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PROTOCOL FOR MANAGEMENT OF INFECTION DUE TO PARASITES

This guidance does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and / or carer. Healthcare professionals must be prepared to justify any deviation from this guidance.

INTRODUCTION

This policy is designed to give guidance on the management of patients known or suspected to have parasitic infection. The guidance includes anti-parasitic therapy and infection control precautions.

THIS POLICY IS FOR USE BY ALL STAFF GROUPS

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Ratified by Trust Infection Prevention & Control
Committee on:

19th December 2018

Review Date:

19th December 2020

This is the most current document and is to be used until
a revised version is available

Key amendments to the guideline:

Date	Amendment	By:
June 2010	Title name change only	Dr J Stockley
October 2012	All sections change to guidance on treatment of clothes and bedding 9d Change to treatment of head lice	Dr Claire Constantine
August 2015	Document extended for 12 months as per TMC paper approved on 22 nd July 2015	TMC
April 2016	Document extended for 12 months as per TMC paper approved on 22 nd July 2015	TMC
August 2017	Document extended for 6 months as per TMC paper approved 22 nd July 2015	TMC
December 2017	Document extended for 3 months as per TLG recommendation	TLG
January 2017	Change wording of 'expiry date' on front page to the sentence added in at the request of the Coroner	
March 2018	Document extended for 3 months as approved by TLG	
June 2018	Document extended for 3 months as per TLG recommendation	TLG
October 2018	Document extended until end of November	Heather Gentry
December 2018	No clinical content changes , approved at TIPCC , changes to lead clinicians	TIPCC

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Alexandra Hospital, Redditch (01527) 503030 Ext: 44744

Index Page:

1	BED BUGS (<i>Cimex lectularis</i>)	Pg.4
	1a Introduction	Pg.4
	1b Clinical features	Pg.4
	1c Treatment	Pg.4
	1d Environment, clothing and bedding	Pg.4
	1e Exclusion	Pg.4
2	HUMAN FLEAS (<i>Pulex irritans</i>)	Pg.4
	2a Introduction	Pg.4
	2b Clinical features	Pg.5
	2c Treatment	Pg.5
	2d Environment, clothing and bedding	Pg.5
	2e Exclusion	Pg.5
3	SCABIES (<i>Sarcoptes scabiei</i>)	Pg.5
	3a Introduction	Pg.5
	3b Transmission	Pg.5
	3c Clinical features	Pg.6
	3d Incubation	Pg.6
	3e Treatment	Pg.6
	3f Contacts	Pg.7
	3g Environment, clothing and bedding	Pg.7
	3h Exclusion	Pg.7
4	CRUSTED SCABIES	Pg.7
	4a Introduction	Pg.7
	4b Clinical features	Pg.7
	4c Transmission	Pg.8
	4d Treatment	Pg.8
	4e Environment, clothing and bedding	Pg.8
	4f Contacts and exclusion	Pg.8
5	OUTBREAKS OF SCABIES IN HOSPITAL / RESIDENTIAL SETTINGS	Pg.8
	5a Action for one confirmed case	Pg.8
	5b Treatment of contacts	Pg.8
	5c Management of outbreaks	Pg.8
6	THREADWORMS (<i>Enterobius vermicularis</i>)	Pg.9
	6a Introduction	Pg.9
	6b Clinical features	Pg.9
	6c Transmission	Pg.9
	6d Incubation period	Pg.9
	6e Treatment and advice	Pg.9
	6f Contacts	Pg.9
	6g Environment, clothing and bedding	Pg.9
	6h Exclusion	Pg.10

Index Page continued:	Pg.10
7 BODY LICE (<i>Pediculus humanus corporis</i>)	Pg.10
7a Introduction	Pg.10
7b Transmission	Pg.10
7c Clinical features	Pg.10
7d Incubation period	Pg.10
7e Treatment	Pg.10
7f Contacts	Pg.10
7g Environment, clothing and bedding	Pg.10
7h Residential settings	Pg.10
7i Exclusion	Pg.11
8 PUBIC LICE (<i>Phthirus pubis</i>)	Pg.11
8a Introduction	Pg.11
8b Transmission	Pg.11
8c Clinical features	Pg.11
8d Incubation period	Pg.11
8e Treatment	Pg.11
8f Treatment of eyelash infestation	Pg.11
8g Contacts	Pg.12
8h Environment, clothing and bedding	Pg.12
8i Exclusion	Pg.12
9 HEAD LICE (<i>Pediculus humanus capitis</i>)	Pg.12
9a Introduction	Pg.12
9b Transmission	Pg.12
9c Prevention	Pg.12
9d Treatment options	Pg.12
9e Responsibilities	Pg.13
10 References	Pg.15
11 Contribution List	Pg.15

1 **BED BUGS (*Cimex lectularius*)**

1a INTRODUCTION

These are flat triangular insects, the young are white-yellow and the adults are red-brown in colour. The adult can grow to 5 mm long and has stink glands, which produces a characteristic odour.

During the day, the insect hides in crevices of walls, under loose wallpaper, in beds, furniture and carpets.

They are nocturnal and feed at night, usually one or two hours before dawn, biting their sleeping victim to suck blood, causing minor skin lesions. The parasite can survive for long periods without feeding (eg 150 days). Liquid urine from the insects can leave small brown or black marks on the sheets etc.

1b CLINICAL FEATURES

There is a wide variation in the effects of bites from minimal to marked irritation and swelling. In more marked reactions, erythematous macules in great number may be seen.

1c TREATMENT

Local application of calamine lotion to bites is first line, and an antihistamine may also be given if irritation is severe. Eradication of living / breeding sites is important (follow advice for environment, bedding and clothing).

1d ENVIRONMENT, CLOTHING AND BEDDING

Occasionally, transmission by clothing contact may occur.

Clothing and bedding should be treated as infected; bagged wearing apron and gloves sealed and sent for a hot wash if practicable. They should be dried on as hot a cycle as possible.

Eradication with a long-acting pesticide for heavy infestation in the domestic setting is required, followed by structural repair and redecoration. Bed bugs are naturally tolerant to insecticides and it is recommended an expert in pest control undertakes eradication procedures.

1e EXCLUSION

None

2 **HUMAN FLEAS (*Pulex irritans*)**

2a INTRODUCTION

Human flea infestations are uncommon. They prefer cool, damp, and dirty conditions. The larva and adults are most commonly found in beds, particularly where unwashed blankets are used without a sheet. They can also breed in cracks in dirty floors and may use other primary hosts, including cats and dogs.

Note: Cat and dog fleas will bite humans, mainly on exposed skin (For example: around the ankles), but do not stay on humans. Animal fleas can mature in carpets, soft furnishings, and animal bedding, behind panelling and even in air ducts. Eggs

Protocol for the management of infection due to parasites		
WAHT-INF-010	Page 5 of 19	Version 5

can hatch and pupae remain viable for months, independent of the animal host. It is possible therefore, for a human to suffer flea bites months after an infected animal has left a house. Re-infection of the animal is also common from these sources.

2b CLINICAL FEATURES

Bite marks from human fleas, can occur anywhere on the body and blood speckles may be found on clothing and bedding. Bite marks are discrete erythematous maculo-papules with a central bite point usually visible. Itchiness is quite variable.

2c TREATMENT

Local application of calamine lotion to bites is first line, and an antihistamine may also be given if irritation is severe. Eradication of living / breeding sites is important – see below.

2d ENVIRONMENT, CLOTHING AND BEDDING

A long lasting insecticide should be laid down in the house, along the skirting boards, floor cracks, wall cracks, and under furniture.

Carpets and soft furnishings should be treated with a recommended insecticide. (Advice can be sought from the local Environmental Health Department or Pest Control Specialist Company).

Clothing and bedding should be treated as infected; bagged wearing apron and gloves sealed and sent for a hot wash if practicable. They should be dried on as hot a cycle as possible.

Domestic animals should be treated with an appropriate insecticide (advice should be sought from a vet).

2e EXCLUSION

None

3 **SCABIES (*Sarcoptes scabiei*)**

3a INTRODUCTION

Human scabies is a parasitic disease of the skin caused by infection with the mite *Sarcoptes scabiei*. The mite burrows under the skin and produces an allergic response in the host. The excreta and saliva of the mite cause this allergic response. The burrows can occur anywhere but are mainly present on the hands and arms. Sometimes a few are found on the genitals or female breasts.

3b TRANSMISSION

Transmission is by direct, prolonged, skin to skin contact, For example: by holding hands. Mites do not survive on the surface of the skin; they will die very quickly if they are not kept warm and moist.

Spread via bedding, clothing and soft furnishings is not normally a route of transmission (except in the case of crusted scabies).

3c CLINICAL FEATURES

The allergic reaction produces an extremely itchy and widespread rash. The rash has the appearance of small, raised pimples and patches of crusty skin. The itchiness is severe and is generally more intense at night.

The site of the rash, which can be widespread, does not correspond to the sites of the mites.

Secondary infection can alter the clinical appearance, and this problem may need specific treatment once after once the scabies treatment has been completed.

3d INCUBATION PERIOD

The symptoms of scabies take several weeks to appear in a first infection (2 to 6 weeks). However individuals who have had scabies before will produce symptoms within a few days of becoming re-infected (1 to 4 days).

3e TREATMENT

Since the symptoms of scabies take several weeks to appear, it is easy for close contacts to become infected before the disease is suspected. **Therefore anyone who is in close (body) contact with the first patient (index case) should also be treated at the same time as the index case.**

Contacts need treatment whether they are itching or not.

It is important that the treatment is carried out correctly to ensure a successful outcome.

The recommended preparations for treatment of scabies are Permethrin (as Lyclear dermal cream 5%) and Malathion 0.5% in an aqueous base (For example: Derbac M or Quellada M lotions). These preparations are both very effective if used correctly. It is important to apply the lotion or cream properly and leave on for the recommended time period (as per manufacturer's instructions). Treatment times vary between 8 and 24 hours.

NB: Lyclear dermal cream is not recommended for use by pregnant or breast feeding women.

Application

1. A hot bath is **not** necessary before treatment. If a bath / shower is taken for hygiene purposes, then the skin should be dried and allowed to cool.
2. Application of a thin smear of the lotion to cover the whole body, excluding the face is necessary. It is important that **all** other areas of the body are treated these include:
 - behind the ears
 - around the hair-line (and scalp where the hair is scanty, thinning or balding)
 - soles of the feet
 - palms of hands and underneath finger nails
 - skin webs between fingers and toes
 - buttocks, groins and genital area

NB: In the elderly and young children it is recommended that the whole body including the face and head is treated. Care should be taken to avoid the eyes.

The lotion must be reapplied to the hands (or other body areas) each time they are washed during the treatment period.

The success of the treatment will depend upon how well it is applied.

3. Following the treatment period (see product recommendations, i.e 8 to 24 hours) a bath / shower or all over wash should be taken and all clothing and bedding changed.
4. Itching may persist for 2 to 3 weeks after successful treatment, but this should reduce substantially during the first week, and it can be treated with Eurax cream or calamine lotion.
5. If after one week, symptoms have not substantially reduced, a second treatment may be necessary. For persistent symptoms other allergies or skin conditions should be excluded.

3f CONTACTS

All identified close contacts should receive treatment on the same day and should apply the lotion or cream in the same way. One treatment is sufficient for asymptomatic contacts.

Non-compliance by just one individual may make the difference between a success or failure of a planned treatment.

3g ENVIRONMENT, CLOTHING AND BEDDING

Bedding and clothing should be washed in the normal manner. No special precautions are necessary.

3h EXCLUSION

Exclusion from work, school or nursery is not required once treatment is completed.

4 CRUSTED SCABIES

4a INTRODUCTION

This is a rare condition that affects individuals with impaired immune response, (For example: the elderly, individuals with Downs Syndrome, patients taking immunosuppressive drugs and those infected with HIV). Scabies mites are abundant and may be anywhere on the body.

A dermatologist's opinion should be sought if this condition is suspected.

4b CLINICAL FEATURES

The clinical features are variable and can be difficult to differentiate from other skin disease. The rash if present can take any shape and signs of skin reaction may be anywhere on the body including the head and crusting is seen. There may be little or no itch.

Protocol for the management of infection due to parasites		
WAHT-INF-010	Page 8 of 19	Version 5

4c TRANSMISSION

Direct skin to skin contact. Environmental contamination may also occur (mites may be present in shed skin flakes). Carpets and soft furnishings will need to be vacuumed daily to reduce the risk of spread of infection.

4d TREATMENT

The same lotions are used as for classical scabies but extended treatment is necessary.

Crusted scabies usually causes different problems and needs to be handled in a different way. Advice for individual cases may be sought from the Communicable Disease Team.

4e ENVIRONMENT, CLOTHING AND BEDDING

Clothing and bedding should be treated as infected; bagged wearing apron and gloves sealed and sent for a hot wash if practicable. They should be dried on as hot a cycle as possible. Items which cannot be hot-washed may be dry cleaned. Items that cannot be dry-cleaned or laundered can be disinfested by storing in a closed plastic bag for several days to a week. Scabies mites generally do not survive more than 2 to 3 days away from human skin.

4F CONTACTS AND EXCLUSION

As for classical scabies

5 OUTBREAKS OF SCABIES IN HOSPITAL / RESIDENTIAL SETTINGS

5a ACTION FOR ONE CONFIRMED CASE

Once one case has been confirmed in a member of staff or resident, treatment should be undertaken. (See treatment sheet)

Patients / residents should not visit day units or other establishments until treatment has been undertaken.

Staff can return to work once treatment has been undertaken.

5b TREATMENT OF CONTACTS

If the case is a client, their close contacts (relatives and possibly some staff members) will also need treatment.

If the case is member of staff, their close and household contacts will need treatment.

It often takes about 4 to 6 weeks for symptoms to develop, therefore relatives and close contacts will require treatment whether itching or not. For contacts that are apparently unaffected, one treatment is sufficient. It may be necessary to repeat the process if further contact with an infected client occurs.

5c MANAGEMENT OF OUTBREAKS

Effective control is dependent on early diagnosis, adequate treatment of infected cases and contacts and the prevention of spread.

Protocol for the management of infection due to parasites		
WAHT-INF-010	Page 9 of 19	Version 5

If an outbreak of scabies is suspected seek advice from the Infection Control Team.

6 **THREADWORMS (*Enterobius vermicularis*)**

6a **INTRODUCTION**

Threadworm eggs develop in the small intestine and then colonise the colon. The female worms migrate through the anal orifice, usually at night. They can lay up to 10,000 eggs in the perianal region.

Adult worms may sometimes be seen in faeces, but diagnosis is best confirmed by the microscopic examination of Sellotape, which has been applied to the perianal region in the early morning.

The presence of eggs and worms can lead to discomfort and itching, which may in turn lead to disturbed nights and lack of sleep.

6b **CLINICAL FEATURES**

Infection causes intense perianal itch and irritation, especially at night.

6c **TRANSMISSION**

Eggs can be transmitted when they accumulate under the fingernails when the perianal region is scratched.

They can then be spread to other individuals, surfaces, bedding, clothing and carpets causing indirect spread. Eggs remain infective in an indoor environment for 2 weeks. Man is the only host for this parasite.

6d **INCUBATION PERIOD**

2 to 6 weeks before onset of itching in persons without previous exposure. For those previously infested symptoms may develop in 1 to 4 days.

6e **TREATMENT AND ADVICE**

Either mebendazole (Vermox) or piperazine salts (Antipar, Pripsen) as a single dose to all members of the family.

Strict attention should be paid to personal hygiene with daily showers and hands washed and nails scrubbed before meals and after using the toilet. Nails should be kept short and nailbrushes cleaned thoroughly after each use.

Mebendazole should not be given to children under the age of 2, and is given only once.

Piperazine should be given on 2 occasions 14 days apart.

6f **CONTACTS**

All household contacts of a case should be treated at the same time.

6g **ENVIRONMENT, CLOTHING AND BEDDING**

Underclothes and nightwear should be changed daily in the mornings. Bed sheets should be changed daily during treatment (taking care not to produce aerosols) and

the house should be cleaned / vacuumed daily for several days after treatment. Eggs will only survive up to a fortnight outside the body, and are killed by washing linen using a hot wash.

6h EXCLUSION

None, once treated

7 BODY LICE (*Pediculus humanus corporis*)

7a INTRODUCTION

Adult body lice are slightly larger than head lice; they are found mainly within layers and seams of clothing and also on body surfaces especially in the axillae and around the waist.

7b TRANSMISSION

Transmission, which only occurs in the dark, is usually by indirect contact with personal belongings, especially items of clothing. As long as eggs or lice remain alive on the person and in the clothing they can be transmitted to another person.

7c CLINICAL FEATURES

Itching and irritation of the body is common together with pinpoint macules (feeding points) on the skin, which resolve to leave a pigmented scar.

7d INCUBATION PERIOD

Eggs of body lice hatch in one week and reach maturity in 8 to 10 days.

7e TREATMENT

Treatment of the individual is rarely needed. The individual should take a shower or bath and a change of clothing is usually all that is required. If treatment is needed, a preparation for the treatment of head lice should be used.

7f CONTACTS

Any contacts that may have shared clothing should be investigated.

7g ENVIRONMENT, CLOTHING AND BEDDING

Body lice can survive in clothing for some time away from humans. Boiling or hot water washing and ironing can easily disinfect all items of clothing and bedding. Dry heat in a tumble dryer for 30 minutes is also effective in destroying lice. Clothing and items that are not washable can be dry-cleaned OR sealed in a plastic bag and stored for 2 weeks. Alternatively, clothes can be destroyed (remember to obtain the owners permission).

Borrowing and sharing of clothes should be discouraged.

7h RESIDENTIAL SETTINGS

As lice only transfer in the dark, decontamination procedures should take place in a well lit room. Bedding and clothing should either be destroyed (with the owners permission), or placed in an alginate bag (water-soluble bag), taken immediately to

the laundry area and washed on a hot wash. Staff should wear gloves and an apron when handling items of clothing, bedding and personnel belongings.

No environmental measures are required.

7i EXCLUSION

Work / school / nursery, etc – exclude until clothing is treated.

8 PUBIC LICE / CRAB LICE (*Pthirus pubis*)

8a INTRODUCTION

These lice and their eggs are usually found firmly attached to pubic hair but can also occur in the axillae, chest, legs, beard and eyebrows.

8b TRANSMISSION

Transmission is acquired during intimate contact, such as sexual contact.

8c CLINICAL FEATURES

Local irritation may be characterised by intense itching and occurs about a month after the lice are first present. Areas may often be heavily scratched. Eggs in the pubic hair of the groin may be cemented well away from the skin, but in cooler areas, they are found closer to the skin.

The eggs are oval, opalescent and smaller than those of other lice. Pubic lice move little compared to other varieties, but will frantically move to escape light.

8d INCUBATION PERIOD

Eggs and lice hatch in a week and reach maturity after approximately 8 to 10 days.

8e TREATMENT

Aqueous solutions of insecticides should be used in preference to alcohol based preparations, as infected areas are often heavily scratched.

Recommended agents: Malathion aqueous based lotion 0.5% (For example: Derbac M, Quellada M,).

Treatment advice

Lotion should be applied to **all** parts of the body (not merely the groins and axillae) and left on for 12 hours.

Treatment should be repeated after 7 days to ensure lice emerging from eggs that survived the first treatment are killed.

8f TREATMENT OF EYELASH INFESTATION

Malathion aqueous lotion is effective for crab lice of the eye but does not have a product licence for this indication. If used it should be applied carefully with a cotton bud to avoid contact with the eyes.

8g CONTACTS

Spread is usually through intimate contact, so sexual partners should be treated.

8h ENVIRONMENT, CLOTHING AND BEDDING

Pubic lice do not live long away from a host (about 24 hours). Clothing and bedding do not need to be specially treated.

8i EXCLUSION

None necessary

9 HEAD LICE (*Pediculus humanus capitis*)

9a INTRODUCTION

The head louse is a small insect that lives close to the scalp for warmth and feeds by sucking blood. It moves by crawling through the hair and cannot jump or fly.

Adult head lice are approximately 3 mm long and are difficult to see as they are flesh coloured and only darken after feeding.

A female louse lays 5 to 8 eggs a day at the base of a hair shaft approximately 1 mm from the scalp. The eggs hatch in 7 to 10 days, and the lice reach maturity about 9 days after hatching. As the louse grows it sheds its skin twice; this combined with faeces may be seen on the pillows of infected individuals as black dust.

Live eggs are firmly attached to the hair and are caramel in colour. After hatching, empty egg cases, called nits, grow out of the hair at a rate of approximately 1 cm per month. Nits are white in colour and are often easier to detect than the lice themselves.

Infections are usually symptom free and are only discovered through regular, routine inspection of the hair. The scalp only becomes itchy with prolonged infections of many weeks.

Persistent itching following treatment is not an indication of treatment failure.

Head lice infections are a community problem affecting children and adults alike and should not be seen as a problem that only affects schools.

9b TRANSMISSION

Head lice are transmitted by **direct, relatively prolonged, head to head contact only**. Lice observed on chair backs, pillows, hats or other such items are incapable of transferring to another person.

9c PREVENTION

There is **no effective preventative therapy** for head lice.

9d TREATMENT OPTIONS

If an infection is suspected the head must be detection combed to confirm the presence of live lice. (This is the responsibility of the individual themselves or a parent or carer.)

If live lice are detected, treatment should be commenced. If live lice are not detected, weekly detection combing should be undertaken.

Upon detection of live lice there are 2 treatment options:

- (a) Treatment with parasitocidal lotion
- (b) Treatment without parasitocidal lotion (eg the combing method)

(a) Treatment

First line recommended treatment is now the non-pesticide treatment of dimeticone (commercially available as 'Hedrin'). There are no resistance problems, but treatment does have to be left in the hair for at least 8 hours or overnight.

The odourless dimeticone compound coats head lice and smothers them, and because they use purely mechanical non-toxic methods, resistance cannot develop and they can be used as often as necessary without irritating the scalp.

Non-pesticide lotions should be applied as directed in the pack instructions and repeated usually after one week so that it will catch lice that have hatched between treatments and before they can lay eggs of their own. To check effectiveness, use a detector comb 24 hours after the second treatment and if live lice are found then repeat the entire treatment until no lice are present.

Contact tracing must be undertaken of all close contacts. All individuals with proven infection should be treated at the same time or before contact is resumed.

9e RESPONSIBILITIES

1. Parents and Children

Parents should inspect their children's hair through detection combing once a week. If evidence of infection is found (live lice), other family members and close contacts should also have their hair inspected in the same way.

Parents are responsible for informing all close contacts of infected family members about the infection and should also inform the school, nursery and / or playgroup attended by their children.

Parents are also responsible for visiting their GP surgery, taking with them evidence of the infection (For example: lice attached to paper with sellotape), to obtain advice and a prescription for treatment.

2. General Practitioners and Practice Staff

General Practitioners and Practice staff must adhere to evidence based clinical practice guidelines.

They must be knowledgeable and competent in the control of head lice and be able to teach parents and carers the correct techniques required for its effective management.

General Practitioners should only prescribe the approved preparations and treatment must only be prescribed for those individuals found to be infected with head lice.

3. Health Visitors and School Nurses

Health Visitors and School Nurses should be involved in the education of parents and children about head lice infections, being knowledgeable and competent in the control of head lice and the correct treatment techniques required for effective management.

Emphasis should be placed on the parent's responsibility **to prevent, detect and treat infections as well as contact tracing.**

In cases of head lice outbreaks in schools, nurseries, playgroups, etc, Health Visitors and School Nurses should:

- Follow the clinical practice guideline for head lice management.
- Offer advice, guidance, support and education to families based on the evidence.
- Liaise closely with General Practitioners, Community Medical Officers, and the Communicable Disease Team based in the Department of Public Health.

They should **not**:

- Undertake head inspections as a routine screening procedure

4. Schools

Schools have a responsibility to inform parents of any outbreaks of head lice.

Schools may distribute a standard letter to parents advising on detection combing, treatment and contact tracing incorporating the evidence in the policy and clinical practice guidelines for the management of head lice.

Children **need not** be excluded from school when an infection is found. If treatment is commenced immediately the child may continue at school. (If detection combing is undertaken before the child attends school, adult live lice will be removed from the head, and therefore will not be infectious to others.)

5. Pharmacists

Local pharmacists must be familiar with the evidence based policy and clinical practice guidelines for the management of head lice.

Pharmacists must be knowledgeable and competent in the control of head lice and be able to educate parents and carers in the correct techniques required for its effective management.

The patient information leaflet produced by the Department of Public Health at Worcestershire Health Authority may be given with all prescriptions and sales of head lice treatment.

The information contained in this policy should be freely given to any enquirers.

10 REFERENCES

Clinical Knowledge Summaries – www.cks.library.nhs.uk

British National Formulary

CDC Guidance- [www. CDC](http://www.CDC)

HPA Guidance- www.HPA.org

11 CONTRIBUTION LIST

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Name	Designation
	All members of Trust Infection Prevention & Control Committee

Circulated to the following CDs / Heads of department for comments from their directorates / departments

Name	Directorate / Department

Circulated to the chair of the following committees / groups for comments

Name	Committee / Group
Nick Hubbard	Trust Medicines Safety Committee

It is the responsibility of every individual to ensure this is the latest version of the document

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: <i>(Responsible for also ensuring actions are developed to address any areas of non-compliance)</i>	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.
All	That patients diagnosed with an infestation are treated according to the policy.	Compliance with the guideline will be monitored using records on ICNet and SI reports.	2 times a year	ICDs	TIPCC by exception	2 times a year

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Supporting Document 1 – Checklist for review and approval of key documents

This checklist is designed to be completed whilst a key document is being developed / reviewed.

A completed checklist will need to be returned with the document before it can be published on the intranet.

For documents that are being reviewed and reissued without change, this checklist will still need to be completed, to ensure that the document is in the correct format, has any new documentation included.

1	Type of document	INF Protocol
2	Title of document	PROTOCOL FOR MANAGEMENT OF INFECTION DUE TO PARASITES
3	Is this a new document?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If no, what is the reference number WAHT-INF-010
4	For existing documents, have you included and completed the key amendments box?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
5	Owning department	Infection Prevention and Control
6	Clinical lead/s	Dr C Constantine, Consultant Microbiologist
7	Pharmacist name (required if medication is involved)	Nick Hubbard
8	Has all mandatory content been included (see relevant document template)	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
9	If this is a new document have properly completed Equality Impact and Financial Assessments been included?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
10	Please describe the consultation that has been carried out for this document	Reviewed against national guidance then circulated to relevant clinicians before ratification at TIPCC
11	Please state how you want the title of this document to appear on the intranet, for search purposes and which specialty this document relates to.	Parasite Policy

Once the document has been developed and is ready for approval, send to the Clinical Governance Department, along with this partially completed checklist, for them to check format, mandatory content etc. Once checked, the document and checklist will be submitted to relevant committee for approval.

It is the responsibility of every individual to ensure this is the latest version of the document

Implementation

Briefly describe the steps that will be taken to ensure that this key document is implemented

Action	Person responsible	Timescale
Inclusion in Trust IC Induction and Updates for all staff	IPCT	Ongoing
IPCT work with area reporting an infestation to guide	IPCT	As occurs

Plan for dissemination

Disseminated to	Date
Alert will be placed on IPC website	Once policy placed on Intranet by Risk
Policies with major changes will be reported in senior nurse/matrons report and e-mailed to link staff	Once policy placed on Intranet by Risk

1	Step 1 To be completed by Clinical Governance Department	
	Is the document in the correct format?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
	Has all mandatory content been included?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
	Date form returned 03/04/2013	
2	Name of the approving body (person or committee/s)	TIPCC
	Step 2 To be completed by Committee Chair/ Accountable Director	
3	Approved by (Name of Chair/ Accountable Director):	Dr Chris Catchpole
4	Approval date	25/03/2013

Please return an electronic version of the approved document and completed checklist to the Clinical Governance Department, and ensure that a copy of the committee minutes is also provided.

Office use only	Reference Number	Date form received	Date document published	Version No.
	WAHT-INF-010	03/04/2013	05/04/2013	4