



Title	Infection Control Manual Section 4.4 - Head lice Policy
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4.4 HEAD LICE POLICY

Aim: To provide advice on the rational use of head lice treatments in tandem with effective detection and preventative measures

Standards

- diagnosis must be made by appropriately trained medical or nursing staff
- further advice can be obtained by contacting a member of the IPCT.

General Information

Head lice are a common problem, which can affect a whole community, adults and children alike. Effective management of head lice infection depends on the ability of all relevant professionals and agencies to offer clear, accurate and impartial advice.

The adult head louse is very small (2-3mm in length) with the females being slightly larger than the males. They live close to the scalp and move about the head rapidly by gripping the hair with their claws. They have antennae, which are temperature sensitive and keep them close to the body's warmth.

Head lice actually prefer clean hair and are oblivious to socio-economic status. Patients should be advised of this to avoid stigma.

The female lays approximately 8 eggs daily (often at night) which are cemented firmly on to the hair shaft close to the scalp.

Eggs hatch within 7 to 10 days leaving the empty shells (nits) attached firmly to the hair.

The young lice (nymphs) feed by piercing the skin of the host and sucking blood. When they pierce the skin they inject saliva containing anaesthetic and anticoagulant so that the host blood can be sucked freely without the host experiencing pain. Lice feed about six times a day.

The nymphs can change colour once after they have hatched to blend to the colour of the host's hair. If they move to another host they are unable to change colour again.

The nymphs develop into sexually active adults within 10 days moulting three times as they grow. The adult louse may live for up to four to six weeks and the female may lay up to 300 eggs in her lifespan.

What to Look For:

There are a number of tell-tale signs, which are indicative of head lice infection:

- black gritty powder on collars and pillows - this is faecal matter from the lice
- cast skins on combs, pillows, chair backs etc. - these look similar to lice
- dead or dying lice floating on the surface of the water when the hair has been washed. These can be removed with a tissue for closer inspection
- persistent itching of the scalp. This is caused by an allergic reaction to the head louse saliva. It may take two to three months for the itch to develop the first time a person is infected with head lice although subsequent infections result in the itch developing more rapidly
- the presence of tiny white empty egg shells (nits) attached to the hair is indicative of head lice infection. The hair grows at about 1cm per month and therefore the distance the nit is from the scalp gives an indication of how long ago it was laid.

The hair should ideally be checked once a week using a proper detector comb on damp hair, [[See also the 'bug busting' method](#)]

The hair may either be divided into sections and carefully combed from the roots to the ends or combed forward from the nape of the neck to the forehead.

The hair should be combed over a piece of white paper or cloth to help identify any lice or nits which are combed out.

1. MANAGEMENT [the following guidance is <i>specific</i> to head lice and some only applicable to the hospital inpatient; other precautions may have to be taken following assessment of patient]	
Spread	Direct contact with the head of an infected person. Lice cannot jump or fly but can move readily through dry hair and can cross from person to person when heads touch.
Single room	Not always required; risk assessment must be performed based on likelihood of transmission in the care environment.
PPE	<p>Plastic Apron: must be worn by all members of staff having contact with patient/ linen and immediate patient environment.</p> <p>Gloves: must be worn by all members of staff having contact with patient/ linen and immediate patient environment.</p> <p>Facial Protection: unnecessary for head lice.</p>
Hand Hygiene	After contact with patient, contaminated articles or patients immediate environment. Gloves should be removed and hands washed and dried thoroughly. Instruct patient in hand washing technique as condition allows.
Linen	Treat linen as infected linen. (See Linen Policy).
Crockery, cutlery and medicine cups	Medicine cups are single-use disposable Routine domestic hot wash for other reusable items.
Clinical Waste	Routine disposal, unless otherwise indicated.
Cleaning of room	Routine cleaning, unless otherwise indicated.
Baths/ showers	Routine cleaning, unless otherwise indicated.
Charts	Not applicable unless patient requires isolation. Refer to isolation policy.
Laboratory specimens	See section 4.2. Routine collection and transport sufficient unless otherwise indicated.
Transporting patients	Receiving units must be informed of patient's status and any precautions required.
Visitors	Instruct visitors on correct precautions to take.
Terminal cleaning	Not required unless otherwise indicated; routine discharge cleaning sufficient.

2. TREATMENT

Hair should only be treated if there is evidence of head lice infection. Only currently, recommended insecticide preparations should be used.

Bug Busting approach: see NHS Borders Head Lice Policy for more details. For detection a proper plastic detector comb must be used. Metal ones are unsuitable for detection as they miss small nymphs, cause damage to hair and are designed for the removal of empty egg shells (nits).

For information on current recommended preparations please contact the Pharmacy Department.

These products should be applied following the manufacturers instructions.

Enough product should be used to provide complete cover of the scalp and hair. Particular attention should be paid to the areas behind the ears, at the nape of the neck and under the fringe as these areas tend to be warmer and may be more attractive to the lice.

The product should be left on for the recommended time.

Following treatment with either preparation, dead lice and eggs may be removed using a fine toothed comb on the damp hair.

Commercial cosmetic preparations are available which are promoted as loosening the cement on nits and eggs.

The hair should be checked thoroughly one week after treatment. Preparations are generally highly effective but if viable lice are found after a week, the treatment should be repeated carefully.

Treatment may also fail from either incomplete application of the original preparation or from re-infection from another infected person.

Close contacts of the infected person should have their hair checked on the same day as infection was originally identified if possible and if any signs of infection are found they should also receive treatment.

Shampoos are not recommended for the treatment of head lice. In use they are too dilute to be fully effective and are unable to kill the eggs. Thus repeated applications may be necessary to be effective and there is a greater risk of the lice developing resistance to more dilute formulations as well as increased risk of skin sensitivity.

Patients with asthma, eczema or psoriasis should not use an alcohol based lotion. The alcohol fumes may precipitate an asthma attack and the alcohol in the lotion may irritate sensitive or excoriated skin.

3. CONTACT TRACING
Contact Tracing is vital to prevent re-infection with head lice. It is now generally accepted that, although head lice infection is often originally identified in school children, the condition is frequently spread in the community by asymptomatic adults such as parents, grandparents and others. The very young and the very old tend to be less likely to develop the itch associated with head lice infection and so may remain asymptomatic indefinitely.
It is unlikely that a fleeting contact with an infected head will spread infection. It can take up to one minute for the space between two touching heads to warm up sufficiently to permit lice to move from head to head.
When a case of head lice infection has been identified, all those who are likely to have had close physical contact with that person should be advised to have their hair checked as soon as possible using a detector comb.
Those contacts who are also found to be infected should have their hair treated as soon as possible using an appropriate insecticide, ideally at the same time as the original person is being treated.
Only those who are infected be treated. This helps to minimise the development of resistance to the insecticides and the exposure of people to insecticides when they are not necessary.
If a child has been found to be infected with head lice, the child's school or playgroup must be informed by the parent.
4. PREVENTION
Regular brushing and combing of the hair can damage lice by e.g. breaking their legs resulting in the lice no longer being viable. Regular grooming is therefore recommended to help reduce the risk of infection developing.
Checking the hair regularly with a detector comb is the best way of preventing the development of head lice infection by identifying and treating any infection early.

If concerned, contact Occupational Health / IPCT for advice.