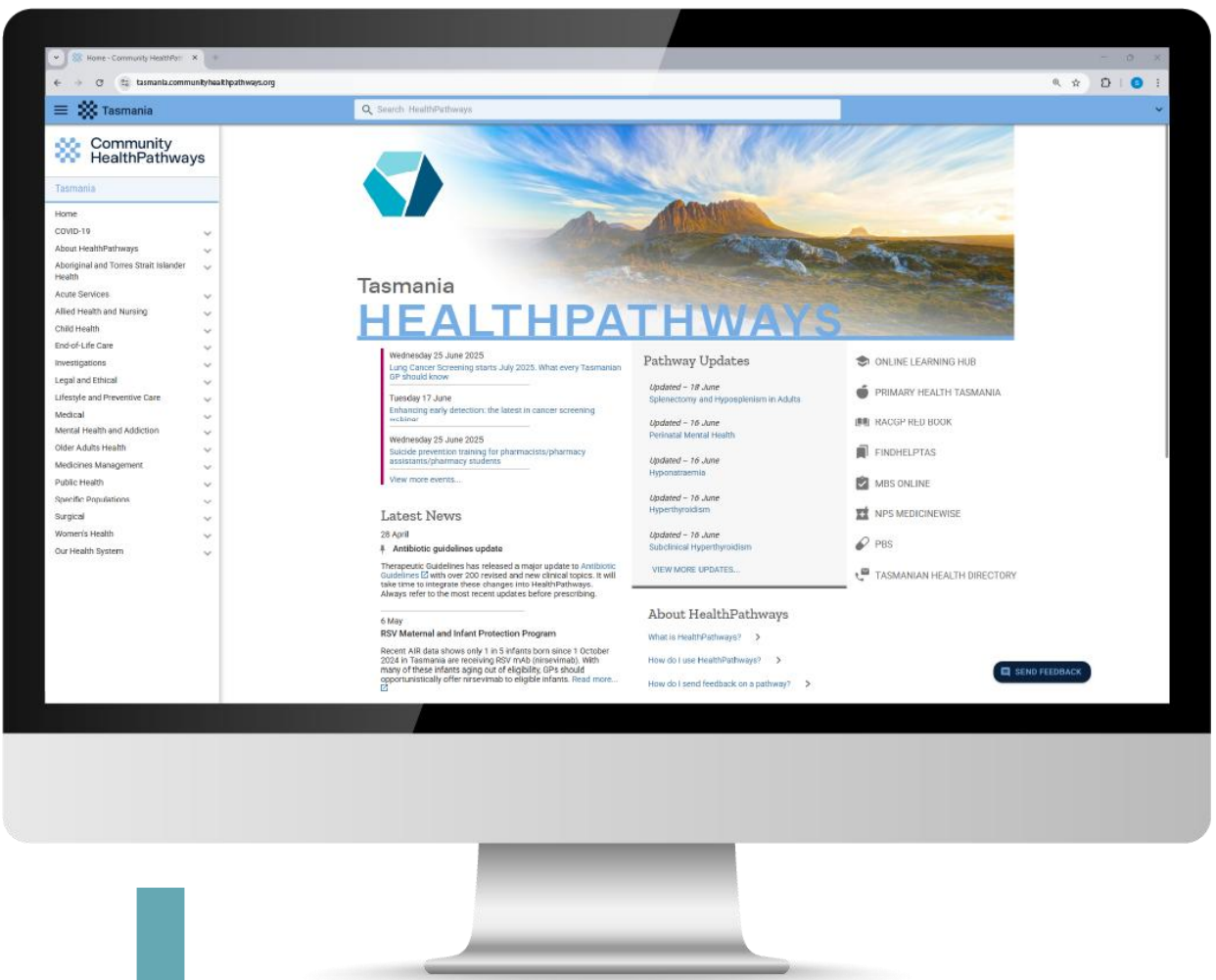
Community HealthPathways

Tasmanian HealthPathways



Scan here to register

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To sign in or register, please visit the Tasmania HealthPathways home page.



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HEALTHPATHWAYS

CPD Events

Tuesday 12 May 2026 – Online and in person, 6.30pm to 8pm (in person registration from 6pm)
Multidisciplinary Care in Diabetes: The Cycle of Care and Beyond

Wednesday 20 May 2026 – 6.30pm to 8pm
Dementia Care for GPs: Behaviour Support, Services and Psychotropics

View more events...

Latest News

4 May
Diphtheria outbreak in northern Australia
Primary Health Tasmania has issued a *Primary Care Alert* for local health providers regarding a diphtheria outbreak in northern Australia. Read more [here](#).

9 March
PRECISE Genomics in Primary Care portal now live
The [PRECISE Genomics in Primary Care Portal](#) helps GPs quickly identify genetic red flags and make appropriate referrals. It offers concise fact sheets, e-learning, and practical guidance to embed genomics in everyday practice.

30 January
Infant formula recall: Sanulac Nutritionals Australia
Public Health Services at the Tasmanian Department of Health advises that Food Standards Australia New Zealand (FSANZ) have issued a food recall for 2 batches of infant formula produced by Sanulac Nutritionals Australia Pty Ltd. [Read more...](#)

22 December

Pathway Updates

Updated – 14 May
Pruritus (Itch)

Updated – 8 May
Shoulder Pain

NEW – 8 May
Acute Shoulder Trauma

Updated – 8 May
Shoulder Dislocation and Chronic Instability

Updated – 8 May
Fibroids

VIEW MORE UPDATES...

About HealthPathways

[What is HealthPathways?](#)

[How do I use HealthPathways?](#)

[How do I send feedback on a pathway?](#)

-  [ONLINE LEARNING HUB](#)
-  [PRIMARY HEALTH TASMANIA](#)
-  [RACGP RED BOOK](#)
-  [FINDHELPTAS](#)
-  [MBS ONLINE](#)
-  [NPS MEDICINEWISE](#)
-  [PBS](#)
-  [TASMANIAN HEALTH DIRECTORY](#)
-  [PRIMARY HEALTH TASMANIA EVENTS](#)

CPD Hours for HealthPathways Use by Specialist General Practitioners

About Continuing Professional Development (CPD)

The aim of the continuing professional development (CPD) requirements of the [Medical Board of Australia](#) is to support quality, lifelong learning for doctors that is relevant, effective, and evidence-based.

The 3 core elements of CPD are:

1. [CPD homes](#) – for quality assurance
2. [Professional development plans](#) – for purpose
3. [Different types of CPD](#) – for value

Using HealthPathways for CPD

HealthPathways is a source of contemporary and practical clinical information, localised to the geographical region of the medical practitioner. Application of knowledge contained within pathways to the individual patient provides an opportunity for reflection upon current understanding of the patient's clinical condition, and how it may be improved. This reflective learning can be self-reported as a CPD activity.

- Clinicians with an [individual HealthPathways account](#) can access a [CPD Reporting](#) tool to help log their HealthPathways CPD activity.

CPD reporting

Allows clinicians to:

- view an automatic log of time spent in HealthPathways (this log is private and secure).
- select specific logs relevant to their personal CPD, and add reflections and learning notes.
- generate and export a PDF report for easy submission to CPD Homes.

To access CPD Reporting, clinicians need to be logged into their [individual HealthPathways account](#), and then click in the secondary pane on the [right-hand side of the HealthPathways site](#).

- Clinicians without an individual HealthPathways account can still self-report time spent in HealthPathways as a reflective activity. To help reporting, reflective learning templates have been developed for both colleges:

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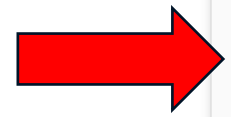
Page information

Topic ID: 1361051

CPD REPORTING

Add learning notes

Create a CPD report



Search results for **burns**

50 results found



[Acute Specialist Burns Advice](#)

[Non-acute Specialist Burns Assessment](#)



[Burn Injuries](#)

[Specialist Burn Services Requests](#)

[Hand Therapy Assessment](#)

[Non-acute Plastic Surgery Assessment](#)

[Specialist Wound Assessment](#)

[Education](#)

[Analgesia in Adults with Acute Pain](#)

This pathway is concerned with the management of acute pain only and does not apply to exacerbations of chronic pain or cancer pain. See also Analgesia in Children with Acut...

[Heat-related Illness](#)

[Oral Lesions, Ulcers, and Infections](#)

[Home](#)

Home

Surgical

Plastic Surgery

Burn Injuries

Burn Injuries

Assessment

1. Take a [history](#).

2. Perform a head-to-toe assessment with a primary survey using the [ABCDE](#) approach.

3. Assess the burn:

Sensation

Blisters

Capillary refill

Colour

Dermal elasticity

Pain – assess with gloved finger

4. Estimate the [total body surface area \(TBSA\)](#) burnt.

5. [Assess burn depth](#).

6. Consider [non-accidental injuries](#), particularly for vulnerable patient groups e.g., children, the elderly, and people with disabilities. If any concern for non-accidental injuries, seek [immediate advice](#) from Strong Families, Safe Kids Advice and Referral line on 1800-000-123 or call 000 if immediate threat to safety.

7. Review [criteria](#) for patients and burns that require transfer to the nearest emergency department for acute specialist burns management ([Australian and New Zealand Burns Association \(ANZBA\)](#) criteria).

8. If criteria for immediate treatment in the emergency department is not met, decide if the nature of the burn or the type of patient fulfils one or more of the [other criteria for acute specialist burns management](#).

Management

Practice point

Seek specialist advice early

Seek immediate [specialist advice](#) from the Tasmanian Burns Service if there are burn injuries > 20% TBSA in adults or > 10% TBSA in children.

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Burn Injuries

fulfils one or more of the [other criteria for acute specialist burns management](#).

Management

Practice point

Seek specialist advice early

Seek immediate [specialist advice](#) from the Tasmanian Burns Service if there are burn injuries > 20% TBSA in adults or > 10% TBSA in children or any uncertainty about appropriate management.

1. If the patient or the burns fulfil one or more of the [criteria for emergency management](#) in the emergency department, arrange transfer to the nearest [emergency department](#).
2. If the patient or the burn does not fulfil the criteria for emergency management in an emergency department, but does fulfil one or more of the [other criteria for acute specialist burns management](#), contact the [Tasmanian Burns Service](#) for advice about immediate management. These patients should be given appropriate [first aid treatment](#) in primary care.
3. Seek immediate [specialist advice](#) from the Tasmanian Burns Service if there are burn injuries > 20% TBSA in adults or > 10% TBSA in children, or any uncertainty about appropriate management.
4. Continue [first aid treatment](#).
5. Give immediate and adequate pain relief for [adult or child](#) – for severe burns, intravenous opioids are often required.
6. Give tetanus toxoid or tetanus immunoglobulin if [indicated](#).
7. Clean wounds with normal saline or 0.1% chlorhexidine if contamination is suspected. Remove all foreign bodies and loose or non-viable skin tissue.
8. Manage swelling:
 - Elevate all burned limbs on pillows as soon as possible.
 - Note that all circumferential burns to limbs, unless epidermal e.g., sunburn, require hourly monitoring of the colour, warmth, and capillary refill of the extremities.
 - Arrange immediate transfer to the nearest [emergency department](#) for emergency assessment if:
 - face, head, or neck is burned. Elevate the head of the bed while waiting for the ambulance.
 - deep circumferential burns with any sign of circulatory compromise.
 - torso burns with associated respiratory distress.
9. Treat eyes if affected:
 - Irrigate gently with saline

Q&A

Please place your questions
in the Q&A chat group now



Some final words

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Evaluation survey Plastics education series – Burns management in primary care



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