Introduction
This study aimed to identify factors associated with palliative care consultation and its impact on end-of-life decision-making in burn patients.

Methods
Retrospective case review was conducted at an American Burn Association-verified regional burn center from June 2007 to May 2016. End-of-life decisions analyzed included withdrawal of life-sustaining care, do-not-resuscitate (DNR) orders, and do-not-intubate (DNI) orders.

Results
From June 2007 to May 2016, 34 burn patients suffered in-hospital demise (79.4% male; mean age, 62 years). Average total body surface area (TBSA) burned was 28.7% (range, 0.21 – 99.6%). Nine patients (26.5%) received palliative care consultation. End-of-life decisions were made for 100% of patients who received palliative input. For patients who did not receive palliative care input, only 84% reached end-of-life decisions before demise. Patient age and hospitalization cost was matched between the two groups.

Inhalation injury, flame burns, higher TBSA burns, and higher percentage of body with 3rd degree burns were associated (p < 0.05) with lack of palliative consultation. Patients who underwent intubation (p = 0.11) and increased procedures (p = 0.19) were less likely to have received palliative consultation. Patients with longer length of stay (p = 0.16) and longer time to end-of-life decision (p = 0.13) were more likely to receive palliative consultation.

Conclusion
Lack of palliative consultation was associated with increased interventions, and the non-significant difference is likely due to sample size. All palliative consultations led to end-of-life decisions, indicating that consultations can help families make choices in light of poor prognoses.
Abstract 5 Healthcare Resource Utilization Associated With Burns and Necrotizing Fasciitis: A Single Center Comparative Analysis

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Objective: Necrotizing Fasciitis (NF) are non-burn wounds that due to similar needs are increasingly managed in regional burn units. Although treated similarly to burns, the healthcare resource utilization (HRU) appears to be increased. The goal of this study is to provide a better understanding of the HRU for NF as compared to burns.

Methods: A retrospective chart review of patients ≥ 18 yr admitted to a regional burn unit with either NF or burns requiring surgery. We examined age, sex, % TBSA, geographic region, anatomical location, cause/circumstance of burn injury, as well as NF injury type and bacteriology.

Results: There were 210 NF patients and 209 burn patients. The NF cohort had a smaller TBSA (3.3% vs. 10%), but a longer median LOS (20 days vs. 14 days) and consequently a longer median LOS/%TBSA (6.0 vs. 1.5 days). This persisted after adjusting for age. A significantly higher proportion of the NF cohort (44.8%) spent ≥ 12 h in intensive care unit than the burn cohort. The NF cohort also had significantly more procedures (median 2 vs. 1), required blood more often (46.2 vs. 16.7%), and were more likely to die in hospital (13.3 vs. 4.3%), have an amputation (12.4% vs. 4.8%) or a free tissue transfer (7.6% vs. 2.9%).

Conclusions: This study shows that NF requires significantly more HRU compared to burns even though they have a smaller TBSA affected. This needs to be accounted for in resource planning for burn uni
Abstract 55 Pain Management strategies for the Burn Patient

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Background: Adequate pain management during dressing changes is a critical element in providing burn care. Without this the ability to perform burn care is limited and it can be detrimental to the patient’s recovery, future pain tolerance, healing and scarring in the future.

Aim: To provide a multi-modal approach to pain control during burn care that best supports the patient’s experience.

Objectives:
Provide and discuss examples of the multi-modal approaches taken to controlling pain during dressing changes on the provincial burn unit. Discuss the new conscious sedation protocol that will be implemented on the unit for nurses to utilize without the presence of an anaesthesiologist. Discuss other adjuncts used during burn care

Methodology: A new protocol was developed for nurse led conscious sedation by the clinical educator after consulting other departments such as anaesthesia, perioperative pain service, complex pain and addiction service and psychiatry.

Impact/Outcomes:
After initiating this new protocol, we will achieve the following:
Adequate pain control during and after burn care procedures. Decrease any long term emotional distress and or anxiety associated with burn care. Ability for nurses to provide complete and thorough burn care during each dressing change

Conclusion:
The varying personalized pain control techniques provide the best possible pain management during burn care, and thus create the best overall experience for the burn patient.
Abstract 53 Outpatient burn care at BC Children’s Hospital burn treatment room: A 3-year review

Outpatient burn care at BC Children’s Hospital burn treatment room: A 3-year review

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Background/Purpose: The Burn Treatment Room (BTR) at BC Children’s Hospital (BCCH) is run by a multi-disciplinary team, providing sedation to burn patients undergoing dressing changes in a monitored setting. The purpose of this study is to review the safety and efficacy of the BCCH BTR in conjunction with a qualitative analysis of staff experience.

Methodology: A retrospective chart review of all patients treated in the BTR from 2013 to 2015 was conducted as well as qualitative interviews with BTR staff.

Results: 59 patients (average age 4.0 years old) with a total of 216 BTR visits (average visit time 64.75 minutes) were included. Scald burns were the most common mechanism of injury (76%), followed by flame (14%) and contact burns (7%). Most burns were superficial dermal (54%) and initially estimated at 5-10% TBSA (57%). A total of 38% of patients received surgical intervention. The majority of patients required intravenous sedation during dressing changes (72%), with the most common medication used for intravenous sedation being propofol (83%). Nine patients were converted from oral to IV sedation, 2 had short apnea periods that recovered spontaneously and 2 had prolonged sedation. Overall, there were no major sedation related complications. Interviews with 6 staff members revealed an overall positive experience and few safety concerns.

Conclusion: Our findings are consistent with current reports from other burn facilities. The BTR at BCCH is a safe and effective way to treat burn patients, preventing what would historically require inpatient management.