Introduction: Staphylococcal scalded skin syndrome (SSSS) is the clinical term used to describe the spectrum of skin diseases induced by the exfoliating toxins of Staphylococcus aureus (Patel and Finlay 2003). The disease is characterised by red blistering skin that looks like a burn or scald. It occurs mostly in children younger than 5 years and in the neonatal period, it can result in nursery outbreaks (Patel and Finlay 2003). The form and severity vary with the route of delivery of the toxin to the skin, ranging from localised bullous impetigo to generalised SSSS involving the whole skin surface. Exquisite tenderness of the skin may herald onset of SSSS.

Signs and Symptoms
SSSS usually presents with fever, irritability and widespread erythema of the skin. Characteristics of the rash:
- Skin takes on tissue paper-like appearance
- 24-48 hours later fluid filled blisters develop in armpit, groin, mouth, nose and ears.
- Rash spreads to other body parts including limbs and trunk.
- Top layer of skin begins peeling off leaving exposed, moist, red and tender areas.
- Dehydration may result.

Indications for treatment:
The condition is excruciatingly painful and the child requires admission for antibiotic therapy, pain relief, wound care and hydration. Parents/guardians need reassurance that recovery is usually rapid once appropriate antibiotic therapy has begun and that healing occurs usually without scarring after 10-14 days.

Complications associated with SSSS
Septicaemia.
Dehydration.
Death (mortality rate 3% in children, Horn et al, 2003)

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| Assess the child  
- the extent of the SSSS, 
- affected areas |
| To enable the early detection and management of SSSS and to facilitate the planning and evaluation of care (An Bord Altranais 2002) |
| Document the assessment appropriately. |
| Maintains accountability through accurate recording of nursing intervention. (NHO, 2009) |
| Pain is be assessed frequently using a validated, age appropriate pain assessment scale, and analgesia is administered as required. Sedation may also be required prior to dressings. |
| The condition is excruciatingly painful (Patel and Finlay 2003). To reduce the pain associated with dressings, thus increasing child’s comfort. (Lloyd Jones 2004) |
| Medications are administered in accordance with national and local medication policies. |
| To ensure safe administration of medication (OLCHC 2010c). (Bruce & Thiers 2010) |
| If intravenous access is necessary the canula should be secured using silicone-based, rather than adhesive tapes (mepitac or siltape) |
| To prevent spread of infection – spread by direct contact (Patel and Finlay 2003, OLCHC 2011). |
| Nurse the child in strict isolation. |
| For culture and sensitivity. (Patel and Finlay 2003)as per wound swab guideline (OLCH 2008) |
| Swabs are taken of the affected area. |
| To assist in confirmation of diagnosis (Patel and Finlay 2003). |
| Two snippings of the roof of fresh blisters may be sent to laboratory  
a) one in formaline  
b) one in saline soaked gauze |
These samples may be delayed for 24 hours. Blood cultures are taken. Administer intravenous antibiotics and intravenous fluids as prescribed. No adhesive strapping is applied to the skin. Mepiform may be used to keep cannula in place.

**Dressings:**
Moist denuded areas should be lubricated and covered with a non-adherent dressing to decrease pruritus, tenderness and prevent infection.

Wash hands thoroughly with antiseptic solution (ANTT Level 2) Explain the procedure to the child and parents. Ensure privacy for the child throughout the treatment.

Dressings may be carried out twice daily as prescribed or by clinical judgement

Areas that are oozing are cleaned gently with warm 0.9% normal saline.

Apply Mepitel to all erythematous (red) areas (this comes in large non-woven sheets and is excellent for all large areas). Secure in place with Tubifast or gauze bandage.

DO NOT apply wound pad over Mepitel, as it will soak the moisture. If there is excessive exudate a secondary foam dressing (mepilex transfer) may be used for absorption

**Infected wounds:**
Flamazine (topical antimicrobial) or Bactroban (topical antibiotic) may be prescribed by the Consultant Dermatologist. These can be applied to the Mepitel at every change of dressing with a wooden spatula, prior to the dressing being applied to the wound.

**Baths:**
As child improves, baths with emulsifying ointment may be given daily. (See bathing a child guideline (OLCH 2008)

**Moisturisers:**
As condition improves paraffin gel (50% liquid paraffin, 50% white soft paraffin) is enough to keep the skin well moisturised. This will need to be applied frequently.

Always apply in a downward direction.

Document care given and evaluate effectiveness of treatment provided

To assist in confirmation of the diagnosis (Patel and Finlay 2003).
To treat infection and prevent dehydration (Patel and Finlay 2003).
Can cause increased irritation and trauma to sensitive skin (Trigg & Mohammed 2010).
To prevent cross infection (OLCSC 2010)

To help reduce anxiety of child and parents, by appropriately informing them of the procedure (Trigg & Mohammed 2010).
To maintain dignity in accordance with Prevention of Abuse of Children by a staff member while in the care of the hospital (OLHSC 2007)
Depending on the severity of the condition (Patel and Finlay 2003).
This is less painful than cold solutions (Trigg & Mohammed 2010).
Mepitel is a non adherent dressing that is safe to use on fragile skin. (Bruce & Thiers 2010)
Skin needs to be kept moist to promote healing. Well moisturised skin is more comfortable and less painful (Patel and Finlay 2003).

To keep skin moisturised. Paraffin Gel is easy to apply and less painful for the child (Trigg & Mohammed 2010).
To prevent clogging of pores causing folliculitis (Trigg & Mohammed 2010).
To facilitate communication, to provide evidence of delivery of quality care, and to ensure evaluation of the effectiveness of care provided (NHO, 2009).

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