GUIDELINE FOR CONTROL AND MANAGEMENT OF HEAD LICE

TARGET AUDIENCE	NHSL wide, Acute, Health and Social Care Partnerships, School Nurses
PATIENT GROUP	All in patients and outpatients

Clinical Guidelines Summary

Head lice cause many problems because of society's reaction to them rather than the organism itself, they are not a serious health problem in this country.[1]

Infection with head lice (Pediculus humanus capitis) occurs on the hair, eyebrows and eyelashes. Lice are host-specific and those of lower animals do not infect man, although they may be present transiently. Infection can be transmitted whenever viable lice or eggs are present on an infected person, and requires intimate head to head contact lasting around one minute. Lice live for 7-10 days away from a host and eggs for about 10 days. They do not jump, swim or fly. The true prevalence of infection is unknown but is probably much lower than the public and professional perception.

INTRODUCTION

Head lice are parasitic insects that only live on human heads. There are three forms of head lice:

- Nits - are head lice eggs. Oval and yellow white eggs
- Nymphs - hatch from the nits.
- Adults - have 6 legs and are greyish white.

Head lice cause many problems because of society's reaction to them rather than the organism itself, they are not a serious health problem in this country.[1]

Infection with head lice (Pediculus humanus capitis) occurs on the hair, eyebrows and eyelashes. Lice are host-specific and those of lower animals do not infect man, although they may be present transiently. Infection can be transmitted whenever viable lice or eggs are present on an infected person, and requires intimate head to head contact lasting around one minute. Lice live for 7-10 days away from a host and eggs for about 10 days. They do not jump, swim or fly. The true prevalence of infection is unknown but is probably much lower than the public and professional perception.

Head lice are not a serious health issue in this country. They rarely, if ever, cause physical health problems other than itching of the scalp. Adverse health effects mainly derive, not from the lice themselves but, from the human perception of them.

- Excessive public and professional reactions lead to an inflated perception of prevalence, to unnecessary, inappropriate, or ineffective action, and to a great deal of unwarranted anxiety and distress.
- These actions and reactions in themselves cause problems, especially from the misuse and overuse of treatments.

Although frequently perceived as a problem of children, almost half the people with lice are adults and most infections are caught outside school. Grandparents, aunts and uncles are often sources of infection. Head louse infection is more a societal than an infectious disease problem. The control of head lice infection must therefore be recognised as the responsibility of parents and adults and not schools and school nurses.

Aim

- To ensure that staff and patients have access to the most current national guidelines and best practice.

Scope

Who is the Policy Intended to Benefit or Affect

This policy is designed to safeguard patients, staff and the wider public from the risk of Headlice.

The policy is aimed at all Healthcare Staff working in NHSL.

Who are the Stakeholders

Patients, Carers, relatives and staff.

Principle content

Symptoms

Only a minority of people with head lice have itchy scalps, or any other symptoms. When an itch does occur, it is because the sufferer has developed an allergy to the saliva of the lice following a prolonged period of sensitisation. Before sensitisation there are no symptoms and nothing but a careful search of the hair will confirm the presence of lice.

[1] Aston R, Duggal H, Simpson J & Burgess I "The Stafford Group" (1998) Head Lice Report, The Public Health Medicine Environmental Group.

Sensitisation is unlikely to occur before a child reaches school age; therefore, infected toddlers are unlikely to itch.
If a person has had lice for a long time, and then they become permanently desensitised and will never itch again in response to them. A desensitised adult therefore has no symptoms, and may become a permanent carrier of low numbers of lice in the community.

Control and prevention
Head louse infection is a problem of the wider community and not primarily of schools. To tackle the problem effectively there must be a shift towards a community based approach involving input from primary care teams, health visitors, pharmacists and the public as well as school nurses.

Families
The primary responsibility for the identification, treatment and prevention of head lice in a family has to lie with the parents/carers, if only for reasons of practicality.
Parents cannot however, be expected to diagnose current infection, or to distinguish it from successfully treated previous infection or other conditions, if they are not adequately instructed and supported by the following professionals/services/settings.

Primary Care Team
(Appendix 1: Notes and guidance for the Primary Care Team)
The primary professional responsibility for the diagnosis, management and treatment of any individual for any disease lies with the general practitioner with which the patient is registered.
General practitioners (or another member of the primary care team) should therefore be knowledgeable and competent in the control of head lice, be able to teach parents the technique of detection combing and be prepared to advise appropriate treatment. They also have a key role in the management of head lice in care homes.
Treatment should never be advised unless there is convincing physical evidence that living lice are present on the head of at least one of the family.

Pharmacists

(Appendix 2: Notes and guidance for Community Pharmacists)

Local pharmacists should inform themselves of local guidelines and should adhere to them. Customers should be dissuaded from the inappropriate, repeated or unnecessary use of insecticidal preparations.

Pharmacists (or another member of their staff) should be knowledgeable and competent in the control of head lice, be able to teach parents the technique of detection combing, and be prepared to advise appropriate treatment.

Treatment should never be advised unless there is physical evidence that living lice are present.

School Health Services

(Appendix 3: Notes and guidance for School Nurses)

The school nurses (or equivalent) have responsibility for professional advice to staff, parents and children in accordance with local guidelines.

They should provide clear, accurate and up to date information about head lice.

Following assessment of individual families/cases (ie- child protection), school nurses should be prepared to teach detection combing to individuals, to families (at their homes if appropriate), and to groups of parents, children and staff as required, and give advice on treatment and prevention.

They should not undertake head inspections as a routine screening procedure.

Health Visitors

Health visitors need to work closely with school nurses and other primary care staff in the control of head lice infections and in the management of outbreaks. They should be aware of local guidelines.

Health visitors should include education about the detection and management of head lice infection where required with families.

Schools

(Appendix 4: Notes and guidance for Head Teachers)

Head lice are not primarily a problem of schools, but of the community. Education professionals do, however, have a responsibility to offer support and advice to parents along with health professionals.

If a parent informs the school of head lice, the school could notify the school nurse where appropriate and dependant on the family individual circumstances.

If the school suspects that a child has head lice: they should in the first instance offer parental educational information and/or signposting to NHS Inform for advice. (https://www.nhsinform.scot/)

Routine Head Inspections

Routine head inspections in school by the school nurse, as a screening measure are without value and should not be done. Regular checking of children's heads is important but is a parental responsibility.

Alert Letters

'Alert letters' should not be sent to the parents of other children in the class of a child who may be infected with head lice.

THERE IS MORE THAN ONE REASON FOR THIS:

'alert letters' are not routinely sent out for other, more communicable disease or infections

- schools are likely to have few pupils with head lice at any one time and on that basis, an 'alert letter' could potentially be required every day of the year
- 'alert letters' can often lead parents to believe that there is an outbreak when in fact, only one child in the class may be infected. Those parents may then treat their own child preventatively, which is neither necessary nor advised
- only the parents of a child who appears to have head lice should be informed

Exclusion

The Education (Scotland) Act 1980, section 58 (5) and 6) makes it clear that it is an offence for a parent to send a child to school with recurrent infection due to their neglect. Head Lice may fall into this category.

EXCLUSION SHOULD NOT NORMALLY BE USED BECAUSE:

- it is an overreaction to a problem which is not a public health threat
- it cannot ensure the elimination of infection from the family of the child
- it is not used for other conditions of low transmissibility such as herpes simplex (cold sores)

Rather than consider exclusion of children from school, families with continuing or repeated head lice infection should be given concerted support and help by community and health professionals, as they would for any other infection.

Private nurseries and playgroups

If a parent/carer informs the person in charge of a private nursery, playgroup etc., of head lice, they should be advised by Nursery Staff where to seek information on treatment such as NHS inform or the family GP or Pharmacist.

Hospitals

If one or more cases of head lice are suspected or confirmed, the appropriate division Infection Prevention and Control Nurse should be contacted to advise about management, treatment and contact tracing.

Care Homes

If a case of head lice is suspected or has been confirmed, the patient or resident's GP should be contacted to advise about management of the case, treatment and contact tracing. If there are several cases advice should be sought from the Health Protection Team at the NHS Board.

The Health Protection Team

(Consultant in Public Health Medicine (Health Protection) and Infection Prevention and Control Nurse colleagues).

The CPHM (Health Protection) and colleagues are responsible for ensuring that a consistent approach is taken to head lice management throughout Lanarkshire. They will also give advice and guidance to professionals and the public if required.

Detection of Lice

Prevention of infection with head lice would be the ideal approach. Unfortunately, there is no current proven method of prevention. Regular grooming has often been recommended as a means of prevention, but there is little evidence of its effectiveness. Regular application of insecticides 'just in case' simply exposes individuals to chemicals unnecessarily and should be discouraged.

The closest to prevention currently available is early identification by regular detection combing.

Checking for lice should be performed at least once a week after washing the hair and applying conditioner to wet hair using the wet combing method. Household and close contacts i.e., those likely to have direct, prolonged head to head contact should be checked at the same time. The whole head must be examined, including the back of the neck and the area around the ears. A wide tooth comb should be used to remove tangles, followed by combing with a fine tooth comb from root to end, one section at a time, while the head is held over a white surface (e.g., tissue or a piece of paper towel or wash basin). The comb should be checked for live lice and cleared between each stroke and any lice removed.

Head lice are smaller than a match head and can be quite difficult to see. They become the colour of the darkest hair that they live on. Un-hatched eggs are near the scalp, but are very difficult to see, although the empty hatched eggs (nits) are white and easily seen. Lice also produce waste products that look like speckles of black dust, which may be present on bed clothing and/or collars.

Treatment

Where infection is found, treatment should be commenced promptly in all infected individuals.

Once infection is detected, there are three treatment options. One is to use insecticide lotion, another is silicone oil (such as dimethicone) and the third is removal by Bug Busting.

"Parents should" be offered information on all approaches so that they can make an informed decision for their family."

Insecticides

There are three main groups of insecticides that can be used for the control of head lice: malathion, carbaryl and pyrethroid compounds (phenothrin and permethrin). Carbaryl has now been designated as a potential human carcinogen and is therefore available only on prescription. However, it may be used as a second-line treatment in cases of resistance, subject to parental agreement.

Preparation Type
Lotions or cream rinses should be used in preference to shampoos. Shampoos are not in contact with the hair long enough and are usually diluted too much in use to be effective.
Aqueous formulations are preferred for asthmatic patients and small children to avoid alcohol fumes.

Application
A contact time of 12 hours or overnight is recommended. The lotion must be allowed to dry naturally on the hair and the hair should not be exposed to any source of direct heat. Twelve hours after application of the lotion, the hair should be washed with an ordinary shampoo. The application should be repeated after 7 days.
Chlorine may lessen the effect of insecticides, therefore it is recommended that if a person has been swimming in a chlorinated pool in the 72 hours prior to treatment, the hair should be washed and dried before the lotion is applied. Swimming need not be banned after treatment.

Safety of Chemical Treatment
The three groups of chemicals currently used have a good track record for safety over many years. The number of reported side effects recorded by the adverse drugs reactions section of the committee on safety of medicines is small. For example, there have been only 26 reported side effects to malathion (in 18 individuals) during more than 25 years of use.

Silicone Oils
Silicone oil coats head lice and interferes with the water balance of the head lice. It is not an insecticide, so resistance isn't a problem. They will advise on how to apply the oil, how long to leave it on the hair and when any repeat application is required for the treatment to be effective." Although the oils seem to work on the eggs, two applications are still recommended. The instructions on the packet should be followed carefully.

ALTERNATIVES TO INSECTICIDES

MECHANICAL REMOVAL OF LICE "BUG BUSTING"
An alternative option for dealing with head lice is wet combing, sometimes called 'bug busting'. This is a non-chemical approach that involves mechanical removal of all lice from the hair after the hair has been washed and conditioned. With the conditioner still in, the hair is combed gradually using a fine toothcomb, section by section, in order to remove the lice. Although this method can be effective it requires considerable effort and time. It is therefore not as effective as insecticide treatment but can be useful in certain circumstances. When a health adviser is quite sure that appropriate and thorough conventional treatment of a definitely diagnosed case of active current infection has failed, mechanical removal might be tried for individual cases and their families. It may also be considered when patients wish to avoid conventional treatment with insecticides.

REPELLENT
Proprietary products, which are claimed to repel lice, are not recommended. Even if they were effective in protecting the individual from infection they do not deal with the control of lice in the population and do not treat existing lice.

NOSTRUMS
Many and varied nostrums have over the ages been claimed to be effective in preventing or treating head lice. Some of these are usually harmless (e.g., dilute vinegar), some may be dangerous. Essential oils such as tea tree and lavender oil can be quite toxic especially as concentrates.

OTHER "CURES"
Other more eccentric "remedies" or "preventives" such as children wearing baseball caps on their heads throughout the day in school are not supported.

PERSISTANT OR RECURRENT HEAD LICE INFECTION
Some cases appear difficult to eradicate: there are three possible reasons for this:

- difficulty with treatment whether insecticide or 'bug busting'
- re-infection
- resistance

Where treatment appears to have failed a careful assessment must be made:

- was there a true infection before application?
- is there a current infection now?
- are the new lice those that have hatched since the first application?
- did the first treatment (two applications 7 days apart) fail?
- if so why? (enough lotion, properly applied, all infected heads treated)
- is this a re – infection following successful treatment?

If treatment (two applications 7 days apart) has been inadequate or there is re-infection:

- offer advice and support as appropriate
- repeat treatment using another product (ensuring correct treatment of case and contacts)

Thus families experiencing continuing or recurring head lice infection should be assisted and supported, as they would be if their child contracted any other infection. This should include co-ordinated and sustained support and help in the community (including the school) and from health professionals. Repeated head lice infection may be symptomatic of other family stresses of neglect.

If a child presents with consistent or repeated head lice infection despite information and support to parents to treat the recurring head lice infection, health professionals and school staff should jointly consider what action to take next. If the family is experiencing difficulties which prevent the parents from treating head lice infection effectively, they may need additional or special help from health service of local authority social work services at home. The Children (Scotland) Act 1995 requires local authority to safeguard and promote the welfare of children in need, with assistance of other agencies, including health services.

If resistance is suspected, consider sending lice for analysis (see below).

Testing for resistance
Several live lice should be collected by wet combing. To ensure that lice reach the testing centre alive they should be collected from the patient just prior to posting. To aid their

survival they should be sent in a universal container with a small piece of damp - not wet - tissue or cotton wool. Place the container in an envelope. On the back of the envelope write the name of your nearest town, the treatment already received by the patient, and include your full name and address. Send by FIRST CLASS post on the same day that lice were removed - they should survive if posted first class, any day from Sunday to Thursday for next day delivery. The resistance testing service is free of charge. **Send to: Medical Entomology Centre, Cambridge Road, Fulbourn, CB1 5EL**

Communication

Guidance will be launched and distributed as follows:

- Staff brief
- Hospital and Health and Social Care Partnership Hygiene Groups
- IPCT Lanarkshire First port
- NHS Lanarkshire external website.

Abbreviastions

NIPCM	National Infection Prevention and Control Manual
HCSW	Health Care Support Worker
HPT	Health Protection Team
IPCT	Infection Prevention and Control Team
SICPS	Standard Infection Control Precautions
TBPS	Transmission Based Precautions

References

Aston, R., Duggal, H., Simpson, J. & Burgess, I., The Stafford Group (1998) **Head Lice Report**, The Public Health Medicine Environmental Group

Scottish Executive (2003), **National Guidance on Managing Head Lice Infection in Children**, Edinburgh.

Appendix 1

NOTES AND GUIDANCE FOR THE PRIMARY CARE TEAM

GENERAL

- Head louse infection is not primarily a problem of schools but of the wider community.
- Health professionals can teach patients the technique of detection/wet combing, and advise appropriate treatment when there is a confirmed infection.
- Health professionals should be able to identify a louse at all stages of its development.
- Patients should be made aware that head lice are only transmitted by direct, head to head contact.

SPECIFIC

- If practical, consider nominating a member of staff to be responsible for advising patients on head louse problems. This may be a practice nurse or health visitor, but

other non-clinical staff may be appropriate as a first contact. If examination is thought necessary, referral can then be made.

- Liaise, as appropriate, with your local/community pharmacists, school nurses, health visitors, head teachers, infection control nurses, early year services and Consultant in Public Health Medicine.

Where possible, stick to the following principles of control:

- Definite diagnosis; a living, moving louse found by detection combing.
- Simultaneous thorough and adequate treatment of all confirmed cases with one of the standard chemical insecticidal lotions or silicone oils and a repeat of the same treatment after seven days, or the use of the wet combing method, also known as 'bug busting' every 3 days for up to 3 weeks.

- Ensure that patients are provided with information, advice and support. At a first consultation, it may be sufficient to ensure that they know how to undertake detection combing and what to do there are head lice present.
- Do not confirm a diagnosis of head louse infection unless you yourself have seen a living, moving louse, or you have physical evidence from the patients; ask them to stick one of the lice on a piece of paper with clear sticky tape and bring it in.
- Make every effort to discourage unnecessary or inappropriate treatment with insecticides.
- Only recommend treatment if a louse has been clearly identified (as described above). If you do recommend treatment, ensure that it is done adequately for the case and infected contacts.
- Ensure that patients know the correct use of insecticidal lotions and silicone oils – follow the British National Formulary's recommendation of two applications of the same lotion (not shampoo) seven days apart. Prescribe one bottle of lotion for each individual affected.
- Do not assume that "reinfections" or "treatment failures" are truly infections. Make sure that a louse is found or produced.
- Do not recommend re-treatment without first of all establishing that living, moving lice are still present after two applications of the same lotion seven days apart.
- Consider using one of the following treatment options: insecticide lotion; silicone oil (such as dimeticone); or wet combing ("bug busting").
- Bear in mind that different formulations of the same active ingredient may be differently efficacious. When a first treatment has definitely failed, it may be useful to try the same agent in a different formulation.
- The use of electronic combs, repellent sprays, or chemical agents not specifically licensed for the treatment of head louse infections, should not be supported.
- Do provide advice and support to families who do not wish to use insecticidal lotions.

Lotions, silicone oils and bug busting kits are all available on the Minor Ailment Service from pharmacists, on prescription from a doctor and from nurse prescribers (some practice nurses and health visitors). They are also available over the counter at pharmacies
Internet link: Community Hygiene Concern

Appendix 2

NOTES AND GUIDANCE FOR COMMUNITY PHARMACIST

GENERAL

- Head louse infection is not primarily a problem of schools but of the wider community.
- Pharmacists are an important source of advice on the management of head louse infection. They should be knowledgeable and competent on the subject, be able to teach patients the technique of detection combing, and be prepared to advise appropriate treatment.
- Pharmacists have an especially important role in limiting chemical treatment to true cases of infection, reducing unnecessary and inappropriate treatment, and thereby reducing the risk of further development of resistant strains of lice.
- Health professionals should be able to identify a louse at all stages of its development.
- Patients should be made aware that head lice are only transmitted by direct, head to head contact.

SPECIFIC

- If practical, consider nominating a member of staff to be responsible for advising patients on head louse problems.
- Liaise, as appropriate, with your local family practices, school nurses, health visitors, head teachers, infection control nurses, early years services and Consultant in Public Health Medicine.

Where possible, stick to the following principles of control:

- definite diagnosis; a living, moving louse found by detection combing;
- simultaneous thorough and adequate treatment of all confirmed cases with one of the standard chemical insecticidal lotions or silicone oils and a repeat of the treatment after seven days, or the use of the wet combing method, also known as ‘bug busting’ every 3 days for up to 3 weeks. Ensure that patients are provided with information, advice and support. At a first consultation, it may be sufficient to ensure that they know how to undertake detection combing and what to do if there are head lice present.

- Do not assume a patient has head lice unless you yourself have seen a living, moving louse, or you have physical evidence form the patients; ask them to stick one of the lice on a piece of paper with clear sticky tape and bring it in.
- Make every effort to discourage unnecessary or inappropriate treatment with insecticides.
- Only recommend treatment if a louse has been clearly identified (as described above).
- Ensure that patients know the correct use of insecticidal lotions and silicone oils – follow the British National Formulary’s recommendation of two applications of the same lotion (not shampoo), seven days apart.
- Prescribe one bottle of lotion for each individual affected
- Do not assume that “reinfections” or “treatment failures” are truly infections. Make sure that a louse is found or produced.
- Do not recommend re-treatment without first of all establishing that living, moving lice are still present after two applications of the same lotion seven days apart and after a full professional assessment as to the ways in which the family may not have complied carefully with the first attempt.
- Consider using one of the following treatment options: insecticide lotion; silicone oil (such as dimeticone); or wet combing (“bug busting”).

- Bear in mind that different formulations of the same active ingredient may be differently efficacious. When a first treatment has definitely failed, it may be useful to try the same agent in a different formulation.
- The use of electronic combs, repellent sprays, or chemical agents not specifically licensed for the treatment of head louse infections, should not be supported.
- Ensure that you can provide patients with an effective detection comb. This will have rigid plastic teeth set no more than 0.3 mm apart.
- Do provide advice and support to families who do not wish to use insecticidal lotions.

The '**Bug Buster Kit**' is now available for prescribing by health professionals. Only one kit is required for a family and it is reusable. The kit, which includes an illustrated guide and combs, is available from some pharmacies and by mail order from:

Community Hygiene Concern, (Charity Reg No: 801371), 6-9 Manor Gardens, London, N7 6LA, Helpline: 020 7686 4321, Internet: www.chc.org

Appendix 3

NOTES AND GUIDANCE FOR COMMUNITY PUBLIC HEALTH NURSING TEAM

GENERAL

- Health professionals should be able to identify a louse at all stages of its development.
- Parents and staff should be made aware that head lice are only transmitted by direct, head to head contact.

SPECIFIC

- Routine head inspections should never be undertaken as a screening procedure. Detection combing should be done by parents, but it is important that staff can give them proper information, advice and support, **when required advising on the following principles of control:**
    - definite diagnosis; a living, moving louse found by detection combing
    - listing and examination of contacts by the family
    - simultaneous thorough and adequate treatment of all confirmed cases
    - repeat of the same treatment after seven days or the use of the wet combing method, also known as 'bug busting' every three days for up to three weeks
- Be able to make a professional assessment of reported cases of head louse infection of any child.
- Do not diagnose head louse infection unless you yourself have seen a living, moving louse, or you have physical evidence from the parents.
- educational establishments should not issue "alert letters" to other patients/carers, but may issue regular updates to parents and carers, perhaps in newsletters, reminding them of their responsibility to check their children's hair at least once a week using the wet combing method.
- Familiarise yourself with the correct use of insecticidal lotions, silicone oils (such as dimeticone) and wet combing ("bug busting") to advise parents and carers.
- Make every effort to discourage unnecessary treatment with insecticides.
- Do not recommend re-treatment without first of all establishing that living, moving lice are still present after two applications of the same lotion seven days apart. Or if the family were using the wet combing method also known as 'bug busting', ensure they have repeated the process every three days for up to three weeks.
- Be prepared to do a home visit if that is the most tactful and effective way of dealing with a head lice problem within a family (ie- child protection cases). You have the professional skills and training to educate, persuade, inform, guide and support them.
- The use of electronic combs, repellent sprays, or chemical agents not specifically licensed for the treatment of head louse infections should not be supported.

The '**Bug Buster Kit**' is now available for prescribing by health professionals. Only one kit is required for a family and it is reusable. The kit, which includes an illustrated guide and combs, is available from some pharmacies and by mail order from:
Community Hygiene Concern, (Charity Reg No: 801371), 6-9 Manor Gardens, London, N7 6LA, Helpline: 020 7686 4321, Internet: www.chc.org

Appendix 4
NOTES AND GUIDANCE FOR HEAD TEACHERS

GENERAL

- Head louse infection is not primarily a problem of schools but of the wider community. It cannot be solved by the school, but the school can help educate the local community to deal with it.
- Head lice are only transmitted by direct, head to head contact.
- Head lice will not be eradicated in the foreseeable future, but a sensible, informed approach, based on fact not mythology, will help to limit the problem. Education of parents in reliable detection is the first step towards overcoming the head lice problem.
- At any one time, most schools will have a few children who have active infection with head lice. This is often between 0% and 5%, rarely more.

SPECIFIC

- Ensure you have a written protocol on the management of head lice infection, based on the national guidance.
- Keep individual reports confidential, and encourage your staff to do likewise.
- Ensure that your parents are given regular and reliable information, including instructions on proper diagnosis by detection/wet combing, the avoidance of unnecessary or inappropriate treatments, and the thorough and adequate treatment of definitely confirmed infections and their contacts using either an insecticidal lotion or the 'bug busting' technique as described in the national guidance and NHS Inform website.
- Advise concerned parents to seek the professional advice of ~~the school nurse~~, the family practice, or a pharmacist.
- "Alert letters" should never be sent out to other parents.
- Children who have, or are thought to have, head lice should not be excluded from school.

DO NOT routinely exclude children simply because they have head lice.
DO NOT recommend or support any mass action, including wet combing campaigns unless as part of an overall health education package.
DO NOT agree with angry parents that routine head inspections should be reintroduced. They were never effective.
DO NOT refer parents directly to the Consultant in Public Health Medicine (CD & EH). The appropriate clinical advisors are the school nurse, the local pharmacist, the health visitor, and the general practitioner.
DO NOT take, or support, actions simply "to be seen to be doing something" (such as sending out "alert letters").

The '**Bug Buster Kit**' is now available for prescribing by health professionals. Only one kit is required for a family and it is reusable. The kit, which includes an illustrated guide and combs, is available from some pharmacies and by mail order from:
Community Hygiene Concern, (Charity Reg No: 801371), 6-9 Manor Gardens, London, N7 6LA, Helpline: 020 7686 4321, Internet: www.chc.org

Author:	**Infection Prevention & Control Team**
Responsible Lead Executive Director:	**Director of Public Health/Executive Director of Nursing**
Endorsing Body:	**Infection Control Committee (ICC)**
Governance or Assurance Committee	**Public Health Governance Committee**
Implementation Date:	**August 2024**
Version	**6**
Review Date:	**August 2027**
Responsible Person	**Director of Public Health**

CHANGE RECORD			
Date	**Author**	**Change**	**Version No.**
24-11-2016	Health Protection Team/Infection Prevention and Control Team	Policy reformatted.	3
12-12-2019	Governance Review Group	Updated in line with the Vale of Leven requirements	4
29-03-2021	Governance Review Group	Updated in line with national guidance	5
24-07-2024	Governance Review Group	Reviewed and updated in line with NHSL guidance.	6

CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	• Health Protection Team • Infection Prevention and Control Team
Consultation Process / Stakeholders:	• Health Protection Team • Infection Prevention and Control Team • Corporate Management Team • PSSD • Microbiologists • Infection Control Doctor • Lead Antimicrobial Pharmacist • Chief Nurses • Chief Medics • School Nurse and Health Visitor Teams • IPC Care Home Liaison Team
Distribution:	• Available to NHS Lanarkshire staff via Firstport