**Paediatric Wound Assessment & Evaluation Form**

**For multiple wounds complete formal wound assessment for each wound. Add inserts as needed.**

Patient Name …………………………………………… D.O.B. …………………… Hospital Number…………………………

Initial date of assessment ………………….. Nurse completing initial assessment …………………………………

**Diet discussed**

Well balanced Milk based (breast/baby milk or enteral feed)  Poor diet 

Vitamins Discussed (under 5 year olds)  Leaflet given (if appropriate) 

**Factors that could delay healing:**

(please tick relevant boxes)

Immobility  Diabetes  Incontinence  Medication 

Respiratory/circulatory disease  Anaemia  Oedema 

Wound infection  Steroids  Chemotherapy 

Other……………………………… Allergies & Sensitivities ……………………

Poor Nutrition 

**Type of wound/Total number and duration of each wound**

* Pressure Ulcer ………………….

Grade/category …………………….. grade 2 or above requires an incident report completed

* Surgical Wound ………………..
* Burn/Scald ……………………….
* Other (Specify) ………………………………………….

………………………………………….

Body map



Mark location with ‘X’ and number each one

**Formal Wound Assessment**

**Measure and photograph wound weekly or if wound changes then measure and photograph earlier Complete assessment weekly or if needed then earlier.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of assessment** |  |  |  |  |  |  |  |  |
| **Number of Wound** |  |  |  |  |  |  |  |  |
| **Analgesia required**  Pain tool being used …………………………..  Pain score on dressing change ……………. | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** |
| Regular/ongoing analgesia |  |  |  |  |  |  |  |  |
| Pre-dressing only |  |  |  |  |  |  |  |  |
| **Wound dimensions (enter size)** | | | | | | | | |
| Length (cm) |  |  |  |  |  |  |  |  |
| Width (cm) |  |  |  |  |  |  |  |  |
| Depth (cm) |  |  |  |  |  |  |  |  |
| Is wound tracking/undermining – use clock face technique to measure |  |  |  |  |  |  |  |  |
| Trace wound circumference and work out surface area in cm (as per instructions) |  |  |  |  |  |  |  |  |
| Photography obtained |  |  |  |  |  |  |  |  |
| **Tissue type on wound bed (enter percentages)** | | | | | | | | |
| Necrotic (black) |  |  |  |  |  |  |  |  |
| Sloughy (yellow/green) |  |  |  |  |  |  |  |  |
| Granulating (red) |  |  |  |  |  |  |  |  |
| Epithelialising (red) |  |  |  |  |  |  |  |  |
| Hypergranulating (red) |  |  |  |  |  |  |  |  |
| Haematoma |  |  |  |  |  |  |  |  |
| Bone/Tendon visible |  |  |  |  |  |  |  |  |

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| Date of assessment |  |  |  | |  |  |  |  |  |  |  |  |
| **Wound exudate levels/type (tick all relevant boxes)** | | | | | | | | | |  |  |  |
| Low |  |  | |  |  |  |  |  |  |  |  |  |
| Moderate |  |  | |  |  |  |  |  |  |  |  |  |
| High \* |  |  | |  |  |  |  |  |  |  |  |  |
| Serous (Straw) |  |  | |  |  |  |  |  |  |  |  |  |
| Haemoserous (Red/Straw) |  |  | |  |  |  |  |  |  |  |  |  |
| Purulent (Green/Brown/Yellow) |  |  | |  |  |  |  |  |  |  |  |  |
| **Peri-Wound skin (tick relevant boxes)** | | | | | | | | | |  |  |  |
| Macerated (White) |  |  | |  |  |  |  |  |  |  |  |  |
| Oedematous \* |  |  | |  |  |  |  |  |  |  |  |  |
| Erythema (Red) |  |  | |  |  |  |  |  |  |  |  |  |
| Excoriated (Red) |  |  | |  |  |  |  |  |  |  |  |  |
| Fragile |  |  | |  |  |  |  |  |  |  |  |  |
| Dry/Scaling |  |  | |  |  |  |  |  |  |  |  |  |
| Healthy intact |  |  | |  |  |  |  |  |  |  |  |  |
| **Signs of infection \* 1 or more of these signs may indicate possible infection** | | | | | | | | | |  |  |  |
| Heat \* |  |  | |  |  |  |  |  |  |  |  |  |
| New slough/necrosis (deteriorating wound bed) \* |  |  | |  |  |  |  |  |  |  |  |  |
| Increasing pain \* |  |  | |  |  |  |  |  |  |  |  |  |
| Increasing exudate \* |  |  | |  |  |  |  |  |  |  |  |  |
| Increasing Odour \* |  |  | |  |  |  |  |  |  |  |  |  |
| Friable granulation tissue \* |  |  | |  |  |  |  |  |  |  |  |  |
| **Treatment objectives (tick relevant box)** | | | | | | | | | |  |  |  |
| Debridement |  |  | |  |  |  |  |  |  |  |  |  |
| Absorption |  |  | |  |  |  |  |  |  |  |  |  |
| Hydration |  |  | |  |  |  |  |  |  |  |  |  |
| Protection |  |  | |  |  |  |  |  |  |  |  |  |
| Palliative/conservative |  |  | |  |  |  |  |  |  |  |  |  |
| Reduce bacterial load |  |  | |  |  |  |  |  |  |  |  |  |
| **Assessors Printed Initials** |  |  | |  |  |  |  |  |  |  |  |  |
| **Dressing Renewed (planned or unplanned dressing change)** |  |  | |  |  |  |  |  |  |  |  |  |

**Daily wound check**

**Please complete at each visit**

**Wound Treatment Plan and Evaluation of Care**

**To be completed when treatment or dressing type/regime has be altered.**

**NB please write clearly instructions.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Wound Number** | **Cleansing Method, Dressing choice and Rationale** | **Frequency of change** | **Evaluation & Rationale for changing dressing type** | **Nurse Name and signature** |
|  |  |  |  |  |  |
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