



## Community Infection Prevention and Control Policy for General Practice

(also suitable for adoption by other healthcare providers,  
e.g. Podiatry)

# Scabies

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Job title: .....

Adoption date: .....

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# SCABIES

## 1. Introduction

Scabies is a skin condition caused by an immune reaction to the mite *Sarcoptes scabiei* and their saliva, eggs and faeces. The typical clinical presentation of infection is intense itching associated with burrows, nodules and redness, often worse at night. However, asymptomatic infection has been demonstrated in the elderly. Symptoms may last for weeks or months, can be hard to recognise and are often mistakenly attributed to other skin conditions, leading to avoidable transmission.

Scabies occurs when the mite burrows into skin and lays eggs that hatch into larva. The eggs hatch in 3 to 4 days and develop into adult mites in 1 to 2 weeks. Within the skin the adult female lays eggs and deposits waste products. Their presence in the skin usually causes itching, while the hatching of the eggs produces new larvae which can migrate to the surface of the skin and infect new hosts. In a first episode, symptoms are usually experienced within 3 to 6 weeks. People who have been reexposed to scabies after successful treatment may develop symptoms more quickly, in around 1 to 4 days.

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. The rarer type of 'crusted scabies' (formerly known as Norwegian), which may be seen in immunosuppressed individuals, can have thousands or millions of mites causing a more severe reaction in the skin. It develops due to an insufficient immune response in the host.

Untreated scabies is often associated with secondary bacterial skin infection, e.g. cellulitis (infection of the deeper layers of the skin), folliculitis (inflammation of a hair follicle), boils or impetigo. Scabies may also exacerbate other preexisting skin conditions, such as eczema and psoriasis.

Always use 'Standard infection control precautions' (SICPs) and, where required, 'Transmission based precautions' (TBPs). Refer to the 'SICPs and TBPs Policy for General Practice'.

## 2. Transmission

From an infested person:

- Direct skin-to-skin contact, including sexual contact, with a person who is infected with scabies (approximately 10 minutes uninterrupted skin-to-skin contact)
- The mite cannot jump from person-to-person, but can crawl from one individual to another when there is skin-to-skin contact for a period of time, e.g. holding hands. Transmission through casual contact, such as a hand shake, hugging or kissing, is unlikely
- Less commonly, common scabies may spread through recently used clothing or

bedding, but the mites do not survive long away from the skin

- Crusted scabies is highly contagious due to the large number of mites on an infested person and is easily transmissible via bedding, towels, clothes and upholstery. These mites can survive away from the host for up to 7 days

### 3. Diagnosis

Diagnosis of scabies is usually made from the history and examination of the affected person, in addition to the history of their close contacts. The mites create small red bumps, blisters, or thin, wavy lines on the skin. These are most common on the hands, between fingers, wrists, arms, waist, groin, and under the buttocks. In babies, the head, neck, palms, and soles of the feet can also be affected. The itching is usually worse at night or after a hot bath or shower. Misdiagnosis is common because of its similarity to other itchy skin disorders, such as contact dermatitis, insect bites, and psoriasis.

Diagnosis should be confirmed by a GP or Dermatologist, but seeking specialist advice should not significantly delay the commencement of treatment. Skin scraping followed by microscopy can be used to confirm diagnosis. However, negative findings should not be taken to indicate absence of infestation due to its low sensitivity.

Crusted scabies is uncommon and may be seen in patients with low immunity. It usually presents as a scaly rash with 'crusted lesions' containing a high density of mites. The rash may not be itchy and the skin crusts are associated with heavy skin shedding.

### 4. Managing and preventing the spread of scabies

When the patient is in a long-term care or other closed facility, such as a Care Home, advice should also be sought from your local Community Infection Prevention and Control (IPC) or UK Health Security Agency (UKHSA) Team.

Management and treatment of crusted scabies must be undertaken in association with the patient's GP following advice from the Dermatologist.

Contacts are defined as anyone who has close physical contact with the case within the 8 weeks prior to diagnosis.

- This includes sexual partners, all members of their household and any other close personal contacts (even if asymptomatic).

In health and social care settings contacts may include:

- All residents unless there is a clear rationale for more limited tracing
- Residents on a single affected floor or wing if there is no mixing or movement of staff or residents and between floors or wings
- All members of staff, including agency staff, who have provided personal care without

appropriate personal protective equipment (PPE)

- Visitors to the setting who have had prolonged or frequent skin-to-skin contact with a case such as holding hands
- Ancillary staff, for example, hairdressers, podiatrists and community health professionals who have had prolonged or frequent skin-to-skin contact without PPE

Where scabies has been acquired from a sexual partner, a referral for a sexually transmitted infection (STI) screen should be advised.

Contacts should all be treated at the same time as the index case, on two occasions, one week apart. Treatment of a person with scabies should never be delayed by waiting for wider mass treatment in the setting. This is to minimise their symptoms, reduce risk of complications and reduce risk of further onward transmission.

### Outbreaks

If there is a suspected outbreak of scabies in a communal setting, refer to the 'Action plan for the management of scabies in health and social care settings', available to download at [www.infectionpreventioncontrol.co.uk/resources/action-plan-for-the-management-of-scabies-in-health-and-social-care/](http://www.infectionpreventioncontrol.co.uk/resources/action-plan-for-the-management-of-scabies-in-health-and-social-care/).

### Personal protective equipment (PPE) for staff

PPE (gloves and disposable aprons) should be used for all activities with cases and their contacts that involve skin-to-skin contact during the infectious period.

A risk assessment should be undertaken. If arms of staff are likely to have prolonged skin-to-skin contact with either the case's skin or infected linen, then single use long sleeve gowns or sleeve protectors should be used.

PPE should be used until 24 hours after the first treatment dose.

## 5. Treatment

For the clinical management of cases of scabies please follow clinical advice and refer to the <https://cks.nice.org.uk/topics/scabies/> and the <https://bnf.nice.org.uk/>.

Treatment options for classical scabies for adults and children (over 2 months):

- Permethrin 5% cream (available on prescription or via a pharmacy)
- Ivermectin 3 mg oral tablets (licensed once diagnosis has been confirmed clinically or by parasitological examination)
- Malathion aqueous 0.5% liquid

The treatment decision should be based on the individual's clinical situation.

Both options require a second dose after a further 7 days.

**Adults (cases and contacts) usually need 4-6 x 30 gm tubes of permethrin 5% cream**

**for the 2 treatment applications. Insufficient lotion is a contributory factor to treatment failure.**

For crusted scabies treatment advice should be in sought from a Dermatologist as they may require combination treatment of oral ivermectin and topical insecticide.

## 6. Management of topical treatments

Advice can be obtained from your local Community IPC or UKHSA Team.

It is essential that treatment instructions/advice are provided and followed explicitly to ensure treatment is effective.

- Topical treatment consists of the application of two treatments, one week apart.
- Application of the cream/lotion is best done in the evening.
- The cream 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.
- 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 applying the first treatment, patients must wear clean clothing and get into clean bedding.
- Following treatment, itching often can persist for up to 6 weeks and is not an indication that treatment has been unsuccessful. Antipruritic (anti-itch) treatment may be beneficial.

For instructions on the application, 'Scabies treatment: Patient instructions for application of cream or lotion', available to download at

[www.infectionpreventioncontrol.co.uk/resources/scabies-treatment-patient-instructions-for-application-of-cream/](http://www.infectionpreventioncontrol.co.uk/resources/scabies-treatment-patient-instructions-for-application-of-cream/).

## 7. General information

- 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.
- Affected individuals can return to work, school or nursery after completion of the first treatment dose.

## 8. Linen

Clothing, bedlinen and towels, which have been worn or handled by individuals being treated as cases or contacts in the week before, or at any time up to 24 hours from starting first treatment dose, need to be cleaned in accordance with the advice below.

Any items which cannot be laundered in a hot wash may be placed in a sealed plastic bag for at least 4 days prior to laundering, this should be sufficient to kill any mites present.

When laundering items:

- Laundry should be done the morning after treatment
- Do not mix with items belonging to unaffected individuals
- Clothing, bedlinen and towels, should be handled using appropriate PPE to avoid skin contact
- Place laundry into a dissolvable alginate bag (soluble laundry bag) if available, and place the bag without opening it into a washing machine
- Wash the laundry on the hottest cycle
- Clothing should be tumble dried on a hot cycle for at least 10 minutes immediately following the wash if a hot wash has not been carried out

## 9. Environmental cleaning

The aim of cleaning is to remove the skin scales containing the mites from the environment and reducing the likelihood of formite-based transmission.

Common scabies:

- 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 4 full days, to allow any mites on the fabric to die. The items should then be vacuumed

Crusted scabies:

- Daily cleaning of touch points and hard surfaces in the environment with warm water and detergent
- Daily vacuuming until 7 days after treatment
- Deep clean after both treatment cycles to include steam cleaning of soft furnishings and vacuuming of mattresses)

## 10. 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 during the treatment time
- New burrows appear (these are not always easily seen) after the second application of the treatment

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

- Transfer to another health or social care provider should, where possible, be deferred until 24 hours after the first treatment has been completed.
- Non-urgent hospital outpatient attendances or planned admissions should be postponed, refer to the 'Patient placement and assessment for infection risk Policy for General Practice'.
- If the condition of a patient requires urgent hospital attendance or admission, or referral or transfer to another health or social care provider, e.g. hospital, ambulance service, they should be informed of the patient's scabies status prior to the transfer. This will enable a risk assessment to be undertaken to determine the appropriate IPC measures to be taken, e.g. transported without other patients, isolated on admission.
- Staff preparing to transfer a patient to another health and social care provider should complete a patient passport or the Inter-health and social care infection control transfer Form (available to download at [www.infectionpreventioncontrol.co.uk/resources/inter-health-and-social-care-infection-control-transfer-form/](http://www.infectionpreventioncontrol.co.uk/resources/inter-health-and-social-care-infection-control-transfer-form/)). This should accompany the patient. Refer to the 'Patient placement and assessment for infection risk Policy for General Practice'.
- SICPs and TBPs should be followed whenever transferring a patient, whether they have a confirmed infection or not.
- The completed transfer documentation should be supplied to the receiving health or social care provider and a copy filed in the patient's notes.
- Ensure that care equipment used to transfer the patient, e.g. wheelchair, is decontaminated in accordance with the 'Safe management of care equipment Policy for General Practice'.

## 12. Infection Prevention and Control resources, education and training

The Community IPC Team have produced a wide range of innovative educational and IPC resources designed to assist your General Practice in achieving compliance with the *Health and Social Care Act 2008: code of practice on the prevention and control of infection 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:

- 27 IPC Policy documents for General Practice
- Preventing Infection Workbook: Guidance for General Practice
- IPC CQC assessment preparation Pack for General Practice
- IPC audit tools, posters, leaflets and factsheets
- IPC Bulletin for General Practice Staff

In addition, we hold educational study events in North Yorkshire.

Further information on these high quality evidence-based resources is available at [www.infectionpreventioncontrol.co.uk](http://www.infectionpreventioncontrol.co.uk).

## 13. References

Department of Health and Social Care (Updated December 2022) *Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance*

NHS England (Updated 2025) *National infection prevention and control manual (NIPCM) for England*

National Institute for Health and Care Excellence (Updated September 2025) *Clinical Knowledge Summaries Scabies*

UK Health Security Agency (Updated April 2025) *UKHSA guidelines for the management of scabies cases and outbreaks in communal residential settings*