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Cumbria County Council

Community Infection Prevention and Control Policy for Domiciliary Care staff

Scabies

SCABIES

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DC 16

SCABIES

This guidance document has been adopted as a policy document by:

Organisation:	Cumbria County Council
Signed:	
Name:	Pam Duke
Job Title:	Assistant Director Provider Services
Directorate:	People
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For further information and advice regarding infection prevention and control please contact:

Fiona McCredie
Head of Health Protection
Public Health
People Directorate
Cumbria County Council
Penrith Community Fire Station
Carleton Avenue
Penrith
Cumbria CA10 2FA

Tel: 01768 812539
Mob: 07900 668648
Email:
Fiona.McCredie@cumbria.gov.uk

Debbie McKenna
Health Protection Specialist
Public Health
People Directorate
Cumbria County Council
Cumbria House
107-117 Botchergate
Carlisle
Cumbria CA1 1RZ

Mob: 07769 301904
Email:
Deborah.McKenna@cumbria.gov.uk

Your local Public Health England Team:

Public Health England North West	Tel: 0344 225 0562 Option 2

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, naval 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 2 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 cellulitis, folliculitis, boils, impetigo, or lymphangitis. Scabies may also exacerbate other pre-existing skin conditions, such as eczema and psoriasis.

2. How is scabies spread?

- Direct skin to skin 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 short period of time, e.g. holding hands.
- Transmission from clothes or bed linen is uncommon.

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.

Misdiagnosis is common because of its similarity to other itchy skin conditions, such as contact dermatitis, insect bites, and psoriasis.

Classical scabies

Diagnosis should be confirmed by a GP or Dermatologist.

Crusted scabies (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.

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. An erythematous rash is usually found covering the body which appears crusted, but may not be itchy.

Thousands of mites can be present and are capable of spreading into the immediate environment due to the shedding of skin from the crusted lesions, surviving for a day or two in warm conditions.

4. Preventing the spread of scabies

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 and 4-6 tubes for two treatment applications. Insufficient lotion is a contributory factor to treatment failure.

Management and treatment

It is essential that instructions/advice provided by your local Community Infection Prevention and Control (IPC) Team, Public Health England (PHE) Team 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.
- 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.
- Cream/lotion must be applied all over, from top to toe, including the scalp, in between buttocks, fingers, toes, naval, behind the ears, on the palms of hands, soles of feet, under nail edges and genital areas. Cream/lotion should be applied to the face but avoid the lips and eye area.
- Cream/lotion must be re-applied to any parts of the body which have been washed during the 8-12 hour period, e.g. hands, buttocks.
- 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, ensure that nails are

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.
- Treatment should be repeated 1 week later.
- Staff applying the cream/lotion should wear gloves and an apron.
- Other service users, staff members, relatives or close contacts may require treatment. Advice should be obtained from your local Community IPC or PHE Team.
- Following treatment, itching often persists for several weeks and is not an indication that treatment has been unsuccessful.

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

Suspected treatment failure

Treatment failure is likely if:

- The itch still persists at least 6 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
- New burrows appear at any stage after the second application of an insecticide

General information

- Linen and laundry should be washed as normal. 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.
- 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.

5. 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 (see section below).
- Non-urgent hospital outpatient attendances or planned admissions should be

postponed if at all possible, please refer to the 'Patient placement and assessment for infection risk Policy for Domiciliary Care staff'.

- If the condition of an affected or an unaffected service user, living in a supported living or sheltered housing complex, 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, please refer to the 'Patient placement and assessment for infection risk Policy for Domiciliary Care staff'.
- If a service user is fit for discharge from hospital and is symptom free, they can be discharged back to their usual residence, e.g. home, supported living or sheltered housing complex.

6. References

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

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

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*

7. Appendices

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

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NHS

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

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 April 2017
www.infectionpreventioncontrol.co.uk