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757 **A Patient Inclusion Criteria Algorithm for New Burn Centers Seeking to Implement a Burn Registry**

Amanda Guilford, BS, Jeneva Garland, PharmD, Ransom Wyse, MPH, CPH, Lori Harbour, BS, NRP, Rebecca Smith, RN, Monica Bregman, MS, Samuel W. Jones, MD, FACS

*Chippenham Hospital, Richmond, Virginia; Center for Trauma and Acute Care Surgery Research, HCA Healthcare, Nashville, Tennessee; Center for Trauma and Acute Care Surgery Research, HCA Healthcare, Nashville, Tennessee; Center for Trauma and Acute Care Surgery Research, HCA Healthcare, Nashville, Tennessee; Chippenham Hospital, Richmond, Virginia; Chippenham Hospital, Richmond, Virginia; Chippenham Hospital, Richmond, Virginia*

**Introduction:** Data submissions to the NBR are based upon the standardized medical definitions and generalized guidance on patient inclusion criteria found in the ABA Burn Care Quality Data Dictionary. The guidance is complex, often leading to confusion in determining proper patient identification. This is most problematic for new burn centers seeking to implement a burn registry. Therefore, at our burn center, we designed and implemented an algorithm based on a thorough literature review and ABA guidance to improve the accuracy and efficiency of patient identification.

**Methods:** A review of the literature was conducted using the PubMed database. In addition, utilizing the ABA's multitude of resources including, the Burn Care & Quality Platform (BCQP) Data Dictionary 2020 version 1.1 patient inclusion criteria statements, a BCQP Q&A session on admission information, and Quality & Registry Community discussion boards, the following algorithm was developed by the compilation and simplification of the definitions provided for burn and non-burn injury patient inclusion criteria.

**Results:** A thorough literature review produced no articles that address NBR inclusion criteria. According to these documents, all patients admitted to the hospital for treatment of an acute burn or soft tissue wound should be included in the burn registry; however, a BCQP Q&A session expressed the Burn Service must provide medical care in order for a patient to be included in the registry. Furthermore, the BCQP Data Dictionary outlines patient inclusion based on a hospital length of stay >24 hours, a surgical operation, or expire at a hospital facility for registry inclusion. Observation patients and non-burn patient consults are excluded from the NBR. The ABA community discussion board revealed many centers only count and track non-burn injury admissions to the burn center service line. The compilation of information resulted in the development of a standardized algorithm defining a patient for registry inclusion.

**Conclusions:** A comprehensive review of the ABA resource documents was compiled to clarify the patient inclusion criteria for data submission to the NBR. The BCQP Data Dictionary 2020 version 1.1 patient inclusion criteria statements, the collaborative Ameriburn communities, and the BCQP Q&A session influenced the design of the clarification algorithm for patient identification to assist burn centers seeking to accurately and most efficiently implement a burn registry. Further research should be conducted on the utilization of the algorithm in comparison to other burn centers.

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758 **Constant evolution: Early experiences treating COVID-19 in a burn center**

Anthony P. Basel, DO, Garrett W. Britton, DO, Craig Yugawa, MD, Leopoldo C. Cancio, MD, FACS, FCCM

*United States Army Institute of Surgical Research, Fort Sam Houston, Texas; US Army Institute of Surgical Research, JBSA Fort Sam Houston, Texas; Brooke Army Medical Center, Fort Sam Houston, Texas; US Army Institute of Surgical Research, JBSA Fort Sam Houston, Texas*

**Introduction:** The COVID-19 pandemic came as an unexpected challenge to many healthcare systems around the world. Many centers struggled to provide COVID-19 ICU-level care while also maintaining adequate care for non-COVID-19-related conditions, especially in critical care specialty units like trauma and burn. We present a case series of our early experiences treating COVID-19 in a burn center.

**Methods:** We present a case.

**Results:** See Table 1. Though one case was admitted prior to initiation of universal testing, routine infection-control protocols limited exposure to personnel and prevented transmission to staff. In May 2020, we implemented the use of N95 mask and eye protection during all aerosolizing procedures, N95 mask use in all ORs, and universal surgical mask use in all rooms regardless of COVID-19 status. An in-house risk-stratification system was used to screen patients based on symptoms and exposure. Burn-center admissions were screened at a lower threshold than throughout the institution given the unique nature of burn injury. Eventually, because of increasing community spread, all admissions to the hospital were universally screened with RT-PCR prior to admission. To minimize exposure to non-COVID patients and Burn Center staff, COVID-19 positive burn admissions were assessed on a case-by-case basis. High acuity patients were admitted to the Burn Center and followed by the COVID consult team. Lower acuity patients were admitted to the Burn Center but were treated on the medical COVID unit and followed by the burn consult service.

**Conclusions:** The COVID 19 pandemic has strained healthcare systems worldwide. Development and implementation of universal screening, testing, infection-control precautions, and triage strategies are critical elements of burn care during the COVID-19 pandemic. As we prepare for future surges due to more transmissible variants, implementation of standard protocols enables continued provision of quality care, preservation of the healthcare workforce, and efficient use of resources.