

**Standard Operating Procedures**

**Management of Atopic Eczema in Babies and Children (under 12)**

July 2025

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# Introduction

Atopic Eczema (from the Greek word ekzein meaning to boil) or Atopic Dermatitis, is a common skin condition affecting up to 20% of children in the developed world. It is an inherited disorder, which often occurs in association with asthma and hay fever, known collectively as Atopy.

Clinical features of Atopic Dermatitis include skin dryness, erythema, oozing and crusting, and lichenification (thickened skin). Itching and scratching are the most distressing symptoms, with sleep disturbance being a common problem. Although allergies may exacerbate eczema, they are not the primary cause in most cases.

For further information regarding Atopic eczema please refer to the NICE guidelines:

[Overview | Atopic eczema in under 12s: diagnosis and management | Guidance | NICE](https://www.nice.org.uk/guidance/cg57)

*“A child can be diagnosed with atopic eczema when they have an itchy skin condition plus 3 or more of the following:*

* *visible flexural dermatitis involving the skin creases, such as the bends of the elbows or behind the knees (or visible dermatitis on the cheeks and/or extensor areas in children aged 18 months or under)*
* *previous flexural dermatitis (or dermatitis on the cheeks and/or extensor areas in children aged 18 months or under)*
* *dry skin in the last 12 months*
* *asthma or allergic rhinitis (or history of atopic disease in a first-degree relative of children aged under 4 years)*
* *onset of signs and symptoms under the age of 2 years (do not use this criterion in children aged under 4 years).*

*Healthcare professionals should be aware that in Asian, Black Caribbean and Black African children, atopic eczema can affect the extensor surfaces rather than the flexures, and discoid (circular) or follicular (around hair follicles) patterns may be more common.”* **(NICE, 2007)**

These Standard Operating Procedures (SOP) have been developed to guide and advise Health Visitors (HV) caring for babies and children under 5, and School Nurses (SN) caring for children aged 5-11 with mild eczema or dry skin ([SOP 1](#_SOP_1_)). They then outline when to refer to the Children’s Community Nursing Team (CCNT) for further support ([SOP 2](#_SOP_2_)) and provide a framework for the management of more severe Atopic Eczema ([SOP 3](#_SOP_3_)).

Please note:

* these SOPs do not replace professional judgement which should be always used
* a clear rationale should be presented in support of all decision making
* practice should be based on the best available evidence
* appropriate escalation when care needs have this requirement
* when care is delegated to a non-registrant, the registered nurse remains accountable for the appropriateness of the delegation and overall outcome of the delegated task

# SOP 1 Procedure to Support Families Caring for a Child with Atopic Eczema

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| ***Purpose*** |

This SOP provides HV, SN and CCNT with general advice to enable them to support the family of a child with atopic eczema.

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| ***Scope*** |

This SOP applies to infants, children and young people on the caseloads of HV, SN and CCNT, in the home or other community setting.

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| ***Core Requirements/Procedure*** |

In the first instance, Health Visitors, School Nurses and CCNT Nurses should direct parents and carers to the GP or Pharmacist for advice on use of emollients.

*“Children with atopic eczema should be offered a choice of unperfumed emollients to use every day for moisturising. This may be a combination of products or one product for all purposes. Emollients should be prescribed by GP in large quantities (250 g to 500 g weekly) that are easily available to use at nursery, pre-school or school.”* (**NICE 2007, amended 2023**)

For further information about the severity of eczema and its impact on the child’s quality of life, refer to [Appendix 3](#_Appendix_3_-).

Explain to children with atopic eczema and their parents or carers that they should use emollients:

* in larger amounts and more often than other treatments
* on their whole body, both when the atopic eczema is clear and while using all other treatments

Show children with atopic eczema and their parents or carers how to apply emollients, including how to smooth emollients onto the skin rather than rubbing them in.

If their current emollient causes irritation or is not acceptable, offer a different way to apply it or suggest they see GP for an alternative emollient.

Recommend to parents/carers that they should have the child’s repeat prescriptions reviewed annually.

When children with atopic eczema are using emollients and other topical products at the same time of day, explain that:

* they should apply one product at a time, and wait several minutes before applying the next product
* they can choose which product to apply first

Offer personalised treatment plan ([Appendix 1](#_Appendix_1_)) which includes information on washing with emollients or emollient soap substitutes, applying emollients and explain to children with atopic eczema and their parents or carers that:

* they should use leave-on emollients or emollient soap substitutes instead of soaps and detergent-based wash products
* leave-on emollients can be added to bath water
* children aged under 12 months should use leave-on emollients or emollient soap substitutes instead of shampoos
* older children using shampoo should use a brand that is unperfumed and ideally labelled as suitable for eczema, and they should avoid washing their hair in bath water.

Please also refer to the flowchart in [Appendix 2](#_Appendix_2_–) for the pathway Health Visitors and School Nurses should follow in the management of Mild Infantile Eczema, and table in [Appendix 4](#_Appendix_4_–) - Identifying and Managing Trigger Factors in Atopic Eczema.

# SOP 2 Referring to Children’s Community Nursing Team (CCNT) for further support

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| ***Purpose*** |

This SOP provides Health Visitors and School Nurses with information on when to refer on to CCNT

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| ***Scope*** |

This SOP applies to infants, children and young people on the caseloads of HVs and SNs in the home or other community setting.

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| ***Core Requirements/Procedure*** |

Children with eczema may be referred to the CCNT by HV, GP & Paediatrician.

Referrals are not accepted from parents or the Dermatology Department.

If children show signs of food allergies, then referral to paediatrician and dietician should be made. However, be mindful, that parents are often wanting a cause of eczema, and this is not always linked to food allergy, mainly poor emollient use.

HV and SN’s must have followed the Management of mild atopic eczema algorithm for minimum 2 weeks before referral to CCNT.

# SOP 3 Management of children by CCNT with Infected/severe Atopic Eczema

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| ***Purpose*** |

To provide the Children’s Community Nursing Team (CCNT) with guidance on managing children with severe or infected atopic eczema in the home or community setting, using emollients and prescribed topical treatments.

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| ***Scope*** |

This SOP is be used with infants, children and young people on the CCNT caseloads, in the home setting or other community setting.

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| ***Core Requirements/Procedure*** |

Children with eczema can be referred to CCNT by HV, SN, GP and paediatrician.

Referrals are not accepted from parents or the Dermatology Department.

**Stepped approach to management**

Use the stepped approach in table below for managing atopic eczema in children.

Emollients are the foundation of treatment and should be used, even when eczema is clear.

Management can then be stepped up or down, according to the severity of symptoms

Refer to [Appendix 6](#_Appendix_6_–) - Stepped Treatment Options for details

**Flares**

CCNT should educate families on recognising flares and starting treatment promptly.

Treatment should continue for 48 hours after symptoms subside.

Refer to [Appendix 7](#_Appendix_7_–) for flare management.

**Infected Eczema**

If infection is suspected, assess for signs (e.g., weeping, pustules, crusting, fever).

Advise on obtaining replacement medications post-infection.

Follow infection management guidance in [Appendix 8](#_Appendix_8_–): Management of Infected Atopic Eczema.

**Escalation**

If eczema does not improve despite a good emollient regime and prescribed topical treatments, CCNT should refer to the GP or Paediatrician for further assessment.

# Appendix 1 Treatment Plan for Eczema Management

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Name: | | Date of Birth: | |
|  | | | |
| **RECOMMENDED PRODUCTS FOR YOUR CHILD’S SKIN CARE** | | | |
| Bath emollient: | | | |
| Soap substitute: | | | |
| Moisturiser / Emollient: | | | |
| Face: | Body: | | Limbs: |
| Topical steroid: | | | |
| Face: | Body: | | Limbs: |
|  | | | |
| **DAILY MOISTURISING ROUTINE**  Apply the moisturiser to the skin at least………………………. times daily.  If the skin is dry, apply the moisturiser once an hour for one day, applied thinly, gently and quickly. | | | |
|  | | | |
| **RECOMMENDED DAILY BATHING ROUTINE**   * Bath your child once a day * Add the bath emollient to a bath of lukewarm water * Apply the soap substitute all over the body prior to getting in the bath * Allow your child to play in the bath for a maximum of 10 minutes, while the soap substitute is gently massaged into the skin * Following the bath, pat the skin dry with a towel * Then apply the greasy emollient all over the skin. Leave to soak in for 30 minutes. * When topical steroids are required, apply them evenly to patches of eczema so that the skin glistens in the light.     This routine can be repeated morning and evening as recommended    Apply the topical steroid once or twice daily for…………….days / weeks until clear    This may take only a few days or in more severe cases a few weeks. It is safe to apply steroid creams and ointments regularly whilst under the supervision of the General Practitioner, paediatrician or Children’s Community Nursing Team. | | | |
|  | | | |
| **CONTINUE THE BATHING AND MOISTURISING ROUTINE EVERY DAY TO PREVENT ECZEMA FLARING UP**  The eczema may recur. If the skin is dry apply the moisturiser more frequently as recommended above and apply the topical steroid once or twice daily until the eczema is under control again. | | | |

# Appendix 2 – Management of Mild Infantile Eczema by Health Visitors & School Nurses

**Use the prescribed moisturiser as a soap substitute. Avoid soaps.**

**Greasy emollient applied twice a day.**

**Apply this in a downward direction, in line with hair growth**

**For two weeks**

**If improvement - continue regime**

**No improvement**

**Increase frequency application to 4 hourly/with nappy changes.**

**If dry skin continues, apply even more frequently**

**If improvement - continue regime**

**No improvement - refer to GP for 1% hydrocortisone ointment to be prescribed**

**Parents to use 1% Hydrocortisone ointment daily to affected areas of eczema for up to 2 weeks as prescribed by GP**

**If no improvement - refer to Community Children’s Nursing Team or back to GP**

**1% Hydrocortisone ointment to be reapplied if acute relapse**

**If improvement - continue with emollient regime only**

**Daily Bath**

# Appendix 3 - Classification of Severity of Eczema and Impact on Quality of Life (NICE, 2007)

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| --- | --- |
| Skin and physical severity | Impact on quality of life and psychosocial wellbeing |
| Clear: normal skin, no evidence of active atopic eczema | **None**: no impact on quality of life |
| Mild: areas of dry skin, infrequent itching (with or without small areas of redness) | **Mild**: little impact on everyday activities, sleep and psychosocial wellbeing |
| Moderate: areas of dry skin, frequent itching, redness (with or without excoriation and localised skin thickening) | **Moderate**: moderate impact on everyday activities and psychosocial wellbeing, frequently disturbed sleep |
| Severe: widespread areas of dry skin, incessant itching, redness (with or without excoriation, extensive skin thickening, bleeding, oozing, cracking and alteration of pigmentation) | **Severe**: severe limitation of everyday activities and psychosocial functioning, nightly loss of sleep |

# Appendix 4 – Identifying and Managing Trigger Factors in Atopic Eczema

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| --- | --- |
| Category | Details and Recommendations |
| Common trigger factors | * Irritants (e.g. soaps, detergents, shampoos, bubble baths, shower gels, washing-up liquids) * Skin infections * Contact allergens * Food allergens * Inhalant allergens |
| Food allergy | Consider if:   * Immediate symptoms after eating specific food * Moderate/severe eczema not controlled by optimum management * Associated with colic, vomiting, altered bowel habit or failure to thrive |
| Inhalant allergy | Consider if:   * Seasonal flares of eczema * Eczema associated with asthma or allergic rhinitis * Eczema on the face (especially around eyes) in children aged 3+ |
| Allergic Contact Dermatitis | Consider if:   * Eczema has worsened unexpectedly * Reactions to topical treatments |
| Testing for Allergies | * Most children with mild eczema do not require allergy testing * Do not recommend high street or internet allergy tests — they lack evidence |
| Bottle-fed Infants (<6 months) | If eczema is uncontrolled with optimal treatment:  Trial of extensively hydrolysed protein or amino acid formula (6–8 weeks) |
| Dietary Advice | • Refer if cow’s milk-free diet has lasted >8 weeks  • Do not use unmodified animal milks or partially hydrolysed formulas  • Soya-based formulas can be considered (age 6+ months, with dietitian advice) |
| Breastfed Infants | • Changing maternal diet may not affect eczema  • Consider allergen-specific exclusion only if food allergy strongly suspected |
| Environmental factors | • Unclear role of stress, humidity, and temperature  • Recommend avoidance where possible |

(Adapted from [NICE Clinical Guideline CG57, 2023](https://www.nice.org.uk/guidance/cg57))

# Appendix 5 - Atopic Eczema General Guidance for HV, SN and CCNT

**Bathing**:

* Daily bathing is recommended for all children with eczema. Showering appears to be less effective
* Bathing removes skin scales, crusts and dried blood from the skin along with reducing bacterial levels. The child’s moisturiser should be used instead of soap. Maximum 10 minutes in the bath to prevent skin drying out
* Avoid all soaps and commercial bubble baths, which may irritate and dry the skin There is limited research to show the effectiveness of bath oils in improving eczema management and therefore these are no longer prescribed by GP.

**Clothing**:

* Cotton and polyester with a fine construction are both suitable fabrics and do not irritate the skin
* Avoid wool clothing for the child and those who may hold the child
* Avoid biological washing powders and perfumed fabric conditioners

**Temperature**:

* Children with eczema are affected by changes in temperature and humidity. Therefore, they may scratch more when undressed or bathing

**Emollients**/**Moisturisers**:

* Offer a choice of unperfumed emollients. Greasy emollients are often more effective, especially on darker skin types
* Emollients should be suited to the child’s needs and preferences and used for everyday moisturising, washing and bathing
* They should be used more often and in larger amounts than other treatments and used on the whole body, even when the eczema is clear
* Ointments have a greasier consistency and are often most effective for very dry skin, causing less stinging
* Creams have addition of preservatives, which may cause allergic reaction, but are often more cosmetically acceptable particularly for daytime use
* Gels are often soothing because of the cooling effect
* Lotions are often not greasy enough to moisturise the skin effectively
* When atopic eczema is severe, any topical product including emollients can irritate and sting the skin when applied. It is not an indication of allergy to the product.

**Swimming**:

* To prevent the drying effects of chlorine water, a thin layer of emollient can be applied all over the skin prior to swimming
* The child should shower or bath afterwards to remove the chlorine from the skin and frequently apply emollients after

**House Dust Mite:**

* The House Mite survives in warm, moist and dark places
* Reduction in House Dust Mite levels may be beneficial, but parents should be discouraged from becoming too preoccupied with cleaning
* There is greater benefit to the child in providing an effective daily emollient regime, rather than cleaning excessively

**Eczema and the Sun:**

* Some children with eczema improve in the sun, but others deteriorate in the heat.
* Sun protection must still be considered in line with guidelines for children and babies.
* Apply sun cream 20-30 minutes after emollient application and 20-30 minutes before sun exposure
* To be effective sunscreens should be applied 30 minutes before exposure to the sun to allow protective elements time to bond on the skin.
* Sunscreens containing Titanium dioxide are effective at reflecting harmful sunrays and least likely to cause irritant reactions.
* Methyldibromoglutaronitrile, a sunscreen preservative has been shown to cause allergic reactions.
* Sunscreen should be Factor 30-50 and have a 5 star \* rating.

# Appendix 6 – Stepped Treatment Options for Atopic Eczema in Children

Adapted from [NICE Guideline (CG57)](https://www.nice.org.uk/guidance/cg57)

Notes for use:

* *Always use emollients as the foundation of treatment, regardless of severity.*
* *Treatment should be stepped up or down depending on response and symptoms.*
* *Topical corticosteroids should be used in the lowest effective potency for the shortest necessary duration.*
* *Escalate to specialist care if treatment is ineffective or if eczema significantly affects quality of life.*

# Appendix 7 – Flare Management

Adapted from [NICE Guideline (CG57)](https://www.nice.org.uk/guidance/cg57)

# Appendix 8 – Management of Infected Atopic Eczema

Adapted from NICE guideline NG190: Atopic eczema in under 12s – Diagnosis and Management (2021) Section: Managing secondary bacterial infections of eczema [*www.nice.org.uk/guidance/ng190*](http://www.nice.org.uk/guidance/ng190)