

GUIDELINE TITLE: Nursing care of an infant/child with Staphylococcal scalded skin syndrome	Document No: Version No:
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Owner: Suzanne Byrne Title: Chief Director of Nursing	Author: Bernie Evans, CNS Dermatology CHI Crumlin
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1.0 GUIDELINE STATEMENT

Staphylococcal scalded skin syndrome (SSSS) is a painful, blistering skin condition, which may cover a wide area of skin.

It occurs due to the bacteria *Staphylococcus aureus*, which produces a toxin that damages the outer layer of the skin causing it to blister and peel. The affected skin initially looks red, resembling a scald or burn and is very tender to touch (BAD 2019). The severity varies from localised areas to generalised covering the whole body. It can be a potentially a life threatening condition and a medical emergency in the paediatric population (Leung et.al 2018) however prompt treatment and management improves the outcome. Healing usually occurs without scarring (BAD 2019)

The condition is more common in neonates and children younger than 5 years with a peak age of 2-3 years (Hassanin 2022). Infants and young children may not have the protective antibodies against these toxins; due to their immature immune system, (BAD 2019). Immaturity in the renal system resulting in reduced toxin clearance can also be a factor (Hassanin 2022)

Recent epidemiological studies have demonstrated that infants and young children have an increased incidence of Staphylococcal scalded skin syndrome during the summer and autumn months (Handler et.al 2014). The mortality rate is low in children 1-5 % (Hassanin 2022)

2.0 PURPOSE:

This guideline is intended to provide general guidance to all staff across Children's Health Ireland (CHI) involved in the management of children with SSS.

3.0 SCOPE:

3.1 This guideline applies to all CHI employees and healthcare students, and all organisations and individuals acting as agents of CHI (including visiting healthcare professionals, contractors, consultants and volunteers).

3.2 Target Patient Population: all children and young people who present to the ED in CHI with SSSS or while an inpatient of the service or transferred from the maternity hospitals or regional centres.

4.0 DEFINITIONS / ABBREVIATIONS:

Aseptic Technique: protects patients during invasive clinical procedures by employing a variety of infection prevention and control measures that minimize, as far as practicably possible, the presence of pathogenic microorganisms. Aseptic technique is achieved by 1) Always performing effective hand hygiene, 2) never contaminating key parts and key sites, and 3) taking appropriate infection control precautions, e.g. gloves, waste disposal (Department of Health 2023, CHI 2024).

5.0 ROLES and RESPONSIBILITIES

It is the responsibility of:

5.1. All healthcare workers and students to:

- 5.1.1. Be aware of, read and practice in accordance with this guideline.
- 5.1.2. Determine if they have the necessary knowledge, experience and competence to care for a child or young person with SSSS. If not, they should refer to more experienced colleagues for guidance, information and instruction.

5.2. Heads of Department

- 5.2.1. Ensure staff in their area are aware of, have read and understand the content of this guideline.
- 5.2.2. Monitor adherence to this procedure by nursing healthcare workers and students in their service.

5.3. Guideline Owner to ensure the procedure is communicated and disseminated to all relevant staff.

6.0 EXPECTED OUTCOMES

It is expected that the implementation of this guideline will result in:

- 6.1 SSSS will be effectively managed in children and young people
- 6.2 Complications of SSSS will be prevented in so far as possible

7.0 GUIDELINE STEPS

7.1 Signs and Symptoms (BAD 2019)

- SSSS usually begins in children with a prodromal illness of irritability, generalized fatigue, and fever (LIY-Wong et.al 2021)
- Often pain is the first symptom with little effect on the skin.

7.1.1 Affected children may not want to be held or touched.

- The original source of infection may be relatively minor, for example an infected graze, nappy rash or a red sticky eye. Other sites can include, nose, throat, umbilical stump, and surgical wounds (LIY-Wong et al.2021)
- After a few days, a widespread patchy red rash appears with little blisters and then the patches rapidly join up to cover most of the skin surface.

7.1.2 Gentle pressure on the skin can cause it to peel leaving painful raw patches this is known as a positive Nikolsky sign (LIY-Wong et.al 2021)

7.2 Diagnosis (BAD 2019)

- A swab from the skin or blister fluid is taken and cultured to out rule other infections.
- A.Sample of blood for culture
- Swabs from the nose for culture and sensitivity
- A skin biopsy may be performed if needed.
- Diagnosis based on clinical symptoms and history.

8.0 Indications for treatment

- When large areas of skin peel, body fluids and salts can be lost causing dehydration.
- Poor outcomes are associated with sepsis, electrolyte imbalance, and dehydration (LIY-Wong et. al 2021)
- The condition is extremely painful and the child requires admission for :
 - Intravenous antibiotic therapy
 - Pain relief,

- wound care and
- hydration.
- Children who contract SSSS generally experience complete recovery within two weeks if diagnosed and treated promptly (Hassanin 2022)

9.0 Assessment, and care	Rationale and reference
Admit child to a single room. Wear a disposable apron and always decontaminate hands before and after patient contact	To minimise the risk of infection to the child and reduce the risk of cross infection (OLCHC 2017)
Gather required equipment to do assessment on child.	Prepare the environment To prevent cross infection
Explain what treatment involves to the child and parents/guardian.	To ensure child and parents understands the procedure and gain their trust and co-operation
Infection prevention and control: always use aseptic technique	(Department of Health 2023, CHI 2024) CHI Guide to Aseptic Technique (CHI 2024).
Perform hand hygiene before and after any interventions in accordance with the 5 Moments of Hand Hygiene	CHI 2024
Put on appropriate PPE, i.e. apron and gloves, when handling the catheter or drainage system	(HSE 2023).
Ensure privacy for the child throughout the treatment	CHI (2023)
Skin Assessment Assess the extent of the SSSS Note affected body areas Document the assessment appropriately.	To facilitate communication, to provide evidence of delivery of quality care, and to ensure evaluation of the effectiveness of care provided (CHI 2020b, NMBI 2015).
Pain Pain is assessed using a validated, age appropriate pain assessment scale and analgesia administered. Medications are	To keep the child as comfortable as possible and allow skin care to be carried out. (CHI 2019b)

administered in accordance with the hospital medication policy. Non-pharmacological methods i.e. adequate preparation and involving play specialist can also help with pain. Medications are administered in accordance with national and local medication policies.	To ensure safe administration of medication (NMBI 2020).
Obtain swabs from nose, throat and skin swabs as requested. Bloods may also be required.	To Confirm diagnosis and treat appropriately (BAD 2019)
Bathing: Gentle washing the skin with a non-perfumed emollient to remove old emollients and keep the skin clean. Pat skin dry gently.	Normal soap is too drying and can irritate the skin, Products used should be fragrance free to avoid skin irritation. (NICE 2021)
Skin Care 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. The insertion and exit of the needle must be made through the same entry and exit point. Gentle pressure can be applied with a piece of soft gauze to empty the blister fluid.	Aim to keep skin intact and prevent wounds forming where possible (Lara- Corrales et al 2010, Denyer et al. 2017)
EMOLLIENTS- A greasy emollient e.g. paraffin gel should be applied frequently to the skin to soothe and promote wound healing. Apply in a downward motion. Use a clean spoon or spatula to decant the moisturiser from the tub	To keep skin moisturized. Paraffin Gel is easy to apply and less painful for the child This avoids potential plugging of the follicles that could lead to infection called folliculitis (BDNG 2012) To avoid emollient contamination from the skin (BDNG 2012)

Dressings Dressings may be required to manage wounds. Non-adherent products e.g. mepitel, are recommended to facilitate wound healing. Antimicrobial dressings may be required in some instances. However this should be discussed with the dermatology team Medications are administered as prescribed. Administer intravenous antibiotics and intravenous fluids as prescribed.	To ensure safe administration of medications (NMBI 2020)
Decontaminate hands and dispose of all products appropriately	CHI 2024, HSE, 2023
Document care given and evaluate effectiveness	To facilitate communication, to provide evidence of delivery of quality care, and to ensure evaluation of the effectiveness of care provided (CHI 2020, NMBI 2020)

10.0 COMMUNICATION AND TRAINING

- 9.1 Communication and Dissemination:** This guideline will be posted on Q-Pulse and the internet, and disseminated to relevant departments.

11. COMPLIANCE MONITORING

- 10.1** This guideline will be reviewed and updated at least every three years by the document author/owner, or earlier if required due to updated guidance, evidence or legislation.
- 10.2** Compliance with the key principles or procedures described within this guideline will be managed locally.

12. APPROVAL:

Proposed: Bernie Evans, CNS Dermatology CHI Crumlin	May 2025
Concurred: CHI Nurse Practice Committee	July 2025
Approved: Nursing Documentation Approval Committee	July 2025

13.0 VERSION CONTROL HISTORY:

Date: dd/mm/yyyy	Revision Number	Summary of changes/ Reason for change	Section ref:	Author:
July 2025	V1	Adapted from existing guidance from CHI sites	All sections	Bernie Evans

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Appendix I: Guideline Development Group/Stakeholders

Development Group/ Key Stakeholders	Approval Date
Bernie Evans, CNS Dermatology Dermatology CNSs CHI Annette Durkan, CNS CHI Crumlin Siobhhan Gilboy, CHI Crumli Nicola O Shea, Senior Librarian, CHI Crumlin Jenny Dunne, CNM 3 Neonatology, CHI Fionnuala O'Neill, Nursing Practice Development Coordinator CHI Nurse Practice Committee	May 2025