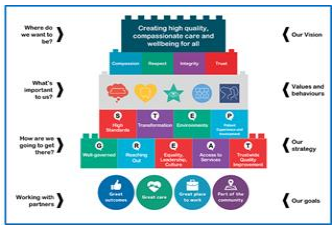


NHS
Leicestershire Partnership
NHS Trust

The management of head lice policy

This policy describes the processes and procedures for the management of head lice. It has been developed for staff working within the Leicestershire Partnership Trust (LPT)

Key words: Infection, Prevention, Control, Head Lice

Version: 8

Approved by: Infection Prevention and Control Assurance Group

Ratified By: Quality and safety committee.

Date this version was ratified: 19th June 2024

Date issued for publication: 21st June 2024

Review date: December 2026

Expiry date: 30th June 2027

Type of Policy: clinical and non-clinical.

Contents

Policy On A Page

SUMMARY & AIM

The aim of this policy is to provide information on the processes required when treating, managing, or giving advice on head lice. It will support the prevention of cross infestation amongst the wider population. The policy aims to give staff clear guidance on the means of transmission of head lice and potential risk to others and will provide information on the detection, treatment, and prevention of head lice. It will also provide staff with information on available products, treatment, contact and treatment times. It also gives clear guidance on procedures to use without the use of chemicals.

KEY REQUIREMENTS

This policy has been developed to give clear guidance to staff in relation to the procedures for the management of head lice set by Leicestershire Partnership Trust (LPT)

Direction for staff is given on the following:

- Means of transmission of head lice
- Potential risks of head lice to others
- Detection and diagnosis of head lice
- Treatment and prevention of head lice
- Management of head lice infestations

TARGET AUDIENCE:

This policy applies to all permanent employees working within Leicestershire Partnership Trust (LPT) including medical staff and any members of staff working on the bank, agency, or Honorary contract.

TRAINING

There are no training requirements relating to this policy.

1.0 Quick look summary

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
Version 1 Draft 1	March 2008	New guideline: infection Control guideline for the management of patients with head lice in the community health services, inpatient facilities and primary care.
Version 2 Draft 1	January 09	Review of guideline by Amanda Howell
Version 3 Draft 1	July 2010	Review of guideline for LCCHS and distributed for consultation.
Version 3 Draft 2	October 2010	Amendments following consultation process, comments received from: Tejas KHATAU, Zoe Harris, Clare Shaw, Chris Otway, Una Willis. Fay Findley, Sally O'Shea, and the health Protection Agency.
Version 3	October 2010	Copy approved at the critical Governance Committee.
Version 4	July 2011	Harmonised in line with LCRCHS, LCCHS (Historical Organisations) and LPT
Version 5	April 2018	Reviewed in line with current guidance and format updated in line with current LPT format.
Version 6	June 2021	Reviewed in line with current guidance- Guidance remains as current. Format updated in line with current LPT policy format.
Version 7	May 2024	Reviewed in line with current guidance, Format updated in line with current LPT policy format.

For Further Information Contact: Infection prevention and control team: 01162952320

1.2 Key individuals involved in developing and consulting on the document.

- Accountable director- James Mullens Interim Director of Nursing, AHPS & Quality,
  Emma Wallis deputy director of nursing & Quality
- Implementation lead- Amanda Hemsley Head of Infection Prevention & Control
- Author(s)- Reviewed by Claire King Infection Prevention & Control Nurse
- Core Policy reviewer Group- Infection Prevention & Control assurance Group

1.3 Governance

Level 2 or 3 approving delivery group – Infection Prevention and control Assurance Group

Level 1 Committee to ratify policy – Quality and Safety Group

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.6 Definitions that apply to this policy.

Consent: a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision.
- have received sufficient information to take it and not be acting under duress.

Due Regard: Having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Head louse/lice- Small wingless, insect with claws which lives on the human head and eyebrow hair.

Infestation- The presence of animal parasites such as fleas, mites, and tapeworms on the skin or in the body, or in the clothing or the home.

Nits- Empty egg cases

Parasite- Any living organism that lives in or on another living organism.

Public Health Consultant- A consultant who is knowledgeable in infectious diseases.

Source isolation precautions-Precautions implemented within inpatient facilities to minimise the risk of transmission of a known or suspected infection form one patient to another.

2.0 Purpose and Introduction/Why we need this policy.

2.1 Purpose of the Policy

Staff working within Leicestershire Partnership Trust (LPT) provides a number of health services to the wider community. This policy provides information on the processes required when treating, managing, or giving advice on head lice. It will support the prevention of cross infestation amongst the wider population. The policy has been produced in accordance with published evidence and national best practice guidelines.

This policy describes the means of transmission of head lice and the potential risk to others. It also provides information on detection, treatment, and the prevention of

head lice, as well as different products that can be used, contact and treatment times and details of procedures that can be undertaken without the use of chemicals.

2.2 Introduction

Head lice are a common problem and though there are no figures available for the number of people in Britain with head lice at any one time a national survey conducted in wales suggested that the figures could be as high as 10%. About 80% of cases are amongst children between the ages of 4-16, head lice being the most common amongst the 7–11-year age group, especially girls.

The main source of infestation from head lice is in the community and adults as well as children can be infected.

This policy is designed to give staff clear guidance to staff on how head lice are transmitted and the risks this poses to others, how to detect head lice and advice on available treatment for head lice infestation.

3.0 Policy Requirements

3.1 Head lice facts

The louse (Pediculosis Human Captius) is a small wingless insect with claws which lives on the human head and eyebrow hair and is about the size of a pinhead and greyish brown in colour.

The severity of the infestation varies from a few lice (less than 10) to more than 1000 in severe cases, but typical infestation might have about 30 lice per head. If left untreated, head lice infestation may persist for long periods.

There are 3 stages in the life cycle of the louse, Nits, Nymphs, and adults.

NITS

Nits are head lice eggs and are oval, yellowy white eggs which are difficult to see and may be confused with dandruff. They attach themselves to the hair shaft and take about 7-10 days to hatch. The eggs remain after hatching and many nits are empty cases.

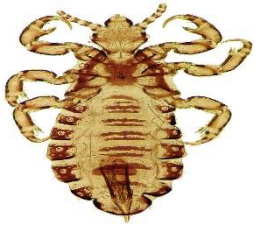
Nymphs

Nymphs hatch from Nits, the baby lice look like the adults but are much smaller in appearance, they take approximately 7 days to mature to adults and feed on blood to survive.

The nymph is on the left of the picture, adult louse is on the right.

Adults

Adults are about the size of a sesame seed and have 6 legs and are tan/greyish white in colour. The legs have hook like claws which are used to hold onto the hair with, adults can live up to 30 days and survive by feeding on blood.



Once hatched, nymphs feed on blood drawn from the scalp of their host and grow into adult lice (Aronson & Shope, 2009). They are then able to reproduce for 2-3 weeks, and the female louse may lay up to eight nits each day,

In general adult lice that successfully feed on a human host may survive up to 40 days and can start laying eggs when they are 7 days old. Adult lice are the size of a sesame seed, a female will live for approximately one month laying 4-6 eggs a day which take up to 7-10 days to hatch. During their lifespan they are capable of laying 100 eggs. They cannot live more than 48 hours away from a feeding source. Both saliva and faecal matter from lice may lead to inflammation of the hosts scalp and itching may continue for weeks after treatment.

Infestation of head lice rarely leads to secondary infection, but it is possible in patients who scratch the affected area. Live lice can be transmitted through close personal contact or sharing of personal items such as pillows, hats, or hairbrushes (ferri, 2012). They cannot fly or jump neither can they burrow into the scalp.

Head lice are not spread or eradicated when a patient is swimming: when immersed in sea water or chlorinated water, head lice have been observed to become immobile and grip firmly to the patient's hair. As soon as head lice are removed from the water they begin to feed, death was not observed within 4 hours after a 30-minute submersion and recovery in both types of water (Canyon &Speare 2007).

Head lice stay close to the scalp where it is warm and they can easily feed by sucking blood, they lay their eggs close to the scalp also gluing them to the base of the hair. The eggs are yellowy/white colour until they hatch, making them difficult to detect. As soon as the louse feeds it becomes coloured but remains camouflaged by reflecting the colour of its surroundings. Live eggs and head lice are not spotted easily on the head.

Nits are empty egg cases left after the louse has hatched, these are glued onto the hair shaft; they are white and can look like dandruff but are shiny and are difficult to remove from the hair.

Nits may be present, but this does not automatically mean that the person has live lice on their head: close inspection should be undertaken to ascertain if there is an

active case of head lice. An individual only has head lice if they can find a living moving louse (Not a nit).

3.2 Clinical features of head lice

The majority of infestations are asymptomatic, lice use a local anaesthetic to make the feeding process painless. An allergic reaction develops to the louse saliva causing an itch. This reaction can take up to 3 months to develop and carriers easily become desensitised and no longer notice the bites.

When noticed though symptoms may include:

- Itching and/or tickling feeling of something moving in the hair
- A pruritic (Itchy eczema like rash) may be apparent at the back of the neck.
- Secondary bacterial infection may be a complication.
- Scratch marks and a sticky weeping scalp may be visible.
- Small itchy pink bumps around the edge of the scalp, particularly on the back of the neck.
- Enlarged glands in the neck and impetigo (bacterial infection)
- Secondary bacterial infection may be a complication.

3.3 Diagnosis of head lice

Diagnosis can only be made by demonstrating the presence of live lice, in most cases this can be best achieved by using a detection comb (Available from pharmacists) on wet hair to remove any live lice. The detection comb has been specially developed to remove head lice. This is by way of the small diameter of the teeth on the comb. Normal combs do not achieve the same result as the teeth are to wide apart. Head lice become immobile when wet so are easier to remove from the hair shaft.

Wet combing is a method of detecting live head lice, but it can also be used as a treatment method (See section 3.4).

To detect head lice, you will need the following:

- A plastic detection comb (Teeth spacing of <0.25mm)
- Any brand of hair conditioner (The purpose of the conditioner is that it makes the hair too slippery for the lice to hold on to)
- A piece of white paper
- Good lighting

Before detecting lice, you may need to untangle the hair using a normal comb (Which should be washed prior to re-using)

Fine metal combs are not recommended as they can damage the skin and pull the hair which can cause it to break off at the roots.

- Wash the hair well with ordinary shampoo (any brand is suitable), rinse then towel dry using a clean towel (The hair should be damp).
- Apply hair conditioner, do not rinse off (A **2 in 1 shampoo/conditioner preparation is not acceptable)**
- Starting with the teeth of the detection comb touching the skin of the scalp at the top of the head, comb carefully towards the end of the hair onto a piece of white paper, this aids visible identification.
- Look carefully at the teeth of the comb in good light: any head lice will be caught between the teeth, wipe the comb between strokes.
- Do this repeatedly from the top of the head to the end of the hair, working all the way around the head.
- The process will take a minimum of 10-15 minutes to be performed effectively.
- Rince the conditioner out of the hair
- Dry hair naturally or with a hair drier
- Complete wet combing on days 1,5,9 and 13 to catch any newly hatched headlice.
- Check that the hair is free of headlice on day 17.
- Wash combs with warm soapy water after each use
- Wash towels/linen as normal (Do not share linen)

When a case of head lice is detected, all those that have been in close contact with that person should be informed and advised to have their hair checked preferably using the wet combing method.

3.3 Transmission of head lice

Lice are transmitted by human head-to-head contact; lice crawl they cannot jump or fly. It is not scientifically proven that head-to-head contact has to be prolonged to catch head lice- close contact is enough with just enough time to allow a louse to move from one head to another.

Head lice that are found in clothing and bedding will be dying and can readily be washed off. Once away from the scalp of the human host they have lost their source of food and warmth and will die within 1-2 days. Lice that live in clothing are clothing lice and are rare in developed countries.

Head lice that are caught on combs and brushes are rarely damaged and can re-establish themselves if brushed back into the hair within 24 hours. Combs and brushes should always be checked and washed with detergent and water and rinsed between uses and should not be shared with others.

3.4 Treatment of head lice

Can a head lice infestation be treated?

Yes, but it is not always easy as some lice are now resistant to the insecticides used to treat them and repeated infestations are common.

How can a head lice infestation be treated?

Treatment is needed only when an active louse infestation is present as shown by the presence of living and moving lice or of eggs that have not hatched and are attached to the hairs close to the scalp. Neither itching by itself, nor evidence of an old infestation (Only empty egg cases) is a reason for starting treatment.

Background

Neuro-toxic, insecticide medications are not recommended within these guidelines for the treatment of head lice. This includes lotions, liquids, crème rinse, mousse and shampoos containing malathion, permethrin, phenothrin or carbaryl.

Treatment failure using insecticides products is common, but it is unclear whether this is due to poor application of the product, or resistance issues. In recent years head lice have become resistant to many existing treatments resulting in long term infestations within schools and communities (Downs et al 2002).

‘**Natural’ medications are not recommended within these guidelines for the treatment of head lice,** this includes shampoos, solutions, conditioners containing plant essentials oils, enzymes, and herbal extracts etc. They are usually marketed as a substitute for insecticides to be used in conjunction with a detection comb.

There is no proof of effectiveness of these products and they are unlikely to kill eggs some that have been tested have been found not to have any effect at all. They may be potentially toxic or an irritant and may contain conventional pesticide residue.

Electronic combs are not recommended within these guidelines for the treatment of head lice. These are battery powered devices with fine-tooth metal

combs that aim to electrocute the lice with an electrical current that runs through the teeth.

These devices are no safe to use on wet hair and when used on dry hair the lice move away from the disturbance and therefore evade the comb teeth and electrocution. They cannot be used on people with epilepsy, heart disease, those with pacemakers or other neurostimulator.

Wet combing is recommended within these guidelines for the detection of head lice. However, it can also be used as a treatment method. Wet combing as described in section 3.3 can be repeated 3 times at intervals of 4 days to gradually remove all adult lice and the lice as they hatch from the eggs. The combing process is time consuming: the length of time it takes is dependent upon the extent of the infestation and the length of hair. A bug buster kit containing special combs is available from the community hygiene concern (https://www.chc.org).

The bug busting technique has been reported to be highly effective at eradicating infection and is particularly useful for treating children. However, controversy exists about the practicality of mechanical method of lice eradication that is very time consuming.

First line treatment

First line treatment is with 4% dimeticone lotion.

This is an odourless, colourless formulation which does not contain neurotoxin insecticides and can be purchased over the counter at pharmacists and retail outlets. It contains 4% dimeticone (a silicone) in a silicone base called cyclomethicone. Both silicones are used extensively in cosmetics and toiletries.

The product dries by the evaporation of the cyclomethicone, leaving the dimeticone fully encapsulating the louse and thus killing it by preventing it from functioning. As dimeticone lotion kills lice physically rather than poisoning, it is effective against lice resistant to insecticide treatments. Lice cannot become resistant to this type of treatment.

As dimeticone is not absorbed through the skin it can be used on children (From 6 months of age) and can be recommended for asthmatics, pregnant women and breast-feeding mothers, it can also be used repeatedly as required. In a previous clinical trial 2% of patients reported irritant reactions to dimeticone and 9% to phenothrin (BMJ,18th June 2005, pp 1423-1425).

Treatments should only be started when living lice have been shown to be present. To ensure that the treatments work it is important that it is applied correctly as per manufacturer's instructions.

This is normally a two-dose treatment, it should be applied to dry hair, ensuring that the hair is fully covered from roots to tip and should be left to dry for 8 hours or left overnight. The hair can then be washed and combed in the usual way to remove dead the dead lice. The nits can be removed with the fingers or a fine-toothed comb. A second treatment should be applied after 7 days to deal with any eggs that may have hatched since the first application. To check that the treatment has been effective use a detector comb 24 hours after the second treatment. If live lice are found, then the entire treatment should be repeated until no live lice are present. A 50ml bottle should be sufficient for a two-dose treatment of short hair, longer hair or multiple treatments will require a 150ml bottle.

If repeated treatment with this product, 4% Dimeticone does not clear an infestation or a patient is not able to or will not use Hedren, an alternative method of treatment will have to be considered. The UK Health Security Agency (UKHSA) East midlands Branch should be contacted for alternative treatment. Their contact details are as follows: Telephone 03442254254 (Option 1)

3.5 Infection prevention and control precautions within in-patient areas

Patient who has an active case of head lice must be nursed using source isolation precautions until 24 hours following completion of the initial treatment and the hair has been checked and is clear of live lice.

The infection Prevention and Control team must be informed which can be done by one of the 3 methods listed below:

- **Phone**: 0116 295 1668 (Answerphone service)
- **Staffnet**: Send an automated email alert to IPC via Staffnet. https://staffnet.leicspart.nhs.uk/support-services/infection-prevention-control/contact us/ipcform/
- **E-Referral on SystmOne**:

All of the patient's night clothing and bed linen once treatment is completed must be washed and changed, all linen will need to be treated as infective and will need to be placed in the appropriate waste streams:

Infectious linen includes linen that has been used by a patient who is known or suspected to be infectious and/or linen that is contaminated with blood and/or other body fluids e.g., faeces:

- Infectious linen must not be sorted but should be sealed in a water-soluble bag, which is then placed in an impermeable bag immediately on removal from the bed/chair etc. and secured before it is transported to the waste disposal room.

- Infectious linen bags/receptacles must be tagged (e.g., Hospital ward/care area) and dated.
- Used/infected linen must be stored in a designated, safe, lockable area whilst waiting for collection.

Patients should be treated with a lotion whose active ingredient is 4% dimeticone lotion. In difficult cases where a patient cannot comply with treatment or if the following treatment with the lotion which has the active ingredient of 4% dimeticone lotion live lice are still detected please contact UKHSA to discuss the use of an alternative lotion. This alternative treatment should only be prescribed following discussion with a public health specialist.

3.6 Infection prevention and control precautions within the community

Adults or children with an active case of head lice should not be excluded from nursery, educational establishments or work or any other social contact.

It is recommended that following the detection of live head lice treatment is carried out before returning to nursery, educational establishments work.

In a school setting where a number of children are affected with head lice it may be appropriate to inform parents of the situation. This should not be routine when there is one affected child. The school nurse and/or health visitor need to be involved to offer support and education to parents and children on the management of head lice.

There is no need to specially treat clothing or linen that has been in contact with anyone who has live head lice. It should be washed as per manufacturer's instructions.

3.7 Risks to staff

There is minimal risk to staff as there needs to be direct head-to-head contact for the lice to transfer from one head to another.

3.8 Family members, carers, and close associates.

Family members, carers and close associates do not need to be treated unless live head lice are detected. It is therefore important that anyone having head-to-head contact with the affected person is advised to have their hair checked using the wet comb method.

3.9 Prevention

When a case of head lice is detected all those that have been in close contact with that person should be informed and advised to have their hair checked, preferably using the wet combing method described in section 3.3.

Following treatment of head lice, it is recommended that wet combing is used weekly as a preventative measure. It should be introduced as part of the childs bathing routine, using conditioner and wet combing technique to check for live lice.

It is recommended that those households with school age children (particularly nursery and primary school age) make wet combing a weekly activity for all members of the household.

Hairbrushes and combs should not be shared, it is unlikely that head lice are transferred this way but if a hairbrush is used immediately after someone with head lice there is potential for a louse to be transferred via the brush.

4.0 Duties within the Organisation

Duties in regard to this policy can be located in the LPT infection prevention and control assurance policy.

5.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

6.0 Monitoring Compliance and Effectiveness

Compliance with regards to this policy is outlined in the LPT Infection Prevention and Control Assurance policy.

7.0 References and Bibliography

Aronson, SS & Shope TR Managing infectious diseases in childcare and schools: A quick reference guide 2nd ed, American Academy of paediatrics, Elk Grove Village IL 2009.

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https://www.chc.org

https://wwwcks.nice.org.uk/topics/head-lice/diagnosis

https://www.gov.uk/guidance/head-lice-pediculosis

NHS England National Infection Prevention and Control manual for England: v2.9 15th February 2024.

Pontius DJ Demystifying pediculosis: school nurses taking the lead. Paediatric Nursing 2014 Sep-Oct;40 (5) 226-35

https://www.nhs.uk/conditions/head-lice-and-nits

8.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix 1 Training Needs Analysis

Training topic/title:	No training required to support implementing this policy		
Type of training: (see Mandatory and Role Essential Training policy for descriptions)	**Yes - Not required** ☐ Mandatory (must be on mandatory training register) ☐ Role Essential (must be on the role essential training register) ☐ Desirable or Developmental		
Directorate to which the training is applicable:	☐ Directorate of Mental Health ☐ Community Health Services ☐ Enabling Services ☐ Estates and Facilities ☐ Families, Young People, Children, Learning Disability and Autism ☐ Hosted Services		
Staff groups who require the training: (consider bank /agency/volunteers/medical)			
Governance group who has approved this training:		Date approved:	
Named lead or team who is responsible for this training:			
Delivery mode of training: elearning/virtual/classroom/ informal/adhoc			
Has a training plan been agreed?			
Where will completion of this training be recorded?	☐ uLearn ☐ Other (please specify)		
How is this training going to be quality assured and completions monitored?			
Signed by Learning and Development Approval name and date	A O'Donnell. ALISON O'DONNELL.	Date: May 2024	

Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers- yes.

Respond to different needs of different sectors of the population- yes.

Work continuously to improve quality services and to minimise errors- yes.

Support and value its staff -yes

Work together with others to ensure a seamless service for patients- yes.

Help keep people healthy and work to reduce health inequalities -yes.

Respect the confidentiality of individual patients and provide open access to information about services, treatment, and performance yes

Appendix 3 Due Regard Screening Template

Section 1	
Name of activity/proposal	The management of head lice policy
Date Screening commenced	05-06-2024
Directorate / Service carrying out the assessment	Enabling Infection Prevention and control team
Name and role of person undertaking. this Due Regard (Equality Analysis)	Claire King Infection Prevention and Control Nurse
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The aim of this policy is to provide staff with information on the processes required when treating, managing, or giving advice on head lice. The policy aims to give staff clear guidance on the means of transmission of head lice and potential risk to others and will provide information on the detection, treatment, and prevention of head lice. It will also provide staff with information on available products, treatment, contact and treatment times. It also gives clear guidance on procedures to use without the use of chemicals.	
OBJECTIVES: The objective of this policy is to provide staff with clear guidance in relation to the procedures for the management of head lice set by Leicestershire Partnership Trust (LPT) Direction for staff is given on the following: ➢ Means of transmission of head lice ➢ Potential risks of head lice to others ➢ Detection and diagnosis of head lice ➢ Treatment and prevention of head lice Management of head lice infestations	
Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	None Identified
Disability	None Identified
Gender reassignment	None identified
Marriage & Civil Partnership	None identified
Pregnancy & Maternity	None identified
Race	None identified
Religion and Belief	None identified
Sex	None identified
Sexual Orientation	None identified
Other equality groups?	None identified
Section 3	

Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		No - tick	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	
Section 4			
If this proposal is low risk, please give evidence or justification for how you reached this decision:			
Signed by reviewer/assessor	Claire King	Date	05-06-2024
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Emma Wallis	Date	05-06-2024

Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.		
Name of Document:	The management of head lice policy	
Completed by:	Claire King	
Job title	Infection Prevention and Control Nurse	Date; 05-06-2024
Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	NO	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	NO	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	NO	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	NO	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	NO	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	NO	

7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	NO	
8. Will the process require you to contact individuals in ways which they may find intrusive?	NO	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.		
Data Privacy approval name:		
Date of approval		

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Checklist for the review and approval of policies

Document on how to make a word document accessible

Governance of Trust Policies_.docx

Policy Group.txt