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Community Infection Prevention and Control Policy for Domiciliary Care staff

Scabies

SCABIES

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DC 16

SCABIES

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This Policy has been adopted by:

Organisation: ..... …

Signed: .....

Job Title: .....

Date Adopted: .....

Review Date: .....

If your organisation would like to exclude or include any additional points to this Policy, please include below. Please note, the Community IPC Team cannot endorse or be held responsible for any addendums.

Community Infection Prevention and Control
Harrogate and District NHS Foundation Trust
Gibraltar House, Thurston Road
Northallerton, North Yorkshire. DL6 2NA
Tel: 01423 557340
email: infectionprevention.control@nhs.net
www.infectionpreventioncontrol.co.uk

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1. Introduction

Scabies is a skin infection caused by mites known as Sarcoptes Scabie. After mating with adult male mites, the females burrow into the skin, laying eggs as they go. The new mites hatch from the eggs in 10-13 days, tunnel up to the skin surface and grow into adults. The main symptoms of scabies are due to the body's allergic reaction to the mites and their waste. Symptoms include an itchy, widespread rash (often worse at night-time) which occurs mainly between the fingers, on the waist, armpits, wrists, navel and elbows, and it usually affects both sides of the body alike. The rash is an allergic reaction and does not correspond to where the mites are located on the body.

There are two forms of scabies both caused by the same mite. The most common form of 'Classical scabies' has fewer than 20 mites all over the body, whereas the rarer type of 'Crusted scabies' can have thousands of mites causing a more severe reaction in the skin.

Symptoms occur on average 3-6 weeks following infection; however, if a person has had scabies in the past, symptoms will develop more quickly.

Untreated scabies is often associated with secondary bacterial infection which may lead to skin infections, e.g. impetigo, cellulitis. Scabies may also aggravate other pre-existing skin conditions, such as eczema and psoriasis.

Always use standard infection control precautions and transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for Domiciliary Care staff'.

2. Transmission

Scabies can be transmitted from a person infected with scabies before they have any symptoms.

The mite cannot jump from person to person, but can crawl from one individual, or environment, to another:

- By direct skin to skin contact with a person who is infected with scabies (approximately 10 minutes uninterrupted skin-to-skin contact), e.g. holding hands

Classical scabies

On average, the mites can survive in the environment for 24-36 hours, therefore, can be transmitted from clothing or bedding,

Crusted (Norwegian) scabies (highly contagious due to the large number of mites)
The mites can survive in the environment for 7 days, therefore, can easily be transmitted from towels, clothing, bedding, upholstery.

3. Diagnosis

Symptoms take 3-6 weeks to develop after infestation if a person has never had scabies. In a person who has had scabies before, the symptoms usually appear much earlier,1-3 days.

Diagnosis of scabies is usually made from the history and examination of the affected person, in addition to the history of their close contacts. Misdiagnosis is common because of its similarity to other itchy skin disorders, such as contact dermatitis, insect bites, and psoriasis.

Classical scabies
Diagnosis should be confirmed by a GP or Dermatologist.

Crusted (Norwegian) scabies
A diagnosis by a Dermatologist is essential.

This form of scabies is uncommon and may be seen in service users with a low immunity.

Highly contagious, it usually presents itself in the form of 'crusted lesions' which are found mainly around the wrist areas, but can also affect other parts of the body. A rash is usually found covering the body which appears crusted, but may not be itchy.

Thousands or millions of mites can be present and are capable of spreading into the immediate environment due to the shedding of skin from the crusted lesions containing mites that can survive for up to a week.

Management and treatment of this form of scabies must be undertaken in association with the service user's GP.

4. Topical preparations for treatment

Treatment is in the form of a lotion or cream that is available on prescription or from a pharmacy:

Lyclear Dermal Cream (permethrin 5%):	Low toxicity. 8 hour treatment
Derbac - M (malathion):	24 hour treatment

Adults usually need 2-3 x 30g tubes for one treatment application (treating those without symptoms) and 4-6 tubes for two treatment applications (treating those with symptoms). Insufficient lotion is a contributory factor to treatment failure.

5. Management and treatment

Other service users, staff members, relatives or close contacts may require treatment, as advised by the service user's GP. Advice can also be obtained from your local Community Infection Prevention and Control (IPC) or Health Protection (HP) Team.

It is essential that treatment instructions/advice provided by the service user's GP or other health and social care adviser is followed explicitly to ensure treatment is effective.

- Application of the cream/lotion is best done in the evening.
- Treatment consists of the application of two treatments, one week apart.
- Cream/lotion must be applied to cool dry skin to be most effective. It is not recommended to have a hot shower or bath prior to any application.
- Clean hands and wear disposable apron and gloves when there is close contact, e.g. when performing personal hygiene, and gloves, for example, when assisting a service user when walking to the toilet if skin to skin contact is likely until the second treatment has been completed.
- If a lotion is used rather than cream, it can be poured into a bowl and a sponge or disposable cloth used to apply it.
- Mites can harbour themselves under the nails, therefore, the affected person's nails should be kept short.
- After the duration of the treatment (8 or 24 hours), clean clothing should be worn and bed linen changed.
- Clothing and bed linen should be washed as normal.
- Clean hands after removing and disposing of each item of PPE, e.g. pair of gloves, apron.
- Following treatment, itching often persists for several weeks and is not an indication that treatment has been unsuccessful. Antipruritic (anti-itch) treatment may be beneficial.

For instructions on the application, see 'Scabies Treatment: Instructions for application of cream or lotion' available to download at www.infectionpreventioncontrol.co.uk.

6. Scabies outbreak

If an outbreak (two or more cases, e.g. a service user and a member of staff) is suspected, contact your local Community IPC or HP Team who will be able to confirm or exclude an outbreak situation. They will be able to give advice and help coordinate prescribing arrangements with the GP(s) for identified individual's treatment(s) to take place on a specified time and date.

7. General information

- Linen and clothing should be washed at 60^{o}C or as recommended by the manufacturer and tumble dried if possible. If a duvet is used, it is adequate to wash the cover only.
- Any clothing difficult to wash can be pressed with a hot iron if the fabric is suitable for ironing at a high temperature. Items that cannot be washed should be placed into plastic bags and sealed to contain the mites for 3 full days if 'Classical scabies' or 7 full days if 'Crusted scabies', to allow the mites to die.
- Other members of the household and visitors should avoid prolonged skin to skin contact, e.g. holding hands, until treatment is completed. Brief contact such as kissing and hugging is acceptable.

8. Environmental cleaning

Scabie mites live on and under the skin. The most common type 'Classical scabies' can only survive off the body for 24-36 hours, and the rarer 'Crusted scabies' can survive for 7 days.

- Routine cleaning of hard surfaces in the environment with warm water and detergent is sufficient.
- Soft furnishings with non-wipeable covers should be removed from use following treatment and placed into plastic bags and sealed for 3 full days if 'Classical scabies' or 7 full days if 'Crusted scabies', to allow any mites on the fabric to die. The items should then be vacuumed.

9. Suspected treatment failure

Evidence shows that unsuccessful eradication is usually due to failure to adhere to the correct procedures and treatment instructions.

Treatment failure is likely if:

- The itch still persists for longer than 2-4 weeks after the first application of treatment (particularly if it persists at the same intensity or is increasing in intensity)
- Treatment was uncoordinated or not applied correctly, e.g. scalp and face not treated, not reapplied after washing hands, etc., during the treatment time
- New burrows appear (these are not always easily seen) after the second application of the treatment

10. Management of treatment failure

If treatment failure is suspected, the service user's GP should be notified.

11. Referral or transfer to another health or social care provider

- Transfer to another Domiciliary Care Agency or a Care Home should, where possible, be deferred until the service user is no longer infectious.
- Non-urgent hospital outpatient attendances or planned admissions should be postponed, refer to the 'Patient placement and assessment for infection risk Policy for Domiciliary Care staff'.
- If the condition of a service user requires urgent hospital attendance or admission, staff with responsibility for arranging a service user's transfer should complete the Inter-Health and Social Care Infection Control (IHSCIC) Transfer Form (see Appendix 1). The unit at the hospital they are attending and the transport service taking them, must be notified of the service users infection risk, prior to them being transferred. This ensures appropriate placement of the service user, refer to the 'Patient placement and assessment for infection risk Policy for Domiciliary Care staff'.

12. Infection Prevention and Control resources, education and training

The Community Infection Prevention and Control (IPC) Team have produced a wide range of innovative educational and IPC resources designed to assist Domiciliary Care in achieving compliance with *The Health and Social Care Act 2008*: *Code of Practice on the prevention and control of infections and related guidance* and CQC registration requirements.

These resources are either free to download from the website or available at a minimal cost covering administration and printing:

- IPC Policy documents for Domiciliary Care staff
- 'Preventing Infection Workbook: Guidance for Domiciliary Care staff'
- IPC audit tools, posters, leaflets and factsheets
- 'IPC Bulletin for Domiciliary Care staff'

In addition, we hold educational study events in North Yorkshire and York and can arrange bespoke training packages. Prices vary depending on your requirements and location.

Further information on these high quality evidence-based resources is available at www.infectionpreventioncontrol.co.uk.

13. References

Burgess I (2006) *Medical Entomology Centre Insect* R&D Ltd Cambridge

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

NHS England and NHS Improvement (March 2019) *Standard infection control precautions: national hand hygiene and personal protective equipment policy*

National Institute for Health and Care Excellence Clinical Knowledge Summaries (2017) *Management of Scabies*

Public Health Laboratory Service (2000) *Lice & Scabies. A health professional's guide to epidemiology and treatment*

14. Appendices

Appendix 1: Inter-Health and Social Care Infection Control Transfer Form

Appendix 1: Inter-Health and Social Care Infection Control Transfer Form

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Inter-Health and Social Care Infection Control Transfer Form

The *Health and Social Care Act 2008: Code of Practice on the prevention and control of Infection and related guidance* (Department of Health 2015), states that "suitable accurate information on infections be provided to any person concerned with providing further support or nursing/medical care in a timely fashion". This form has been developed to help you share information with other health and social care providers. The form should accompany the patient and, where possible, a copy filed in the patient's notes.

Patient Name: ..... Address: ..... NHS number: ..... Date of birth: ..... Patient's current location:	GP Name and contact details:

Receiving facility, e.g., hospital ward, hospice: .....

If transferred by ambulance, the service has been notified: Yes ☐ N/A ☐

Is the patient an infection risk:
Please tick most appropriate box and give details of the confirmed or suspected organism

☐ Confirmed risk Organisms: .....
☐ Suspected risk Organisms: .....
☐ No known risk

Patient exposed to others with infection, e.g., D&V, Influenza: Yes ☐ No ☐ Unaware ☐

If yes, please state: .....

If the patient has a diarrhoeal illness, please indicate bowel history for last week, if known, (based on Bristol Stool Form Scale):

.....

Is diarrhoea thought to be of an infectious nature? Yes ☐ No ☐ Unknown ☐

Relevant specimen results if available

Specimen:				
Date:				
Result:				

Treatment information:

Is the patient aware of their diagnosis/risk of infection? Yes ☐ No ☐

Does the patient require isolation? Yes ☐ No ☐

If the patient requires isolation, phone the receiving facility in advance: Actioned ☐ N/A ☐

Additional information:

Name of staff member completing form: .....

Print name: .....

Contact No: ..... Date .....

Community Infection Prevention and Control, Harrogate and District NHS Foundation Trust
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