Greetings! It is an honor to have been recently bestowed the privilege of chairing the ABAs Burn Prevention Committee (BPC). This talented and passionate group of multidisciplinary experts represents an impressive array of professional backgrounds. While diverse in professional pedigrees, they are unified in their commitment to making a difference in the lives of people through the prevention of burn injuries. The BPC embodies the mantra that it “takes a village” to successfully reduce injury incidence. This newsletter edition highlights several great examples of the power of using multidisciplinary collaborations to reduce injuries. Read on to learn how you can join the call-to-action to find creative and innovative ways to prevent burn injuries from continuing to occur throughout the world!

As we look to the future, the BPC is applying a strategic approach to “raising the bar on burn prevention.” Results from a recent multi-center survey indicate that burn professionals across the United States do not have updated knowledge on best practices in fire safety and burn prevention. Providing accurate, consistent prevention education that targets patients, families, and high-risk populations in the community is essential in reducing the national incidence of burn injury. A new priority of the BPC is to “raise the bar” on injury prevention by addressing the identified knowledge gaps and using a research-based strategic approach to facilitate implementation of current best practices. Two new subcommittees have been established to assist with these goals: 1) Burn Prevention Research and Data; and 2) Burn Prevention Education Materials, Media, and Advocacy. Tasks of these groups will include promoting and facilitating collaborative burn/fire prevention research at the national/international level; acquiring comprehensive quality data to direct research priorities; compiling an easily-accessible repository of burn prevention and fire safety resources; updating safety education materials; developing seasonal burn prevention PSAs; and expanding the reach of the BPC.

You spoke, we listened! The national survey also revealed that over 90% of responding burn professionals want best practice fire safety burn prevention fact sheets for use in patient education. A priority of the BPC is to develop these materials, and to train burn professionals on specific methods to incorporate fire safety and burn prevention in your own home, in burn patient and family education, and in community outreach activities. If you are interested in assisting, please don’t hesitate to contact me at: kahrns@med.umich.edu

Yours in prevention,

Karla S. (Ahrns) Klas
Chair, ABA Burn Prevention Committee
FROM ADMIN TO ADVOCATE:
How Support from Leadership Can Make a Difference
Tina L. Palmieri, MD, FACS, FCCM

Burn injuries are devastating. They impact the person who was burned as well as family, friends, and society as a whole. Once the injury has occurred, some type of damage is inevitable, be it physical, psychological, or social. We as burn providers have insight into the impact of burn injury, and we have built teams dedicated to improving the lives of burn survivors. But we cannot “fix” everything. Wouldn’t it be better for all concerned if the injury never happened? Isn’t burn prevention everybody’s business?

Burn prevention, similar to burn care, is best approached as a team. The many facets of burn prevention need people with different skills, insights, and passion for prevention to be most effective. The leader of the burn prevention team brings together people with diverse backgrounds, provides an environment which fosters collaboration, encourages input from all team members, and helps the team to establish and achieve goals. There are many challenges to this process. Clinical demands are high, funding is limited, and everyone has other responsibilities. Yet burn prevention needs to be a priority.

What is the best way to foster burn prevention? First recognize that burn prevention is important and deserves attention. Second, learn about ongoing prevention initiatives. Prevention opportunities exist locally, state-wide, nationally, and internationally. Learning about these resources will not only be informative, but can also improve your ability to care for burn survivors and provide an opportunity to develop new collaborations and alliances. And you might just have fun. Third, talk to people interested in prevention, encourage their efforts, and provide them with support. This does not necessarily involve exorbitant expenditures of money (although money always helps). It may be as simple as attending a conference, informing legislators about burn injury impact, helping gather data on a preventable injury, supporting an outreach program, giving people working on prevention time to carry out their prevention efforts, advocating for burn prevention, or talking to a patient about burn prevention.

Burn prevention is everybody’s responsibility. By working together, we can make a difference.

Across the deep blue…
a unique approach to researching house fires

Owain Thompson and David Wales

Within the United Kingdom, no other type of fire has the same human impact as an accidental dwelling fire (ADF). Although only constituting approximately 10% of all reported fires, ADFs are the cause of almost 70% of all reported fire-related injuries and deaths. However, despite this, very little is known about what people do when they discover a fire in their home, what motivates them to take specific actions and how those actions relate to the final outcome of the incident. While fire prevention work has been very successful, Kent Fire and Rescue Service (KFRS) recognized that developing a greater understanding of people’s actions during and after such fires, will be of enormous value in further reducing the number of deaths, injuries and damage to property that occur as a result of this type of fire.

Consequently KFRS asked its Fire Investigation and Research Team (FIRT) to develop what is now a large scale project to build a generalized yet comprehensive understanding of behaviors motivations and associated timescales of those who have experienced an ADF.

At the heart of the research is a survey questionnaire which, following a trial in Kent, will now be rolled out across fire and rescue services within the South East of England and then made available throughout the UK.

National Scald Prevention Campaign

B. Daniel Dillard

Scalds are the leading cause of burn injury in young children, aged 0-4 years old. Of all scald burn injuries, from birth to death, 40% occur to young children aged 0 – 4 years of age. Over 40 per cent of all types of burn injuries treated in hospital emergency departments are scalds. The primary causes of scald injuries are stove top/heat, hot beverage spills, hot tap water, steam and excessively hot food. The majority of scalds occur in the home. A higher incident of scald injuries occur in lower-income households, as well as single parent households. Hospitalized fire and burn injuries total $1 billion each year, with scalds being the leading cause of burn injuries. Source: American Burn Association: National Burn Repository - 2010 report (5 year review 2005 – 2009).

The grim statistics above were the call-to-action for the ABA Burn Prevention Committee and its national partners to collaborate on a sustained effort to reduce the prevalence of scald injury in North America, especially to young children. The result has been the development of a National Scald Prevention Campaign. Thanks to a series of three FEMA Fire Prevention & Safety Grants secured by the International Association of Fire Fighters, project collaborators (American Burn Association, Federation of Burn Foundations, International Association of Firefighters, International Association of Fire Chiefs and SafeKids Worldwide) have completed two phases.

Continued on pages 6 & 7
LESSONS FROM THE FIELD: Keys to Success for Smoke Alarm Promotion Programs

Eileen M. McDonald, MS

ABA members Andrea Gielen and Eileen McDonald, in collaboration with colleagues from the Johns Hopkins Center for Injury Research and Policy and a variety of community partners in Baltimore, are in the final phase of a multi-year study to enhance and evaluate a long-standing smoke alarm distribution program in their city. The Home Safety Project (2009-2013) is supported through funds from the Centers for Disease Control and Prevention and the National Institute of Child Health and Human Development.

The multi-phased program included:

1. Formative work to establish baseline rates of working smoke alarms in the community and to solicit input from community members and fire personnel about their perceptions of and experiences with the existing smoke alarm home visiting program;
2. Implementation and monitoring of the enhanced home visiting program between April 2010 to April 2011 with over 3000 homes;
3. Evaluation of the program through a follow up household survey 6-9 months after the home visits; and
4. Dissemination of program results.

Dr. Gielen described the program and some of its results at the 45th annual meeting. Manuscripts about each phase of the program have been published or are underway. Currently, a dissemination brochure is in its final production stage and will be posted to their website (www.jhsph.edu/InjuryCenter) free of charge. The brochure will be used to promote the program and its findings to a broader audience, including fire service leadership, health professionals, and public health and injury control colleagues. The major recommendations from the Home Safety Project include:

1. Expanding the number of fire departments that provide home visiting programs;
2. Collaborating with community health workers to increase the number of residents who participate in home visiting programs;
3. Enhancing implementation of the home visiting programs to maximize impact; and
4. Expanding partnerships with new community organization and agencies that can help promote fire and life safety.

During the 13 month implementation phase, 21 fire companies participated in a total of 171 home visiting events. Of the 3216 homes where someone was home, successful completion of 2197 homes visits where water temperature was tested, 3816 new homes were installed with 10-year, lithium battery tamper resistant alarms and 344 new CO alarms were provided and 712 coupons for reduced cost alarms were distributed.

NEW ABA BURN PREVENTION SUBCOMMITTEES

Materials, Media & Advocacy

B. Daniel Dillard

The ABA Burn Prevention Committee has responded proactively in follow-up to the National Partnership Conference held by the ABA this past March in Washington, D.C., by creating a special subcommittee on Burn Prevention Education Materials, Media and Advocacy chaired by Burn Prevention Committee immediate past chair, Dan Dillard. Dan explained that the purpose of this subcommittee is to advance the strategic initiatives of the burn prevention committee as presented to the ABA Board of Trustees. “We will be responsible for establishing the ABA/BPC as the leading authority expert on burn prevention information; compiling easily-accessible repository of burn prevention and fire safety resources; developing/updating educational materials for patient teaching (per IP survey results); developing seasonal burn prevention PSAs and rapid media response statement; and evaluating if ABA/BPC should reinstitute coordination of the Burn Injury Awareness Week”, stated Dillard.

The Burn Prevention Committee will work closely with other ABA standing committees as it develops work plans for these initiatives and formulates specific proposals for action by the ABA BOT.

Research and Data

Carlee Lehna, PhD, APRN-BC

As a need identified by the ABA Burn Prevention Committee, a new subcommittee has formed and will be responsible for promoting & facilitating collaborative burn/fire prevention research at the national/international level. In addition, members of this subcommittee will identify research priorities; collaborate with Burn Epidemiology SIG, NBR & Research Committees to promote prevention research and quality data; and mentor & support inexperienced researchers.

At a result of their first teleconference meeting, members reviewed and refined the research sub-committees’ goals. These goals are:

1. Identify burn prevention (BP) research priorities;
2. Promote and facilitate BP research at the national/international level;
3. Collaborate with other American Burn Association committees (e.g., Burn Epidemiology Special Interest Group, National Burn Repository and Research Committees) to advance mutual research endeavors and expand quality data availability;
4. Investigate the possibilities of multi-site projects;
5. Mentor and support researchers at all career levels.

Continued on page 7
**Initial First Aid Treatment for minor Burns**

**Ernest Grant, RN, MSW**

Think of the skin as a coat of armor for the human body. When a burn injury occurs, it causes a break in the skin and may subsequently cause an infection if it is not treated appropriately or right away. Frequently the question is asked, “How do I treat a minor burn?”

The American Burn Association’s Burn Prevention Committee recommends the following guidelines for the treatment of minor burns. Please note that even a small burn, may have the potential to become infected. It is always advisable to seek medical attention as soon as possible. Remember when in doubt or if you think the individual’s life is in danger, call 911. Remember if you call 911 using a cell phone you may or may not get the local 911 for the area you may be in. Remain calm and provide the operator with the necessary information to get the EMS personnel to you.

Burns are primarily divided into three categories, first-degree or superficial burns, second-degree, or partial thickness burns and Third-Degree or full thickness burns. How these types of burns are treated initially will determine whether there is a successful outcome.

**First-Degree burns** – are burns which involve the outer most layer of skin and are usually associated with a sun burn. Such an injury may occur from too much exposure to the sun (gardening, sunbathing, etc.). The skin is usually still intact, but may appear to be red, very warm or hot to touch and painful. There may also be small blisters, and swelling in and around the area of injury. Initial first-aid treatment for a first degree burn includes the following:

**DO’s**

- Stop the burning process: **cool the burn with running cool (not cold) water for at least 5 minutes**. But do not use ice, as this may cause further skin damage. Do not over cool! If the victim starts to shiver, stop the cooling process.
- Remove all jewelry, watches, rings and clothing around the burned area as soon as possible.
- Administer an over-the-counter pain reliever such as ibuprofen or acetaminophen for pain control. Follow the directions on the label. Consult a physician or health care provider if pain is not relieved.
- Cover the burn with a sterile gauge bandage or clean cloth. Wrap the burned area loosely to avoid putting too much pressure on the burn tissue.
- Minor burns will usually heal without further treatment.
- For small area burns, apply soothing lotions that contains aloe vera to the burned area to help relieve the pain and discomfort.
- Seek medical attention if there is a persistent fever not relieved by medication or redness that may extend beyond the border of the burn or pain is not controlled by ibuprofen or acetaminophen.
- Drink plenty of fluids (electrolyte containing solutions such as gator aid) if the person appears to be dehydrated.

**DON'Ts**

- Do not apply ice – this may cause further damage to the skin.
- Do not use any butter, ointments or other home remedies on the burn. Such substances may trap the heat in the tissue and makes the burn worse.
- Do not break any blisters…leave intact.
- Do not delay seeing medical attention if the burn is larger than the size of the victim's palm.

**Second degree burn** – occurs when the second layer of skin (dermis) is burned. This burn usually has the following characteristics: very red, blister formation, extremely painful and a fair amount of swelling. In general, if a second degree burn is smaller than 2-3 inches (7 centimeters) it may be treated as a minor burn. If the area burned is larger than this, or involves functional parts of the body such as feet, face, eye, ears, groin or located over major joints, more in-depth medical attention is needed.

Take the person to the nearest emergency room, family doctor or minor emergency clinic to have the burn evaluated. Failure to do so may result in permanent disfigurement or loss of function.

**Third degree burns** – are NOT minor burns and should be evaluated and treated by a healthcare provider. A third degree burn is a very serious burn, no matter what the size or area of the body that may be involved. A third degree burn involves all layers of the skin and can cause permanent tissue damage. The skin may appear to be charred, blackened, or white. The skin texture may be very dry or leathery. All third degree burns should be evaluated by a healthcare provider immediately.

**Healing** – it may take several days for a mild first degree or second degree burn to heal. During that time, it is important that the affected area is observed for infection such as redness extending beyond the burned area, changes in the appearance of the wound or slight fever not relieved by Tylenol. As your skin begins to heal, you may also notice that it will itch, which can be very uncomfortable at times. This is normal and will eventually decrease. Frequent application of lotion can help keep the skin hydrated and minimize the itching process. If the itching is too severe, an over-the-counter medication such as Benadryl® may be helpful in easing the discomfort. Remember...always follow the directions on the label. The wound should be kept clean with daily dressing changes. If you have any concern or questions, consult your healthcare provider. Once the burn has healed, limit the exposure of the burn skin to direct sunlight. Always wear sun protection.

Following the above guidelines should promote healing to most minor burns. It is important to note that the consumer should always seek the advice of a healthcare provider if there is any question regarding the healing process of a minor burn. The American Burn Association and the Burn Prevention Committee is not responsible or liable for any untoward complications suffered by any individual following these suggested guidelines.
Save Yourself! Annette Matherly, RN, CCRN

Burn Centers are critical to a community’s response to major disasters and emergencies. This community resiliency centers on the ability of its leaders to develop plans and provide guidance to others in their regions, especially non-burn centers. But whether it is a fire, flood or zombie apocalypse, we as ABA leaders have the responsibility to not only educate and help prepare our communities, but also to be ready ourselves.

Whether an emergency or disaster keeps you at home or requires you to evacuate, you’ll be better prepared to deal with the situation, and to help others, if you have adequate emergency supplies on hand. Water, food, and articles needed to maintain your body temperature and provide protection against the elements are the most important items to include. Also, certain individuals require prescription medications to sustain their lives.

Tips:
Consider creating two types of kits: one that has everything you will need if you are required to stay in your home and a smaller, lightweight version to take with you if you have to evacuate. Both kits should include enough supplies to take care of your needs for at least three days.

Workers and students should consider keeping a small kit at their place of work or school. For those who spend a lot of time in the car, keep a kit in the trunk.

Must-Haves:
- Water, one gallon of water per person per day for at least three days, for drinking and sanitation
- Food, at least a three-day supply of non-perishable food
- Battery-powered or hand crank radio and a NOAA Weather Radio with tone alert and extra batteries for both
- Flashlight and extra batteries
- First aid kit
- Whistle to signal for help

Dust mask, to help filter contaminated air and plastic sheeting and duct tape to shelter-in-place
- Moist towelettes, garbage bags and plastic ties for personal sanitation
- Wrench or pliers to turn off utilities
- Can opener for food (if kit contains canned food)
- Local maps

Additional Items:
- Prescription medications and glasses
- Infant formula and diapers
- Pet food and extra water for your pet
- Important family documents such as copies of insurance policies, identification and bank account records in a waterproof, portable container
- Cash or traveler’s checks and change
- Sleeping bag or warm blanket for each person.
- Complete change of clothing including a long sleeved shirt, long pants and sturdy shoes. Consider additional clothing if you live in a cold-weather climate.
- Household chlorine bleach and medicine dropper - When diluted nine parts water to one part bleach, bleach can be used as a disinfectant. Or in an emergency, you can use it to treat water by using 16 drops of regular household liquid bleach per gallon of water. Do not use scented, color safe or bleaches with added cleaners.
- Fire Extinguisher
- Matches in a waterproof container
- Feminine supplies and personal hygiene items
- Mess kits, paper cups, plates and plastic utensils, paper towels
- Paper and pencil

As we all prepare for the unthinkable, our challenge is to work together pro-actively to achieve the impossible.

Scald Prevention Campaign Continued from page 2

of the 3-Phase Campaign Roll-out. The final phase, Phase 3, will be completed by Fall 2014, culminating with a full National Roll-out.

During Phase 1, the partners developed turnkey tools in a toolkit to help fire fighters, burn foundations, burn centers, community groups and fire departments to educate their communities about scald prevention. The national partners also compiled scald data from various sources and burn registries and produced a comprehensive Scald Fact Sheet. In Phase 2, the tool kit was utilized in five high risk Target Areas. Based on the results of that pilot test, enhancements were recommended to the Scald Prevention Toolkit, and a National Roll-out strategy developed.

Presently, in Phase 3, Campaign developers will: create a scald prevention educational video for high-risk audiences; establish a dedicated web portal allowing all users to access all program materials; launch a social media campaign to create an awareness among the target constituency of the National Scald Prevention Campaign and where to access Campaign Resources; develop a series of up to 4 Campaign streaming video public service announcements; develop a series of up to 4 Campaign radio public service announcements; and develop an evaluation protocol to assess the effectiveness of the social media campaign to promote the use of the products of the National Scald Prevention Campaign Toolkit.
Home Medical Oxygen and Smoking: A Preventable Injury
Rebecca Coffey, RN, MSN, CNP

Home oxygen therapy (HOT) is the treatment of choice for the hypoxemia related to COPD (Chronic Obstructive Pulmonary Disorder). Currently there are 800,000 people using home oxygen therapy (HOT) in the United States with the numbers continuing to grow. While the use of home oxygen allows people to stay out of the hospital there are dangers associated with home oxygen in the home. As the use in the home increases, so do burn injuries related to HOT therapy. Between 2003 and 2006 an estimated 1,190 thermal burns occurred annual from HOT therapy; however, the true incidence is unknown because many injuries go unreported.

The greatest cause of HOT injuries, deaths and property damage are from smoking materials (over 70%) followed by use of the stove (10%) or candles (9%). The use of nasal prong oxygen allows a significant amount of oxygen to exit the prongs and bathe the lower face with oxygen. The oxygen tubing acts as a torch and the flame travel quickly down the tubing toward the oxygen source. Patients continue to smoke in alarming numbers upwards of 50-80% while using home oxygen despite the risks.

Patients on average get 10 minutes of teaching and patient education handout when started on HOT therapy. Teaching topics include fire safety, no smoking, no open flames, care with using electrical equipment that may spark, avoiding static electricity, avoiding petroleum based products on the lips and nose or lower part of your face, proper storage of the equipment and traveling with oxygen. When the DME (Durable Medical Equipment) Company delivers the equipment a home safety inspection is done by the DME Company to look for hazards, and door signs are posted that home oxygen is in use. Some companies will ask the patient to sign a contract stating that they confirm they have been trained in the safe use, they have received patient education, they have been trained in the storage and that they agree not to smoke.

We have many opportunities to improve prevention for these injuries. To date evaluation of the teaching provided to patients has not been done. How do we know that they understand what has been taught and how often should follow up education occur? Is there an opportunity for a structured education program with a pre and post-test? Do random home inspections by the DME Company occur? If so, is this ethical? What would the consequences be? Removal of oxygen from the home? Reporting of the unsafe use of oxygen to the payer – Medicaid, Medicare or private insurance company? Again is this ethical? Who is liable for the unsafe condition? There are lots of unanswered questions, however we have many opportunities to develop burn prevention programs regarding home oxygen safety.

The second issue is that despite smoking being the number one cause of HOT related injuries, up to 50-80% of home oxygen users continue to smoke. Smoking cessation is encouraged but not mandated. Smoking is highly addicted and less than 3% of attempts to quit are successful for 12 months. Currently there is no guidance from national organizations about prescribing home oxygen and smoking. All too often, oxygen-dependent smokers are unable to give up the habit which likely contributed to their illness. If confined to their home, they frequently persuade sympathetic friends and relatives to make smoking materials available, despite the danger involved. Sufficient follow-up and ongoing assessment is needed. Providers are the key in assessing smoking cessation, and the safe use of home oxygen. In a study by Lacasse et al of 890 patients on home oxygen only 5% were asked about their compliance with not smoking on home oxygen. Patients who smoke must be offered nicotine replacement therapy but how often is this done? Should providers monitor cotinine levels at office visits? If cotinine levels are positive then what? Mandatory smoking cessation programs, discontinuation of home oxygen therapy? Is it ethical? Our opportunity is in educating providers on how to monitor safe home oxygen use and provide safety education to patients.

HOT injuries are preventable. National standards on education and follow up for home oxygen users need to be developed. Smoking cessation programs are key. Other prevention measures may be to develop less combustible materials for the nasal cannula and more efficient delivery systems for home oxygen. Finally, structured ongoing education programs to prevent these injuries will allow patients using home oxygen to remain in their homes. The prevention of HOT injuries will decrease health care costs, and protect caregivers as well as patients from unnecessary injuries.

Researching house fires Continued from page 2

By giving new focus and weight to the narrative of those who have experienced a fire, this work has already challenged many assumptions and allowed KFRS to radically re-assess its approach to reducing the impact of fire (and other incidents). While initially it was expected to primarily inform a new range and style of targeted prevention messages, it has quickly become clear that the project has application to many aspects of the service including risk profiling, call handling and operational procedures and post fire services.

The survey results and related research provide an ability to really focus on the victims’ needs, experience and expectations and place them at the heart of what we do. This is also affirming our ability to work with partner agencies including the burns care sector.

There appears to be some commonality between this project and the ABA Prevention work, particularly in terms of a commitment to achieving the best possible outcome for the victim and ensuring effective and casualty centered multi-agency procedures.

Kent Fire and Rescue Service are partnered in this unique research project by the Fire Safety Engineering Group at the University of Greenwich. The university team is headed by Professor Ed Galea, one of the world’s foremost experts on evacuation behavior. As a
A
toughed over by society, youth fire misuse represents a significant problem for families, schools, fire departments, and communities. Fire misuse behaviors (firesetting, arson, playing with lighters, experimenting with bottle bombs, igniting aerosols, etc.) are associated with devastating costs, injuries, and lifechanging consequences. Many people are not aware that these behaviors can also result in criminal charges, when in fact children under 18 years old account for nearly 50% of all arson arrests in the United States.

To help communities and agencies address this challenging issue, a video toolkit is available free of charge. Funded by a FEMA grant, the “Sean’s Story” toolkit was created with input from a large group of multidisciplinary, nationally-recognized experts in youth firesetting prevention and intervention. This group included burn clinicians, firefighters, mental health professionals, safety experts, juvenile justice, police, arson investigators, and specialists in youth education. The “Sean’s Story” toolkit and its associated website (www.traumaburn.org/Seans-Story):

- Tells the true story of a convicted juvenile arsonist and the long-term consequences that can occur if fire misuse behavior is minimized, ignored, unrecognized, or untreated.
- Is a unique prevention and intervention tool for organizations and professionals committed to youth education and safety.
- Facilitates appropriate and constructive discussion regarding high-risk fire misuse behaviors.

Who Will Find This Video Toolkit Helpful?

Organizations and professionals committed to youth education and safety, including: burn centers, schools, fire departments, public educators, law enforcement, mental health, juvenile justice, injury prevention programs, youth assistance, hospitals, medical clinics, community organizations, and social service agencies. The most effective, comprehensive approach to firesetting prevention and intervention is to engage community collaboration and build multidisciplinary partnerships. For ideas, refer to the online “Call to Action: Coordinated Community Efforts” handout.

To request a free copy of the toolkit or obtain supplemental materials, visit: www.traumaburn.org/Seans-Story

For additional information, contact: Karla S. Klas, BSN, RN, CCRP at kahrns@med.umich.edu

Research and Data

Continued from page 3

The subcommittee agreed to examine existing burn prevention research to identify gaps in the literature (e.g., scald prevention versus home fire safety) and in format style (e.g., classic review of the literature versus evidence-based guides versus an update of an existing Cochrane Review) in the identification of their first project. Other Burn Prevention committee members were surveyed as to their burn prevention research literature expertise (e.g., familiarity with large data bases or older adult burn prevention literature). Anyone interested in getting involved, please contact Carlee Lehna at colehn01@louisville.edu or ABA Burn Prevention Committee Chair, Karla Klas at kahrns@med.umich.edu.

result of this project, there have already been 3 articles published and 5 presentations at various conferences.

Although the initial focus is on accidental fires in dwellings the underpinning research model is expected to be transferable to developing improved understanding of human behavior issues in a range of other civil contingencies.

For further details on this project please visit: www.kentfirt.info
2014 Burn Prevention Award Nominations

Do you know someone who has been the catapult for a local, statewide or nationwide prevention effort? Do you know someone who’s prevention model benefits other prevention programs within your organization, your local region, statewide or nationwide? The Burn Prevention Award is awarded at the ABA Annual Meeting to an ABA member for contribution in burn prevention with these in mind. Any individual is eligible for this annual award if the work is new and significant and continues to fulfill at least one of the above criteria. The award, under the auspices of the ABA Burn Prevention Committee, includes an honorarium of $1,500. Individuals wishing to nominate an ABA member for this award must submit the completed nomination forms by October 30, 2013. Form MUST be completed for nominee to be considered.

2013 Prevention Poster Contest Winners

ABA 45th Annual Meeting • April 2013, Palm Springs, CA

POSTER CONTEST WINNERS (counterclockwise from top):
1st Place Winner: Children’s Hospital Colorado Burn Program
2nd Place Winner: Shriners Hospitals for Children, Northern California, Sacramento, CA
3rd Place Winner: Firefighters Burn Institute Regional Burn Center at UC Davis, Sacramento, CA
People’s Choice Award Winner: The Hospital for Sick Children, Toronto, ON Canada

3rd Place

People’s Choice

Not all fairy tales have a happy ending
70% of childhood burns are scalds... they are 100% preventable