



# Healthcare Practitioners' perspectives on paediatric burns management at Korle Bu Teaching Hospital, Ghana

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## ABSTRACT

**Background:** Paediatric burns pose significant challenges in healthcare management. Paediatric burns require specialized care due to the distinct anatomical and physiological characteristics of children, which make them more vulnerable to complications. In resource-limited settings like Ghana, the absence of adequate supplies and standardized protocols can exacerbate these challenges, necessitating the need for a comprehensive understanding of the perspectives of healthcare practitioners involved in their care.

### Study Objective.

To explore healthcare practitioners' perspectives on paediatric burns management at a tertiary hospital, Ghana, covering current practices, barriers, impacts on patients and families, and recommendations for improvement.

**Methodology:** This study employed a qualitative research approach utilizing Focus Group Discussion (FGD) with 15 participants from various disciplines, including Plastic Surgery, Medicine, Anaesthetics, Physiotherapy, Occupational Therapy, Dietetics, Nursing, Pharmacy, Clinical Psychology, Public Health Nursing and. Laboratory Scientist. Participants were recruited through a convenience sampling technique. The discussion lasting approximately 90 min, were audio recorded, and facilitated by a discussion guide based on existing literature. The audio recordings were transcribed verbatim, and the transcripts were compared with handwritten notes for accuracy. The final transcribed data were coded and analyzed using thematic content analysis to identify recurring themes and patterns.

**Results:** Findings revealed four primary themes: strengths of current practices (multidisciplinary approach, experienced practitioners), barriers (lack of formal protocols, infrastructure limitations, financial burdens), contextual factors influencing burn care (psychological trauma, inadequate support, socio-cultural beliefs and socioeconomic status), and recommendations for enhancing burns care (improved social welfare, facility upgrades, staff training and mental health support).

**Conclusion:** While burns care has improved in Ghana, there are clear opportunities for improvement. A move towards more integrated care, the development of locally adapted protocols, better financial support, and enhanced caregiver education are essential next steps in elevating the quality of paediatric burn management in Ghana.

## 1. Introduction

Paediatric burns represent a serious public health issue due to their high incidence rate and potential for long-term consequences [1]. Burns is reported to be the third common cause of death in children between 1 to 9 years of age [2]. In sub-Saharan Africa, approximately 300,000 new burn cases occur annually in children under five years of age [3].

Children who sustain burns face not only psychological, emotional, and physical challenges but also significant financial hardships for their families and strain on the healthcare system [4]. While the incidence of burn cases has been declining in high-income countries (HICs), where advanced treatment protocols have been developed, the opposite trend is observed in many LMICs [5,3,6].

The management of paediatric burn cases demands unique and

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specialized approaches compared to adult care [7]. This is largely due to the anatomical, physiological, and psychosocial differences between children and adults [8]. Children have different body proportions, thinner skin, smaller airways, reduced blood volume, and are more prone to distress [9]. These factors make them more vulnerable to severe outcomes following burn injuries, necessitating specialized care [10]. For instance, for children, burns involving more than 10 % of their total body surface area necessitate formal fluid resuscitation and careful maintenance to address these distinct needs [8]. Preston et al., [7] further noted that, distinct considerations for paediatric burn cases include specialized airway management, transfusion strategies, and carefully designed pain management protocols. These specific needs are further complicated in resource-limited settings, as illustrated by a study conducted among Ugandan anesthetists, which found that only 13 % had access to the essential supplies required to safely administer anesthesia to paediatric patients [11]. Healthcare practitioners are therefore expected to stay updated with the unique considerations required for paediatric burn management and to receive the necessary resources to provide effective care.

Moreover, effective management of burns requires a multidisciplinary approach involving various healthcare practitioners, including anaesthetists, surgeons, nurses, psychologists and physiotherapists [12]. Holistic management, which addresses not only the physical but also the emotional and social aspects of the injury, has been proven to be highly effective in reducing the physical and mental illness and death linked to such injuries. Effective burn management has significantly reduced morbidity and mortality in high-income countries (HICs), where survival rates for children with burns covering up to 60 % of their total body surface area (TBSA) are high [3]. However, in resource-limited countries, burns affecting as little as 20 % TBSA can be fatal, with survival rates for burns exceeding 45 % TBSA remaining very low. The mortality rate in these settings is still high at 6.9 per 100,000 among children under 15, compared to 0.2 to 0.6 per 100,000 in HICs [3]. The literature has revealed several challenges LMICs such as Ghana faces in the management of burn injuries, including limited resources, inadequate infrastructure, specialized health personnel and socio-cultural factors. A study conducted by Allorto et al., [6] in South Africa, reported similar constraints in infrastructure and staffing, such as limited access to isolation facilities and after-hours coverage highlighting the broader regional challenges in burn care.

In Ghana, and at Korle Bu Teaching Hospital in particular, the management of paediatric burns is often hindered by a lack of adequate resources, skilled healthcare practitioners, and accessible healthcare facilities Albertyn et al., [13]. This gap in care contributes to higher rates of complications and mortality compared to HICs [3,6]. Korle Bu Teaching Hospital, one of the largest tertiary hospitals in Ghana, plays a critical role in the management of burn patients. Healthcare practitioners at this institution face unique challenges in providing care, including limited resources, lack of specialized equipment, and cultural barriers. Understanding their perspectives on the current burn management practices, challenges, and areas for improvement is essential for enhancing the quality of care and improving patient outcomes. By addressing these issues, the hospital can move towards developing more effective and comprehensive care protocols that are better suited to the needs of paediatric burn patients in Ghana.

## 2. Methods

This study employed an explorative qualitative research approach, using focus Group Discussion (FGD) to gather opinions from healthcare providers working in the Burns and Plastics Unit of a tertiary Teaching Hospital in Ghana.

### 2.1. Study participants

Participants were recruited using a convenience sampling technique,

where they were invited to partake in the study through a formal letter from their respective departments, allowing for easier access and encouraging the sharing of valuable insights and experiences. The discussion included at least one representative from each of the following disciplines: Plastic Surgery, Medicine, Anaesthetics, Physiotherapy, Occupational Therapy, Dietetics, Nursing, Pharmacy, Clinical Psychology, Public Health Nursing and Laboratory Scientist reflecting the MDT approach required for effective burns management. All participants had at least eight years of work experience, ensuring they had valuable knowledge and expertise to share.

### 2.2. Data Collection and analysis

FGD is an effective method for exploring complex issues by facilitating in-depth discussion among participants with shared experiences or expertise [14]. The focus group consisted of 15 participants comprising 9 females and 6 males. This size was considered optimal for a focus group as it allowed for a wide range of perspectives while ensuring that each participant has ample opportunity to contribute to the discussion [14]. The focus group discussion was conducted in a single session lasting about 90 min. The discussion took place at the conference room of the Burns and Plastic Center at Korle Bu Teaching Hospital. Participants were seated in a round table to facilitate face-to-face interaction, and the entire session was audio recorded. A discussion guide with questions generated from the review of literature on paediatric burn management was used to facilitate the FGD. The guide was piloted with a small group of healthcare professionals prior to the full study to ensure clarity, relevance, and comprehensiveness of the questions. Feedback from the pilot was incorporated to refine the guide. After the focus group discussion, the audio recording was transcribed verbatim by two research assistants, and the transcript were compared with the handwritten notes to ensure accuracy. The final transcribed data was coded and analyzed using thematic content analysis. Themes were identified based on recurring patterns in the data, allowing for a comprehensive understanding of the perceptions and experiences of healthcare practitioners regarding paediatric burns management at Korle Bu Teaching Hospital.

### 2.3. Ethics

Ethical approval was obtained first from the University of Witwatersrand (26/05/23, M230512 MED23-05-033) and Institutional Review Board of KBTH (7/09/23, KBTH-IRB 000166/2023). Before the discussion, participants were informed of the study's purpose, and informed consent was obtained for recording the session. Participants were also informed that, due to the nature of focus group discussion, absolute confidentiality and anonymity cannot be guaranteed. However, all audio recordings and transcripts were stored in password-protected files, and any identifying information was anonymized during transcription. Only authorized personnel had access to the data.

## 3. Results

The results from the FGDs revealed four primary categories regarding the management of paediatric burns at the burn centre: (1) Strengths of Current Practices (2) Barriers of burns management, (3) Contextual Factors Influencing Burn Management, (4) Recommendations for Enhancing Burn Care.

### 3.1. Strengths of current burn practices

The participants felt that the strength of the current burns practices was due to the MDT approach in burns management, and the availability of experienced healthcare practitioners.

### 3.1.1. Multidisciplinary approach to burn management

Healthcare practitioners emphasized the strengths of the multidisciplinary approach in burn care at Korle Bu Teaching Hospital. The collaboration among various healthcare professionals ensures that paediatric burn patients receive comprehensive care that addresses their immediate medical needs and long-term recovery goals.

*"I think our main strength for our department would be our multidisciplinary approach. And I think that's a strength you hardly find in other departments. And that's what has contributed to the success of our program." (Participant 2)*

*"When the patients come, the resuscitation here is so solid. Wound care is solid. Every discipline is called upon to do his or her part." (Participant 8)*

In addition, participants emphasized the need to further improve synergy and collaboration among the various professionals involved in burn care. They recognized that enhancing these aspects could significantly contribute to better outcomes for paediatric burn patients.

*"One of the things that we're looking for is to enhance or build on the synergy between the various professionals..." (Participant 14)*

### 3.1.2. Experienced healthcare practitioners

Participants noted the strengths brought by experienced healthcare practitioners, particularly through experience, knowledge sharing, and the use of adapted protocols in managing burn cases at the center. Despite the lack of a formal, hospital-wide burn protocol, the expertise of some staff helped to develop internal protocols for burn care.

*"With the experience of practice, everybody knows what to do. You don't sit and wait for something to happen before you step in." (Participant 15)*

*"The nurses have developed their own protocol that they use in management of patients who come. We use what we have to also train others so that we can all be on the same level." (Participant 5)*

*"As dieticians we also use the American Burn Association protocol. And based on experience, we've come up with a protocol for paediatrics and adults." (Participant 2)*

## 3.2. Barriers to burn management

### 3.2.1. Lack of formalized protocol

Healthcare practitioners highlighted the absence of formalized protocols for paediatric burns management. This lack of standardized guidelines leads to variability in practices, with individual practitioners relying on their judgment or external guidelines such as the American Burns Association's criteria. The lack of a standardized protocol can impact patient outcomes due to the uncertainty in determining the appropriate course of treatment.

*"I wouldn't say that there is a lay down protocol that anyone can look at and say, okay, this is a stage of treatment we are in... I'm not aware of any such document." (Participant 14)*

*"So, for 10 % of the cases, our management usually is based on the American Burns Association's criteria so far... But as to whether, for Korle Bu, the hospital itself has written or laid down protocols, that we don't have." (Participant 10)*

### 3.2.2. Infrastructure and facility limitations

Inadequate facilities and infrastructure were cited by participants as significant challenges in providing optimal care. Healthcare practitioners highlighted the lack of specialized diagnostic equipment and inadequate physical environments for therapy and rehabilitation as critical weaknesses.

*"At times, there are certain lab diagnostic investigations you have to do. The best center in this facility is not here." (Participant 15)*

*"Then looking at an adult opposite, I mean that one alone is scary. And it has a psychological impact." (Participant 6)*

### 3.2.3. Financial burden of burn management

Financial limitations on the part of patient and caregivers were identified as a significant barrier to effective paediatric burns management. The lack of funding for essential medications and resources often forces healthcare providers to make compromises in patient care.

*"In terms of finance, there's a lot of problem when it comes to financing the drug and things that you need for the care... So, it's a bit of a challenge." (Participant 6)*

*"Sometimes it's the finance that determines what you do. And that's not good enough. Because your hands are tied behind your back." (Participant 6)*

## 3.3. Contextual factors influencing burn management

The management of paediatric burns was revealed to be profoundly influenced by various contextual factors, including socio-cultural and religious beliefs, socioeconomic status of patients and the attitudes and approach of caregivers to burn care.

### 3.3.1. Psychological and emotional trauma

Participants noted that the lack of dedicated space for paediatric patients within the hospital affects the emotional support that can be provided. When children are not grouped together, it can be difficult for them to find encouragement and solace from peers in similar situations.

*"...When you go to any paediatric wards and you are passing, because they are all children there, they encourage themselves. But in this facility, I don't know who the child is going to encourage, the mother or the father. So, it becomes a weakness of our path." (Participant 5)*

### 3.3.2. Family involvement and support

A key issue identified by participants was the lack of family involvement and support for burn patients during their hospital admission. Many participants expressed concern that families often do not provide financial assistance for necessary expenses, which adds to the challenges faced by patients and healthcare providers alike. Participants noted that while social welfare services may step in to assist with financial difficulties once a patient is discharged, there is generally a lack of ongoing support for patients during their stay in the hospital.

*"The hospital doesn't have any support for them. Unless, maybe, a patient is discharged and can't afford to pay bills, then the social welfare come in to support." (Participant 1)*

### 3.3.3. Socio-cultural and religious beliefs

Findings from the FGD revealed that, socio-cultural beliefs greatly affected how paediatric burns are managed at the Burn centre. Many parents strongly believed in alternative treatments, like herbal medicine, which can cause delays in getting standard medical care for their children. Participants voiced out their concerns as follows;

*"A lot of people have this ideology here that herbal medication helps... they take their kids out to continue with the herbal treatment because they believe that herbal helps." (Participant 7)*

Moreover, religious beliefs also play a crucial role in the treatment process. For instance, parents might refuse certain medical procedures or treatments based on their faith. This was evident in the experience shared by few participants.

*"Most often when children are brought in, the decisions are taken by their parents... At times, parents taking their decision is based on their faith." (Participant 8)*

*"When you tell parents that we need to do physiotherapy because the child will get contracture, they tell you that they believe in God and nothing is going to happen." (Participant 13)*

### 3.3.4. Socioeconomic factors

Participants mentioned that socio-economic factors play a significant role in the management of paediatric burns, often leading to inadequate care and poor outcomes. The financial burden on families was a recurring concern, as many are unable to afford essential medical supplies and treatments for their children.

*"Most of the consumables, the medicine and medication that we use for these children have to be purchased by the parents." (Participant 1)*

*"It's disheartening to see a child we write medication for and the parents cannot buy... Sometimes, everything parents cannot buy, even dressing items, parents cannot buy." (Participant 10)*

### 3.3.5. Caregivers' attitudes and approach to care

Participants noted that the attitudes and understanding of caregivers have a significant impact on the treatment process for paediatric burns. Some caregivers exhibit a lack of engagement in their child's care, which negatively affects treatment adherence and outcomes. One participant observed,

*"There are some parents who come across as not being interested in the care being given to the child" (Participant 13).*

Another participant expressed concern over the actions of some caregivers, stating,

*"They don't buy the dressings, they don't buy medications, nothing. It seems like they are waiting for the child to pass away" (Participant 13)*

## 3.4. Recommendations for enhancing paediatric burn care

### 3.4.1. Strengthening social welfare and post-discharge follow-up services

Participants emphasized the need to revive and enhance the role of social welfare in paediatric burns management, particularly for vulnerable children. They recommended involving social workers to assist with follow-up care and addressing social and financial challenges. Some participants recommended as follows;

*"I want to add that some years back, I think quite long ago we had social welfare was very active care and it helped in following up some of the patients and helping us solve all these social and then some of the financial issues." (Participant 13)*

*I think in doing that, we should perhaps have an avenue where we can have a team following up post-discharge services. Because if you are doing a physical rehabilitation, it's supposed to go on until 18 months after they've been in for the survival. That's a long time, and we need to find ways to encourage people to continue their rehab today. (Participant 8)*

### 3.4.2. Expanding and upgrading burn facilities and infrastructure

Participants stressed the need for facility improvement and adequate resources to enhance paediatric burn management. They advocated for the expansion or construction of a new unit, emphasizing the limitations of the current infrastructure and the need for more space and modern facilities. One participant had this to say;

*"Looking into the future, are we going to expand or build a new unit? This was, those of you who don't know, the structure there was from a decommissioned hospital in Scotland. They brought the furniture, including wooden furniture, operating tables, instruments, all came from that decommissioned hospital. We need to improve on it. More space for the patients, more space for training people." (Kofi)*

As part of the recommendations to upgrade facilities, some

participants also mentioned the importance of creating a child-friendly environment with tools like television, toys among others, that that will keep them active so they don't think much about their condition. One participant emphasized the therapeutic value of such an environment, stating,

*"Then the playground. We cannot take play out of the growth of children. If we have a playground with colorful pictures, fun videos, and a television showing paediatric content, it would be therapeutic on its own. So, if we should get that setting for them alone. I think it will also help with that. (Participant 13)*

### 3.4.3. Staff training and professional development

Participants identified significant gaps in training within the burns unit, particularly in managing paediatric emergencies and addressing child protection issues. They emphasized the need to reassess and restructure the unit's training programs to ensure that staff are adequately prepared to respond to emergencies and recognize cases of child abuse. Two participants were of this opinion;

*"I think we as a unit have a goal for training, but I think we should have a second look at it. At times a child gets here and there's no emergency nurse here. As a center, you don't have. Then you tell the person to go back to the main emergency... And everything is slacking behind. Why? Because there was no one there who knew what to do, when to do at that moment. So if we as a unit can restructure our training needs again, it will go in a long way to help." (Participant 15)*

*"I think the unit should train a child protection person attached to the burn unit. Or to the old plastic surgery unit. So that. That person coordinates all these atrocities. Because at times you see a child that you know is purely abused. But you don't know what to do." (Participant 5)*

### 3.4.4. Psychological support for staff

Some participants noted the importance of providing periodic psychological support to staff to maintain their sensitivity to patients' needs and prevent burnout. They recognized the emotional toll that working in such a demanding environment can take on healthcare professionals.

*"So, I commend periodic psychological support for staff and them. Because I realize when you work about, I worked for, I've been for about seven, eight years on a row. At a point we became so insensitive to the pain the patient goes through, and the dying." (Participant 1)*

*"This kind of work is difficult comparing to other specialties so the staff also need periodic assessment health talk that will free their more psychologically free their minds." (Participant 10).*

## 4. Discussion

This study sought to explore healthcare practitioners' perspectives on paediatric burns management at a tertiary hospital in Ghana. Four major themes emerged from the findings.

### 4.1. Strength of current practices

The emphasis on the strength of the multidisciplinary approach in burn care at Korle Bu Teaching Hospital by Healthcare practitioners is consistent with previous literature. Cambiaso-Daniel et al., [15] emphasizes the multidisciplinary approach as a cornerstone of effective burn management. According to Cambiaso-Daniel et al., [15], the integration of different specialties allows for a holistic treatment plan that can adapt to the complex and evolving needs of burn patients. Schlottmann & Lorbeer [16] similarly posited that, this collaborative approach addresses the complex needs of burn patients, ensuring that all aspects of their recovery, from acute care to long-term rehabilitation, are managed effectively. Although MDT has been well established in the literature, recent studies suggest a transition from a multidisciplinary to a



transdisciplinary approach in paediatric burn teams as it improves patient outcomes by fostering more integrated and cohesive care strategies [12]. The study also emphasized the importance of experienced and skilled professionals in the management of child burns. The complexity of paediatric burn care, due to factors such as the higher fluid losses, increased risk of hypothermia, and thinner skin in children compared to adults, requires specialized knowledge and expertise to improve chances of survival [9,10]. The above assertions therefore point to the need for continuous professional development for healthcare practitioners that supports the intricate needs of paediatric burn patients in order to maintain high standards in their ongoing care.

#### 4.2. Barriers of burns management

One major barrier reported by healthcare practitioners in the management of paediatric burn injuries was the absence of formalized protocols. Practitioners often relied on their judgment or external guidelines, such as those from the American Burn Association (ABA). The lack of formalized protocols for burn management is not unique to the current study. A recent study by Patterson et al., [17] highlights the significant variability in paediatric burn care across the country, emphasizing the need for standardized quality measures and performance benchmarks to guide improvements in paediatric burn centers. Another study conducted by Holbert et al., [18] in Australia reported a lack of a formal protocol for integrating adjunctive Negative Pressure Wound Therapy (NPWT) into acute burn care. Despite these challenges McWilliams et al., [19] revealed that there were several ways practitioners could obtain guidelines or protocols for the initial assessment and treatment of paediatric burn patients, such as online sources if their context has not yet developed one. This was consistent with the practices of some healthcare practitioners in the current study who relied on guidelines developed by ABA. However, it is worth noting that, external guidelines may not be uniformly adopted in all healthcare settings, particularly in regions with limited resources such as Ghana [1]. The lack of local adaptations of external guidelines can lead to poor burn care because these guidelines are usually created in countries with better resources and advanced technology. In places with fewer resources, like Ghana, hospitals may not have the needed equipment, medicines, or enough trained workers to follow these guidelines properly.

Financial limitations being identified as another significant barrier to effective paediatric burns management in Ghana is a pressing issue. This finding aligns with previous research that has revealed that burn care requires a substantial allocation of hospital resources, with expenses being influenced by various factors such as patient demographics, the extent of the burn, and the length of hospitalization [20,21]. Contrasting findings, however, emerged from Latifi et al., [22] who found that the age of the patient, whether child or adult, did not significantly impact the costs of burn management. Instead, factors such as TBSA, duration of hospital stay, and male gender were more strongly associated with hospital charges. These findings suggest a need for improving National Health Insurance coverage for the management of burns as requested by burn patients in earlier studies in Ghana [23].

#### 4.3. Contextual factors influencing burn management

Furthermore, healthcare practitioners in this study expressed their concerns regarding certain contextual factors such as socio-cultural and religious beliefs and practices, socioeconomic status, and the attitudes of caregivers that influences the care burn patients received at the center. Practices of caregivers such as poor first aid management was found to influence burn outcomes. Consistent with this finding Gete et al., [24] reported that majority of caregivers attending burn units demonstrated poor knowledge of burn first aid. In addition, the study found that positive attitudes of caregivers, such as the willingness to learn and improve first aid knowledge, are crucial for the immediate and long-term recovery of burn victims [24]. Many caregivers especially in the

African context, still hold strong beliefs in alternative treatments, such as herbal medicine, which can delay access to essential medical care for improving burn outcomes [25]. The study revealed that some caregivers exhibit a lack of engagement in their child's care, which can adversely affect treatment adherence. This observation reflects broader trends identified in research that link caregiver involvement with improved health outcomes for paediatric patients care [26].

#### 4.4. Recommendations for enhancing burn care

Healthcare providers emphasized the need to revive social welfare roles in paediatric burn management. Similar to this recommendation, a study conducted by Curtis et al., [27] and Komhaber et al., [28] highlighted the importance of continuous support systems through social workers, that facilitate recovery beyond initial treatment. Social workers can address barriers such as financial constraints, access to rehabilitation, and the psychosocial needs of children and families, which are important for long-term recovery [27]. However, long-term rehabilitation and continuous support do not rely on social workers alone. Other members of the MDT such as physiotherapists, and psychologists still have a role to play to ensure that all aspects of a child's recovery, both physical, social and emotional, are addressed to achieve best outcomes. The suggestion to create child-friendly environments, including play areas, aligns with research showing that such spaces can aid healing by reducing stress and anxiety in young patients [28]. Studies in paediatric psychology emphasize the therapeutic value of play and colorful settings, highlighting their positive impact on children's emotional well-being [29,30]. This evidence supports the need for incorporating these elements into burn care facilities especially in low resourced settings to enhance the healing process for paediatric patients. Furthermore, healthcare providers advocated for regular psychological support to prevent burnout and maintain sensitivity towards patients' needs. This recommendation is supported by literature indicating that emotional exhaustion among staff can negatively impact patient care quality and staff retention rates [31]. A study by Murji et al., [32] indicates that healthcare workers in burn units are more likely to experience burnout compared to those in other specialties due to the long-term nature of care and the emotional burden of treating severely injured patients.

### 5. Conclusion and recommendations

The findings of this study demonstrates that there are clear opportunities for improvement in paediatric burn care at the Korle Bu Teaching Hospital. A move towards more integrated care, the development of locally adapted protocols, better financial support, and enhanced caregiver education are essential next steps in elevating the quality of paediatric burn management in Korle Bu Teaching Hospital. Healthcare practitioners at Ghana's premier burn center recommend enhancing paediatric burn care through several key initiatives. They emphasized the need to strengthen social welfare and post-discharge follow-up services by involving social workers to support vulnerable children and ensure continued rehabilitation. Healthcare practitioners also mentioned the urgent need to expand and upgrade burn facilities, including modern infrastructure and creating child-friendly environment. Furthermore, there is a need to improve staff training to ensure they are updated with current burn management practices. Lastly, healthcare practitioners highlighted the importance of providing periodic psychological support for staff to prevent burnout. Lastly, future studies could consider employing a mixed-methods approach, where perspectives of participants are resolved into scalar quantities for easier evaluation. To ensure that these recommendations lead to tangible improvements, the next steps will involve actively engaging with key stakeholders at Korle Bu Teaching Hospital, including hospital management, department heads, and relevant healthcare practitioners. A formal report summarizing the study's findings and recommendations

will be presented to these stakeholders to discuss how the suggestions can be integrated into the hospital's current burn care practices.

## 6. Limitation

The study is contextually limited to the Burns and Plastics Unit at Korle Bu Teaching Hospital, a single tertiary institution. Since the study is based on this specific setting, the findings may not fully reflect the experiences or challenges faced in other hospitals or healthcare settings in Ghana. For instance, hospitals in rural areas or those with fewer resources might deal with different issues in paediatric burns management. The resources, patient demographics, and available support at the burn centre at Korle Bu Teaching Hospital might not be the same elsewhere, making it harder to apply the study's results broadly across the country.

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## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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