

**Management Team**

Date: January 3, 2013

Time: 9:30 a.m.

Place: Fairmount Boardroom

Members: Julie Shillington      Mary Lake  
              Deb Crawford         Gail Williams  
              Tom Mercer             Rosemarie Christian Jones

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1. Welcome and Introductions
2. Adoption of Minutes of the Previous Meeting
3. Additions to Agenda under Other Business
4. Delegations
5. Communications
6. Business Arising out of Minutes
  - a) Dietary Workflow (LTS Consulting)
  - b) **"We Love Your Opinion" Book**
  - c) Finger Food Policy
  - d) Evacuation Chair Instruction Sheet/Numbered Labels
  - e) Scent Awareness Policy
  - f) Locking Doors for 1North Care Carts/Care Cart Curtain Repairs/Replacement
  - g) Well Project
  - h) Fire Drill Scenarios
  - i) Snoozelen Policy
  - j) Fire Plan Updates
  - k) Emergency Callback Exercise
  - l) Door/Door Frame Protection for Med Rooms
  - m) Evacuation Sites re Emergency
  - n) 1North Humidity RFP
  - o) Ethics Policy
  - p) Garbage Receptacle Lids (Pathways)

6. Business Arising out of Minutes

- q) Bomb Threat Exercise
- r) Missing Resident Exercise
- s) Resident Wall Unit Repairs
- t) Clinical Chart Policy Update re Sections/Filing of Electrical Checklists
- u) Location of Evacuation Lists
- v) MSDS Binder Updates
- w) Scabies Checklist/Policy
- x) 2North Chart Room Set-Up for Documentation Assistants
- y) Removal of Black Marks on Resident Room Floors
- z) Storage Unit
- aa) Phone/Power Outage Communication
- ab) Lift/Repositioning Policies
- ac) New Performance Appraisal Format
- ad) Clean Linen Cart Cover
- ae) Accreditation Report (due January 10, 2013)
- af) Cleaning of 1st and 2nd Floor Servery Sinks on PM Schedule
- ag) Annual Cleaning and Sanitizing of Cambro Ice Unit and Ice Machines on PM Schedule
- ah) Chair Count for Resident/Family Christmas Dinner
- ai) Staff Body Mechanics when Doing Dishes
- aj) 2North Tub Room - Removal of Hard Water Scale
- ak) 2South Refrigerator Interior Cleaning
- al) Management Inspection Schedule for 2013
- am) Fire Pull Cover (2North - End of North Hallway)
- an) Staff Survey
- ao) Swipe Verification Form
- ap) 11-7 Duties for PSW (weights)
- aq) Butterfly Symbols (palliative resident doors)
- ar) Incontinence Products
- as) LTC Protocols re Antibiotic Stewardship
- at) Bed Alarms
- au) Purchase of TV by Family (1South Activity Room)
- av) Survey of Nursing Supplies for Residents

7. New Business

- a) Resident Care – Compliance, Accreditation, Classification
    - i) Compliance
    - ii) Accreditation
    - iii) Residents' Council Update
    - iv) PIDAC Document-Identify and Track Infections
    - v) Proposed Amendments re Admissions Process for Short-Stay Convalescent Care Program Beds
    - vi) One-Time Investment for High Acuity Residents
    - vii) One-Time Investment in Training and Development for LTC Staff
  - b) Support Services
  - c) Treasury
  - d) Administration
    - i) Concerns
    - ii) Risk ID's
    - iii) Work Plan
  - e) Human Resources
    - i) Staffing
  - f) Health & Safety
    - i) Monthly Fire Drill
    - ii) Management Inspections
- Schedule:**
- Julie** – June 13, 2013, November 7, 2013
  - Tom** – February 8, 2013, July 11, 2012, December 12, 2013
  - Rosemarie** – March 7, 2013, August 8, 2013, January 11, 2014
  - Gail** – April 11, 2013, September 12, 2013
  - Mary** – May 9, 2013, October 10, 2013
- g) Information Technology
  - h) Communications
  - i) Education Information Sharing (Staff Attendance at Conventions/Workshops)
  - j) Quality Improvements/Audits
    - i) Hazard Analysis Report (Quarterly-Feb)
    - ii) Complaint Documentation Report (Quarterly-March)

j) Quality Improvements/Audits

iii) Symptoms Report (Monthly-Dec. due in Jan.)

iv) Near Misses/Incident Reports (Quarterly-Feb)

v) Restraint Audits (Monthly – done the 3rd week, report the 4th week)

8. Other Business

9. Confirmation of time, date and location of next meeting

10. Adjournment

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Subject: Scabies

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Objectives:

- To have a standardized protocol for diagnosing and treating scabies

Preamble:

**ISSUES**

1. Scabies is a parasitic infection that can occur in long-term care facilities.1-3
2. It is highly contagious and can result in outbreaks in LTC if not contained.1-3
3. The diagnosis of scabies is often based on clinical history and skin lesions in the absence of microbiological diagnosis.1,2,4
4. Scabies *should* be considered as the cause of any undiagnosed pruritic skin rash.
5. An outbreak is an increase incidence over the baseline rate.

**OBJECTIVES**

1. Prompt diagnosis of scabies based on history and examination of skin lesions.
2. Prompt treatment of scabies to prevent outbreaks.
3. Implementation of infection prevention and control measures to contain the spread of scabies in LTC.

**ETIOLOGY**1-4

Scabies is caused by infestation of the skin by a mite, *Sarcoptes scabiei var. hominis* which belongs to the arthropod class. It is an obligate parasite that completes its entire life cycle on humans. *Sarcoptes scabiei* undergoes four stages in its life cycle with only female mites burrowing into the skin. The maturation process lasts about 15 days with larvae appearing approximately 3-4 days after the eggs are hatched.

**TRANSMISSION**1,2,4

1. Scabies is passed primarily by direct skin-to-skin contact with an infested person. However, crusted (Norwegian) scabies can spread with only brief skin-to-skin contact due to its high volume of mites.
2. Avoid direct skin-to-skin contact with any infested resident.
3. Contact with items such as bedding, clothing and furniture of infested residents is also a source of transmission.

**RISK FACTORS**1,2,4

1. Elderly
2. Institutionalized
3. Immunocompromised

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4. Failure to recognize an infestation
5. Failure to treat close contacts including health care workers

**DIAGNOSIS**<sup>1,2,4</sup>

The most common symptoms of non-crusted or typical scabies are pruritus with a skin rash and possibly visualization of burrows. The pruritus is usually worse at night.

Tiny burrows sometimes are seen on the skin caused by the female scabies mite tunneling just underneath the skin surface. Burrows appear as tiny, raised and crooked grayish-white or skin-coloured lines on the skin surface. They are often found in the webbing between the fingers, in skin folds on the flexor surfaces of the wrist, elbow or knees and on the breasts and penis.

For a *primary* infestation with scabies mites, symptoms may not appear for 2-6 weeks after being infested. For a *secondary* re-infestation with scabies, symptoms appear as soon as 1-4 days after exposure.

An infected person can transmit scabies while being asymptomatic.

The pruritus caused by scabies is due to a hypersensitivity reaction to both the mites and their feces. Itching may continue for several weeks after treatment even if all the mites and eggs are killed. It is important to continue to monitor the rash areas for continuation of spread as this will indicate that the treatment has been unsuccessful and needs to be repeated.

**Crusted (Norwegian) Scabies**<sup>1,2,4</sup>

This was initially described in Norwegian leprosy patients. It is a more severe presentation of infestation that often affects the elderly, the immunocompromised or those with neurological conditions such as neuropathies or being cognitively challenged that prevent them from noticing pruritus and/or scratching. It is characterized by marked thickening and crusting of the skin (hyperkeratosis dermatosis<sup>5</sup>), particularly on the hands, although the entire body including the face and scalp can be affected. The mites in crusted scabies are much more numerous (up to 2 million mites per patient<sup>4</sup>) resulting in those who are infected being much more contagious. It is a common cause of institutional outbreaks of scabies.

Definite diagnosis occurs with skin scrapings identifying mites, mite eggs or mite fecal matter (scybala) under low light microscopy.<sup>1,2,4</sup> In order to obtain a sample, scrape the skin with razor blade and place skin specimens in a sterile container with 70% rubbing alcohol (just enough alcohol to cover bottom of jar). Place the labelled container with a public health requisition in a specimen bag and have it transported to a public health laboratory.

A negative skin scraping from a person with typical scabies does **not** rule out scabies infestation.

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**TREATMENT**<sup>1,2,4,5</sup>

- If scabies are suspected, the Physician or NP will be notified immediately
- The Physician or NP shall prescribe a cream or lotion
- One treatment usually kills the mites. If treatment is effective, no new burrows or rashes should appear within 24 to 48 hours after treatment. **Note: itching can persist for weeks after mites are eradicated**
- If you see a new rash or a continuation of previous rashes, contact the physician or NP, who may order a second treatment

First Line

The first line drug is topical permethrin cream 5% which is the most effective topical agent with minimal treatment failures and low toxicity<sup>5</sup>. The cream must be applied to the whole body from the neck down to the feet and toes including skin folds, finger and toenails, behind the ears and the groin. Do not apply the cream to the head or face. If the patient washes any area where the cream has been applied during the treatment period, it must be reapplied.

Apply 1 application topically to the skin and wash off thoroughly after at least 8 hours, but no more than 14 hours. A second application may be repeated 1 week later.

Do **not** use permethrin 1% solution which is used to treat head lice since this has been shown to be ineffective in treating scabies.

Second Line

Oral ivermectin<sup>6</sup> appears to be more effective than both placebo and lindane but less effective than topical permethrin.<sup>5</sup> It is given as a single dose of usually 3-12 µg (150-200 µg/kg) on an empty stomach. Ivermectin is contraindicated in children under the age of five, those that weigh less than 15 kg<sup>7</sup>, those who are breastfeeding, and those who have a hepatic or renal disease. In Canada, ivermectin is a special access drug (<http://www.hc-sc.gc.ca/dhp-mpps/acces/drugs-drogues/index-eng.php>).

Oral anti-histamines may be used to control the itching as needed. Topical and oral antibiotics may be used to treat skin infections such as impetigo and cellulitis as indicated.

**MANAGEMENT**<sup>1,2,4</sup>

1. The infested resident, his or her family and any close contacts including health care workers **must** be treated at the same time, regardless of whether they are symptomatic.
2. If there are 2 or more cases of scabies identified on a particular unit, strong consideration should be given to prophylactically treating all residents and staff on the unit.
3. Initiate Contact Precautions (gowns, gloves) for residents diagnosed with scabies. Precautions must remain in place until effective treatment has been completed.
4. Identify all family members, friends and staff including health care workers who have had direct contact and exposure with the infested resident(s) and/or to clothing, bedding and furniture for the 6 weeks prior to the diagnosis of scabies. Inform them about the diagnosis and the need to watch

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for symptoms. If they have had several contacts with the resident, they should receive prophylactic treatment.

5. Visitors should use the same contact precautions and protective clothing as staff, when providing direct care.

6. Clean hands thoroughly after providing care to any infested resident.

7. Asymptomatic staff can return to work the day after receiving prophylactic treatment.

8. Symptomatic staff can return to work the day after receiving treatment.

9. Ensure bedding and clothing used by an infested resident within the last 3 days is collected and transported in a plastic bag. These need to be machine washed using hot water and dried using high heat cycles (T > 50oC for at least 30 minutes).<sup>4</sup> If hot water is unavailable, place all linen and clothing into plastic bags for one week. **Cleaning of clothing and linens needs to be done at the same time as treatment to effectively manage the spread of scabies.**

- Non-washable items can be put in the dryer for 30 minutes, dry cleaned or stored in a sealed plastic bag for 10 days
- Footwear such as slippers, etc. – if washable, wash or put in dryer as explained above -if leather, vinyl, etc., no special treatment required

10. Thoroughly clean and vacuum the room of the infested residents. Disinfect furniture and surfaces in the resident rooms. Steam cleaning of upholstered furniture may be necessary.

- Chairs, couches, etc. can be vacuumed. The vacuum bag will be disposed of immediately after using it

11. Continue to monitor all residents for rashes for the next 6 weeks (incubation period of scabies).

12. Consult Infection Control at Public Health for further guidance on management of scabies.

13. There may be reimbursement for staff treatment through WSIB and the HIN program.

#### REFERENCES

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