



Community Infection Prevention and Control Policy for General Practice

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

Scabies

SCABIES

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Contents	Page
1. Introduction.....	4
2. Transmission	4
3. Diagnosis.....	5
4. Managing and preventing the spread of scabies.....	6
5. Topical preparations for treatment	6
6. Management and treatment.....	6
7. General information	7
8. Environmental cleaning	7
9. Suspected treatment failure	7
10. Referral or transfer to another health or social care provider	8
11. Infection Prevention and Control resources, education and training.....	8
12. References	9
13. Appendices.....	9
Appendix 1: Scabies treatment: Patient instructions for application of cream or lotion	10
Appendix 2: Inter-Health and Social Care Infection Control Transfer Form	11

SCABIES

1. Introduction

Scabies is due to a parasitic mite *Sarcoptes scabiei* variety *hominis*. They are too small to be seen by the naked eye. The adult female is around 0.4 mm long and 0.3 mm wide; males are slightly smaller. The female lays 2-3 eggs a day in burrows several millimetres in length under the surface of the skin.

After 2-4 days, larvae emerge to mature on the skin surface and then make new burrows. They mature, mate, and repeat this cycle which takes 10-17 days. Males die after a short time, but the females live for up to 6 weeks.

The characteristic rash is not due to the mite itself but to an allergic reaction to the mite, its eggs and faeces.

Symptoms include an intense itchy, symmetrical rash (often worse at night), which occurs mainly between the fingers, on the waist, armpits, wrists, navel and elbows. 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.

Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.

2. Transmission

Spread is normally from person to person via direct skin contact, including sexual contact. Although the mites cannot fly or jump, they can crawl as fast as 2.5 cm per minute on warm skin. It was previously believed that prolonged skin-to-skin contact was necessary for transmission to occur, but there is

evidence that they can survive for at least three days off the skin surface. Lower temperatures and higher relative humidity prolong survival.

However, the average infested adult may have as few as 10 to 15 mites on their body surface at any one time and, in such cases, transmission does not normally occur via the bedding or clothing from an infected person.

Crusted (Norwegian) scabies

In cases of severe infestation (Norwegian or crusted scabies), thousands of mites may be shed daily and, therefore, transmission via fomites is possible as the mites survive on the sloughed and crusted skin in the environment. 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 patients 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 7 days.

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

4. Managing and preventing the spread of scabies

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 Establishments', available to download from www.infectionpreventioncontrol.co.uk.

5. Topical preparations for treatment

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

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

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.

6. Management and treatment

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 and 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.
- 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.

- 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: Patient instructions for application of cream or lotion' (see Appendix 1). This is also available to download at www.infectionpreventioncontrol.co.uk.

7. General information

- Linen and clothing should be washed at 60°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

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

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

- Transfer to another Health or Social Care provider should, where possible, be deferred until the patient 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 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 infection prevention and control (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 the Inter-Health and Social Care Infection Control Transfer Form (see Appendix 2) or patient passport. This should accompany 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'.

11. 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:

- 25 IPC Policy documents for General Practice
- 'Preventing Infection Workbook: Guidance for General Practice'
- 'IPC CQC inspection 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 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.

12. 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*

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*

13. Appendices

Appendix 1: Scabies treatment: Patient instructions for application of cream or lotion

Appendix 2: Inter-Health and Social Care Infection Control Transfer Form

GP 21

Appendix 1: Scabies treatment: Patient instructions for application of cream or lotion



Scabies treatment

Patient instructions for application of cream or lotion (for external use only)

- **Do not bathe or shower before putting on the cream or lotion.**
 - **Make sure there are 2-3 x 30 g tubes for 1 treatment application and 4-6 tubes for two treatment applications before starting the treatment**
1. Application of the cream or lotion is best done in the evening.
 2. Wash hands.
 3. Remove all clothing and jewellery.
 4. The cream or lotion needs to be applied to the whole body (apply externally all over the body from chin and ears to toe). If it is not possible to remove a ring, move it to one side, then treat the skin surface that is normally underneath the ring. Wait for the skin to dry before returning the ring to its normal position. In the very young, elderly and immunosuppressed, apply to the scalp and face, avoiding the eyes and lips.
 5. Squeeze the cream into the middle of the gloved hand or tips of fingers. If a lotion has been prescribed, it can be poured into a bowl and a disposable sponge or disposable cloth used to apply it. The sponge or cloth should be disposed of after completion of the treatment.
 6. Apply to the skin.
 7. Take special care to get it into all the external skin creases of the body, e.g. under breasts, the nipples (scabies treatment should be washed off nipples before breast feeding, then re-applied after breast feeding), scrotum and between the buttocks (bottom). Particular attention needs to be paid to the skin between the fingers and toes, under the nails and behind the ears. You will need someone to apply the cream or lotion to your back. Mittens may be used to prevent infants putting treated hands into their mouths.
 8. Let the cream or lotion dry before getting dressed or it may rub off. This takes 10–15 minutes.
 9. Do the soles of the feet last after the body treatment has dried. Do not bathe or shower during the treatment (Lyclear dermal cream [permethrin 5%] 8 hour treatment or Derbac – M [malathion] 24 hour treatment).
 10. Apply more cream or lotion on any body parts that may have to be washed, e.g. hands, during the treatment period. Depending on the treatment used, this may be for up to 24 hours after first application of the cream or lotion.

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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:	