

disaster resilience and can be utilized in educational and training settings for medical command and control.

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Integrating Response Plans for Burn Mass Casualty Incidents

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Introduction: Across the United States (US), there are approximately 2,000 burn beds in 133 burn centers, only 72 of which are verified by the American Burn Association (ABA). As such, many areas in the US are hundreds of miles from the closest burn center. Eight states do not have a burn center, and another 11 do not have an ABA-verified center. Further, the average center has 15 beds, and, on average, there are 90 available beds across the US. Therefore, in addition to patient care complexities, the broader infrastructure for burn patients is severely limited. These constraints suggest the burn healthcare system is particularly vulnerable to disasters, where the needs will exceed the resources available.

Method: A literature review was conducted of available burn mass casualty incident (BMCI) plans from stakeholders in each level of a response. These response partners included prehospital agencies, hospitals (those with and without trauma center designations), emergency management agencies (local, state, and federal), healthcare coalitions, public health (district, state, and federal), regional coordinating burn centers, and the ABA.

Results: The amalgamation of the BMCI plans yields a tripartite infrastructure not unfamiliar to emergency management professionals. The burn care agencies integrate into a response, similar to the way in which public health integrates into the emergency management infrastructure. The local to state to federal escalation of assets is reflected by an escalation from the local burn center to the regional coordinating burn center to the ABA. However, gaps remain in the communication between response partners. Few plans, particularly at the local level, reflect the integration of the burn system response.

Conclusion: The burn healthcare infrastructure in the US is constrained and therefore is particularly vulnerable to a BMCI. Emergency responders should preemptively examine their plans and systems to specifically integrate the burn care and response infrastructure.

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Role of General Practice Led Observation Ward to Support Emergency Ward to Improve Health Outcomes at a Major Kathmandu Hospital in Nepal

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Introduction: Tribhuvan University Teaching Hospital (TUTH) is a tertiary care hospital in Kathmandu. The emergency department sees between 130 to 140 cases per day.

These patients get initial evaluation and basic investigation for acute emergency management and treatment. Those requiring further treatment are then admitted to the department of General Practice for post emergency care which acts as an observation ward. This step allows for the patients to be observed on a short-term basis and permits patient monitoring and/or treatment for an initial 24–48 hour period and up to a maximum of five days. These steps allow for focused follow up, improved efficiency and minimizes inappropriate admissions to other hospital inpatient wards. This paper evaluates functionality, admission criteria, patient categorization and subspecialty referral to specialty patient care, discharge criteria and cost effectiveness.

Method: A descriptive observational study was carried out of the patients admitted to the observational ward between 2020–2021.

Results: Most articles suggest these wards improve patient satisfaction and clinical care, decrease length of stay, reduce unnecessary inpatient hospital admissions and are useful in fever under evaluations, COPD, poisoning, pneumonia, mild head injuries, high sugar, hypertension, gastroenteritis etc. Around 14% of patients were sent to the observation ward after acute emergency care. 84% were discharged from observation ward with a mean stay of three days and were followed up in community care or GP OPD. Nine percent were admitted to hospital wards, and 7% transferred to yellow/red area emergencies for derange vitals.

Conclusion: Observation wards seem to have advantages, excluding those who will inevitably need longer treatment, reduces cost savings and unnecessary burden of hospital admission.

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Quality Improvement Project: Optimizing Compliance with NICE CG176 Head Injury CT Time Standards at Wexford General Hospital Emergency Department

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Introduction: Head trauma is a high-risk presentation to the emergency department (ED). Preventing secondary brain injury through earlier diagnosis and intervention relies on timely access to head CT. Wexford General Hospital (WGH) ED uses NICE guidelines, which recommend specific timeframes for acquiring CT in head trauma. Following an audit demonstrating low compliance to NICE CG176 time standards in