Scabies, Lice and Fleas Infection Prevention and Control Policy

Policy information

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Summary of document:
This policy provides guidance to all those involved in care provision of patients who have scabies, lice or fleas.

Scope:
This policy must be used by infection prevention team, health and social care managers, nurses, doctors or other health and social care providers.

To be read in conjunction with:
149 - Hand Hygiene Policy (opens in new tab)
353 - Transmission Based Precautions TBP Policy on Contact/Airborne/Droplet Precautions (opens in new tab)
151 - Personal Protective Equipment PPE Policy (opens in new tab)
154 - Safe Management of Linen Policy (opens in new tab)
236 - Outbreak Management Policy (opens in new tab)
258 - Waste Management Policy (opens in new tab)
354 - Standard Infection Prevention and Control Precautions SICPS Policy (opens in new tab)
230 - Management of Blood and Body Fluid Spillages Policy (opens in new tab)
232 - Environmental Cleaning Policy (opens in new tab)

Patient information:
Include links to Patient Information Library

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Director of Nursing, Quality and Patient Experience

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1.0 – New Policy – 23.03.2016
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3.0 – Full Review – 12.12.2024
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Keywords
Scabies, Head Lice, Fleas

Glossary of terms
GP - General Practitioner
IPT - Infection prevention team
PPE - Personal protective equipment
ESR - Electronic staff record
SICPS – Standard infection control precautions
CEO – Chief executive officer
COO – Executive Director and Chief Operating Officer

Contents

Executive Summary/Key Points

The prospect of a close encounter with scabies, lice or fleas usually induces alarm in most people however they are unlikely to transfer infection in hospital.

Scabies

- Diagnosis of scabies can be difficult but may be established if mites can be recovered via skin scrapings from the burrow and identified microscopically.
- Transmission of scabies is by prolonged skin-to-skin contact only. However, less prolonged skin contact may be significant in the event of crusted scabies (formally known as Norwegian scabies)
- Staff should adhere to standard infection control precautions when dealing with the patient e.g. gloves, aprons / long sleeved gowns
- If a diagnosis of scabies is made, the patient must be isolated for 24hrs post first treatment.
- Patients diagnosed with crusted scabies must be treated as highly contagious and isolated until treatment is completed and been effective.
- All linen must be processed as infected linen.

Head lice

- Head lice are transmitted by direct head to head contact with infested individual.
- Treatment must only be given to patients who have been shown to have live, moving lice.
- Two applications of treatment are recommended 7 days apart
- For patients not wishing to use and insecticide, the 'wet combing method' must be used.
- Isolation precautions are not required for patients with head lice and linen can be processed via the non-infective route.

Pubic (crab) Lice

- Patients diagnosed as infested with pubic (crab) lice do not require isolation facilities
- Health care workers to wear gloves and aprons as per standard infection control precautions
- Close contacts to be checked for crab lice
- All linen must be processed as infected linen.

Fleas

- Patients admitted with fleas must be nursed in isolation room until fully treated.
- Patients clothing must be removed and placed in patient washing soluble bag for relatives to take home and wash at hottest temperature possible. An information leaflet must be given to the relatives so they are informed on how to use the bags in the washing machine correctly (see appendix 1)
- All hospital linen to be treated as infected linen
- Pest control Officer to advise on environmental cleaning of areas within the Health Board if required

Introduction

The prospect of a close encounter with scabies, lice or fleas usually induces alarm in most people. Although insects and mites are unlikely to transfer infection in hospital in the United Kingdom, the problem of infestation is often referred to the Infection Prevention Team. An understanding of how they are transmitted is essential if the treatment is to be carried out effectively.

Insecticides used for application to the skin are potentially toxic and only those approved by the Pesticides Safety Precautions Scheme must be used and directions must be carefully followed. Environmental treatment must only be ordered by the Pest Control Officer.
Treat all rashes as infectious until a diagnosis is confirmed and until this diagnosis, staff must wear gloves and aprons for direct contact.

Inform the Infection Prevention Team if you suspect an infestation of an inpatient/ resident/healthcare worker.

Policy statement

The commitment of the Health Board is to prevent and reduce all potential healthcare-associated infections.

Scope

This policy must be used by infection prevention team, health and social care managers, nurses, doctors or other health and social care providers.

Aim

The aim of this document is to:

- Advise all health care professionals within the Health board of the Infection Prevention and Control precautions required to treat patients with scabies, lice and fleas.

Objectives

The aim of this document will be achieved by the following objectives:

- For all the staff to adhere to the scabies, lice and fleas infection prevention and control measures to aid prevention and transmission.

Scabies

Scabies is caused by infestation with the mite Sarcoptes scaei, which burrows into the upper layer of the skin. The female lay eggs in the burrows, which are raised, skin coloured or grey, and usually measure a few millimetres in length. The eggs and the mite proteins cause an allergic type reaction. It is this reaction that is responsible for the characteristic itching rash. Although socially embarrassing, it is a relatively common dermatological disease, which in most cases is easily cured.

The disease affects all social classes. There is a relatively high incidence amongst the elderly in nursing homes and long-term institutions.

The adult mite penetrates the host's skin by dissolving it with secretions that disrupts the bounding membrane lysis to human cells. Mites can burrow beneath the skin surface in 2.5 minutes. The female mite lays eggs in the burrows at a rate of 2-3 per day for up to 2 months. The eggs hatch in 3-4 days. The young larvae leave the burrow and enter hair follicles or skin folds and become adult in 10-14 days. The life cycle is repeated as an adult female mite burrows into the skin and is subsequently fertilised. The mite cannot jump or fly but can walk up to 2.5cm per minute on warm skin.

Symptoms

The typical scabies eruption consists of burrows, papules, pustules, nodules and on occasion urticarial lesion. Itching can be severe due to a reaction to mite proteins and worse at night or after a hot bath /

shower. The rash is usually found on fingers, hands, wrists, elbows, axillae, areola, periumbilical region, lower abdomen, genitals and buttocks. The rash is symmetrical but may not appear at all sites at once. The rash is an allergic response and does not necessarily occur at the site of the mite burrows. Burrows are greyish scaly lesions around 0.5cm in length. They may become secondary infected.

Diagnosis
Diagnosis can be difficult and generally made on the presence of unexplained itchy rash, body area the rash covers and its appearance. Referral to Dermatology must be considered, as scabies can be easily misdiagnosed. Diagnosis may be established if mites can be recovered via skin scrapings from the burrow and identified microscopically or established clinically. Ensure that that the suspected or infected case is provided with a Scabies information sheet (see appendix 1)

Incubation Period
2-6 weeks before commencement of itching in people without previous exposure. Individuals who have been previously infected develop symptoms within 1-4 days post exposure.

Mode of Spread
Transmission of scabies is by prolonged skin-to-skin contact only. Brief contact e.g. shaking hands does not allow for transmission. Hand-holding and close patient / client support / assistance for long periods are probably responsible for healthcare associated scabies.

Single case management
Recommended treatment involves the application of permethrin (5%) cream (Lyclear), or malathion (0.5%) aqueous liquid (Derbac-M) if permethrin is not appropriate.

- Affected individuals can return to work, school or nursery after completion of the first 24 hour treatment dose as prescribed by a clinician.
- Affected individuals should avoid close physical contact with other people until completion of the first 24 hour treatment dose.
- People with scabies should be advised that symptoms may persist for up to 6 weeks after treatment. Clinicians should consider prescribing antipruritics for the management of the itch if persistent or distressing.
- Where scabies has been acquired from a sexual partner a referral for and sexually transmitted infection (STI) screen should be advised.
- Staff and carers should wear appropriate PPE when handling and providing personal care until the first 24 hour treatment dose has been completed.
- Transfer of cases to other settings should be avoided until the first 24 hour treatment dose has been completed.

Contacts
Contacts are defined as anyone who has close physical contact with the case without appropriate PPE, for example, providing personal care with skin-to-skin contact, sharing a room or other similar household setting, and sexual partners, within the 8 weeks prior to diagnosis.

In the event of cases or outbreaks of crusted scabies, a higher index of suspicion of transmission via more transient contacts may be warranted. An individual case-by-case risk assessment is recommended to take into account severity of infection in the patient and any evidence of transmission without skin-to-skin contact, for example if a member of staff in contact with the patient environment but not with direct skin-on-skin contact is identified as a secondary case.

- Contacts should all be treated at the same time as the index case, on 2 occasions 7 days apart (even if asymptomatic). If staff contacts are off duty at the time of treatment, they should complete the first 24-hour treatment dose before returning to work.
- Have a low index of suspicion for identifying potential contacts of a case of crusted scabies due to the increased risk of transmission.
- Staff should be vigilant for signs and symptoms of scabies for an 8-week period and if 2 or more cases of scabies are identified in the setting then management should proceed as per an outbreak scenario.
- If the case has been transferred within 8 weeks of symptom onset from another setting, staff should inform management at that setting to investigate for possible close contacts and to consider implementing other control measures.

Post scabetic itch

Itching may continue for up to two weeks after successful treatment for scabies, but treatment failure should be suspected if new burrows appear or if the itching persists for longer that 2-4 weeks, afte the last treatment. Treat post scabetisc itch with Crotamiton 10% cream, 2-3 times a day or if the scabies mite have definitely eradicated, with topical hydrocortisone 1%. Night time use of a sedative antihistamine (eg chlorheniramine or hydroxyzine) may help with sleep and reduce scratching. Dry skin/eczema can be treated with emollients

Treatment in Pregnancy or Breast Feeding – A Working Group established by National Public Health Service is not aware of any definitive evidence that any of the currently emplaned topical scabicides have been responsible for harmful effects in pregnancy following appropriate use. It suggests that topical therapy with Permethrin preparations is safe in the absence of evidence of foetal toxicity. Absorption of scabicide is generally low and metabolised rapidly therefore only very low concentrations of the drugs can be expected to pass into breast milk. Permethrin is the treatment of choice for breast-feeding mothers in the UK.

Management of Outbreaks

If 2 or more linked cases within an 8 week period, assess all individuals (staff and residents) within the setting for scabies infection.
Identify close contacts (up to 8 weeks prior to diagnosis) including visitors.
Co-ordinate treatments of all cases and contacts linked to the setting.
Provide hygiene and exclusion advice and avoid transfers to other settings during treatment.
inform visitors to setting until mass treatment completed.

Co-ordination of mass treatment

All cases and contacts including agency nurses etc should be treated at the same time to break the cycle of transmission. If staff are off duty at the time of treatment, they should complete the first 24-hour treatment dose before returning to work. Individual case management should happen simultaneously for all cases and contacts in the outbreak.
Environmental measures are generally taken to reduce the potential risk of fomite transmission and reinfection. The evidence for a single optimal approach to environmental management is limited (8). Ivermectin is a recognised off-label single- or double-dose oral treatment for scabies within closed settings, when there are logistical considerations in the successful delivery of topical therapy, or in the

context of immunosuppression or crusted scabies (9). The decision to prescribe ivermectin in this context lies with local specialist dermatology and infectious diseases services.

Declaring the outbreak over
For the purposes of reporting and determining provision of ongoing support, an outbreak can be considered over when all cases and contacts have received the full recommended treatment regimen (for example, 2 doses of topical cream application). However, ongoing monitoring and a period of heightened surveillance after all cases and contacts have completed treatment is advised to reduce the risk of outbreaks continuing unchecked.

This period of heightened surveillance should include regular re-assessment of staff and patients for any new symptoms, and to ensure symptoms are resolving as expected following treatment, and should last for 12 weeks (that is, 2 mite incubation cycles) after the onset date of symptoms in the last known case.

A scabies outbreak can be declared over if no new cases are identified within 12 weeks of symptom onset date of the last known case. Nodules can take several months to resolve after successful treatment.

Standard Infection Control Precautions (SICP's)

Patient Placement
Refer to 353 - Transmission Based Precautions TBP Policy on Contact/Airborne/Droplet Precautions (opens in new tab).
If a patient in a hospital or community setting is diagnosed as having scabies it is recommended that they are placed in a side room for 24 hours post application of the second application of scabicide. If isolation facilities are not available then patients / clients must not have skin to skin contact with other patients / clients pre and post treatment (24 hours).

- If the patient is in a residential home and difficult to isolate, they must be kept away from other patients as much as possible.
- Place Transmission Based Precautions poster for Contact on the outside door (See Appendix 2)

Hand Hygiene
Hand hygiene is essential for contact precautions. Refer to the 149 - Hand Hygiene Policy (opens in new tab)

Respiratory Hygiene and Cough Etiquette
Reinforce good respiratory hygiene with the patient at all times and assist as necessary

- Ensure patients cover the mouth and nose with a disposable tissue.
- Wearing gloves, place tissue into a waste bin.
- Remove gloves and wash hands.

Personal Protective Equipment (PPE)
PPE is essential for contact precautions. Refer to the 151 - Personal Protective Equipment PPE Policy (opens in new tab).

Gloves and Aprons

- Disposable gloves and plastic aprons must be put on and worn during care activities and where there will be contact with the patient or their immediate environment.
- The use of a disposable long sleeved fluid repellent gown maybe more appropriate in order to gain more protection during potential long periods of skin to skin contact e.g. assisting with hygiene purposes during the isolation period. Advice must be sought from the IPT.

Face Protection

- Face/eye protection including masks and goggles are required if there is a risk of mucosal splashing to the eyes and mouth.

Good Practice Points

- Supplies of PPE must be available at the entrance to single or cohort rooms.
- Aprons and gloves must be put on before undertaking care activities.
- No outer coats to be worn.
- PPE must be removed immediately upon leaving the room followed by hand washing.
- PPE must be changed between different procedures and care activities including gloves.
- PPE must be changed and hand hygiene performed between contact with every patient/client/resident, including others being cared for under contact precautions within the same area.
- Safe disposal of PPE is essential immediately following removal.

Management of Care Equipment

Care equipment must be given additional consideration to prevent the spread of infectious agents that might be contaminating items.

- Equipment must be allocated to individuals being cared for under contact precautions e.g. commodes.
- Equipment must not be shared with others unless thoroughly decontaminated first.
- Items of equipment must be intact. Items that are not intact must be removed and replaced with intact items.
- Where possible use single use only disposable products.

Control of the Environment

Care of the environment must be given additional consideration. Refer to the 232 - Environmental Cleaning Policy (opens in new tab).

- The environment must be cleaned at least daily and when visibly contaminated. Particular attention must be given to frequently touched items e.g. door handles, bed tables etc.
- The environment must be clutter free to allow for effective cleaning
- Equipment for cleaning must follow the Health Board's colour coded cleaning system. These items must be clean, fit for purpose and decontaminated and/or disposed of appropriately
- Terminal cleaning of the environment MUST be performed prior to use by any other patient.

Safe Management of Linen

Linen that could be contaminated must be managed safely in order to avoid cross transmission. They must be bagged following the 154 - Safe Management of Linen Policy (opens in new tab) as follows;

- Place contaminated linen into an alginate bag at the point of removal. DO NOT carry linen out of the room.
- Place alginate bag in appropriate colour coded bag.
- Remove gloves and wash hands.

- Communicate with others who may handle linen to ensure they take appropriate precautions.

Patient clothing
Clothing which has been worn by affected individuals in the period prior to completion of the first 24 hour treatment dose should be handled using appropriate PPE. It is recommended to collect these items in a dissolvable alginate bag (soluble laundry bag), which is placed without opening into a compatible washing machine where available (see appendix 3 Patient Soluble Bag Information Leaflet).

If patients' clothing will not be able to withstand an infected linen process, it is acceptable to process these items separately in a hot wash (minimum 50°C (122°F)). Do not place in a mixed wash with other clothing or overload the machine. The wash should be followed by tumble drying on a hot cycle for at least 10 minutes.

Any items which cannot be laundered in a hot wash may be placed in a sealed plastic bag for at least 4 days prior to laundering: this should be sufficient to kill any mites present. It should not be necessary to launder any items that have not been touched by the patient in the past wee

Management of Blood and Body Fluid Spillages
All body fluid spillages must be cleaned and decontaminated following the 230 - Management of Blood and Body Fluid Spillages Policy (opens in new tab).

Safe Management of Waste
All waste must be segregated and disposed of in accordance with 258 - Waste Management Policy (opens in new tab).

- Waste that could be contaminated must be managed safely in order to avoid cross infection of infectious agents.
- All waste generated from an infected or suspected of being infected patient must be disposed of into orange clinical waste bags (acute setting) or appropriate colour waste bags for contaminated waste.

Crusted Scabies (formally known as Norwegian Scabies)

This type of scabies is due to reduced host immune response and the host may harbour thousands of mites – making this a highly infectious condition. Itching is often minimal and crusting / scaling appears on the face, scalp, hands, feet and pressure bearing areas. Nail involvement may be striking/obvious. Crusts/scales may break away from the body. Individuals with atypical scabies are highly contagious.

Mode of Spread
Direct contact with an infected person, their clothes and environment because of the large numbers of mites and exfoliating skin.

Treatment
For treatment of crusted scabies, refer to Pharmacy and/or Dermatology department for advice as or a combination of oral and topical medicines will be required.

Incubation Period

2-6 weeks before commencement of itching in people without previous exposure. Individuals who have been previously infected develop symptoms within 1-4 days post exposure.

Standard Infection Control Precautions

- A patient / client with Norwegian Scabies must be isolated until treatment is completed and has been effective (as advised by the infection prevention team / dermatologist).
- All close contacts / family to be treated for Norwegian scabies.
- Health care workers contacts should be assessed if the case is initially unrecognised.
- All bedding, towels, clothes to be processed as infected linen. In community / residential home setting all linen must be washed above 65˚C and separate from all other washing.
- The patient's room must be thoroughly vacuumed on a daily basis and vacuum cleaner bag emptied / changed and filter cleaned.

Outbreak of Scabies

Where an outbreak of scabies has been identified on a hospital ward / community residential unit the outbreak will be controlled / investigated by the IPT. Control measures may indicate the prophylactic treatment of all staff and patients / clients and will be conducted via IPT and Occupational Health Department. For larger outbreaks, Ivermectin is recommended and outbreak measures commenced (Refer to policy 236 – Outbreak Management Policy – opens in a new tab)

Resistant Cases of Scabies: Apparent Failure of Treatment

If there has been a failure of treatment then treatment will have to be repeated for cases and contacts, but it is helpful to:

- Seek advice from a Consultant Dermatologist in order to confirm the diagnosis
- Emphasise the importance of correct application of the lotion or cream and arrange for professional assistance if necessary. A frequent reason for treatment failure is that the sites of the rash are treated rather than the whole body.
- Check on compliance from known contacts and make sure the index case has listed all contacts, and that they have been informed and treated at the same time as the case.
- Consider using an alternative product (discuss with pharmacist) that contains a different active scabicide in case of possible resistance. It must be noted, though, that resistance is still at a low levels.
- A small number of patients have 'delusional parasitosis'. These patients firmly believe they have a parasitic infection in the face of all evidence to the contrary. It is helpful to know that this is a recognised psychiatric condition and its management is beyond the remit of the Infection Prevention Team.

Refractory Pseudo-Scabies

Occasionally cases occur where no amount of treatment produces relief or does so only temporarily. Sometimes, these occur singly but often in the form of an outbreak involving a hospital ward or similar social group. The outbreaks can be long-term if expert help is not sought.

Usually the cause is some other mite than *Sarcoptes scabiei* e.g *Cheyletiella*, a parasite of dogs and cats. The route of transmission is not obvious and the assistance of a Medical Entomologist is essential.

Lice

There are 3 specimens of human lice: - head lice, pubic (crab) lice and body lice.

Head Lice

Head lice (Pediculus Humanus Capitis) are very small insects about 2 - 3mm in length and are grey / brown in colour (the size of a small sesame seed). The head louse lays about 10 eggs a day at the base of the hair. The eggs stick to the hair close to the scalp. On average there may be 10 lice per head but if the infestation is not treated it may be as many as 200.

Head lice are not an indication of poor personal hygiene. Head lice are almost invariably acquired from members of the family, the extended family, and close friends.

Incubation Period

There are 3 stages to the head louse life cycle: -

- Eggs hatch after 7-10 days into nymphs, 7 - 13 days later the nymphs become adults.
- Egg to egg cycle is about 3 weeks.
- Nits are empty egg shells which grow out with the hair.

Mode of Spread

Head lice are transmitted by direct head to head contact with an infested individual. Head lice can survive for long periods of time away from the host but they are thought to be unable to re-establish themselves back on the head from formites e.g. clothing / bedding. Headlice are often seen behind the ears and nape of neck. The eggs or nits are shiny and firmly attached to the hair.

Symptoms

Patients / clients may be asymptomatic but in 15-30% of the population itching is present. Diagnosis of lice can be established by using a detection comb (available from Pharmacy) on wet hair over a pale surface e.g. white paper.

Treatment

Only treat individuals who have been shown to have live, moving lice. Using insecticide 'just in case' helps encourage resistance and may expose patients / clients to side effects.

Pharmacy will advise on the appropriate treatment. Head lice treatment with a liquid or lotion formulation is important as shampoos have been found to be diluted too much to be effective. Alcoholic formulations are effective but aqueous formulations are preferred in severe eczema, patients with asthma and small children.

A course of head lice treatment is usually 2 applications of the product 7 days apart. Manufacturer's instructions must be followed in method of application and directions.
Treatment of head lice in pregnancy and during breast feeding must be discussed with the Pharmacy department before use.

Wet Combing Method

If a patient with head lice does not wish to use an insecticide the following 'wet combing' method must be performed every 3 - 4 days for 4 weeks or longer if live lice are still detected:

- Wash hair in the normal way with an ordinary shampoo (do not use 2 in 1 preparations).
- Towel dry.

- Lots of conditioner must be applied to the damp hair (use an ordinary conditioner to straighten and untangle hair).
- Part the hair into small sections, and using the detection comb, comb through the hair getting as close to the scalp as possible.
- Clean the comb after each stroke using paper towel.
- If the hair begins to dry during the procedure, dampen with water and add more conditioner.
- Once all sections of hair have been thoroughly combed, rinse off the conditioner and dry as normal.

Patient's Clothing and Environment
Patient's clothing must be laundered at the hottest wash the clothing material will withstand. There is no specific treatment for the environment apart from routine cleaning as lice usually die in the environment at room temperature within a few days.

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Standard Infection Control Measures (SCIP's)
- Health care workers to wear gloves / aprons as per standard infection control precautions.
- Close contacts must be checked for head lice in wards / mental health community homes and close family contacts advised to check their heads and if appropriate get treatment via chemist / GP.
- Isolation of the patient / client is not generally required for head lice.
- Wash all combs / hairbrushes used on a patient / client with hot soapy water and dry.
- Treat all linen / laundry processed via Trust laundry system as routine. Any linen / laundry / clothing washed on mental health community home sites to be washed on hottest possible temperature for fabrics concerned. The machine washing / hot air tumble drying or ironing process with kill all head lice.

Public Crab Lice

Pubic (Crab) lice are generally found in pubic hair but can also be found in axillae, chest, beards and eyebrows. Itching or observation of live lice / crabs is most common signs and symptoms. Crab lice live for 2 days off a host.

Treatment
An aqueous preparation (e.g. Permethrin) must be applied to all areas of the body including scalp, neck, ears and face (pay particular attention to eyebrows and any facial hair). It must be allowed to dry naturally and washed off after 12 hours. A second treatment is required after 7 days to kill any new emerging lice.

Alcoholic lotions are not recommended (owing to irritation of excoriated skin and the genitalia). Washing of patient's clothing must be performed with items being laundered at the hottest wash the clothing material will tolerate.

Standard Infection Control Measures (SCIP's)
- Health care workers to wear gloves / aprons as per standard infection control precautions.
- Close contacts must be checked for crab lice in wards / mental health community homes and close family contacts also given advice and treatment sought via chemist / GP.

- Isolation of the patient / client is not generally required for pubic lice.
- Treat all used linen / laundry via Trust laundry system as infectious. Any linen / laundry / clothing washed on mental health community home sites to be washed on hottest possible temperature for fabrics concerned i.e. >65^{0}C. The machine washing / hot air tumble drying or ironing process with kill all crab lice.

Body Lice

Body lice are found mainly on clothing but also on body surfaces especially axillae and waist area. Patients / clients do not require specific treatment but must be bathed and all clothing / bedding changed. All patient's /client's laundry must be processed via the Health Board laundry system as per section 'Mode of Spread'.

Fleas

There are over 1000 species of fleas and although they feed on any warm blooded animal they require a specific host on which to breed. Human fleas are very rare and unlike cat or dog fleas, as they dislike the warm, dry environment of modern homes and they are generally only found in association with homeless people. Most flea bites in the UK are due to cat or dog fleas. These fleas lay eggs in flooring, carpets, furnishings and especially pet bedding and they thrive in the warm, dry conditions of modern homes. Fleas are able to survive for weeks / months in the environment without feeding.

Incubation Period

Not applicable for cat / dog fleas as they do not remain with the human. Once it has fed on the human it drops off into the environment.

Mode of Spread

Contact with infested host (e.g. cat / dog) and their immediate environment (e.g. carpets, pet bedding).

Signs and Symptoms

Cat / dog fleas bite 'uncovered areas' of human body e.g. ankles and legs. It is often 48 hours after a flea bite before evidence of the bite is obvious.

Treatment

Cat / dog fleas – anti pruritis treatment may be required. It is important that the patient's / client's home is treated and preventative measures implemented and this responsibility is with patient / family or other agencies involved with the patient e.g. local council / social services.

Standard Infection Control Measures (SICP's)

- Patients admitted with fleas must be nursed in isolation room (Refer to the 353 - Transmission Based Precautions TBP Policy on Contact/Airborne/Droplet Precautions (opens in new tab)). Long sleeved gowns may be assessed as necessary for staff instead of aprons if heavy infestation is apparent.
- Remove all patient's clothing and accompanying blankets. Seal patient's personal clothing in a plastic bag for relatives / carers to take home. Relatives / carers must wash the clothes on the hottest wash possible that the clothing material will tolerate i.e. above 65°C as a minimum. If it is not possible for clothes to be washed by relatives / carers then they must be placed into a red alginate bag and carefully labelled with patient's details, ward and contents. Contact Hotel Services supervisor whom will arrange processing via the hospital laundry system.

- For community mental health homes wash on hottest wash i.e. >65˚C.
- Identify species of flea by placing flea into a specimen pot and liaising with pest control officer in Hotel Services Department. Question the patient / client regarding domestic pets at home. If a dog / cat flea they must be advised to treat their pet / home environment.
- Pest control officer to advise on possible use of insecticide to kill visible fleas and use on surfaces in a Health Board healthcare setting.
- All hospital clothing / laundry must be treated as infectious laundry and processed routinely through hospital laundry.

Infection in Hospital/Residential Units

- On the direction of the pest control officer a Health Board premises may require the environment, carpet, furnishings, upholstery etc. to be thoroughly vacuum cleaned and a residual insecticide implemented. Post vacuum cleaning the cleaning bag must be replaced and filters cleaned.
- If a cat is resident in community mental health units then the cat must be treated and have preventative measures implemented (Refer to the 227 - Management of Resident/Visiting Animals in Health Care Settings Policy (opens in new tab)). If feral cats present on site, then arrange to have them removed via local county council.
- All patient clothing / bedding / curtains must be heat disinfected above 65˚C. This may need to be arranged via Health Board used laundry system.

Responsibilities

It is important that the following key health care workers understand their individual roles in promoting compliance with this policy.

Chief Executive Officer (CEO)

The CEO has ultimate responsibility for infection prevention and control within Hywel Dda University Health Board. This responsibility is delegated to the Director of Nursing, Quality and Patient Experience.

Executive Director and Chief Operating Officer (COO)

The Director of Nursing, Quality and Patient Experience has delegated responsibility for infection prevention and control in the Health Board and along with COO must be familiar with this policy and support the implementation of the policy throughout the organisation.

Deputy Director of Nursing, Quality and Patient Experience

Operational responsibility for infection prevention and control within the Health Board lies with the Deputy Director of Nursing, Quality and Patient Experience who is responsible for ensuring that this policy is complied with.

Locality Infection Prevention Team

The Locality IPT will promote implementation of this policy in clinical practice and will conduct regular compliance audits for feedback towards/departments and Locality management teams.

Ward Manager/Senior Nurse/Directorate Nurses

Ensure all staff are familiar with this policy and ensure the policy is complied with. They are also responsible for conducting regular quality audits e.g. hand hygiene audits, and equipment cleaning audits ensuring that areas of non-compliance are feedback to clinical teams and actions addressed.

It is the responsibility of the person in charge to ensure that the care area is safe for practice and this includes environmental cleanliness/maintenance. The person in charge has the authority to act if this is deficient.

All Clinical Staff
All health care workers are required to be familiar with this policy and comply with its contents and are responsible for informing the IPT and their manager immediately of any concerns related to poor compliance.

Training
Infection Prevention and Control Training is mandatory every 3 years and contents of this policy are included in this training. The Infection Prevention Team perform this training and attendance is recorded via ESR; however, it is the line managers who are responsible to ensure ALL staff attend this training at the required time.

Monitoring
Implementation of policies and procedures can only be effective if adequate evaluation and monitoring is used to check the system and ensure any shortcomings are identified and dealt with. Locally, Managers are responsible for initiating an ongoing monitoring process within their areas of responsibility.

From an organisation perspective, the Infection Prevention Sub Committee shall be responsible for monitoring that this policy and that appropriate actions are being taken to maintain patient safety.

References

Further Reading
National Institute for Health and Care Excellence 2014 'Difficult-to-treat Scabies: Use of Ivermectin'.@ nice.org.uk/guidance/esuom29 Key points from the evidence | Difficult-to-treat scabies: oral ivermectin | Advice | NICE

National Institute for Health and Care Excellence 2014' Child maltreatment: when to suspect maltreatment in under 16s'.@ Overview | Child maltreatment: when to suspect maltreatment in under 18s | Guidance | NICE
nice.org.uk/guidance/cg89

Appendix 1 – Scabies Information Sheet

Scabies explained

Sarcoptes scabei is a human mite which penetrates the outer layers of the skin. The body's immune system reacts to the mite's droppings and saliva resulting in an immune reaction, which produces an intense itching.

The incubation period is up to 8 weeks after contact with an affected person. Skin penetration is visible as papules, vesicles or tiny linear burrows containing the mites and their eggs. The lesions occur mainly on the hands, finger webs, wrists and inside of arms, abdomen or waist, groin and under buttocks. In infants, the head, neck, palms and soles may be involved; these areas are often spared in older individuals.

The intense itch is aggravated by warmth and moistness. Itching occurs especially at night or after a hot bath or shower. Because of scratching, lesions can develop a secondary infection.

How scabies is spread

The mite is transferred to other people by prolonged, direct skin-to-skin contact, especially via the hands. It can also be acquired during sexual contact. Transfer from underclothes or bed linen may occur if these items have been contaminated by an affected person immediately before contact; mites do not survive away from their host, as it is too cold for them outside the skin. An individual is infectious until after effective treatment and should be kept away from work or school until this has been completed.

How scabies is treated

A scabies infection will not resolve without treatment. Insecticide creams or lotions are used to treat scabies, which are available through your GP. The following principles should be followed:

Apply the cream over the whole body onto clean, cool, dry skin, but not directly after a bath.

Ensure the cream is put under the nails, on the skin of the face, scalp, behind the ears, the soles of feet and on the genitals regardless of manufacturer's instructions taking care to avoid eyes, nose and mouth.

Directly after treatment, put on clean clothes and change the bed linen.

Leave the cream on for 8 to 12 hours (overnight treatment will ensure this).

If you wash your hands within 8 to 12 hours, reapply the cream to the hands making sure to put cream under the nails. Re-treat after one week.

All bed partners and close family contacts should also be treated as above.

Machine wash (at 50ºC (122ºF) or above) clothes, towels and bed linen on the day of application of the first treatment.

If someone has crusted scabies, it is important to thoroughly clean the affected person's environment to remove any skin scales in dust. This includes vacuuming carpets and furniture, washing bedding, clothes, curtains and cushion covers. Keep any items of clothing that cannot be washed in plastic bags for at least 4 days to contain the mites until they die. Pressing clothes with a warm iron, dry cleaning and putting items in a dryer on the hot cycle for 10 to 30 minutes is also effective.

After treatment it may take up to 6 weeks for the itching to stop, but this does not mean treatment has failed. Itching is a result of an allergic reaction to the mites. Antihistamines may help to relieve the itching.

Printed 30th January 2025

Atodiad 1 – Taflen Wybodaeth Clefyd Crafu

Esboniad clefyd crafu

Gwiddonyn dynol yw Sarcoptes scabei sy'n treiddio i haenau allanol y croen. Mae system imiwnedd y corff yn adweithio i faw'r gwiddonyn a'r poer gan arwain at adwaith imiwn, sy'n cynhyrchu cosi dwys.

Mae'r cyfnod magu hyd at 8 wythnos ar ôl dod i gysylltiad â pherson yr effeithiwyd arno. Mae treiddiad croen i'w weld fel papiwlau, fesiglau neu dyllau llinol bach sy'n cynnwys y widdon a'u hwyau. Mae'r briwiau'n digwydd yn bennaf ar y dwylo, gweoedd bys, arddyrnau a thu mewn i'r breichiau, abdomen neu ganol, afl ac o dan y pen-ôl. Mewn babanod, gall y pen, y gwddf, y cledrau a'r gwadnau fod yn gysylltiedig; mae'r ardaloedd hyn yn aml yn cael eu harbed mewn unigolion hŷn.

Mae'r cosi dwys yn cael ei waethygu gan gynhesrwydd a lleithder. Mae cosi yn digwydd yn enwedig yn y nos neu ar ôl bath neu gawod boeth. Oherwydd crafu, gall briwiau ddatblygu haint eilaidd.

Sut mae clefyd crafu yn cael ei ledaenu

Mae'r gwiddonyn yn cael ei drosglwyddo i bobl eraill trwy gyswllt croen-i-groen estynedig, uniongyrchol, yn enwedig trwy'r dwylo. Gellir ei gaffael hefyd yn ystod cyswllt rhywiol. Gall trosglwyddo o ddillad isaf neu ddillad gwely ddigwydd os yw'r eitemau hyn wedi'u halogi gan berson yr effeithiwyd arno yn union cyn iddynt ddod i gysylltiad; nid yw gwiddon yn goroesi i ffwrdd o berson, gan ei fod yn rhy oer iddynt y tu allan i'r croen. Mae unigolyn yn heintus tan ar ôl triniaeth effeithiol a dylid ei gadw i ffwrdd o'r gwaith neu'r ysgol nes bod hyn wedi'i gwblhau.

Sut mae clefyd crafu yn cael ei drin

Ni fydd haint clefyd crafu yn gwella heb driniaeth. Defnyddir hufenau neu eli pryfleiddiad i drin y clefyd crafu, sydd ar gael trwy eich meddyg teulu. Dylid dilyn yr egwyddorion canlynol:

Rhowch yr hufen dros y corff cyfan ar groen glân, oer a sych, ond nid yn syth ar ôl bath.

Sicrhewch fod yr hufen yn cael ei roi o dan yr ewinedd, ar groen yr wyneb, croen y pen, y tu ôl i'r clustiau, gwadnau'r traed ac ar yr organau cenhedlu, waeth beth fo cyfarwyddiadau'r gwneuthurwr, gan ofalu osgoi'r llygaid, y trwyn a'r geg.

Yn syth ar ôl y driniaeth, gwisgwch ddillad glân a newidiwch y dillad gwely.

Gadewch yr hufen ymlaen am 8 i 12 awr (bydd triniaeth dros nos yn sicrhau hyn).

Os ydych chi'n golchi'ch dwylo o fewn 8 i 12 awr, rhowch yr hufen ar y dwylo gan wneud yn siŵr eich bod chi'n rhoi hufen o dan yr ewinedd. Ail-drin ar ôl wythnos.

Dylid trin pob partner gwely a chysylltiadau teuluol agos fel yr uchod hefyd.

Golchi dillad, tywelion a dillad gwely mewn peiriant (ar 50ºC (122ºF) neu uwch) ar ddiwrnod cyntaf y driniaeth.

Os oes gan rywun clefyd crafu crofennog, mae'n bwysig glanhau amgylchedd y person yr effeithir arno yn drylwyr i dynnu unrhyw groen o'r llwch. Mae hyn yn cynnwys hwfro carpedi a dodrefn, golchi dillad gwely, dillad, llenni a gorchuddion clustogau. Cadwch unrhyw ddillad na ellir eu golchi mewn bagiau plastig am o leiaf 4 diwrnod i ddal y widdon nes iddynt farw. Mae smwddio dillad gyda haearn cynnes, sychlanhau a rhoi eitemau mewn sychwr ar yr opsiwn poeth am 10 i 30 munud hefyd yn effeithiol.

Ar ôl y driniaeth gall gymryd hyd at 6 wythnos i'r cosi ddod i ben, ond nid yw hyn yn golygu bod y driniaeth wedi methu. Mae cosi yn ganlyniad i adwaith alergaidd i'r widdon. Gall gwrthhistaminau helpu i leddfu'r cosi.

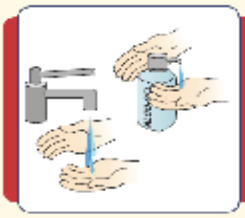
Argraffwyd 30 Ionawr 2025

Appendix 2 – Contact Isolation Poster

VISITORS PLEASE REPORT TO NURSE IN CHARGE BEFORE ENTERING THIS ROOM

CONTACT PRECAUTIONS FOR ISOLATED PATIENT

ALL HEALTHCARE WORKERS



Hands

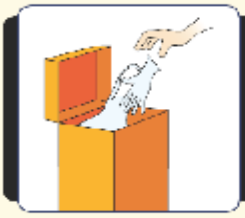
Decontaminate hands before entering this room.

Personal Protective Equipment

Wear disposable apron and gloves before entering this room.

Door
Keep door closed

Risk assessed __
Door required to remain open.
Initials: _____ Date: _____



Before leaving

Decontaminate equipment prior to removal from room.
Discard gloves and apron in healthcare waste bin.
Decontaminate hands.

GIG CYMRU NHS WALES

Infection Prevention Team May 2019
PRO-P943 05/19

Appendix 3 - Patient Washing Instructions for Soluble Bags

Why are NHS hospitals unable to wash personal clothing? DO NOT TUMBLE DRY THE PLASTIC BAG

- Tumble dry or air dry your relative's clothing and iron as normal.

Please remember: -

When dealing with used linen (nightwear, underwear or other clothing) the risk of infection to healthy people is minimal. However, it is sensible to take some basic good hygiene precautions:

- Before dealing with the laundry, cover cuts or sores on your hands prior to handling.
- Hold the laundry bag away from yourself
- Wash the bag separately from your own clothes and on the hottest possible wash.
- Wash your hands after handling any laundry.

If you have need any further advice please speak to the nurse in charge or ask to speak to a member of the Infection Prevention Team.

NHS hospitals are unable to wash personal items of patient's clothing for the following reasons: -

- The hospital linen is washed at high temperatures that are unsuitable for personal clothing and may damage the patient's clothing.
- Because of the number of patients within the hospital it is extremely difficult to trace individual items of clothing.
- Washing powders used for hospital linen may not be compatible with materials used for personal clothing.

How to use the patient clothing bag

The hospital has given you a patient clothing bag that may be used at home in your washing machine. This helps you to take home the soiled clothes from your relative and put the bag unopened unto your own washing machine.

DO NOT TUMBLE DRY THE PLASTIC BAG

- Tumble dry or air dry your relative's clothing and iron as normal.

Please follow these instructions: -

- Do not open the patient clothing bag. It has been designed to go straight into your washing machine.
- Please wash this bag on its own and do not add any other items of linen of clothing to the machine.
- The seam and tie of the bag will dissolve in the water at any temperature. However, we do advise that you wash the items of clothing in the bag on the highest temperature the clothing will allow (usually shown on the clothing care label).
- Use a biological powder / liquid / tablet if possible.
- When the washing machine has finished, remove the plastic bag that is left in the machine and put into your normal rubbish bag as it is now clean.

Produced by the Infection Prevention Team, October 2021

Department of Infection Prevention and Control

PATIENT CLOTHING BAGS

Information for relatives and carers

Pam na all ysbytai'r GIG olchi dillad personol?

Ni all ysbytai'r GIG olchi eitemau personol o ddillad cleifion am y rhesymau canlynol: -

Caiff dillad gwely ysbyty eu golchi ar dymheredd uchel sy'n anaddas ar gyfer dillad personol, a gallai niweidio dillad cleifion.

Oherwydd nifer y cleifion mewn ysbyty, anodd iawn yw mynd ar drywydd eitemau unigol o ddillad.

Efallai nad yw'r powdwr golchi dillad a ddefnyddir i olchi dillad gwely ysbyty yn addas ar gyfer deunyddiau dillad personol.

Sut mae defnyddio'r bag dillad?

Mae'r ysbyty wedi rhoi bag dillad claf i chi y gellir ei ddefnyddio yn eich peiriant golchi adref. Mae hyn yn eich helpu i fynd adref â dillad brwnt eich perthynas a rhoi'r bag, heb ei agor, yn eich peiriant golchi eich hun.

Peidiwch ag agor y bag dillad claf. Mae wedi'i gynllunio i fynd yn syth i'ch peiriant golchi dillad.

Peidiwch â rhoi unrhyw ddillad arall yn y peiriant golchi gyda'r bag hwn.

Bydd sêm a chwlwm y bag yn toddy yn y dŵr ar unrhyw dymheredd. Fodd bynnag, rydym yn eich cynghori i ddefnyddio'r tymheredd uchaf y mae'r dillad yn y bag yn ei ganiatáu.

Defnyddiwch bowdwr / hylif / tabled biolegol os oes modd.

Pan ddaw'r gulch i ben, tynnwch y bag plastig o'r peiriant golchi a'l roi yn eich bag sbwriel arferol, gan fod y bag bellach yn lân.

PEIDIWCH Â RHOI'R BAG PLASTIG YN Y PEIRIANT SYCHU DILLAD
Sychwch y dillad mewn peiriant neu yn yr aer a'u smwddio fel arfer.

Cofiwch: -

Wrth ddelio â dillad sydd wedi'u gwisgo (dillad nos, dillad isaf neu ddillad arall) mae'r risg o haint i bobl iach yn fach iawn.

Fodd bynnag, mae'n synhwyrol cymryd rhai rhagofalon hylendid da sylfaenol:

Cyn delio â'r dillad golch, gorchuddiwch unrhyw doriadau neu friwiau sydd ar eich dwylo.

Daliwch y bag dillad golch allan hyd braich.

Peidiwch â rhoi unrhyw ddillad arall yn y peiriant golchi dillad gyda'r bag. Defnyddiwch y tymheredd twymaf posib.

Golchwch eich dwylo ar ôl trin unrhyw ddillad golch.

Os oes arnoch angen unrhyw gyngor pellach, siaradwch â'r brif nyrs neu ag aelod o'r Tîm Atal a Rheoli Heintiau.

TÎM ATAL HEINTIAU

BAGIAU DILLAD CLEIFION

Gwybodaeth i berthnasau a gofalwyr

Cynhyrchwyd gan y Tîm Rheoli Heintiau 2021


PATIENTS CLOTHING

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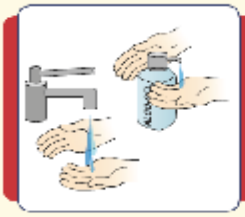
ALL HEALTHCARE WORKERS



Hands

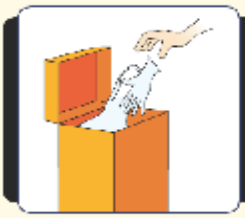
Decontaminate hands before entering this room.

Personal Protective Equipment

Wear disposable apron and gloves before entering this room.

Door
Keep door closed

Risk assessed __
Door required to remain open.
Initials: _____ Date: _____



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Decontaminate hands.

GIG CYMRU NHS WALES

Infection Prevention Team May 2019

PRO-P943 05/19