LRI Children's Hospital

Wound Assessment and Dressing Procedure

Staff relevant to:	Clinical, nursing and support staff working within the UHL Children's Hospital.
Team approval date:	March 2025
Version:	V 4
Revision due:	March 2030
Written by: Revised by:	Tracey Bloodworth (V2) Deborah Wilson
Trust Ref:	C33/2006

1. Introduction & Scope

The aim of this guideline is to provide guidance for Health care professionals working within UHL Children's Hospital when changing a child's wound dressing. This document provides guidance in the preparation, treatment and immediate aftercare of children requiring wound dressing removal/application causing minimal disturbance to the wound as possible, using an aseptic technique. This guideline includes recommendations for wound dressing care when treating burns.

Related Documents:

Aseptic Non Touch Technique UHL Guideline B20/2013

Infection Prevention UHL Policy B4/2005

Consent to Examination or Treatment UHL Policy B35/2024

Pressure Ulcers UHL Policy B23/2014

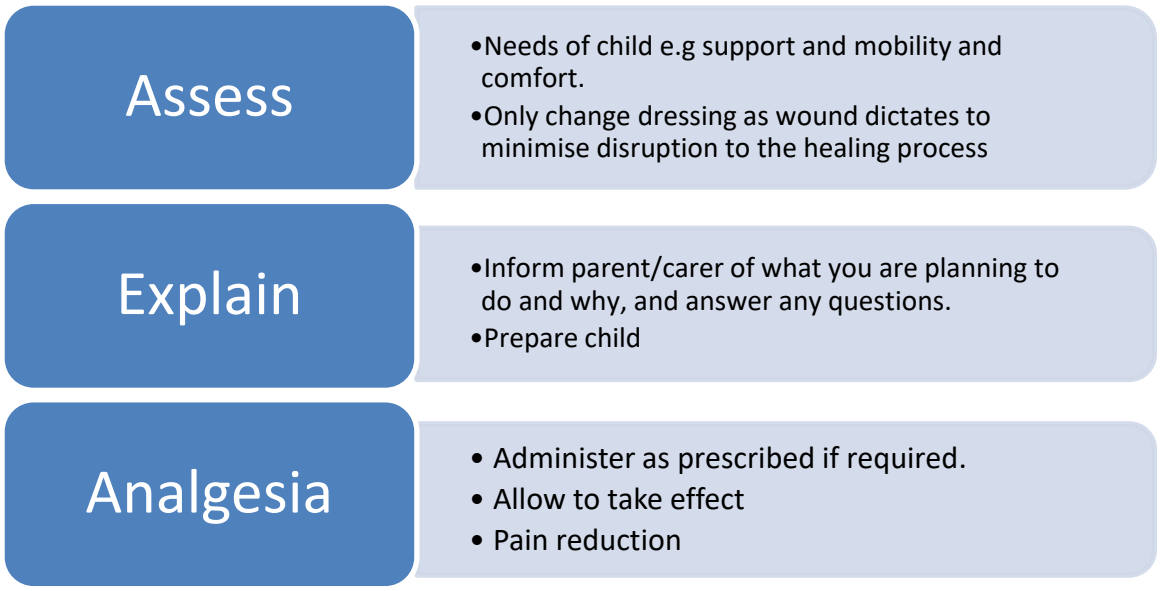
2. Clinical Procedure

2.1 Resources

- Sterile Dressing Pack
- Supply of 0.9% sodium chloride solution sachets (Normasol) (as clinically indicated)
- Non-sterile gloves
- Sterile gloves
- Appropriate dressing and tape

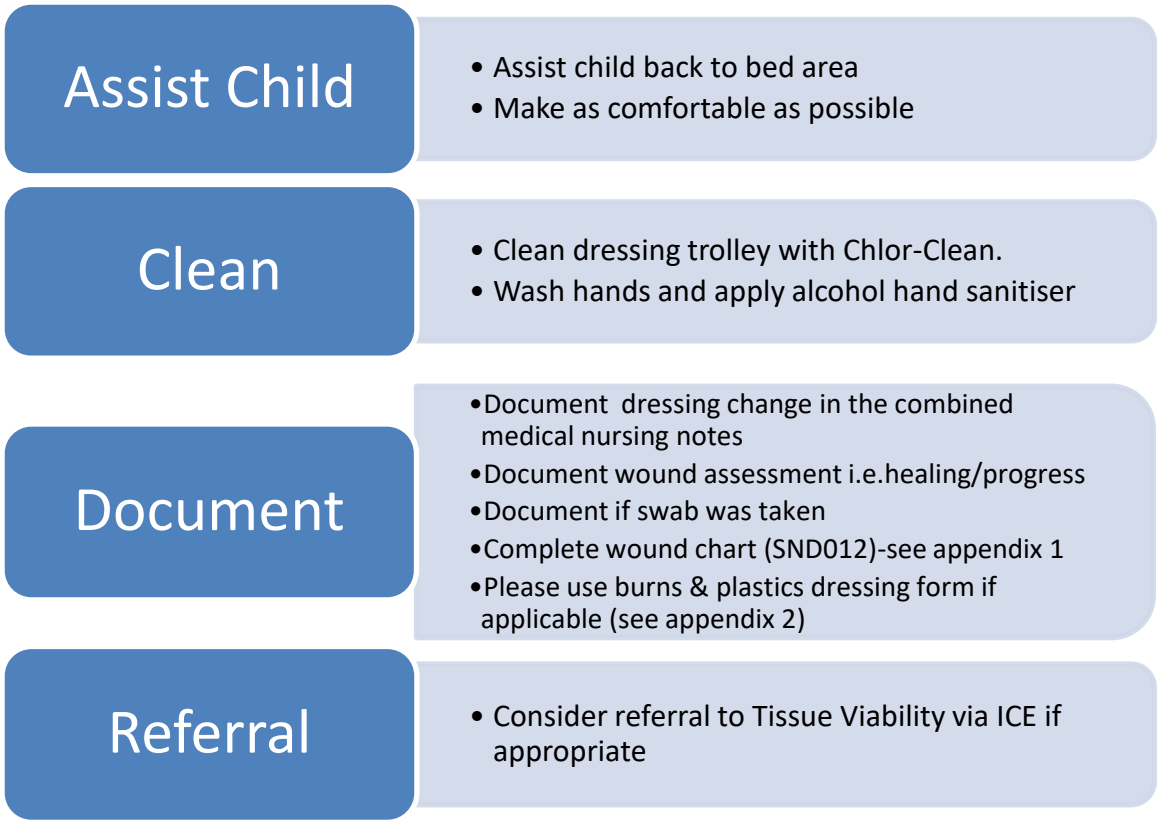
  Children's Day Care Unit can be contacted for further advice regarding dressings. Contact on ext 16317 Mon-Fri 08:00-18:00
- Chlor-Clean
- Assistance as required
- Expertise of play specialist
- Qualified children's nurse experienced in the management of wounds and aseptic technique

2.2 Procedure



Equipment	•Clean trolley with Chlor-Clean, allow to dry. •Place all equipment on lower shelf of dressing trolley maintaining clean work surface on top shelf.
Environment	•Escort suitable for childs clincal need , to take child to treatment area •Maintain dignity and as much comfort as possible
Play Specialist	•To provide distraction and support to child during procedure
Sterile (use ANTT)	•Open sterile dressing pack onto clean trolley and use as the aseptic field •Open other sterile equipment onto aseptic field •Open clinical waste bag (if using) and place away from the sterile field.
Soiled/Old Dressings	•Put on non-sterile gloves and loosen edges around child's old dressing •Remove soiled dressing •Take care to not dislodge any wound drains •Place soiled dresssing in clinical waste bag/bin

Assess	•Assess drainage from wound •Assess healing and for signs of infection •Obtain wound swab for culture & sensitivity if clincally indicated following cleaning of the wound. •Use form SND012 for day case dressing changes(see appendix 1) •Please use burns & plastics dressing form if applicable (see appendix 2)
Prep	•Remove non-sterile gloves •Wash hands and apply alcohol hand sanitiser •Open Normasol solution as clinically indicated and pour into galipot. It is the mechanical action which cleanses the wound
Clean Wound	•Put on sterile gloves and ***EITHER*** •Clean from centre outwards **OR** from top to bottom •Use one gauze swab for each wipe. Do not use cotton wool as this leaves fibres in the wound bed •Clean around drains from the drain site outwards in a circular motion.
Dry wound	• Use dry sterile gauze swabs • Repeat the technique described above
Apply appropriate sterile Dressing	• Apply appropriate sterile dressing • Apply covering dressing as appropriate • Remove gloves and apply tape or bandage as required.
Dispose of waste	• Dispose of waste in orange clinical waste bag • Prevention of environmental contamination



3. Education and Training

No new training is required to implement this guideline.

4. Supporting Documents and Key References

Ayliffe, G.A.J., Fraise, A.P., Geddes, A.M., Mitchell, K. (2000) **Control of Hospital Infection**. A Practical Handbook, 4th edn, Arnold, London.

Bree – Williams, E.J., Waterman, H. (1996) **An Examination Of Nurses Practices When Performing Aseptic Technique For Wound Dressing**. Journal of Advanced Nursing, 23, 48 –54.

The Royal Marsden Hospital. (2004) **Manual Of Clinical Nursing Procedures**, 6th edn, Blackwell Publishing Ltd.

5. Key Words

Assessment, Burns, Dressing, Tissue Viability

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) D Wilson – Deputy Ward Sister	**Executive Lead** Chief Nurse
Details of Changes made during review: **Removed references to Tilsept® solution** **Updated Hyperlinks** **Minor changes to procedure**	

Appendix1. Tissue Viability Assessment Form

		Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:
Exudate:	Type e.g: (please refer to guide):					
Offensive Odour:	Present:					
	Not Present:					
Pain (wound related):	Type (describe)					
	Score (see guide)					
Signs of Infection	Yes (please describe - refer to the guide)					
	No					
	Action: * Swab/date taken					
	Results: * Inform medics (antibiotic therapy may be required)					
Referral: (if indicated) Date:	- Dietitian					
	- Tissue Viability					
	- Vascular					
	- Diabetic Foot Clinic					
	- Dermatologist					
	- Other (please specify)					
Signature:						
Print Name:						
Designation:						

Please document treatment regime on the relevant Care Plan

GUIDE

Allergies:
Specific allergies including wound care products
Dimensions:
Trace or photograph the wound weekly/ as indicated
Exudate type:
- Serous - Straw coloured fluid.
- Haemoserous - Reddish in colour.
- Pus - Creamy yellow/greenish colour.
- Haemopurulent - Creamy yellow/green, containing blood
- Blood/sanguinous - Frank blood.

Amount of exudate:
+ Minimal - Spotting on the dressing
++ Moderate - Leaking through the dressing
+++ Heavy - Leakage through the bandage

Signs of Infection:
- Increasing exudate/pain
- Malodour
- Erythema (redness) +/- cellulitis
- Friable granulation tissue (bleeds easily)
- Wound breakdown/dehiscence
- Delayed healing

Guide to scoring wound-related pain:
Pain 0 = No pain at rest or movement
Pain 1 = No pain at rest, slight pain on movement
Pain 2 = Some pain at rest, worse pain on movement
Pain 3 = Severe pain at rest, patient can't move (consider referral to acute pain team)

Pressure ulcers grading (EPUAP 2005, NICE 2005):
Grade 1 - red non blanching skin intact
Grade 2 - superficial skin loss, abrasion, shallow crater, blister
Grade 3 - full thickness skin loss, not extending through fascia
Grade 4 - extensive destruction, tissue necrosis, damage to muscle, bone

Tissue Viability Service
Generic Wound Management Care Plan

Name:	Hospital No:	Ward:	Site:
Date of Birth:	Consultant:	Date/Time:	

Problem	Objectives (dependent on initial assessment)	Action
_____ has a wound situated on _____ _____ _____ Date first noticed: _____ Admitted with the wound Y/N * Please use a 'Wound Assessment Chart for wound description. * Please delete as appropriate	• To remove necrotic tissue • To remove slough • To protect fragile tissue • To promote healing • To control symptoms eg. Increased exudate, increased pain, odour • To ensure patient's comfort (terminal patients) • To improve patients quality of life	1. Complete the attached wound assessment form to provide baseline information in order to monitor healing. 2. Dressing to be changed as indicated below using a septic/clean technique* (Please follow the UHL Infection control guidelines). 3. Explain and discuss procedure with the patient to relieve anxiety and position the patient comfortably. 4. If necessary, gently irrigate the wound cavity/clean the surrounding skin with warm 0.9% normal saline. 5. Apply primary +/- secondary dressing and ensure protection of surrounding skin as per regime below. 6. Dispose of all waste as per clinical waste policy. 7. Document all changes in condition of the wound on the wound assessment chart. 8. If the wound shows clinical signs of infection, obtain wound swabs (if required) Results of swab/date: 9. If complex wound or no improvement after initial treatment - please consider consulting the Tissue Viability Link Nurse or refer to the Tissue Viability Team (via IOM). 10. Please ensure that a 'MUST' tool has been completed and appropriate nutritional management plans are in place. Refer to Dietitian if indicated. **N.B. This is a generic care plan. For specific wounds/problems, please complete the relevant care plan i.e.** leg ulcers, diabetic foot ulcers, pressure ulcer prevention and skin care, VAC therapy, Nutritional Support for Tissue Viability patients

	Regime 1	Regime 2	Regime 3	Regime 4	Regime 5
Date/Time					
Primary Dressing					
Secondary Dressing					
Frequency					
Protection of surrounding skin					
PRINT NAME					
Sign					

Appendix 2 Burns & Plastics Assessment Form

Leicester Children's Hospital

University Hospitals of Leicester NHS
NHS Trust

Burns & Plastics Dressings Clinic and Outreach Team

PAEDIATRIC WOUND CARE DOCUMENTATION

ASSESSMENT

CHILDREN'S BURNS & PLASTICS DRESSINGS CLINIC AND OUTREACH TEAM

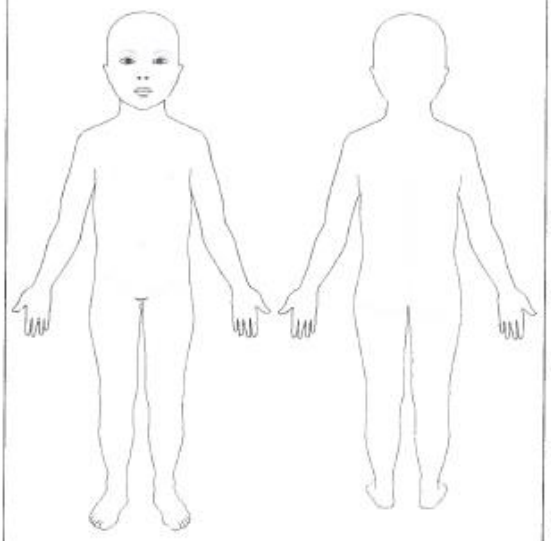
Patient ID Label

Date: **Consultant:**

Allergies/Dressing Allergies:

Known infection risk:

Location of wound/s:



Front Back

Type of wound referred for:

Burn classification:

Superficial:

Superficial partial thickness:

Deep partial thickness:

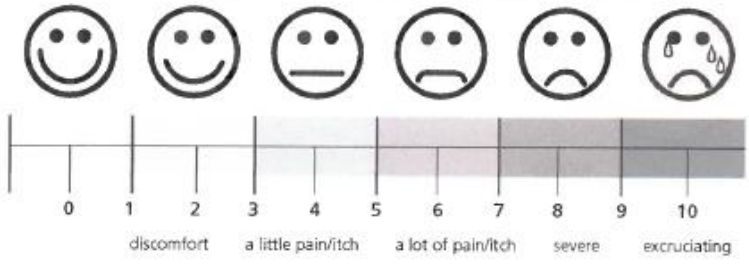
Full thickness:

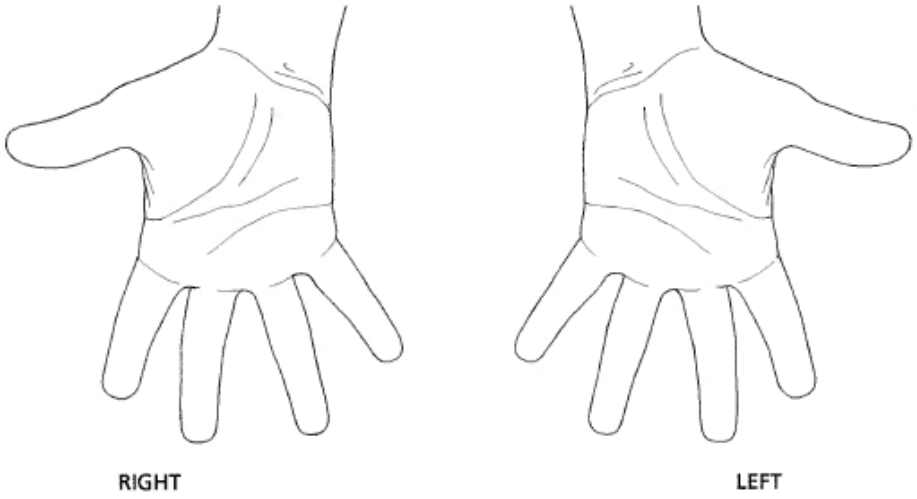
%TBSA

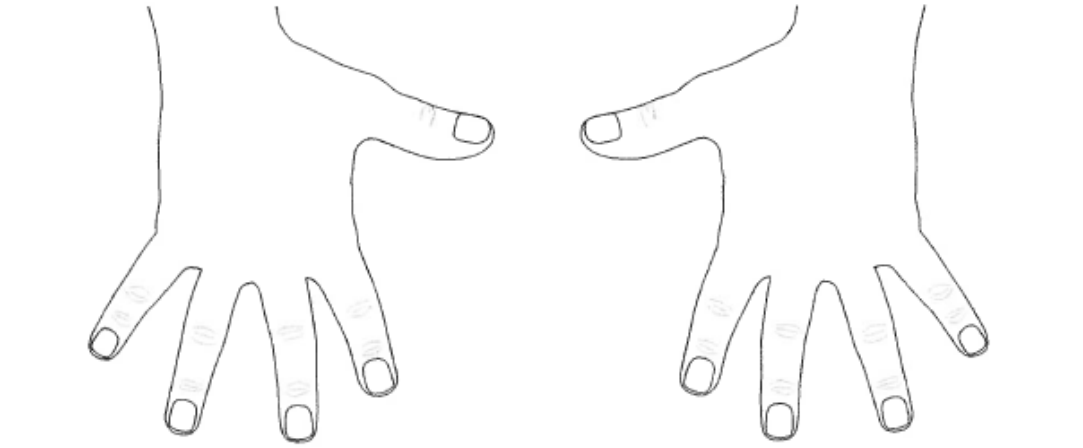
Safeguarding / welfare issues:

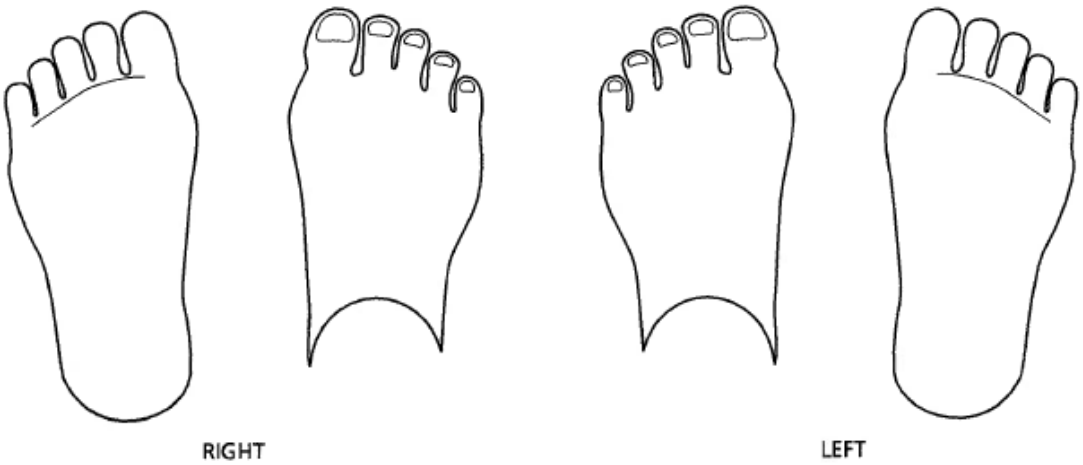
Confirmation that the following has been completed: LSCB <2yrs ☐
Health Visitor Liaison: ☐ Social Worker: ☐

Pain/Itch assessment tool:









Hospital No.: Surname: Forename:

ASSESSMENT

		Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time	Date/Time
		Wound:	Wound:	Wound:	Wound:	Wound:	Wound:	Wound:	Wound:
Size (cm)	Suture line								
	Undermining								
	Max. length								
	Max. width								
	Max. depth								
% tissue type wound bed	Non-blanching erythema								
	Blister								
	Epithelium (pink) %								
	Granulation (red) %								
	Overgranulation								
	Sloughy (yellow/green) %								
	Necrotic (black) %								
Exudate	None								
	Low								
	Moderate								
	High*								
	Excessive*								
	Colour/Type								
Odour	None								
	Mild								
	Moderate								
	Offensive*								

		P	I	P	I	P	I	P	I	P	I	P	I	P	I	P	I
Pain / Itch score	None																
	At dressing change																
	Other times																
	Continuous*																
Surrounding skin	Healthy																
	Oedematous																
	Macerated																
	Red/Inflamed*																
	Dry/Flaky																
	Fragile																
	Discoloured/Purple																
	Excoriated																

Localised Pressure Areas

OBSERVATIONS OF POTENTIAL SKIN DAMAGED AREAS UNDER BANDAGES, SPLINTS, CASTS OR GARMENTS

Please use in conjunction with the 'Best Shot' poster and SHA Midlands and East Pressure Ulcer grading poster

1	Normal colour and skin texture. No pressure damage	6*	Superficial skin break / moisture lesion
2	Red blanching	7***	Full thickness skin damage / pressure ulcer - grade 3
3*	Red non blanching - grade 1	8***	Deep ulcer - grade 4
4**	Blister (clear or haemoserous) on pink base - grade 2	9***	Purple lesion - grade 3/4
5**	Superficial skin break / Pressure ulcer - grade 2	10***	Blood filled blister on purple / black base - grade 3/4

Pressure Area Score:									
Signature:									
Initials:									

CHILDREN'S BURNS & PLASTICS DRESSINGS CLINIC AND OUTREACH TEAM

Hospital No.:	Surname:	Forename:

ASSESSMENT

Date swab taken	Result	Antibiotic Prescribed and Date Commenced	Sign and Print Name

Date	Medical Photography	Consent Obtained	Sign and Print Name

PLAN

OBJECTIVES
• to promote healing
• to protect fragile tissue
• to remove necrotic tissue / blisters
• to remove slough
• to control symptoms
• to ensure patient's comfort
• to improve patient's quality of life

AIMS	
1	Complete wound assessment
2	Reassess at every BPDC appointment
3	Dress wound using aseptic/clean technique within UHL infection control guidelines as per regimen documented
4	Take and send swabs, seek medical advice if indicated, check sent swab results if infection is indicated.
5	Complete pain / itch assessment tool, advise patient regarding analgesia and itch management, seek medical advice if indicated
6	Explain and discuss procedures with patient, alleviate any anxieties and position patient comfortably
7	Advise patient regarding factors that will affect healing and wound outcome i.e. diet, hygiene, smoking
8	Work in collaboration with the multidisciplinary team e.g. Occupational Therapist, Physiotherapist, Dietitian
9	Promote psychological well being e.g. scar management, sun protection, body image, work, education
10	For patients with bandages, splints, pressure garments or casts, ensure skin inspection at each intervention, record assessment, and plan accordingly

Signature:	Print Name:
Date:	Designation:

Hospital No.: Surname: Forename:

ACTION					
	Wound Sign & Date	**Wound** Sign & Date	**Wound** Sign & Date	**Wound** Sign & Date	**Wound** Sign & Date
Removal of sutures/clips/tie-overs/drains:					
Cleanse the wound using normal saline/ trisept Or other:					
Apply topical preparation as indicated and primary dressing					
Apply secondary dressing					
Secure dressing					
Review BPDC					
Community services:					
GP letter					
Referral Diana Team					
Referral Outreach					
Referral HV / School Nurse					
Referral TVN					
Dressings supplied					
OPA review					
Advice given — Wound care					
Advice given — Pain management					
Information sheets provided e.g. Care of child burn Health prevention leaflet					
Refer to Dietitian	Date referred:				
Refer to OT	Date referred:				
Refer to Physiotherapist	Date referred:				
Reviewed by Outreach/Specialist Nurse	Date reviewed:				
Reviewed by Plastic Surgeon	Date reviewed:				

CHILDREN'S BURNS & PLASTICS DRESSINGS CLINIC AND OUTREACH TEAM

Hospital No.: Surname: Forename:

EVALUATION				
Date	Time	Evaluation	Signature	Print name

Hospital No.: Surname: Forename:

EVALUATION				
Date	Time	Evaluation	Signature	Print name

Hospital No.: Surname: Forename:

EVALUATION

Date	Time	Evaluation	Signature	Print name