

National Guidance

on Managing Head Lice Infection in Children



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National Guidance

on Managing Head Lice Infection in Children

Foreword



Head lice are a common problem, which can affect anyone, but are most prevalent amongst children.

This national guidance has been written to clarify the respective responsibilities of the health service, local authorities and schools, and other care services on managing head lice infection in children. We are aware that there is currently a lack of consistency and clarity in the advice provided for parents and carers across Scotland. This guidance is intended to address that by promoting a more consistent approach to policy and practice.

We want to ensure that all children and their families or carers have access to accurate, up-to-date and impartial advice and support on detection and treatment of head lice. The Health Education Board for Scotland (HEBS) is preparing a leaflet for parents to complement the advice provided for professionals in this guidance.

Many colleagues and partners from health and education backgrounds have contributed to the development of the guidance and we are very grateful to them. All NHS Boards, local authorities, school nurses, head teachers and a wide range of other health and education professionals, now have an important role to play in taking forward this guidance to ensure effective management of head lice infection in children. A sustained and joined up approach from everyone involved will ensure that the problem is dealt with effectively, and without stigmatising children or families.

A handwritten signature in black ink that reads "Malcolm Chisholm". The signature is written in a cursive style.

Malcolm Chisholm, MSP
Minister for Health
and Community Care

A handwritten signature in black ink that reads "Cathy Jamieson". The signature is written in a cursive style.

Cathy Jamieson, MSP
Minister for Education
and Young People



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Aim

Head lice are a common problem, which can affect the whole community, adults and children alike. However, head lice infection is most common amongst children and this guidance is intended to offer advice to health, education and social work professionals on managing head lice infection in schools and other child care settings such as hospitals, nurseries, out of school clubs and residential and foster care. Although this guidance is aimed specifically at the management of head lice infection in children, the same principles would apply for the management of head lice infection in adults.

The 1998 Stafford Report, *Guidelines on the Diagnosis and Treatment of Head Lice*, gave rise to changes in the way head lice infection is managed and where the responsibility for detection lies. This guidance seeks to disseminate learning from the Stafford Report and take forward implementation of some of its recommendations.

The Stafford Report states:

'Head lice are not primarily a problem of schools, but of the community. Stigma and tradition, however, combined with inadequate public and professional knowledge continue to hold schools responsible.'

Effective management of head lice infection depends on the ability of all relevant professionals/agencies to offer clear, accurate and impartial advice and support to parents on detection and treatment.

The control of head lice is not the responsibility of any one agency alone.

Most NHS Boards in Scotland have developed their own guidelines on the management of head lice infection. Whilst dealing with the problem remains a local responsibility, the Scottish Executive is aware of concerns about the current lack of consistency in the advice and procedures for managing head lice infection across Scotland. This guidance therefore seeks to promote a more consistent approach to policy and practice.

Throughout this guidance, the term "parents" includes all those with parental responsibility, including carers.

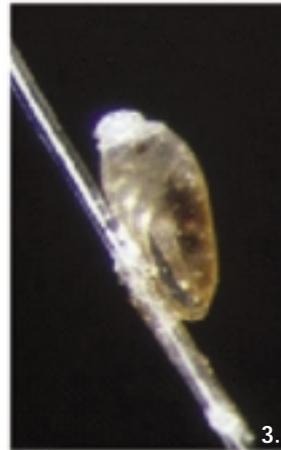
What are head lice?

Head lice are small, six-legged wingless insects which are pin-head size when they hatch, less than match-head size when fully grown and are grey/brown in colour. They are difficult to detect in dry hair even when the head is closely inspected. Head lice can cause itching, but this is not always the case.

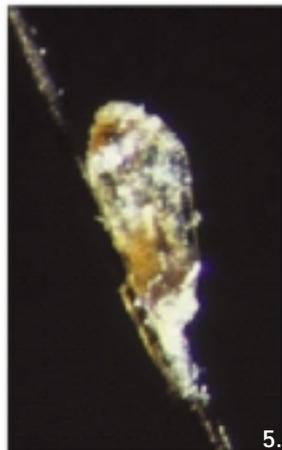
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Images to Assist in the identification of head lice and their eggs



1. Adult female louse on nit comb
2. Viable egg on hair ~2 days old
3. Viable egg ~1 day before hatching
4. Empty egg (hatched)
5. Dead egg (>2 weeks old)
6. 'Pseudo-nit' (Debris often confused as eggs)



©2000 President and Fellows of Harvard College <http://www.hsph.harvard.edu/headlice.html>

Head lice live on, or very close to, the scalp at the base of the hair, where they find both food and warmth. They feed through the scalp of their host. The female louse lays eggs in sacs which are very small, dull in colour and well camouflaged. These are securely glued to hairs where the warmth of the scalp will hatch them out in 7 to 10 days. Nits are the empty egg sacs, which are white and shiny and may be found further along the hair shaft as the hair grows. Nits are often easier to see than the head lice themselves. Many people mistake the empty egg sacs – or 'nits' – for head lice or believe that it is evidence of an active head lice infection. This is not true; it is evidence of a previous infection.

A head lice infection cannot be diagnosed unless a living louse has been found on the head.

During their life span of one month, head lice will shed their skin up to three times. This skin, combined with louse droppings, looks like black dust and may be seen on the pillows of people with head lice.

Head lice cannot fly, jump or swim; they are contracted only by direct head to head contact. Contrary to popular belief, the length, condition or cleanliness of hair does not predispose any particular group to head lice infection.

Anyone with hair can catch head lice, meaning that the problem, whilst often more prevalent in children, is not unique to them.

Whilst cleanliness is not related to contracting a head lice infection, regular hair washing and combing does offer a good opportunity to detect any infection so that it can be treated. Head lice cannot be prevented, but daily hair brushing and grooming can aid early detection.

Responsibility

The Stafford Report states that,

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

Previous practice relied on the school nurse conducting regular inspections of pupils for head lice. The Stafford Report recommends that parents are best placed to be responsible for regularly checking their children for head lice. There are sound reasons for this.

The first, and most important, is that 'wet combing' (see below) is the only truly effective way to carry out an inspection. Inspections in school by the school nurse were conducted on dry hair and were not, therefore, effective. To be effective, inspection also needs to be done on a regular basis. Inspection of a whole class of school children on one day will not detect a child who may become infected the next or any other day. School inspections are time consuming and can never be done on a sufficiently regular basis to make any real impact.

The Stafford Report also highlighted the importance of de-stigmatising the identification of head lice for children and parents, by moving away from school inspection.

Regular checking of children's heads is important, but it is a parental responsibility.

Education and health professionals do, however, have a key responsibility to offer supportive advice to parents about how to identify and treat infections effectively.

Head lice infection can be distressing and disturbing for children and parents. However, head lice are not harmful, and children and parents should be re-assured that having head lice is nothing to be ashamed of. There are many misleading notions about head lice, and helping parents and children to understand the facts is crucial in de-stigmatising head lice infection.

Schools have a key role in this, and can provide valuable support by issuing comprehensive information about head lice detection and treatments to parents that includes information about sources of advice.

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Detection

The Stafford Report highlighted that weekly checks, by 'wet combing', are the most effective method of detection.

'Wet combing' involves washing the hair and applying conditioner, then combing through with a wide-tooth comb to remove tangles. Taking a section at a time, a fine tooth detection comb is then pulled downwards through the hair, keeping the comb close to the scalp (where head lice are often located). The comb is checked for lice after each section. The comb must be fine enough to catch the lice and a pharmacist should be able to recommend a comb for this purpose, if parents are in any doubt. This process should be completed weekly. If head lice are found, all other family members should be checked and, if necessary, treated. Checks should be continued following treatment to ensure that it has been effective and to detect any re-infection.

Treatment

Once infection is detected, there are two treatment approaches. One option is the use of insecticide lotions and an alternative is removal by wet combing, sometimes called 'bug busting'. Both methods require continued combing to remove any unhatched eggs.

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

Re-infection can occur if a child has direct head to head contact with someone else who has head lice. It is likely that a child will become re-infected unless the whole family, and all those who have been in close contact with the child, have been checked and, if live lice are found, treated.

Insecticides

There are a number of different insecticide lotions available and pharmacists, GPs and school nurses should provide advice to parents about these on request or where they have identified/confirmed the presence of a head lice infection. School nurses, health visitors, pharmacists or GPs can give advice on which particular lotion is the most effective. The advice of a health professional should also be sought where whoever is being treated is under 1 year of age, suffers from asthma or allergies, or is pregnant or breastfeeding.

One treatment using insecticide lotions involves two applications of the same insecticide, seven days apart. This is because insecticide lotions do not kill any eggs that may be present at the time of the first application. If eggs hatch and are not treated, the infection will continue. This treatment should be applied by parents at home.

If live head lice are discovered after the second application, the advice of a health professional should be sought before any further lotion treatment is applied.

Insecticide treatment should never be used as a preventative measure as the use of insecticidal products on a regular basis may result in insecticidal resistance. Insecticide lotions should only be used when a living louse has been found on the head.

'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 tooth comb, section by section, in order to remove the lice.

'Bug busting' is time consuming and to be effective, must be carried out every 3 days for up to 3 weeks to remove newly hatched lice. Insecticide treatments offer a more immediate solution to a head lice infection, but some parents may have concerns about using these sorts of treatments.

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
Help Line: 020 7686 4321
Internet: www.chc.org

Other treatments

As there is little evidence of clinical effectiveness, we cannot recommend the use of alternative methods of treating head lice such as aromatherapy, tea tree oil or 'electronic zappers'. However, the guidance will be updated should new evidence come to light.

Prescription of treatments

District nurses and health visitors (and those practice nurses who have a district nurse or health visitor qualification) who have had additional training are allowed to prescribe from a limited Nurse Prescribers Formulary, which includes head lice treatments. The number of nurses who are able to undertake this training will increase from April 2002, and the formulary will be widened to cover all over the counter medicines including all pharmacy only medicines and around 140 prescription only medicines. We anticipate that a significant number of practice nurses will adopt this new role, as will some school nurses.

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The Scottish Executive, through *The Right Medicine: A Strategy for Pharmaceutical Care in Scotland*, is working towards allowing community pharmacists to prescribe medicines free of charge to treat common conditions, such as head lice, for those who are normally exempt from prescription charges, to save them having to visit their GP for a prescription.

A Patient Group Direction (PGD) may be an effective local mechanism to improve access to head lice treatments. A PGD is a locally agreed protocol, produced within an established framework which allows nurses (or others, including pharmacists) to issue a specified medication to a specified group of patients in specified circumstances.

Families will be able to get free prescription treatments for head lice infection for their children from a variety of sources, and will not have to wait for a GP appointment.

'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.

Firstly, 'alert letters' are not routinely sent out for other, more communicable diseases or infections. Secondly, most schools are likely to have a few pupils with head lice at any one time. On that basis, an 'alert letter' could potentially be required every day of the school year.

'Alert letters' also often lead parents to believe that there is an 'outbreak' when in fact, only one child in the class may be infected. Those parents might then treat their own child preventatively, which is neither necessary nor advised.

Only the parents of a child who appears to have a head lice infection should be informed, in writing or by telephone. This should be handled sensitively as it may be distressing for parents. Schools should also take account of the needs of parents for whom English is not their first language, or who may have difficulty in reading.

Schools, working with the school nurse, should helpfully provide parents with information about the detection and treatment of head lice infection in a proactive and systematic way, at the start of every new term as well as at any point in the school year when a general (rather than individual) problem has been identified. For example, monthly reminders or 'flyers' can be sent home from school, informing and reminding families about detection through 'wet combing' and general grooming.

Exclusions

The power to exclude a pupil from school and the circumstances in which that power may be exercised are set out in regulation 4 of the Schools General (Scotland) Regulations 1975 as amended. The power to exclude rests with education authorities who are required to establish and operate local exclusion guidelines.

The 1975 Regulations state that education authorities shall not exclude a pupil from school unless certain specific circumstances prevail.

There are a number of statutory provisions concerned with exclusions, ensuring the cleanliness of pupils, and preventing the spread of disease among schools. Head lice infection is not considered to constitute a disease or a danger to health.

The Scottish Executive's view is that exclusion is a serious disciplinary measure that should only be used in appropriate circumstances as a last resort, and should not be used to manage head lice infection as a matter of course. Parents should also be advised that it is not necessary to keep children off school because they have head lice. Missing school means that pupils may miss out on learning, and it can be difficult for them to catch up. Exclusion risks stigmatisation and can have a serious impact on a child or young person's self-esteem. Children and young people may also feel discouraged and may, inadvertently, be disengaged from learning altogether.

Persistent or recurrent head lice infection

A distinction between re-infection and a continuing infection should be made. If a child still has head lice following full treatment, their parents should take them to a health professional to establish whether it is a re-infection, or if previous treatment has not been effective.

If insecticide lotions are not applied properly or the second application is not given, the treatment will not be effective. Similarly, the 'bug busting' approach will not be effective unless parents continue the process every 3 days for up to 3 weeks and have successfully removed all the head lice and eggs.

A major cause of concern for parents is re-infection of children who have been treated following contact with children who have not.

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 or 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 the health service or local authority social work services at home. The Children (Scotland) Act 1995 requires the local authority to safeguard and promote the welfare of children in need, with the assistance of other agencies, including health services.

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Any decisions taken should have the child's welfare as the paramount consideration.

Under section 58 of the Education (Scotland) Act 1980 it is an offence, ultimately punishable by fines or imprisonment, for a parent to send a pupil to school with recurrent infections due to their own neglect. However, health and education professionals must approach parents who neglect to treat their children from a position of support and encouragement, rather than with threats of punishment.

NHS Board and Local Authority policies

In order to promote consistent and effective management of head lice infection across Scotland, it is recommended that NHS Boards, in partnership with Local Authorities, should establish a clear policy document on the management of head lice infection that is consistent with the advice in this guidance. The policy should include clear statements on

- detection;
- treatment;
- prescription of insecticides and bug busting kits;
- advice and support for parents; and
- advice/action to support families affected by persistent or recurrent infection.

Note should be taken of the recommendation in the Stafford Report that the term "infection" should be used rather than "infestation" in all head lice policy and information materials, to address the pervasive problem of stigma.

The NHS Board's policy document should be disseminated to all health professionals who may have contact with children or who may be approached by parents or schools for advice. Boards should also liaise with local authorities to ensure that policies are communicated effectively to staff in the full range of child care and education settings.

The Stafford Group produced a series of guidance notes for health and education professionals; separate notes and guidance were produced for primary care staff, pharmacists, school nurses and head teachers. These are attached as annexes and have been updated to reflect the Scottish position and the advice given in the guidance.

It is crucial that all agencies take responsibility for giving accurate, consistent and impartial information and advice.

Annex 1

Head lice: 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 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 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 if 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.

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- Ensure that patients know the correct use of insecticidal lotions – follow the British National Formulary's recommendation of two applications of the same lotion (not shampoo) seven days apart.
- 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.
- Generally, Malathion or one of the pyrethroids is considered as first line treatment.
- Consider using Carbaryl for cases in which true resistance to one of the other agents has been established. There is so far little resistance to Carbaryl, but it is available only on prescription.
- 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.

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
Help Line: 020 7686 4321
Internet: www.chc.org

(This document has been adapted from appendix 1 of *Head Lice: a Report for Consultants in Communicable Disease Control* (CCDCs).)

Annex 2

Head lice: notes and guidance for pharmacists

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 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 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).

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- Ensure that patients know the correct use of insecticidal lotions – follow the British National Formulary’s recommendation of two applications of the same lotion (not shampoo), seven days apart.
- 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.
- Generally, Malathion or one of the pyrethroids is considered as first line treatment, and Carbaryl as second line treatment. There is little resistance so far to Carbaryl, but it is available only on prescription.
- 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 not more than 0.3mm 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
Help Line: 020 7686 4321
Internet: www.chc.org

(This document has been adapted from appendix 2 of *Head Lice: a Report for Consultants in Communicable Disease Control* (CCDCs).)

Annex 3

Head lice: notes and guidance for school nurses and health visitors in nurseries or other responsible school or nursery health officers

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 you give them proper information, advice and support.
- Where possible stick to 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 3 days for up to 3 weeks.
- Make a professional assessment of reported cases of head louse infection of any child in the school. If the report is from the child's parent, make sure that the parents are provided with information, advice and support. If the report is from a teacher, for example that the child is scratching continuously or that a moving louse has been seen on the head, it may be necessary to confidentially and sensitively inform the parents or carers of the child. If your knowledge of the parents or carers is good, it may be sufficient to make contact with them to ensure that they know how to undertake detection combing and what to do if there are head lice present.
- Do not diagnose head louse infection unless you yourself have seen a living, moving louse, or you have physical evidence from the parents; ask them to stick one of the lice on a piece of paper with clear sticky tape and bring it in to you or one of their other health advisors.
- Nurseries and other educational establishments should not issue "alert letters" to other parents/carers.
- Do 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.

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- Familiarise yourself with the correct use of insecticidal lotions to be able 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 3 days for up to 3 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. 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.
- You should play an active part in providing regular helpful and accurate information about head lice to parents and staff. This could be done in conjunction with other health professionals.
- Don't wait until there is a perceived major outbreak – a regular education programme rather than a reactive "campaign" is more sensible.

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
Help Line: 020 7686 4321
Internet: www.chc.org

(This document has been adapted from appendix 3 of *Head Lice: a Report for Consultants in Communicable Disease Control* (CCDCs).)

Annex 4

Head lice: notes and guidance for head teachers, heads of establishments or managers of services for children

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.
- Ensure that your school nurse is informed in confidence of cases of head louse infection. The school nurse will assess the individual report and may decide to make confidential contact with the parents to offer information, advice and support.
- Keep individual reports confidential, and encourage your staff to do likewise.
- Collaborate with your school nurse in providing educational information to your parents and children about head lice, but do not wait until there is a perceived "outbreak". Send out information on a regular basis reminding parents of their responsibility to check their children's hair at least once a week using the wet combing method.
- Consider asking your school nurse to arrange a talk to parents at the school if they are very concerned. Be present yourself and encourage your staff to attend. Some schools organise workshops for parents of P1 children. Others hold 'bug busting' awareness weeks to educate and encourage both children and parents/carers to check for head lice at home on a weekly basis.

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- Ensure, with the school nurse, 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.
- Advise concerned parents to seek the professional advice of the school nurse, the family practice, or a pharmacist.
- Ensure that all new parents are given contact details and information about the role of the school nurse.
- "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.

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:

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London
N7 6LA
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(This document has been adapted from appendix 4 of *Head Lice: a Report for Consultants in Communicable Disease Control* (CCDCs).)

This guidance is available to view, download and print on the Scottish Executive website at www.scotland.gov.uk

Requests for hard copies of the guidance should be directed to Kelly Martin on 0131 244 2272.

Any queries about the guidance or head lice in general should be sent to:

Scottish Executive Health Department

Women and Children's Unit

St Andrew's House

Regent Road

Edinburgh

EH1 3DG

Email: womenandchild.unit@scotland.gsi.gov.uk.

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