

Nurse Practice Committee

Guidelines for the Management of Infants/Children with Epidermolysis Bullosa (EB)

Authors

1st Edition: Sharon Keogh, CNS in Epidermolysis Bullosa
Dr Rosemarie Watson, Consultant Paediatric Dermatologist
2nd Edition: Annmarie Ormonde, CNS in Epidermolysis Bullosa

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1.0 Care of an Infant Admitted with Epidermolysis Bullosa (EB)

Introduction:

Health care professionals who come in contact with children with Epidermolysis Bullosa (EB) should be aware of the general management of the condition and of the necessary techniques to minimise trauma and complications (Nandi and Howard 2010).

Definition of Epidermolysis Bullosa:

Epidermolysis Bullosa is a genetic disorder characterised by blistering of the skin as a result of friction or trauma (Lara-Corrales et al 2010). However mucus membranes can be affected including pharyngoesophageal mucosa (Mortell and Azizkhan 2010).

EB can be inherited in two ways

- Dominant inheritance in which one parent has symptoms themselves and there is a 50% chance in each pregnancy that their children will be affected. Dominant inheritance can also occur as a new mutation.
- Recessive inheritance in which both parents carry one gene for EB. There is a one in four chance for each pregnancy that their children will be affected (Atherton and Denyer 2003).

There are 4 classifications of Epidermolysis Bullosa

- Simplex
- Dystrophic
- Junctional
- Kindler

Complications

- Skin trauma resulting in blistering episodes due to improper handling of an infant.
- Infection
- Blistering of the oral, pharyngeal and oesophageal mucosa
- Management of a difficult airway
- Scar tissue formation and contractures
- Nutritional problems
- Chronic pain and pruritis
- Constipation and anal fissures
- Dysphagia
- Anaemia
- Cardiomyopathy
- Osteopenia
- Dental decay
- Renal Dysfunction
- Ophthalmologic issues i.e. erosions
- Squamous cell carcinoma

1.0 Admission of an infant with EB

Equipment

- Newborn Epidermolysis Bullosa baby pack (located on Nazareth ward)
(Remember to remove any adhesive material from the room to avoid accidental use of same)
- Appropriate dressings e.g., mepitel®, mepilex transfer®, mepilex®, mepiform®, tubifast®.
- Corn flour.
- Height adjustable cot.
- Melolin roll.
- Orange needles/sharps box (located in the treatment room for safe disposal of sharps).
- Digital thermometer, stethoscope, Dynamap
- Soft sterile gauze.
- Weighing scales.
- Skin swabs.

ACTION	RATIONALE & REFERENCE
<p>Admit the infant to a large single room if available.</p> <p>Wear a disposable apron on and always decontaminate hands before and after patient contact.</p> <p>Consider the temperature of the room if possible an air conditioned room should be used. Only nurse the infant in an incubator if medically necessary e.g. prematurity</p> <p>Nurse the infant in a height adjustable cot if available.</p> <p>When handling an infant with EB remember friction and sheering forces will cause skin damage - direct pressure is safe.</p> <p>Never lift the infant under the arms. When it is necessary to lift the infant, roll the infant onto his/her side, place a hand under the head and neck and a hand under the buttocks, allow the infant to roll onto your hands and lift. Nurse the infant on a soft surface such as a piece of melolin roll. This can be used also when lifting the infant.</p> <p>Obtain a baseline of vital signs on admission. Daily Temperature, Pulse and Respiration rate is sufficient. Increase frequency of observations if abnormal or clinically indicated. NOTE Do not use tempadot thermometers. When using a digital thermometer, lift the infants arm gently and place the probe in the axilla. Do not slide the thermometer in or out of the axilla.</p> <p>When checking the heart rate using a stethoscope, place the metal part over an item of clothing e.g. vest or dressings. Never place it directly onto the skin. If a blood pressure reading is required ensure the cuff is not directly on the skin; place it over an item of clothing.</p> <p>Obtain skin swabs for culture and sensitivity and MRSA screen. Swab should be taken in a zig zag pattern and rotated over the wound to maximise contact with wound</p> <p>If nasal and throat swabs are required they should be taken under direct vision with a swab moistened with 0.9% normal saline.</p>	<p>To prevent cross infection (OLCHC 2010b) To provide privacy for dressing changes. To provide the space required for parents, staff, and equipment for dressing changes and to reduce the risk of skin damage caused by caring for the infant in a cramped environment (Atherton and Denyer 2003)</p> <p>To minimise the risk of infection to the child with EB and reduce the risk of cross infection (OLCHC 2010a, OLCHC 2011)</p> <p>A hot humid environment can exacerbate blistering. The risk of developing blisters is increased for infants with EB when they are nursed in a warm environment (Denyer 2010, OLCHC 2011b)</p> <p>A risk assessment should be carried out by staff to prevent back strain for staff and parents during dressing changes as they can take some time (OLCHC 2012)</p> <p>Correct lifting techniques prevent skin damage (Nandi and Howard 2010)</p> <p>To prevent skin damage caused by friction and to minimise trauma to skin (Denyer 2010)</p> <p>.</p> <p>Tempadots will adhere to the skin causing trauma and blistering(Nandi and Howard 2010)</p> <p>To prevent any skin trauma and further blistering (Nandi and Howard 2010)</p> <p>Blood pressure cuffs and tourniquets can exert sheering forces and cause skin blistering (Mortell and Azizkhan 2010).</p> <p>Early detection of infection can be addressed and treatment can commence (OLCHC 2008, Mellerio 2010). Rubbing the swab on the skin may cause skin damage (Mellerio 2010).</p> <p>They may cause serious mucosal detachment and blistering (Nandi and Howard 2010)</p>

<p>Obtain a baseline weight and height. Line the scales with a piece of melonin roll and weigh the infant with dressings in place.</p> <p>The identification band is applied over a piece of tubifast. Ensure the band does not come into contact with the infant's skin.</p> <p>Pain Management Pain is assessed using a validated, age appropriate pain assessment scale and analgesia administered. Non pharmacological methods i.e. adequate preparation and play specialist can also help with pain. Infants may require strong analgesia such as morphine prior to dressing changes. Paracetamol and Ibuprofen may be administered for general comfort. Administer analgesia 30-45 minutes prior to examination and dressing change.</p> <p>NOTE: Do not administer suppositories to an infant with EB.</p> <p>Skin care On initial examination of the infant clinical photographs are taken, with parental consent.</p> <p>Bathing is delayed until the birth damage has healed, and is performed in conjunction with dressing changes. Commercial cling film can be used as a temporary dressing after bathing.</p> <p>If an umbilical clamp is present observe the surrounding skin for signs of friction from it. Apply a piece of mepilex transfer onto the skin to protect the area if required. The clamp can be removed and replaced by a ligature if required.</p> <p>The skin must be inspected regularly and blisters burst. Burst all blisters with a sterile 23G orange needle inserting the needle at the base of the blister. It is important to drain fluid gently and completely. Gentle pressure can be applied with a piece of soft gauze</p> <p>The roof of the blister should be left intact if possible and corn flour can be lightly dusted onto the area however when the blistered area is raw a dressing should be applied. Non Viable skin can be cut away.</p> <p>Wounds must be dressed with a non-adherent dressing. Choice of dressing is limited as many dressings described as non-adherent behave differently on the skin of those with EB. Mepilex®, mepilex transfer®, mepitel and mepiform® (molnlycke) are recommended. Dressings are held in place with tubifast</p>	<p>The risk of skin damage is increased if the infant is naked and without dressings (Denyer 2009).</p> <p>To prevent skin damage caused by friction on the skin (Denyer 2010).</p> <p>To ensure patient is pain free and reduce anxiety of parents and child. To reduce the risk of skin damage (Goldschneider and Lucky 2010,OLCHC pain guidelines 2012) To ensure safe administration of medications (OLCHC 2010, An Bord Altranais 2007).</p> <p>To ensure the maximum result of the analgesia is experienced during examinations/dressing changes(OLCHC 2012) Risk of trauma to anus (Snelson and Clapham 2010)</p> <p>Photographs can be used as a tool to make an assessment of wound healing (Ahn and Salcido 2008)</p> <p>Patient is most at risk from skin damage when naked (Denyer 2010)</p> <p>Cling film will adhere to itself and not on the skin of a child with EB (Nandi and Howard 2010)</p> <p>Periumbilical cord damage is common from the plastic cord clamps (Denyer 2010)</p> <p>Blisters are not self limiting and will extend if left intact (Lara-Corrales <i>et al</i> (2010)</p> <p>Corn flour helps the blister to dry up and reduces friction (Denyer 2010).This is regular cornflour and should be used within expiry date. To promote healing and prepare the wound bed(Lara-Corrales <i>et al</i> 2010)</p> <p>These wound dressings are recommended as they do not adhere to the skin. They are 'sticky' to the touch but are easily removed from the wound without pain or trauma Dressings provide extra protection against injury when handling the child .Dressings are used to protect existing wounds, promote healing, minimise trauma and prevent further blistering (Denyer 2010,Lara- Corrales <i>et al</i> 2010).</p>
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<p>When carrying out dressings the infant should not be fully exposed. Dressings should be changed on a limb to limb basis.</p> <p>Paraffin gel can be used</p> <ul style="list-style-type: none"> • General skin care • On crusted wounds, • On sticky material accidentally applied to the skin. <p>Infants with EB should not be nursed naked. Select flat seamed soft clothes or turn garments inside out. Tags can be removed to prevent friction. Disposable nappies can be used but nappies must be lined with a soft nappy liner which should extend beyond the elasticised part of the nappy especially around the groin and at the top of the nappy.</p> <p>To obtain a urine specimen a clean urine should be obtained.</p> <p>Feeding</p> <p>Some infants have problems with severe blistering of the mouth and sometimes are reluctant to feed. In the infant who is not breast feeding, use of a special feeder (Haberman bottle) is recommended.</p> <p>Apply Vaseline™ petroleum jelly or paraffin gel™ to the lips and moisten the teat with cooled boiled water prior to feeding.</p> <p>Analgesia and or topical applications may be required to reduce pain during feeding if blisters are present in the mouth</p> <p>Liaise with the dietician regarding ease of feeding, regurgitation, type of feed and weight.</p> <p>Document care given and evaluate effectiveness of treatment provided.</p>	<p>Naked infants can cause damage to themselves while they are undressed (Denyer 2010)</p> <ul style="list-style-type: none"> • As a moisturiser • To soften the crust • To aid easy removal of the item adhered to the skin (Denyer 2010) <p>Naked infants will cause damage to themselves due to friction from their own skin. Flat seamed clothes will create fewer traumas. Liners will prevent friction and trauma caused by the nappy (Denyer 2009, Denyer 2010)</p> <p>Never use adhesive material on the skin of a child with EB as trauma will occur upon removal of same (Lara-Corrales et al 2010)</p> <p>A Haberman bottle minimises risk of trauma to the gum margin and reduces the need for strong sucking so even a weak suck delivers a satisfactory milk flow (Haynes 2012)</p> <p>The teat, if dry, may stick to the blistered areas and cause more damage (Atherton and Denyer 2003). Feeding itself can cause trauma to the mucus membranes (Denyer 2009)</p> <p>To ensure adequate nutritional intake of the infant as infants with EB has additional nutritional requirements. These children require a high calorie feed to ensure adequate growth because some of the nutrition is diverted into wound healing (Haynes 2012)</p> <p>To facilitate communication, to provide evidence of delivery of quality care, and to ensure evaluation of the effectiveness of care provided (An Bord Altranais 2002).</p>
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2.0 Bathing or Washing an Infant with Epidermolysis Bullosa

This guideline should be used in conjunction with OLC HC 2011 Guidelines on Bathing an Infant (under 1 yr)

Introduction:

Although bathing is considered to be a normal activity of daily living it is not an easy task for a patient with EB (Arbuckle 2010). The infant with E.B is at greater risk of skin damage when unclothed from friction i.e. kicking of legs rubbing of arms and from adhering to certain surfaces e.g. soft plastic (Denyer 2009). These surfaces can be temporarily covered with commercial plastic kitchen film as cling film adheres to itself but not to skin (Nandi and Howard 2010). Bathing should be delayed until initial birth trauma is healed (Denyer 2010). Health care professionals who come in contact with children with EB should be aware of the general management of the condition and of the necessary techniques to minimise trauma and complications (Nandi and Howard 2010)

Indications

When bathing infants with EB is necessary to meet the infants hygiene needs (Trigg and Mohammed 2010), and to prevent infection and facilitate dressing removal (Arbuckle 2010).

Complications

Trauma to skin and further blistering episodes caused by friction (Denyer 2010)

Equipment:

- Bath
- Disposable gloves and apron
- Soft padding (for base of bath)
- Soft cotton cloth or gauze
- Soft towels 3-4
- Emollient for bath e.g. elave® , Oilatum plus®
- Non-perfumed shampoo
- Cream / ointment for buttocks / perineal area e.g. paraffin gel
- Fresh nappy and nappy liners
- Rounded end nail scissors / clippers (if required)
- Fresh clothes
- Weighing scales (if required)
- Cotton wool
- 2 Sheets, soft blanket

ACTION	RATIONALE & REFERENCE
Ensure the nurse/carers who will bathe the infant are familiar with the correct way to handle an infant with E.B. Two people should be present: one to bathe the infant and one to prevent the infant from causing trauma to skin from kicking feet together.	The infant is most at risk of trauma when undressed (Denyer 2010)
Explain procedure to parents and encourage involvement. Ensure privacy for the infant and parents throughout the treatment.	To ensure child and parents understand the procedure and gain their trust and co-operation (Trigg and Mohammed 2010)
Decontaminate hands before patient contact and wear an apron.	To prevent cross infection (OLCHC 2010a, 2011)
Prepare the environment by gathering the required equipment	Prepare the environment (Trigg and Mohammed 2010)
Pain is assessed, prior to bathing, using a validated, age	E.B. is a very painful condition (Goldschneider and Lucky

<p>appropriate pain assessment scale and analgesia administered if required. Paracetamol is the first medication of choice, with opioids often necessary for change of dressings. This is dependent on the nursing assessment.</p> <p>Medications are administered in accordance with the hospital medication policy</p> <p>Line the bottom of the bath with some soft padding e.g. a soft towel or a piece cut from a roll of Melolin</p> <p>Check bath is at correct temperature not too hot, and add emollient to same</p> <p><u>Hair Washing:</u> When tilting the infant's head back to wash the hair, soft padding is placed between the back of the infant's neck and the hand of the person bathing them, to prevent friction. Wash the infant using a dabbing rather than 'wiping' method, then dry the infant on a soft, non adherent surface using a soft towel. Pat gently with a soft towel to dry.</p> <p>Document care given and evaluate effectiveness of treatment provided.</p>	<p>2010)The role of the nurse is to assess patients pain level, administer analgesia, assess effectiveness and determine if review of same is needed (An Bord Altranais 2007,OLCHC 2012)</p> <p>To ensure safe administration of medications (An Bord Altranais 2007, OLHSC 2010c,).</p> <p>Prevention of discomfort and to prevent trauma and blistering episodes(Denyer 2009,Denyer 2010)</p> <p>To prevent scalding(Himsworth 2010) Emollients provide a surface lipid layer on the skin which slows down the escape of water (Stalder 2011)</p> <p>To prevent skin trauma (Denyer 2010)</p> <p>Prevention of skin damage due to friction (Denyer 2009.)</p> <p>To facilitate communication, to provide evidence of delivery of quality care, and to ensure evaluation of the effectiveness of care provided (An Bord Altranais 2002).</p>
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3.0 Applying Electrocardiograph (ECG) Electrodes or a Respiration Sensor (MRIO Graseby) on a Child with Epidermolysis Bullosa.

Introduction:

The infant / child with E.B. are at greater risk of skin damage from the application of adhesives material directly onto the skin (Lara-Corrales et al 2010). ECG electrodes and respiration sensors contain adhesive materials which can cause friction to the skin (Nandi and Howard 2010). Avoiding skin trauma is a priority therefore the introduction of monitoring equipment should always be discussed with the Dermatology team. Care must be taken during the application and removal of such monitors (Denyer 2010)

Equipment:

- Mepitac tape ®
- Scissors,
- ECG electrodes / respiration sensor.
- Adhesive spray remover/paraffin gel.
- Mepitel®

ACTION	RATIONALE & REFERENCE
<p>Cut holes in the Mepitel® to fit (a) the size of the gel part of each ECG electrode or (b) the size of the respiration sensor and to correspond with the desired positions on the chest. The Mepitel® will be easier to cut when the backing is still in place.</p> <p>Apply the Mepitel® to the chest. Attach the electrodes / sensor to the Mepitel® ensuring that none of the adhesive is in contact with the patient's skin. Secure with mepitac tape.</p> <p>When an electrode/ sensor needs to be replaced, leave the Mepitel® in place, unless clinically indicated. Remove the used electrode / sensor and replace it with a new one. When monitoring is completed, gently remove the Mepitel® with the electrodes / sensor from the skin. If electrodes or a sensor are placed directly on the skin in error or in an emergency situation use an adhesive remover to remove same or paraffin gel.</p> <p>Document care given and evaluate effectiveness of treatment provided.</p>	<p>To prevent damage to the skin by using non-adhesive methods of securing electrodes to the patient. (Lara-Corrales <i>et al</i> 2010).</p> <p>To protect the skin from the adhesive of the electrodes as this may cause blistering (Nandi and Howard 2010)</p> <p>Silicone wound products/non-adherent dressings prevent trauma to skin and allow monitoring of the child. (Nandi and Howard 2010)</p> <p>Prevention of skin damage due to friction (Denyer 2009.)</p> <p>Ease of adhesive removal prevents further skin trauma and reduces blistering episodes(Lara-Corrales <i>et al</i> 2010)</p> <p>To facilitate communication, to provide evidence of delivery of quality care, and to ensure evaluation of the effectiveness of care provided (An Bord Altranais 2002).</p>

4.0 Care of a Child with Epidermolysis Bullosa requiring a general anaesthetic for a procedure.

Introduction:

Health care professionals who come in contact with children with EB should be aware of the general management of the condition and of the necessary techniques to minimise trauma and complications (Nandi and Howard 2010). When a child with EB is going to theatre or requiring a general anaesthetic rigorous planning is required to avoid risk of trauma to the skin and mucus membranes (Azizkhan *et al* 2006)

Common Surgical Procedures in Children with EB

- Change of Dressing/Plaster of Paris
- Repair of Pseudosyndactyly/Surgery to contractures
- Oesophagoscopy and Dilatation
- Open Gastrostomy
- Insertion of Intravenous Access (portacath)
- Ophthalmic Surgery
- Skin Biopsy
- Nissen's Fundoplication
- Excision of Squamous Cell Carcinoma and Skin Grafting (rarely for children)
- Dental Treatments

Complications associated with epidermolysis bullosa

- Fluid loss
- Pain
- Heat loss
- Severe pruritis
- Bacterial infection
- Management of a difficult airway
- Skin trauma resulting in blistering

Theatre Equipment:

- Full range of airway management equipment, including fibroscope, guedel airway and LMA
- A range of appropriate dressings, including Mepitac®, Mepiform®, Mepilex Transfer®, Mepitel, Vaseline gauze, Episil®
- Melolin® Roll
- Crepe and tubular bandages, Tubifast®
- Cling film
- Clip on oximetry probe
- Foam padding for pressure areas
- Bipolar/dry pad diatherm
- Petroleum jelly
- Medical adhesive removal spray

Please consult with the EB CNS and or the dermatology team when a child with EB needs to go to theatre

ACTION	RATIONALE & REFERENCE
<p><u>Psychological preparation</u> Standard preoperative procedures apply using the following adaptations when dealing with a child with EB.</p> <p>The child and parents should be prepared as normal for theatre with reassurance that all involved know about their child's condition and how to care for them.</p> <p><u>Consent</u> Informed consent should be obtained as per hospital policy.</p>	<p>Effective preparation of children who undergo anaesthesia and surgical procedures is an important factor in reducing the anxiety experienced by the child and the family/carer. (Trigg and Mohammed 2010).</p> <p>Preoperative planning and care are essential when dealing with a child that has EB (Azizkhan <i>et al</i> 2006).</p>

<p><u>Assessment</u> A thorough history is essential including a full discussion with the family paying particular attention to airway involvement, neck movement, nasal airway patency, laryngeal involvement, mouth opening, and oral contracture formation.</p> <p>Any current medical problems such as oesophageal reflux, anaemia, cardiac and renal complications should be identified and treated if possible (e.g. Antacids or H2-antagonists for oesophageal reflux).</p> <p>Need for a premedication is assessed.</p> <p><u>Physical preparation</u> The child's identification (ID) band should be applied over a piece of tubifast® or the normal dressing. Ensure the ID band does not come into contact with the child's skin.</p> <p>A topical local anaesthetic such as Amethocaine may be applied in preparation for an intravenous cannula. Do not use an adhesive dressing over the Amethocaine and care must be taken when wiping away any residue. Cling film can be used as a temporary cover.</p> <p>If adhesive tapes or dressings are used in error, they should be left in place until removal is required, when 50% liquid paraffin/50% white soft petroleum and or an adhesive remover can be used to aid removal.</p> <p>All dressings usually worn by the child should be left in place especially during transportation to and from theatre. Dressings should be removed only when necessary. Clingfilm may be used as a temporary dressing for open areas when dressings are removed in the theatre department.</p> <p><u>Pre-medication</u> An oral sedative such as midazolam may be administered if clinically indicated.</p> <p>Atropine may be administered at the discretion of the anaesthetist.</p> <p>Medications are administered in accordance with the hospital medication policy. Monitor the child as clinically indicated</p> <p><u>Transportation to theatre and transfer onto the theatre trolley</u> Where possible transport the child to theatre on his/her own bed.</p>	<p>Subtype of EB can influence airway management. Children with dystrophic or junctional EB are more likely to have airway management problems which can result in difficult intubations (Nandi and Howard 2010).</p> <p>To prevent post-operative complications (Nandi and Howard 2010)</p> <p>Premedication can help promote a calm induction reducing risk of trauma to skin and mucus membranes (Azizkhan <i>et al</i> 2006).</p> <p>To prevent skin damage due to friction on the skin (Denyer 2010).</p> <p>Cling film will adhere to itself and not on the skin of a child with EB (Nandi and Howard 2010)</p> <p>Never use adhesive material on the skin of a child with EB as trauma will occur upon removal of same. Adhesive tapes or dressings can cause trauma to the skin resulting in blistering episodes. (Atherton and Denyer 2003, Lara-Corrales <i>et al</i> 2010).</p> <p>Dressings provide extra protection against injury when handling the child (Denyer 2010).</p> <p>Sedative premeditation is used in younger children to avoid restlessness, particularly during inhalation induction thus preventing injury and trauma (Nandi and Howard 2010).</p> <p>This is used as a drying agent to help control airway secretions, as excessive salivation may occur (Nandi and Howard 2010).</p> <p>To ensure safe administration of medications (OLCHC 2010, An Bord Altranais 2007).</p> <p>To reduce the number of transfers from one surface to another thus reducing the possibility of skin damage</p>
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<p>The theatre trolley should be covered with melolin roll or other soft padding. The trolley should then be covered with cling film, ensuring to cover the sides. All sharp edges should be well padded with melolin roll and cling film.</p> <p>A sheet of melolin roll should be placed directly against the child's skin so that the child may subsequently be lifted onto the operating theatre on this.</p> <p>Patient transfer aids, which involve sliding and sheering forces, should be avoided. Use a "lift and place" method of positioning the child.</p> <p>When it is necessary to lift an infant or small child, roll the child away from you onto his/her side, place a hand underneath the head and neck and a hand under the buttocks, allow the child to roll onto your hands and lift. Do not slide your arms under the child.</p> <p><u>Theatre preparations</u></p> <p>Remove all equipment that should be avoided with the child with EB from the operating room e.g. elastoplast, self-adhesive items such as, oximetry probes, ECG electrodes, diathermy pads and tempadot thermometers. Ensure all equipment coming in contact with the child is well padded or soft and in the case of anaesthetic equipment, well lubricated with materials such as Vaseline gauze or petroleum jelly. Ensure appropriate equipment, as listed previously, is readily available.</p> <p><u>Anaesthesia</u></p> <p>An intravenous cannula if required it should be performed with gentle pressure to distend the veins. Sheering forces should be avoided. Mepitel, Mepiform Episil or Mepitac are very effective for securing devices such as intravenous cannulae. Non-adhesive elasticated netting and conforming bandages may also be useful to secure cannulae.</p> <p>All equipment coming in contact with skin should be lubricated i.e. masks, gloves and instruments. The anaesthetic facemask should be covered with Vaseline gauze and mepitel should be placed against the child's skin where the underside of the jaw is held by the anaesthetist and any other area of the child's skin where pressure is likely to be needed.</p> <p>Endotracheal tube should be one size smaller than would be normally used and the tube and laryngoscope blade should be well lubricated with KY gel prior to intubation. The tube should be held in place with ribbon gauze or mepitac tape, all tubing should be padded and Vaseline gauze should be applied where it comes in contact with skin.</p> <p>Suction and the use of oropharyngeal airways should be avoided if possible although in some cases this is unavoidable. Pharyngeal suctioning should be performed under direct vision, taking care not to apply the suction</p>	<p>caused by friction (Nandi and Howard 2010).</p> <p>To reduce the risk of skin damage, the trolley and sharp edges are padded. The use of cling film helps to reduce the possibility of the skin adhering to any surface (Nandi and Howard 2010).</p> <p>To reduce the risk of skin damage caused by friction (Mortell and Azizkhan 2010).</p> <p>Sliding and sheering forces cause damage to the skin (Nandi and Howard 2010, Snelson and Clapham 2010)</p> <p>Correct lifting techniques prevent skin trauma (Denyer 2010).</p> <p>To avoid skin trauma and friction to the skin and mucous membranes. Inappropriate equipment should be removed if possible from the environment to reduce the risk of skin damage (Nandi and Howard 2010).</p> <p>Sheering forces can cause skin damage. Mepitel, Mepiform, Episil and mepitac have adhesive properties to hold an intravenous cannula securely, but, in contrast to adherent tapes, removal does not cause damage to the skin (Denyer 2010, Mortell and Azizkhan 2010, Nandi and Howard 2010).</p> <p>Holding the child's skin can cause major damage around the mandible and mouth. This will protect the child's skin from trauma (Mortell and Azizkhan 2010)</p> <p>To avoid trauma to mucus membrane and to avoid friction which may damage the skin (Mortell and Azizkhan 2010 Nandi and Howard 2010)</p> <p>They may cause serious mucosal detachment and blistering (Nandi and Howard 2010).</p>
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<p>catheter to the mucosa directly. The eyes should be carefully closed and covered with Vaseline gauze and not adhesive material. Mepitac tape or gel pads can be used to keep eyes closed.</p> <p><u>Nursing Observations</u></p> <p>A non-adhesive pulse oximetry probe of the 'clip-on' variety should be placed onto the ear lobe.</p> <p>ECG electrodes should be adapted using Mepitel or Mepilex transfer directly on the skin, underneath the adhesive and securing with mepitac.</p> <p>NB Do not use tempadot use a digital thermometer to record temperature.</p> <p>Non-adherent soft gauze padding such as melolin roll should be placed around the child's arm prior to application of blood pressure cuffs or tourniquets.</p> <p><u>Skin care</u></p> <p>Skin is prepared with antiseptic solution as normal for surgery but avoid rubbing. Use patting motions.</p> <p>The appropriate dressings should be used for surgical wound sites post surgery. All dressings normally worn by the child should be left in situ and they should only be removed when clinically indicated.</p> <p><u>Post –operatively</u></p> <p>Postoperative care is carried out as appropriate for the surgical procedure.</p> <p>A general skin assessment should be performed to document any new blistering episodes. Temporary dressings or open wounds should be re-dressed with the appropriate dressings.</p> <p>Pain is assessed using a validated, age appropriate pain assessment scale and analgesia administered. Medications are administered in accordance with the hospital medication policy. Non pharmacological methods i.e. adequate preparation and involving play specialist can also help with pain.</p> <p><u>NOTE:</u> The rectal route, frequently used in paediatric postoperative pain management, should be avoided.</p> <p>On return to the ward the child should be transferred safely from the trolley to the bed on the melolin sheet. Should the child need to be lifted, please refer to the correct lifting technique above.</p> <p>Postoperative observations should be carried out as clinically indicated using the techniques outlined above and by referring to the "Guidelines on the care of a new baby with EB on admission". Document care given and evaluate effectiveness of treatment provided.</p>	<p>To prevent corneal abrasions and to protect the eyes (Mortell and Azizkhan 2010)</p> <p>Direct pressure will not cause damage to the skin(Nandi and Howard 2010)</p> <p>To protect the skin from the adhesive of the electrodes as this may cause blistering (Nandi and Howard 2010)</p> <p>To prevent any skin trauma and further blistering(Nandi and Howard 2010)</p> <p>Blood pressure cuffs and tourniquets can exert sheering forces and cause skin blistering (Mortell and Azizkhan 2010).</p> <p>Rubbing the skin is to be avoided as this is a severe cause of blistering (Nandi and Howard 2010).</p> <p>Recommended dressings are non-adherent and dressings left in situ will protect the child's skin (Denyer 2010).</p> <p>To ensure safe recovery from procedure and anaesthetic (Trigg and Mohammed 2010).</p> <p>All care is undertaken to ensure minimal blister formation and unnecessary trauma However trauma can occur if child is unsettled or in pain(Nandi and Howard 2010)</p> <p>Effective postoperative analgesia is essential to minimise discomfort and skin trauma (Nandi and Howard 2010). To ensure patient is pain free and reduce anxiety of parents and child. To reduce the risk of skin damage (Goldschneider and Lucky 2010).</p> <p>Risk of trauma to the mucus membranes of the anus (Snelson and Clapham 2010)</p> <p>Sliding and sheering forces cause damage to the skin (Nandi and Howard 2010 ,Snelson and Clapham 2010)</p> <p>All care is undertaken to ensure minimal blister formation and unnecessary trauma (Nandi and Howard 2010).</p> <p>To facilitate communication, to provide evidence of delivery of quality care, and to ensure evaluation of the effectiveness of care provided (An Bord Altranais 2002).</p>
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