1.0 PURPOSE:

1.1 To prevent infestations and outbreaks of Scabies within Long Term Care Facilities (LTCF) in the Winnipeg Health Region.

1.2 To effectively treat cases of Scabies within Long Term Care Facilities (LTCF) in the Winnipeg Health Region.

2.0 DEFINITIONS:

2.1 Crusted Scabies: (also known as Norwegian or keratotic Scabies). An uncommon clinical syndrome characterized by crusted lesions caused by many infesting Scabies mites on any part of the body. Unrecognized Crusted Scabies is often the source of institutional outbreaks.

2.2 Exposure to Typical Scabies: Direct skin-to-skin contact with the infested person during the period of communicability (4-6 weeks before symptoms develop until 24 hours after initiation of effective treatment).

2.3 Exposure to Crusted Scabies: Minimal direct or indirect contact with the infested person during the period of communicability (4-6 weeks before symptoms develop until 24 hours after initiation of effective treatment). Only minimal contact is required with Crusted Scabies because of the large number of mites present on the source person. Indirect exposure to Crusted Scabies can include exposure to the heavily infested individual’s clothing, bedding, and/or furniture.
2.4 **Outbreak**: The occurrence in a facility/unit of cases of an illness with a frequency clearly in excess of normal expectancy. The number of cases indicating an outbreak will vary according to the infectious agent, size and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence. Therefore, the status of an outbreak is relative to the usual frequency of the disease in the same facility/unit, among the same population, at the same season of the year.

2.5 **Scabicide**: A medication used to treat Scabies.

2.6 **Scabies**: A skin infestation caused by a mite; *Sarcoptes scabiei* subspecies *hominis*.

2.7 **Scabies Outbreak**: Consider the possibility of an outbreak if a health care worker or a resident in the personal care home meets the criteria for diagnosis of Scabies.
   - **Typical Scabies**: Consider the possibility of an outbreak if more than one resident in the site meets the criteria for diagnosis of Scabies.
   - **Crusted Scabies**: Consider the likelihood of an outbreak when only one case of Crusted Scabies is identified.

2.8 **Typical Scabies**: An infestation of Scabies producing the classic presentation of: intense puritis (itching), widespread papules (bumps), and winding burrows a millimeter or two in length in the spaces between the fingers or on the forearm. Puritis (itching) is caused by irritation from the eggs, feces, and saliva of the mite, which reproduces in the spaces between the fingers, toes, and genital regions of infested residents. The usual response is to scratch, killing the mite and therefore keeping the numbers of infesting organisms low.

3.0 **PREVENTION:**

3.1 Early detection, treatment, and implementation of appropriate precautions and infection control practices are essential in preventing Scabies Outbreaks. An aggressive approach to preventing and controlling Scabies in institutions, particularly when Crusted Scabies is confirmed or suspected, is recommended in the literature.

3.1.1 All facilities should maintain a high index of suspicion that undiagnosed skin rashes and conditions or skin conditions that are not responding to treatment may be Scabies even if characteristic signs and/or symptoms of Scabies are absent (e.g., no itching).
3.1.2 All resident admissions should be assessed for:
• Any history or clinical findings consistent with Scabies
• Skin lesions and rashes

4.0 **Control and Management**

4.1 Assessment and Diagnosis
4.1.1 Immediately upon suspicion of Scabies, implement Contact Precautions (gowns, gloves) for direct resident contact only. Otherwise, use Routine Practices and emphasize good hand hygiene.

4.1.2 Restrict the resident(s) to their room(s) and maintain Contact Precautions until 24 hours after the start of effective treatment.

4.1.3 For Crusted Scabies, contact Precautions will be prolonged due to treatment requirements. Precautions must remain in place until the resident’s rash resolves.

4.1.4 Document any skin lesions or rashes the resident(s) has in the Integrated Progress Notes. Contact the resident’s attending physician and the site ICP or designate if Scabies is suspected. Appendix A can be used within sites to promote timely diagnosis.

4.1.5 Confirm the diagnosis of Scabies. This often requires consultation to a dermatologist or infectious diseases specialist as Scabies infestations are difficult to diagnose.

4.1.5.1 Skin scrapings (Appendix B) may be done by the attending physician, dermatologist, infectious diseases specialist, or trained professional to confirm the presence of the Scabies mites, ova, or inflammation caused by same.

4.1.6 The Infection Control Professional (ICP)/designate is responsible to declare a Scabies Outbreak upon meeting the definition.

4.2 Contact Identification
4.2.1 As soon as a possible case of Scabies is identified the ICP/designate is responsible to develop a contact identification list. This should include every resident who may have had direct skin contact with the symptomatic resident within the previous 6 weeks using the Outbreak Investigation Form (Appendix C).

4.2.1.1 Include roommates transferred to other nursing units or to another facility within the previous 6 weeks.
4.2.1.2 Determine if these contacts are symptomatic or asymptomatic.

4.2.1.3 If the symptomatic resident was transferred to another health care facility for treatment (e.g. dialysis), within the past 6 weeks, notify the other facilities’ ICP/designate.

4.2.1.4 Determine if there are symptomatic residents on other nursing units.

4.2.2 Occupational Environmental Safety & Health (OESH) or designate is responsible to identify health care workers and volunteers who have had direct physical contact with the symptomatic resident within the past 6 weeks.

4.2.2.1 Determine if these contacts are symptomatic or asymptomatic.

4.2.2.2 Determine if there are symptomatic health care workers or volunteers on other nursing units.

4.2.2.3 Ensure a proactive employee health service approach to Scabies including providing information to all staff.

4.2.2.4 Staff who are symptomatic, have had direct skin to skin contact with symptomatic resident, or diagnosed with Scabies require treatment with Scabicide and may return to work after treatment.

4.2.2.5 Exposed staff who refuse treatment will be required to wear personal protective equipment (gloves, gown) for direct resident contact (skin to skin) for a minimum of 6 weeks. This PPE must be changed between tasks and between residents.

4.2.2.6 Advise staff that exposed household members and intimate contacts should seek medical evaluation from a community health centre or physician regarding evaluation of risk, diagnosis and/or treatment.

4.2.3 The unit is responsible to notify visitors (spouses, family members, and friends) who may have visited the symptomatic resident within the past 6 weeks.

4.3 Treatment

4.3.1 One of the keys to successful control of an outbreak is the simultaneous treatment of cases and of all exposed individuals to prevent re-exposure and ongoing transmission.
4.3.2 Identify and obtain prescriber orders to treat the resident(s) infested with Typical Scabies and anyone meeting the definition for Exposure to Typical Scabies simultaneously.

4.3.3 Crusted Scabies is difficult to treat, and has a significant treatment failure rate. Several products may need to be tried, and multiple treatments may need to be given. Consider ‘prophylactically’ treating the entire unit(s)/affected area(s) when even a single case of Crusted Scabies is identified as the likelihood of transmission and progression to an outbreak is high.

4.3.4 Permethrin 5% (e.g., Nix® Dermal Cream)

4.3.4.1 More effective than all other Scabicides; reduced systemic absorption. Preferred treatment for adults with Scabies.

4.3.4.2 Massage the permethrin cream thoroughly into the skin over the entire body from the base of the hairline downwards to the toes/soles of the feet with special attention to skin folds, creases, and interdigital spaces. Place the resident in clean clothing.

4.3.4.3 Wash the permethrin cream off after 12 hours.

4.3.4.4 Symptomatic residents should be treated twice, one week apart, and asymptomatic resident contacts once.

4.3.4.5 Ensure there is enough cream available to effectively cover the resident’s body as insufficient coverage could result in ongoing infestation. A 30 gram tube of permethrin cream typically is enough to cover the body of an average sized resident. For larger residents, more than 1 tube may be required.

4.3.4.6 Permethrin 1% cream rinse is not effective for Scabies treatment.

4.3.5 Crotamiton 10% (e.g., Eurax® cream)

4.3.5.1 Low toxicity even when applied to excoriated skin and has a beneficial antipruritic effect. Less effective than permethrin and resistance has been reported.

4.3.5.2 Massage the crotamiton cream thoroughly into the skin over the entire body from the base of the hairline downwards to the toes/soles of the feet with special attention to skin folds, creases, and interdigital spaces. Place the resident in clean clothing.

4.3.5.3 Repeat application in 24 hours. Wash the crotamiton cream off 48 hours after the last application.
4.3.5.4 Repeat the treatment in symptomatic residents after 7-10 days. Asymptomatic resident contacts only need to be treated once.

4.3.6 Precipitated sulfur 10% in petrolatum ointment (compounded)
4.3.6.1 Massage the precipitated sulfur cream thoroughly into the skin over the entire body from the base of the hairline downwards to the toes/soles of the feet with special attention to skin folds, creases, and interdigital spaces. Place the resident in clean clothing.
4.3.6.1 Wash the precipitated sulfur cream off after 12 hours. Repeat on 3 consecutive days to provide the best balance of efficacy and adverse effects (e.g. sulfur dermatitis)

4.3.7 Lindane 1% has been discontinued in all forms in Canada due to potential neurotoxicity.

4.3.8 Ivermectin (Stromectol®) - oral antiscabietic
4.3.8.1 Treatment for resistant Typical Scabies or as an adjuvant to permethrin in Crusted Scabies.
4.3.8.2 Dosing for Typical Scabies:
   • Ivermectin 200 mcg/kg orally; repeat the dose in 2 weeks
4.3.8.3 Dosing for Crusted Scabies:
   • Ivermectin 200 mcg/kg orally on days 1, 2, 8, 9, and 15; for severe cases, additional treatment on days 22 and 29 may be required.
   • Combine with daily application of 5% permethrin cream applied over the entire body as described in 4.3.3.2 for 7 days then twice weekly until cure.
4.3.8.4 Available as 3 mg tablets through the Health Canada Special Access Program Health Canada's Special Access Programme: Special Access Request - Form A.
4.3.8.5 Take Ivermectin with food to increase bioavailability, thus increasing penetration of the drug into the epidermis.
4.3.9  Puritis may take a few weeks to resolve. If puritis is bothersome to the resident, the following treatments are suggested:

- Emollients/moisturizers
- Cool, wet compresses
- Topical corticosteroids (note: this may further mask signs and symptoms of infestation and should be avoided while the infestation is active)
- Antipruritic topical lotions
- Antihistamines
- Keep fingernails closely trimmed to reduce injury from excessive scratching

4.3.10  Staff and visitor contacts should discuss treatment with their pharmacist or physician.

4.4  Environmental Cleaning

4.4.1  Coordinate the cleaning of the environment and linen with the timing of treatment.

4.4.2  Laundry

4.4.2.1  For Typical Scabies;

4.4.2.1.1  Remove bed linens, and replace with clean bedding before the resident returns to the room after the scabicide is washed off in keeping with the routine of changing bed linens with the resident’s bath day. Typical Scabies is transmitted by skin to skin contact therefore laundering personal bedspreads, blankets, and afghans are not required.

4.4.2.1.2  There are no special precautions for handling contaminated laundry. Follow Routine Practices when handling any contaminated laundry/linens.

4.4.2.2  For Crusted Scabies;

4.4.2.2.1  All laundry should be laundered in hot water.

4.4.2.2.1  Remove bed linens, including personal bedspreads, blankets and afghans. Replace with clean bedding before the resident returns to the room after the scabicide is washed off.

4.4.2.2.2  Launder separately, and/or seal all clothing/laundry worn by the resident for 4 days before treatment in a plastic bag.
4.4.2.2.3 Where infrastructure and/or resources do not permit the quantities of laundry required (e.g., in a large outbreak where an entire unit is being treated), personal clothing and bedding items (e.g., afghans) can also be bagged for 4 days. Sites may also choose to have the resident infested with Crusted Scabies wear a ‘hospital’ gown and robe and segregate all the resident’s personal clothing in their closet for 4 days instead of laundering those items.

4.4.3 Equipment
4.4.3.1 For Typical Scabies
4.4.3.1.1 Per Routine Practices, all equipment must be cleaned between resident use. Typical Scabies are transmitted by skin to skin contact, therefore cleaning in excess of Routine Practices is not required.

4.4.3.2 For Crusted Scabies,
4.4.3.2.1 Clean and disinfect, with facility approved disinfectant, multiple use equipment that has had direct skin to skin contact with a symptomatic resident and/or a contact of a symptomatic resident (e.g. walking belts, slings, blood pressure cuffs) or their potentially contaminated environment.
4.4.3.2.2 Clean & disinfect, with facility approved disinfectant the mattress, wipeable pillow cases, bed frame, and bed side equipment before the resident returns to the room after Scabicide has been washed off.

4.4.4 Housekeeping
4.4.4.1 Carpeting and soft surface seating should not be used in LTC settings, however there are some sites that have installed carpet or permitted families to bring in fabric recliners for resident use against infection prevention and control recommendations.
4.4.4.1.1 Typical Scabies are transmitted by skin to skin contact therefore nothing other than routine cleaning is necessary.
4.4.4.1.2 For Crusted Scabies, the large numbers of mites involved in an infestation can lead to contamination of the environment. Soft surface seating should be segregated for 4 days and vacuuming is sufficient for carpeted areas. Hard surfaces (e.g., bed frames) should be cleaned and disinfected with facility approved disinfectant.

4.4.4.2 Use of insecticide sprays and fumigants is not recommended.

4.5 Monitoring

4.5.1 Ongoing monitoring is essential to plan further control and prevention measures if required.

4.5.1.1 Nursing staff and Health Care Aides are responsible for:

4.5.1.1.1 Continuing to monitor all residents for signs and symptoms of Scabies for 6 to 8 weeks following the last case.

4.5.1.1.2 Reporting all new and suspected cases of Scabies to the ICP/designate.

4.6 Communication

4.6.1 The ICP/designate is responsible to:

4.6.1.1 Notify Unit Staff, Medical Director, and Attending Physician/Nurse Practitioner within the facility.

4.6.1.2 Notify Population & Public Health Communicable Disease Coordinator to report an outbreak.

4.6.1.3 Notify and keep informed throughout the duration of the outbreak, the WRHA Manager, PCH Infection Prevention and Control.

4.6.1.4 Delegate the communication and education for the staff, volunteers and visitors.

4.6.1.5 Communicate the action plan to the various departments (e.g. housekeeping, laundry, dietary) and/or develop an outbreak management team that meets regularly to share pertinent information in a timely and effective manner.

4.6.2 Unit staff are responsible to:

4.6.2.1 Notify the ICP/designate of any new Scabies cases and suspected Scabies cases promptly upon recognition/suspicion.
4.6.2.2 Communicate Scabies status when transferring a resident to another facility. Inform the facility of any known or suspected Scabies or exposure to Scabies in the resident or in the transferring facility. Inform the receiving facility of the interventions taken to date.

4.7 Documentation

4.7.1 The ICP/designate is responsible for the following documentation:

4.7.1.1 If an outbreak is suspected, complete the Outbreak Report Manitoba Health Form Initial Assessment (Appendix D). Scabies outbreaks are not reportable using the Canadian Network for Public Health Intelligence (CNPHI) at this time. Fax a copy to:

- Manitoba Health CDC Unit fax # (204) 948-3044
- Population & Public Health Communicable Disease Coordinator fax # (204) 940-2690

Scan and email a copy the WRHA Manager, PCH Infection Prevention and Control

4.7.1.2 Use the Infestation Outbreak Investigation Form (Appendix C) as a tool to track cases in the facility. For internal use only; do not fax or email this document outside of the site as it contains confidential resident information.

4.7.1.3 At the end of the outbreak, complete the Outbreak Report Manitoba Health Form, Final Report (Appendix E). Fax a copy to:

- Manitoba Health CDC Unit fax # (204) 948-3044
- Population & Public Health Communicable Disease Coordinator fax # (204) 940-2690
- Scan and email the WRHA Manager, PCH Infection Prevention and Control

4.7.2 Nursing staff are responsible for the following documentation:

4.7.2.1 Documenting the results of daily assessments of signs/symptoms of Scabies infestation in the Integrated Progress Notes (IPN), until resolution.

**Guideline Contact: Manager, LTC Infection Prevention & Control**

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>LTC IP&amp;C Committee</td>
<td>September 3, 2015</td>
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<tr>
<td>LTC DOC</td>
<td>October 20, 2015</td>
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<td>October 29, 2015</td>
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<td>LTC Medical Advisory Council</td>
<td>October 15, 2015</td>
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Operational Guideline: Management of Scabies FINAL October 2015
5.0 REFERENCES:

5.1 APIC Text of Infection Control and Epidemiology (2005).


5.7 Chan, LY, Tang, WYM, Ho, HHF, & Lo, KK. (2000) *Crusted (Norwegian) scabies in two old-age home residents;* Hong Kong Medical Journal, (6), pp 428-430.


Does your resident have a skin condition that is **not responding to treatment**?

Does your resident have a rash or rashes in/on the:
- **✓** Wrists
- **✓** Anticubital fossa
- **✓** Areolas
- **✓** Beltline
- **✓** Webs of the fingers
- **✓** Axilla
- **✓** Buttocks
- **✓** Groin/Genitals

Think Scabies

Operational Guideline: Management of Scabies FINAL October 2015
**Skin scraping**

Skin scrapings are done to achieve laboratory confirmation of a scabies infestation. They may be done by a dermatologist or a trained professional. A ‘negative’ result does not always imply that mites are not present; as with any communicable disease, lab results must be collaborated with clinical presentation.

**Equipment:**
- Gloves
- Magnifying glass
- Light source
- Alcohol swabs
- #15 scalpel blades
- Glass slide

**Procedure:**
1. Shoulders, back and abdomen are choice areas in the elderly. Other sites: hands, wrists, elbows, feet, ankles, buttocks, axillae, knees, thighs and breasts
2. Use magnifying glass to identify recent burrows or papules. A bright light and magnifying glass will assist in visualizing the mite (tiny dark speck) at the end of the burrow
3. Explain the procedure to the resident and perform hand hygiene
4. Using an alcohol swab scrub the area to be scraped for 30 seconds and allow to air dry
5. Apply a single drop of mineral oil over unexcoriated burrow
6. Don gloves
7. Scrape non excoriated, non-inflamed areas (burrows) 6-7 times with a #15 scalpel blade until tiny specks of blood appear. The mineral oil will emulsify the scrapings
8. Using the blade put the emulsified scrapings on a slide; cover the slide with a cover slip
9. Send covered slide with a completed requisition to the Cadham laboratory for diagnostic purposes

**Burrow Ink Test (BIT)**

The BIT can be used as an alternative to skin scrapings to assist with the diagnosis of scabies. It is less invasive and does not require professional training to perform. The ink test does not always identify the presence of scabies mites (which occasionally appear as a tiny dark dot at the end of a track), but it can help illuminate the tracking caused by the mite as it burrows. As with any diagnostic test, results must be collaborated with clinical presentation.

**Equipment:**
- Gloves
- Alcohol swabs
- Dark colored washable wide-tipped marker

**Procedure:**
1. Explain the procedure to the resident and perform hand hygiene
2. Use the marker to ‘color’ over areas of suspected burrows
3. Wipe off ink with alcohol swabs or alcohol based hand rub and disposable towel

The alcohol will remove the most surface ink but will not remove the ink taken up by the burrow, thus leaving a dark irregular (often zig-zag) line illuminating the burrow track(s). If the resident has straight lines that take up ink these may be due to scratching and not the presence of burrowing mites.
## WRHA LTC IP&C OUTBREAK INVESTIGATION FORM

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB MM/DD/YY</th>
<th>AGE</th>
<th>Unit</th>
<th>RESIDENT Room #</th>
<th>STAFF</th>
<th>Signs and Symptoms (see legend)</th>
<th>Date of symptom onset</th>
<th>Date precautions started</th>
<th>Date precautions discontinued</th>
<th>Specimen Collection date/Date submitted</th>
<th>Lab confirmed (specify organism)</th>
<th>Clinical case only</th>
<th>DEATH?</th>
<th>HOSP?</th>
<th>Comments</th>
</tr>
</thead>
</table>

**Legend:**
- Ar = Arthralgia
- Ac = Acute cough
- F = Fever
- H = Headache
- P = Prostration
- My = Myalgia
- ST = Sore Throat/Difficulty Swallowing
- O = Other (see comments)

**Case Definition:**
- Maculopapular and/or itching rash, +/- physician diagnosis, +/- lab confirmation or link to another person with lab confirmed scabies

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Operational Guideline: Management of Scabies FINAL October 2015
## INITIAL OUTBREAK SUMMARY REPORT
(All OUTBREAKS EXCEPT: ENTERIC, RESPIRATORY or VACCINE PREVENTABLE DISEASE (VPD) OUTBREAKS)

Instructions: Upon suspicion of a communicable disease outbreak that IS NOT an enteric, respiratory or vaccine preventable disease outbreak, please complete the Outbreak Identification sections on both of these pages and the Initial Assessment. Please refer to "Enteric Outbreak Report" and "Respiratory/VPD Outbreak Report" for entering enteric, respiratory or VPD outbreaks.

### OUTBREAK IDENTIFICATION:

- Month outbreak recognized (MM/YYYY): ___ / ___
- CPL "outbreak" code: _____________ OR □ not assigned
- Choose one syndrome:  □ Fever/Rash  □ STI/UTI
  □ Fever/Headache  □ Other Specify: _____________
- Please choose a unique name to be used for this outbreak only: (max 20 letters, no numbers or special characters)

### INITIAL ASSESSMENT:

- Contact person: ____________________________
- Phone/fax: ____________________________
- RHA(s) involved: ___________________________
- Today's date (YYYY/MM/DD): ________ / ________ / ________
- Site/Location (check all that apply)

  □ Food handling establishment: ____________________________
  □ Geriatric extended care facility: ____________________________
  □ Other extended care facility: ____________________________
  □ Correctional facility: ____________________________
  □ General community on reserve – specify Reserve(s): ____________________________
  □ General community – specify area, city, town(s), etc. involved: ____________________________
- Total # cases: ____________________________

### Working case definition (check all that apply):

- □ Local working case definition included cases identified using clinical signs and symptoms
- □ Local working case definition used laboratory confirmed results
- Onset of first symptoms of first case (YYYY/MM/DD): ________ / ________ / ________
- Infectious agent: □ Unknown  □ Suspected  □ Confirmed (organism: ____________________________)

### Current/proposed interventions (check all that apply and provide details below)

- □ Handwashing/Hygiene enhancement
- □ Barrier procedures (e.g. gloving, etc.)
- □ Isolation/Restriction of movement
- □ Closure (e.g. institution, ward, restaurant)
- Details: ____________________________

### People notified (check all that apply):

- □ Facility infection control nurse
- □ Regional MOH(s)
- □ Environmental Health (PHI/EHO)
- □ Office of the Chief MOH
- □ Office of Drinking Water
- □ Cadham Lab Outbreak Liaison
- □ Cadham Lab Infection Control
- □ City of Winnipeg
- □ MSB
- □ Other: ____________________________

### Other details/comments: ____________________________

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**EMAIL COMPLETED REPORT TO:** OUTBREAK@GOV.MB.CA OR FAX TO: (204) 948-3044

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Operational Guideline: Management of Scabies FINAL October 2015
### FINAL OUTBREAK SUMMARY REPORT

#### (All Outbreaks Except: Enteric, Respiratory or Vaccine Preventable Disease (VPD) Outbreaks)

Instructions: Upon suspicion of a communicable disease outbreak that is NOT an enteric, respiratory or vaccine preventable disease outbreak, please complete the Outbreak Identification sections on both of these pages and the Final Report. Please refer to "Enteric Outbreak Report" and "Respiratory/VPD Outbreak Report" [here](http://www.gov.mb.ca/health/publichealth/surveillance/forms.html) for reporting enteric, respiratory or VPD outbreaks.

#### OUTBREAK IDENTIFICATION:

- **Month outbreak recognized (MM/YYYY):**
- **CPL "outbreak" code:** OR □ not assigned

Choose one syndrome:

- □ Fever/Rash
- □ STI/UTI
- □ Fever/Headache
- □ Other Specify: □

Please choose a unique name to be used for this outbreak only: (max 20 letters, no numbers or special characters)

#### FINAL REPORT:

- **Today's date (YYYY/MM/DD):**

#### RHA(s) involved (check all that apply):

- □ Winnipeg
- □ Southern
- □ Interlake-Eastern
- □ Northern
- □ Prairie Mountain

#### Working case definition (check all that apply):

- □ Local working case definition included cases identified using clinical signs and symptoms
- □ Local working case definition used laboratory confirmed results

#### Infectious agent:

- □ Unknown
- □ Suspected
- □ Confirmed (organism: )

Please list symptoms necessary to case definition:

#### Case details:

- **Onset of first symptoms (YYYY/MM/DD):**
- **First case:**
- **Last case:**
- **Outbreak finished:**

#### Case Numbers:

<table>
<thead>
<tr>
<th>Total cases</th>
<th>Symptomatic but NOT lab confirmed</th>
<th>Lab confirmed</th>
<th>Staff cases</th>
<th>Client cases</th>
</tr>
</thead>
</table>

#### Transmission mode and source with highest index of suspicion (check one in each column):

- □ Indirect (e.g. contact with inanimate object, insect/animal vector, airborne)
- □ Transfusion/Transplant/surgery
- □ Direct animal to person
- □ Sexually transmitted from person to person
- □ Fecal/oral transmitted person to person
- □ Droplet spread person to person
- □ Other:

#### Source:

- □ Water
- □ Food/food handler
- □ Animal
- □ Environment (e.g. soil, air conditioner)
- □ Biologic (e.g. blood, HGH, vaccine)
- □ Propagated:
- □ Break in control of endemic illness

#### Major interventions (check all that apply and provide details below):

- □ Closure
- □ Exclusion
- □ Prophylaxis
- □ Water boil order
- □ Product recall
- □ Training/education

Details:

#### Recommendations for policy/practice change(s):

Completed by: ___________________________ Organization: ___________________________

Epidemiology and Surveillance, Public Health Branch, Manitoba Health

Version dated: March 12, 2013

EMAIL COMPLETED REPORT TO: **OUTBREAK@GOV.MB.CA** OR FAX TO: (204) 948-3044

Operational Guideline: Management of Scabies FINAL October 2015