

Children's Burns Research Centre: Burns & Scalds Assessment Template

For ALL children 0-16th birthday, presenting with a burn or scald injury, the **WHOLE** form **MUST** be completed ticking **ALL** answers which apply in **EACH** section.

Centre	ID no. <i>(allocated by research team)</i>

Person completing this form: Research Nurse Nurse SHO REG ENP CONS ANP

Who is accompanying the child? Mum Dad Grandparent Unaccompanied Other: _____

Assessment undertaken: Date: ____/____/____ (dd/mm/yyyy) Time: ____:____ (24 hrs)

Injury occurred: Date: ____/____/____ (dd/mm/yyyy) Time: ____:____ (24 hrs)

Details of child: Gender: _____ *Age: _____ (please record age in months if child ≤ 2 years)

Section 1: History of injury

1.1. Type of Injury

<input type="checkbox"/> Scald	<input type="checkbox"/> Sunburn
<input type="checkbox"/> Contact burn	<input type="checkbox"/> Flame
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Electrical

1.2. Location

<input type="checkbox"/> Home	<input type="checkbox"/> Café/restaurant
<input type="checkbox"/> Other: _____	<input type="checkbox"/> School

1.3. Details of Incident

Was anyone in the room/vicinity at the time? Yes No

If yes, who?

<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Peer
<input type="checkbox"/> Other: _____	

If yes, did they see what happened? Yes No

What is the explanation for the injury?

1.4. In which position was the child just before the incident?

<input type="checkbox"/> Running/walking	<input type="checkbox"/> Lying down
<input type="checkbox"/> Standing	<input type="checkbox"/> Being carried/held
<input type="checkbox"/> Sitting	
<input type="checkbox"/> Other: _____	

1.5. Agent/Mechanism *(please complete all applicable)*

***Agent**

<input type="checkbox"/> Hot drink: _____	<input type="checkbox"/> Oven hob	<input type="checkbox"/> Iron
<input type="checkbox"/> Hot food: _____	<input type="checkbox"/> Oven door	<input type="checkbox"/> Radiator
<input type="checkbox"/> Hot water	<input type="checkbox"/> Hair tongs/ straightener	<input type="checkbox"/> BBQ grill
<input type="checkbox"/> Fat/oil		<input type="checkbox"/> Sun
<input type="checkbox"/> Other: _____		<input type="checkbox"/> N/K

Source if scald

<input type="checkbox"/> Mug/cup	<input type="checkbox"/> Bowl	<input type="checkbox"/> Tap
<input type="checkbox"/> Kettle	<input type="checkbox"/> Pan	<input type="checkbox"/> Bath
<input type="checkbox"/> Other: _____		<input type="checkbox"/> N/K

Location of hot item

<input type="checkbox"/> Kitchen surface	<input type="checkbox"/> Low table	<input type="checkbox"/> Floor
<input type="checkbox"/> On cooker hob	<input type="checkbox"/> Dining table	<input type="checkbox"/> Oven
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Garden/outdoor
		<input type="checkbox"/> N/K

Mechanism

<input type="checkbox"/> Touch	<input type="checkbox"/> Spill	<input type="checkbox"/> Immersion
<input type="checkbox"/> Pull down	<input type="checkbox"/> Splash	<input type="checkbox"/> Child fell/ran into
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Exposure to sun
		<input type="checkbox"/> N/K

1.6. First aid *(including inappropriate first aid)*

Was first aid given by parent/carer? Yes No

If yes, was it:

<input type="checkbox"/> Cold water
<input type="checkbox"/> Other: _____

If cold water:

a) How was the water applied?

<input type="checkbox"/> Tap/shower (running water)	<input type="checkbox"/> Put into water (immersion)
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b) How long was water applied for? _____ (min)

Was the burn covered? Yes No

If yes, what with: _____

Section 2: Details of child

2.1. Is there any developmental impairment?

(please tick as many as apply) N/A

<input type="checkbox"/> Motor	<input type="checkbox"/> Neurological	<input type="checkbox"/> Hearing
<input type="checkbox"/> Behavioural	<input type="checkbox"/> Learning	<input type="checkbox"/> Vision
<input type="checkbox"/> Other:		

2.2. Current 'best' stage of motor development

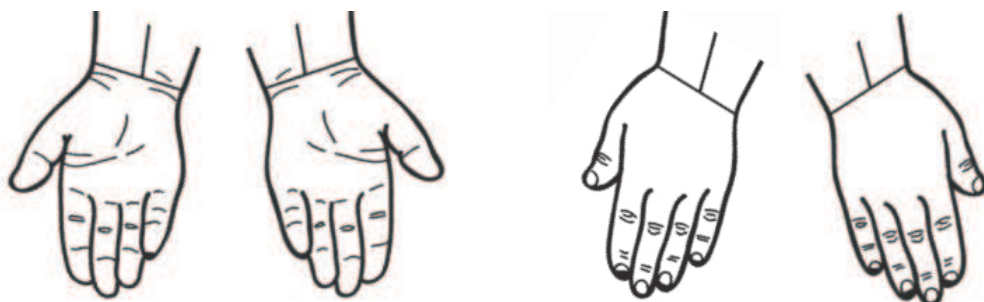
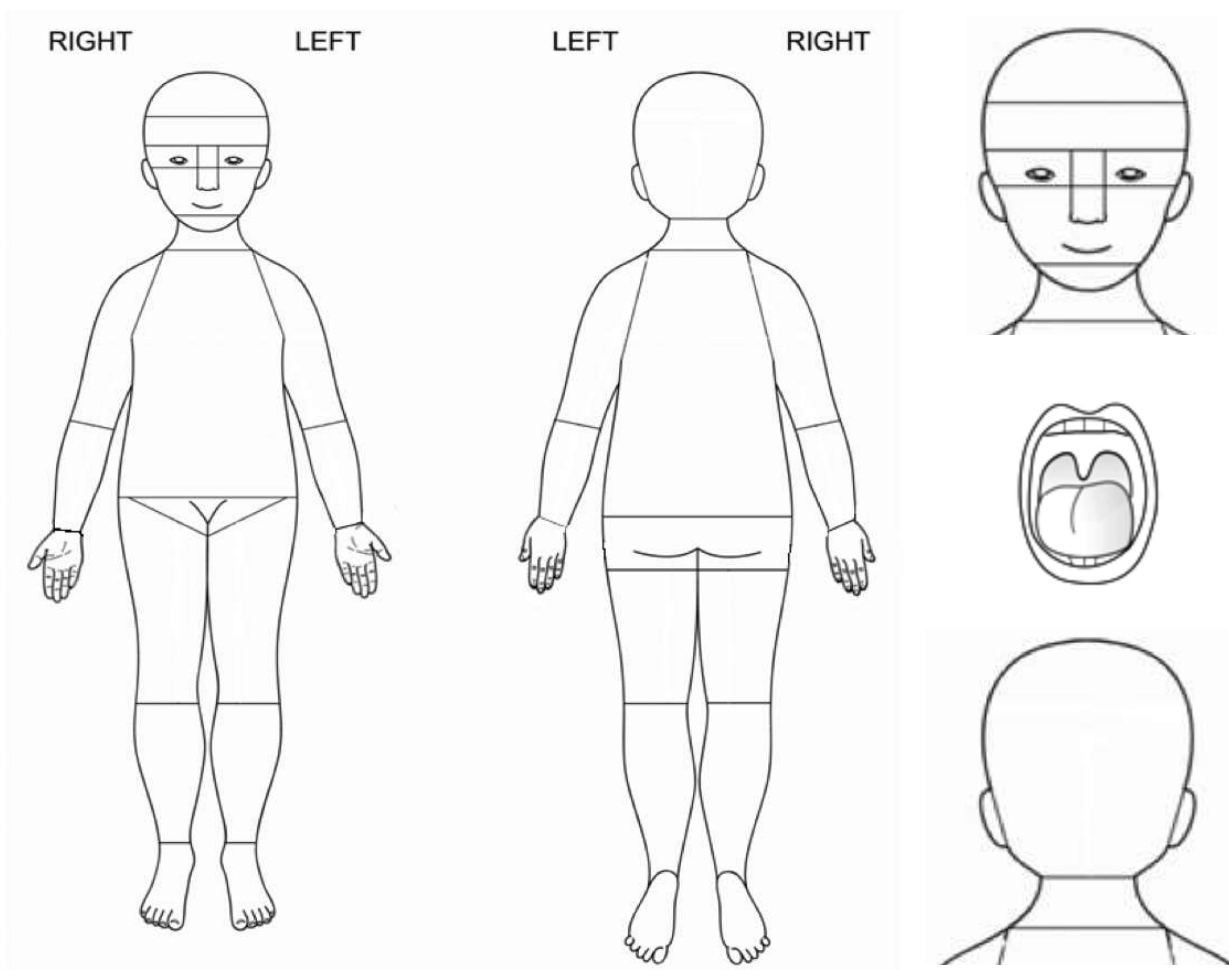
(please complete for children <3 years and if answered yes to Q 2.1) N/A

<input type="checkbox"/> Non-mobile baby	<input type="checkbox"/> Crawling
<input type="checkbox"/> Baby able to roll over	<input type="checkbox"/> Cruising
<input type="checkbox"/> Sitting	<input type="checkbox"/> Walking

Section 3: Characteristics of injury on examination

***3.1. Body map**

Please shade the distribution of the burn: N/A - no visible injury



***3.2. Pattern of injury** N/A

(please tick as many as apply)

- Symmetrical (both sides of body)
- Glove/stocking distribution (circumferential)
- Clearly defined margins
- Skin fold sparing
- Margin in the shape of an implement
- Multiple contact burns (more than one)

***3.3. Depth of injury** N/A

(please tick as many as apply)

- Erythema/redness
- Blisters, not burst
- Wet, pink
- Dry, white or charred

3.4. TBSA N/A

(if TBSA>1% consider referral to Specialist Burns Unit, School Nurse, Health Visitor)

Percentage of body injured:

- ≤1% 2-9% 10-14% ≥15%

3.5. Any other injuries on examination?

- Yes No

Details if yes:**3.6. Was there any previous ED attendance for:**Burn Injury Yes NoOther injury Yes No**Details if yes:****Section 4: Screening, Referrals & Outcomes*****4.1. Social Services (SS) involvement****Does the child/family have a social worker (SW) now?**

- Yes No

Did the child/family have a SW or any SS involvement in the past?

- Yes No

Is there any domestic violence in the home?

- Yes No (A proposed way to ask this question is "Do you feel safe at home?" – Only ask this question if you can talk to one of the parents independently.)

4.2. Do you have any concerns about...*Appropriate adult supervision?**

- Yes No

Late presentation?

- Yes No

If yes, is there a valid reason for delay?

(previous GP/ED attendance, etc.)

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4.3. If an explanation was given...*Was it consistent with the stage of development?**

- Yes No

Did it fit with the burn pattern seen?

- Yes No

4.4. Referrals and outcomes (please tick as many as apply)***Was a Child Protection referral made?**

- None
- Social Services Hospital safeguarding team

Were any other referrals made?

- None
- School Nurse Health Visitor
- Other:

Outcome

- Discharged home GP/ Practice Nurse
- ED review Specialist burns unit
- Transfer to acute ward
- Other:

Overall additional comments:

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