POLICY & PROCEDURE NUMBER: ***4.14***

DEPARTMENT: *Infection Control* **SUBJECT:** *Management of Scabies*

APPROVAL DATE: **REVISION DATE**: Dec. 2019; Nov. 2022
REVIEW DATE: Nov. 2018; Dec. 2020

Background

Scabies is a parasitic infestation of the skin caused by a mite, *Sarcoptes scabiei*. The infestation appears as papules, vesicles or tiny linear burrows containing the mites and their eggs. The lesions are most prominent around web spaces between fingers, anterior surfaces of wrists and elbows, axillary folds and belt line.

In the elderly, infestation often appears as a generalized dermatitis more widely distributed than the burrows, with extensive scaling, and sometimes vesiculation and crusting. The usual severe itching may be reduced or absent.

Recovering the mite from the burrow and examining it under a microscope can make the diagnosis of scabies.

Humans are the only reservoir for the mite. It is transmitted most commonly between people by direct prolonged skin contact with infested skin. Contaminated linens and clothes and bed linens can be a source for transmission as mites can live on other objects for two – three days. Mites can burrow under the skin surface in 2.5 minutes. In people who have never had scabies, it can take two to six weeks before the onset of itching. People who have previously been infested will develop symptoms one to four days after an exposure. People remain infectious until all the mites have been killed by treatment.

The atypical presentation of scabies in the elderly may cause delays in diagnosis and treatment. This has been the source of many outbreaks in long-term care facilities. In residents of long-term care facilities, scabies may present as a mixture of typical scabies and atypical heavy infestation of scabies' mites. Skin lesions often occur on buttocks or back as well as the more typical locations. Large numbers of mites may reside under the fingernails of a heavily infested resident due to scratching. Outbreaks of crusted or "Norwegian" scabies have been documented in LTCHs.

The best management of scabies is prevention. Each LTCH should maintain a high degree of suspicion, and scabies should be considered whenever residents present with rashes. Skin integrity of new residents should be assessed and any rashes investigated. Routine practices must be followed and health care providers should wear gloves for any contact with non-intact skin and undiagnosed rashes.

When a resident is diagnosed with scabies, the ICP should search for unrecognized cases in other residents and health care providers. It is highly unusual to have a single case of scabies. Any rash, regardless of site, should be investigated and scabies ruled out. Symptoms of itching may not be present and cannot be relied on as an indicator of infestation. All cases should be treated simultaneously and individuals who have had skin-to-skin contact should be treated prophylactically. Contact precautions should be used for all case residents until 24 hours after the treatment has been completed. Skin creams and ointments that have been used by infested residents should be discarded as part of the treatment process.

The treatment of choice for scabies is a topical cream (usually 5% permethrin). The directions in the product monograph should be followed exactly. Treatment failures may result if instructions are not followed precisely. In most cases, treatment involves the application of the cream to the entire body surface from the neck down. It is left on for a period of several hours and then washed off. Once the resident has been bathed, their clothing and bed linen should also be changed. Washing and drying of clothes and linen in the hot cycle is sufficient to kill the mite. No extra disinfection is required. Itching, if present, may persist for several weeks. Re-treatment (7-10 days) should not be done unless the physician evaluates the resident and identifies new lesions.

PURPOSE:

To eradicate the symptoms and to prevent the spread of scabies.

POLICY:

To take all measures possible to eradicate and to prevent the spread of scabies if it should occur.

PROCEDURE:

For Symptomatic Cases

- Inform the Registered Staff, IPAC program manager and/or MRC if scabies is suspected.

- Once scabies has been diagnosed by a physician, symptomatic residents should be placed under contact precautions immediately and until 24 hours after treatment.

- Don PPE as outlined in Contact Precautions (gloves, gown) to prevent any skin to skin contact or skin to clothing contact until 24 hours after resident is treated with the appropriate medicated lotion, the resident laundry has been washed and room disinfected.
- A treatment of Kwellada lotion will be considered for all residents and staff on that particular unit who have had unprotected skin to skin contact. Treatment involves applying Kwellada on the skin below the neckline to the sole of the feet, and leaving it on for 12 hours. Staff should pay particular attention to the areas between the fingers and toes, under the fingernails and toenails, wrists, armpits, genital area and buttocks. Contractured hands must be opened (if possible) and Kwellada applied. Do not take a hot bath prior to applying Kwellada. Do not apply to the head or face.

- Bath the resident, at least 12 hours after application of Kwellada. Use tub room, normal care.

- Reapply Kwellada for incontinent residents, if Kwellada is removed during pericare if during the initial 12-hour time period. Do not reapply if the lotion had been applied for the required 12 hours.

- A single case of suspected or confirmed scabies should prompt active surveillance and contact tracing for additional cases among HCWs. Check roommates and other residents in the same geographic region.

- Residents should remain on their units until treatment has been completed. Residents should not be attending programs on other units and should not be going to the Dining Room. Regular activities can resume 24 hours after treatment has been completed.

- Any resident with scabies will be treated again in 7-10 days if there are new lesions or live scabies mites or as directed by the physician.

- Staff should reapply Kwellada after each hand washing (if during the initial 12 hour application period).

- Ensure bed linen is removed (see under laundry below) and mattress disinfected with appropriate disinfecting agent, which can be obtained by housekeeping staff. Any item that the resident has touched should be disinfected i.e., Wheelchairs, geri-chairs, dining

room chair, toilet seats, combs etc. The laundering of linens, clothing and disinfection of resident environment must coincide with the treatment / bathing (12 hours post application) and donning of newly laundered clothing.

- Closets to be kept locked and access as directed by registered staff. All other clothes in drawers, etc (clean) can be placed in garbage bag and locked in resident's closet.
- All pads and covers should be sent to Laundry. Anything that cannot be washed can be placed in a plastic bag for 4 days as mites cannot live past 4 days without a host.
- The above contact precautions and procedures can be discontinued 24 hours after effective treatment. All families of affected resident(s) to be notified.

Laundry

- Wash all bed linen, towels, and clothes in hot water and dry in clothes dryer at the hottest setting (greater than 50°C). Place clothing in a clear plastic bag followed by a red bag and forward items to the laundry.
- All clothing that the resident has worn within the previous 4 days should also be washed.
- Room cleaning with an appropriate disinfectant.
- Thorough vacuuming of environmental surfaces is recommended following use of a room by a patient with crusted (Norwegian) scabies, otherwise is not required

For Asymptomatic Contacts

- Treatments of roommates and close contacts is not recommended unless symptoms appear

For Staff

- Infested personnel should not work until 24 hours after treatment at any facility.

- Consider treating caregivers who have had prolonged skin to skin contact with cases prophylactically to prevent future recurrence of outbreaks. Infested caregivers and family contacts must also be considered as candidates for treatment.

For the Facility

- Because of the communicability of scabies and close contact required in the LTCH, any resident's skin lesion(s) should be evaluated immediately, and special precautions instituted until a diagnosis is made.
- Investigate all contacts who might have had skin-to-skin contact. Heightened surveillance is required within LTCH. Case finding efforts are required to search for unreported or undiagnosed cases.
- All residents with scabies should be treated at the same time, if possible. Treatment of resident(s) with scabies must be carefully coordinated and administered appropriately to be effective.
- Preadmission assessments should include any history or clinical findings consistent with scabies and a thorough visual assessment of the entire skin surface.

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