



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Guideline for the control of Head Lice infection in children

Community Healthcare Organisation (CHO) Area 1
(Donegal, Cavan, Monaghan, Sligo and Leitrim)

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Table of Contents:

	Page
1.0 Policy Statement	3
2.0 Purpose	4
3.0 Scope	5
4.0 Legislation/ other related policies	5
5.0 Glossary of Terms and Definitions	5
6.0 Roles and Responsibilities in relation to implementation of Guideline	6
 7.0 Guideline – Best Practice	 7
7.1 Prevention of head lice infection	7
7.2 Confirmation of head lice infection	8
7.3 Treatment of head lice infection - Principles	9
7.4 Treatment of head lice infection –Recommendations	10
 8.0 Guideline – Responsibility for control of head lice infection children	 12
8.1 Parents	12
8.2 General Practitioners and Practice Nurses	13
8.3 Community Pharmacists	14
8.4 School Public Health Nurses	15
8.5 Area Public Health Nurses	16
8.6 Medical Officers	17
8.7 School Principals and Managers of Childcare services	18
 9.0 Implementation Plan	 19
10.0 Monitoring, Revision and Audit	19
 11.0 Appendices	
Appendix I Membership of Development Group	20
Appendix II Signature sheet	21
Appendix III Life cycle of louse	22
Appendix IV Algorithm for Control of Head Lice in Children	23
Appendix V Desktop guide to Recommended Treatment of Head Lice	24
Appendix VI Monitoring checklist	25
Appendix VII Audit tool	26
Appendix VIII Sample letter for parents	30
Appendix IX Health Information available for parents and children	31
Appendix X Peer Approval forms	32

1.0 Policy Statement and Context:

1.1 Policy Statement

- (i) The primary responsibility for the identification, treatment and prevention of head lice in a family lies with the parents. However, they cannot be expected to diagnose current infection, or to distinguish it from successfully treated previous infection or other conditions, without instruction and support from health professionals.
- (ii) All those involved in supporting parents in the identification, treatment and prevention of head lice should be knowledgeable and competent and have a clear understanding of the respective contributions of parents, pre-school service providers, teachers, community groups, community pharmacists, primary care GPs and practice nurses, area and school public health nurses and community medical officers.
- (iii) The term 'infection' is used in this document and should be used in communications with parents and others – this is to avoid any negativity or stigma that may be associated with the use of other terms such as 'infestation'.
- (iv) The Health Service Executive (HSE) has a statutory duty for the care and protection of children and their families (HSE, 2012), and all HSE personnel and health professionals, irrespective of their position, have a responsibility towards child protection and welfare (HSE, 2011).

1.2 About Head lice

- (i) Head lice (pediculosis capitis) is an infectious disease, but as highlighted in the Stafford Update (2012) it is more a societal than an infectious disease problem.
- (ii) The type of louse which affects the head is particularly common and anyone can catch them. They only live on humans; you cannot catch them from animals.
- (iii) Head lice are small insects (about 1-3mm long, from the size of a sesame seed up to the size of a match head) with moving legs. They cannot jump, swim or fly and their presence does not reflect standards of hygiene.
- (iv) The female lice lay eggs which glue to the hair shafts. The empty cases (nits) that are left when the eggs have hatched are easily visible. A nit remains on the hair shaft until the hair grows out and is cut, or falls out (which may take up to 2 years).
- (v) Lice spread by direct head-to-head contact, walking along the hair from one head to another. Head lice tend to be more common in children as their play activities facilitate this type of contact.
- (vi) Lice can also be passed indirectly by use of someone else's hairbrush or comb. Lice that fall from the head or amble onto bedding or hats are usually dying and harmless. Lice caught on combs can re-establish if they are combed back on again within 48 hours. Lice cannot live far away from a human; most die within 3 days.
- (vii) Studies suggest that infections occur most often in primary school aged children although there is no evidence of a link with school attendance. The peak age for infection is 7-8 years.

- (viii) The life cycle from egg (nit) to adult louse takes 21-27 days on the human host. Each female deposits 50-150 nits during her lifetime (Appendix I).
- (ix) Head lice are not a serious problem; they rarely cause physical symptoms other than itching of the scalp. Skin on the scalp may become infected from scratching.
- (x) Itching and scratching are usually the first signs of head lice; these are due to an allergic reaction and may take four to eight weeks to develop. Therefore, a person may have head lice for up to eight weeks before they notice any itching
- (xi) Some adults do not have an itch and only one third of children itch or scratch.
- (xii) Other adverse health effects mainly derive from the human perception of the lice rather than from the lice themselves. Excessive public and professional reaction to head lice leads to:
 - i. an inflated perception of prevalence
 - ii. unwarranted anxiety and distress,
 - iii. unnecessary, inappropriate or ineffective actions and
 - iv. misuse and overuse of treatments.
- (xiii) The BMJ Best Practice review states that although prevalence has been estimated in some communities, there are few studies in resource-rich countries. The review highlights a prevalence of 13% in Australian school children, with a range between schools of 0% to 28%. A UK prevalence of 2% was identified with an annual incidence (new cases) of 37%. True data does not exist in the US as data collection is not standardised and often inferred from sales of head lice treatments.
- (xiv) In relation to management of head lice, regular wet-combing of the hair (once a week) with a fine-toothed comb by a parent should be encouraged at all times. The presence of nits is not an indication for treatment; treatment is only required if a living, moving louse is seen. Exclusion from pre-school or school is unnecessary

2.0 Purpose of Guideline:

- 2.1 To have a consistent, evidence-based approach to the control of head lice infection, across CHO Area 1 (Donegal, Cavan, Monaghan, Sligo and Leitrim)
- 2.2 To support parents and children experiencing a consistent, evidence-based approach to the control of head lice, by HSE staff collaborating with Community pharmacists, GPs/Practice Nurses, Teachers and Early Years service providers in agreeing the respective responsibilities and in the development of this Guideline.
- 2.3 To have a consistent approach to the education of parents, children, teachers, Early Years service providers and other community groups and to support dissemination of shared information on the agreed respective responsibilities of parents, pre-school service providers, teachers, community groups, community pharmacist, primary care GPs and practice nurses, area and school public health nurses
- 2.4 To facilitate staff induction and act as a basis for audit.

3.0 Scope:

- 3.1 This Guideline refers to children with head lice at home, in child care facilities or schools and in other community settings.
- 3.2 A 'child' means a person under the age of 18 years, excluding a person, who is or has been married (Dept of Children and Youth Affairs, 2011).
- 3.3 This Guideline applies to HSE staff in HSE West West (Donegal, Cavan, Monaghan, Sligo and Leitrim).

4.0 Legislation /other related policies:

- British Medical Journal (BMJ)– Best Practice Review
<http://bestpractice.bmj.com/best-practice> - accessed February 2015
- Child Care Act 1991
- Children First: National Guidance for the Protection and Welfare of Children
- Child Protection and Welfare Practice Handbook 2011
- Health Protection Agency North West (Nov 2010) www.hpa.org.uk
- Health Service Executive (Sept 2013) Management of Infectious Diseases in Schools
- Health Protection Surveillance Centre (2012) Management of Infectious Diseases in Early Years facilities www.hpsc.ie
- Public Health Medicine Environmental Group UK (2012) Head Lice: Evidence-based guidelines based on the Stafford Report 2012 Update

5.0 Glossary of Terms and Definitions:

Evidence Based Practice – consensus approaches for handling recurring health management problems aimed at reducing practice variability and improving health outcomes (WHO 2009 ref in HSE doc Dev of PPPGs).

GP – General Practitioner

Guideline – a guideline is defined as a principle or criterion that guides or directs action (Concise Oxford Dictionary 1995). Guideline development emphasizes using clear evidence from the existing literature, rather than expert opinion alone, as the basis for advisor materials (WHO 2009).

Healthcare Audit – healthcare audit is audit of current practice against standards in any aspect of healthcare and includes both clinical and non-clinical audit (Clinical Audit Criteria and Guidance Working Group 2008).

Monitor – any parameter that is regularly and consistently used to evaluate the quality of care. (WHO 2009).

Parent – the word parent is used in the document and also refers to guardians or carers, where applicable

PHN – Public Health Nurse

6.0 Roles and Responsibilities in implementation of Guideline:

6.1 HSE Senior Medical Officer (Sligo)

- (i) to ensure that they are fully informed and up-to-date with current scientific knowledge and practice on control of head lice
- (ii) to ensure that Managers providing services to children are aware of the Guideline
- (iii) to ensure that the Guideline is audited (Appendix VII) to determine level of compliance and outcomes from implementation
- (iv) to ensure that revisions of the Guideline are carried out in association with the Primary Care Pharmacist, as per revision date on the cover of the most current version of the Guideline, or sooner if indicated
- (v) to ensure that service Managers are aware of revised version and the need to withdraw previous version

6.2 HSE Service Managers

- (i) to ensure that staff providing services to children are aware of the Guideline and sign the Signature sheet to confirm same (Appendix II)
- (ii) to facilitate training/ further information sessions for staff where necessary
- (iii) to ensure that staff comply with the Guideline
- (iv) to ensure that implementation of the Guideline is monitored (Appendix VI)
- (v) to ensure that staff are aware of revised version and the need to withdraw previous version

6.3 Health Professionals

- (i) to ensure that they are fully informed and up-to-date with current scientific knowledge and practice
- (ii) to comply with this Guideline
- (iii) to identify any professional training needs or seek further information if required
- (iv) to identify any components of the Guideline that require review

6.4 Important Note

- (i) Each health professional/HSE employee is accountable for their practice. This means being answerable for decisions he/she makes and being prepared to make explicit the rationale for those decisions and justify them in the context of legislation, case law, professional standards and guidelines, evidence based practice, professional and ethical conduct.
- (ii) This Guideline represents a statement reflecting an expected standard of care and may be introduced in law as evidence of the standard of care expected.
- (iii) The public may request access to policies, procedures, protocols and guidelines, and public bodies may be called on to publish such documents under Freedom of Information Act (1997) and appropriate legislation.

7.0 Guideline – Best Practice:

This section is summarised in Appendix IV – Algorithm for control of head lice in children. It is recommended that practitioners/staff make a Desktop copy for easy consultation

7.1 Prevention of head lice infection:

The following measures can help to reduce head lice infection in children and parents should be advised to undertake them:

- (i) Wet comb children's hair once a week, using a detection comb. This will help to identify a head lice infection at the earliest possible stage and reduce the number of people in the family, or who are close to the child, who will get infected
- (ii) Also, wet comb children's hair, if prolonged (>1 minute), close (head to head) contact with an infected person has occurred (e.g. 'alert' letter home from school/childcare service), or when members of a household have been named as contacts
- (iii) Use an effective detection comb; this should be plastic, with rigid, flat-toothed, plastic teeth, set not more than 0.3mm apart. These are available to purchase in all pharmacies
- (iv) There is a commercial 'Bug buster' kit available with special fine-tooth combs and instructions for use and a DVD. This may be a useful support to parents. It may also be useful to staff for demonstrating to parents, or reiterating, correct technique for wet combing.
- (v) Avoid the use of repellent sprays, alternative preventive products or electronic combs, as there is no evidence to support their use
- (vi) Encourage children not to share hair brushes, combs, hats or hair accessories.
- (vii) Do not use treatment products as a preventive measure; they should only be used when infection is present i.e. a living, moving louse is seen. The treatments are safe, but should not be over-used. They can make the scalp flaky and itchy.

7.1.1 How to carry out Detection wet combing

- Buy the detection comb in a pharmacy
- Wash the hair with regular shampoo
- Put on lots of any conditioner – this makes the lice really wet and keeps them still
- Slot the teeth of the comb into the hair at the roots and draw the comb down to the ends of the hair
- Have plenty light; daylight is best
- Check the comb for lice each time
- Continue until you have worked through each section of hair and checked the whole head
- Rinse off the conditioner and repeat the combing while the hair is still wet
- If moving lice are found, check all family

7.2 Confirmation of head lice infection:

- (i) Wet combing can be used to diagnose current infection
- (ii) A diagnosis of head lice should not be confirmed unless you yourself have seen a living, moving louse, or you have physical evidence from the parent (louse fixed on piece of paper with clear sticky tape)
- (iii) Recurrent scalp problems may be missed if it is assumed without evidence that head lice are the cause of scalp irritation
- (iv) The presence of nits (egg cases) is not an indication of current infection or need for treatment
- (v) Health professionals should be able to identify a louse (Appendix III)
- (vi) When a head lice infection is confirmed, parents should be advised to identify close contacts of the child with head lice (anyone living in the home/grandparents/ cousins/ close friends etc) and to inform them to inspect hair, and treat immediately if a living, moving louse is discovered.

7.3 Treatment of head lice infection: Principles

- (i) Treatment should not be used as a preventive measure and should only be used when an infection is present i.e. a living, moving louse is seen
- (ii) The correct use of the recommended treatments is the scientifically confirmed way to treat head louse infection
- (iii) Parents should be advised to promptly treat (at the same time) any members of the family (including adults) who are infected (living, moving louse present)
- (iv) Parents should be advised to identify any other close contacts of the child (where there would have been head-to-head contact) and inform them to inspect hair, and treat immediately if a living, moving louse is discovered
- (v) Some products can only be used on children of 2 years of age and older
- (vi) Any anti head lice treatment should only be used with medical supervision in babies under the age of 6 months
- (vii) The course of treatment consists of two applications of one of the recommended preparations (not shampoo or mousse), seven days apart. Check hair 2 days after the repeat treatment
- (viii) If infection is still present following the course of treatment, it could be because the child has been re-infected (from a close contact who was not treated), or because the treatment wasn't carried out correctly
- (ix) 'Re-infections' and 'treatment failures' may not be true infections – make sure a live louse is found or produced, and assess ways in which the family may not have complied carefully with the above principles for the first treatment
- (x) Children may continue to scratch following treatment; it doesn't mean they still have an infection. Treatments can make the scalp flaky and itch. Also, some people scratch just thinking or talking about lice.
- (xi) A second course of treatment should not be started without evidence of current infection
- (xii) When a first treatment has definitely failed, it may be useful to try the same agent in a different formulation; as different formulations of the same active ingredient may have different efficacies. All the family should be checked, and only those with lice treated again
- (xiii) Parents may suggest that a child has a 'resistant strain'. In the past chemical insecticides were used to treat head lice. Oil based products are now recommended. Let parents know that the current products have a physical, rather than chemical effect on the lice, so the lice do not get 'resistant' to them
- (xiv) A third course of treatment should not be started without consulting with GP. Parents should be advised to attend GP if infection is still present. Pediculocides (chemical treatments) may sometimes be prescribed by a GP if he/she feels this is indicated.

7.4 Treatment of head lice infection: Recommendations

- (i) Products need to contain sufficient active agent and have sufficient contact time with the child's head to allow the active agent to work
- (ii) **Dimethicone/ Cyclomethicone /Mineral oil treatments** are now considered as first-line treatment. These products have a physical, rather than chemical effect on the lice. They are sold under a few different product names
- (iii) Shampoo and mousse formulations are not recommended as they contain low concentrations of the active ingredient, or don't allow for sufficient contact time.

Recommended Products of Choice,

currently on sale in Ireland (these are not available on Medical Card)

Product	Active Ingredient	Application Time	Repeat	Age Restriction
Full Marks Solution	Isopropyl myristate Dimethicone	10 minutes	7 days	2 years of age and upwards
Full Marks Spray/ Solution	Isopropyl myristate 50% Cyclomethicone	10 minutes	7 days	2 years of age and upwards
Hedrin Once Spray Gel	Simethicone 4% plus Penetrol	15 minutes	7 days <i>Manufacturer's instructions advise only one application</i>	6 months of age and upwards

How to use treatment products

- Treat everyone in family who is infected, at the same time; this is so that untreated people don't infect the treated people again
- Pharmacist will advise on which product to use
- There will be instructions with the product on how to put on the treatment and how long to leave it on for – each of the products are slightly different
- Hair should be dry
- The hair should be parted near the top of the head and the lotion or solution put onto the scalp and rubbed in. The hair is then parted further down and the application of the product repeated. Work through hair section by section until all of scalp has lotion on it
- The lotion does not need to be put any further down the hair than where a ponytail band would go
- **Repeat one week later** – even if the instructions recommend one application only. The reason for this is that no treatment is guaranteed to kill un-hatched eggs and these hatch out over about one week
- **Check hair about 2 days after** the repeat treatment
- Once treatment is complete and has got rid of the lice, it is important that the weekly wet combing, to check the hair, continues.
- If treatment does not get rid of infection, a second treatment is recommended following check of compliance with treatment. A third course of treatment should not be started without consulting with GP.

The following treatments are Not Recommended

1. Mechanical removal of head lice
 - Mechanical removal of lice is less effective at treating infection than recommended treatments. There is some evidence that if the commercial 'Bug buster' kit (fine-tooth combs & DVD) is used correctly and rigorously it can be effective in a proportion of cases. However, it is labour intensive and requires a lot of commitment on the part of parents.
 - The kit is a useful educational support to staff for demonstrating to parents or reiterating correct technique for wet combing. Wet combing is recommended weekly, for early detection of infection.
2. Mousses, shampoos or repellents
 - Shampoo and mousse formulations are not recommended as they contain low concentrations of the active ingredient, or don't allow for sufficient contact time. Therefore, even if the active agent has the potential to kill lice, it is unlikely to do so.
 - Repellents are sold to prevent re-infection; there is no evidence that repellents work.
3. Lyclear Rinse
 - This product is not recommended as clinical trial evidence shows that the contact time is too short to be effective.
4. Alternative Products
 - A number of products containing essential oils such as tea tree and eucalyptus oil are marketed as 'natural' remedies for head lice. Different products contain different concentrations of the oil.
 - For many alternative products, there is a lack of an evidence base on which to assess effectiveness
 - The safety of some alternative methods is unknown and therefore there is the risk that safety problems could arise
5. Other devices are available which claim to electronically aid the removal and/or killing of lice.
 - These include Electronic combs and dry air devices.
 - The use of these devices for the treatment of head louse infections is not recommended, as evidence of effectiveness is generally absent and their incorrect use may present a safety risk.

8 Guideline – Responsibility for the control of head lice:

All those involved in supporting parents in the control of head lice infection in children should have a clear understanding of the evidence-based information and the respective contributions of parents, pre-school service providers, teachers, community pharmacists, GPs and practice nurses, area and school public health nurses.

This section is designed for the convenience of a service /agency having the option to print off a desktop copy of their respective key role. There is therefore a lot of repetition because of the significant overlap in the roles of all those who come into frequent contact with children/ their parents.

8.1 Parents:

- 8.1.1 The primary responsibility for the identification, treatment and prevention of head lice in a family lies with the parents
- 8.1.2 Parents cannot be expected to diagnose current infection, or to distinguish it from successfully treated previous infection or other conditions, without adequate instruction and support by health professionals
- 8.1.3 Parents should be given clear, consistent, evidence-based information (Appendices IX– Information leaflets for children and parents) from all those involved in supporting them in the control of head lice infection: pre-school service providers, teachers, pharmacists, GPs and practice nurses, area and school public health nurses and community medical officers
- 8.1.4 Parents should be advised that they are responsible for:
 - 8.1.4.1 Wet combing their children’s hair weekly to help identify a head lice infection at the earliest possible stage
 - 8.1.4.2 Inspecting hair for head lice, using an effective detection comb, once a week
 - 8.1.4.3 Inspecting hair for lice if head to head contact with an infected person has occurred or when members of a household have been named as contacts
 - 8.1.4.4 Promptly treating (at the same time) any members of the family who have head lice (living, moving lice present)
 - 8.1.4.5 Only using treatments when an infection is present and never as a preventive measure
 - 8.1.4.6 Asking pharmacist for advice in selecting a treatment, so that only an effective treatment will be used
 - 8.1.4.7 Informing all contacts, both children and adults, to look out for signs of infection, to inspect hair and to treat with head lice lotion if living moving lice are discovered
 - 8.1.4.8 Contacting the pharmacist, GP, practice nurse, area or school public health nurse, if advice or support is needed

8.2 General Practitioners and Practice Nurses:

Please nominate a named person to ensure that this guideline and subsequent updates are brought to the attention of all relevant practitioners

- 8.2.1 General practitioners and Practice nurses 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 on appropriate treatment when there is a confirmed infection
- 8.2.2 Head louse infection is a community health problem
- 8.2.3 Health professionals should be able to identify a head louse (Appendix III). Keep a magnifying glass to hand
- 8.2.4 A diagnosis of head lice should not be confirmed unless the Practice nurse or GP has seen a living, moving louse, or has physical evidence from the parent (louse fixed on piece of paper with clear sticky tape)
- 8.2.5 Parents can be mistaken when they believe their child has lice. Recurrent scalp problems may be missed if it is assumed without evidence that head lice are the cause
- 8.2.6 Liaise as appropriate with local pharmacist, public health nurses, school principals and the public health department HSE
- 8.2.7 Make sure that parents are provided with information, advice and support. At a first consultation it may be sufficient to ensure that they know how to carry out detection combing and what to do if head lice are present. The responsibility of the family in the control of head lice infection should be emphasised (Appendix IV Information sheets – separate attachments)
- 8.2.8 Advise parents to get an effective detection comb, one which has rigid, flat-toothed, plastic teeth set not more than 0.3mm apart
- 8.2.9 Don't support the use of electronic combs, repellents or treatments not specifically recommended for the treatment of head louse infections. Let parents know that the correct use of the recommended treatment is the scientifically confirmed way to treat head louse infection (Appendix IV – Desktop Guide to recommended treatments)
- 8.2.10 Recommend two applications of the recommended treatment (not shampoo or mousse), seven days apart and advise parents to consult with pharmacist (Appendix V Desktop guide to treatment)
- 8.2.11 Parents may suggest that their child has a 'resistant strain'. Traditionally, insecticides were used, but head lice would often develop resistance to them. These treatments have virtually been replaced with silicone and oil-based preparations, which have a physical (smothering) rather than chemical action on lice, so resistance is not a feature.
- 8.2.12 If infection is still present after first treatment, check compliance with technique, identification of close contacts and timing of treatment, prior to advising a second course of treatment
- 8.2.13 A third course of treatment should not be started without consulting with GP. Parents should be advised to attend GP if infection is still present. Pediculocides (chemical treatments) may sometimes be prescribed by a GP if he/she feels this is indicated

8.3 Community Pharmacists:

Please nominate a named person to ensure that this guideline and subsequent updates are brought to the attention of all relevant practitioners

- 8.3.1 Community Pharmacists are an important source of advice on the control 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
- 8.3.2 Head louse infection is a community health problem. Consider nominating a member of staff to advise patients on head lice problems
- 8.3.3 Health professionals should be able to identify a louse at all stages of its development (Appendix III). Keep a magnifying glass to hand.
- 8.3.4 A diagnosis of head lice should not be confirmed unless the Pharmacist has seen a living, moving louse, or has physical evidence from the parent (louse fixed on piece of paper with clear sticky tape)
- 8.3.5 Parents can be mistaken when they believe their child has lice. Recurrent scalp problems may be missed if it is assumed without evidence that head lice are the cause
- 8.3.6 Liaise as appropriate with GP, practice nurse, public health nurse, school principal and the public health department HSE
- 8.3.7 Make sure that patients are provided with information, advice and support. At a first consultation it may be sufficient to ensure that they know how to carry out detection combing and what to do if head lice are present (Appendix IX Information sheets– separate attachments)
- 8.3.8 Advise parents to get an effective detection comb, one which has rigid, flat-toothed, plastic teeth set not more than 0.3mm apart
- 8.3.9 Don't support the use of electronic combs, repellents or treatments not specifically recommended for the treatment of head louse infections. Let parents know that the correct use of the recommended treatment is the scientifically confirmed way to treat head louse infection (Appendix IV – Desktop Guide to recommended treatments)
- 8.3.10 Recommend two applications of one of the recommended treatments (not shampoo or mousse), seven days apart
- 8.3.11 Parents may suggest that their child has a 'resistant strain'. Traditionally, insecticides were used, but head lice would often develop resistance to them. These treatments have virtually been replaced with silicone and oil-based preparations, which have a physical (smothering) rather than chemical action on lice, so resistance is not a feature.
- 8.3.12 If infection is still present after first treatment, check compliance with technique, identification of close contacts and timing of treatment, prior to advising a second course of treatment
- 8.3.13 Different formulations of the same active ingredient may have different efficacies – when a first treatment has definitely failed, it may be useful to try the same agent in a different formulation
- 8.3.14 A third course of treatment should not be started without consulting with GP. Parents should be advised to attend GP if infection is still present. Pediculocides (chemical treatments) may sometimes be prescribed by a GP if he/she feels this is indicated
- 8.3.15 Keep fully informed and up-to-date with current scientific knowledge on the range of treatments available in Ireland, and their efficacy. If you become aware of any new evidence-based treatment product, please inform the primary care pharmacist.

8.4 School Public Health Nurses (PHNs):

The Assistant Director/s PHN is the named person to ensure that this guideline and subsequent updates are brought to the attention of all school PHNs

- 8.4.1 School PHNs have responsibility for core health screening of school-aged children at Junior Infants and Fifth Class, and so have access to school children, parents, teachers and principals
- 8.4.2 Head louse infection is a community health problem. School PHNs 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 on appropriate treatment when there is a confirmed infection.
- 8.4.3 School PHNs do not carry out routine head inspections of school children. Research has shown that routine head inspections do little to reduce the head lice problem. School/Clinic PHNs should be able to identify a louse (Appendix III - photographs). Keep a magnifying glass to hand.
- 8.4.4 School PHNs should make a professional assessment of reported cases of head louse infection – confirm head lice infection only when a living, moving louse has been seen, or there is physical evidence from the parent/teacher (louse fixed on piece of paper with clear sticky tape)
- 8.4.5 Sharing of evidence-based clear information with parents and teachers on head lice should be integrated into routine school contacts (e.g children starting school, at time of screening) rather than just in response to parent / teachers' concerns or when there is an "outbreak" in the school
- 8.4.6 Information should include correct technique for detection combing and how to carry out thorough and effective treatment. Advise parents to get an effective detection comb, one which has rigid, flat-tooth, plastic teeth, set not more than 0.3mm apart. The responsibility of the family in the control of head lice infection should be emphasised (Appendix IX Information sheets– separate attachments)
- 8.4.7 School PHNs should be prepared to teach detection combing and to give education on a one-to-one or group basis where there is repeat infection
- 8.4.8 Don't support the use of electronic combs, repellent sprays or treatments not specifically recommended for the treatment of head louse infections. Let parents know that the correct use of the recommended treatments is the scientifically confirmed way to treat head louse infections (Appendix IV – Desktop Guide to recommended treatments)
- 8.4.9 Advise parents to consult with the pharmacist - Recommend two applications of a scientifically proven treatment (not shampoo or mousse), seven days apart
- 8.4.10 School PHNs should liaise as appropriate with parent, teacher, pharmacist, area public health nurse, and the public health department HSE
- 8.4.11 Parents may suggest that their child has a 'resistant strain'. Traditionally, insecticides were used, but head lice would often develop resistance to them. These treatments have virtually been replaced with silicone and oil-based preparations, which have a physical (smothering) rather than chemical action on lice, so resistance is not a feature.
- 8.4.12 If infection is still present after first treatment, check compliance with technique, identification of close contacts and timing of treatment, prior to advising a second course of treatment
- 8.4.13 A third course of treatment should not be started without consulting with GP. Parents should be advised to attend GP if infection is still present. Pediculocides (chemical treatments) may sometimes be prescribed by a GP if he/she feels this is indicated

8.5 Area Public Health Nurses (PHNs):

The Assistant Director/s PHN is the named person to ensure that this guideline and subsequent updates are brought to the attention of all PHNs

- 8.5.1 Area PHNs have responsibility for screening and surveillance of pre-school children. They provide support and advice to parents and families, from pregnancy and birth until the child is in primary school.
- 8.5.2 Head louse infection is a community health problem. Area PHNs 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 on appropriate treatment when there is a confirmed infection
- 8.5.3 Area PHNs do not carry out routine inspections of children's hair, but should be able to identify a louse (Appendix III). Keep a magnifying glass to hand.
- 8.5.4 Area PHNs should be prepared to teach detection combing to individuals and families at their homes if appropriate, and groups of parents/ children as required, and give advice on prevention and treatment. Advise parents to get an effective detection comb, one which has rigid, flat-tooth, plastic teeth, set not more than 0.3mm apart. The responsibility of the family in the control of head lice infection should be emphasised (Appendix IX Information sheets– separate attachments)
- 8.5.5 A diagnosis of head lice should not be confirmed unless the PHN has seen a living, moving louse, or has physical evidence from the parent (louse fixed on piece of paper with clear sticky tape)
- 8.5.6 Don't support the use of electronic combs, repellent sprays or treatments not specifically recommended for the treatment of head louse infections. Let parents know that the correct use of the recommended treatments is the scientifically confirmed way to treat head louse infections (Appendix IV – Desktop Guide to recommended treatments)
- 8.5.7 Advise parents to consult with the pharmacist - Recommend two applications of a scientifically proven treatment (not shampoo or mousse), seven days apart
- 8.5.8 Area PHNs should liaise as appropriate with parent, teacher, pharmacist, area public health nurse, and the public health department HSE
- 8.5.9 Area PHNs should note that:
 - (a) many preparations are only suitable for children 2 years of age and older
 - (b) for babies under the age of 6 months, head lice treatment should only be used with medical supervision
- 8.2.1 Parents may suggest that their child has a 'resistant strain'. Traditionally, insecticides were used, but head lice would often develop resistance to them. These treatments have virtually been replaced with silicone and oil-based preparations, which have a physical (smothering) rather than chemical action on lice, so resistance is not a feature
- 8.2.2 If infection is still present after first treatment, check compliance with technique, identification of close contacts and timing of treatment, prior to advising a second course of treatment
- 8.2.3 A third course of treatment should not be started without consulting with GP. Parents should be advised to attend GP if infection is still present. Pediculocides (chemical treatments) may sometimes be prescribed by a GP if he/she feels this is indicated

8.6 Medical Officers:

Senior medical officer child health is the named person to ensure that this guideline and subsequent updates are brought to the attention of all relevant practitioners

- 8.6.1 Medical Officers have responsibility for responsibility for assessment and follow-up of pre-school and school-aged children when required, and so have access to children, parents, teachers and principals
- 8.6.2 Head louse infection is a community health problem. Medical Officers should be able to identify a head louse (Appendix III). Keep a magnifying glass to hand
- 8.6.3 Medical Officers should provide evidence-based, clear information to school staff, parents and children on head lice when the need is identified, emphasising that head lice control is the responsibility of the family (Appendix IX Information leaflets – separate attachments)
- 8.6.4 Parents can be mistaken when they believe their child has lice. Recurrent scalp problems may be missed if it is assumed without evidence that head lice are the cause
- 8.6.5 A diagnosis of head lice should not be confirmed unless the medical officer has seen a living, moving louse, or has physical evidence from the parent (louse fixed on piece of paper with clear sticky tape)
- 8.6.6 Medical Officers 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 on appropriate treatment when there is a confirmed infection (Appendix IV – Desktop Guide to recommended treatments)
- 8.6.7 Medical officers should note that:
 - (a) many preparations are only suitable for children 2 years and older
 - (b) for babies under 6 months of age, head lice treatment should only be used with medical supervision
- 8.6.8 Parents may suggest that their child has a 'resistant strain'. Traditionally, insecticides were used, but head lice would often develop resistance to them. These treatments have virtually been replaced with silicone and oil-based preparations, which have a physical (smothering) rather than chemical action on lice, so resistance is not a feature.
- 8.6.9 If infection is still present after first treatment, check compliance with technique, identification of close contacts and timing of treatment, prior to advising a second course of treatment
- 8.6.10 A third course of treatment should not be started without consulting with GP. Parents should be advised to attend GP if infection is still present. Pediculocides (chemical treatments) may sometimes be prescribed by a GP if he/she feels this is indicated.
- 8.6.11 Keep fully informed and up-to-date with current scientific knowledge on the range of treatments available in Ireland, and their efficacy. If you become aware of any new evidence-based treatment product, please inform the primary care pharmacist.

8.7 School Principals and Managers of Early Years services:

Please nominate a named person to ensure that this guideline and subsequent updates are brought to the attention of all relevant staff

- 8.7.1 Diagnosis of head lice is only on the basis of a living, moving louse being seen.
- 8.7.2 If a staff member sees a living, moving louse or nits in a child's hair, this should be discussed with the child's parent. The parent(s) should be advised to inspect the child's hair and treat **if** a living, moving louse is seen. Lice which fall from the head are usually dying. If a staff member witnesses this, it might be beneficial to stick it to paper with clear tape to show to parent
- 8.7.3 Advise parents that if live lice are on one member of a family, it is important that all other family members are checked for head lice, and treated if living, moving lice are seen
- 8.7.4 Do not advise parents to use products that are not on the recommended list (See Appendix IV); let them know that the correct use of the recommended treatments is the scientifically confirmed way to treat head louse infections
- 8.7.5 'Alert letters' should not be sent out routinely. However, if there are several cases of head lice in the school or Early Years facility it may be of benefit to send a letter to all parents advising them to inspect their children's heads and start treatment only if live lice are seen (Appendix VIII – Sample letter).
- 8.7.6 The perception of parents and staff is often that there is a 'serious outbreak' in the school or service, with many of the children infected. While this is hardly ever the case, it causes agitation and alarm
- 8.7.7 A sensible, informed approach based on fact, not myths, will help to reduce head lice.
- 8.7.8 Where transmission of lice from one child to another happens at school, it is usually from a 'best friend'. Head lice are transmitted by direct, head-to-head contact of one minute or more, by walking along the hair from one head to another. Lice can also be passed indirectly by use of someone else's hairbrush, comb or hat. Lice can be combed back in from comb/brush for up to 48hrs
- 8.7.9 Schools and Early Years services should have a protocol on the management of head louse infections – this Guideline could form the basis for that. Appendix III is a summary on the control of head lice, which can be printed off as a Desktop guide
- 8.7.10 Head louse infection is a problem of the community. While it cannot be solved by the school/ Early Years service, they can help the local community to deal with it
- 8.7.11 Information sheets (Appendix IX - separate attachments) include leaflets for children and parents and an A4 sized poster for children. This information aims at ensuring that the issue is 'normalised' for children and that they understand the importance of detection combing, and that parents get clear instructions on proper diagnosis, detection combing, avoiding unnecessary treatment and thorough treatment
- 8.7.12 Use /send out this information on a regular basis (preferably included with other issues e.g. induction pack, newsletter), encouraging and reminding parents to check their child's hair weekly. Do not wait until there is a perceived 'outbreak'
- 8.7.13 Advise concerned parents to seek the advice of public health nurse, pharmacist, family doctor or practice nurse
- 8.7.14 Keep individual reports of head lice infection in children confidential.

9.0 Implementation Plan:

- 9.1 Senior Medical Officer Child Health will ensure that the Guideline is communicated to managers of/liaison person for all relevant staff in:
- HSE (PHN service, Medical officer service, other services which deal with children) and
 - outside services/agencies (Pharmacists, GPs, Practice Nurses, School Principals, Early Years service providers)

10.0 Monitoring, Revision and Audit:

- 10.1 Monitoring, review and audit will take place on a consistent, planned ongoing basis, as referenced on the revision date on the cover of the most current version of the Guideline.
- 10.2 Service managers in PHN and Medical Officer services will monitor the implementation of the Guideline in their service 3-6 months following implementation, to confirm staff awareness and compliance.
- 10.3 Monitoring, review and audit will take place on a consistent, planned ongoing basis, as referenced on the revision date on the cover of the most current version of the Guideline.
- 10.4 Service managers in PHN and Medical Officer services will monitor the implementation of the Guideline in their service 3-6 months following implementation, to confirm staff awareness and compliance.
- 10.5 Senior Medical Officer, Child Health, will ensure that feedback from the monitoring process is used to address any barriers to implementation and to influence future development of the Guideline.
- 10.6 Senior Medical Officer, Child Health, will audit the Guideline one year after it has been implemented and ensure that feedback from the review and/or audit is communicated to all relevant service managers in order to ensure continuous improvement, sharing of best practice, learning from experiences and knowledge of what works best in the service /organisation.
- 10.7 Revisions to the Guideline will be agreed by Senior Medical Officer, Child Health and Community Primary Care Pharmacist and circulated
- 10.8 Service managers will ensure that only current versions of this Guideline are in circulation and that previous versions are withdrawn when the Guideline is reviewed
- 10.9 A sample monitoring tool and sample audit tool have been devised and are included in the appendices (Appendix VI & VII)

11.0 Appendices:

Appendix I

Membership of Development Group

Ms Eilish Boyle, Clinic Public Health Nurse HSE

Ms Bríd Brady (**Chair**), Child Health Development Officer HSE

Dr Mary Connolly, Senior Medical Officer Child Health HSE

Mr Trevor Hunter, Primary Care Pharmacist

Ms Geraldine Love, School Public Health Nurse HSE

Ms Patricia Magee, Clinic Public Health Nurse Donegal HSE

Ms Frances McGloin, Area PHN Donegal HSE

Ms Joan McGrath, Support & Development Worker, Sligo County Childcare Committee

Ms Bernie McNulty, Assistant Director Public Health Nursing HSE

Mr Enda Nolan, Principal, Scoil an Linbh Íosa, Killymard, Donegal Town

Ms Kathy Taaffe, Professional Development Coordinator, Practice Nursing

Acknowledgements

- Members of the Development group for their contribution and commitment to the process of developing this Guideline document.
- Peer Reviewers (Appendix X).

Appendix II

Signature Sheet:

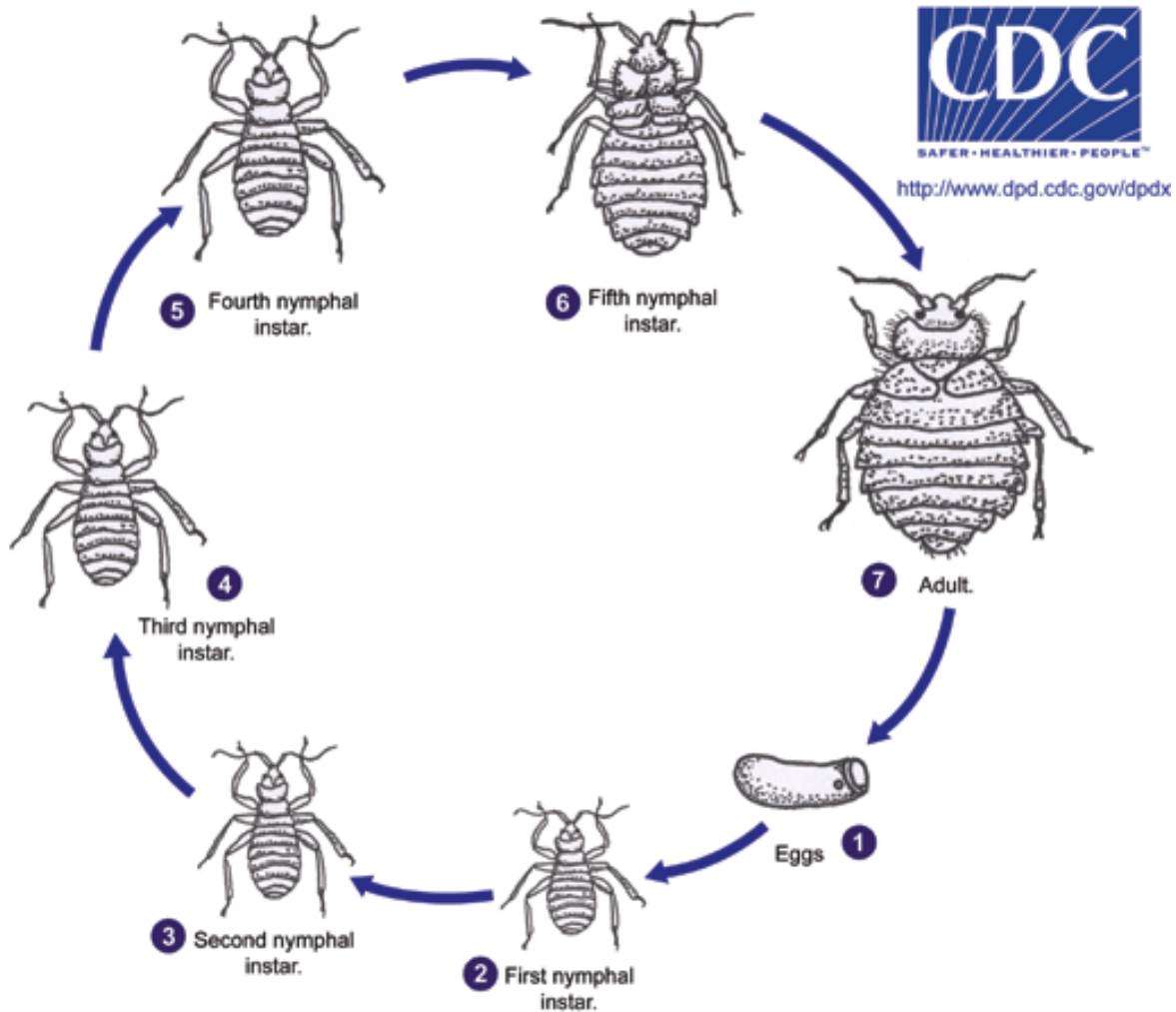
*I have read, understand and agree to adhere to the attached **Guideline for the control of head lice infection in children**:*

[illegible]

Appendix III

A. Life cycle of head louse:

Accessed: 09.02.2015 – Centre for Disease Control and Prevention <http://www.cdc.gov/dpdx/index.html>



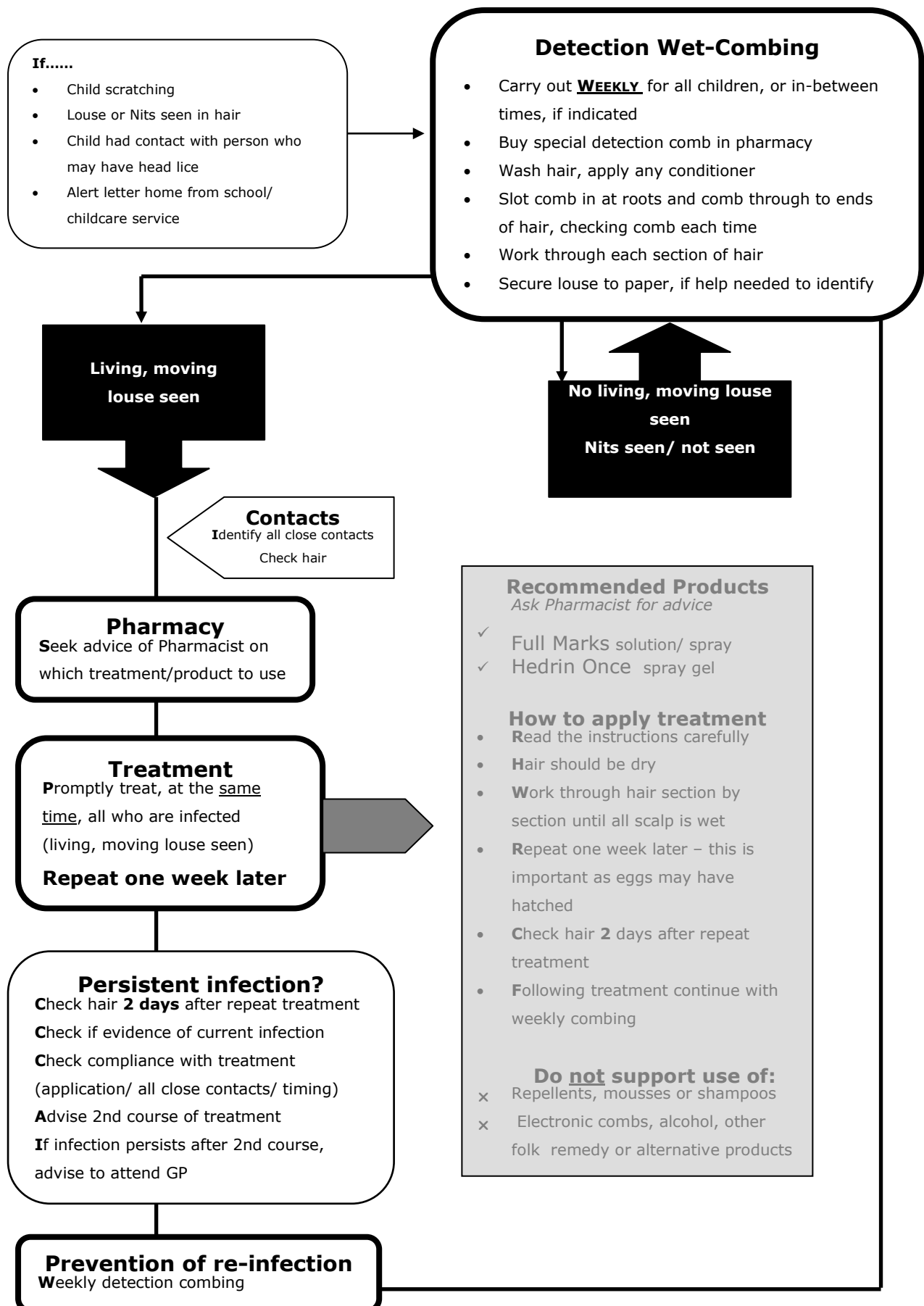
B. Male head louse

Accessed: 20.04.15 Wikipedia http://en.wikipedia.org/wiki/Head_louse



Appendix IV

Algorithm for Control of Head Lice in Children:



Desktop Guide to Treatment of Head Lice in Children:

Recommended Products of Choice currently on sale in Ireland				
Product	Active Ingredient	Application Time	Repeat	Age Restriction
Full Marks Solution	Isopropyl myristate Dimethicone	10 minutes	7 days	2 years of age and upwards
Full Marks Spray/ Solution	Isopropyl myristate 50% Cyclomethicone	10 minutes	7 days	2 years of age and upwards
Hedrin Once Spray Gel	Simethicone 4% plus Penetrol	15 minutes	7 days <i>Manufacturer's instructions advise only one application</i>	6 months of age and upwards

Applying Treatment

- ✓ Treat everyone infected, at the same time
- ✓ Read instructions
- ✓ Hair should be dry
- ✓ Part hair near top of head, rub lotion into scalp
- ✓ Work through hair section by section
- ✓ Lotion only needs to go as low as a ponytail band would go
- ✓ Repeat one week later – even if the instructions say one application only
- ✓ Check hair **2 days** after repeat treatment
- ✓ Once treatment complete, continue with weekly wet-combing

Not Recommended as treatment: with rationaleMechanical removal of head lice:

This is less effective than recommended treatments. Some evidence that if the commercial 'Bug buster' kit (fine-tooth combs & DVD) is used correctly and rigorously it can be effective in a proportion of cases. It is labour intensive and requires a lot of commitment. The kit is a useful educational support to staff in demonstrating correct technique for detection combing.

Mousses, shampoos or repellents:

No evidence that repellents work in preventing re-infection.

Shampoo and mousse formulations contain low concentrations of active ingredient, or don't allow for sufficient contact time. Therefore, even if active agent has potential to kill lice, it is unlikely to do so.

Lyclear Rinse: This product is not recommended as clinical trial evidence shows that the contact time is too short to be effective.

Alternative Products

Products containing essential oils e.g. tea tree /eucalyptus oil are marketed as 'natural' remedies for head lice. Different products contain different concentrations of the oil. For many, there is a lack of an evidence base on which to assess effectiveness. The safety of some alternative methods is unknown and therefore there is the risk that safety problems could arise.

Other devices – some devices claim to electronically aid the removal and/or killing of lice (e.g. electronic combs and dry air devices). Evidence of effectiveness is generally absent and their incorrect use may present a safety risk.

Appendix VI

Monitoring Checklist – Guideline for the control of head lice infection in children. CHO Area 1 (Donegal, Sligo, Leitrim and West Cavan)

To be Completed as part of the routine monitoring of compliance with this Procedure					
Completed By _____ Date Completed _____					
Monitoring Checklist and Guidance	Response	Corrective action required	Responsibility	Date due	Outcome from Corrective action
How do you ensure that all staff are aware of the Guideline?					
Is the Guideline easily accessed by staff?					
When the Guideline is reviewed, is there a process in place to ensure that only current version is in circulation?					
Is there a system in place to monitor service statistics on supporting the control of head lice in schools/ community?					

Appendix VII

Audit Tool

Guideline for the control of head lice infection in children CHO Area 1 (Donegal, Sligo, Leitrim and West Cavan)

Guidance on conducting audit

Source of information for audit purposes - Parents, School Principals, Managers of Early Years services, GPs, Practice Nurses, Community Pharmacists, Area and School PHNs and Medical Officers in Sligo Leitrim West Cavan and Donegal

Selection – Representative sample of parents (urban/rural) and representative sample of practitioners from each service/ agency

Completing the audit tool -

- One copy of the audit tool can be used to record audit results from six contacts.
- The criteria statements are answered as Yes, No or Not Applicable.
- The tool is divided into sections for Parents (Pre-school aged children and school-aged children), Early Years service managers, School Principals, Pharmacists, Practice Nurses, GPs, Area and School PHNs and Medical Officer. Complete the relevant section only.
- Record the results in the relevant section using the small shaded boxes in the column under the identifying number 1-6.

Record **1** for **Yes**, if the criterion **is** found evidenced in the report.

Record **0** for **No**, if the criterion **is not** found evidenced in the report.

Record **N/A** for **Not applicable** if the criterion is not applicable.

Reporting results from the audit – the total of **Yes** and **Not Applicable** answers in each column of the relevant section (e.g. parent of pre-school aged child), are added and calculated as a percentage of the total number of answers (Yes, No and Not applicable). The result is a percentage representation of adherence to the Procedure. Results can then be totalled across the full set audited to present the % compliance with the Guideline, within each service/ agency.

The results are then discussed at service management level and quality improvement actions required are identified and a plan put in place for implementation of the improvements and a re-audit is scheduled.

Audit Details

Service / Area		Date of Audit	
Auditor(s) Name(s)		Auditor(s) Title (s)	
Identifier (name/service use abbreviations)	1.	2.	3.
	4.	5.	6.

Criteria	Identifier					
	1	2	3	4	5	6
1. Parent of <u>pre-school aged child</u> experiences a consistent evidence-based approach to the control of head lice						
Parent reports having received head lice leaflet for parents from Early Years service						
Parent reports having got the same information (verbal/leaflet) from other relevant services (Pharmacist, GP, Practice Nurse, PHN, Medical Officer)						
Parent reports feeling knowledgeable on how to prevent/ manage head lice infection						
2. Parent of <u>school-aged child</u> experiences a consistent evidence-based approach to the control of head lice						
Parent reports having received head lice leaflet for parents from school						
Parent reports that either child or parent received 'Detection Comb Hero' head lice leaflet for children, from school						
Parent reports having got the same information (verbal/leaflet) from other relevant services (Pharmacist, GP, Practice Nurse, PHN, Medical Officer)						
Parent reports feeling knowledgeable on how to prevent/ manage head lice infection						
3. Early Years service manager						
Reports having received this Guideline (electronic format with leaflets included)						
Reports circulating the information leaflet to parents/children						
Reports consulting the Guideline						
Reports having enough knowledge to guide parents on preventing/managing head lice						
Reports knowing how to manage cases of head lice infection that might arise in their Early years service						
4. Teacher Primary School						
Reports having received this Guideline (electronic format with leaflets included)						
Reports circulating the information leaflet to parents/children						
Reports consulting the Guideline						
Reports having enough knowledge to guide parents on preventing/managing head lice						
Reports knowing how to manage cases of head lice infection that might arise in their school						
5. Pharmacist						
Reports having received this Guideline (electronic format with leaflets included)						
Reports circulating the information leaflet to parents						
Reports consulting the Guideline						
Reports that Guideline has enough information to support Pharmacist in guiding parent on scientifically proven way of treating head lice infection						

6. Practice Nurse							
Reports having received this Guideline (electronic format with leaflets included)							
Reports circulating the information leaflet to parents							
Reports consulting the Guideline							
Reports that Guideline has enough information to support Practice Nurse in guiding parent on scientifically proven way of controlling head lice infection							
7. General Practitioner (GP)							
Reports having received this Guideline (electronic format with leaflets included)							
Reports circulating the information leaflet to parents							
Reports consulting the Guideline							
Reports that Guideline has enough information to support GP in guiding parent on scientifically proven way of controlling head lice infection							
8. School Public Health Nurse (PHN)							
Reports having received this Guideline (electronic format with leaflets included)							
Reports circulating the information leaflet to parents							
Reports consulting the Guideline							
Reports that Guideline has enough information to support school PHN in guiding parent on scientifically proven way of controlling head lice infection							
8. Area Public Health Nurse (PHN)							
Reports having received this Guideline (electronic format with leaflets included)							
Reports circulating the information leaflet to parents							
Reports consulting the Guideline							
Reports that Guideline has enough information to support area PHN in guiding parent on scientifically proven way of controlling head lice infection							
9. Medical Officer							
Reports having received this Guideline (electronic format with leaflets included)							
Reports circulating the information leaflet to parents							
Reports consulting the Guideline							
Reports that Guideline has enough information to support Medical Officer in guiding parent on scientifically proven way of controlling head lice infection							
Total Scores for Yes							
Total Scores for No							
Total Scores for N/A							
Total % (Total of Yes + N/A as a percentage of Total)							

Guideline for the control of head lice infection in children CHO Area 1 (Donegal, Sligo, Leitrim and West Cavan)

Comments and Recommendations arising from the audit:

Consider differences in implementation of this Guideline, identify implementation issues, identify quality improvement actions and schedule re-audit.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on the right side, suggesting it's resting on a surface.

Completed by: _____ **Date:** _____

Date: _____

Dear Parent or Guardian,

There has been a case of head lice in your child's childcare facility/ school and your child may have been exposed.

What are head lice?

Head lice are little insects with moving legs. They are often not much bigger than a pin head, but may be as big as a sesame seed (the seeds on burger buns). They live on, or very close to, the scalp and don't wander far down the hair shaft for very long. They can only live on humans; you cannot catch them from animals.

What are nits?

Nits are not the same thing as lice. Nits are egg cases laid by lice, stuck on to hair shafts. They are smaller than a pin head and pearly white. If you have nits it doesn't always mean that you have headlice. When you get rid of all the lice, the nits will stay stuck to the hair until it grows out.

How are they spread?

Anyone can pick up head lice. They are most common among young children as they often put heads together during play allowing the lice walk from one head to the next. **Head lice do not reflect standards of hygiene. They are just as willing to live in clean or dirty hair.**

Can you stop them?

The best way is for families to learn how to check their own heads. This way they find any lice before they have a chance to breed. They can then treat them and stop them being passed round the family. The way to check someone's head is called "detection combing". This should be done regularly and in the case of a confirmed infection in one family member, the other members of the household should carry out "detection combing" twice weekly for one week.

How do I do detection combing?

You need a plastic detection comb, good lighting and an ordinary comb.

- Wash the hair well, then dry it with a towel. The hair should be damp, not dripping. A small amount of conditioner may help if the hair is tangled.
- Make sure there is good light, daylight is best.
- Comb the hair with an ordinary comb.
- Start with the teeth of the detection comb touching the skin of the scalp at the top of the head.
- Draw the comb carefully towards the edge of the hair.
- Look carefully at the teeth of the comb in good light.
- If there are head lice, you will find one or more lice on the teeth of the comb. A magnifying glass may be useful.
- Do this over and over again from top of head to the edge of the hair in all directions, working round the head.
- Do this for several minutes. It takes 10 to 15 minutes to do it properly for each head.

Who needs treatment?

Only treat those who have living, moving lice. If more than one family member has lice, treat all those at the same time.

How do I treat them?

A head lice lotion (not shampoo) should be used. Ask your local pharmacist, public health nurse or GP which lotion to use, and how long to leave it on. Follow the instructions that come with the particular product.

- Repeat treatment again seven days later, in the same way, with the same lotion.
- Check all heads a day or two after the repeat treatment. If you still find living, moving lice, ask your public health nurse or GP for advice.

Appendix IX

Head Lice Information available for Parents and Children

- Parent Information Leaflet: 'Don't bug me – truth and lice'
Suitable for back-to-back (both sides) printing
- Child Information Leaflet: Cartoon strip 'Detection Comb Hero'
Suitable for back-to-back (both sides) colour printing
- Child Information A4 Poster: Cartoon strip 'Detection Comb Hero'
Suitable for colour printing

} Available as
separate
electronic
attachments

Appendix X – Peer Approvals

HSE Procedure for developing Policies, Procedures, Protocols and Guidelines

Peer Review of Policy, Procedure, Protocol or Guidance

Reviewer: The purpose of this statement is to ensure that a Policy, Procedure, Protocol or Guideline (PPPG) proposed for implementation in the HSE is circulated to a peer reviewer (internal or external), in advance of approval of the PPPG. You are asked to sign this form to confirm to the committee developing this Policy or Procedure or Protocol or Guideline that you have reviewed and agreed the content and recommend the approval of the following Policy, Procedure, Protocol or Guideline:

Title: Guideline for the control of head lice infection in children
CHO Area 1 (Donegal, Sligo Leitrim W Cavan).

I acknowledge the following:

I have been provided with a copy of the Guideline described above.

I have read the Guideline document.

I agree with the Guideline and recommend its approval by the committee developing the PPPG.

MARY CONNOR
Name

Maryland
Signature

22/06/2015
Date

CNS - Paediatric Liaison
Title

Please return this completed form to:

Bríd Brady
Child Health Development Officer
Primary Care Centre
Barrack Street
Sligo

bridp.brady@hse.ie
0879126747

HSE Procedure for developing Policies, Procedures, Protocols and Guidelines

Peer Review of Policy, Procedure, Protocol or Guidance

Reviewer: The purpose of this statement is to ensure that a Policy, Procedure, Protocol or Guideline (PPPG) proposed for implementation in the HSE is circulated to a peer reviewer (internal or external), in advance of approval of the PPPG. You are asked to sign this form to confirm to the committee developing this Policy or Procedure or Protocol or Guideline that you have reviewed and agreed the content and recommend the approval of the following Policy, Procedure, Protocol or Guideline:

Title: Guideline for the control of head lice infection in children
CHO Area 1 (Donegal, Sligo Leitrim W Cavan).

I acknowledge the following:

I have been provided with a copy of the Guideline described above.

I have read the Guideline document.

I agree with the Guideline and recommend its approval by the committee developing the PPPG.

COLIN DEERY
Name


Signature

16/8/2015
Date

Community Pharmacist
Title

Please return this completed form to:

Bríd Brady
Child Health Development Officer
Primary Care Centre
Barrack Street
Sligo

bridp.brady@hse.ie
0879126747

HSE Procedure for developing Policies, Procedures, Protocols and Guidelines

Peer Review of Policy, Procedure, Protocol or Guidance

Reviewer: The purpose of this statement is to ensure that a Policy, Procedure, Protocol or Guideline (PPPG) proposed for implementation in the HSE is circulated to a peer reviewer (internal or external), in advance of approval of the PPPG. You are asked to sign this form to confirm to the committee developing this Policy or Procedure or Protocol or Guideline that you have reviewed and agreed the content and recommend the approval of the following Policy, Procedure, Protocol or Guideline:

Title: Guideline for the control of head lice infection in children
CHO Area 1 (Donegal, Sligo Leitrim W Cavan).

I acknowledge the following:

I have been provided with a copy of the Guideline described above. ✓

I have read the Guideline document. ✓

I agree with the Guideline and recommend its approval by the committee developing the PPPG. ✓

CATRIONA DUIGAN
Name

[Signature]
Signature

1/07/2015
Date

Public Health Nurse
Title

Please return this completed form to:

Brid Brady
Child Health Development Officer
Primary Care Centre
Barrack Street
Sligo

bridp.brady@hse.ie
0879126747

HSE Procedure for developing Policies, Procedures, Protocols and Guidelines

Peer Review of Policy, Procedure, Protocol or Guidance

Reviewer: The purpose of this statement is to ensure that a Policy, Procedure, Protocol or Guideline (PPPG) proposed for implementation in the HSE is circulated to a peer reviewer (internal or external), in advance of approval of the PPPG. You are asked to sign this form to confirm to the committee developing this Policy or Procedure or Protocol or Guideline that you have reviewed and agreed the content and recommend the approval of the following Policy, Procedure, Protocol or Guideline:

Title: Guideline for the control of head lice infection in children
CHO Area 1 (Donegal, Sligo Leitrim W Cavan).


I acknowledge the following:

I have been provided with a copy of the Guideline described above.

I have read the Guideline document.

I agree with the Guideline and recommend its approval by the committee developing the PPPG.

Dr. Frank Hayes
Name


Signature

27.08.2015
Date

Sligo - Leitrim CME Tutor
Title

Please return this completed form to:

Brid Brady
Child Health Development Officer
Primary Care Centre
Barrack Street
Sligo

bridp.brady@hse.ie
0879126747

Dr. Frank Hayes, M.R.C.G.P.
No. 1, Wine Street,
Sligo.
Phone: 071-9170522

HSE Procedure for developing Policies, Procedures, Protocols and Guidelines

Peer Review of Policy, Procedure, Protocol or Guidance

Reviewer: The purpose of this statement is to ensure that a Policy, Procedure, Protocol or Guideline (PPPG) proposed for implementation in the HSE is circulated to a peer reviewer (internal or external), in advance of approval of the PPPG. You are asked to sign this form to confirm to the committee developing this Policy or Procedure or Protocol or Guideline that you have reviewed and agreed the content and recommend the approval of the following Policy, Procedure, Protocol or Guideline:

Title: Guideline for the control of head lice infection in children
CHO Area 1 (Donegal, Sligo Leitrim W Cavan).

I acknowledge the following:

I have been provided with a copy of the Guideline described above.

I have read the Guideline document.

I agree with the Guideline and recommend its approval by the committee developing the PPPG.

<u>Niamh Kavanagh</u>	<u>Niamh Kavanagh</u>	<u>21.08.15</u>
<i>Name</i>	<i>Signature</i>	<i>Date</i>
 <u>Practice Nurse</u>		
<i>Title</i>		

Please return this completed form to:

Brid Brady
Child Health Development Officer
Primary Care Centre
Barrack Street
Sligo

bridb.brady@hse.ie
0879126747

[Faint circular stamp, likely a library or archive mark]

HSE Procedure for developing Policies, Procedures, Protocols and Guidelines

Peer Review of Policy, Procedure, Protocol or Guidance

Reviewer: The purpose of this statement is to ensure that a Policy, Procedure, Protocol or Guideline (PPPG) proposed for implementation in the HSE is circulated to a peer reviewer (internal or external), in advance of approval of the PPPG. You are asked to sign this form to confirm to the committee developing this Policy or Procedure or Protocol or Guideline that you have reviewed and agreed the content and recommend the approval of the following Policy, Procedure, Protocol or Guideline:


Title: Guideline for the control of head lice infection in children
CHO Area 1 (Donegal, Sligo Leitrim W Cavan).

I acknowledge the following:

I have been provided with a copy of the Guideline described above.

I have read the Guideline document.

I agree with the Guideline and recommend its approval by the committee developing the PPPG.

<u>ELIZABETH LANG.</u> Name	<u></u> Signature	<u>17/8/15.</u> Date
<u>Community PHARMACEUT</u> Title		

Please return this completed form to:

Bríd Brady
Child Health Development Officer
Primary Care Centre
Barrack Street
Sligo

bridp.brady@hse.ie
0879126747

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<u>Arlin McMonagle</u> Name	<u>Arlin McMonagle</u> Signature	<u>09/06/15</u> Date
<u>Manager Donegal CCC</u> Title		

Please return this completed form to:

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Child Health Development Officer
Primary Care Centre
Barrack Street
Sligo

bridp.brady@hsc.ie
0879126747

Donegal County Childcare Committee Ltd
Coiste Cúram Páisti Chontae Dhún na nGall Teo
10-11 St. Columba's Terrace, High Road,
Letterkeny, Co. Donegal.
Tel: 074 91 23442

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<u>DEBORAH HUGGAN</u> Name	<u>Deborah Huggan</u> Signature	<u>17/6/15</u> Date
<u>Senior Medical Officer</u> Title		

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