
108 Development and Implementation of a Burn Nurse Educator

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Introduction: Prior to the introduction of the Burn Nurse Educator (BNE), at a growing and newly established burn center, the education of the Burn Trauma ICU staff was completed by the Burn Director and Burn Supervisor. In this burn center, large amounts of education became difficult to create and distribute by the current Burn Director and Burn Supervisor due to the demand of their respective job roles. The role of the BNE was to create initial and ongoing education for the Burn Trauma ICU Staff, Ortho-Trauma staff, ED staff, local EMS agencies, and the community.

Methods: The Burn Nurse Educator reviewed previous education that was provided to the staff, compared it to the Burn Nurse Competencies established by the American Burn Association, and was able to formulate a new education plan. The Burn Nurse Educator created several burn-based courses. These classes included: *Floating into Burn Care*, *Burn Boot Camp*, and *Burns in the Pediatric Population*. There was also the introduction of mock codes focused on the pediatric burn population. In addition to the formulation of these educational opportunities, the Burn Nurse Educator worked directly with the Quality Improvement Committee to find gaps in care. These gaps were then turned into project improvement plans and additional education was provided to the bedside staff. The Burn Nurse Educator formed relationships with local EMS agencies and was able to provide burn lectures and continuing education.

Results: Each class offered had a pre and post test administered, all with improved scores. A sample size of 30 nurses who enrolled in *Burns in the Pediatric Population* had a score increase from 46% to 94%. A sample size of 14 nurses had a score increase of 55% to 80% after enrolling in *Floating into Burn Care*. A sample size of 30 nurses who enrolled in *Burn Boot Camp* had a score increase of 71% to 95%. More importantly, the staff expressed a higher level of confidence when caring for a burn patient after these classes. The outreach with local EMS agencies also increased our EMS admits to the hospital, improved knowledge for caring for burn victims, and created a relationship with our local cities EMS.

Conclusions: It is anticipated that as the program continues to expand, the role of the Burn Nurse Educator will continue to grow and encompass new responsibilities. To ensure each nurse remains competent in their skill set, additional knowledge testing will be completed one year after a nurse has completed a class.

109 The Impact of Distance to Treatment Center on Long-term Outcomes of Burn Patients

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Introduction: Geospatial access to American Burn Association (ABA)-verified burn centers or self-designated burn care facilities varies across the country. It is often necessary to transport patients hundreds of miles to provide definitive burn care and rehabilitation services. This study evaluates the impact of distance to treatment center on long-term outcomes of burn patients.

Methods: Data from the National Institute on Disability, Independent Living, and Rehabilitation Research Burn Model System (BMS) National Database, collected from 2015 to 2019, were analyzed to investigate the impact of distance to BMS center on long-term, patient-reported outcomes. Distance was calculated as driving distance between home zip code centroid and BMS center. Demographic and clinical data were compared between groups by distance from BMS center (< 20, 20-49.9, >50 miles). The following patient-reported outcome measures, collected 12 months after injury, were examined: Veterans Rand 12 Physical Component Summary Score (VR-12 PCS), Veterans Rand 12 Mental Component Summary Score (VR-12 MCS), Satisfaction with Life (SWL), employment status, and days to return to work. Mixed regression model analyses were used to examine the associations between distance to BMS center and each outcome measure, controlling for demographic and clinical variables.

Results: Of the 726 participants included in this study, 191 (26.3%) and 204 (28.1%) were < 20 and between 20-49.9 miles from a BMS center, respectively; 331 (46.6%) were >50 miles from a BMS center. Greater distance to BMS center was associated with white race/ethnicity ($p < 0.001$) and employment at time of injury ($p = 0.001$). Greater distance to BMS center was also associated with flame injury ($p < 0.001$) and larger burn size ($p < 0.001$). There were no significant differences in length of stay or number of operations between groups. Regression analyses did not identify significant associations between distance to BMS center and VR-12 PCS, VR-12 MCS, SWL, employment at 12 months, or days to return to work.

Conclusions: After burn injury, patient-reported outcome measures of physical and psychosocial function, as well as employment, do not differ based on distance to BMS center.