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# Burns & Scalds Assessment Template. (BASAT)

Please complete for ALL children 0-16th birthday  
presenting with a BURN or SCALD injury.

Please complete ALL sections, ticking ALL answers that  
apply

## Patient Details (or addressograph)

Hospital or NHS number:

Name: Date of Birth:

Gender: Post code:

Ethnicity:

White	Asian	Other
British	Indian	Arab
Irish	Pakistani	Any other back ground
Gypsy or Irish Traveller	Bangladeshi	
Any other white back ground	Chinese	
Mixed	Any other Asian back ground	
White & Black Caribbean	Black	
White & Black African	African	
White & Asian	Caribbean	
Any other mixed back ground	Any other Black back ground	

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Name:	Centre
Hospital No.	ID. No.
DOB:	
Clinician completing form:	
Person completing this form: <input type="checkbox"/> Research Nurse <input type="checkbox"/> Nurse <input type="checkbox"/> SHO <input type="checkbox"/> REG <input type="checkbox"/> ENP <input type="checkbox"/> CONS <input type="checkbox"/> ANP	
Who is accompanying the child? <input type="checkbox"/> Mum <input type="checkbox"/> Dad <input type="checkbox"/> Grandparent <input type="checkbox"/> Unaccompanied <input type="checkbox"/> Other:	
Assessment undertaken: Date: / / (dd/mm/yy) Time: : (24hr)	
Injury Occurred: Date: / / (dd/mm/yy) Time: : (24hr)	
Details of child: Gender: *Age (record in mths if child < 2)	

### 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"/> Electrical	<input type="checkbox"/> Other:

#### 1.2 Location

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

#### 1.3 Details of Incident

Was anyone in the room/vicinity at the time?

☐ Yes ☐ No

If yes, who?

☐ Parent ☐ Grandparent ☐ Peer

☐ Sibling ☐ Other:

Did they see what happened? ☐ Yes ☐ No

What is the explanation for the injury?

#### 1.4 What was the child doing just before the incident?

<input type="checkbox"/> Running/Walking	<input type="checkbox"/> Being Carried/ held
<input type="checkbox"/> Lying Down	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing
<input type="checkbox"/> N/K	<input type="checkbox"/> Other:

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### 1.5 Agent/Mechanism (please complete all applicable)

#### \*Agent

<input type="checkbox"/> Hot Drink	<input type="checkbox"/> Oven Hob	<input type="checkbox"/> Radiator	<input type="checkbox"/> BBQ	<input type="checkbox"/> Iron
<input type="checkbox"/> Hot Food	<input type="checkbox"/> Oven Door	<input type="checkbox"/> Hair Tongs/ Straighteners		
<input type="checkbox"/> Water	<input type="checkbox"/> Fat/Oil	<input type="checkbox"/> Sun	<input type="checkbox"/> N/K	

Other:

Source if scald

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

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"/> Garden/outside	
<input type="checkbox"/> N/K	<input type="checkbox"/> Other:		

Mechanism

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

#### 1.6 First Aid (including inappropriate first aid)

Was First Aid given by Parent/carer? ☐ Yes ☐ No

If yes was it? (tick all that apply)

<input type="checkbox"/> Cold Water	<input type="checkbox"/> Sudocrem	<input type="checkbox"/> Butter
<input type="checkbox"/> Wet compress	<input type="checkbox"/> Talcum Powder	<input type="checkbox"/> Honey
<input type="checkbox"/> Ice	<input type="checkbox"/> Toothpaste	<input type="checkbox"/> Tumeric
<input type="checkbox"/> Other "cooling" agent (e.g frozen peas)	<input type="checkbox"/> Other cream/gel/ointment (specify)	<input type="checkbox"/> Egg

If cold water how was it applied?

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

Was the burn covered? ☐ Yes ☐ No

If yes, what with?

Was Analgesia administered by the parent/carer prior to arrival at ED?

<input type="checkbox"/> None	<input type="checkbox"/> Paracetamol	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Other (specify)
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Name: Hosp. No. DOB:

### Section 2: Details of child

#### 2.1. Is there any developmental impairment?

(Please tick all that apply) ☐ N/A

☐ Motor ☐ Neurological ☐ Hearing ☐ Behavioural ☐ Learning ☐ Vision ☐ Other:

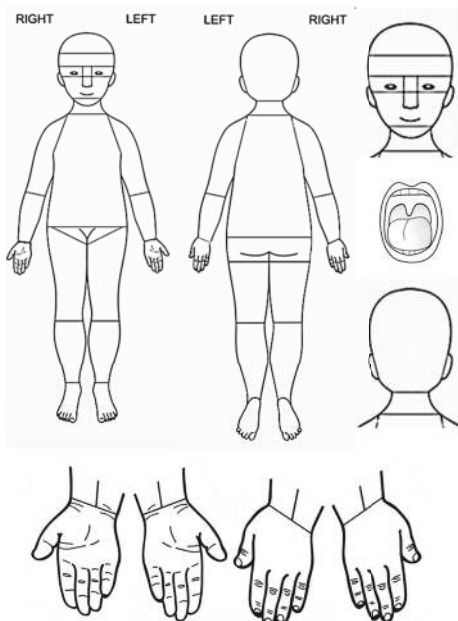
#### 2.2. Current 'best' stage of development.

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

☐ Non mobile Baby ☐ Baby able to roll over ☐ Sitting ☐ Crawling ☐ Cruising ☐ Walking

### Section 3: Characteristics of injury on examination.

#### 3.1 Body map—please shade distribution of injury. ☐ N/A—no visible injury



Name: Hosp. No. DOB:

### \*3.2 Pattern of injury (tick all that apply)

N/A

<input type="checkbox"/> Symmetrical (both sides of the body)
<input type="checkbox"/> Glove/stocking distribution
<input type="checkbox"/> Clearly defined margins
<input type="checkbox"/> Skin fold sparing
<input type="checkbox"/> Margin in shape of an implement
<input type="checkbox"/> Multiple contact burns (more than one)

### \*3.3 Depth of Injury (tick all that apply) N/A

<input type="checkbox"/> Erythema/redness	<input type="checkbox"/> Blisters, not burst
<input type="checkbox"/> Wet, pink	<input type="checkbox"/> 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:

<input type="checkbox"/> ≤ 1%	<input type="checkbox"/> 2-9%	<input type="checkbox"/> 10-14%	<input type="checkbox"/> ≥ 15%
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### 3.5 Any other injuries on examination?

☐ Yes ☐ No

Details if yes:

### 3.6 Have there been any previous ED attendance for:

☐ Burn Injury ☐ Other Injury

Details if yes

### Section 4: Screening, Referrals & Outcomes

#### \* 4.1 Social Service (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 the parent on their own)

#### \* 4.4 Referrals & Outcomes (tick as many as apply)

Was a Child Protection referral made?	Were any other referrals made?	Outcome?
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Discharged Home
<input type="checkbox"/> Social Services	<input type="checkbox"/> Health Visitor	<input type="checkbox"/> ED review
<input type="checkbox"/> Hospital Safeguarding Team	<input type="checkbox"/> School Nurse	<input type="checkbox"/> GP/Practice Nurse
	<input type="checkbox"/> Other	<input type="checkbox"/> Specialist Burns Unit
		<input type="checkbox"/> Transfer to Acute ward
		<input type="checkbox"/> Other

Overall Additional comments:

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