Standards of Care for Children with Pediculosis capitis

I. Title: Standards of care for children with pediculosis capitis

II. Type of Standard: Service

III. Outcome: Early recognition of pediculosis capitis (head lice) infestation and prompt intervention and treatment will result in a reduction of transmission. Based on current literature, head lice infestation can affect adults but is most common among children 3 to 12 years of age and affects approximately 6 to 12 million children yearly. A prehistoric survivor, head lice are small parasitic insects that live on the scalp of human hosts. Head lice are transmitted from person to person by direct contact or shared use of hair grooming items, hats or bedding. Head lice are not found on animals or household pets and are not transmitted from animals to humans. The most common symptom of head lice infestation is itching. Head lice are not a health hazard, a sign of uncleanliness, or considered to be vectors of disease. Complications of head lice infestation are rare but may involve a secondary skin infection. Interventions for head lice infestation must include environmental controls, as well as, direct scalp treatment. Counseling and education of the child and the parent are essential to attain the goals of prevention, early detection and effective treatment, thus reducing transmission to others.

IV. Personnel: M.D., D.O., A.R.N.P., P.A., R.N., L.P.N., and Aides/Techs within the constraints of their practice acts and protocols

1. Subjective and objective data gathering: M.D., D.O., A.R.N.P., P.A., R.N., L.P.N., Aide/Tech
2. Assess and evaluate: M.D., D.O., A.R.N.P., P.A., R.N.
3. Planning/Education/Counseling: M.D., D.O., A.R.N.P., P.A., R.N., L.P.N.

4. Intervention: M.D., D.O., A.R.N.P., P.A., R.N., L.P.N., Aide/Tech
5. Evaluation: M.D., D.O., A.R.N.P., P.A., R.N., L.P.N. Aide/Tech
6. Emergency: M.D., D.O., A.R.N.P., P.A., R.N.
7. Documentation: M.D., D.O., A.R.N.P., P.A., R.N., L.P.N., Aide/Tech

V. Competencies: Health care professionals should demonstrate knowledge of the responsibilities related to prevention, diagnosis, and treatment of Pediculosis capitis (head lice). This should have included didactic, practicum, and clinical training that covered assessment and evaluation, pharmacology, clinical studies, counseling, client management, and complications.

VI. Areas of Responsibility:

A. Subjective Data:

1. Obtain client's history from a reliable source. Client history should include:
    a. Symptoms of infestation (itching and scratching of scalp)
    b. Duration of symptoms
    c. Family history of head lice infestation
    d. Social history, including daycare or school attendance, overnight stays outside of the home, close physical contact with others, and sharing of clothing or personal items, such as combs and brushes.
    e. Days missed from daycare or school due to head lice infestation and disruption of family routine.
    f. Parent/guardian's knowledge of head lice transmission, symptoms, and treatment.

B. Objective Data:

1. Observation of live lice on client's head.

2. Observation of lice eggs or nits on scalp hair within 1 cm from scalp.

C. Assessment and Treatment:

1. Careful examination of hair and scalp are necessary to differentiate between live lice or nits and other hair debris, such as dandruff.
2. Ensure that a correct diagnosis/identification has been made prior to determining treatment options. Treatment should be considered only when active lice or viable eggs are observed.
3. Several treatment options, with varying degrees of effectiveness, exist to eliminate head lice infestation. Successful treatment may require an integrated approach, including topical treatment, manual removal of nits, and environmental interventions.
4. According to the American Academy of Pediatrics and the Harvard School of Public Health, 1% permethrin (Nix [Pfizer Consumer Health Care Group, New York, NY]) is the recommended treatment of choice for head lice. It has extremely low mammalian toxicity and does not cause allergic reactions in individuals with plant allergies.
5. Guidelines for use of 1% permethrin:
   a. Shampoo hair with nonconditioning shampoo, towel dry
   b. Apply (1% permethrin) crème rinse, allow at least 10 minutes before rinsing with warm water.
   c. 1% permethrin leaves a residue on the hair that kills 20-30% of emerging nymphs not killed with initial application.
   d. Application may be repeated in 7 to 10 days, if live lice or nits within 1 cm. of the scalp are present.
6. No pediculicide is 100% ovicidal. Manual removal of nits, especially nits within 1 cm. of the scalp, is recommended by some experts.

7. All household members should be checked for head lice.
8. Household members with live lice or nits within 1 cm. of the scalp should be treated.

D. Environmental Interventions: (Head lice survival off a human host is extremely rare after 48 hours.)

1. All items that have had contact with the head of the infested person should be thoroughly cleaned.
2. To kill stray lice and nits, bed linens and clothing should be washed with detergent and hot water and machine dried at temperatures greater than 130 degrees F.
3. All hair care items (combs, brushes, ornaments) should be cleaned with detergent and hot water, soaked in alcohol or disinfectant, and dried thoroughly.
4. Furniture, carpet, car seats, and other fabrics or fabric-covered items should be thoroughly vacuumed.
5. Items that cannot be washed can be closed in plastic bags for 2 weeks, during which time any viable lice or nits will die without a feeding source.
6. Enviornmental pediculicide sprays should not be used due to the risk of toxic chemical exposure to humans, animals, and plants.

E. Education and Counseling:

1. Parent education should include prevention measures, signs and symptoms of head lice infestation, and treatment procedures.
2. Multi-media (brochures, video tapes, visual aids, diverse language) information regarding head lice should be available at county health departments, day care settings, schools, and

other community agencies.

3. Treatment failure may indicate misdiagnosis, noncompliance with treatment regimen, reinfestation, or parasite resistance to pediculicide. Multiple treatments and use of multiple types of pediculicides should be discouraged and professional medical advice should be sought when treatment failure occurs.

VII. Supportive Data:

1. Frankowski, B.L.& Weiner, L.B. (2002). Head Lice, a clinical report, *Pediatrics,* 110 (3), pp. 638–643.

2. Pollack, R.J., Kiszewski, A., & Speilman, A. (2000). Overdiagnosis and consequent mismanagement of head louse infestations in North America, *Pediatric Infectious Disease Journal,* 18, pp. 689-693.

3. Head Lice Information. Retrieved August 14, 2006 from: http://www.hsph.harvard.edu/headlice.html

4. Head Lice (Pediculus humanus capitis). Retrieved August 15, 2006 from: http://www.dpd.cdc.gov