Shropshire Community Health
NHS Trust

Document Details	
Title	Scabies Policy
Trust Ref No	782
Local Ref (optional)	
Main points the document covers	This policy details guidance on the care and management of scabies within Shropshire Community Health NHS Trust (SCHT)
Who is the document aimed at?	All staff who undertake direct patient care within Shropshire Community Health NHS Trust
Author	Deputy Director of IPC
Approval process	
Who has been consulted in the development of this policy?	This policy has been developed by the IPC team in consultation with appropriate senior Operations and Quality managers, Locality Clinical Managers, Specialist Nurses, Medicine Management and Public Health England
Approved by (Committee/Director)	Infection Prevention and Control Committee – notified to Quality and Safety Committee
Approval Date	24 February 2025
Initial Equality Impact Screening	Yes
Full Equality Impact Assessment	N/A
Lead Director	Director of IPC
Category	Clinical
Sub Category	Infection Prevention and Control
Review date	23 February 2028
Distribution	
Who the policy will be distributed to	Electronically to IPC Committee members and available to all staff via the SCHT website
Document Links	
Required by CQC	Yes
Key Words	Scabies, Outbreak

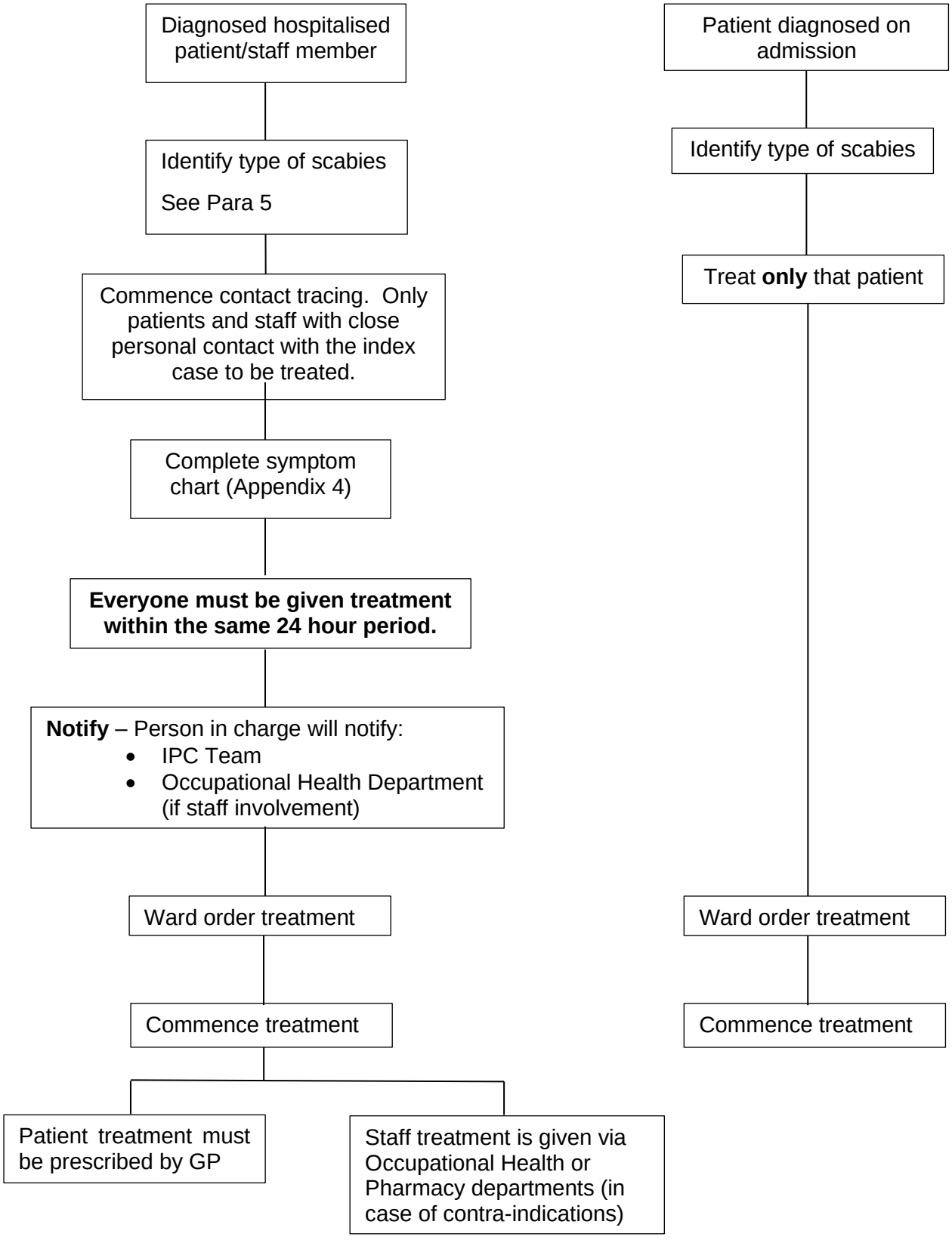
Amendments History		
No	**Date**	**Amendment**
1		
2		
3		

Contents

Policy on a Page

FLOW CHART FOR MANAGEMENT OF SCABIES

Scabies Management



1 Purpose

The purpose of this policy is to inform all healthcare staff within Shropshire Community healthcare NHS Trust (SCHT) who are involved in the care of patients that develop or suffer from symptoms or infestation of scabies, the process and management of the infestation.

2 Definitions that apply to this policy

	Explanation / Definition
Hyperkeratosis	Is a thickening of the outer layer of the skin, which contains a tough protein called keratina. This thickening is often part of the skin's normal protection against rubbing, pressure and other forms of local irritation and causes calluses and corns on the soles of the feet or of the hands.
Index Case	The first person identified as having the infection
Impetigo	Is a common and highly contagious skin infection that mainly affects infants and young children. It usually appears as reddish sores on the face, especially around the nose and mouth and on the hands and feet
Lymphangitis	Is an inflammation of the lymphatic system, which is a major component of your immune system.
Outbreak	The occurrence of two or more cases of the same infection linked in time and place or, the situation when the observed number of cases exceeds the number expected.
Papules	A papule is a raised area of skin tissue that is less than 1 centimetre around. A papule can have distinct or indistinct borders. It can appear in a variety of shapes, colours, and sizes. It is not a diagnosis or disease. Papules are often called skin lesions, which are essentially changes in your skin's colour or texture
Pustules	Are small bumps on the skin that contain fluid or pus. They usually appear as white bumps surrounded by red skin.
Symptomatic	Physical or mental sign of the disease.
Treatment	Care provided to improve a situation (especially medical procedures or applications that are intended to relieve illness or injury)
Vesiculations	The formation of blisters

3 Introduction

Scabies is a contagious infestation caused by a mite Sarcoptes scabiae which burrows into the skin and lays its eggs. The scabies mite is approximately 0.5mm in size. The condition is recognised by an allergic reaction to the saliva and faecal material excreted by the mite.

It is a world-wide disease, more common where overcrowded conditions prevail. It can affect any individual irrespective of social class, age or race. Scabies is known to cause sporadic cases and outbreaks in hospitals, nursing/residential homes, schools and any other communal care environments where people have direct skin contact. Effective control is dependent on early diagnosis, adequate treatment of cases and contacts and the prevention of further spread.

Clinical symptoms arise only when patients have become sensitised to the mites.

Scabies is primarily characterised by itching and vesiculations. Signs of slightly elevated tracts may also occur. Miniature papules, vesiculations, pustules and excoriations soon

appear. Scratching of these areas may lead to secondary bacterial infection and the formation of pustules. The appearance and severity of symptoms are strongly influenced by the immune status of the affected person.

Untreated scabies is often associated with secondary bacterial infection which may lead to cellulitis, folliculitis, boils, impetigo, or lymphangitis.

Scabies may also exacerbate other pre-existing dermatoses such as eczema and psoriasis.

The appearance and severity of symptoms are strongly influenced by the immune status of the affected person. Scabies may present as the following:

- Classical scabies
- Atypical scabies
- Crusted scabies (Norwegian scabies)

See paragraph 5 below for more information about the different types of scabies.

4 Duties

4.1 Responsibility for Infection Prevention and Control (IPC) outside the immediate scope of this policy

For duties and responsibilities for IPC practices outside the specific scope of this policy, please refer to the IPC Arrangements and Responsibilities Policy on the Staff Zone SCHT Staff Zone (shropcom.nhs.uk).

4.2 IPC Duties specific to this policy

Provide advice in relation to the care and management of a patient with scabies who is under the care of SCHT.

To review and revise this policy in line with expert guidance and national policy.

5 Types of scabies

5.1 Classical scabies

This is a form of scabies generally found in healthy people with a normal immune system:

- The number of mites present in classical scabies is small (15-20) and spread is usually by direct physical contact.
- Burrows caused by the mites appear as irregular, raised discoloured lines 0.5 t0 1.5cm long in the skin, which are not always be visible to the naked eye.
- Often a bilateral symmetrical rash can be seen in areas such as the midriff, inner thighs, and axillae.
- extreme itching is often experienced, especially at night.
- The sites of the rash and burrows do not necessarily correspond.

5.2 Atypical scabies

Atypical scabies occurs in any person with immature or impaired immune response, many mites may be present in atypical scabies and symptoms may be variable. Scaling or crusting of the skin may be present but is usually slight, itching may also be very slight or even absent.

5.3 Crusted scabies (Norwegian scabies)

This form of scabies is extremely infectious and occurs in those whose immune systems are severely impaired.

- Hyperkeratotic skin lesions appear as hardened crusts containing thousands or millions of mites.
- Itching may be slight or absent.
- Skin becomes crusted especially on palms, soles, nail beds, wrists, buttocks, and penis. The whole body can be affected including the head and scalp.

6 Mode of Transmission

Scabies is host specific i.e. it lives only on humans.

Scabies is mainly spread from person to person by direct prolonged skin contact with an infected person, such as prolonged holding of hands.

Scabies mites rapidly die once away from the human body and therefore clothing and linen etc is not the main route for transmission. However, mites shed in skin scales and can live in the environment longer and therefore the risk of spread through contact with soft furnishings/carpets, clothing and linen is increased with heavy skin shedders. Pets do not spread scabies.

The length of time between contact with an affected person and developing signs of scabies (i.e., itching and a rash) is between four and six weeks, if this is the first infection. For re-infection of scabies symptoms appear within 48 hours.

7 Diagnosis of scabies

Diagnosis is by identification of the mite, eggs or faecal matter from skin scrapings. A clinical diagnosis may be made by a combination of severe itching especially at night and a typical or atypical distribution of a rash in persons who have had skin to skin contact with suspected or diagnosed cases.

Another hallmark of scabies is the appearance of track-like burrows in the skin, these raised lines are usually greyish-white or skin coloured. They are created when female mites tunnel just under the surface of the skin, after creating a burrow each female lays 10-25 eggs inside.

If clinical diagnosis is difficult, obtaining skin scrapings for the scabies mites or their faecal pellets may be helpful. Skin scales may be sent by the clinician caring for the patient in a closed, sealed container (e.g., universal container) to the microbiology laboratory for microscopy for Scabies. Once diagnosis is confirmed a dermatology opinion may be necessary.

8 Specific treatment for scabies infection

Individual treatment should be given if scabies has been diagnosed.

Recommended treatments include:

Permethrin 5% (Lyclear dermal cream) 30g (Low toxicity, non-irritant) Leave on for 8- 12 hours.

Malathion 0.5 % (Derbac-M) Leave for 24 hours. Malathion 0.5% is the treatment of choice in pregnancy, during breastfeeding and for infants under 2 months of age.

Permethrin 5% is the treatment choice in children over the age of 2 months and under the age of 6 months.

For each treatment, the following amounts will be required:

200ml of lotion or 30g of cream for the average sized person

More than 200ml of lotion or more than 30g of cream may be required for a larger person or for a patient where there is a need for frequent washing.

Insufficient lotion is a contributory factor to treatment failure.

Transmission of the mite ceases after the first application has been applied. However, itching may persist for several weeks after the infection has cleared. In fact the symptoms may become more pronounced. This is because the body reacts to the dead mite and its waste products, which remain in the skin. Skin becomes scaled, crusted and unsightly due to the numbers of mites present and for this reason an anti-puretic liquid or cream may be helpful.

8.1 Application of the treatment

The lotion or cream should be applied to all skin surfaces starting at the jawline and around behind the ears, extending to the soles of the feet.

It should be applied to cool dry skin and never after a hot bath, the lotion or cream should be reapplied to skin whenever it has been washed during the treatment time (as these areas will not undergo the recommended time for treatment and may promote infection). The lotion or cream used should then be allowed to dry before the person dresses.

The head and scalp may be affected and should be carefully examined for any signs of scabies and be treated if present after seeking medical advice.

Following the recommended treatment time, depending on the type of medication being used the lotion or cream should be washed off thoroughly with plenty of water. This should be done preferably by a shower (or a bath if a shower is not an option).

Two courses of treatment are required and must be administered at least one week apart.

Itching may persist and the rash may be present for up to 6 weeks after treatment, the use of calamine lotion, crotamiton (Eurax) or antihistamines may be helpful in the management of itching.

If hyperkeratotic lesions are present, specialised advice on appropriate management will be needed from a dermatologist.

9 Contact Tracing

Following consultation with the medical practitioner, consultant in public health or IPC team, the treatment of close contacts should be arranged. A risk assessment will be made to ascertain the patient's current status and the level of contact others have with the patient.

Management of treatment is discussed in Section 13 of this policy.

If a care home is involved, please inform Shropshire Telford and Wrekin Integrated Care Board IPC Team and the local UKHSA team.

10 Further courses of treatment

Further courses of treatment may be necessary depending on the extent and severity of the scabies infection.

In the management of severely infected patients at least 3 treatments will be necessary.

If multiple treatments are prescribed for an individual, they should be at least 7 days apart.

Where treatment has failed advice should be sought from the medical team or microbiologist.

Persons are classed as non-infectious when their treatment regime has completed, and the medication has been washed off.

11 Management of scabies for inpatient areas

Inform IPC team as soon as a case is suspected or confirmed.

If a patient is admitted with a rash diagnosed as scabies, only the affected patient and close contacts will require treatment.

If a patient develops a rash which is diagnosed as scabies, they will require two treatments as outlined in para 8 above. (see also Appendix 1 Patient Has Rash – Letter) and all

contacts require one treatment (see Appendix 2 Patient with NO Rash – Letter and Appendix 3 – Staff).

Staff must observe all patients and staff for symptoms of scabies. A skin monitoring form (see Appendix 4) must be used to record symptoms and track management of all patients and staff, including agency staff.

All close and sexual contacts of the affected patients in the previous 2 - 6 weeks will require treatment even if symptom free.

If a member of staff is considered to be a close contact of a patient diagnosed with scabies the member of staff, if not symptomatic, will require one treatment. Please see paragraph 11.3 below

If two or more cases are identified this is classed as an outbreak (refer to SCHT Outbreak Management policy).

If there are two or more cases, a co-ordinated approach to treatment is essential so all cases and contacts are treated simultaneously on an agreed treatment date. It is reasonable and advisable to delay treatment until plans have been properly made and a full assessment of contacts has been done.

Where staff require treatment, this will be managed by the Occupational Health department. In conjunction with the dermatologist, the consultant in public health (UKHSA) will decide who needs treatment and the type of treatment regime to be carried out taking into account the following information:

- The number of symptomatic patients in the affected unit
- The number of symptomatic staff working in the unit
- The total number of patients and staff within the unit with or without symptoms
- The severity of symptoms of each affected individual

From this information the consultant in public health will decide on whether to treat symptomatic individuals only or all patients and all staff based in the unit. Close contacts must be treated at the same time as the last treatment of the symptomatic individual.

All patients in communal health care environments who are suspected of having or have been diagnosed as having scabies should be cared for in a side room using Contact Precautions until treatment has been administered and washed off, or an alternative diagnosis has been made. The IPC team must be informed of the patient as soon as possible. Two courses of treatment are required and must be administered a week apart.

Precautions must continue until the two courses of treatment are required and must be administered and washed off or an alternative diagnosis made.

Disposable nitrile gloves and plastic aprons must be worn when in contact with the patient, bed linen and patient clothing, The use of personal protective equipment (PPE) must be used until the second course of treatment has been administered and washed off.

Hand washing with liquid soap and water must be carried out after contact with the patient and their environment, hands must be dried thoroughly with single use disposable paper towels.

Advise visitors to seek advice from their GP if they or a family member develops a rash.

A scabies information leaflet is available on the SCHT website.

11.1.1 Movement of symptomatic patients

Symptomatic patients should ideally not be transferred or discharged to other communal health care environments including other hospital units, residential or nursing homes until coordinated treatment has been given and washed off.

In circumstances where patient movement is necessary, communication is vital between the two areas so that appropriate IPC precautions can be adopted.

11.2 Management of Staff

If a member of staff acquires a scabies infection during the course of their work and has been diagnosed by their GP, they must obtain treatment. The cost of treatment for staff will be reimbursed following submission of a SCHT request for manual payment form (see Appendix 5) a receipt for payment is required.

Staff can return to work once the first treatment with a scabicide is completed.

It is absolutely essential that all their household contacts be treated when they receive their first treatment. If they do not ensure this happens then they may become re-infected from a member of their household.

Staff with rashes will also be given a letter (see Appendix 6 – GP Staff Close Contact) to show the GP who cares for their household contacts, explaining why treatment is necessary.

Contact tracing should also be undertaken for all those who have had skin contact with the member of staff (this may include patients if staff were not wearing PPE).

In instances of treatment failure the staff member should be referred back to their GP for further advice.

All patients on the caseload who have been treated by the staff member and deemed to have had prolonged skin to skin contact will need to be reviewed.

If a member of staff acquires scabies they should inform the Occupational Health Department.

12 Linen

For inpatient facilities, bedding used in the 48 hours prior to and during treatment should be placed in a red soluble bag and securely tied before being placed into a white outer plastic bag (Please refer to the IPC policy for the management of linen and laundry).

Clothes, used prior to and during treatment should be laundered in a hot wash (Over 50c). If this is not possible the laundry should be stored in a sealed plastic bag for 72 hours prior to being washed, then it can be washed following the washing instructions on the garment. The laundry must not come into contact or be stored with clean clothing or linen.

Linen should be treated as infected until the patient has had the second course of treatment, clean clothing and bed linen should be available after treatment has been washed off.

13 Post treatment observations / monitoring

Many people experience continued itchiness following treatment. These symptoms may persist for many weeks. This does not necessarily indicate a treatment failure, but is caused by allergy to the mite residue. If this is the case, the GP or the IPC team or Community Pharmacists should be approached for advice.

Resistance to treatment is rare; where a rash persists it is mainly due to either a failure in the treatment process, reintroduction of scabies or misdiagnosis.

Re-infestation can occur if the treatment is not carried out thoroughly, or by contact with someone else who is infected and has not been treated at the same time. There is no protective immunity to scabies, so multiple re-infestation can occur. If scabies is reintroduced to an individual the onset of symptoms is usually much faster – within a week.

14 Suspected Treatment Failure

Treatment failure is likely if:

- the itch still persists at least 6 weeks after the first application of treatment (particularly if it persists at the same intensity or is increasing in intensity)

- treatment was uncoordinated or not applied correctly
- new burrows appear at any stage after the second application of an insecticide

15 Management of Treatment Failure

Re-examine the person to confirm that the diagnosis is correct and look for new burrows.

Consider alternative diagnoses.

If all relevant service users, staff members, relatives or close contacts were treated simultaneously and treatment was applied correctly, give a course of a different insecticide:

- if permethrin 5% dermal cream was used initially, then prescribe malathion 0.5% aqueous solution; or
- if malathion 0.5% aqueous solution was used initially then prescribe permethrin 5% dermal cream.

If contacts were not treated simultaneously or treatment was incorrectly applied, either re-treats with the same insecticide, or use a different insecticide.

Ensure that all relevant service users, staff members, relatives or close contacts are re-treated simultaneously.

16 Prevention

- Promote good surveillance of new patients especially if they have come from another healthcare facility. Observe for rashes on admission and for the next six weeks
- If a patient develops a rash, ensure gloves are worn when having skin contact
- Maintain a high level of suspicion if patients present with undiagnosed skin rashes
- Observation of patients itching, particularly at night or after a bath/shower
- Educate staff on presentation and transmission of scabies
- Encourage staff to report rashes

17 Consultation

This policy has been developed by the IPC team in consultation with appropriate clinical services managers, Medicines Management, Occupational Health Department, IPC Operational Group members and IPC Committee members.

17.1 Approval Process

The IPC Committee members will approve this policy and its approval will be notified to the Quality and Safety Committee.

18 Dissemination and Implementation

This policy will be disseminated by the following methods:

- Managers informed who then confirm they have disseminated to staff as appropriate
- Staff – via IPC newsletter
- Awareness raising by the IPC team
- Published to the Staff Zone of the Trust website

The web version of this policy is the only version that is maintained. Any printed copies should therefore be viewed as 'uncontrolled' and as such, may not necessarily contain the latest updates and amendments. When superseded by another version, it will be archived for evidence in the electronic document library.

18.1 Advice

Individual Services' IPC Link staff act as a resource, role model and are a link between the IPC team and their own clinical area and should be contacted in the first instance if appropriate.

Further advice is available from the IPC team or the Consultant Microbiologist at Shrewsbury and Telford Hospital (SaTH) via the Royal Shrewsbury Hospital switchboard on 01743 261000.

18.2 Training

Managers and service leads must ensure that all staff are familiar with this policy through IPC induction and update undertaken in their area of practice.

In accordance with the Trust's mandatory training policy and procedure the IPC team will support/deliver training associated with this policy. IPC training detailed in the core mandatory training programme includes Standard Infection Control Precautions and details regarding key IPC policies. Other staff may require additional role specific essential IPC training, as identified between staff, their managers and / or the IPC team as appropriate. The systems for planning, advertising and ensuring staff undertake training are detailed in the Mandatory Training Policy and procedure. Staff who fail to undertake training will be followed up according to the policy.

Further training needs may be identified through other management routes, including Root Cause Analysis (RCA) and Post Infection review (PIR), following an incident/infection outbreak or following audit findings. Additional ad hoc targeted training sessions may be provided by the IPC team.

19 Monitoring Compliance

Compliance with this policy will be monitored as follows:

- Audit isolation practices.

As appropriate the IPC team will support Services' Leads to undertake reviews / SBAUR reports. Managers and Services' Leads will monitor subsequent service improvement plans and report to the IPC Governance Meeting.

Knowledge gained from reviews and SBAUR reports will be shared with relevant staff groups using a variety of methods such as reports, posters, group sessions and individual feedback.

The IPC team will monitor IPC related incidents reported on the Trust incident reporting system and, liaising with the Head of Risk and Governance, advise on appropriate remedial actions to be taken.

20 References

British national formulary 2020

National institute for health care and excellence (NICE) clinical skills summaries scabies https://cks.nice.org.uk/scabies~topicsummary Scabies NHS.UK

http://www.nhs.uk/conditions/scabie

21 Associated Documents

This policy should be read in conjunction with SCHT:

- Cleaning and Disinfection Policy
- Community Hospital Cleaning Policy
- Isolation Policy
- Linen and Laundry Policy

- Outbreak Management incorporating Bed and Ward Closures
- Standard Infection Control Precautions Policy

22 Appendices

Appendix 1 – Patient Has Rash – Letter

Shropshire Community Health
NHS Trust

Dear Sir or Madam,

You will be aware that _____ has been complaining of a rash and skin irritation.

The Medical team have diagnosed scabies and treatment will be started.

Scabies is an infectious condition and is passed from person to person by touch. People who are incubating the infection can pass it on before their rash or irritation appears.

If you have been in close contact with _____, it is strongly advised you contact your GP as soon as possible to be prescribed the appropriate treatment.

You may find the attached leaflet informative.

Please contact the ward if you have any queries.

Yours faithfully

Designation

Appendix 2 – Patient with NO Rash – Letter

Shropshire Community Health
NHS Trust

Dear Sir or Madam,

You may be aware that some patients on the ward have been complaining of a rash and skin irritation.

The medical team have diagnosed scabies and treatment will be commenced.

Scabies is an infectious condition and although your _____ does not have a rash, we would like to treat all our patients. This is because the incubation period for scabies is long and people are infectious whilst they are incubating scabies even though they have no symptoms.

You may find the attached leaflet informative.

Please contact the ward if you have any queries.

Yours faithfully

Designation

Appendix 3 – Staff

Shropshire Community Health
NHS Trust

To All Staff

You may be aware that a number of patients and/or staff on the ward/department have reported skin rashes. The medical team has confirmed that this is due to scabies.

Scabies is a very common infection and spreads from person to person by skin to skin contact. People are infectious whist they are incubating scabies and because of the long incubation period it can spread easily. To prevent the spread of scabies it is essential we treat everyone involved within a 24 hour period.

Following discussion with the SCHT Infection Prevention and Control Team and Occupational Health Department the following treatment plan has been developed. If you have symptoms which have been diagnosed by your GP to be scabies, you will require two treatments, one week apart.

It is absolutely essential that all your household contacts be treated when you complete your first treatment. If you do not ensure this happens then you may become re-infected from a member of your household.

Staff with rashes will also be given a letter to show their GP explaining why treatment is necessary.

If you are considered to be a contact and do not have a rash you will still need one treatment.

The cost of treatment for staff will be reimbursed following submission of a manual payment form which is available in the Scabies Policy, which is available on the staff section of the SCHT website; a receipt for payment is also required.

Please contact the contact the Occupational Health Department or Infection Prevention and Control team if you have any queries.

Your cooperation is essential and greatly appreciated.

Yours faithfully

Designation

Appendix 4 – Scabies Skin Monitoring Form for ALL Staff and Patients. (separate charts to be completed for staff and patients)

Name	Date rash appeared	Appearance of rash	Symptoms e.g. itching, excoriation	Areas affected	Name of scabicide prescribed	Number of times used and when	Person with rash is immuno-compromised	Person with rash is prescribed steroids, systemic or topical

Appendix 5 – Request for Reimbursement of Prescription Cost

Shropshire Community Health
NHS Trust

Shropshire Community Health NHS Trust

Request For Manual Payment

Supplier/Payee _____

Address _____

_____

_____

Payment In
Respect of _____

		£	p
Budget Code	___-___-___/___-___-___	_____	:_____
	___-___-___/___-___-___	_____	:_____
	___-___-___/___-___-___	_____	:_____
	___-___-___/___-___-___	_____	:_____
	___-___-___/___-___-___	_____	:_____
	___-___-___/___-___-___	_____	:_____
	___-___-___/___-___-___	_____	:_____
	___-___-___/___-___-___	_____	:_____
	Total Amount	_____	:_____

Vat Recoverable Y/N *

Date _____

Prepared by _____

Authorised by _____

Please tick box if the payment is URGENT ϒ

* Delete as appropriate

Appendix 6 – GP Staff Close Contact

Shropshire Community Health
NHS Trust

Dear Dr

Scabies Outbreak on……..…….……Ward……..…….……Hospital

Your patient ……..is a close contact of a member of staff who has a rash and symptoms of scabies. The staff member is currently receiving treatment.

To manage and control scabies it is essential all close contacts of those with rashes are treated once even when they have no symptoms. We would be very grateful if your patient, as a close contact, could be prescribed one treatment with an appropriate scabicide.

Your cooperation is greatly appreciated.

If you have any queries about this letter, please contact the ward on

Telephone number …….

Yours sincerely

Designation

Appendix 7 – Treatment Application

The cream or lotion **must** be applied meticulously to every part of the body. This may require assistance especially to apply to difficult to reach places.

Please ensure that you have enough cream or lotion to cover the whole of the body prior to starting application

- Do not take a shower or bath prior to treatment as this increases systemic absorption
- Skin must be dry and cool prior to cream/lotion being applied
- Take off all clothes remembering to remove jewellery, watches and rings
- Staff must wear disposable gloves and disposable plastic apron when applying treatment to patients
- If using a lotion, pour it into a bowl for ease of application then use disposable sponge/gauze for even coverage
- The lotion or cream must be spread all over the body including the face, scalp, neck, soles of feet, between toes, ears (especially behind the ears) under nails (finger and toe), naval, armpits, behind knees, groins and genitalia
- If using lotion allow this to dry completely before putting clothes back on or it may be rubbed off
- If the person has a wound or bandages then the bandages/ dressings should be removed and cream/lotion applied to 1cm from the edges of the wound and bandages/ dressings reapplied.
- Leave the cream or lotion on for the required time (see individual treatment)
- If during the treatment time hands or any part of the body is washed the cream or lotion must be reapplied
- If a patient is incontinent, following washing of the groin/sacral area the cream/ lotion must be reapplied every time
- If hands are washed during the treatment time the cream/lotion must be reapplied every time
- After the required contact time the cream or lotion should be washed off and clean clothes put on. All bed linen and towels should be changed. Linen and towels should be placed in red alginate bags if in a community hospital. Clothes should be washed in the usual way
- Breastfeeding mothers should remove the liquid or cream from the nipples before breastfeeding and reapply treatment afterwards.