NHS Lanarkshire

Control of Scabies

Guideline for the Control and Treatment of Scabies

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NHS Lanarkshire

TARGET AUDIENCE	NHSL WIDE, Acute, Health and Social Care Partnerships
PATIENT GROUP	All in patients and outpatients

Clinical Guidelines Summary

Scabies is an infectious disease of the skin caused by a burrowing mite called *Sarcoptes scabiei*. The infection commonly affects the whole household with a reported secondary attack rate within families of around 40%. It is only transmitted by direct skin contact with an infected person. Despite major improvements in living standards scabies affects people from all walks of life regardless of age, sex, race or standards of personal hygiene.

Transmission is more likely where there is a high level of infection. The scabies mite does not survive more than 48-72 hours off a person. Infection is not normally acquired by contact with patient's clothes and bedding. However, fomites may rarely be a factor in transmission in cases of atypical presentations e.g. crusted (Norwegian) scabies.

Guideline Body

1.0 INTRODUCTION

Scabies is an infectious disease of the skin caused by a burrowing mite called *Sarcoptes scabiei*. The infection commonly affects the whole household with a reported secondary attack rate within families of around 40%. It is only transmitted by direct skin contact with an infected person. Despite major improvements in living standards scabies affects people from all walks of life regardless of age, sex, race or standards of personal hygiene.

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2.0 AIM, PURPOSES AND OUTCOME

- To ensure that patients receive appropriate and timely investigation, care and management in line with current national guidelines and best practice
- To ensure all NHSL staff can identify and diagnose patients who have Scabies
- To ensure that NHSL staff minimise the transmission of Scabies

3.0 SCOPE

3.1 Who is the Guideline Intended to Benefit or Affect

This Guideline is designed to safeguard patients, staff and the wider public from the risk of Scabies.
The Guideline is aimed at all Healthcare Staff working in NHSL.

3.2. Who are the Stakeholders

Patients, Carers and relatives, staff and those defined within Section 5 Roles and Responsibilities.

4.0 PRINCIPAL CONTENT

4.1 Clinical features

The mite burrows into the skin. The burrows are often slightly scaly at one end where the mite has entered and at the other end there is a tiny vesicle (blister). The burrows commonly occur on the flexor aspects of the wrist, finger webs, and sides of the fingers, borders of the hand and less often on the palm. Other diagnostic lesions are the genital lesions in males and burrows or vesicles on the soles of the feet particularly in infants.

The main symptom of scabies infection is itching. Itch occurs 2-4 weeks after infection as at this point the patient develops an allergic sensitivity to the mite or its by-products. The itch is often worse at night or after a hot bath or shower and can be severe leading to excoriation and crusting of the lesions. It is important to note that subsequent reinfection after treatment can produce a severe itch within 24 hours.

The allergic eruption causing the itch is characterised by widespread pinhead size papules and papulo-vesicles on the arms, the axillary folds, around the areola and on the abdomen (peri-umbilical region), buttock, thighs and penis. These can become crusted and excoriated. In patients with high standards of personal hygiene there may be few burrows and they may be difficult to find. In such cases the allergic rash is the main visible clinical feature.

The face and scalp are not usually involved except in infants and the elderly. Scabies in the elderly may have an atypical presentation (sometimes known as crusted scabies) with no itching and frequently involves the scalp especially if the hair is thinning. Similar atypical presentations may occur in immunocompromised patients. Outbreaks in nursing and residential homes and long stay hospital wards often go unrecognised until infection is widespread.

4.2 Diagnosis
The clinical appearance of burrows is unambiguous and their presence is diagnostic. In atypical cases the diagnosis may need to be made by microscopic examination of a skin sample for the presence of mites, ova or faeces or by histological examination of a skin biopsy. When a patient or staff member complains of an otherwise unexplained intense itch, scabies should be suspected and advice sought from the Health Protection Team/Infection Prevention and Control Team/Occupational Health Service as appropriate. Diagnosis can be difficult and early advice should be sought from a dermatologist, particularly in an institutional setting.

4.3 Mode of Transmission
Transfer of parasites commonly occurs through prolonged direct contact with infested skin and also during sexual contact. Transfer from undergarments and bedclothes occurs only if these have been contaminated by infested people immediately beforehand. Mites can burrow beneath the skin surface in 2.5 minutes.

4.4 Incubation Period
In people without previous exposure, 2-6 weeks before onset of itching. People who have been previously infested develop symptoms 1-4 days after re-exposure.

4.5 Period of Communicability
Until mites and eggs are destroyed by treatment, ordinarily after 1 or occasionally 2 courses of treatment, a week apart.

4.6 Treatment

Treatments include permethrin cream (Lyclear Dermal cream) and malathion aqueous liquid (Derbac-M). Alcohol based lotions such as malathion liquid (Prioderm) should not be used as the alcohol will irritate excoriated skin. Prescribers should alternate permethrin and malathion to avoid resistance developing.
If treatment is indicated during pregnancy, lactation or in children under 6 months of age further advice should be sought from a Consultant Dermatologist.
The standard textbooks and the manufacturers of scabicides recommend that the face and scalp should not be treated. However, scabies is commonly a disease of the elderly, whose heads frequently do have scabies mites. Treatment failure in such cases is due to failure to treat the whole body. Treatment should be applied to the scalp of patients especially if hair thinning is present.

4.7 Treatment of Cases

- On the first night, the lotion or cream is applied to the whole body surface including the scalp, especially if hair is thin (take care to avoid eyes). Pay particular attention to the webs of the fingers and toes and brush lotion under the ends of nails as mites are easily missed in these parts. Traditionally scabicides have been applied after a hot bath, this is not necessary and there is even evidence that a hot bath may increase absorption into the bloodstream, removing them from their site of action on the skin. Leave the cream or lotion on for 24 hours. Have a bath or shower the next night to remove the cream or lotion. Re-application is required if the hands are washed with soap and water during the application period. Where this would cause difficulties e.g., healthcare staff, use of permethrin may be preferable as a shorter (8-12 hour) application time can be used
- The above regime should get rid of the mites but the itch can persist for a week or so after treatment. Calamine cream, oily calamine cream or an oral antihistamine can be used to control itching
- On the seventh night after the first treatment, repeat the treatment with lotion or cream. Wash off after 24 hours (or 8-12 hours if a shorter application time has been recommended)
- After each treatment, change all bedclothes and underwear and wash them in the usual way. There is no need to boil bed linen or clothing, normal laundering is adequate
- Patients with atypical presentation (crusted scabies) may require 2-3 applications of an insecticide on consecutive days to ensure that enough penetrates the skin crusts to kill all the mites. Contact the Infection Prevention and Control Team, Health Protection Team, Consultant Dermatologist or General Practitioner for advice.
- In resistant cases or where topical therapy is impractical a single oral dose of the scabicides Ivermectin (Mectizan) may be indicated. It is unlicensed and must be prescribed on a named patient basis
- Exclude cases from school or work until the day after the first treatment
- Hospital, nursing home staff or carers handling a patient with scabies should wear a plastic apron and gloves until 24 hours after treatment.
- Secondary infection and dermatitis may need appropriate treatment

4.8 Contacts of Scabies Cases

- All members of a household where there is a case of scabies must be treated within the same 24 hours as the case whether symptomatic or not
- In hospitals, residential establishments, day centres etc., potential contacts may be many and excessive use of insecticides should be avoided. Advice should be sought from the Infection Prevention and Control Team or the Health Protection Team particularly if there is a single case only and evidence of spread within the establishment is absent. It may be appropriate to treat the index case only (+/- very close contacts) and monitor for any subsequent cases
- Contacts with symptoms should receive full treatment with cream or lotion on two occasions
- Contacts without symptoms should be given only one course of treatment with cream or lotion. Contacts of asymptomatic contacts do not require any treatment
- Contacts who have been treated with cream or lotion can go to school or work

Grandparents and baby-sitters are often overlooked as contacts when a child has scabies

5.0 SOP

Standard Infection Control Precautions (SICPs) / Transmission Based Precautions (TBPs)
(refer also to the National Infection Prevention & Control Manual)

SICPs & TBPs	
Patient placement	• All patients with confirmed or suspected scabies should be nursed in a single room with en suite facilities. If a single room is not available staff should inform the IPCT and complete a risk assessment to ensure that there is at least 2 metres between bed centres to minimize cross transmission. Cohorting of patients in the same bay may be advised by the IPCT following risk assessment. • If a patient is nursed in a side room appropriate signage should be displayed prominently at the entrance to identify the area. • Patients should remain in an isolation room whilst they are considered infectious. IPCT should be contacted if an isolation room is unavailable and a risk assessment should be completed. • Patients with prolonged illness or complications should be assessed by clinical staff and the IPCT, and isolation precautions discontinued if deemed appropriate. Patients who fall into this category must be assessed individually.

Hand hygiene	• Strict adherence to hand hygiene guidelines, hands must be decontaminated before and after each direct patient care episode. • Patients and visitors should be offered guidance on appropriate hand hygiene • Refer to National Infection Prevention and Control Manual (NIPCM) Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) • Hand Rub (AHBR) can be used to decontaminate hands if hands are visibly clean. Refer to Hand hygiene Policy. **For Noting:** that the term 'alcohol-based hand rub (ABHR)' has been updated to 'hand rub'. A hand rub (alcohol or non-alcohol based) can be used if it meets the required standards.
Moving between wards, hospitals and departments	Patients diagnosed with Scabies who remain infectious must not leave the area unless there is a clinical need. If a patient requires transfer to another department the following procedures must be followed: • The department must be informed in advance.
Equipment	• Use single-use items if possible. • Where possible allocate equipment for individual patient use e.g. washbowl, commodes etc.
Equipment & Environmental cleaning	• **Domestic Staff** - Daily environmental cleaning must be undertaken with a solution of 1,000ppm available Chlorine releasing agent. • **Nursing Staff** - Dedicated equipment should be cleaned after each use with Clinell Universal Disinfectant wipes (Green Clinell wipes). • Additional cleaning may be advised by the IPCT. • Single patient use equipment – clean as above after each use. Ensure that the rooms of patients with infection are cleaned (at least daily) with a focus on increased cleaning for frequently-touched surfaces (e.g. over-bed tables, lockers, lavatory surfaces in patient bathrooms, door knobs) and equipment in the immediate vicinity of the patient. Frequently touched surfaces must be decontaminated at least daily as well as after any AGP and immediately if visibly contaminated/soiled. • Keep environment clean and clutter free
Personal Protective Equipment (PPE)	The recommended PPE required to minimise the risk of cross-transmission of infection to self and others when providing patient care can be found in Appendix 16 (NIPCM).
Patient Information	• The clinical team with overall responsibility for the patient must inform the patient of their status and provide information for the patient/relatives.

Linen	Linen should be treated as 'infectious linen' as outlined in the Laundry: 'Bagging & Tagging' poster. • Linen hamper bags must be tagged appropriately (e.g. date, hospital ward/care area) to ensure traceability. • Bed linen and patient clothing should be changed daily. • Laundry leaflet would be provided for relatives and infected linen guidance followed.
Patient Clothing	• There are no special requirements when handling patients clothing, however, advise relatives to wash hands thoroughly after clothing is put into the washing machine. Clothes should be washed at the temperatures advised on the clothing labels. Laundry Guidelines information leaflet is available if required – if this leaflet is provided document this in the personal care record. • HCWs handing patient clothing should use the appropriate PPE Refer to the Management of Scabies Guidelines.
Waste	• Waste from patients with Scabies must be designated as clinical waste and placed in an orange bag.
Removing Precautions	Precautions can be removed on resolution of symptoms. Discuss further arrangements with the IPCT. Discharge planning When medically fit for discharge the clinical team with overall responsibility for the patient must inform the General Practitioner of the patient's diagnosis.
Terminal Cleaning ***Following transfer, discharge or once the patient is no longer considered infectious***	Remove all of the following from the vacated single room healthcare waste and any other disposable items (bagged before removal from the room); • bedding/bed screens/curtains and manage as infectious linen (bagged before removal from the room); and • reusable non-invasive care equipment (decontaminated in the room prior to removal). The room should be decontaminated using: • a combined detergent disinfectant solution and chlorine releasing such a Chlorine releasing agent at a dilution, (1,000ppm av.cl.) (this process applies for **domestic staff** for the environment only. • Universal Disinfectant wipes **clinical staff** only for decontaminating the environment including near patient equipment) • The room must be cleaned from the highest to lowest point and from the least to most contaminated point. Please refer to NHSL Standard Operating Procedure (SOP) Terminal Clean

	of a Multi-bed Bay or Ward following Outbreak
Last Offices	Precautions for hygiene preparation of the body are the same as those required during life. Refer to the NIPCM
Visitors	• Visitors must speak to a member of staff and be instructed on hand hygiene practice before entering and on leaving the patients room.

6.0 ROLES AND RESPONSIBILITIES

Who	**Roles & Responsibilities**
NHS Board	• To implement this guideline across NHS Board
Hospital Management Teams	• Support the HCWs, HPT and the IPCT in following this policy.
HPT/IPCT	• Keep this Guideline up to date. • Engage with staff to support implementation of IPC precautions described in this Guideline as required. • Review national guidance • Provide education opportunities on this policy.
Senior Charge Nurse (Ward Manager) **Care Home Manager**	• To provide leadership within the clinical area and act as role models in relation to IPCT. • To ensure implementation and ongoing compliance with Standard Infection Control Precautions (SICPs) and TBPs and take appropriate action to address any area of non compliance. • To report any difficulty in accessing or providing sufficient resource to achieve this. • Recognise and report to the HPT/IPCT any incidences of clinical conditions where the signs/symptoms are suggestive of an outbreak.
HCWs	• To ensure implementation and ongoing compliance with SICPs and TBPs. • Recognise and report to the HPT/IPCT any incidences of clinical conditions where the signs/symptoms are suggestive of an outbreak.

7.0 RESOURCE IMPLICATIONS

There are no resource implications.

8.0 COMMUNICATION

Guideline will be launched and distributed as follows:

- Staff brief
- Electronic launch through dissemination by Chiefs of Nursing Services
- The guideline will be available on the Infection Prevention and Control Page on First Port

9.0 ABBREVIATIONS

NIPCM National Infection Prevention and Control Manual
HCSW Health Care Support Worker
HPT Health Protection Team
IPCT Infection Prevention and Control Team
SICPS Standard Infection Control Precautions
TBPs Transmission Based Precautions

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CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	• Health Protection Team • Infection Prevention and Control Team
Consultation Process / Stakeholders:	• Infection Prevention and Control Team • Health Protection Team • PSSD • Microbiologists • Infection Control Doctor • Lead Antimicrobial Pharmacist • Chief Nurses • Chief Medical Staff
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CHANGE RECORD			
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