THE STATE HOSPITALS BOARD FOR SCOTLAND

CONTROL AND TREATMENT OF SCABIES POLICY

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Lead Author	Senior Nurse for Infection Control	
Contributing Authors	The State Hospital Infection Control Committee	
	NHS Lanarkshire Guideline for the Control and Treatment of Scabies	
Advisory Group	The State Hospital Infection Control Committee	
Approval Group	Policy Approval Group (PAG)	
Implementation Date	29 September 2023	
Next Review Date	29 September 2025	
Accountable Executive Director	Director of Nursing and Operations	

The date for review detailed on the front of all State Hospital policies/ procedures/ guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/ procedure/ guidance at any time due to organisational/legal changes.

Staff are advised to always check that they are using the correct version of any policy/ procedure/ guidance rather than referring to locally held copies.

The most up to date version of all State Hospital policies/ procedures/ guidance can be found on the intranet: http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx

REVIEW SUMMARY SHEET

No changes required to policy (evidence base checked)	☒

Changes required to policy (evidence base checked)	☐
Summary of changes within policy:	

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1. INTRODUCTION

Scabies is an infectious disease of the skin caused by a burrowing mite called *Sarcoptes scabiei*. The infection commonly affects the whole household i.e. ward environment, with a reported secondary attack rate within families of around 40%. It is only transmitted by direct skin contact with an infected person. Spread can be exacerbated by crowded living conditions and 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 48-72hours off a person. Infection is not normally acquired by contact with patients' clothes and bedding. However, fomites (objects or materials which are likely to carry infection) may rarely be a factor in transmission in cases of atypical presentations e.g. crusted (Norwegian) scabies. Mites can burrow beneath the skin surface in 2.5 minutes.

2. AIM

To ensure that patients receive appropriate and timely investigation, care and management in line with national guidelines and best practice (NICE Clinical Knowledge Summaries – Scabies June 2022).

To provide all State Hospital staff with the information to enable prompt identification of patients who have Scabies.

To ensure that State Hospital staff minimise the transmission of Scabies.

3. SCOPE

This policy is designed to safeguard patients, staff and volunteers from the risk of Scabies. In particular the policy is aimed at all clinical staff working in the State Hospital.

4. ROLES AND RESPONSIBILITIES

Who	Roles & Responsibilities
NHS Board	• To ensure this policy is implemented across the State Hospital
Infection Control Team	• Keep this policy up to date • Engage with staff to support implementation of IPC precautions described in this policy as required • Review national guidance • Provide education opportunities on this policy
Lead Nurses	• Support clinical staff in following this policy
Senior Charge Nurses	• To provide leadership within the clinical area and act as role models in relation to Infection Prevention and Control • To ensure implementation and ongoing compliance with Standard Infection Control Precautions (SICPs) and take appropriate action to address any area of noncompliance • To report any difficulty in accessing or providing sufficient resource to achieve this • Recognise and report to the Infection Control Team any incidences of clinical conditions where the signs/symptoms are suggestive of an outbreak
Clinical staff	• To ensure implementation and ongoing compliance with SICPs • Recognise and report to the Infection Control Team any incidences of clinical conditions where the signs/symptoms are suggestive of an outbreak

5. PRINCIPAL CONTENT

5.1. 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, sides of the fingers, borders of the hand and less often on the palm. Other diagnostic features 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 (faeces or eggs). 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 re-infection after treatment can produce a severe itch within 24 hours.

The itch is characterised by widespread pinhead size papules (pimples or swellings) and papulo-vesicles (papule that changes into a blister), most commonly found on the arms, the auxiliary folds, around the areola and on the abdomen (belly button 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 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.

5.2. Diagnosis

Diagnosis can be difficult and early advice should be sought from the Senior Nurse for Infection Control / Health Centre or Occupational Health Service (as appropriate).

The clinical appearance of burrows is open to more than one interpretation. When a patient or staff member complains of an otherwise unexplained intense itch, scabies should be suspected and advice sought. 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.

5.3. Mode of Transmission

Transfer of parasites commonly occurs through prolonged direct contact with infested skin and also during sexual contact. Transfer from towels, goal keeping gloves, undergarments and bedclothes occurs only if these have been contaminated by infested people immediately beforehand.

5.4. 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.

5.5. Period of Communicability

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

Exclude cases from placement or groups until the day after the first treatment.

5.6. Treatment

Treatments is permethrin cream (a common product Lyclear Dermal cream).

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 insecticides 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.

5.7. Treatment of Cases

First night of prescribed medication

1) Apply cream (by patients, supervised by staff) to the whole body surface including the scalp, especially if hair is thin (take care to avoid the face and eyes)
2) Nursing staff providing direct care to a patient with scabies should wear a plastic apron and gloves until 24 hours after treatment. No other precaution is necessary
3) 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
4) 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
5) Leave the cream on for 24 hours
6) Have a bath or shower the next night to remove the cream
7) Re-application to the hands 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

Seventh Night following first application - repeat steps 1-7 above.
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.

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 Control Team or Health Centre for advice.

In resistant cases or where topical therapy is impractical a single oral dose of the scabicides Ivermectin may be indicated. It is unlicensed and must be prescribed on a named patient basis.

Secondary infection and dermatitis may need appropriate treatment.

5.8. Contacts of Scabies Cases

Within TSH there may be many potential contacts and excessive use of scabicicides should be avoided. Advice should be sought from the Senior Nurse for Infection Control, Health Centre or Infection Control Doctor (via UHW switchboard) 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 on two occasions
- Contacts without symptoms should be given only one course of treatment with cream
- Contacts of asymptomatic contacts do not require any treatment
- Contacts who have been treated with cream can resume normal activities

6. EQUALITY AND DIVERSITY

The State Hospitals Board (the Board) is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and / or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person-Centred Improvement Lead on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments are in place to enable staff to understand and comply with policies and procedures. The Equality and Impact Assessment (EQIA) considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Patient pre-admission assessment processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. Dementia, Autism, Intellectual Disability, sensory impairment). Rapid access to interpretation / translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith / religion / beliefs, highlighting any adapted practice required to support individual need in this respect. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Carers / Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and / or other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy".

The volunteer recruitment and induction process supports volunteers to highlight any barriers to communication, physical disability or anything else which would prevent them from contributing meaningfully to patient care and / or engage in other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

7. STAKEHOLDER ENGAGEMENT

Key Stakeholders	Consulted (Y/N)
Patients	N/A
Staff	N/A
The Board	N/A
Carers	N/A
Volunteers	N/A

8. COMMUNICATION, IMPLEMENTATION, MONITORING AND REVIEW OF POLICY

This policy will be communicated to all stakeholders within the State Hospital via the intranet and through the staff bulletin.

The State Hospital Infection Control Committee will be responsible for the implementation and monitoring of this policy.

This policy will be reviewed every two years or earlier if required.