## Our Lady's Children's Hospital, Crumlin Nursing Care plan 18a Skin Fragility



All care plans must be used in conjunction with care plan 1

Care plan 18a Problem	Skin Fragility Issue date: March Goals Review date: March	
	will receive safe and appropriate care relating to his/her skin condition.	
Has skin fragility related to	It is essential to remember there can be no friction or adhesion to the skin.	
Commenced, date, time and signature	Nursing Intervention	Discontinued, date, time and signature
1	Wound care	
	<ul> <li>Ensure adequate analgesia/sedation is administered one hour prior wound care.</li> <li>Continuously assess the infant/child for signs of pain using age/ developmental pain scales.</li> <li>Use pharmacological and non-pharmacological means of pain relief.</li> <li>Monitor and record effectiveness of analgesia</li> <li>Assess the child's skin for signs of skin fragility and blisters</li> <li>Assess the skin signs of infection. e.g. oozing, crusting and erythema</li> <li>Using aseptic technique prepare for a wound dressing.</li> <li>Use non-adherent wound dressings.</li> <li>Never use tapes or adhesives.</li> <li>Specific management of Blisters:</li> </ul> Dressings to be used: <ul> <li>Primary Layer as per patient's needs (e.g.Polymem or Mepitel or Urgutol)</li> <li></li></ul>	
2		
	Clothing: For a baby ensure seams are flat and baby clothes are turned inside out. Use 100% cotton clothing and remove all clothing tags. Use non-restricted clothing Bathing: A Tepid Bath with emollient added	

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	Napkin area care:	
3	Handling and Mobilisation	
	<ul> <li>Minimise further damage/blisters by careful handling avoiding friction.</li> <li>Nurse the infant on melolin roll or a soft blanket</li> <li>Lift the infant on the melolin roll or a soft blanket.</li> <li>Handle the infant/child with direct pressure using the flat palm of the hand avoiding friction</li> <li>Encourage older children to do as much as they can themselves thus avoiding further skin damage or blisters.</li> <li>Remove jewellery/watches/ sharp objects before handling an infant/child with fragile skin.</li> <li>Nurse the child on a pressure- relieving mattress or similar device.</li> <li>Liaise with the physiotherapist and the occupational therapist</li> <li>Regularly assess the infant/child's skin for pressure/friction induced wounds</li> <li>Record and report any changes</li> </ul>	
4	Observations of Vital Signs	
	<ul> <li>Monitor and record vital signs as clinically indicated.</li> <li>Avoid the use of tempadots, use a digital thermometer or non-adhesive probe thermometer for checking temperature.</li> <li>When using a stethoscope for checking the heart rate, place the metal part over an item of clothing.</li> <li>Apply an item of clothing under the blood pressure cuff thus ensuring the cuff does not come in contact with the child's/infants skin.</li> <li>A non-invasive pulse oximetry probe of the clip-on variety may be placed onto the ear lobe or finger.</li> <li>A non-invasive monitoring mattress can also be used for the infant refer to the guidelines on applying ECG electrodes or respiratory sensor on a</li> </ul>	
5	Nutrition  - Record strict intoles and output	
	<ul> <li>Record strict intake and output</li> <li>Weigh infant/child as indicated with dressing in place instructions.</li> <li>Ensure the child's/infants lips are well lubricated with paraffin gel/Vaseline prior to commencement of feeding.</li> <li>Liaise with the dietician:</li> <li>Specific feeding instructions.</li> </ul>	
6	Liaise with the EB CNS( Dermatology)  Refer to Epidermolysis Bullosa guidelines as per NPC folder	

Updated 2016	Patient name
	HCRN
	Ward