

SCABIES AND HUMAN LICE POLICY
**(To be read in conjunction with the
 Personal Protective Equipment Policy)**

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DOCUMENT CONTROL

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Intended recipients: All staff whatever their grade, role or status. Permanent, temporary, full-time, part-time staff including locums, bank staff, volunteers, trainees and students. This Policy will be available to the general public on the Trust Internet.			
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1. INTRODUCTION

- 1.1 Scabies is a contagious infection caused by a mite *Sarcoptes scabiae* var. *hominis*. The condition is recognised by an allergic reaction to the saliva and faecal material excreted by the mite. It is a worldwide disease, more common where overcrowded conditions prevail. It can affect any individual irrespective of social class or race. It is primarily characterised by itching and vesiculations. Signs of reddish, slightly elevated tracts may also occur. Miniature papules, vesiculations, pustules and excoriations soon appear. Scratching of these areas may lead to secondary bacterial infection, sometimes requiring antimicrobial treatment (Health Protection Agency North West, 2010).
- 1.2 Policy is required to assist with the management and treatment of patients with Scabies or Human Lice Infestations, to ensure adequate treatment and to prevent the risk of cross contamination to staff and patients.

2. PURPOSE & SCOPE

- 2.1 The purpose of this policy is to provide staff with the necessary information to identify the signs and symptoms of Scabies and human lice infestations and to manage and treat these conditions appropriately.
- 2.2 The policy applies to all staff working within Trust clinical and social care environments (including Temporary, Locum, Bank, Agency and Contracted staff).

3. DUTIES AND RESPONSIBILITIES

3.1 The Trust Board, via the Chief Executive will:

- ensure there are effective and adequately resourced arrangements for the management of scabies and lice within the Trust.
- identify a board level lead for infection control.
- ensuring that the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled by appropriate and competent persons as defined by DH, (2009b).

3.2 Director of Infection Prevention and Control (DIPC)

The DIPC will oversee the local control of and the implementation of the scabies and human lice policy.

- 3.3 **The Infection Prevention and Control Group** will ensure that the procedures for the management of scabies and lice are continually reviewed and improved within the Trust.

3.4 **The Infection Prevention and Control Team** will offer advice and education as required on scabies or lice infestations.

3.5 **Ward and Team Managers** are

- Responsible for ensuring that staff are aware of the policy and have current updates.
- Responsible for ensuring that staff are released to attend relevant Training and for recording attendance at training in local training records. All non-attendance at training will be followed up by managers.

3.6 **All healthcare staff** are:

- Required to adhere to the policies, guidelines and procedures pertaining to the management of scabies and human lice which provide a framework for safe and best practice.
- Responsible for booking themselves onto initial and update mandatory training and for attending mandatory training.

3.7 **The Learning and Development Department** is responsible for entering all data relating to Mandatory and Non-Mandatory training attendance onto the Electronic Staff Record (ESR) system and reporting non-attendance to Ward and Team Managers.

4. EXPLANATIONS OF TERMS USED

4.1 Infestation – where an individual has parasites on or in the body.

4.2 Transmission – the movement of a parasite from one individual to another.

4.3 The host – the individual who is infested with the parasite

4.4 Scabies - a small mite, *Sarcoptes scabiei*. The mites live in the superficial layers of the epidermis, moving up to 5mm a day burrowing through the skin. The female can live for 4 – 6 weeks and in this time can lay 40 – 50 eggs; the resulting larvae hatch after 3 - 4 days and then establish more burrows off the maternal one. These burrows can be seen if you look carefully, they appear as tiny white lines with a black spot at the end, usually on the inner surface of the wrists and finger webs. Further spread to the elbows, axillae, waist and groin may occur. Nodules may be seen on genitalia or the pubic area. The larvae mature to become adults in 10 – 15 days.

4.5 Norwegian/crusted scabies - in this form the mite population may be huge, possibly reaching hundreds of thousands, and can present all over the body, including the head and face. Typical burrows may not be seen and the rash may resemble a chronic dermatitis or psoriasis. However the

patient **may not** complain of itch. It is more common in the elderly and immuno-compromised

- 4.6 Lice – a parasite which lives on the skin or inner layers of clothing, feeding on their hosts up to 5 times daily. Eggs take 7 – 10 days to hatch and as adults the lice remain viable for up to 30 days. An allergic reaction to the bites causes an itch but this can take up to 3 months to develop and within this time the individual may become desensitised. Three species of lice use humans as their host, each living on a specific area, Head Lice, Body Lice and Pubic (Crab) Lice.
- 4.7 Head lice – are found on the head and eyebrows. The adult is flesh coloured (in darker haired people the adult lice is also darker) approximately 1 – 4mm and moves very fast. Each female produces over 50 eggs, usually around 6 each day, sticking them close to the base of the hair where it is warm. Eggs hatch in 6 – 10 days leaving the old egg cases (nits) attached to the hair. They reach adulthood in 6 – 12 days and are ready to mate after 11 – 18 hours.
- 4.8 Body lice – are similar to, but slightly bigger, than head lice. They are associated with poor living conditions, lack of cleanliness and poor nutrition. The louse lives in clothing, laying clusters of eggs in the seams and fibres. Occasionally if the infestation is heavy, they will lay eggs in body hair. If clothing is worn continuously, the eggs will hatch within 8 days and they reach adulthood in up to 21 days. The louse remains viable for up to 30 days but can only survive for a few days without food. Bites are very itchy and red wheals often surround them. These lice can transmit serious infection including typhus, relapsing fever and trench fever but this is most commonly seen in Africa and is very rare in Europe.
- 4.9 Pubic/crab lice – these are much larger and flatter than head lice and have large claws on the second and third pairs of legs enabling them to move around in less dense body hair. The female lays several eggs on a single hair which hatch in 6 – 8 days. The nymphs take 17 days to mature. Reactions take up to 6 weeks and the itching can be severe. These lice can be found in all course body hair including, chest, axilla, beard, eyebrows and eyelashes.
- 4.10 Parasitocidal - a treatment for scabies and lice infestations.
- 4.11 The Trust – Somerset Partnership NHS Foundation Trust.

5. DETECTION

- 5.1 Definitive diagnosis of scabies infestation is only possible by carrying out microscopic examination of skin scrapings. However, the visible 'burrow' is often used as a diagnostic tool. It is a discoloured and often raised line which may be straight, tortuous or dotted and is commonly found in the webs of fingers, wrists, flexors of the arms, axilla, lower abdomen, genitalia, buttocks and feet. This rash is very itchy especially at night.

- 5.2 Norwegian/Crusted Scabies must be confirmed by a doctor with experience of infestation due to its similar presentation to Eczema and other chronic skin complaints.
- 5.3 Lice and their old egg cases (nits) are large enough to be visible and infestation may be obvious, especially if severe.

6. TRANSMISSION

- 6.1 Scabies mites require prolonged, skin to skin contact with an infested individual (over 3 minutes) for transmission however, prolonged contact with or in an infested individual's environment (bedding, linens etc) will also lead to transmission.
- 6.2 Head lice may be transmitted to another host if there is direct head to head contact for 1 minute or more. They move rapidly in dry hair.
- 6.3 Body lice are transmitted through prolonged skin to skin contact or contact with infested clothing or bedding.
- 6.4 Pubic lice require close intimate contact and do not survive long away from the host. They are not easily transmitted through clothing or bedding.
- 6.5 Typically, the new scabies or lice host will show symptoms in approximately 2 – 6 weeks; however, individuals who have had previous scabies infestation may show symptoms within hours if re-infested due to prior sensitisation.

7. TREATMENT

- 7.1 Chemical treatment for scabies and lice infestation is by topical agents but is often ineffective unless other practical measures are also used.

7.2 Scabies Treatment

- 7.3 Permethrin 5% cream is the first line treatment.

Malathion 0.5% aqueous liquid may be used if Permethrin 5% cream is not suitable for example, if patients are known to be hypersensitive to Permethrin.

Both should be prescribed in line with BNF/pharmaceutical guidance. Permethrin should be washed off after 8-12 hours and Malathion after 12 hours.

Reapplication to hands is required if they are washed during this time.

- 7.4 Treatment should be applied to the whole body including the soles of the feet and left in situ for the prescribed period of time. The skin should be cool as, if applied following a hot bath there may be increased systemic

absorption, increasing the risk of toxicity and reducing effectiveness. and in all cases if an area is washed within its allotted treatment time that area should be retreated.

- 7.5 Most symptomatic cases require 2 applications, 7 days apart.
- 7.6 Gloves and apron should be worn by staff if applying treatment and if giving close personal care until the whole treatment course is complete.
- 7.7 The inpatient should be isolated until completion of the treatment.
- 7.8 Bedding, towels and linens (including clothing) should be changed daily and treated as infective. (See Infection Control: Standard Precautions Policy).
- 7.9 Any equipment should be classed as contaminated and decontaminated when removed from the room. (See Decontamination of Hospital Equipment and Medical Devices Policy).
- 7.10 Other inpatients should be monitored closely for signs and symptoms for up to 6 weeks and treated if transmission suspected.
- 7.11 In the community, close contacts and family members will require treatment via their GP. All treatments should commence on the same date.
- 7.12 Itching may continue for up to 6 weeks following successful treatment due to a reaction to waste products rather than an active mite and a cream or sedating antihistamine may be required (see BNF for further information).
- 7.13 **Head Lice Treatment**
- 7.14 Malathion 0.5% aqueous liquid is the first line treatment and should be prescribed in line with BNF/pharmaceutical guidance.
- 7.15 Malathion 0.5% aqueous liquid should be rubbed into dry hair and the scalp and allowed to dry. After 12 hours it should be removed by shampooing the hair in the normal way. The application should be repeated after 7 days to kill lice emerging from eggs that survived the first application.
- 7.16 Chemical treatment on its own is often ineffective and should be used in conjunction with 'Wet Combing' to remove the dead lice and eggs.
- 7.17 Wet Combing Method using a plastic detection comb:

After shampooing off Malathion 0.5% aqueous liquid.

Apply lots of conditioner and comb out the tangles using the broader toothed end of the detection comb over a pale surface or paper towel (eg over the empty bath). Wet lice find it difficult to grip onto conditioned hair.

Clear the comb following each stroke and repeat the process using the fine toothed end of the comb.

Continue to comb the whole head of hair, small sections at a time, from root to tip, cleaning the comb after each stroke for at least 30 minutes.

Once the process has been completed, rinse and dry the hair in the normal way.

This process should be repeated at 4 day intervals for a minimum of 2 weeks in order to remove any newly emerging lice before they have chance to mature and lay eggs and should only be discontinued when no lice have been found on 3 consecutive sessions.

- 7.18 Gloves and apron should be worn by staff if applying treatment or combing and when giving close personal care until the treatment course is complete.
- 7.19 Isolation is not generally required however, the patient should be discouraged from close physical contact with other inpatients until completion of the treatment and staff are required to use standard infection control precautions whenever giving clinical care. (See Infection Control: Standard Precautions Policy).
- 7.20 Bedding, towels and linens (including clothing) should be changed daily and treated as infective. (See Infection Control: Standard Precautions Policy).
- 7.21 Any equipment should be classed as contaminated and decontaminated immediately following use. (See Decontamination of Hospital Equipment and Medical Devices Policy)
- 7.22 Other inpatients should be monitored closely for signs and symptoms for up to 6 weeks and treated if transmission suspected.
- 7.23 In the community, close contacts and family members will require treatment via their GP. All treatments should commence on the same date.
- 7.24 **Body Lice Treatment**
- 7.25 Chemical treatment for body lice is not normally advocated however, advice and guidance should be sought from a Consultant Dermatologist or Microbiologist if the infestation is severe.
- 7.26 First line treatment is to shower the individual to remove the lice from any body hair, apply clean clothing and change all bedding, towels and linens.
- 7.27 Any worn or used bedding, towels and linens should be treated as infective. (See Infection Control: Standard Precautions Policy)
- 7.28 Any personal clothing that may be taken by relatives for washing should be transported in an alginate bag, washed at a minimum of 65 degrees and ideally tumble dried and ironed to remove and destroy lice, larvae and eggs.

- 7.29 Isolation is not always required and should be based on an individual risk assessment. However, the patient should be discouraged from close physical contact with other inpatients until completion of the treatment and staff are required to use standard infection control precautions whenever giving clinical care. (See Infection Control: Standard Precautions Policy)
- 7.30 Until completion of treatment staff should use apron and gloves.
- 7.31 Any equipment should be classed as contaminated and decontaminated immediately following use. (See Decontamination of Hospital Equipment and Medical Devices Policy)
- 7.32 Other inpatients should be monitored closely for signs and symptoms for up to 6 weeks and treated if transmission suspected.
- 7.33 In the community, close contacts and family members will probably require treatment via their GP. All treatments should commence on the same date.
- 7.34 **Pubic Lice Treatment**
- 7.35 Malathion 0.5% aqueous liquid is the first line treatment and should be prescribed in line with BNF/pharmaceutical guidance.
- 7.36 Malathion 0.5% aqueous liquid should be applied over the whole body (including scalp, neck and face, paying particular attention to all hairy areas including beards and moustaches) and allowed to dry. After 12 hours (or overnight) it should be washed off. The application should be repeated after 7 days to kill lice emerging from eggs that survived the first application.
- 7.37 The patient should shower and apply clean clothing.
- 7.38 Eyelashes should be treated by using petroleum jelly twice daily for 10 days.
- 7.39 Bedding, towels and linens should be changed daily throughout the treatment period.
- 7.40 Transmission from linens is a lower risk than with other lice, however, in the inpatient setting all worn clothing and all used bedding, towels and linens should be treated as infective. (See Infection Control: Standard Precautions Policy)
- 7.41 Isolation is not always required and should be based on an individual risk assessment. However, the patient should be discouraged from close physical contact with other inpatients until completion of the treatment and staff are required to use standard infection control precautions whenever providing clinical care. (See Infection Control: Standard Precautions Policy)
- 7.42 Gloves and long apron should be worn by staff if applying treatment and when giving close personal care until the treatment course is complete.

- 7.43 Sexual partners should be treated simultaneously whether infestation is confirmed or not.

8. INFESTATION OUTBREAKS

- 8.1 If 2 or more linked cases of lice or scabies are confirmed on a ward, the Infection Prevention and Control Team must be informed and a Datix form completed.
- 8.2 Prophylactic treatment of some or all of the other inpatients may be indicated, especially if the host(s) wander or fail to comply with isolation or other management recommendations. Each episode should be assessed on an individual basis and advice and guidance taken from a Consultant Dermatologist or Microbiologist.
- 8.3 It may be necessary to restrict access to the ward during and for 24 hours after completion of prophylactic treatment in the event of a scabies outbreak.
- 8.4 If 2 or more cases of scabies are suspected/confirmed **the Consultant in Communicable Disease Control (CCDC) must be notified.**

9. STAFF

- 9.1 All staff who suspects that they have lice or scabies should consult their GP for diagnosis and treatment.
- 9.2 The GP will risk assess treatment requirements for the staff's close family and contacts on an individual basis.
- 9.3 If confirmed they should inform their line manager and Staff Occupational Health.
- 9.4 If the infestation is an occupational illness (linked to a known infested patient), a Datix report should be completed.
- 9.5 If the infestation is not linked to a known infested patient, observation of all patients that the member of staff has had close contact with should occur for up to 6 weeks and treatment commenced if transmission suspected.
- 9.6 Prophylactic treatment of staff during an outbreak will be risk assessed on an individual basis.
- 9.7 Staff who have a scabies or lice infestation should maintain good personal hygiene standards, including regular changes of clothing, bedding, towels and linen. This should be laundered on the hottest wash that the fabric tolerates (ideally a minimum of 65 degrees) and preferably tumble dried.
- 9.8 The duration for which staff are excluded from work depends on the treatment and guidance should be sought from the prescriber, but if the staff

member has applied the cream for a 12 hour period (i.e. overnight) then they should be fit for duty on the following day.

10. COMMUNICATION

- 10.1 The implications and treatment of scabies and lice will be explained to the patient and, where appropriate their family and carers in a format and language which they can easily understand. This may necessitate the use of an interpreter. Staff will be aware of the different cultural and diversity needs of patients when treating scabies and will take appropriate steps to ensure these needs are fully taken into account.
- 10.2 Trust managers will be aware of the different cultural and diversity needs of members of staff when treating scabies and lice infestations and will take appropriate steps to ensure these needs are fully taken into account.
- 10.3 If the patient was admitted from a nursing/residential home, then the home must be informed.
- 10.4 Similarly, if the patient is transferred to another residential or nursing setting (including other hospitals) prior to completion of their treatment, the receiving area should be informed in advance.

11. TRAINING REQUIREMENTS

- 11.1 The Trust will ensure that all necessary staff (qualified, unqualified, other clinical staff, bank and agency staff) are appropriately trained in line with the organisation's training needs analysis.
- Staff Induction – Standard Infection Control Precautions
 - Hand Hygiene Training
 - Infection Control mandatory training
 - Untoward Event Reporting

12. EQUALITY IMPACT ASSESSMENT

- 12.1 All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

13. MONITORING COMPLIANCE AND EFFECTIVENESS

- 13.1 Overall monitoring will be by the Infection Prevention and Control Assurance Group. These incidents will be monitored by the Infection Prevention and Control team using DATIX Untoward Events Reporting system. The Infection Prevention and Control report at the conclusion of an outbreak should include comment as to whether the procedure within this policy has

been followed. Any actions identified will be implemented and monitored via the Infection Prevention and Control Assurance Group. Areas of concern will be escalated to the Clinical Governance Group within the quarterly report.

14. COUNTER FRAUD

- 14.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

15. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

- 15.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the **fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

- 15.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 18:	Notification of other incidents
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- 15.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

Relevant National Requirements

- The Health and Social Care Act 2008, Code of practice for health and adult social care on the prevention and control of infections and related guidance.

16. REFERENCES

16.1 References

- Brown,C. 2003, Human Lice and Their Management, Nurse2Nurse, 3(6) 30 – 31
- Burgess, I. 2002, The Life of a Head Louse, Nursing Times (Suppl), 98(46)
- Burgess, I. 2003, Understanding Scabies, Nursing Times (Suppl), 99(7)
- British National Formulary, ed British Medical Association and Royal Pharmaceutical Society, current edition
- The Management of Scabies infection in the Community. 2010, Health Protection Agency North West.

16.2 Cross reference to other procedural documents

- Infection Control: Standard Precautions Policy
- Decontamination of Hospital Equipment and Medical Devices Policy
- Risk Management Policy and Procedure.
- Untoward Event Policy and Procedure.
- Hand Hygiene Policy.

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.