

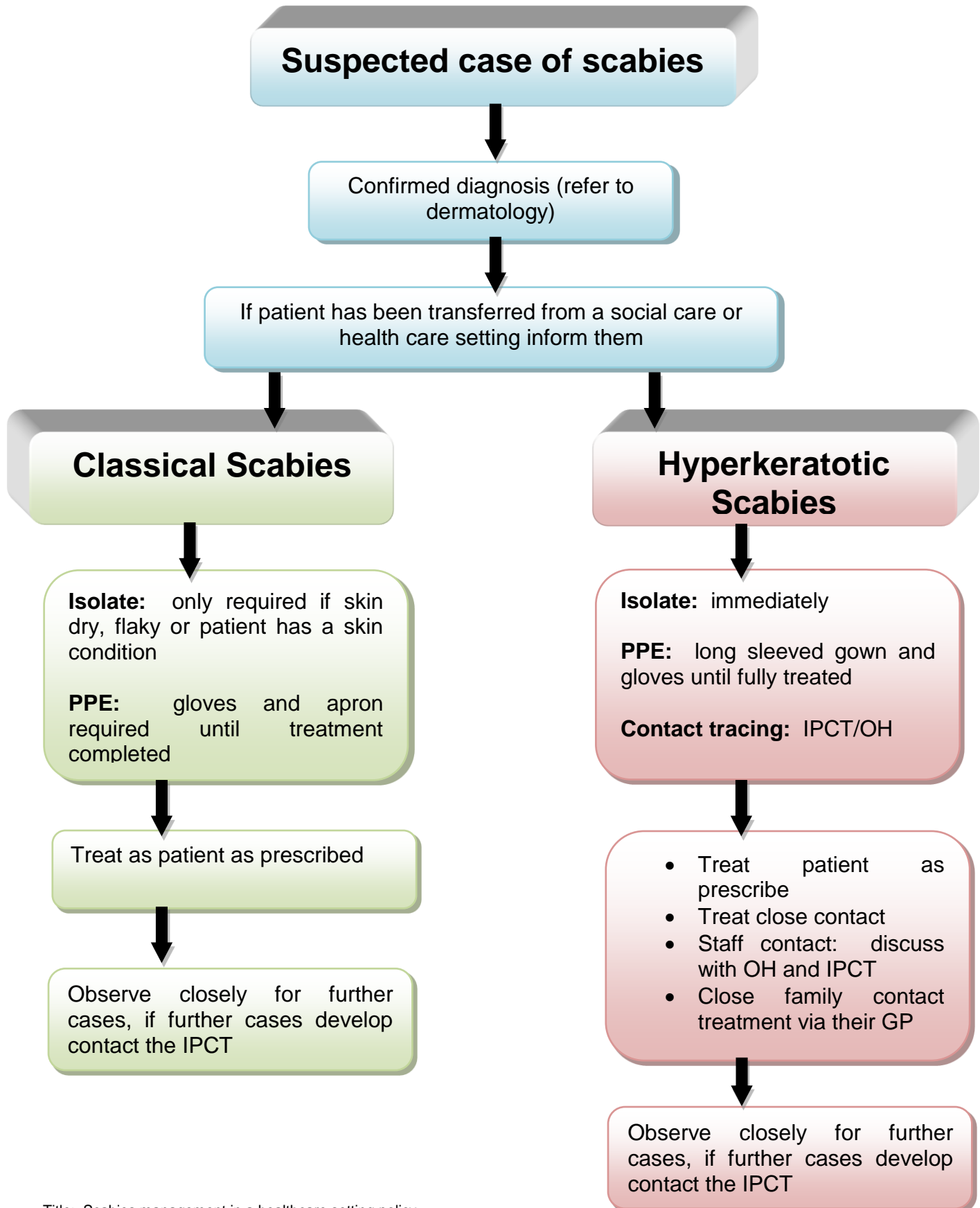
SCABIES MANAGEMENT IN A HEALTHCARE SETTING POLICY

		POLICY
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Approving Body	Infection Prevention and Control Committee	
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1. <i>Not Applicable</i>	<i>Not Applicable</i>	

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Flow chart for the management of scabies



1.0 INTRODUCTION

Scabies is a common, itchy, inflammatory disease of the skin caused by a tiny mite called *Sarcoptes scabiei*. It is highly contagious and outbreaks have occurred in hospitals and care homes where both patients/residents and staff have been affected (Hawker 2005, CDC 2017). The condition is recognised by an allergic reaction to the saliva and faecal material excreted by the mite (PCDS 2016). It is a worldwide disease, but is more common where overcrowded conditions prevail. It can affect any individual irrespective of social class or age (CDC 2017).

2.0 POLICY STATEMENT

This policy intends to provide healthcare staff with the information required to identify, manage and treat patients with scabies and prevent onward transmission.

This clinical policy applies to:

ALL Staff groups

ALL Clinical areas

Patient group(s):

- All patients suspected or confirmed of having scabies

Exclusions

- None

3.0 DEFINITIONS/ ABBREVIATIONS

Trust:	Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employers of the Trust including those managed by a third party on behalf of the Trust
DH:	Department of Health
HPU:	Health Protection Unit
PHE:	Public Health England
CDC:	Center for Disease Control (USA)
CCDC:	Consultant in Communicable Disease Control
HCAI:	Healthcare Associated Infection
IPCT:	Infection Prevention and Control Team
DIPC:	Director of Infection Prevention and Control
ICD:	Infection Control Doctor
IPCN:	Infection Prevention and Control Nurse
OH:	Occupational Health
PPE:	Personal Protective Equipment
IPCC:	Infection Prevention and control Committee

4.0 ROLES AND RESPONSIBILITIES

4.1 Chief Executive

The Chief Executive is ultimately responsible for ensuring that there are effective arrangements for infection prevention and control according to Department of Health (DH) directives. This responsibility is delegated to the Director of Infection Prevention and Control.

4.2 Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) is responsible for the Trust adoption of the policy for the control and management of scabies infection.

4.3 Infection Prevention and Control Team

The IPCT is responsible for giving expert advice and training related to all infection prevention and control practices concerning scabies management. The IPCT will commence contact tracing in the event of a scabies outbreak for patients.

4.4 Occupational Health

Occupational Health (OH) is responsible for commencing contact tracing for staff management issues.

4.5 Ward Sister/Charge Nurse

Ward Sister/ Charge Nurse/ Departmental Manager is responsible for ensuring that all staff are familiar with the policy and the management of patients or members of staff diagnosed with scabies, which is carried out in their area in accordance with this policy.

4.6 All staff

All staff both clinical and non-clinical must ensure they have read and understood the policy and incorporated the guidance in the care and management provided for patients with scabies in their clinical areas. They must be aware of their role in the prevention of Healthcare Associated Infections (HCAI's) in the working environment, including reporting of unusual rashes and pruritic conditions to the manager and OH.

Staff must inform OH if they suspect or develop symptoms of scabies.

5.0 APPROVAL

This policy will be approved of via the Infection Prevention and Control Committee

6.0 DOCUMENT REQUIREMENTS

The purpose of this policy is to provide guidance for staff that is responsible for patients within the Trust in the event of a scabies outbreak as well as the individual case; it highlights the requirements and processes for the management and treatment for scabies.

6.1 Recognition of scabies

Positive diagnosis is made by finding and identifying the mite or its eggs or faeces, this can be done by skin scraping between the popular lesions; patients must be referred to the Dermatology Team for a formal diagnosis, because scabies can be easily misdiagnosed.

If confirmation of diagnosis is required for a staff member, OH may need to refer the member of staff to their GP who will then make a referral to the Dermatology Team.

Scabies (*Sarcoptes scabiei*) is a contagious skin infestation caused by a parasite. A diagnosis **must** be made by a dermatologist, as patient management is different for each of the following conditions:

- Classical (typical) scabies (approximately 12 mites)
- Hyperkeratotic (crusted) scabies
 - Hyperkeratotic scabies is caused by the same mite that causes classical scabies, but usually occurs when the infested person is immunologically or neurologically compromised and in the elderly. In this form many more mites are present and the skin presents as thickened with crust, gross nail thickening can also occur. Sometimes the presentation may be atypical, with no crusted lesions or itching. Individuals develop widespread grey/brown scales or crusted areas. Skin scales and crusts are heavily contaminated with mites and this form of infestation is highly contagious. It can mimic other skin conditions such as eczema and psoriasis. The crusting of the skin can lead to secondary bacterial infections such as *staphylococcus aureus*, cellulitis, boils, impetigo etc

The scabies mites burrow into the epidermis, where the female mite lays their eggs, which hatch between 50 – 72 hours later. The larvae mature, and the new female mites will be ready to lay new eggs. Once the mite has left the human body, they will not survive for long (<72hrs).

The period of communicability is from original infestation, with or without symptoms until the mites and eggs are destroyed (24 hours after appropriate treatment). An infested individual may be contagious before the onset of itching or the rash.

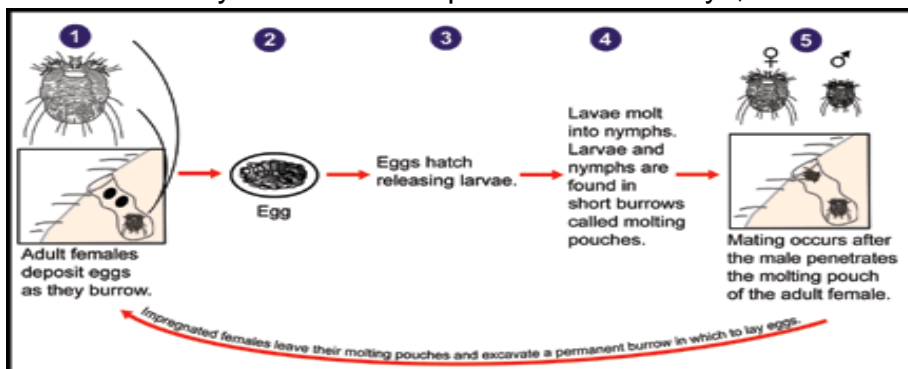
6.2 Transmission

Scabies are host specific therefore scabies cannot be caught from pets or other animals. Transmission is by direct personal contact i.e. prolonged skin-to-skin contact of a sexual or social nature, and thus a quick handshake or hug will not spread the infestation (CDC 2017). Mites usually pass from person to person in close communities, particularly within households. It is recognised that the spread is not limited to family members, but includes everyone who has intimate personal contact with the infected individual. Infestation occurs following transference of mites, which burrow into the skin. People who have acquired the infection for the first time

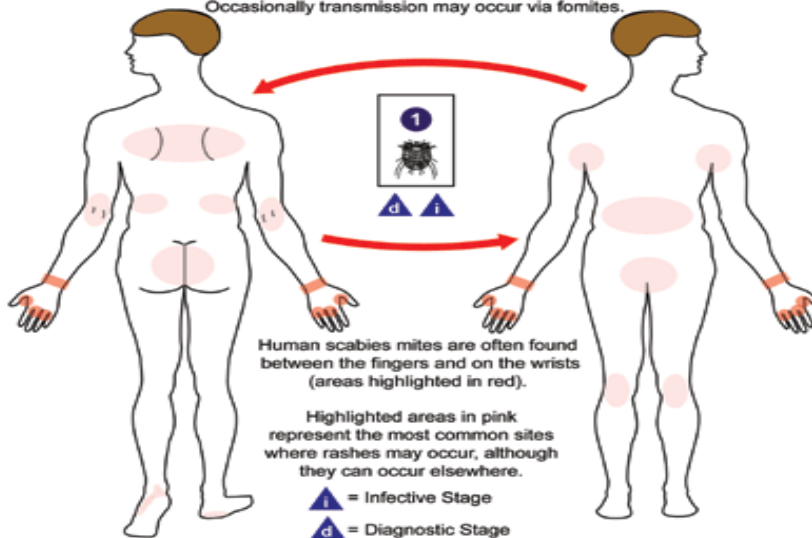
may not show any symptoms for 2-4 weeks, so this makes spread of the mite difficult to identify and contain in institutions such as Care Homes (CDC 2017).

6.3 Life cycle of the mite

- The newly mated female burrows through the skin, often at the finger webs, wrists and elbows
- Eggs are laid in the burrows at a rate of 2-3 per day for up to 2 months
- Eggs mature, and larvae emerge from the eggs 3-4 days after they have been laid
- After emerging from the egg, the larva passes through two moults before becoming adult
- Adult mites mate
- The entire life cycle can be completed in 10-14 days, mites live for around 30 days



Transmission occurs primarily during person-to-person, skin-to-skin contact. Occasionally transmission may occur via fomites.



6.4 Sites of infection

The most common areas affected are between the fingers (finger webs), wrists, elbows, armpits, waist, thighs, genitalia, nipples, breasts and lower buttocks. In infants, young children the elderly and those who are chronically ill, the mites can be found on the face, ears and scalp. It should be recognised that scabies causes an allergic reaction, and the itch and the rash may not always coincide with the actual site of the mite.

6.5 Incubation period

The incubation period for a first infection is usually 2-4 weeks in people without previous exposure, as the mites faecal contamination takes time to cause an allergic reaction. Subsequent infection will cause an allergic reaction within 1 week. Scabies can be easily managed when treatment is performed correctly. However, as a result of the extended incubation period there may also be asymptomatic carriers who can re-infect others after treatment has been performed. It is therefore important to undertake a thorough risk assessment when planning eradication treatment and to undertake follow up skin assessments for at least two weeks post treatment.

6.6 Symptoms

The main symptom of scabies in healthy individuals is a wide spread itching, particularly at night. Symptoms often take 2-6 weeks after the initial exposure when an allergy develops to the mite saliva and faeces, an itchy symmetrical rash appears. The rash is a symmetrical itchy red papular rash. The rash may not correspond with the site where the mite may actually be found, the rest can be seen anywhere on the body (CDC 2017). If the person has had scabies before, the rash may appear within a few hours or days after re-exposure, as the individual is already sensitive to the mite (scabies infestation does not produce immunity). The elderly, immune-compromised, infants and young children are at particular risk and can even develop the rash on their face, neck, scalp and ears (Hawker 2005, CDC 2017).

Burrows may be visible as a thin light brown or silvery wavy line, which will be approximately 5 cm in length, this can occur anywhere on the body, but are often more easily identified on the skin folds of the wrists, elbows or knees, the hands in particular between the fingers on the finger web, the feet, genitalia, breast and shoulder blades. The burrows may be hard to find, as they are easily destroyed or distorted by the scratching. Excessive scratching may cause sores, which then become infected which make the symptoms worse.

The appearance and severity of symptoms varies from person to person and as with all allergies, the symptoms and their severity are strongly influenced by the immune status of the affected individual.

6.7 Contact tracing

Unless the original source of infection and all contacts are identified and treated, the infestation will continue to spread with the possibility of re-infestation for those already treated. The purpose of contact tracing is to identify anyone who may be infected and advise them about treatment options. All those with intimate skin contact for a prolonged period of time (greater than 15 minutes at one time) within the previous 2-6 weeks must be identified. It is beneficial for those individuals to seek information and guidance from their family doctor, practice nurse, community pharmacist or where appropriate their occupational health department.

6.8 Infection prevention and control precautions for Classical Scabies

Prevention of scabies is dependent on an early diagnosis and prompt effective treatment ([Appendix 1](#)).

- **Isolation:** a patient with suspected or confirmed classical scabies should be isolated until they have had one course of treatment (please discuss with the IPCT). Patients presenting with dry, flaking skin should be isolated until a positive diagnosis is established
- **Personal Protective Equipment (PPE):** gloves and aprons must be worn for close contact with the patient and placed in clinical waste after use (Refer to IPC 9 policy)
- **Linen:** hospital bed linen must be placed in red alginate bags and outer red bag (Refer to IPC 10 policy). Potentially contaminated clothing and bedding (those worn or slept in within the 3 days prior to the commencement of treatment, of the patient, exposed staff and close household contacts should be machine washed in hot water and preferably dried at a temperature of at least 60°C. For clothing that cannot be washed, dry clean or place in a plastic bag, secure and leave undisturbed for 3 days then wash as normal will be effective
- **Hand hygiene:** hands must be washed with soap and water once PPE are removed. Staff must pay strict attention to hand hygiene after contact with an individual will reduce the risk of transmission (Refer to IPC 17 policy)
- **Medical equipment:** re-useable medical equipment must be decontaminated thoroughly after use according to manufacturer's instructions prior to being used for subsequent patients
- **Housekeeping:** routine daily cleaning of the patient(s) room/bed space is sufficient.

6.9 Treatment for Classical Scabies

When an individual resident (single case) has a clinical diagnosis of scabies infection then they should be treated as soon as possible. A suitable parasitological preparation must be prescribed by the physician or dermatologist. Treatment must be applied following the manufacturer's guidance and instructions. It is vital that compliance with the treatment is thorough. Secondary bacterial infection may occur if left untreated or from constant scratching. The index case (first person identified as having scabies) and all members of the affected household must be treated simultaneously even in the absence of symptoms. It is also important to stress that this is not limited to family members and should include everyone who has had intimate contact with infected individuals. All members of the household must be treated at the same time (preferably within 24 hours). For those who have been diagnosed with scabies rash, treatment should be undertaken twice, one week apart. Staff providing direct personal care should be risk assessed, and treated as appropriate.

The two most commonly used treatments for scabies in the UK are:

- **Lyclear Dermal Cream (Permethrin):** currently the agent of choice for treatment of scabies and for prophylactic treatment of contacts. However, it is **not** recommended during pregnancy or breast feeding. The preparation should be applied all over the body including the soles of the feet and between the toes, BNF (2015) also recommends that

the solution be applied to the scalp, neck, face, and ears. Lyclear tends not to irritate the skin and should be left on for 8 to 12 hours, or overnight, before being washed off.

This product is licensed for use in children over 2 months old

- Derbac M (Malathion): currently the product of choice for the treatment of individuals with scabies who are pregnant or breastfeeding. Derbac should be left on the skin for 24 hours, and then washed off. The use of this product for children under 6 months old should be avoided, or only used under medical supervision

General advice:

- Ensure the patient's skin is clean, dry and cool before application. Individuals do not need to have a hot bath before treatment. All persons having treatment must do so at the same time so as to not re-infect one another
- Particular attention should be paid to the webs of the fingers and toes, treatment should be reapplied to the hands if they are washed.
- For adults and children more than 2 years of age, apply treatment to cover the whole body from the neckline down including the genital area. Usually the best time to do this is last thing at night before bed
- Children less than 2 years of age and the elderly must be treated with a thin film of the treatment applied to their scalp, face and ears. Care must be taken to avoid the vicinity of the mouth where it could be licked off, and the areas close to the eyes
- Nails should be trimmed and medication applied with cotton wool buds to the nails and nail bed. If hands are subsequently washed re-apply the treatment to the hands and nails
- Remove medication by washing thoroughly with soap and water between 12- 24 hours after application (refer to the manufactures instructions for the precise time)
- Repeat treatment may be considered after one week on patients with clinical infection (not contacts). Bedding and all clothing worn must be changed and laundered as normal at the end of the treatment
- Patients should be advised that the itching will persist for a few weeks after treatment. Moisturisers may be applied to residual itching areas. Calamine lotion or Aqueous cream is **not** advocated by the dermatology team. Family contacts of infested patients should consult their GP for treatment, even if they are asymptomatic, this also applies to patients from Care Homes, where the person in charge of the Care Home is informed as well as the community IPCT immediately
- Pregnant women and parents of young children should discuss treatment options with their doctor or pharmacist
- If there has been contact with staff prior to the patient's diagnosis, consideration must be given to treating staff. This would be under the guidance of OH in conjunction with the IPCT
- If a member of staff develops scabies, treatment is recommended for their close household contacts and they may return to work once treatment has been completed
- Payment for any treatment that is advised will not be met by OH, staff must contact their manager to discuss possible reimbursement
- Any treatment that is recommended for family members of the affected (infested) staff member will need to obtain their treatment via their GP. Reimbursement for these treatment costs will be at the discretion of the line manager of members of staff
- Advice **must** be sought from OH regarding whether the staff member needs to be excluded from work

6.10 Infection prevention and control precautions for Hyperkeratotic Scabies

Commonly known as crusted, Norwegian and atypical scabies. It is an unusual form of the infestation that is highly contagious and occurs in immune-deficient individuals i.e. the frail elderly. Infection often appears as a generalised dermatitis more widely distributed than the burrows and the usual severe itching may be reduced or absent. Persons with hyperkeratotic scabies are highly contagious because of the large number of mites present in the skin scales. Skin becomes thickened, scaled, crusted and unsightly due to the number of mites present.

- **Isolation:** a patient with hyperkeratotic scabies **must** be isolated until treatment has been completed as transmission can also occur via skin scales on bedding, clothes and soft furnishings and is more infectious than classical scabies
- **Personal Protective Equipment (PPE):** long sleeved aprons and gloves **must** be worn for close contact with the patient and placed in clinical waste after use (refer to ICP 9 policy)
- **Linens:** hospital bed linen must be placed in red alginate bags and outer red bag and treated as infectious linen (Refer to ICP 10 policy). After treatment the patients' bed linen **must** be changed. Potentially contaminated clothing and bedding (those worn or slept in within the 3 days prior to the commencement of treatment, of the patient, exposed staff and close household contacts should be machine washed in hot water and preferably dried at a temperature of at least 60°C. For clothing that cannot be washed, dry clean or place in a plastic bag, secure and leave undisturbed for 3 days then wash as normal will be effective
- **Hand hygiene:** hands must be washed with soap and water once PPE are removed. Staff must pay strict attention to hand hygiene after contact with an individual will reduce the risk of transmission (Refer to IPC 17 policy)
- **Medical equipment:** re-useable medical equipment must be decontaminated thoroughly after use according to manufacturer's instructions prior to being used for subsequent patients
- **Housekeeping:** routine daily cleaning of the patient(s) room/bed space is sufficient. Vacuuming of fabric chairs and other soft furnishings will minimise environmental contamination and the curtains in the side room **must** be changed once treatment is completed
- **Contact tracing:** A contact list of both patients and staff must be completed. This will include all those who have been in contact with the affected patient for instance, patients in the same bay, staff who have seen the patient. The list must be given to the IPCT and OH ([Appendix 2](#) and [Appendix 3](#))
- **Outbreak:** in the event of an outbreak of scabies, the IPCT will advise on the planned co-ordinated management of the situation

6.11 Treatment for Hyperkeratotic Scabies

Treatment is as for classical scabies; however in the case of patients with hyperkeratotic scabies it may be necessary to increase the number and frequency of applications of treatment in order to eliminate all the mites. Infection control precautions must continue until the treatment period has been completed. If patient has been transferred from a social care setting or another health care setting facility, the manager must be informed of the diagnosis, to enable them to instigate the appropriate treatment if required. The index case (first person identified as having scabies) and all members of the affected household must be treated simultaneously even in the absence of symptoms. It is also important to stress that this is not limited to family members and should include everyone who has had intimate contact with infected individuals. All members of the household must be treated at the same time (preferably within 24 hours). For those who have been diagnosed with scabies rash, treatment should be undertaken twice, one week apart.

An oral product, Ivermectin is available on a named person basis and has been used in combination with topical treatments for the treatment of hyperkeratotic scabies that does not generally respond to topical treatment alone. Patients with hyperkeratotic scabies may require 2-3 applications of topical treatment on consecutive days to ensure that enough penetrates the skin crusts to kill all mites.

6.12 Risk assessment process

It must be acknowledge that it will never be possible to completely eradicate the risk of scabies infection entering the Trust, so awareness of symptoms and early detection are key factors in limiting the impact of scabies infection within the Trust. The purpose of the risk assessment process is to identify the potential source of scabies infection and then to take control measures that will minimise the impact of the infestation within the Trust.

If scabies infestation is identified or suspected then the change of possible transmission to others should be assessed as 'high', 'medium' or 'low' risk, this will aide the appropriate follow up and treatment of contacts.

- **High risk:** are staff members who undertake direct personal care for symptomatic patients, and who move between patients. This will include both day and night staff, and will include all symptomatic patients and staff members
- **Medium risk:** are staff and other personnel who have intermittent direct personal care. It will also include asymptomatic patients who have their care provided by staff members categorised as 'high risk'
- **Low risk:** those at lowest risk are staff member who have no direct or intimate contact with affected patients. It also includes asymptomatic patients who carers are not considered to be 'high risk'. Direct personal care is provided by staff who have not undertaken direct personal care of symptomatic patients or who have not worked in the affected area(s)

6.13 Outbreak management

- If a diagnosis is made in more than one person the IPCT and OH need to be informed
- An outbreak meeting will be convened organised by the IPCT
- Treatment must be agreed with the dermatologist and all close contacts including patients and staff are advised to have treatment
- All close contacts must be informed
- Treatment will be co-ordinated by OH for staff members
- Treatment will be co-ordinated by the IPCT for patients
- Everyone identified as a close contact must receive treatment at the same time to prevent re-infestation (staff not on duty, must treat themselves prior to returning to work)
- During the ensuing 6 weeks, observe for any further presence of scabies so that any possible cases can be dealt with promptly
- The IPCT will inform the PHE and the community IPCT of the outbreak

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Isolation of patient	IPCT	Audit	Annually	IPCC

8.0 TRAINING AND IMPLEMENTATION

There are no specific training requirements in relation to the content of this policy. When treating patients with suspected/confirmed scabies healthcare staff should follow this policy. If required, further assistance can be sought from senior colleagues and/or the Infection Prevention and Control Team.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix 4](#)
- This document has been subject to an Environmental Impact Assessment, see completed form at [Appendix 5](#)

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

1. Ayliffe GAJ et al (2000) *Control of Hospital Infection: a practical handbook*. London: Arnold p 22-23
2. British National Formulary. (2018) <https://bnf.nice.org.uk/treatment-summary/skin-infections.html> (accessed 14/2/2018)
3. Burgess. I. 2003. *Understanding scabies*. Nursing Times Infection Control Supplement. Vol. 99. No. 7
4. CDC. (2017). Parasites -Scabies <https://www.cdc.gov/parasites/scabies/prevent.html>(accessed 14/2/2018)
5. Department of Health. 2010. *Health and Social Care Act 2008* (accessed 14/2/2018)
6. Hawker. J. et al. 2005. *Communicable disease control handbook*. Blackwell Publishing. Oxford
7. Johnston. G., Sladden. M. 2006. *Scabies: diagnosis and treatment*. British Medical Journal 331 (7517) 619 – 622 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1215558/>
8. (accessed 14/2/2018)
9. NHS Clinical Knowledge Summaries (CKS). (2016). <https://cks.nice.org.uk/scabies>(accessed 14/2/2018)
10. Primary Care Dermatology Society (2016) <http://www.pcids.org.uk/clinical-guidance/scabies#!prettyPhoto>(accessed 14/2/2018)
11. Roberts. D (Ed). 2000. *Lice and scabies. A health professionals guide to epidemiology and treatment*. PHLS. London

Related SFHFT Documents:

This document should be used in conjunction with other relevant Trust Infection Prevention and Control and Trust policies such as:

- ICP 1 Standard operating procedure on infection control
- ICP 5 Disinfection policy for Sherwood Forest Hospital
- ICP 9 Policy for the use of personal protective equipment
- ICP 10 Policy regarding safe linen disposal
- ICP 17 Hand hygiene policy
- ICP 31 Isolation precautions for patients with a confirmed or suspected infectious illness policy

11.0 APPENDICES

[Appendix 1](#) – Pictures of scabies infestation

[Appendix 2](#) – Hyperkeratotic scabies staff contact tracing form

[Appendix 3](#) – Hyperkeratotic scabies patient contact tracing form

[Appendix 4](#) – Equality Impact Assessment

[Appendix 5](#) – Environment Impact Assessment

Appendix 1: Pictures of scabies infestation



Figure 1.
Sarcoptes scabiei var. hominis



Figure 2.
Scabies - wrists



Figure 3.Scabies
The arrow denotes a burrow



Figure 4.
Dermoscopic appearance of scabies mites
The brown triangles denote the heads of the mite with a 'jet-plane' appearance (black arrows)



Figure 5.
Scabies on the trunk with urticated papules



Figure 6.
Crusted scabies



Figure 7.
Crusted scabies

Images provided by PCDS.Org (2016)

APPENDIX 4 – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Scabies			
New or existing service/policy/procedure: Existing			
Date of Assessment: 28/2/2018			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	None	None
Gender	None	None	None
Age	None	None	None
Religion	None	None	None
Disability	None	None	None
Sexuality	None	None	None
Pregnancy and Maternity	None	None	None
Gender Reassignment	None	None	None
Marriage and Civil Partnership	None	None	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	None	None

What consultation with protected characteristic groups including patient groups have you carried out? Nil
What data or information did you use in support of this EqIA? None
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? No
Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: Low Level of Impact For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.
Name of Responsible Person undertaking this assessment: Rosie Dixon
Signature:
Date: 28/2/2018

APPENDIX 5 – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	<ul style="list-style-type: none"> Is the policy encouraging using more materials/supplies? Is the policy likely to increase the waste produced? Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled? 	Yes Yes NA	
Soil/Land	<ul style="list-style-type: none"> Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.) 	No	
Water	<ul style="list-style-type: none"> Is the policy likely to result in an increase of water usage? (estimate quantities) Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal) 	Yes	
Air	<ul style="list-style-type: none"> Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) Does the policy fail to include a procedure to mitigate the effects? Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations? 	NO	
Energy	<ul style="list-style-type: none"> Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities) 	Yes	
Nuisances	<ul style="list-style-type: none"> Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)? 	Yes	