Leicestershire Partnership NHS Trust

The Management of Patients with Scabies Policy

This policy describes the processes and procedures for the management of patients with known or suspected scabies

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Name of Author:	Amanda Hemsley	
Name of responsible Committee:	Infection Prevention and Control Committee	
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Target audience:	All LPT staff	
Type of Policy	Clinical ✓	Non Clinical
Which Relevant CQC Fundamental Standards?		

Contents

Version Control and Summary of Changes

Version	Date	Comment
1.	June 2010	Review of current interim guidelines. Circulated for comments to all members of LCCHS Infection Control Sub Committee and Infection Control Link Staff Adults and Children's Community Health Service
2.	July 2010	Amendments following consultation process. Revisions to incorporate requirements of NHSLA Standards
3.	July 2010	Re-circulated for comments Amendments following consultation process. Forwarded to LCCHS Clinical Governance Committee for approval.
4.	August 2011	Harmonised in line with LCRCHS, LPT, LCCHS (Historical organisations)
5.	June 2015	Review and update in line with organisation policy requirements
6.	May 2018	Review and update in line with organisation policy requirements

For further information contact: Infection Prevention and Control Team

Definitions that apply to this Policy

Allergy	A condition of increased sensitivity to a substance (an allergen) considered harmless to most people.
Consultant in Public Health	A consultant who is knowledgeable in Infectious Diseases
Contact Tracing	The identification and diagnosis of persons who may have come into contact with an infected person.
Hyperkeratosis	Is a thickening of the outer layer of the skin, which contains a tough protein called keratina. This thickening is often part of the skin's normal protection against rubbing, pressure and other forms of local irritation and causes calluses and corns on the soles of the feet or of the hands.
Infection	An organism present at a site and causes an inflammatory response or where an organism is present in a normally sterile site.
Isolation	When a patient is cared for in a separate area or room due to them having an infection that may be detrimental to other individual's health. Or when the patient may be vulnerable to infection.
Outbreak	The occurrence of two or more cases of the same infection linked in time and place or, the situation when the observed number of cases exceeds the number expected.
Personal Protective Equipment (PPE)	Specialised clothing or equipment worn by employees for protection against health and safety hazards. Gloves, aprons, gowns, masks and eye protection
Symptomatic	Physical or mental sign of the disease.
Treatment	Care provided to improve a situation (especially medical procedures or applications that are intended to relieve illness or injury)

1.0 Purpose of the policy

The purpose of this policy is to inform all healthcare staff within Leicestershire Partnership Trust (LPT) who are involved in the care of patients that develop or suffer from symptoms or infection of scabies, the process and management of the infection. When individuals are in close and frequent contact with each other, infectious diseases can spread rapidly both within a healthcare setting and in the community.

Staff working within LPT provide a number of health services to the wider community. This document provides information on the processes required when treating, managing or giving advice regarding scabies. It supports the prevention of cross infestation amongst the wider population. This policy has been produced in accordance with published evidence and national best practice guidelines. As a duty of care LPT must ensure that staff are given guidance as to the appropriate steps they need to undertake to ensure that they can protect the patients within their care.

2.0 Summary and key points

The provision of healthcare carries with it inherent risks to the health care worker. The purpose of this policy is to ensure that all staff are aware of their responsibilities for safe practice in relation to the management of scabies and take the appropriate precautionary measures to protect themselves, their co-workers and their patients.

3.0 Introduction

This policy has been developed to provide organisational wide guidance for the management and treatment of cases of scabies. It defines scabies and discusses presentation, transmission and diagnosis. Infection prevention control precautions are then highlighted with particular reference to the management and treatment of scabies with the overall aim being to reduce the risk of transmission.

Appendices detail contacts for advice and a flowchart for the management of an increased incidence/outbreak of scabies have been included for reference.

4.0 The management of scabies

4.1 Scabies

Scabies is an infestation caused by a mite known as Sarcoptes scabiei, which burrows into the skin and lays its eggs. An allergy to mite eggs and the faecal droppings produced is responsible for symptoms of intense itching and a characteristic rash.

Scabies is known to cause sporadic cases and outbreaks in hospitals, nursing/residential homes, schools and any other communal care environments where people have direct prolonged skin contact. Effective control is dependent on early diagnosis, adequate treatment of cases and contacts and the prevention of further spread

The Scabies mite is:

- Oval in shape and measures 0.2 – 0.4 mm in length
- The body is covered with fine lines and long hairs
- Is blind
- Has 8 legs when an adult
- Usually lives for 30 – 60 days
- Cannot jump
- Females burrow into the skin to lay eggs
- Males live on the surface of the skin
- Life cycle of 4 – 6 weeks
- Not related to hygiene standards

Scabies is most common:

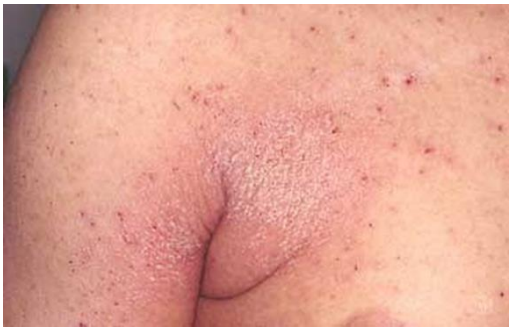
- In females
- In people aged 10 – 19 years
- In areas with high levels of social deprivation
- During winter

The appearance and severity of symptoms are strongly influenced by the immune status of the affected person. Scabies may present as follows:

4.2 Classical scabies

This is the form of scabies generally found in healthy people with a normal immune system.

- The number of mites present in classical scabies is small (15-20) and spread is usually by direct physical contact.
- Burrows appear as irregular, raised discoloured lines 0.5 to 1.5cm long in the skin, which are not always visible to the naked eye.
- Often a bilateral symmetrical rash can be seen in areas such as the midriff, inner thighs and axillae.
- There is extreme itching, especially at night.
- The sites of the rash and burrows do not necessarily correspond



4.3 Atypical scabies

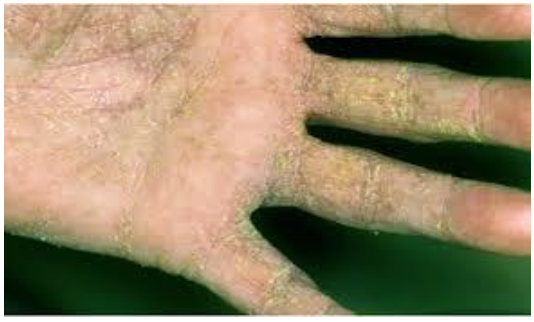
Atypical scabies occurs in any person with immature or impaired immune response. Many mites may be present in atypical scabies and symptoms may be variable. Scaling or crusting of the skin may be present but is usually slight.
Itching may also be very slight or even absent

A high proportion of atypical cases occur in the elderly, and particularly within residential/nursing homes and elderly units.

4.4 Crusted scabies (Norwegian scabies)

This form of scabies is extremely infectious and occurs in those whose immune systems are severely impaired.

- Hyperkeratotic skin lesions appear as hardened crusts containing thousands or millions of mites.
- Itching may be slight or absent.
- Skin becomes crusted especially on palms, soles, nail beds, wrists, buttocks and penis. The whole body can be affected including the head and scalp.



4.5 Transmission

Scabies is mainly spread from person to person by direct, prolonged skin contact with an infected person, such as prolonged holding of hands

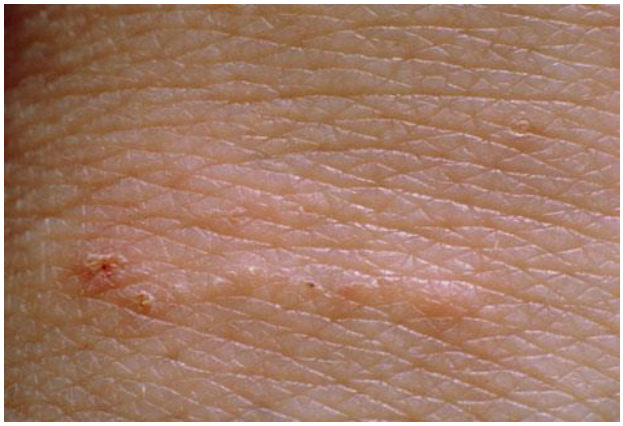
Scabies mites rapidly die, once away from the human body and therefore clothing and linen etc. is not the main route for transmission. However, mites shed in skin scales, can live in the environment longer and therefore the risk of spread through contact with soft furnishings / carpets clothing and linen is increased with heavy skin shedders. Pets do not spread scabies.

The length of time between contact with an affected person and developing signs of scabies (i.e. itching and a rash) is between four and six weeks, if this is the first infection. For re-infection symptoms appear within 48 hours.

4.6 Diagnosis

Diagnosis is by identification of the mite, eggs or faecal matter from skin scrapings. A clinical diagnosis may be made by a combination of severe itching especially at night and a typical or atypical distribution of a rash in persons who have had skin to skin contact with suspected or diagnosed cases.

Another hallmark of scabies is the appearance of track-like burrows in the skin. These raised lines are usually grayish-white or skin-colored. They are created when female mites tunnel just under the surface of the skin. After creating a burrow, each female lays 10 to 25 eggs inside.



If clinical diagnosis is difficult, obtaining skin scrapings for the scabies mites or their faecal pellets may be helpful. Skin scales may be sent by the clinician caring for the patient in a closed, sealed container (e.g. universal container) to the Microbiology Laboratory University Hospitals Leicester NHS Trust for microscopy for scabies.

Once the diagnosis is confirmed a dermatology opinion may be necessary.

4.7 Infection prevention and control precautions for inpatient areas

All patients in communal health care environments who are suspected of having or have been diagnosed as having scabies should be cared for in source isolation until treatment has been administered and washed off, or an alternative diagnosis has been made. The infection prevention and control team must be informed of the patient as soon as possible. Two courses of treatment are required and must be administered a week apart.

Precautions must continue until the two courses of treatment have been administered and washed off or an alternative diagnosis made.

Disposable nitrile gloves and plastic aprons must be worn when in contact with the patient, bed linen and patients clothing. The use of personal protective equipment (PPE) must be used until the second course of treatment has been administered and washed off.

Hand washing with liquid soap and water must be carried out after contact with the patient and their environment. Hands must be dried thoroughly with single use disposable paper towels.

Linen should be treated as infected until the patient has had the second course of treatment. Clean clothing and bed linen should be available after treatment has been washed off.

The environment and equipment must be cleaned with chlor-clean as per the Cleaning and Decontamination policy.

5.0 Specific treatment for scabies infection

5.1 Individual treatment

Individual treatment should be given if scabies is diagnosed.

5.2 Recommended treatments

Permethrin 5% (Lyclear Dermal Cream), - 30g (low toxicity, non-irritant). Leave for 8-12 hours.

Malathion 0.5% (Derbac-M) – leave for 24 hours

Malathion 0.5% is the treatment of choice in pregnancy, during breast feeding and for infants under 2 months.

Permethrin 5% is the treatment of choice in children over the age of 2 months and under the age of 6 months

For each treatment the following amounts will be required:

- 200ml of lotion or 30g cream, for an average sized person.
- More than 200ml of lotion or more than 30g of cream may be required for a larger person or for a patient where there is a need for frequent washing

5.3 Application of treatment

The lotion or cream should be applied to all skin surfaces starting at the jawline and around behind the ears, extending to the soles of the feet.

It should be applied to cool dry skin and never after a hot bath. The lotion or cream should be reapplied to skin whenever it has been washed during the treatment time (as these areas will not undergo the recommended time for treatment and may promote reinfection).

The head and scalp maybe affected and should be carefully examined for any signs of scabies and be treated if present after seeking medical advice.

Following the recommended time, depending on the type of medication being used the lotion or cream should be **washed off thoroughly** with plenty of water. This should be done preferably by a shower (or bath if a shower is not an option).

Itching may persist and the rash may be present for up to 2 weeks after treatment.

The use of calamine lotion, crotamiton (eurax) or antihistamines may be helpful in the management of itching.

For inpatient facilities; clothes, underwear and bedding used in the 48 hours prior to and during the treatment should be placed into a **red soluble bag** and securely tied before being placed into a **white outer plastic bag** (Please refer to Infection prevention and Control Policy for the Management of Linen and Laundry).

Within community facilities and/or primary care clothes, underwear and bedding used in the 48 hours prior to and during the treatment should be laundered in a hot wash (over 50°c). If this is not possible, the laundry should be stored in a sealed plastic bag for 72 hours prior to being washed, when it can then be washed following the washing instructions on the garment. This laundry must not come into contact or be stored with clean clothing or linen.

Floors and upholstery should be vacuumed after the removal of contaminated linen. Clean clothing and bedding should be used after the lotion has been washed off

If hyperkeratotic lesions are present then specialist advice on appropriate management is needed from a dermatologist.

Inform the Infection Prevention and Control Team. Please refer to Contacts for advice (Appendix 1) of all suspected and diagnosed cases of scabies.

5.4 Treatment of a patient in their own home

An initial assessment should be made by the clinician caring for the patient as to whether the client is suitable for treatment in their own home.

The patient should be mobile/flexible enough to be able to have the treatment applied to the whole of their body and be able to have the treatment washed off preferably in a shower or bath. However where a bath or shower is not available or possible, then lotion should be thoroughly washed and rinsed off with care. For further advice on the management of individual patients please contact the Infection Prevention and Control Team.

Where patients already attend social services day centres for bathing, the treatment should be applied by the appropriate health care staff prior to them attending the care home.

Arrangements may be made in advance with the Care Home Staff for the treatment to be washed off. Patients should not attend day centres until the treatment has been completed.

In the case of children attending school or nursery the child must be kept away from the school or nursery until treatment has been completed.

For patients who are difficult to treat at home, advice should be sought from the Infection Prevention and Control Team.

5.5 Contact tracing of an individual case

Following consultation with the Medical Practitioner, Consultant in Public Health or Infection Prevention and Control Team the treatment of close contacts should be arranged by the individual who has been diagnosed with scabies. A risk assessment will be made to ascertain the patient's current status and the level of contact others have with the patient.

In the case of children, contacts should have one treatment at the same time as the second treatment of the affected case. Treatment should include the entire household and close contacts.

Close contacts may include partners, parents, siblings, young dependent children, carers and staff caring for the affected patient.

5.6 Further courses of treatment

- Further treatment may be necessary depending on the extent and severity of the scabies infection.
- In the management of severely infected patients at least 3 treatments will be necessary.
- If multiple treatments are prescribed for an individual, they should be at least 7 days apart.
- Where treatment has failed, advice should be sought from the Infection Prevention and Control Team.
- Persons are classed as non-infectious when their treatment regimen has finished and the medication washed off.

5.7 Control of increased incidences and outbreaks (also see Appendix 2 – increased incident/outbreak flowchart)

If two or more cases of scabies are detected in the same inpatient facility and are linked in time, (2 weeks or less apart) then the Infection Prevention and Control Team must be notified (appendix 2).

If two or more cases of scabies are detected in the same nursing/residential home, closely linked in time (2 weeks or less apart), then the Infection Prevention and Control team for the local authority and Public Health England, East Midlands Health Protection Team must be notified.

If two or more cases of scabies are detected in the same school/nursery, closely linked in time (2 weeks or less apart), then the Infection Prevention and Control Team and Public Health England, East Midlands Health Protection Team must be notified.

If an increased incident or outbreak is suspected, referral to a dermatologist is required to urgently confirm diagnosis of scabies. The referral for patients should be made by their clinician i.e. medical practitioner, ANP. A referral for staff should be made by an Occupational Health Doctor (Please refer to Contacts for Advice, Appendix 1). Once an increased incident/outbreak has been identified the increased incident/outbreak policy will be implemented.

Planned coordinated treatment is essential and where possible, individuals should be treated at the same time to prevent the likelihood of re-infection.

Where staff require treatment, this will be managed by the Occupational Health Department.

In conjunction with the Dermatologist, the Consultant in Public Health (please refer to Contacts for Advice, Appendix 1) will decide who needs treatment and the treatment regimen to be carried out, taking into account the following information:-

a) The number of symptomatic patients in the affected unit.
b) The number of symptomatic staff working in the unit.
c) The total number of patients and staff within the unit with or without symptoms.
d) The severity of symptoms of each affected individual.

From this information the Consultant in Communicable Disease will then decide on whether to treat symptomatic individuals only or all patients and all staff based in the unit.

Close contacts must be treated at the same time as the last treatment of the symptomatic individual.

5.8 Movement of symptomatic patients from an affected unit

Symptomatic patients from an affected unit should ideally not be transferred or discharged to other communal health care environments including other hospital units, residential or nursing homes until coordinated treatment has been given and washed off. In circumstances where patient movement is necessary communication is vital between the two areas so that appropriate infection prevention and control precautions can be adopted. In such instances the Essential Steps Inter-Hospital Transfer Form is to be used (Please refer to appendix 3).

5.9 Health care personnel

It is the responsibility of the Occupational Health Department to manage the treatment of staff when there is a case of occupationally acquired scabies.

A referral to a dermatologist may be necessary to confirm the diagnosis of scabies in staff. In this case, the Occupational Health Department managing the healthcare personnel should contact the dermatology department for urgent assistance in confirming diagnosis.

The Occupational Health Department will prescribe treatment for staff and close contacts of staff as necessary. LPT will meet the cost of the necessary treatment that has been prescribed by the Occupational Health Department.

6.0 Training

There is no training requirement identified within this policy

7.0 References and bibliography

The supporting Infection Prevention and control policies can be located at:

http://www.leicspart.nhs.uk/SupportServices

Management of Linen and Laundry in Community Health Services, Inpatient Services and Primary Care

Management of a Patient requiring source isolation in Community Health Services, Inpatient Facilities and Primary Care

Personal Protective Equipment for use in Healthcare Policy

Hand hygiene Policy (including Bare Below the Elbows)

British National Formulary September 2014

National Institute for Health and Care Excellence (NICE) - Clinical skill Summaries: Scabies, https://cks.nice.org.uk/scabies#!topicsummary

Scabies – NHS.UK http://www.nhs.uk/conditions/Scabies

Public Health England www.phe.gov.uk
(Listed under S for scabies)

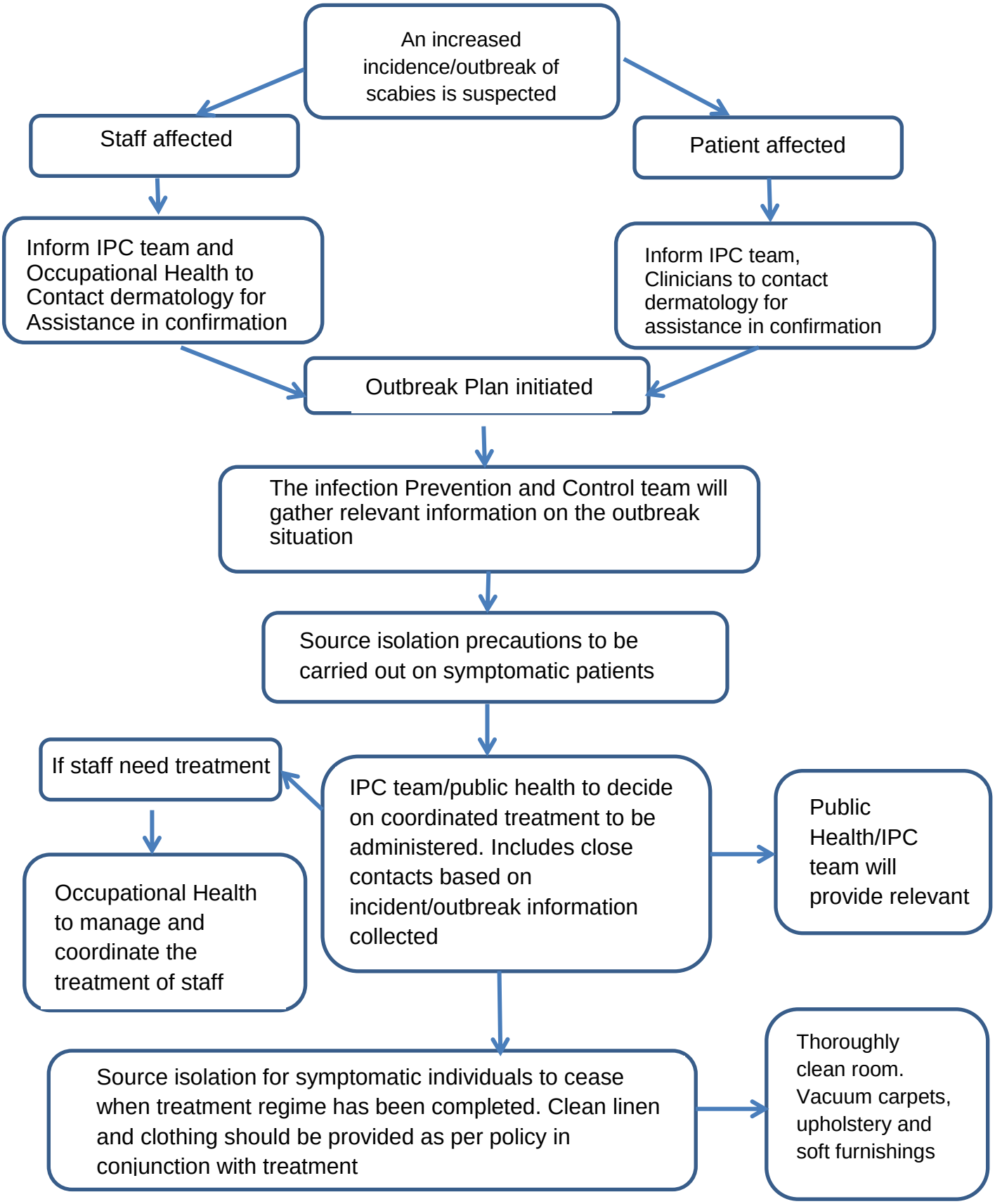
Wilson, J (2006) Infection Control in Clinical Practice. London: Bailliere Tindall.

Appendix 1

Contact details		
Name	**Address**	**Telephone number**
Public Health England East Midlands Health Protection Team	East Midlands Health Protection Unit Seaton House City Link Nottingham NG2 4LA **Email:** emhpt@phe.gov.uk **Area's covered:** Leicestershire, Rutland. Lincolnshire, Nottinghamshire, Derbyshire	☎0344 225 4524 (option 1) Fax: 0116 263 0453
Occupational Health Department	Baldwin Lodge Glenfield General Hospital	☎0116 225 5431
Infection Prevention and Control Team Leicestershire Partnership Trust	Riverside House Bridge Park Plaza Bridge Park Road Thurmaston Leicester LE4 8BL	☎0116 2951668

Appendix 1

Management of an increased incident/outbreak of scabies



Appendix 3

PRIVACY IMPACT ASSESSMENT SCREENING

Privacy impact assessment (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment. **The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**The management of patients with scabies policy**		
Completed by:	**Mel Hutchings**		
Job title	**Infection Prevention and Control Nurse**	**Date**	**10/07/2018**

	Yes / No
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	**No**
2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.	**No**
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	**No**
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**No**
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	**No**
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	**No**
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	**No**
8. Will the process require you to contact individuals in ways which they may find intrusive?	**no**

If the answer to any of these questions is 'Yes' please contact the Head of Data Privacy Tel: 0116 2950997 Mobile: 07825 947786
Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until approved by the Head of Data Privacy.

IG Manager approval name:	
Date of approval	

Acknowledgement: Princess Alexandra Hospital NHS Trust

Appendix 4

Stakeholders and Consultation

Key individuals involved in developing the document

	Designation
Amanda Hemsley	Lead Infection Prevention and Control Nurse
Antonia Garfoot, Mel Hutchings Annette Powell Andy Knock	Infection Prevention and Control Team

Circulated to the following individuals for consultation

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Emma Wallis	Lead Nurse, CHS – Inpatient areas (physical health)
Laura Belshaw	Lead Nurse, CHS – MHSOP
Joanne Wilson	Lead Nurse, FYPC
Jane Martin	Matron
Claire Armitage	Lead Nurse, AMH&LD - Community
Michelle Churchard-Smith	Head of Nursing, AMH&LD - Inpatient
Katie Willetts	Senior Nurse, Specialist nursing team
Kam Palin	Occupational Health Nurse
Tejas Khatau	Lead Pharmacist for FYPC
Sarah Latham	Matron
Bernadette Keavney	Head of Health and Safety, Security
Tracy Yole	Lead Nurse, CHS - Community
Sally Smith	Senior Zone Coordinator
Helen Walton	Property Manager, Estates and Facilities