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1.0 INTRODUCTION

1.1 This policy has been developed for use by staff in hospitals served by South Devon Healthcare Services.

1.2 The aim of the document is to facilitate effective evidence-based treatment of scabies infections and prevent further spread of scabies. It describes the actions to be taken by staff when one or more cases of scabies is suspected or confirmed.

1.3 **In all cases, the Infection Control Team must be contacted.**

1.4 Infection Control will assist with the following:

- Ensuring the diagnosis of scabies has been confirmed, either by the medical team or dermatologist
- Identifying the source of infestation if possible and confirming if mass treatment is indicated
- Identifying contacts who will require treatment
- Issuing written information about scabies
- Informing and involving appropriate medical staff
- Informing Occupational Health Department
- Advising on best treatment
- Planning co-ordinated treatment
- Ensuring follow-up occurs.

2.0 FACTS ABOUT SCABIES

2.1 Scabies is an itchy condition caused by a tiny mite (sarcoptes scabiei). The itchy rash is caused by a reaction to the mite’s faeces and saliva.

2.2 There are two forms of scabies:

i. Classical scabies
ii. Crusted (Norwegian) scabies

In both forms the infecting mite is identical, but the infected individuals react in different ways.

i. Classical Scabies

Mites are few in number – often less than 20 mites on the whole body. Mites pass from person to person during prolonged, constant, skin-to-skin contact (>3 minutes), especially during hand holding.

Adult female mites start to tunnel into the skin’s stratum corneum within 30 minutes and lay up to 3 eggs per day in a burrow.

The allergic rash can take up to six weeks to develop, although less than two weeks if the person has been sensitised by previous scabies infection.

ii. Crusted (Norwegian) Scabies

Individuals in whom the immune system has been or is impaired, i.e., steroids topical, immunocompromised, may develop crusted scabies. Itching does not occur and mites build up in crushed lesions on the skin. These crusts contain large amounts of mites and are more infectious when they slough off into the immediate environment.
3.0 MANAGEMENT OF SCABIES INFECTION

3.1 When the diagnosis of scabies is suspected or confirmed, Infection Control should be contacted as soon as possible.

3.2 Diagnosis

3.2.1 Diagnosis of scabies can be confirmed using the following criteria:

- Evidence from skin scrapings and/or presence of burrows between fingers
- Confirmation by dermatologist
- Clinical history of an itchy symmetrical rash, worse at night, on hands, wrists, upper arms, waist, thighs, ankles AND has been in contact with a person with a similar rash within the previous two months.

3.2.1 If in doubt, please ask a member of the Infection Control Team for advice.

3.3 Management of staff cases

3.3.1 If there are no other staff or patients with symptoms, an individual member of staff with symptoms should remain off work until treated. They should be advised to ensure close family members are treated at the same time.

3.3.2 If risk assessment indicates that mass treatment of staff is required, this will be co-ordinated by Infection Control. In this situation the responsibility for staff management rests with the employer.

3.4 Management of patients

3.4.1 Isolate, if possible, in a single room until treated. Contact Infection Control for further advice.

3.4.2 Gloves and aprons must be worn for direct contact (as per Isolation Policy 0394).

3.5 Source of infection

3.5.1 Whenever possible, the source of the infection will be identified. The following information will be required by Infection Control:

- Does a sleeping partner have a rash?
- Does a family member have a rash?
- Does the person live or work in an institution or care-giving setting?
- If yes, do any other clients or staff within the care setting have a rash?

3.5.2 It would be helpful if the person in charge could collate this information and place on contact sheet (see Appendix A).

If two or more linked cases (including the index case) are identified, mass treatment will need to be performed, as detailed below.
3.6 Identify contacts who require treatment

3.6.1 Infection Control will identify contacts of the case(s) who also need treatment. In order to do this, they will require a list of all skin-to-skin contacts of >3 minutes in the past 8 weeks, including young children and elderly/other dependants. Other information will be required as listed in Appendix A.

3.6.2 This will be done in collaboration with Occupational Health Services.

3.7 Advise on treatment

3.7.1 Infection Control will advise on the most appropriate treatment and provide specific advice on the application of the treatment. The written information issued with the treatment should be followed (Appendix C).

3.8 Co-ordinating treatment in a care setting

3.8.1 When cases occur in a care setting, the treatment must be co-ordinated. The person in charge will be provided with advice as per Appendix B.

3.8.2 It is important that staff are aware of the need to co-ordinate treatment and do not rush out to treat themselves. Staff will be given an information leaflet (see Appendix D). If the treatment is not co-ordinated, scabies mites can be transmitted back from those awaiting treatment to those who have already received treatment. This can result in further cases a few weeks later and the whole exercise then has to be repeated.

3.9 Crusted scabies

3.9.1 Crusted (Norwegian) scabies is much more infectious than normal scabies and is usually diagnosed by a dermatologist, who will advise on treatment. If cases occur in a care setting, the patient should be isolated and additional precautions are necessary (see Appendix C).

3.10 Follow-up

3.10.1 The skin of carers and clients should be checked during the 4 weeks following treatment, to ensure that existing rashes disappear and new rashes do not appear.

3.10.2 If new rashes appear, or those with existing rashes do not improve, then Infection Control should be asked for further advice.

Acknowledgements:

Thanks to Infection Control at Southampton University Hospital Trust and Walsall NHS Trust for allowing us to use their guidelines to adapt our own.
SCABIES - Questions

1. Has patient/s been seen/diagnosed by a Dermatologist?

2. Number of patients

3. Number of staff in direct patient contact.

4. Any Agency/Bank staff?

5. Any staff working in other establishments?

6. Any staff who have left in last two months? Ward Manager to contact them if possible with information on incubation and signs and symptoms.

7. How may staff symptomatic?

8. How many of these live with partners/families?

9. Note number of family contacts.

10. How many patients symptomatic?

11. How many of these have relatives who help with their care or spend long periods with the patients? (Skin to skin contact of > 3 minutes?) Consider need to treat them too.
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In-Patients from ………………………………………………. Ward/Department

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PLEASE RETURN TO INFECTION CONTROL WHEN COMPLETED

Scabies – Discharged Patient List

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PLEASE RETURN TO INFECTION CONTROL WHEN COMPLETED

Scabies – Staff List

Staff Group: ........................................... Date: from ...................... to .........................

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TREATMENT OF OUTBREAK OF SCABIES

1. Treatment of all cases should be simultaneous. However, in the hospital setting this is not practicable therefore staff must wear gloves for all patient contact until all the patients and staff have been treated. It will not succeed if treatment is staggered as those treated first will become re-infected by those who are untreated. Staff and patients must be treated even if they are NOT symptomatic. In the case of staff with symptoms, other members of their household must be treated, also at the same time as the staff member. Household members of non-symptomatic staff do not require treatment. (But the staff do!)

2. In the case of patients with symptoms, we should also treat regular visitors who have close contact or assist in the care or feeding of their relative.

3. Do not bath or shower just before application of the cream.

4. Cream must be applied all over the body including the soles of the feet, paying particular attention to skin folds and webbing between fingers and toes. Apply up to the hairline. It needs to be applied to every inch of skin, NOT just the spots! If you miss one mite, scabies will appear again! **For patients or staff over 12 stone two tubes of cream must be used.**

5. Use ALL THE CREAM FOR ONE APPLICATION. Wear gloves when applying. Use separate gloves for each patient. Wash hands after removing gloves. It may be useful to save a very small amount of the cream to reapply to areas that are washed (i.e. hands after toileting) during the night, or when incontinent patients are washed.

6. The directions indicate that the cream should be left on for 8 hours, but from experience we find that 12 hours is not only more practicable, but perfectly safe.

7. Lyclear is not contra-indicated during pregnancy, but medical advice should be sought if planning treatment for children under 6 months of age. If a sufferer of a skin condition, for example, eczema then Derbac M may need to be used instead.

8. If well executed, mass treatment should be successful. The itch will prevail for 3-4 weeks and some people may need “anti-itch” medication. The rash should begin to lessen within one week.

9. Watch for and report fresh spots within 4 days of treatment. It could indicate that a second treatment is necessary.
SCABIES –
Additional Measures for Crusted Scabies

When a case of Crusted Scabies is diagnosed, the following additional measures are required to minimise transmission:

1. The patient should be kept in a side room until treatment has been carried out and has been successful.

2. Staff should cover exposed skin on hands and arms when giving direct care.

3. Used bed linen, towels and clothing should be bagged in the room by staff who are wearing gloves and plastic apron and sent to the laundry.

4. Careful cleaning of the room to remove skin flakes containing the mites.

5. Following successful treatment, a further thorough clean should take place.

6. Any items that are difficult to clean or wash can be left in a cool, well-ventilated area for 48 hours, which will allow any remaining mites to die.
SCABIES

General Information

It has been identified that we have had two patients on the ward recently who have scabies. As a precaution a decision has been taken therefore to treat all patients and staff on this ward.

If your relatives or visitors have any questions please ask them to contact the Infection Control Support Department on 01803 655757 Monday-Friday 0830-1700 or for community staff Community Infection Control 01803 210547 Monday-Friday 0830-1700.

Scabies is a highly infectious parasitic infestation caused by the mite *Sarcoptes scabiei*.

Anyone can get scabies, regardless of age, sex, race or standards of personal hygiene. IT IS NOT A CONDITION THAT ONLY DIRTY PEOPLE GET! It is quite difficult to diagnose initially and can be mistaken for other skin conditions sometimes. This is a particular problem when the patient already has eczema or psoriasis.

Incubation

After acquiring the mites there are usually 2 – 6 weeks without symptoms. Symptoms usually begin with itching, which is worse at night because of the warmth, followed by a papular (or ‘pimply’) rash.

What happens?

The mite burrows into the skin and “tunnels”, leaving tracks that appear on the surface as burrows. The female lays eggs which hatch in 3 days and emerge from the tunnel onto the skin after two weeks. Unless treated, the process will continue.

Transmission of Infection

It is easily passed on by skin to skin contact - holding hands or linking arms and, at home within the family unit, it is likely that all members of the family will become exposed to the mite. It takes just >3 minutes of skin-to-skin contact to pass it on.

The chance of infection from bedding or clothes worn by the affected person is very very slight, as the mite does not survive for long away from the body heat.

Treatment

This is by application of a prescribed cream that needs to be applied all over the body. This means every inch. If you miss one mite (and you cannot usually see them), the treatment will fail.

Pay particular attention to skin creases and folds, areas between the fingers and toes.

The cream should remain on for 12 hours. If the cream is washed off during the 12 hours (hand washing), cream must be reapplied to that area. Having been prescribed cream for treatment, it is important to realise that ALL THE CREAM MUST BE USED, ALL OVER THE BODY – NOT JUST ON THE SPOTS. It would however, be wise to save a tiny squeeze for reapplying to hands or other areas that you might need to wash during the 12 hours.

**Do not bathe before application of the cream** - it reduces the effect of treatment.
After 12 hours, wash the cream off, wear clean clothing and wash previous clothing in a hot wash. Bed linen used before cream application should also be washed.

The Management of Cases of Scabies

A case of scabies is suspected

Confirm the diagnosis with doctor or dermatologist

NO

Arrange treatment for non-scabies skin condition with medical/nursing staff

YES

Inform Infection Control Team who will advise and coordinate treatment for patient/staff and other close contacts

YES

Could there be other cases now or in the last two months?

Inform Infection Control Team who will advise and coordinate treatment for patient/staff and other close contacts

NO

Classical

Crusted?

YES

Confirm the diagnosis

• Ensure case(s) receives adequate treatment
• Ensure close contacts are identified and treated
• Give information leaflet about scabies
Protocols and Guidelines – Document Control

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

Ref: 0909 Title: Scabies Infections in Healthcare Settings

Date of Issue: 20 January 2017 | Next Review Date: 20 January 2019
Version: 6
Author: Infection Prevention & Control Team
Division Responsible: Organisation Wide
Classification: Protocol
Applicability: All staff
Evidence based: Yes

Equality Impact: The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief.

References:
4. CDC Parasitic Disease Information – www.cdc.gov

Produced following audit: No
Audited: No
Approval Route: See ratification sheet | Date Approved: 24 November 2016
Approved By: Infection Prevention and Control Committee

Links or overlaps with other policies: 0394 Isolation Policy
All TSDFT Trust strategies, policies and procedure documents.

PUBLICATION HISTORY:

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The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions.

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person’s ability to make a decision due to ‘an impairment of or disturbance in the functioning of the mind or brain’ the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual’s right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.
**Quality Impact Assessment (QIA)**

### Who may be affected by this document?

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**Please select**

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- Voluntary / Community Groups
- Trade Unions
- GPs
- NHS Organisations
- Police
- Councils
- Carers
- Staff
- Other Statutory Agencies
- Others (please state):

### Does this document require a service redesign, or substantial amendments to an existing process?

☐

If you answer yes to this question, please complete a full Quality Impact Assessment.

### Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?

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If you answer yes to any of these strands, please complete a full Quality Impact Assessment.

If applicable, what action has been taken to mitigate any concerns?

### Who have you consulted with in the creation of this document?

**Note - It may not be sufficient to just speak to other health & social care professionals.**

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- Staff
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